

BMJ Open Mapping the evidence of intimate partner violence among women living with HIV/AIDS in sub-Saharan Africa: a scoping review

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ABSTRACT

Objectives The present study undertakes a scoping review aimed to map the evidence of intimate partner violence (IPV) against women living with HIV/AIDS in Africa.

Design We used the online database to identify papers published from 1 January 2009 to 1 April 2019, from which we selected 21 articles from Uganda, Nigeria, Kenya, South Africa, Zambia, Ethiopia, Cameroon, Tanzania and Swaziland that used IPV as an outcome variable among women living with HIV/AIDS.

Data sources PubMed, MEDLINE, EBSCO host, Google Scholar.

Eligibility criteria We included women who were aged 15 years and above, living with HIV/AIDS in sub-Saharan Africa.

Data extraction and synthesis We conducted the abstract screening with two independent reviewers. We also performed full-text screening. We used the six methodological frameworks proposed by Arksey and O'Malley. The Mixed Method Appraisal Tool was used to determine the quality of the studies. We used NVIVO software V.12 to undertake a thematic analysis.

Results Of the studies, the majority, 57.1%, reported cross-sectional results. In comparison, 23.8% examined qualitative studies, 9.5% were clinical trials, 4.8% were cohort studies and the remaining 4.8% covered grey literature. This review revealed evidence of IPV experience among women with HIV/AIDS, evidence of how HIV status disclosure influences IPV, proof of the association of sociodemographic characteristics with IPV and implications for practice. Moreover, the review revealed that following the serostatus disclosure, there is evidence of heightened risk for IPV.

Conclusions This study found evidence of IPV among women living with HIV/AIDS. The HIV-positive women were at considerable risk of IPV after disclosure of their serostatus to a male partner. Therefore, further research is needed to promote action to reduce IPV among HIV-positive and HIV-negative women and to determine healthcare workers' IPV screening experience.

INTRODUCTION

Women living with HIV/AIDS who disclose their HIV serostatus are more likely to experience intimate partner violence (IPV) than women who are HIV-negative.¹ Among the

Strengths and limitations of this study

- This review aimed to assess in-depth associations among women living with HIV/AIDS, and we obtained baseline evidence for future research in intimate partner violence (IPV).
- One of the limitations of this review is that it only included the literature published in the English language.
- The studies published in other languages were not included and the additional evidence of IPV among women infected with HIV/AIDS was not part of this review's assessment is also a limitation.
- We did not include all the articles in our review because some were published in journals inaccessible to us.

former, IPV and HIV/AIDS may provide overlapping, or perhaps intersecting, challenges.² The reason that women experience this violence is that the abusers have usually been shown to want to establish and maintain power and control over another person. This is often reflected in the imbalance of power between the women and their abusers.³ IPV is defined as any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship. This also includes emotional abuse and controlling behaviours by an intimate partner.⁴

Worldwide, IPV is of public health and social concern. The prevalence of IPV in the WHO's different regions varies but was similar in the Eastern Mediterranean and South-East Asian regions, where IPV was reported to be 37% and 37.7%, respectively, to that in sub-Saharan Africa (SSA), where the prevalence was 36.6%.⁵ Over a third of women in SSA reported IPV, and because this high prevalence of IPV was among both women and young girls, it is of concern.^{2,5} The harmful consequences of IPV among women and

Box 1 The proposed scoping review following the six Arksey and O'Malley steps

Stage 1: formulating the study question.
 Stage 2: identifying the relevant studies.
 Stage 3: study selection.
 Stage 4: charting the data.
 Stage 5: collating, summarising and reporting.
 Stage 6: consultation.

young girls are well documented and have been shown to affect their mental, sexual and reproductive health.⁵⁻⁷ In response to stress due to abuse, the immune system can be compromised, which later exacerbating the spread of cancer and viral infections.⁵ To the biological stress response, there are behavioural and other risk factors that also influence the link between IPV and adverse health outcomes.⁵

Studies on IPV and depression show that women who are exposed to physical violence, childhood sexual abuse, mild or severe emotional violence and high levels of spousal control are more likely to be depressed,⁶⁻⁸ to abuse alcohol⁵⁻⁷ and give birth to babies of low birth weight.⁵⁻⁷ Since they may not be able to negotiate condom use,⁵⁻⁷ they are also at risk of sexually transmitted infections, including HIV/AIDS.^{5-7,9}

