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Review

Understanding the Intersections of IPV and HIV and Their Impact on Infant Feeding Practices among Black Women: A Narrative Literature Review

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Abstract: Intimate partner violence (IPV), particularly sexual and emotional violence, against Black mothers who acquire human immunodeficiency virus (HIV) during childbearing age is a significant health and social concern requiring targeted interventions and precautions. IPV against women increases the chances of early mixed feeding, placing infants at high risk of mother-to-child transmission of HIV and increasing infant morbidities. Although violence complicates many Black mothers' lives, limited research evidence exists about the critical intersections of violence, HIV, and motherhood. Women's fear associated with IPV makes them less likely to disclose their positive HIV status to their partners, which subsequently prevents them from applying the guidelines for safe infant feeding practices. This review aims to explore the critical intersections between IPV and HIV and their impact on the infant feeding practices of Black mothers living with HIV. Furthermore, the theme of IPV and how it overlaps with other factors such as HIV-positive status and gender dynamics to compromise the motherhood experience is also the focus of this narrative review of existing literature. Understanding the intersection of IPV and other factors influencing infant feeding practices among women living with HIV will help inform programming and policy interventions for HIV-positive Black women who may experience IPV during the perinatal period.

Keywords: HIV; intimate partner violence; childbearing; infant feeding practices

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1. Introduction

Intimate partner violence (IPV), a rising health issue in the public health sector globally, involves harassment, physical violence, emotional violence, sexual violence, and psychological assault that may include coercive tactics by a current or former intimate partner [1]. The IPV epidemic is estimated to affect one-third of women worldwide [2]. IPV can limit a person's ability to obtain sexual healthcare and increase their risk of contracting human immunodeficiency virus (HIV) and other sexually transmitted infections (STIs) [3]. HIV is an infection that attacks the body's immune system, and it weakens a person's immunity against infections, such as tuberculosis and fungal infections. A growing body of literature has confirmed a positive relationship between IPV and HIV [4] and concludes that IPV is a risk factor for acquiring HIV [5,6].

While African American women comprise only 13.4% of the U.S. female population, they represente 42% of the new HIV diagnoses in 2018 and accounted for 64% of U.S. HIV cases among women. In addition, African American women have a high HIV infection rate—28 times higher than Asian females and 15 times higher than White females [7]. The majority of those who became infected are women in heterosexual relationships with most being infected by their primary partner [8]. Black Canadians make up about 5% of the country's total population, but in 2019, Black women and men accounted for 42% and 18% of reported new HIV cases among all women and men, respectively [9]. Overall, the Black

population accounts for one in every four new diagnoses yearly. Moreover, Black people are more likely than their White counterparts to die from HIV-related causes [10].

Research on women's HIV risk and the experiences of emotional and economic IPV is rarely taken into account [6]. IPV most frequently takes the form of emotional abuse. Despite being the most frequent kind of violence suffered by women, emotional violence (EV) has been largely overlooked [11,12]. The risk of acquiring HIV increases with the degree of tissue trauma, such as vaginal lacerations and abrasions that often develop when marital rape occurs [13]. Sexual violence, including rape, can interfere with women's ability to access treatment and care, sustain adherence to antiretroviral therapy (ART), and adopt recommended infant-feeding choices [14]. Women with a history of IPV develop psychological trauma, which makes them less likely to advocate for safe sex, leading to increased HIV vulnerabilities [15].

