Author’s response to reviews

Title: Intimate Partner Violence among HIV Positive Women in Care - Results from a National Survey, Uganda 2016

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Version: 1 Date: 29 May 2019

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BMWH-D-19-00108

"Intimate Partner Violence among HIV Positive Women in Care - Results from a National Survey, Uganda 2016"

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BMC Womens Health
Dear Dr. Leonard Ajah,

On my own behalf and on behalf of all the other co-authors, I would like to thank you for reviewing our manuscript, "Intimate Partner Violence among HIV Positive Women in Care - Results from a National Survey, Uganda 2016" (BMWH-D-19-00108), and giving us the opportunity to improve it. Below this letter are point by point responses to each of the comments raised by the reviewers:

Editor Comments:

Comment: The should do revise the manuscript based on the observation made by the reviewers.
Response: We have reviewed all the comments raised by the reviewers and revised the manuscript taking into consideration the comments raised.

Reviewer reports:

Lucky Lawani (Reviewer 1): COMMENTS TO THE AUTHORS

General comment

Comment: This is an interesting reproductive health topic in the care of HIV positive women. However, I have some comments and recommendations which if addressed will improve the quality of the manuscript. I also recommend thorough English editing to enhance the quality of the manuscript.

Response: We thank the reviewer for the positive comment. The manuscript has been re-read and re-edited to improve the quality of the English.
Abstract

Comment: Conclusion: Stated that… "Experiencing IPV was associated with circumstances related to the relationship between the woman and her male partner".

Comment: Be specific on what relationship.

Response: We thank the reviewer for this comment. The phrase has been revised to specify the intimate nature of the relationship that was being referred to. (Line 69)

Main text

Introduction: The last paragraph states that…. "We analyzed data from this survey to establish the prevalence of intimate partner violence against women in HIV care and assess the factors associated with experiencing intimate partner violence".

Comment: What knowledge gap do you hope to address and what is novel about the current study?

Response: We thank the reviewer for this pertinent question. Our study population here are women who are HIV+. There are context specific factors that perpetuate the documented gender disparities in the HIV/AIDS burden one of which is the violence against women in intimate relationships. Uganda as a whole is a patriarchal society where violence against women is endorsed by both women and men (Uganda Demographic Health Survey 2016). The gap in knowledge is the factors that predispose (particularly HIV+) women to experiencing violence which can inform the development of interventions to curb violence not only in Uganda but other countries with similar contexts. We must also emphasize the uniqueness of this population (HIV+ women) as some could be in sero-discordant relationships and thus experiencing sexual violence can predispose their partners to HIV infection. We have further elaborated these issues in the background of the manuscript to make the knowledge gap clearer. Also to our knowledge, this is going to be the first study to provide national level estimates of IPV among women living with HIV in Uganda.
Methods:

Comment: The first paragraph states that:"This was a secondary analysis of data from a facility based cross-sectional study that was conducted across the 5 geographical regions of Uganda to assess the uptake of family planning services and establish the unmet need for family planning services among HIV infected women in care".

The current study has nothing to do with family planning? This statement contradicts the research question and the last paragraph of the introduction. The focus of this paper was supposed to be on IPV, how come data from unmet family planning needs of patients were used?

Response: We thank the reviewer for this comment. We agree that the focus of the paper is intimate partner violence and the data that were used were from a survey on family planning/reproductive health among HIV+ women; hence IPV was a secondary objective. However, intimate partner violence can influence the reproductive health choices made within the relationship. Research has shown that intimate partner violence is associated with a loss of reproductive control that may involve coercion by the male partner for the female partner to become pregnant and birth control sabotage or male partner interference with contraception (Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, et al. Pregnancy coercion, intimate partner violence and unintended pregnancy. Contraception. 2010;81(4):316-22). Intimate partner violence and reproductive health are so tightly intertwined that IPV may lead to a woman becoming pregnant against their will, increase risk of sexually transmitted infections or among women who are HIV positive in a sero-discordant relationship increase the risk of HIV transmission to their partner. This background explains the close linkage between reproductive health among HIV+ women and intimate partner violence. We do however recognize and acknowledge the limitation of using the data in the limitations of the paper.