The relationship between IPV and HIV/AIDS among women and young girls is a topic of intense debate within the scientific community.^{2,10} Some researchers consider that IPV increases women's vulnerability to HIV infection,¹⁵⁻⁷ while other researchers suggest that HIV-positive status among women may influence IPV.^{2,11} A study conducted in Zimbabwe among pregnant women living with HIV/AIDS revealed an IPV prevalence of 40%.¹² Another study in Kenya showed that after HIV-positive serostatus disclosure, one in three women experienced IPV.¹³ Moreover, both the combination of physical and sexual IPV (OR: 2.00; 95% CI 1.24 to 3.22) and the experience of any type of IPV were associated with HIV/AIDS infection in women (OR=1.41; 95% CI 1.16 to 1.73).¹⁴

IPV and HIV/AIDS are thus two pandemics that require integrated and collaborative interventions. The Joint United Nations Programme established new targets for the scaling up of HIV/AIDS treatment by 2030. Among its aims are to increase the number of people who know their HIV/AIDS status by 90%, to increase the number of people who receive sustained antiretroviral therapy (ART) by 90% and to strive to ensure that 90% of all people who are HIV/AIDS seropositive receive ART.¹⁵ These new targets are promising, but achieving them could be compromised by women and young girls experiencing IPV. Therefore, we conducted a scoping review to systematically map the IPV research conducted among women living with HIV/AIDS to identify the existing gaps in knowledge. The information generated through this scoping review can be used by researchers, policymakers

and programme developers to foster appropriate programmes and policy frameworks.

METHODS

The protocol¹⁶ of this review was published in the *BMJ Open*. Currently, the International Prospective Register of Systematic Reviews does not register a scoping review. This review is part of a large-scale study on IPV among women in Ethiopia living both with and without HIV/AIDS. We used the six frameworks proposed by Arksey and O'Malley¹⁷: (i) identifying the research questions and defining the eligibility criteria; (ii) identifying relevant studies by conducting an extensive search; (iii) making the study selection and appraising its quality; (iv) synthesising the included studies (charting the data) and presenting the findings by using a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) chart; (v) collating, summarising and reporting; (vi) consulting (box 1).

Stage 1: identifying the research questions

This scoping protocol is based on the following research questions:

1. Is there evidence of IPV experience among women living with HIV/AIDS in Africa?
2. Is there evidence that shows that HIV/AIDS status disclosure influences IPV among women in Africa?
3. Is there evidence that sociodemographic characteristics are associated with IPV among women living with HIV/AIDS in Africa?

Eligibility criteria

Inclusion criteria

1. Studies with study participants aged 15 years and above.
2. Studies with evidence of IPV against women.
3. Studies with evidence about HIV-positive persons.
4. Studies on IPV over the past 10 years for the maximum amount of updated information: years of publication from 1 January 2009 to 1 April 2019.
5. Peer-reviewed literature, grey literature, government documents, policy briefs, systematic reviews and meta-analysis.
6. Studies conducted in sub-Saharan African countries (all the countries in Africa except Algeria, Djibouti, Egypt, Libya, Morocco, Somalia, Sudan and Tunisia).

Exclusion criteria

Articles published in a language other than English.

The elements of the population, concept and context criteria to map studies correctly¹⁸ (table 1).

Stage 2: identifying the relevant studies

We created a Google form to search the literature in which we included the topic of the study, author and date and a review questionnaire. The Google form enabled screeners to record studies for screening that have been included in the Endnote library. We inserted the keywords

Table 1 PCC framework

PCC	Description
P=Population	The population for this study were all women aged 15 years and above living with HIV/AIDS or receiving ART
C=Concept	IPV (physical, and/or sexual and/or emotional/psychological violence) or domestic violence
C=Context	Sub-Saharan African countries where the problem of IPV mostly exists among women living with HIV/AIDS

ART, antiretroviral therapy; IPV, intimate partner violence.

into the PubMed advanced search menu, and the results that appeared were selected and exported to Endnote.

In addition, using a comprehensive strategy, we searched for published evidence and included it in this study. A variety of literature, including peer-reviewed articles and grey literature, were retrieved. In the PubMed advanced search, we used MeSH terms such as IPV, women, HIV, Africa, domestic violence, and focused on dates of publication after 1 January 2009.

In addition to PubMed, we used MEDLINE with full text via EBSCO host, Google Scholar, Science Direct and Scopus. We found a total of 750 articles from the PubMed search and identified 128 additional records through other sources. We completed the search on 8 April 2019 (online supplemental file 1).

Stage 3: study selection

Screening

In our search strategy, we piloted to check the appropriateness of the selected electronic databases and the keywords we decided to include. The principal author conducted title screening, and two reviewers conducted the abstract screening independently. The purpose of the title screening was to assess the titles for eligibility and to remove duplicates. We created an Endnote library to which all the eligible titles were exported. We removed any duplicates before the screening of the abstract. Relevant articles based on the inclusion criteria of the scoping review were selected.