Critical intersections within the context of IPV and HIV among Black women are reinforced by mutual risk factors, such as poverty, race, gender roles, lower socio-economic status, young age, unemployment, and cultural norms [16–18]. IPV against Black women living with HIV is very prevalent and may affect their ability to make good decisions, such as adherence to optimal breastfeeding practices or practice safe sex [19]. The 2016 World Health Organization (WHO) guidelines detail optimal feeding practices and include that "mothers living with HIV should breastfeed for at least 12 months . . . while being fully supported for ART adherence". Also, "Mothers known to be HIV-infected . . . should exclusively breastfeed their infants for the first six months of life, introducing appropriately complimentary feeds thereafter and continue breastfeeding" [2]. The fear of IPV, which may happen due to their partner finding out about their HIV status, increases the women's nonadherence to the recommended feeding practices and increases the possibility of early mixed feeding, thereby exposing infants to the danger of mother-to-child (vertical) transmission of HIV [20–23]. Mixed feeding refers to the practice of feeding an infant both breast milk and other fluids or foods such as infant formula, water, or solid foods. The infant may contract HIV when mixed feeding is practiced. If these breast milk alternatives are not prepared and handled safely, they can become contaminated with pathogens, including HIV, and then ingested by the infant, increasing the risk of HIV transmission. Also, mixed feeding can sometimes lead to breast tissue damage or cracks in the nipples due to irregular and sometimes aggressive breastfeeding patterns. These wounds can serve as an entry point for the virus increasing the transmission risk [23]. Besides the negative effects of IPV on infant feeding practices, Black women are very likely to face life-threatening lethal injuries and homicides [24,25]; have their children separated from them [26]; experience social stigma [27]; acquire HIV and other sexual diseases [28]; have low confidence and self-esteem [29]; become incarcerated [26]; engage in substance abuse activities [30]; and have an increased likelihood of mother-to-child HIV transmission as a result of early mixed feeding [31]. As such, an in-depth understanding of Black women's experiences who suffer at the crossroads of IPV and HIV is deemed necessary.

To advance the current understanding of the critical intersection between IPV and HIV and their impact on infant feeding practices among Black women, this narrative literature review will appraise relevant recent literature. The objective of this project is to assess the intersection of IPV and HIV and its impact on infant feeding practices among Black women. The research question for this study explores how and to what extent the existing research data explain the intersections of IPV and HIV in the context of infant feeding practices among Black women. The specific objectives are as follows:

1. Review the associated factors of IPV among Black women living with HIV;
2. Assess the impact of IPV on infant feeding practices among Black women living with HIV;
3. Examine how Black women living with HIV experience IPV in relation to infant feeding practices.

This review aims to provide insights and practical implications for this topic by synthesizing current research while reflecting on the authors' expertise. This narrative review avoids overly theoretical discussions and highlights real-world applications.

2. Methods

The narrative nature of this review was selected to obtain a broad perspective on the intersections of IPV and HIV and its impact on the infant feeding practices among Black women. A narrative review is useful for critical issues that may require a new approach to obtain an in-depth understanding. In the narrative review, the reviewers serve as research instruments to interpret the literature from their point of view and propose a new approach in order to understand a specific issue. The narrative review outlines the existing literature and analyzes what is known about a specific issue. A clarification of the current state of research around the relationships between IPV and HIV and its impact on infant feeding practices was deemed necessary to obtain a comprehensive understanding of these intersections. This review investigated diverse research and obtained a clear understanding of how IPV and HIV intersect and affect infant feeding practices. In conducting this narrative review, the researchers did not seek a complete accounting of all statements made about this topic; instead, they reflected on their expertise and selected research that best addressed their research questions and that had the potential to change the way their field views this issue.

The inclusion criteria for this review were peer-reviewed studies published in English. The population of the studies were women who experienced IPV, lived with HIV, and were of reproductive age (typically 15–49 years old). All study types were considered, including quantitative, qualitative, mixed methods, reviews, and others. The exclusion criteria included studies that were published in languages other than English. Opinion pieces, letters to the editor, and abstracts were excluded. Studies with a population who did not identify as Black women and had not experienced IPV or living with HIV were excluded. Also, studies that did not pertain to the intersections of IPV, HIV, and infant feeding practices among Black women were excluded.