Furthermore, we contend that given the large sample size of 5198 HIV+ women, and a total population of about 600,000 HIV+ women in Uganda (Uganda Population Based HIV Impact Assessment 2016/2017), the study was powered to assess the prevalence of intimate partner violence and its associated factors given the already high prevalence of physical (44%) and sexual violence (25%) in the general population according to the most recent 2016 Uganda Demographic Health Survey. Indeed, the current study established that the prevalence of physical intimate partner violence was 32.1% while that of sexual intimate partner violence was 28.3%; both of which are comparable to the prevalence in the general population.
Comment: The authors stated also in the first paragraph that….."A detailed description of the methods including the study sites, sample size determination and sampling procedures have been published elsewhere [13]" Since both publications are different, kindly include the details of the methodology used in the current study by highlighting; selection of subjects/sampling procedures, sample size calculation, inclusion and exclusion criteria etc.

Response: We thank the reviewer for this comment. Details of the sample size calculation and the sampling procedure have been included in the methods section. (Lines 122-138)

Comment: Line 124-126 stated that…. All eligible women were identified and randomly selected at the sampled health facilities using systematic sampling.

Provide detailed explanations on how this was done?

Response: A detail of the systematic sampling procedure has been included. This was part of the second stage of sampling at the facility level where by all women aged 15-49 years who presented for HIV care at the facilities on the interview days were listed on attendance forms. Systematic sampling was then done to select the number of eligible women using a sampling interval based on the client volume at the health facility. (Lines 122-138)

Assessment of Intimate Partner Violence:

Comment: The authors stated that..."For the purposes of this study, the definition of intimate partner violence was restricted to experiencing any physical or sexual violence. A questionnaire was used to assess women's experience of any form of physical or sexual violence by their partner".

Comments: This approach of not applying the standard definition (World Health Organization) of IPV in the recruitment of subjects will eliminate a large and very significant number of women who experienced IPV and constitute a major drawback and source of bias in the current study. I recommend that women with emotional/psychological violence should be included.
Response: We do agree with the reviewer about this limitation of the current study and have acknowledged it in the limitations. The definition of intimate partner violence was narrower than it should be as it excluded emotional/ psychological violence. Unfortunately the questionnaire used did not elicit information on other forms of violence aside from physical and sexual violence. This means that there was an underestimate and not an overestimate of the associations thus biasing our results towards the null hypothesis. This means that any interventions to address intimate partner violence on the basis of the conclusions of the study would not be misplaced, misdirected or evidence misinformed. We acknowledge the drawback although do not believe that it negates, nullifies or trivializes the findings from the study. Sexual and physical violence perpetrated by an intimate partner are forms of intimate partner violence and we believe that interventions to address these forms of violence could address emotional/ psychological violence as well.

Comment: Where and how were the questionnaires administered, especially for those who were accompanied by their partner's, considering the challenges of disclosure under such setting?

Line 137-140 stated that. Participants were also asked about possible predictors such as their partner's age, HIV status disclosure to sexual partner (and whether or not both partners had mutually shared their HIV results), relationship status and HIV status of partner, HIV treatment status (ART versus non-ART and duration on treatment)…….

How possible was this for those who were accompanied by their partners, especially when a significant proportion of your subjects have not disclosed their HIV status and even treatment to their partner's (as reflected by the high non-disclosure rate in your results)?

IPV and these other assessment/evaluation are best conducted one-on-one with strict privacy and confidentiality assured, otherwise the true situation will never be disclosed or reported?

Response: Each interview was carried out by a trained interviewer after obtaining informed consent from the interviewee. The nature of the interview process was one-to-one and all responses given by participants were anonymized to protect the confidentiality of the data collected. The questionnaire also emphasized the anonymous nature of the responses to allow for the disclosure of sensitive information like the partners HIV status without the fear of any consequences. These details have been added to the Ethics Approval and Consent to participate section of the manuscript. (Lines 341-352)
Comment: Line 142-144 stated that….The questionnaire was pre-tested to check the suitability of various aspects such as the clarity of the translation, skip patterns and filtering questions.

How was it pretested, on which group of subjects and what number was used?

Response: We thank the reviewer for this comment. More information regarding the quality of the questionnaire and how it was pretested has been provided. “In order to ensure internal validity of the questionnaire, continuous roles plays among the 5 research assistants from each of the 5 regional teams were conducted for two days after training to ensure a thorough critic of the flow of the tools. This approach appeared more rewarding compared with the conventional approach of field pretesting of study tools as the research assistants had more time to interact with tools and as such became more familiar with them. There was sufficient time for comparison of scenarios, discussion and revision of the tools. (Lines 157-163)

Results:

Comment: Line 177-179 stated that....."This study was based on an analysis of data from 5198 HIV positive women who participated in a survey to assess the unmet need for family planning services among HIV infected women in care".