The independent reviewer abstract screening was to minimise reporting bias.¹⁸ Moreover, we undertook the full-text article screening independently, based on the eligibility criteria. We contacted the authors for the articles that were not available electronically and requested these be sent to us directly. During the full article retrieval, we used the University of KwaZulu-Natal library. When a disagreement arose between the two reviewers, a third reviewer made the decision. We presented the update of the findings by using a PRISMA chart.

Quality assurance of the study

To determine the methodological quality, we adapted and used the Mixed Methods Appraisal Tool (MMAT) 2018

version to evaluate each review.¹⁹ Additionally, we used the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols 2015 and PRISMA Extension for Scoping Reviews checklists to check whether the recommended items were included or not.^{20 21} During analysis, we reviewed the checklist of the Consolidated Criteria for Reporting Qualitative Research, a 32-item checklist for interviews and focus group discussions.²²

Stage 4: charting the data

We used the data charting table (table 2) to extract the necessary background information and to extract information from each selected study. We used an Excel spreadsheet for the data charting. This form highlighted essential ideas regarding the variables from the background and included the research questions which were addressed by the variables and the themes. Two reviewers jointly developed the data charting form to decide which variables to extract, which they charted independently. We continuously updated the data charting form during the duration of the study.

Data items

We abstracted data on the article characteristics (eg, year, country of origin), aim of the study, IPV and population (HIV-positive women), sample size, age group, and the study design.

Stage 5: collating, summarising and reporting the result

We undertook qualitative data analyses using NVIVO software V.12 to collate, summarise and report the results. First, the researchers read and reread the articles thoroughly, noting down the initial ideas to find codes. The notable features of the data across the entire article were systematically coded, and data relevant to each code was collated. We then developed the codes into potential themes and finally defined and named the themes and produced the report.²³ We used the description of the coding tree and thematic content analysis to analyse the data. We extracted and coded the data that were related to the IPV experience among HIV-positive women, identified the emerging themes and then coded the data according to these themes. The analysis process used the following steps: (i) coding data from the selected articles; (ii) categorising the codes into themes; (iii) displaying the data; (iv) identifying key patterns in the data and the subthemes; (v) summarising and synthesising.

Stage 6: consultation

We held consultations with the stakeholders, such as policymakers (two), clinicians (three), patients (five) and families (two), in addition to other appropriate groups who researched IPV, in order to obtain more references and to provide insights on what the literature failed to highlight.²⁴ Moreover, these consultations helped in mapping the evidence of the existence of physical, emotional and sexual violence among HIV infected women. The talks helped to gain further insight into IPV.

**Table 2** Data charting table

Author	Country	Study aim	Population	Sample Size	Age group (years)	Study design
Ashaba <i>et al</i> ²⁵	Uganda	To explore psychosocial challenges experienced by women living with HIV	Women	20	22–40	Qualitative
Bernstein <i>et al</i> ²⁶	South Africa	To assess the prevalence and correlates of IPV among HIV-infected pregnant women	Women	623	18–44	Cross-sectional
Lauren and Van Zyl ²⁷	South Africa	To measure how IPV impacts women's safety following mobile HCT diagnosis	Women	255	18+	Clinical trial
Colombini <i>et al</i> ¹³	Kenya	To explore women's experiences of IPV risks following disclosure to their partner	Women	30	15–49	Qualitative
Conroy <i>et al</i> ²⁸	Uganda	To examine the association between relationship power and sexual violence	Women	307	19–75	Cross-sectional
Emusu <i>et al</i> ²⁹	Uganda	To explore the experiences of sexual violence among women in HIV-discordant unions	Women	26	Not mentioned	Qualitative
Ezeanochie <i>et al</i> ³⁰	Nigeria	To evaluate the prevalence and correlates of IPV among HIV-positive women	Women	305	21–43	Cross-sectional
Ezechi <i>et al</i> ³¹	Nigeria	To determine the prevalence, types and correlates of IPV	Women	652	<20–≥40	Cross-sectional
Fiorentino <i>et al</i> ³²	Cameroon	To assess the prevalence and factors of IPV against HIV-positive women and its relationship with ART interruption ≥1 month	Women	894	≥21	Cross-sectional
Hampanda <i>et al</i> ³³	Zambia	To determine how IPV against HIV-positive women affects safe infant feeding practices	Women	320	18+	Cross-sectional
Hampanda and Rael ³⁴	Zambia	To advance the current understanding of the relationship between IPV against women and their HIV status disclosure behaviours	Women	320	18+	Cross-sectional
Iliyasu <i>et al</i> ³⁵	Northern Nigeria	To assess prevalence and risk factors of domestic violence among HIV-positive women	Women	300	18–70	Descriptive and cross-sectional
Malaju and Alene ³⁶	Ethiopia	To assess women's expectations of their partner's violence on the disclosure of the HIV test	Women	400	15–49	Cross-sectional
Mulrenan <i>et al</i> ³⁷	Swaziland	To explore the risks of experiencing IPV after HIV infection among women with HIV	Women	19	18–44	Qualitative