For this review, six electronic databases, including CINAHL, Google Scholar, ScienceDirect, Scopus, ResearchGate, and PubMed, were searched to obtain English publications from the last ten years (2012–2022) pertaining to IPV, HIV, and their associated risks among Black women together with the impact of their intersection on sub-optimal infant feeding practices. The rationale behind choosing these databases was to provide a comprehensive exploration of the current research. While some overlap of journal content coverage between databases, such as MEDLINE and CINAHL, existed, all databases were searched to achieve comprehensive retrieval of the literature related to the review question. This narrative review embraces pluralism by including a wide range of databases. Also, a manual search through references of articles and abstracts and peer review was conducted. Multiple search terms were used including IPV, HIV, and feeding practices and their synonyms (refer to Table 1). A combination of three key concepts (core key terms and their synonyms) was used: "IPV" AND " HIV" AND "population" AND "infant feeding practices". The key search terms were used in various combinations, employing the Boolean operators ("AND" and "OR") (refer to Figure 1). In searching, each main concept was connected with its synonyms by the Boolean operator "OR". Then, all main concepts were combined using "AND" to recognize related studies. Search terms were combined in the following manner:

(All 'IPV' terms were connected by the search term OR) AND (all 'population' terms were connected by the search term OR) AND (all 'during perinatal period' terms were connected by the search term OR). Table 1 shows the key search terms used in this review.

Thematic mapping method was used to analyze and synthesize extracted data from the selected articles. By using thematic mapping, we created the main themes outlined below. Etowa et al. described thematic mapping as a process whereby data extracted from individual articles are initially coded and then categorized together in similar groups.

This is followed by further analysis and synthesis of all groups to yield the final main themes [32].

Table 1. Key terms.

#1. Intimate partner violence "Intimate partner violence" OR "IPV" OR "intimate partner abuse" OR "intimate violence" OR "partner violence" OR "partner abuse" OR "domestic abuse" OR "domestic violence" OR "wife abuse" OR "abuse of wife" OR "couple violence" OR " martial violence" OR "intimate aggression" OR "dating violence" OR " family violence" OR "physical violence" OR " physical abuse" OR " gender violence" OR " gender based violence" OR" gender and sexual violence" OR "sexual assault" OR " sexual abuse" OR "emotional violence" " emotional abuse" OR " abused women" OR "women abuse" OR " battered women" OR "physiological abuse" OR "physiological violence" OR " sexual and gender based violence" OR "wife beating" OR " spouse abuse" OR "dating violence" OR "GBV" OR "VAW" OR "sexual violence" OR " relationship violence"
#2. Population "Black women" OR "African American women" OR "women of African descent"
#3. "HIV" OR "human immunodeficiency virus"
#4. Specific period "perinatal period" OR " pregnancy" OR " after pregnancy" OR " postpartum" OR " before pregnancy" OR "postnatal" OR "prenatal" OR "antenatal" OR " maternal" or "pregnant" " " Breast feeding" OR " infant feeding practices"
#5. "Intersection" OR "impact" OR "effects" OR "relationship"
#6. #1 AND #2 AND #3 AND #4 AND #5

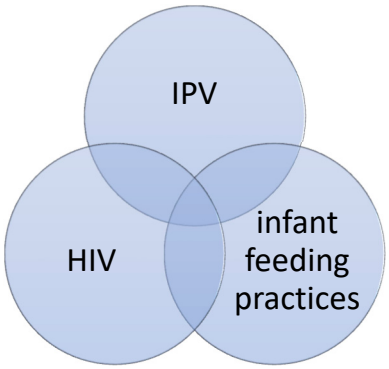

Figure 1. Boolean operator example: IPV AND HIV AND infant feeding practices.

3. Findings

The main themes for this narrative review are as follows:

(1) IPV against women;
(2) HIV among Black women;
(3) IPV and HIV-positive Black women;
(4) Intersections of IPV, HIV, and infant feeding practices among Black women.

3.1. Intimate Partner Violence (IPV) against Women

IPV is well recognized as a global health problem that violates human rights, and female partners are significantly more likely than males to experience all forms of IPV [33]. Also known as domestic violence, IPV encompasses physical violence, emotional abuse, sexual violence, psychological harm, verbal abuse, stalking, and reproductive coercion by a current or former partner. IPV comprises one person exerting control over the other individual in the relationship. Lack of control impacts women's lives in many ways, including their ability to negotiate safe sex practices, such as condom use, and decisions related to infant feeding practices [34].