I am still of the opinion that the current study has nothing to do with family planning and this statement contradicts the research question which was supposed to be on IPV among HIV positive women in care.

Response: We thank the reviewer for this comment. We agree that the focus of the paper is intimate partner violence and the data that were used were from a survey on family planning/reproductive health among HIV+ women. However, intimate partner violence can influence the reproductive health choices made within the relationship. Research has shown that intimate partner violence is associated with a loss of reproductive control that may involve coercion by the male partner for the female partner to become pregnant and birth control sabotage or male partner interference with contraception (Miller E, Decker MR, McCauley HL, Tancredi DJ, Levenson RR, Waldman J, et al. Pregnancy coercion, intimate partner violence and unintended pregnancy. Contraception. 2010;81(4):316-22). Intimate partner violence and reproductive health are so tightly intertwined that IPV may lead to a woman becoming pregnant against their will, increase risk of sexually transmitted infections or among women who are HIV positive in a sero-discordant relationship increase the risk of HIV transmission to their partner. It is this background that explains why data on family planning and reproductive health were used to assess the prevalence of intimate partner violence and its associated factors. We do however recognize and acknowledge the limitation of using the data in the limitations of the paper.
Furthermore, we contend that given the large sample size of 5198 HIV+ women, and a total population of about 600,000 HIV+ women in Uganda (Uganda Population Based HIV Impact Assessment 2016/2017), the study was powered to assess the prevalence of intimate partner violence and its associated factors given the already high prevalence of physical (44%) and sexual violence (25%) in the general population according to the most recent 2016 Uganda Demographic Health Survey. Indeed, the current study established that the prevalence of physical intimate partner violence was 32.1% while that of sexual intimate partner violence was 28.3%; both of which are comparable to the prevalence in the general population.

Comment: Line 185….. "Of the 5198 women that participated in the survey, 1664 (32.1) reported to have experienced physical violence"….. 1664 (32.1%). Line 192-193 stated that….. "1491 (48.4%) had experienced some form of intimate partner violence".

What form of violence does this represent, since only physical and sexual assaults were assessed in the present study?

Response: We thank the reviewer for pointing this out. We have clarified that it represented physical or sexual intimate partner violence. (Line 213)

Comment: Line 199-203 stated that…. "Women in relationships where the partner was younger were more likely to experience any form of intimate partner violence PRR= 1.43, 95% CI: 1.14-1.79, as were women in relationships where the partner was <10 years older PRR= 1.20 .95% CI: 1.00-1.43, and women in relationships where the partner was ≥10 years older PRR=1.31, 95% CI: 1.05-1.64". This result and its significance are difficult to appreciate, as it is not clear cut. The results shows that women who had either younger or older partners (equal/less than 10 years and equal/greater than 10 years) had greater risk of experiencing IPV, indicating that age is not a significant contributor as reported by the authors- The results show that both younger and older partners have higher risks of IPV.

Response: This is a very interesting observation by the reviewer and we agree that indeed this finding was not so much about age as it was about the power differentials in the relationship between the two people. In the discussion we note that the desire to have power over and control one’s partner might be the explanation to our observation that compared with women in relationships where the woman and her partner were of the same age, women in relationships where the woman and her partner were of different age were more likely to experience intimate partner violence. The explanation is that power differentials are more pronounced when the woman and man are of different age compared to when they are of the same age.
Comment: Line 203-206 stated that…"Compared with women who did not have any biological children, women with 3-4 biological children were more likely to experience any form of intimate partner violence PRR= 1.27 95% CI: 1.00-1.59 as were those with 5 or more biological children PRR=1.34 95% CI: 1.06-1.71".

Comment: I think the authors should compare those with biological children vs those without biological children, instead of comparing no children vs 3-4 and ≥5 biological children.

Response: We thank the reviewer for this comment. Although we recognize the significance of this submission, we believe that collapsing those who have 1-2, 3-4 and ≥5 into one category of those who have biological children and then comparing them to those who do not have biological children would dilute the association that we see. In any case, the data as presented are in essence a comparison of those without biological children (0) to those with biological children only that those with biological children are broken down to 3 categories (1-2, 3-4 and ≥5). Furthermore, when you look more closely at the data presented, compared with women who do not have biological children, those with 3-4 children [PRR=1.27 95%CI (1.00-1.59)] and those with ≥5 children [PRR=1.34 95%CI (1.06-1.71)] were more likely to experience intimate partner violence. The association was not statistically significant for those who had 1-2 children [PRR=1.20 95%CI (0.95-1.51)], so combining these 3 categories would be diluting and therefore misrepresenting the data. The information would be richer if the data are represented in those 3 categories instead of collapsing them to one category of having biological children.