Continued

Table 2 Continued

Author	Country	Study aim	Population	Sample Size	Age group (years)	Study design
Olowookere <i>et al</i> ³⁸	Nigeria	To assess the prevalence and correlates of IPV among women living with HIV/AIDS in an antiretroviral clinic in Nigeria	Women	360	18+	Cross-sectional
Onu <i>et al</i> ³⁹	Kenya	To examine SV against HIV-positive women enrolled in HIV care in Kenya	Women	25	18+	Qualitative
Osinde <i>et al</i> ⁴⁰	Uganda	To measure the prevalence and factors associated with IPV among HIV-infected women	Women	317	15+	Cross-sectional
Wilson <i>et al</i> ⁴¹	Kenya	To assess the prevalence and correlates of IPV in the past year by a regular male partner in HIV-positive female sex workers in Mombasa, Kenya	Women	357	18+	Cross-sectional
Young <i>et al</i> ⁴²	Uganda	To examine physical and sexual IPV prevalence and correlates among WLWH in Uganda	Women	455	18+	Cohort
United Nations Educational, Scientific and Cultural Organization ⁴⁴	Tanzania	To discuss the links between gender-based violence and HIV and AIDS in conflict and post-conflict situations in the Great Lakes Region	Women	N/A	N/A	Workshop report
Matseke <i>et al</i> ⁴³	South Africa	Intimate partner violence among HIV positive pregnant women in South Africa	Women	673	18+	A clinic-randomised, controlled trial

ART, antiretroviral therapy; HCT, HIV Counseling and Testing; IPV, intimate partner violence; SV, Sexual Violence; WLWH, Women Living With HIV.

RESULTS

Screening results

We found 750 articles in the original data search. A total of 159 publications remained after we removed duplicates and other unrelated topics. A 136 articles were excluded, which did not meet our inclusion criteria, and 23 items were included for full-text screening. After the full-article screening, we excluded two studies, providing reasons for this, and a final 21 articles remained from which to extract data (figure 1).

Characteristics of the included studies

Out of the 21 included studies, 20 were published in peer-reviewed journals,^{13 25–43} while the remaining one was categorised as grey literature.⁴⁴ From the included studies, 12 were quantitative and cross-sectional in nature,^{26 28 30–36 38 40 41} 5 were qualitative,^{13 26 29 37} 2 was a clinical trial,^{27 43} 1 was a cohort design⁴² and the remaining one was grey literature (a conference discussion report)⁴⁴ (figure 2).

Out of the 21 studies, 5 were conducted in Uganda,^{25 28 29 40 42} 4 in Nigeria,^{30 31 35 36} 3 in Kenya,^{13 39 41} 2 in South Africa,^{26 27} 2 in Zambia,^{33 34} 1 in Ethiopia,³⁶ 1 in Cameroon,³² 1 in Tanzania⁴⁴ and the remaining 1 in Swaziland³⁷ (figure 3).

Study findings

Four themes emerged from the identified studies: evidence of IPV experience among women with HIV/AIDS, evidence of HIV/AIDS status disclosure influencing IPV, evidence of the association of sociodemographic characteristics with IPV and implications for future practice.

Evidence of IPV experience among women with HIV/AIDS

We found evidence of IPV experience from almost all of the 21 included studies in the 11 countries in the Sub-Saharan African region.^{13 25–44} The prevalence of IPV varied among countries; we identified the highest prevalence of IPV in South Africa (67.3%)²⁷ and the lowest