Globally, 1 in 3 women have disclosed that they have experienced physical abuse by an intimate partner at least once in their lives [35]. However, these numbers are

an underestimate since many IPV incidences go unreported [36,37]. Intimate partner violence is estimated to affect 27% of ever-partnered women between the ages of 15 and 49 worldwide. Adolescent girls and young women are particularly affected by IPV, which affects 24% of women aged 15–19 years and 26% of women aged 20–24 years [38]. These data show that IPV is a significant worldwide health problem among women, specifically those who are pregnant and of childbearing age [22,39].

A recent systematic review of 12 studies reported the prevalence of IPV among pregnant women. The results showed that 1.6–78% of women experienced physical IPV and 1.8–67.4% experienced psychological IPV during pregnancy [40]. A previous systematic review of 13 studies on IPV prevalence in Africa stated that between 2 and 57% of women experienced some kind of IPV during pregnancy. Emotional violence was most prevalent at 41–49%, physical violence ranged from 22.5 to 40%, and sexual violence ranged from 2.7 to 26.5% [41]. Exposure to IPV during pregnancy can negatively affect adherence to recommended feeding practices [22].

Various studies have demonstrated that women who experience IPV have a greater chance of acquiring HIV [42–44]. Moreover, considering the knowledge, attitudes, and behavioral practices of HIV-positive mothers, it has been observed that mixed infant feeding practices are more common than exclusive breastfeeding [45,46]. The biggest obstacles to HIV-positive mothers practicing exclusive breastfeeding in the first six months are the lack of infant feeding counseling, concern over HIV transmission through breast milk, returning to work, and nursing challenges [47]. Infant feeding counseling and suggestions from partners and family are the key variables affecting HIV-positive mothers' choices for infant feeding [48].

The current global health goals include improving infant survival rates and preventing HIV transmission from mothers to their children (PMTCT). Sub-optimal infant feeding practices are high among HIV-exposed infants [49]. HIV can be transmitted from a mother to her child during pregnancy, labor, delivery, or breastfeeding for various reasons such as social determinant factors [50]. Efforts have been made to address these challenges and promote optimal infant feeding practices among HIV-exposed infants. Programs and interventions that provide comprehensive medical attention and specific medications to HIV-positive mothers have been initiated in order to achieve better adherence to recommended feeding practices. Major advancements have been made in the last two decades in order to fight against HIV transmission from mothers to their children through the PMTCT program [51]. For HIV-positive pregnant women, the WHO has recommended certain antiretroviral drug combinations, and women who are established on these can breastfeed. For example, zidovudine (AZT) is an antiviral medication that reduces the risk of mother-to-child transmission of HIV during pregnancy, labor, and delivery. It can be administered to HIV-positive pregnant women to reduce the viral load and the likelihood of transmitting the virus to infants. Also, lamivudine (3TC) is an antiviral medication that can be used as part of antiretroviral regimens for pregnant women with HIV to reduce the risk of transmitting the virus to their infants [52]. HIV-positive women need to consistently adhere to their antiviral medication regimen in order to be able to breastfeed without complications. However, women who are experiencing IPV may face challenges to adherence. Fear, stress, and disruptions caused by abusive partners can make it difficult to prioritize medication adherence [53]. Therefore, despite advances such as the PMTC program, IPV has the potential to negatively influence how children are fed [54]. Ultimately, IPV exposure can have serious negative effects on a mother's and child's health [55].

