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The social, cultural, and health context of controlling behavior and emotional intimate partner violence among adolescent girls and young women living with human immunodeficiency virus in Uganda: A qualitative study

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Abstract

Background: Many adolescent girls and young women (AGYW) living with human immunodeficiency virus (HIV) report intimate partner violence (IPV), including emotional IPV and controlling behavior. Yet, few studies have examined the association between these forms of IPV and health outcomes among AGYW living with HIV.

Objectives: We conducted an exploratory qualitative study to understand the contexts in which controlling behavior and emotional IPV might impact the health of AGYW living with HIV in Uganda.

Design: We used a participatory action research design involving community stakeholders (health workers, program managers of non-governmental organizations serving IPV survivors, and AGYW living with HIV).

Methods: Data were collected through in-depth interviews and focus groups. We analyzed data using an inductive thematic analysis approach.

Results: The following four themes related to different dimensions of controlling behavior and emotional IPV among AGYW living with HIV emerged from the data: (1) age-related controlling behavior and emotional IPV; (2) HIV-related controlling behavior and emotional IPV; (3) isolation-type controlling behavior and poor HIV health; (4) financial control and poor HIV health. Embedded throughout the four themes were issues related to male partners' misuse of power.

Conclusion: AGYW living with HIV experience unique forms of emotional IPV and controlling behavior that impede their ability to remain healthy. Inequitable gender norms may further increase the risk of emotional IPV and controlling behavior among AGYW living with HIV. Couples-based interventions that build healthy relationship skills and offer social support may help to reduce these forms of IPV.

Keywords

domestic violence, gender-based violence, spousal abuse, psychological abuse, HIV care, HIV stigma, mental health, youth, Uganda, sub-Saharan Africa

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Introduction

Intimate partner violence (IPV), defined as physical aggression, sexual coercion, emotional abuse, or controlling behavior by a spouse or intimate partner,[1] negatively affects the ability of adolescent girls and young women (AGYW) living with human immunodeficiency virus (HIV) to obtain optimal health. Consequently, a substantial proportion of AGYW living with HIV in sub-Saharan Africa (SSA) specifically may be at risk of poor HIV care engagement and, thereby, transmitting HIV, considering IPV is highly prevalent among this population, especially AGYW living in Uganda. An examination of data from the most recent Demographic and Health Surveys conducted across 27 countries in SSA revealed rates of physical and/or sexual IPV among married or cohabiting AGYW aged 15–24 ranging from 6.5% to 43.3%, with a median of 25.2%.[2] Among the 10 East African countries represented, Uganda had the second highest prevalence of reported physical and/or sexual IPV (32.5%) among AGYW.[2] IPV rates are even higher when considering emotional IPV and controlling behavior, with national estimates indicating that 41.5% of ever-married adolescent girls aged 15–19 and 52.1% of young women aged 20–24 in Uganda experienced physical, sexual, or emotional IPV in the prior year.[3] Additionally, 36.6% of ever-married adolescent girls aged 15–19 and 38.8% of young women aged 20–24 living in Uganda reported experiencing three or more types of controlling behaviors by their spouse (e.g., gets jealous or angry if you talk to other men; insists on knowing where at all times).[3]

AGYW living with HIV in Uganda reported similar rates of physical or sexual IPV as their counterparts: 30% aged 15–19 and 41% aged 20–24.[4] However, less is known about the prevalence of emotional IPV and controlling behavior among this population. Additionally, researchers have inconsistently measured controlling behavior in studies involving women living with HIV. For example, some researchers studying IPV among women living with HIV have defined controlling behavior as a form of IPV,[5] while others have tested controlling behavior as a predictor of IPV.[6] Nonetheless, there is evidence to suggest that emotional IPV and controlling behavior are associated with poor HIV care engagement and treatment adherence among AGYW living with HIV in SSA.[5] Thus, there is a need to further understand how emotional IPV and controlling behavior may impact the health of AGYW living with HIV in Uganda. The current study aims to fill this knowledge gap.

Health consequences of IPV among AGYW living with HIV in SSA

Research in Uganda examining the impact of IPV on the physical and mental health of people living with HIV has primarily focused on women older than 24 years.[7–9] Nonetheless, there is evidence from other parts of SSA to suggest IPV negatively impacts the health of AGYW living with HIV and, therefore, may impact the health of those in Uganda. These studies suggest AGYW living with HIV in SSA with IPV experiences have worse HIV clinical and disease outcomes (e.g., antiretroviral therapy (ART: HIV medication that helps to reduce the amount of HIV in the body) adherence; HIV viral suppression (a very low or undetectable amount of HIV in the body)), and worse care engagement than those without IPV.[5,10–15] A recent study conducted in South Africa found that adolescents aged 10–19 who reported past-year IPV (physical abuse, emotional abuse, or controlling behavior) were 41% less likely to report ART adherence than adolescents who did not report past-year IPV.[5] Further, among AGYW living with HIV aged 12–24 in South Africa, past-year IPV (physical and/or sexual IPV) was negatively associated with viral suppression.[12] A common theme found in qualitative research involving 42 adolescents living with HIV (mean age: 17 years) in western Kenya was that trauma, including ongoing IPV, was associated with their disengagement in HIV care.[11]

In addition to negatively impacting the physical health outcomes of AGYW living with HIV, IPV negatively impacts their mental health. Compared to AGYW living with HIV in SSA with no IPV history, AGYW living with HIV in SSA with IPV history have worse mental health outcomes, including depression and anxiety, which, in turn, may increase their risk for poor HIV care outcomes.[7,8,16] In Kenya, AGYW living with HIV with experiences of emotional IPV and/or moderate or severe depressive symptoms were significantly at higher odds of having poor ART adherence than AGYW living with HIV without these experiences.[10] Similarly, Kidman and Violari found that past-year physical and or sexual IPV was positively correlated with depressive symptoms and ART adherence among AGYW living with HIV in South Africa.[14] The adverse mental health impact of IPV among AGYW living with HIV warrants the need to conduct further research to understand the types of mental health care and IPV services that should be integrated into routine HIV care for AGYW living with HIV.