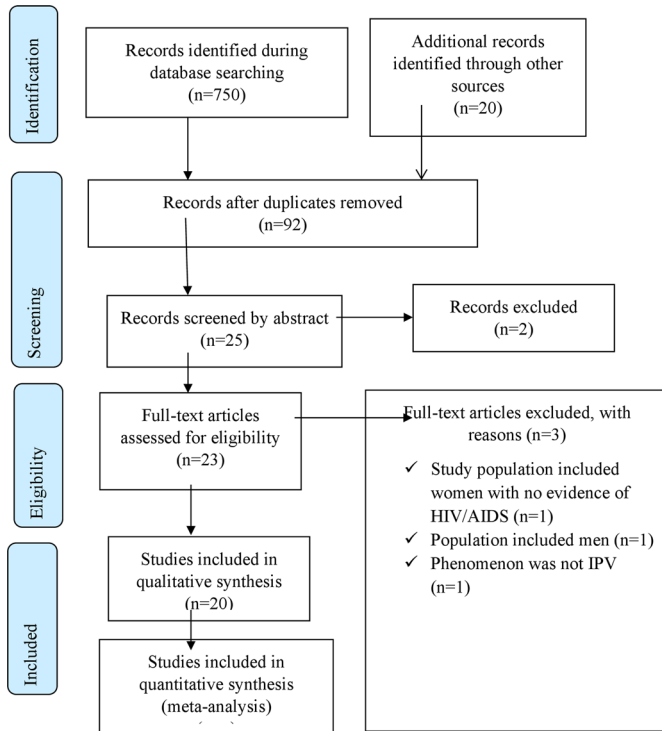


Figure 1 The Preferred Reporting Items for Systematic Reviews and Meta-Analyses 2009 flow diagram. Source: PRISMA Group: doi: 10.1371/journal.pmed.1000097.²⁰

prevalence in Kenya (14.6%).⁴¹ IPV was also identified in Nigeria (65.8%),³¹ in South Africa, overall, 56.3% reported having experienced either psychological or physical IPV,⁴³ Uganda (29%),⁴² another study in South Africa, (21%),²⁶ Nigeria, (23.6%),³⁸ Kenya, nearly one-third of women in the study,¹³ Cameroon (23%),³² Nigeria (22.1%)³⁵ and Uganda (29.3%).⁴⁰ On average, one-third (30.2%) of HIV-positive women experienced IPV among the included studies. Psychological, emotional or verbal abuse was the most common form of violence reported

among HIV-positive women and ranged from 12.1% to 51.7%.^{30–32 38 40} One study showed that physical violence had a more pronounced effect on status disclosure than sexual or emotional violence.³⁴ Sexual violence was found to be the least common type of abuse among HIV-positive women, ranging from 2% to 44.8%.^{26 31 32 38}

Three studies showed evidence of further abuse following IPV, such as the difficulty of engaging in HIV/AIDS care, interruption of ART adherence, partner stigma and abuse, and financial withdrawal.^{13 25 32} There was also evidence showing that physical weakness, economic and social dependence on a partner and alcohol abuse by a male partner were the leading causes of IPV.^{29 44}

Evidence of HIV/AIDS status disclosure influencing IPV

Evidence of IPV after HIV/AIDS status disclosure was reported from six studies.^{31 34–38} Following the sero-disclosure, there was evidence of heightened risk for IPV, stigma, abuse, marriage disruption and financial withdrawal.^{13 25 31 32 35 36} Evidence from one study showed about 74% of abuse coming after HIV/AIDS status disclosure.³¹ However, some studies found that sero-concordance is protective of emotional or verbal abuse.¹³ Women who had their own income, those who did not have a stigmatising attitude towards people living with HIV/AIDS, those who had attained secondary level education and above, those with a positive attitude towards counsellors, and those able to access health facilities were all associated with positive partner reaction.³⁶ On the other hand, having an HIV-negative spouse and disclosure of HIV/AIDS status was associated with abuse.³¹

Studies also explored the expectation of adverse reactions related to HIV/AIDS in the community, including gossip and discrimination.^{25 36} Evidence even existed that some women did not disclose their HIV/AIDS status because of expected fear of rejection, abuse and anticipated loss of trust from their partner.^{25 31 44} For instance,

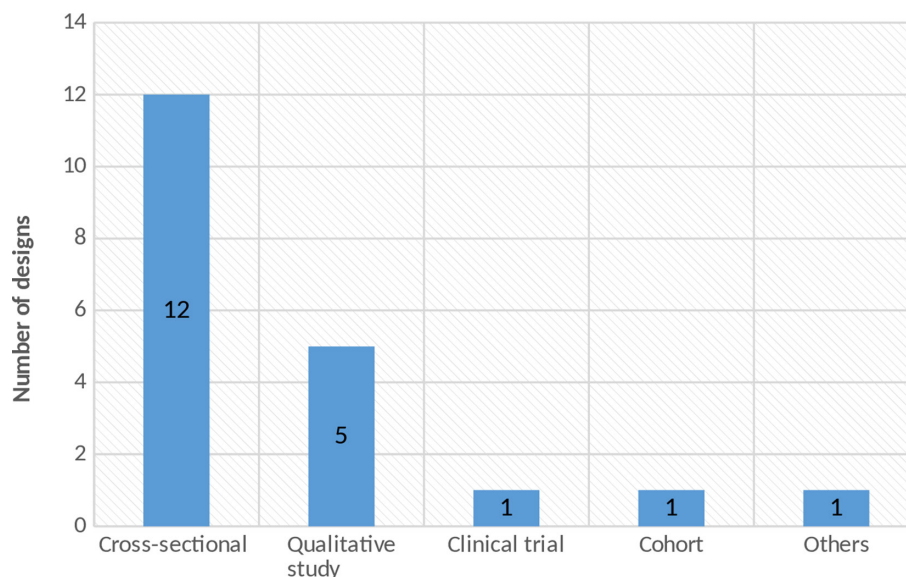


Figure 2 Distribution of study designs used in the study (n=20).