To illustrate these negative effects, we examine an investigation of a cross-sectional aspect that used the Ethiopian Demographic and Health Survey (EDHS) 2016 data. Of all child–mother pairs from Ethiopia's various regions who participated in the EDHS 2016, 1307 observations were included in the study. Mothers were on average 29 years old and children were on average 14 months old. Thirty-two percent of women reported experiencing IPV during the perinatal period. Eight percent of children had a minimum wholesome diet in which they received essential nutrients, energy, and hydration to support

overall health and well-being, 15% had a minimum dietary diversity (diet from four or more food groups out of the seven food groups during the previous day), and 43% had a minimum number of meals each day (infant who is breastfed receives two or more daily feedings of solid, semi-solid, or soft foods). Violence in intimate relationships reduces a child's minimum permissible diet (minimal amount of food and nutrients required to maintain basic health and prevent malnutrition) by 65%. The minimal permissible diet was also influenced by the caregiver's completion of secondary education, employment status, and desire for children [56].

In addition to the assessment of the relationships between IPV, breastfeeding habits, and a mother's mental health, we examined a study whose primary objective was to identify risk factors for IPV during pregnancy and the postpartum period in Bangladesh. The cross-sectional study included 2000 women from four districts of Bangladesh with children under six months old. Among 28% of mothers, high levels of common mental disorders (CMD) were observed, and 49.7% of mothers had suffered violence in the previous year. Only 54% of mothers said that they had started nursing early, and 64% said that they exclusively breastfed. Living in food-insecure families, with poor socioeconomic positions and little autonomy, or being less educated than their spouses increased the likelihood that women would encounter IPV. Women who had experienced IPV were 2–2.3 times more likely to experience severe CMD and 28–34% less likely to exclusively breastfeed [57].

3.2. HIV among Black Women

Despite advances in policies, programs, and treatments, HIV remains a significant global health issue, and Black women continue to be disproportionately affected compared to other demographic groups. According to the Centers for Disease Control and Prevention (CDC) in the United States, Black women accounted for the majority of new HIV diagnoses among women in 2018 [7]. Sub-Saharan Africa is heavily impacted by HIV, and within that region, Black women face a higher risk due to various social, economic, and cultural factors [58]. HIV prevalence per 100,000 individuals is 800.9 among Black women compared with 45.3 among White women [7]. In the United States, Black women have a 15 times higher risk of acquiring HIV than White women. Furthermore, HIV-related illnesses are among the leading causes of death for Black women at the reproductive age between 29 and 34 years old. Multiple risk factors contribute to the epidemic among Black women, including higher rates of poverty, lack of access to proper health care services, higher rates of some sexually transmitted infections, lack of HIV status awareness, and social stigma [59]. In the immigrant context, discrimination, stigma, and systematic barriers are all significant factors that prevent women from knowing the importance of receiving an HIV test, seeking more information on prevention and treatment options, and disclosing their status. Fear of HIV disclosure, judgment, or rejection may lead to delayed diagnosis, reduced adherence to treatment, and lack of connecting with supportive services, thereby negatively impacting overall health outcomes [60,61]. In their study, Nydegger et al. found that engaging in behaviors with a higher risk of HIV transmission, such as unprotected sex, having multiple sexual partners, and substance abuse, can contribute to the higher HIV prevalence among Black women [62]. Also, gender inequality including gender-based violence, power imbalances in relationships, and cultural norms, can compromise women's ability to negotiate safer sex practices, access prevention methods like condoms, or control their sexual health decisions.

Cultural beliefs associated with HIV and infant feeding practices have been investigated in the context of immigrant Black women. Many researchers have studied how Black women living with HIV sustain their cultural beliefs about infant feeding upon migrating to Canada. The desire to breastfeed was found to be a mutual existential perception shared by Black women, including those living with HIV [58]. For example, Greene et al. found that Black women, including those living with HIV, considered breastfeeding inseparable from their maternal role and suffered from guilt as a result of breastfeeding avoidance. "Good mothers" who breastfeed versus "bad mothers" who do not breastfeed was a shared belief

that was expressed in the same study [63]. In the same context, Leshabari et al. quoted a Tanzanian mother as saying, "A real mother should breastfeed her child", indicating that the term "bad mother" is used to describe women who are not breastfeeding their infants [47]. A positive perception towards breastfeeding was also considered critical to a baby's well-being by strengthening physical and spiritual bonds between mothers and their infants [64]. Social expectations also play an influential role in affecting Black women's decision to breastfeed [65]. As such, infant feeding practices among Black mothers must be understood via their sociocultural contexts, with due consideration given to cultural beliefs and gender roles. Infant feeding is more than a physiological process; it is also an emotional, psychological, social, and cultural process.