IPV risk factors among AGYW in SSA

A recent systematic review of key correlates of IPV victimization among adolescents and young adults living in SSA identified that education level (mainly lower education attainment), age, trauma exposure (e.g., child maltreatment, witnessing parental IPV), substance use, sexual risk behavior, gender attitudes, and relationship status were IPV risk factors.[17] Unique to HIV, in their scoping review of IPV among women living with HIV aged 15 or older in SSA involving 21 studies, Meskele et al. found

evidence that HIV status disclosure, having a child living with HIV, and use of ART were risk factors for IPV.[18]

Additionally, researchers have found that endorsing IPV acceptance is associated with IPV victimization among adolescents living in SSA.[19,20] This is concerning for AGYW living with HIV in Uganda, considering Ugandan AGYW aged 15–19 (57.5%) and 20–24 (48.8%) reported the highest prevalence of IPV acceptance (i.e., agreeing with ⩾1 reason for "wife-beating") relative to other age groups and higher than their male counterparts.[3] Further, IPV risks among AGYW living with HIV in Uganda are likely exacerbated by cultural norms that condone IPV and tolerate men's controlling behaviors.[21,22] In Uganda, societal norms place men in dominant positions and expect women to be submissive, putting AGYW at risk of facing IPV. IPV is regarded as a private matter, resulting in social isolation and heightened vulnerability to violence.[23] These norms can make it challenging for AGYW to extricate themselves from abusive relationships or seek assistance.[24]

Current study

In summary, IPV negatively affects the physical and mental health of AGYW living with HIV in SSA, and these AGYW face a high risk of IPV. Research examining IPV among AGYW living with HIV in SSA has primarily focused on physical and sexual IPV, despite high reported rates of emotional IPV and controlling behavior among AGYW living in SSA. Although limited, there is evidence that these forms of IPV may increase the risk of poor HIV care engagement and ART (HIV medication) adherence among AGYW living with HIV in SSA. However, possible reasons for this relationship remain unclear. Such research will provide much-needed insights into the potential processes by which controlling behavior and emotional IPV impact the health of AGYW living with HIV. This research could inform the development of more holistic interventions for reducing IPV and improving health within this population.

The present study conducted qualitative research to explore the following question: How do IPV and couple dynamics affect AGYW's ability to be engaged in HIV care and achieve optimal health? This work informs the development of the Kisoboka Mukwano intervention, a couples-based intervention we are designing and piloting to improve Ugandan AGYW's HIV care engagement by aiming to reduce male partners' alcohol use and, thereby, AGYW's IPV risk. Male partner alcohol use increases IPV victimization risk among women living with HIV in Uganda, including AGYW.[25–27] Alcohol use is prevalent in Uganda: the average per capita (for each person) alcohol consumption is 12.2 L of pure alcohol (1220 "drinks" or eight hundred seventy-two 12 oz beers).[28] This rate is three times the African region average and more than twice the global average. On average, Ugandan men drink four times more than Ugandan women (19.9 L versus 4.9 L).[28]

Currently, limited research exists on controlling behavior and emotional IPV among AGYW living with HIV. We add to the IPV and HIV knowledge base by exploring the association between social, cultural, and health factors and controlling behavior and emotional IPV among AGYW living with HIV in Uganda. Study findings will aid in ensuring that the Kisoboka Mukwano intervention will address key IPV-related barriers to HIV care engagement among AGYW living with HIV. Additionally, the study's findings will provide researchers and practitioners with a better understanding of the IPV experiences of AGYW living with HIV, how to assess for and prevent emotional IPV and controlling behavior, and how these forms of IPV may impact the health of AGYW living with HIV.

Methods

Using a participatory action research design[29] to inform the refinement of the Kisoboka Mukwano intervention, we conducted in-person, in-depth interviews and focus groups with key stakeholders involved in the study, including AGYW living with HIV and their male partners and key informants working with the populations of focus (i.e., health workers, youth-serving leaders, alcohol treatment providers, and program managers of non-governmental organizations serving IPV survivors). Overall, 21 AGYW living with HIV, 7 male partners, and 11 key informants participated in the qualitative research. However, given the study's purpose, we only included data collected from AGYW living with HIV and key informants working in health care and IPV programs in the current study. Specifically, we used data from eight in-depth interviews and two focus groups ($n=13$) with AGYW living with HIV and seven in-depth interviews with health workers and IPV program managers. Male partner interviews were not included in the study as questions and themes in these interviews were primarily related to alcohol use. We applied methods following suggested guidelines from the COREQ (COnsolidated criteria for REporting Qualitative research) Checklist.[30] The Arizona State University and San Diego State University IRBs and the Uganda National Council for Science and Technology approved all study procedures.