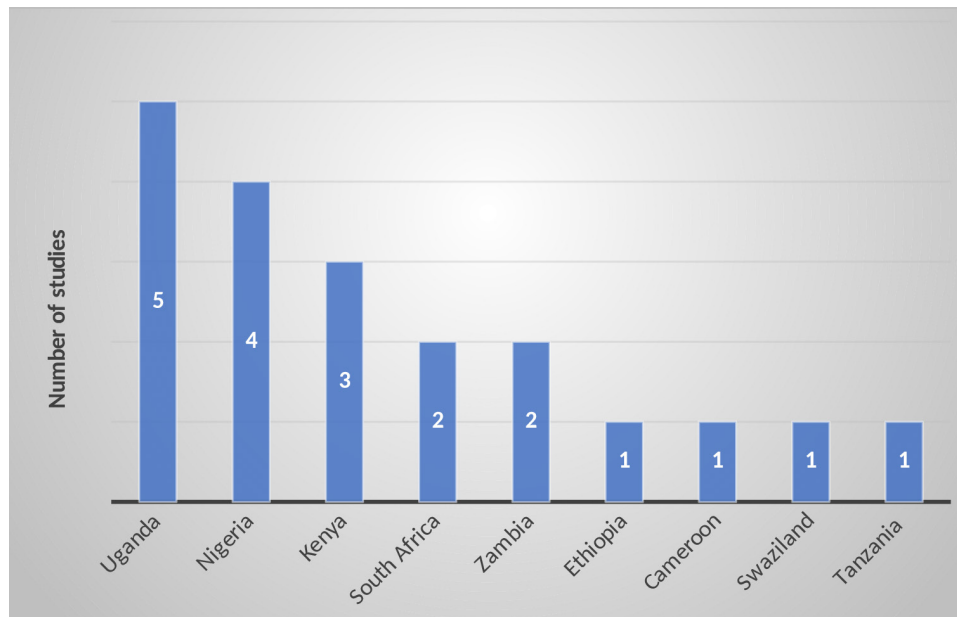


Figure 3 Distribution of countries represented in the included studies (n=20).

studies showed that some women kept their HIV serostatus a secret to prevent an adverse reaction.^{25 44} One study also presented evidence of early mixed feeding following the disclosure of an HIV-positive status.³³ Findings show that physical violence is the most prevalent form of IPV that occurs after status disclosure rather than sexual abuse.³⁴

Evidence of the association of sociodemographic characteristics with IPV

We found evidence of sociodemographic characteristics which were associated with IPV in four studies.^{35 38 40 42} One study identified that older age groups of women, those >40 years, were at risk for IPV.³⁵ Contrary to this, a study in Uganda showed that being older was associated with a lower risk for IPV.⁴² Similarly, one study in Nigeria showed that younger partners (20–39 years) were more at risk for IPV.³⁸

A study from Nigeria showed that multiparity, being a respondent with an HIV-positive child, and marital status (divorced women) were associated with IPV.³⁵ However, a study in Uganda showed that being married was associated with a higher risk of IPV.⁴²

Two studies revealed that non-formal education of husbands (ie, lack of education) was associated with IPV.^{30 35} Contrary to this, a study in rural Uganda showed that there was a significant, but inverse, the association between educational level and physical partner violence.⁴⁰ There was also an inverse association between the educational level of the respondent and sexual/psychological abuse, as well as psychological/sexual violence.⁴⁰

Only one study from Uganda reported that a higher household asset index score was protective from IPV.⁴² The sociodemographic factor of alcohol abuse by male partners was an essential factor associated with IPV among HIV-positive women.^{29 38 41} Additionally, IPV was associated with the experience of violence before women

had an HIV-positive diagnosis.³⁰ Moreover, a Ugandan study reported that the use of ART was associated with an increased prevalence of IPV.⁴⁰ One study result also showed that women experiencing controlling behaviour by the index partner was associated with IPV.⁴¹

Implications for future practice

Evidence from four studies indicated that the prevention of IPV is through the integration of partner violence identification and care into other healthcare services (sexual and reproductive services and services such as HIV testing and counselling).^{13 28 30 34} A study in Uganda recommended the integration of various stakeholders, including partners, family, policymakers, community members and funders and programme implementers who could work together to prevent IPV.²⁵