Tables

Table 1:

Comment: What does -n- indicates?

Response: -n- indicates number and it has been replaced as such in the table. (Line 475)

Comment: What is the difference between Pentecostal/Born Again/Evangelical and Anglican and protestant?

Response: We thank the reviewer for this suggestion. This variable has been deleted from Table 1 and Table 2 and was not included in the association analysis.
Comment: What is the difference between "in relationship but never married" and the group "never married"?

Response: According to the most recent Uganda Demographic Health Survey 2016, 30.3% of women in Uganda were married, 25.8% were never married 30.3% were living together (in a relationship but not married), while the rest were divorced, separated or widowed. It is not uncommon in Uganda for a man and a woman to cohabit and have children without being officially married. This fundamental difference could lead to people officially married differing in levels of intimate partner violence compared to those in unions/relationships.

Comment: Why not classify region of residence as urban or rural?

Response: We cannot classify region of residence as urban or rural because the country is divided into the 5 regions and in each of these regions, there are areas that are urban and those that are rural and yet information on urban/rural residence was also not collected.

Comment: What is significance of owning a radio, mobile phone or bicycle in the current study?

Response: These data were used in the calculation of the wealth quintile into the lowest, second, middle, fourth and highest depending on the number of these household items that an individual owned using principal content analysis.

Comment: What do ART and HC mean? Please indicate full meaning on first use.

Response: This comment is noted. The two abbreviations have been written in full in the table and have been included in the list of abbreviations (Line 475 and Lines 337-339)

Table 2:

Comment: Table 2 is too congested, kindly edit

Response: We agree with the reviewer. We have deleted some rows from Table 2 that are not relevant to the association analysis in the Table 3.
Comment: All is not a variable, do you mean total?
Response: We thank the reviewer for this observation. What was meant was total and the table has been revised as such. (Line 479)

Comment: What does “any violence” represent? The methodology indicates that this group was excluded. Please indicate what constitute any violence?
Response: Any violence was physical or sexual violence and this has been clarified as such in the table. (Line 479)

Table 3:

Comment: Just like Table 2, table 3 is also too congested. Can only important variables be considered? Indicate p-values that are statistically significant.
Response: Only important variables with a potential to be associated with intimate partner violence were included in the model. (Line 484) The p-values that are statistically significant have also been indicated with an asterisk. (Line 485) We thank the reviewer for this recommendation.

Comment: What does P indicate?
Response: A clarification has been made that this is the p-value (Line 484).
Discussion

Comment: Line 272-275 stated that… "In addition, the lower prevalence of IPV in sero-discordant relationships might reflect the extra support and attention these couples receive in anticipation of the violence compared with their positive concordant counterparts in a setting like Uganda where the prevalence of IPV is already high".

The message is not clear. It appears you mean that sero-discordant partners get extra support and care as compensation or in anticipation for IPV which will occur? Kindly rephrase to make statement more explicit.

Response: We thank the reviewer for this recommendation. The message has been made clearer. The explanation is that couples in sero-discordant relationships receive extra support in terms of the counseling they receive which could address the anticipated escalation of the violence compared with couples in sero-concordant relationships. (Line 302)

Comment: Line 286-287 stated that…" excluding emotional/ psychological violence and controlling behavior both of which were not assessed".

So what does any violence in table 2 mean or what constitute any violence? This is a major limitation, as there are likely to be more emotional/psychological torture than physical and sexual assault in the African setting where families/couples are likely to keep their HIV status as a secret to society, making physical violence a red flag to neighbors. In such cases the prevalence of emotional/psychological violence are likely to be concealed and even higher. Therefore, excluding women who experienced emotional/psychological violence is a major flaw.

Response: We do agree with the reviewer about this limitation of the current study and have acknowledged it in the limitations. The definition of intimate partner violence was narrow as it excluded emotional/ psychological violence. Unfortunately the questionnaire used did not elicit information on other forms of violence aside from physical and sexual violence. This means that there was an underestimate and not an overestimate of the associations thus biasing our results towards the null hypothesis. This means that any interventions to address intimate partner violence on the basis of the conclusions of the study would not be misplaced, misdirected or evidence misinformed. We acknowledge the drawback although do not believe that it negates, nullifies or trivializes the findings from the study. Sexual and physical violence perpetrated by an intimate partner are forms of intimate partner violence and we believe that interventions to address these forms of violence could address emotional/ psychological violence as well.
Conclusion

Comment: This is too long and contains a lot of irrelevant information; please edit to make conclusion more concise by highlight the key findings and recommendations in one or two sentences.