Study population

Our goal was to inform the design of the Kisoboka Mukwano pilot intervention trial based on the perspectives of AGYW who would be receiving the intervention. Therefore, our inclusion criteria matched the criteria for this population. Specifically, to be eligible for the study, AGYW had to meet the following criteria: aged 18–24 or self-reported as emancipated minors aged 15–17 per

national guidelines (i.e., minors aged 15–17 who are married or have children); married or cohabiting with a male partner for at least 6 months (intervention period); confirmed HIV-positive; non-engaged in HIV care (verified by clinic chart or self-reported); self-report a least one incident of IPV (emotional, physical, and/or sexual IPV, and/or controlling behavior) with their current partner; live in or within 10 miles of Wakiso District; and agree to let research staff contact their male partner. We included the latter criterion to reduce the potential risk for new IPV that may occur due to inadvertent disclosure of a participant's HIV status to a partner,[18] given AGYW's male partners also participated in the Kisoboka Mukwano study (findings not reported in the current study). Being non-engaged in HIV care was defined as meeting one or more of the following: not currently enrolled in an HIV clinic (e.g., never enrolled or dropped out); not currently taking ART; missed one or more scheduled HIV care appointments requiring physical presence (e.g., viral load (VL) testing) in the last 12 months; self-reported <90% ART adherence in the last 2 weeks using the AIDS Clinical Trials Group (ACTG) Adherence Questionnaire[31]; most recent VL or expected recent VL test results absent in clinic records despite initiating ART >6 months ago. We excluded AGYW who reported experiencing severe physical IPV in the past 3 months. Key informants had to be 18 years or older and affiliated with public or private non-profit agencies in Wakiso District, Uganda, offering services to the populations of focus.

Participant recruitment

We recruited AGYW through both Mildmay Uganda-supported HIV clinics and the Wakiso District community using a purposive sampling approach. Clinic recruitment entailed clinic staff reviewing their clinic records to identify potentially eligible AGYW and sharing potentially eligible AGYW's contact information with the study's research assistants. Research assistants then contacted potentially eligible AGYW via phone or in person if the potential participant and research assistant were at the clinic when the potential participant was identified. When contact was made, research assistants first determined that it was an acceptable time for them to talk in terms of confidentiality and, if so, obtained verbal informed consent and conducted eligibility screening. If the potential participant was contacted by phone and their confidentiality could not be assured, the research assistant offered other times to call back. If contacted in person, eligibility screening took place in a private room at the clinic.

Community-based recruitment was conducted in partnership with Reach the Youth-Uganda, a non-government organization serving youth in Uganda. We limited our community-based recruitment to areas within 5–6 km from the Mildmay-supported HIV clinics we were recruiting from to facilitate linkage to accessible HIV testing (if needed to confirm self-reported HIV-positive status, an inclusion criterion). Reach the Youth research assistants collaborated with the local Secretaries for Women's Affairs, local female Community Health Workers, and linkage facilitators at Mildmay-supported HIV clinics to create a contact list of potentially eligible AGYW. Reach the Youth research assistants screened potentially eligible AGYW based on eligibility criteria related to self-reported incidents of IPV. If meeting these criteria, AGYW were invited to a research office at one of the partnering HIV clinics for HIV counseling and testing. If test results revealed the potential participant was HIV-positive, following the HIV counseling and testing, screening was conducted to determine whether AGYW met the remaining eligibility criteria.

All AGYW eligibility screenings included questions about various health services to mask the study's purpose to the broader community. Eligible AGYW were invited to participate in the study. In addition, we used snowball sampling to recruit more potential AGYW living with HIV in the community, asking eligible AGYW living with HIV to help connect us to others like themselves who might be interested in participating in the study by sharing the study contact information (phone number and email address).

We identified key informants with the help of our Intervention Steering Committee (community advisory board), local study investigators, and online resources. Committee members and study investigators either shared the contact information of potentially eligible participants or contacted them directly to inquire about their interests in being interviewed for the study. If interested, research assistants followed up to seek consent and conduct eligibility screening, inviting key informants identified as eligible to be part of the study.

Data collection

All participants provided written informed consent before participating in the study's interviews and focus groups and received a cash incentive of 15,000 Shillings (~$4) for their participation. Focus groups and interviews took place in a private room at one of the local health clinics or another agreed-upon private location, with only the interviewer/focus group facilitator and participants present. Data were collected between July 2023 and January 2024 using a semi-structured interview or focus group guide with open-ended questions related to the Kisoboka Mukwano intervention's conceptual framework and content and perceived acceptability and feasibility. For the current study, we examined data related to the study's conceptual framework. Kisoboka Mukwano is based on the ecological intra- and interpersonal process framework[32] and developmental perspective.[33] Thus, questions and probes (see Supplemental Material) focused on environmental factors (e.g., gender norms),

family/interpersonal-level factors (e.g., social support), and mutual stress (e.g., marital conflict) possibly originating from AGYW development (individual-level factor) and bidirectionally related to male partner alcohol use and AGYW's HIV care engagement. We assumed that addressing barriers related to these factors through Kisoboka Mukwano can help partners achieve compatible individual and conjoint dyadic coping and, thereby, improve their individual and relationship health. The guides were not piloted; however, we adjusted the guides after the first few interviews to improve the effectiveness and efficiency of future interviews and focus groups.[34]

In-depth interviews lasted an average of 45 min, and focus groups an average of 1 h and 25 min. All in-depth interviews and focus groups were conducted in Luganda or English, audio-recorded, transcribed, and translated into English, as needed, by a trained male research assistant. The research assistant had a Master's degree in public health and approximately 5 years of experience conducting, translating, and transcribing qualitative research focused on women living with HIV in Uganda. We have worked with this male research assistant on several qualitative studies and have received feedback from both male and female participants that they are comfortable working with him. Further, this research assistant has been able to probe in a way that allows for the collection of rich data. Nonetheless, to ensure AGYW participants were comfortable working with a male, a female research assistant who was familiar with study participants and had established rapport called participants to schedule the interviews and ask if they would be comfortable with the male research assistant conducting the interview/focus group. The male research assistant was not an author in the current study and did not have an established relationship with any participants prior to the study's commencement.