Healthcare workers (HCWs) should ensure safe disclosure to avoid post-disclosure abuse. Safe disclosure, including couple counselling, mutual disclosure between partners, separate counselling sessions for men and facilitated disclosure were recommendations.^{13 25 37} A study also reported that HIV/AIDS counsellors should evaluate the advantages and disadvantages of status disclosure among women.³⁴ Furthermore, a Zambian study indicated that IPV prevention required training counsellors to facilitate discussions with women about IPV.³⁴ Moreover, evidence from two studies showed the importance of ensuring that women's decisions to disclose their HIV serostatus are fully informed and voluntary.^{13 34} Evidence from five studies reported that routine screening for IPV to identify abused women during HIV/AIDS care services is necessary.^{26 30 32 40 42} Furthermore, evidence from a Ugandan study also highlighted that HCWs should inform HIV-discordant couples appropriately on their reproductive options and referral systems and link couples with counselling services on sexual violence.²⁹



A study also proposed a way forward by improving public awareness and family counselling as a strategy of IPV prevention.³⁷ Four studies recommended that promoting gender equity, empowering women economically, as well as promoting positive masculinities that support and protect women are measures to prevent IPV.^{25 28 37 41} Moreover, two studies reported the involvement of men in programmes of IPV prevention.^{25 37}

DISCUSSION

This scoping review was aimed at mapping the evidence of IPV against women living with HIV/AIDS in SSA. It revealed evidence of IPV experience among women with HIV/AIDS, how HIV/AIDS status disclosure influences its prevalence, and proof of the association of sociodemographic characteristics with IPV. The implications for future practice and recommendations were also made evident.

The experience of IPV varies among SSA countries. On average, 30.2% of HIV-positive women had experienced IPV. This overall finding corresponds to the results of Ugandan and Kenyan studies.^{13 40 42} Of the types of IPV, emotional abuse was the most common form of violence reported among HIV-positive women^{30–32 38 40}; sexual violence was found to be the least common type of abuse among HIV-positive women.^{26 31 32 38} As a result of this type of violence, women delayed accessing ART for fear of further violence, experienced denial of healthcare or discrimination in healthcare settings, employment, education, housing and enforced HIV testing.^{6 7 44} In light of these findings, studies highlighted strategies to protect women from IPV by the integration of violence identification and care into other healthcare services (sexual, reproductive and HIV/AIDS-related services such as HIV testing and counselling services).^{13 28 30 34} It was suggested that the integration of the family, policymakers, community members, as well as funders and programme implementers in gender-based violence prevention programmes, were a way forward.²⁵

The WHO data in 2018 showed that 25.7 million people are living with HIV/AIDS in Africa,⁴⁵ indicating that HIV/AIDS continues to be one of the significant causes of disease burden in SSA,^{45 46} causing substantial health problems in the region. However, studies have highlighted that the effect of the HIV/AIDS epidemic varies in different countries of SSA.⁴⁶ Significant to this study, research in Africa has also shown that there is a strong association between HIV infection and IPV.⁴⁷ This relationship between the two health problems is complex and iterative⁴⁸; because of this, countries with a high HIV/AIDS prevalence, for instance, South Africa and Nigeria, account for a high prevalence of violence (67.3%)²⁷ and (65.8%),³¹ respectively. The studies in this review included countries with a varying range of HIV/AIDS prevalence; as reported in 2016, these were Swaziland (27.2%), South Africa (18.9%), Zambia (12.4%), Uganda (6.5%), Kenya (5.4%), Tanzania

(4.7%), Cameroon (3.8%), Nigeria (2.9%) and Ethiopia (1.1%).⁴⁹ Moreover, IPV can itself also be both a risk factor for and a consequence of HIV/AIDS.⁵⁰ Therefore, IPV needs safe monitoring, screening and intervention among HIV-positive women in healthcare settings.⁴⁸

Evidence of IPV following HIV/AIDS status disclosure was found in nine studies reviewed.^{13 25 31 32 34–38} If our study had searched only for the effect of HIV/AIDS disclosure without IPV, more evidence of the consequences of HIV/AIDS status disclosure could have come to light. Moreover, stigma, abuse, marriage disruption and financial withdrawal were evident consequences of HIV test result disclosure.^{13 25 31 32 35 36} Therefore, there is a need for safe disclosure such as couple counselling, mutual disclosure between partners, separate counselling sessions for men and facilitated disclosure.^{13 25 37} One study also reported that HIV/AIDS counsellors should evaluate the advantages and disadvantages of status disclosure among women.³⁴ The Zambian study suggested training counsellors to facilitate discussions with women about IPV.³⁴ Moreover, evidence from two studies showed that ensuring women's fully informed and voluntary decision making to disclose their HIV/AIDS serostatus is required.^{13 34}