Response: The conclusion has been re-written to make it more concise. (Lines 321-331)

Comment: Paragraph 1, line 293-295 reads…."This violence could dampen the attitudes of these women towards seeking care and treatment and thereby retard the likelihood of viral suppression". The current study did not assessed or show that women who suffer IPV were less likely to access treatment and care, therefore this cannot be part of the conclusion.

Response: We concur with the reviewer and have deleted this statement.

Comment: Line 295-297 stated that…."Health care workers offering HIV care and treatment services should screen women for intimate partner violence and offer or recommend the appropriate psychosocial or medical assistance".

The approach used to screen women in the current study is subject to bias due to lack of confidentiality, especially for respondents who were accompanied by their partners. Kindly follow the standard approach for screening women for IPV.

Response: We thank the reviewers for this comment. We would like to clarify that this was a recommendation arising from the findings of the current study. Women in this study were not screened for IPV. Women were included in the survey if they were HIV positive and receiving HIV care and treatment in the selected health facilities, aged 15-49 years and sexually active within the past 12 months independently of their experience of IPV. We have noted the recommendation of the reviewer though that the screening of women for IPV should follow standard approaches and have included this as part of the recommendation. (Lines 324-326)
Magdy R. Ahmed (Reviewer 2):

An interesting topic, however some drawbacks

INTRODUCTION

Comment: Intimate partner violence , to be mentioned and discussed at the beginning of the text with detailed prevalence in some African counties

Response: This is a good suggestion from the reviewer. However, we chose to mention the prevalence in other settings, populations and other African countries as part of the discussion where we compared findings to the general population in Uganda, findings in a district in Western Uganda, other countries in Africa, Asia and the Americas. (Lines 242-255)

Comment: The aim not clear, clarify please

It is too long, concise please

Response: The aim of the paper is stated at the end of the background: “We analyzed data from this survey to establish the prevalence of intimate partner violence against women in HIV care and assess the factors associated with experiencing intimate partner violence.” (Lines 112-114)

METHODS

Comment: Ethical approval data are missing (number, code and date)??

Response: The ethical approval information including the number and code have been included in the Ethics approval and consent to participate section. We also obtained approval from the Makerere University School of Public Health Higher Degrees, Research and Ethics committee Protocol Number 357 and registered the study with the Uganda National Council for Science and Technology Registration Number HS 1992. (Lines 350-352)
Comment: Questionnaire which used are they reliable and valid ?

Response: We thank the reviewer for this comment. More information regarding the quality of the questionnaire has been provided. “In order to ensure internal validity of the questionnaire, continuous roles plays among the 5 research assistants from each of the 5 regional teams were conducted for two days after training to ensure a thorough critic of the flow of the tools. This approach appeared more rewarding compared with the conventional approach of field pretesting of study tools as the research assistants had more time to interact with tools and as such became more familiar with them. There was sufficient time for comparison of scenarios, discussion and revision of the tools.” (Lines 157-163)

Comment: Sample size calculation on what basis ?

Response: The sample size calculation has been included in the methods section. (Lines 122-129)

Comment: Statistical analysis, too long . Mention only test which were used

Response: We thank the reviewer for this comment. Only the statistical tests that were used in the manuscript are mentioned as well as the justification of the use of each.

Comment: Inclusion / exclusion criteria to be added

Response: The inclusion and exclusion criteria have been indicated in the methods section. (Lines 135-139)

Results

Comment: Table 3 , missing explanation

Response: An explanation about Table 3 has been included. (Lines 222-233)
Discussion

Comment: More comparison with other studies were needed
Response: We thank the reviewers for this comment. We have compared with findings about intimate partner violence in the general population in Uganda, among HIV+ women in a district in Uganda over a 5 year period, among HIV+ women in Nigeria, among HIV+ women in Nepal as well as several studies in the US some measuring sexual and physical violence albeit not mentioning the perpetrators of the violence. (Lines 243-256)

Comment: Conclusion, It is too long , concise please
Response: The conclusion has been re-written to make it more concise. (Lines 322-332)

Comment: Some linguistic and grammar mistakes ; reconsider please ??
Response: The entire manuscript has been re-read and re-edited to correct any English grammar or linguistic mistakes.