Despite having an interest in the research topic, the interviewer/focus group facilitator did not share his personal reasons for doing the research with the participants. Rather, at the beginning of each interview and focus group, he provided participants with a general overview of the purpose and goals of the current study. Specifically, he informed participants that the purpose of the study was to learn how we might be able to help people live healthy lives, including how to reduce their alcohol consumption, stay engaged in HIV care, and have healthy relationships with spouses/intimate partners. Participants were also informed that our goal was to use the data to help design the intervention.

We provided eligible AGYW the option to participate in either a focus group or in-depth interview based on feedback from our prior qualitative work in which participants expressed that they would feel more comfortable speaking in a one-on-one interview due to the study topics' sensitive nature (i.e., IPV and HIV). Relatedly, we felt that including both focus groups and interviews could strengthen the research design by allowing for a greater range of perspectives and experiences and method triangulation; thereby enhancing data richness.[35,36] Lastly, providing the in-depth individual interview option allowed us to offer more scheduling flexibility, improving our chances for successful recruitment of eligible participants approached for participation.

Data analyses

We conducted exploratory data analyses using an applied inductive thematic analysis approach.[37] First, two coders used open coding to independently code 7 completed transcripts (41.2% of the total transcripts). Following this, the two coders met to discuss the codes and develop the study codebook consisting of the set of codes and code definitions. Disagreements in the assignment or description of codes were resolved and, when necessary, codes were redefined and renamed. A consensus was reached on all final codes.

After developing the codebook, it was used to code the remaining 10 transcripts. The two coders met to discuss and resolve discrepancies (i.e., transcripts including text segments with different codes applied by each coder). Finally, after resolving discrepancies and assuring agreement on the coding, the two coders organized the codes into meaningful themes reflecting the participants' perspectives.

Results

Sample characteristics

AGYW's average age was 22.4 years (SD = 1.7). AGYW were married or living as married (95.2%; $n = 20$) or married and separated most of the time (4.8%; $n = 1$). Most AGYW were married for more than 1 year (95.2%; $n = 20$). Only one participant (4.8%) reported being married for 6–12 months. On average, AGYW had 1.8 children (range 0–4; SD = 0.9).

Regarding HIV care and treatment, all AGYW were receiving HIV care; however, 81% were not currently taking medication for HIV and, among those taking HIV medication, 50% ($n = 4$) were taking their medication as prescribed $<86\%$ of the time. In terms of IPV, most AGYW reported experiencing either controlling behavior (90.5%) or emotional IPV (81.0%) in their current relationships; 23.8% reported physical IPV and 19.1% sexual IPV in their current relationships. AGYW reported the following controlling behaviors perpetrated by their current male partners: frequently accuse you of being unfaithful (14.29%); not allow you to meet your female friends (57.14%); try to limit your contact with your family (14.29%); insist on knowing where you are at all times (66.67%); is jealous or angry if you talk to other men (90.48%).

Key informants' average age was 32.6 years (SD = 7.0). The majority of key informants identified as female (85.7%; $n = 6$); 57.1% ($n = 4$) had a secondary school education level, 28.6% ($n = 2$) completed college/university, and 14.3% ($n = 1$) completed graduate school with a master's degree. All except one key informant were health workers (85.7%; $n = 6$); 14.3% ($n = 1$) were an IPV service provider.

Themes

Four themes emerged from the analysis process, they focused on different dimensions of controlling behavior and emotional IPV among AGYW living with HIV: (1) age-related controlling behavior and emotional IPV; (2) HIV-related controlling Sbehavior and emotional IPV; (3) isolation-type controlling behavior and poor HIV health; (4) financial control and poor HIV health. Figure 1 summarizes each theme and the perspective (i.e., AGYW versus provider perspective) from which themes developed. We also discuss these themes in detail below.

Theme 1: age-related controlling behavior and emotional IPV. Participants discussed situations in which AGYW's age may play a role in their experiences with controlling behavior and emotional IPV. Some participants felt these forms of IPV were particularly present due to age gaps between AGYW and their romantic partners. For example, Participant 1 (P1, 46-year-old health worker and key informant) provided an example of how girls in relationships with older men lack the power to make their own decisions and how this lack of power can lead to controlling behaviors. She stated, "*The man refused the girl to take ART . . . she cannot make her own decisions and go against what the husband says . . . these men are older, they stop those girls from taking ART.*" Participant 2, a 19-year-old woman, also expressed how controlling behavior and emotional IPV may be associated with an age gap. She explained ". . . *my partner is a bit older than I am, and so, sometimes, he doesn't consider you to be sensible, in that even when you suggest an idea, he looks at it as useless . . . He puts a lot of restrictions on you . . . My partner does not want me to work. He wants me home.*"

Participant 3 (35-year-old IPV program manager; key informant) explained how power imbalances may exist between AGYW and their male partners, especially related to finances. When asked about her perception regarding the difference between IPV experienced by older women versus AGYW, she provided the following example: "*I can give an example of Makerere University where you know they [young women] are not yet married, they are in relationships but there is a lot of control, there is a lot of power from the male partners . . . there are several girls that told us that their ATMs are kept by their boyfriends. That if they want to use the money, they will ask for permission*."