Nearly half of the total HIV cases in the world are women of childbearing age [58]. However, as a result of concerted worldwide efforts, the number of new child HIV infections dropped by approximately 40% between 2003 and 2011 [66]. A global objective to eliminate the mother-to-child transmission (MTCT) of HIV prioritized breaking the vicious cycle of HIV transmission to newborns [67]. In 2011, a global plan to eliminate all new HIV infections among children by 2015 and keep their mothers alive was launched [68]. This plan consisted of four components of the comprehensive prevention of MTCT program: (1) primary prevention of HIV infection among women during their perinatal period; (2) prevention of unintended pregnancies among HIV-positive mothers; (3) prevention of MTCT; and (4) providing appropriate care to mothers living with HIV and their infants, children, and families [69]. Ultimately, this plan reduced pediatric infection by almost 90% and decreased MTCT to less than 5% worldwide by 2015 with special attention to the 22 sub-Saharan African countries that represent almost three-quarters (69%) of the 23.5 million people infected in the world [70]. However, many social factors put such efforts in danger such as experiencing IPV during the breastfeeding period.

3.3. IPV and HIV-Positive Black Women

The intersection between IPV and HIV has been well recognized globally [71,72] and for Black women specifically [25,28,73]. Previous studies reveal that IPV has been linked with HIV acquisition [74,75]. For Black women in a current abusive relationship, HIV testing and subsequent disclosure of HIV-positive status to a partner and family can increase the risk of partner abuse [76–84]. Many studies have documented that HIV-positive women are more likely to experience IPV than other women [85,86]. IPV can also weaken a woman's ability to disclose her HIV-positive status, especially during the postpartum period as she is afraid of her partner's reaction [87], which negatively affects her ability to choose the proper infant feeding method to prevent MTCT (vertical) transmission of HIV [31].

IPV increases the spread of HIV to Black women, exposing the women, their offspring, and their families to various risks [17]. HIV and intimate partner violence (IPV) afflicts Black women disproportionately [87]. Intimate partner violence (IPV) does not directly lead to HIV infection; however, there is a complex interplay between IPV and HIV risk. IPV can increase a person's vulnerability to HIV in several ways such as physical and sexual violence, which can result in injuries, including genital or anal injuries. These injuries can facilitate the transmission of HIV if exposure to infected bodily fluids occurs. Another example is the HIV disclosure and treatment challenges in which Black women may face stigma and discrimination. Fear of HIV disclosure can also increase the possibility that a woman may experience IPV. Furthermore, IPV can create barriers to accessing healthcare services, including HIV testing and treatment. Abusers may restrict their partners' access to medical care or control their healthcare decisions. For Black women, the complex interplay between HIV and IPV is experienced within a unique setting shaped by gender, ethnicity, religion, race, and other cultural norms and beliefs [28]. As a result of being at the intersection of multifaceted forms of oppression, Black women are more likely to experience adverse health outcomes [88].

As a result of IPV, Black women are very likely to face life-threatening injuries, lethal injuries, homicides, and negative health outcomes. IPV has far-reaching effects, including financial and societal expenses as well as a detrimental effect on women's health outcomes [25]. IPV severity and all-cause mortality among HIV-positive women were examined in an independent investigation. Women living with HIV reported the age-standardized all-cause death rates by IPV severity and the lifetime prevalence of IPV. The findings showed that women experiencing lifetime IPV had the highest rates of mortality [89].