A study in Uganda showed that the sociodemographic status of being married was associated with a higher risk of IPV.²⁰ Another type of marital status, such as being divorced, was also associated with IPV in another context.¹² Hence, the prevention strategy for IPV should be emphasised for both married and divorced women. Age could also be a risk factor, depending on the country. A study in Zimbabwe identified that older women, >40 years, were at increased risk for IPV.¹² Contrary to this, a study in Uganda showed that older age represented a lower risk for IPV.²⁰ Corresponding with this, a survey in Nigeria showed that younger partners (20–39 years) were at increased risk of IPV.¹⁵ However, from these findings, we realised that violence could affect all age groups; hence, the importance of improving public awareness and providing family counselling as a strategy for IPV prevention.¹⁴

Women who are living with HIV/AIDS not only experienced with IPV but also other type of violence/stigma/discriminations. A study in South Africa showed that higher levels of depressive symptoms and greater perceived stigma were associated with physical and psychological IPV.⁴³ It also showed that psychological IPV and physical IPV were also individually associated with high perceived stigma and higher levels of depressive symptoms.⁴³

Studies revealed that other sociodemographic aspects, such as higher household asset value were protective against IPV.⁴² To this end, promoting gender equity, and empowering women economically, as well as promoting positive masculinities that support and protect women should be considered to protect against IPV.^{25 28 37 41} Concerned bodies are also aware that

traditional masculine norms, for instance, aggressiveness and male suppression of emotional vulnerability, can lead to physical violence.⁵¹ Moreover, a male partner's heavy drinking and aggressive behaviour, that men believe to be an accepted norm of masculinity lead to violence.⁵² Hence, wise disclosure of HIV/AIDS status assisted by HCWs, mutual disclosure and involving men in programmes for IPV prevention is advisable.

Health systems should address violence because of its significantly harmful effects on women's health and well-being, including their mental, sexual and reproductive health.⁵³ IPV seems to be a preventable health problem. Thus, the health system needs to develop a response that can provide women with a multisectoral and women-centred response providing privacy, confidentiality and accountability, empowerment of women's decision making and immediate assistance in a holistic way.⁵³

Strengths and limitations

We used an approved MMAT to check the quality of appraisal of the included studies. We also used public health and social science databases for title screening. By doing so, we obtained all relevant published studies; however, we could have found additional pertinent articles if other bibliographical databases had been searched. Other terms, rather than the keywords we searched, could have existed in a different database. In our search, we included articles published in the English language only; therefore, we may have missed critical points published in studies presented in another language. Furthermore, this scoping review was a huge undertaking, and it only includes results up to the date of 10 April 2019.

CONCLUSION

Overall, this scoping review provides a summary of the existing literature showing the evidence of IPV experiences among women with HIV/AIDS. We found evidence of IPV experience from almost all of the studies included. On average, one-third (30.2%) of HIV-positive women experienced IPV among the included studies. Psychological, emotional or verbal abuse was the most common form of violence reported among HIV-positive women. Furthermore, two other relevant categories of evidence reviewed are the negative influence of HIV/AIDS status disclosure on IPV and the association of sociodemographic characteristics with IPV and what the resulting implications are for practice. Psychological and emotional abuse were the most common form of violence reported. Sexual violence was found to be the least common type among HIV-positive women. The review showed the difficulty of women who experienced IPV in engaging in HIV/AIDS care, the interruption of their ART treatment, and that stigma, abuse and financial withdrawal were some of the consequences that followed from IPV. As this

review has shown, IPV was associated with HIV/AIDS status disclosure and having an HIV-negative spouse was a risk factor for IPV. In particular, there is evidence of a heightened risk for partner violence, shame, abuse, marriage disruption and financial withdrawal following serostatus disclosure.

Therefore, the review highlighted the need for strategies such as the integration of IPV screening and care into other healthcare services (sexual, reproductive and HIV/AIDS services). Moreover, safe disclosure such as couple counselling, mutual disclosure between partners, separate counselling sessions for men and facilitated disclosure is vital. The review has also emphasised routine screening for IPV to identify abused women attending HIV/AIDS care services. Most importantly, there is a need for further research among special population groups and on health systems barriers to screening for IPV and for a focus on how victims are treated.

Recommendations for future research

For future research, we suggest investigating the differences and similarities of the IPV experiences for women living with or without HIV/AIDS and the associated factors in the different regions of the various countries in SSA. The lived experience of women, both living with and without HIV/AIDS, and the HCW's experience of IPV screening and its barriers still need to be further studied.

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