One participant provided a divergent perspective. She highlighted how younger age may serve as a protective factor against IPV, suggesting that AGYW are less likely to tolerate IPV because they are not "*developed that well . . . If you are a bit mature then you can stay [in an abusive relationship]. You can realize that a specific problem can't cause you to leave. Ages 24 and below, we can't clearly make decisions on our own*" (P4, 24-year-old young woman; interview participant).

Theme 2: HIV-related controlling behavior and emotional IPV. Participants discussed forms of controlling behavior and emotional IPV unique to AGYW living with HIV, including being belittled or seen as "*useless*" because of HIV, their partner denying them food needed to take HIV medication, being blamed for HIV transmission, and their partner disclosing their HIV status without consent. Regarding being belittled because of HIV, Participant 5 (19- to 24-year-old young woman; focus group participant) implied that it was not until after she was diagnosed with HIV that her husband began putting her down and being controlling. She explained, "*I get a husband when I am not positive, but then I eventually contract the virus from him and then he starts seeing me as someone useless; that even if he is to leave me, I won't be able to get another man. So, he decides to become possessive because he knows that even if you are to go somewhere else [to find another man], you will find it difficult*." Similarly, Participant 6 (19- to 24-year-old young woman; focus group participant) expressed that belittling begins once male partners learn of their female partners' HIV status: "*Challenges come when they get to know that you are positive. They start belittling you about how you will infect them; they start talking to other girls in your presence and you start feeling sad.*"

One young woman included denying food as a form of IPV, stating, ". . . *for most men, the way they torture is by hitting you, denying you food, and not taking care of you. Those are the ways a man can hurt you.*" (24-year-old young woman; interview participant). Participant 6 explained that AGYW living with HIV may allow controlling behavior from their partners because they perceive their life expectancy to be short due to HIV: "*For example, mine doesn't want me to wear a dress like this [knee length], he wants these long ones. You feel bad because you might also want not to wear such dresses but you end up wearing them by force, because our life is short and you might feel that you have to do whatever makes you happy*."

A key informant (P3, 35-year-old IPV program manager) discussed how men blame women for their HIV diagnosis regardless if they were diagnosed first. She also explained how gender norms play a role in men being able to get away with this behavior, stating "*Even with HIV/AIDS, you will see that someone that is positive, a man that is HIV positive will continue blaming the woman even*