A study was performed to highlight the experiences of women who constantly worry about experiencing intimate partner violence (IPV), which raises their risk of contracting HIV. An unprecedented amount of intimate partner violence is being experienced by South African women, putting them at risk of contracting HIV from their partners. Ten study participants—some of whom were married and others who were cohabiting with their partners—were interviewed as part of a qualitative research process. Four themes emerged from the analysis: coercive sexual practices, condom misuse, physical violence due to disagreements over intimate relations, and physical violence as a result of condom use [90]. Coercive sexual practice is a type of IPV in which women have experienced coercive or non-consensual sexual practices within their intimate relationships. By substantially increasing a woman's chances of contracting HIV, coercive abuse can manifest in various forms, including emotional pressure, threats, or physical force. For example, the psychological consequences of coercive sexual behaviors can lead to depression, anxiety, and post-traumatic stress disorder (PTSD). This psychological impact may affect a woman's overall health-seeking behavior and ability to adhere to preventive measures such as regular HIV testing and adherence to ART. Ultimately, IPV may contribute indirectly to contracting HIV.

3.4. Intersection of IPV, HIV, and Breastfeeding Practices among Black Women

The intersection of IPV, HIV, and breastfeeding practices among Black women is a complex and multifaceted issue that requires a comprehensive understanding of the various factors involved. This intersection brings to light several important considerations that need to be highlighted and addressed adequately in culturally sensitive interventions.

IPV among Black women living with HIV continues to be a barrier to status disclosure to their partners [76,77]. Fear of violence, stigma, and other potential repercussions hinder open communication. This lack of disclosure may affect infant feeding practices as women may not feel comfortable discussing their HIV status and the associated risks with their partners or their extended families [77]. Nonetheless, in terms of the law of some jurisdictions, HIV-positive status disclosure to intimate partners is mandatory. This law places the responsibility on individuals living with HIV to disclose their status before engaging in sexual activities. In some cases, such laws imply that if a woman fails to disclose her positive HIV status to her partner, healthcare providers are obligated to share this information with her partner. Therefore, this raises questions about patient confidentiality, medical ethics, and the potential consequences of such disclosure. Despite this law, the lack of status disclosure due to fears of violent repercussions continues to affect the correct infant feeding practices of HIV-positive Black women. This makes IPV an HIV-transmission-associated factor among Black women.

Black women facing IPV may find it challenging to negotiate safe feeding options, such as formula feeding, due to partner control, lack of autonomy, or limited access to resources like clean water and formula. Abusive partners may undermine the breastfeeding efforts of women on HIV medication, manipulate or control feeding choices, or cause interruptions in breastfeeding due to physical violence or emotional stress. These disruptions can result in inconsistent feeding patterns, premature weaning, or a reliance on suboptimal feeding methods [31]. On top of this, Black women experiencing IPV and living with HIV may face challenges in accessing support and resources for good feeding practices. To address barriers, the provision of adequate support services, such as healthcare providers, breastfeeding counseling, and safe housing options, is essential. IPV poses significant safety

risks to women and their children, and Black women are disproportionately affected. In situations where IPV is present, breastfeeding may be further complicated by concerns for the safety and well-being of the mother and child. These safety considerations may influence decisions around infant feeding practices.

4. Discussion and Implications

Intimate partner violence against HIV-positive women significantly increases the probability of early mixed feeding. Thus, it is essential to discuss infant feeding in the context of HIV to ensure that HIV-positive women are aware of the advantages of exclusively nursing for six months while they are on HIV treatment. This study found that Black women with HIV status are at risk of experiencing IPV, which may lead to compromising infant feeding practices and putting the infant at risk of contracting HIV. Many studies explained the relationships of IPV, HIV, and the infant feeding practices among Black women but they fail to clarify the connection to the intersections between these factors or how these Black women suffer at the crossroads of these two conditions. This study adds to the literature by foregrounding the Black women's lived experiences and exploring how their infant feeding practices are impacted by the intersections of HIV and IPV. Further, this study offers insights into how practitioners and community members can better support Black women.