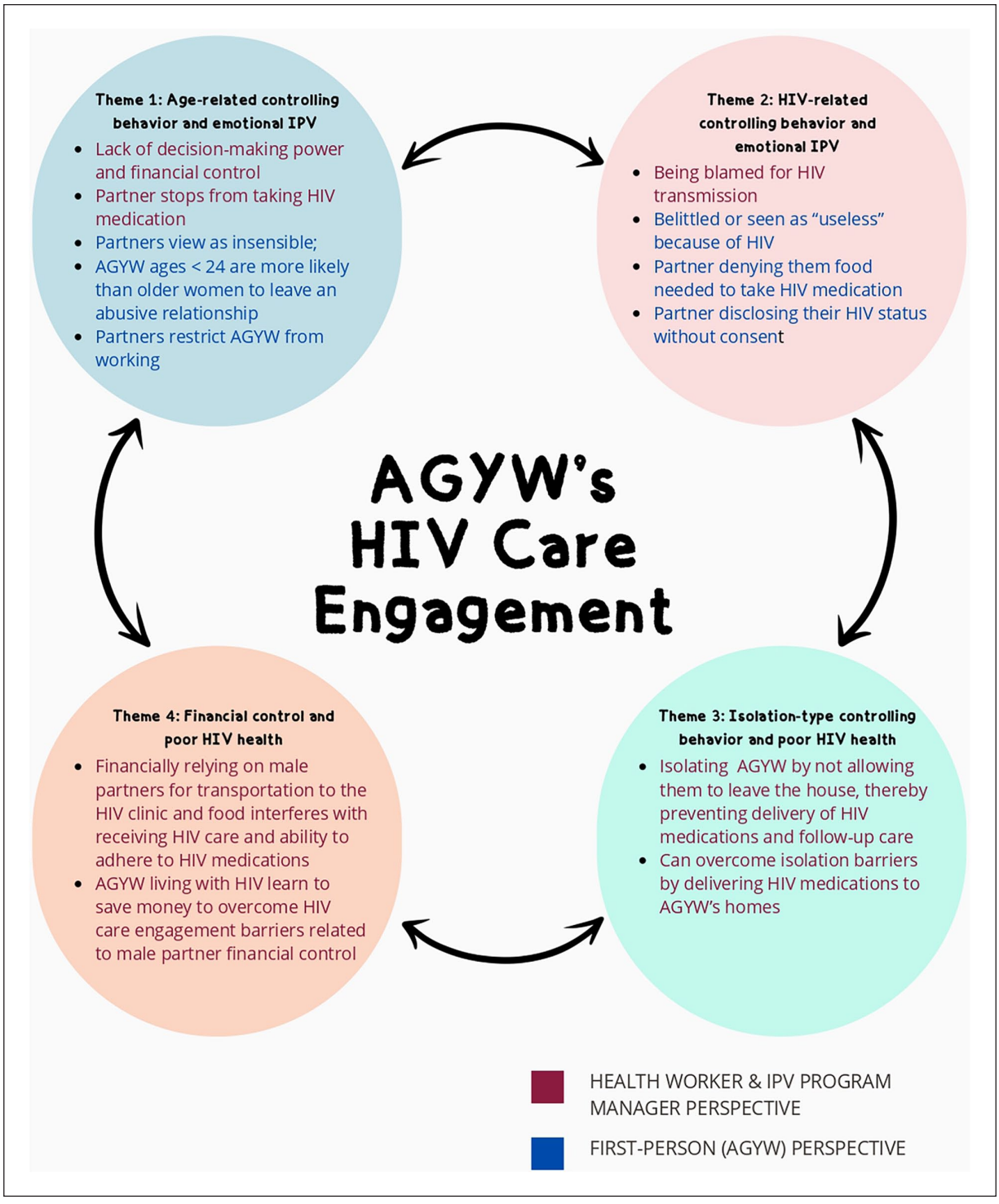

Figure 1. IPV themes associated with AGYW's HIV care engagement.
AGYW, adolescent girls and young women; HIV, human immunodeficiency virus; IPV, intimate partner violence.

when he knows, because he knows that the community will not hold him accountable for anything. Even when he says, they will still know that he is the man."

Participant 4 (24-year-old young woman; interview participant) shared the following story as an example of how men abuse women living with HIV by disclosing their HIV status without consent: "*There is a friend of mine whose husband used to embarrass her in public, by shouting that it was time for her to take her medication and he used to throw her tablets outside for the whole world to*

see. So that was a high level of abuse and such a situation would force someone to lose all hope, separate from the man and also stops using the medication, all because of what this man does. You might have wanted to hide it from your friends, but then this man exposes you." This form of emotional IPV was also described among focus group participants. For example, Participant 5 (19- to 24-year-old young woman; focus group participant) stated "*Another thing, when a man gets to know that you are positive, he might start to think that there is no other man that can court you. But if he gets to know that someone else is courting you, that is when he will start spreading rumors about you. He will start saying* '*leave my woman alone, she has HIV . . ..*'"

Theme 3: isolation-type controlling behavior and poor HIV health. Key informants who were health workers described how male partners' controlling behavior, specifically isolating AGYW, negatively impacts AGYW's ability to receive HIV care. For instance, Participant 8 (30-year-old female health worker; key informant) shared the following story: "*The husband locked her in the house. Now, I used to ring her, but the husband took the phone away from her and broke it . . . He used to keep her within the fence, which to me seemed like she was a prisoner because you no longer have your freedom as a person.*" Participant 9 (30-year-old female health worker; key informant) described how she has overcome isolation barriers by delivering HIV medications (ART) to AGYW: "*Sometimes, their partners refuse them from leaving home. So, when she calls and tells you that, but she is close by, we take it for her so that she does not miss out on taking her ART*."

Theme 4: financial control and poor HIV health. Health workers also described instances in which AGYW's lack of financial control in their relationships prevents them from having money to care for themselves and adhere to their medication. Two health workers discussed how needing money from male partners for transportation to the clinic was a barrier to receiving HIV care for AGYW, especially if the IPV experience was recent:

> It is possible because most of these women do not work. So, when you are a man and are the one who is supposed to give her money, but you beat her at night, as a person, she gets angry. So, she cannot ask him for money to come to the facility and he gives it to her. (P9, 30-year-old female health worker; key informant)

> I think it [IPV] is the major barrier to adolescent girls and young women's adherence to ART because there is no way that I will have fought with my partner at night and I ask him for transport in the morning. (P10, 31-year-old female health worker; key informant)

Another health worker described how relying on male partners for money can interfere with AGYW's ability to adhere to their HIV medication (ART), particularly because they are unable to purchase the food needed to take their medications. She explained: "*With GBV [gender-based violence], it is common . . . However much he refuses to give her money for food at home, it will make her not to take ART on time*." (P11, 33-year-old male health worker; key informant).

Participant 10 felt that helping AGYW living with HIV learn to save money may assist with overcoming HIV care engagement barriers related to male partner financial control, particularly transportation barriers: "*It will help them [AGYW IPV survivors] to get that saving scheme because even if the woman does not ask the man for transport, she herself can get transport to come to the facility. Then, it will also help them to take their ART at home without any hindrance or fear. It improves her quality of life and her viral load will become suppressed*" (31-year-old female health worker; key informant).

Discussion

The study's findings suggest that AGYW living with HIV in Uganda experience unique forms of emotional IPV and controlling behavior, impeding their ability to engage in activities and behaviors necessary to remain healthy. Specifically, IPV affects AGYW's ability to access care and ongoing treatment for HIV, take their HIV medication every day as prescribed, and access support for living with HIV. Emotional IPV and controlling behavior were the highest rates of IPV types reported among AGYW living with HIV participating in the current study, with more than three-quarters reporting these types of IPV in their current relationships compared to about one-fourth reporting physical IPV and one-fifth of sexual IPV. Forms of emotional IPV and controlling behavior discussed by participants included their partners (a) withholding money for food needed to take medication and transportation to the clinic, (b) disclosing their HIV status to others without consent ("outing" HIV status), (c) belittling them because of their HIV status, (d) blaming them for their HIV diagnosis, and (e) making them stop taking their HIV medication once they had started.

These findings highlight how gender norms in Uganda related to financial decision-making and financial control may impact HIV health outcomes among AGYW IPV survivors by making it difficult for them to pay for clinic transportation or nutritious food needed to take their medication. The findings also support prior research.[38–40] In Uganda, men are expected to be financial providers for their households. Therefore, women in Uganda may be economically dependent on men.[21,23] AGYW in SSA may have limited skills and knowledge needed to obtain work,

due to their young age and limited work experience, making them susceptible to being financially reliant on their male partners.[41] Further, past experiences of IPV may influence AGYW's economic vulnerability. For example, controlling/isolating behaviors by a partner can disrupt a woman's ability to seek education and employment.[42] Some men may deprive their partners of financial assistance following HIV status disclosure.[18,43]

We encourage professionals working with AGYW living with HIV to use IPV interventions designed to address economic barriers. Economic strengthening interventions, such as microfinance, have proven effective in increasing economic empowerment and reducing IPV risk among women living in Uganda and other parts of SSA.[44] These interventions are especially effective when combined with gender transformative approaches (e.g., group dialogues/activities that promote gender equality and encourage women's empowerment).[44] For example, one study conducted in South Africa compared groups receiving a combined microfinance, gender, and HIV training intervention [(Intervention with Microfinance for AIDS and Gender Equity (IMAGE)] to pair-matched control groups (villages matched by size and accessibility) and groups receiving microfinance-only interventions. The study found that, after 2 years, women in the IMAGE groups had lower odds of reporting a past-year experience of physical and/or sexual IPV compared to women in the control group and lower odds of condoning IPV compared to women in the microfinance-only group.[45] Similarly, studies in Uganda examining Safe Spaces, a savings intervention for AGYW aged 10–19 composed of gender dialogues with young women mentors aged 20–35 (i.e., Safe Spaces group meetings), reproductive health training, financial education, and savings accounts found that compared to AGYW who only had a savings account, AGYW who received the full intervention were less likely to have been sexually touched and harassed by men.[46] We also suggest educating AGYW living with HIV and their male partners about financial abuse as a form of IPV, as well as teaching them skills for coping with this form of abuse and establishing healthy relationship behaviors to prevent such abuse (e.g., equal decision-making around finances).

There were divergent perspectives regarding reasons AGYW living with HIV experienced emotional IPV and controlling behavior. One perspective was that the abuse was due to age differences between AGYW and their male partners, specifically male partners being older, leading to relationship power imbalances. The other perspective implied that being younger might protect AGYW living with HIV from IPV because they have fewer established norms. The latter perspective conflicts with prior research indicating younger age is an IPV risk factor among women living with HIV in Uganda.[18,47] However, IPV survivors in Uganda are expected to "endure" IPV for the sake of their children and their families.[21] There may also be pressure to stay in an abusive relationship to avoid breaking the exchange of bridewealth.[22] AGYW may be less likely than older Ugandan women to follow these types of norms if the norms are not yet entrenched in their behaviors.

IPV interventions working with AGYW living with HIV should first assess AGYW's perceptions regarding gender norms and, depending on what is identified, work to foster norms that might reduce their IPV risk and change norms that might increase IPV risks. These interventions must also work to shift gender norms among AGYW's peers and male partners. For example, norms can push men to commit IPV just because others do it, or they can stop men from committing IPV if their friends disapprove.[48] Adolescence is a unique developmental period when peer social acceptance is at its peak[49]; thus, shifting norms beyond the individual level may help reinforce improved norms that reduce IPV acceptance and, thereby, IPV risk.

The current study shines new light on the living conditions of women living with HIV in Uganda. Previous studies examining IPV among women living with HIV in SSA have mainly studied HIV status disclosure as a potential risk factor for IPV.[18] However, based on our study's findings, nonconsensual HIV status disclosure may also be a type of emotional IPV experienced by AGYW living with HIV in SSA. Women living with HIV in SSA may fear disclosing their HIV status because of potential adverse reactions from the community, including gossip.[18] By gossiping or disclosing their female partners' HIV status to others without consent, male partners may be further creating HIV stigma.[50] Thus, AGYW IPV survivors may experience a heightened risk of HIV stigma following HIV status disclosure to their male partners. They may also be at increased risk of further emotional abuse following disclosure, based on our study findings showing AGYW were blamed and belittled by their partners because of their HIV status.

Some AGYW participants mentioned accepting emotional IPV and controlling behavior because they felt that other men would not be interested in pursuing a relationship with them due to their HIV status. AGYW also attributed this belief to male partners' abusive behaviors. Thus, both internalized stigma and HIV stigmatization by partners may increase AGYW's risk of remaining in or accepting abusive relationships. Internalized HIV stigma is not uncommon among young people living with HIV in SSA[51–53] and is associated with several adverse health outcomes among this population, such as suicidality,[54] high levels of depressive symptoms,[55] low self-esteem,[55] and low odds of retention in care, ART adherence, adherence motivation, and behavioral adherence skills.[52,55] Additionally, greater acceptance of IPV increases IPV risk among women living with HIV in Uganda.[47]

Some AGYW in our study also reported IPV acceptance due to the perception that they would live a short life because of HIV. Health professionals in Uganda can educate AGYW living with HIV by dispelling HIV myths and stigma, including those related to life expectancy rates.

Life expectancy rates among people living with HIV are similar to rates among people not living with HIV if people living with HIV are on ART and are adherent to their medication.[56] Knowing such information may increase AGYW's sense of hope for the future and, thus, decrease their risk of accepting abusive relationships. Reducing internalized HIV stigma may also help to improve AGYW's mental health and HIV care engagement.[52,55] Moreover, reducing partner stigma may reduce the male partner's risk of IPV perpetration following their female partner's HIV status disclosure.[43]

Lastly, our study findings showing that male partners' controlling behavior in the form of stopping their female partners from taking ART and keeping them isolated provide additional evidence that controlling behavior may interrupt AGYW's HIV medication adherence and make it difficult for them to engage in HIV care.[5] One possible reason for stopping their female partners from taking ART might be that male partners do not want to accept or be blamed for their female partners' HIV-positive diagnosis.[57] AGYW's experiences with controlling behavior in the form of being isolated by their male partners made it difficult for health workers to provide HIV care and treatment to them. This finding supports findings from a recent systematic review of the effects of IPV on HIV-positive pregnant women in SSA which showed that HIV-and-IPV-related isolation negatively affects health-seeking behaviors among women living with HIV.[58] In addition to being physically isolated because of IPV, women living with HIV in SSA might experience social isolation from their partners (e.g., distancing themselves from their partner/stop doing things together with their partner).[18]

Couples-based interventions involving AGYW living with HIV can teach healthy relationship skills focused on spending time or engaging in activities together. Spending time together may help couples build trust and respect for one another[59] and, hopefully, reduce isolation. IPV interventions aiming to reduce social isolation should also engage health workers. Health workers may help identify ways to overcome HIV care engagement and treatment barriers related to social isolation, such as by increasing AGYW's time between prescription refills and using other differentiated care approaches. They may also offer emotional support to AGYW living with HIV who feel isolated. Doing so may decrease the risk of IPV among AGYW living with HIV.[47]

Limitations

Although the current study offers new insight into the IPV experiences of AGYW living with HIV, specifically related to emotional IPV and controlling behavior, it is not without limitations. Therefore, results should be interpreted with caution as they may not represent the viewpoints of all health workers, IPV program managers, or AGYW living with HIV in Uganda. First, we used two different data collection approaches with AGYW, in-depth interviews and focus groups. Most of our study findings were informed by interview participants versus focus group participants. This is because we conducted only two focus groups. We recommend similar research that includes more focus group data to allow for a greater range of perspectives from AGYW living with HIV. Furthermore, because the data collector was male, gender dynamics in Uganda, including power imbalances between men and women, may have made female participants uncomfortable expressing their full perspectives. Second, inclusion criteria for AGYW included living with or being married to (self-definition) a male partner; therefore, the results may not generalize to AGYW living with HIV in other types of relationships. Third, the sample size was small, which is not atypical for qualitative research[60]; however, we note that saturation of themes was reached. Given the focus of our study among AGYW living with HIV in Wakiso District, Uganda, the findings may not generalize to other dissimilar populations or settings. Fourth, despite taking several steps to promote rigor of data (e.g., purposive sampling, regular debrief meetings to check possible research bias, and independent coders[61]), we did not return transcripts to participants for comments or corrections nor gather participant feedback on the findings. Participant checking could have strengthened the credibility of our results. In addition, the interviewer/facilitator did not capture field notes during or after each interview/focus group. Lastly, the interview/focus group guides were not pilot-tested. Therefore, some questions may have been unclear to participants and, therefore, failed to elicit desired information.

Conclusion

Findings from the current study revealed different forms of emotional IPV and controlling behavior unique to HIV. These forms of IPV can make it difficult for AGYW living with HIV to stay healthy, by leading to poor outcomes, such as internalized HIV stigma and interference with access to medical care for HIV and the ability to consistently take HIV medication. Across the four themes identified in the study, male partners' misuse of power was a common denominator. Therefore, to reduce IPV and, thereby, improve the health of AGYW living with HIV, interventions must involve both AGYW and their male partners. Male partners had power over their female partners (AGYW living with HIV) by controlling the households' income, transportation, access to care, and information about their partners' HIV status. Entrenched oppressive gender roles manifested themselves through age differences, lack of employment, income, and transportation, and the lack of support systems for the AGYW. This study—through the voices of AGYW living with HIV experiencing IPV and their allies—documented the oppressive conditions in which many AGYW living with HIV live, their ability to identify those conditions, and—with the necessary support—it gives hope for changing those conditions.

Declarations

Ethics approval and consent to participate

This study was approved by the Arizona State University Institutional Review Board (approval no. STUDY00017114) on January 10, 2023; Makerere University School of Public Health Research and Ethics Committee (approval no. SPH 2023-380) on May 8, 2023; and the Uganda National Council for Science and Technology (approval no. HS2905ES) on June 20, 2023. All participants provided verbal consent prior to participating in eligibility screening and written informed consent prior to participating in focus groups and interviews. Verbal consent was used for eligibility screening because the IRBs determined that screening procedures presented the minimal risk of harm to participants. Verbal consent was not formally recorded. However, it was assumed that verbal consent was obtained if potential participants allowed research assistants to conduct the eligibility screening. Despite possibly being eligible, no minors were included in the current study. However, if included, only emancipated minors (defined by the Ugandan National Council for Science and Technology as those aged 15–17 who are married or have children) would have been eligible for the study. Given their emancipated status, we would have taken consent directly from the minor participant, not a legally authorized representative.

Consent for publication

Not applicable.

Author contribution(s)

Ijeoma Nwabuzor Ogbonnaya: Conceptualization; Formal analysis; Funding acquisition; Methodology; Supervision; Writing – original draft; Writing – review & editing.
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Competing interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Availability of data and materials

Given the study area (Wakiso District, Uganda), specific study populations (e.g., married/cohabiting AGYW living with HIV who are ages 15–24, have experienced intimate partner violence, and have a male partner who heavily drinks alcohol), characteristics (e.g., intimate partner violence and alcohol use), and the narratives they may describe, there is a significant risk for breaches in confidentiality inherent in our collected qualitative data. As a result, we did not make the qualitative data available for data sharing.

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Supplemental material

Supplemental material for this article is available online.

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