This review also highlights that early mixed feeding for infants was significantly predicted by women's social locations and other factors such as IPV. IPV was confirmed to indirectly increase the possibility of a woman's non-adherence to recommended breastfeeding practices. Various studies have expanded the body of data suggesting that adequate information on HIV and breastfeeding, delivered via the health care system, is essential for continued exclusive breastfeeding (EBF) among HIV-positive women [91,92]. EBF should receive critical consideration to improve the rates of adherence among Black women who experience IPV. It is important to recognize that the IPV within the context of Black mothers who have HIV contributes to MTCT ignorance. For example, a Black woman who experiences IPV and HIV may inherently feel shame and guilt that she could not breastfeed her baby. This guilt comes from their cultural belief that if you breastfeed, you are a good mother, and if you do not breastfeed, you are a bad mother. As a result, these women may involuntarily ignore the MTCT. This review supports interventions that may address Black women who experience IPV and the reasons for their unwillingness to take ARVs, including guilt, lack of knowledge, denial, and cultural beliefs.

Findings from this study also resonate with literature reviews that examined the relationship between mothers who suffered IPV during pregnancy, after giving birth, and during their breastfeeding practices. In the imputed analysis, mothers who experienced IPV had a lower likelihood of practicing EBF compared to mothers who did not. Furthermore, psychological and physical IPV were linked to the lower likelihood of EBF practice [93]. Ultimately, IPV causes newborns to have less-than-ideal feeding opportunities [94].

This study also highlights the importance of adapting culturally sensitive interventions in order for these women to adhere to the recommended feeding practices. International organizations have established current global health goals that include improving infant survival rates and preventing HIV transmission from mothers to their children. However, sub-optimal infant feeding practices are high in HIV-prevalent settings [49]. This study calls for culturally sensitive interventions aiming to prevent or reduce IPV during pregnancy in order to minimize the negative impact of IPV on infant feeding practices.

This study found that infant feeding experiences reveal that infant feeding is a social and cultural experience and must be contextualized in relationship to mothers' social and cultural positions [63]. There is a critical need to acquire new knowledge on how healthcare providers can tailor interventions toward the urgent need to minimize IPV among these women. Cultural interventions can include culturally respectful services, patient-centered care, and community support engagement. Healthcare providers should adopt culturally sensitive interventions and determine the most effective plan of care for these clients to be able to adhere to the recommended infant feeding practices. In this context, it is

important for HIV-positive pregnant women to work closely with their healthcare providers to determine the most appropriate culturally sensitive intervention based on their specific social circumstances and the latest treatment guidelines from reputable sources like the World Health Organization or national health authorities. In high-income countries where a client-centric approach is applied, the rates of HIV being passed from mother to child have dropped to less than 1% [95,96]. In contrast, the MTCT rate is still high in many low-income countries [97,98].

Addressing the intersection of IPV, HIV, and breastfeeding practices among Black women requires a holistic approach. It involves providing culturally sensitive support, offering comprehensive healthcare services, and addressing the social determinants of health. Developing comprehensive support systems that address the intersecting needs of Black women experiencing IPV living with HIV is crucial. This support should include access to healthcare, counseling, legal assistance, and social services that are culturally sensitive. This can include raising awareness about IPV and HIV, promoting accessible and non-judgmental healthcare services, improving healthcare infrastructure, enhancing support systems, and implementing policies that prioritize the well-being and autonomy of Black women.

Additionally, community engagement, education, and empowerment initiatives that challenge gender norms, reduce stigma, and promote equitable relationships can play a crucial role in addressing the intersection of IPV and HIV. By addressing the underlying structural and societal factors that contribute to IPV, HIV, and breastfeeding challenges, we can work towards better outcomes for Black women and their families. This will also contribute to empowering Black women with knowledge about IPV, HIV, and feeding practices. Education should focus on providing information about HIV transmission risks, available resources, and safe feeding options. It should also address the importance of autonomy, self-care, and self-advocacy. Ultimately, IPV and HIV are both risk factors that are associated with mixed feeding practices and non-adherence to recommended feeding practices among Black women (Figure 2).

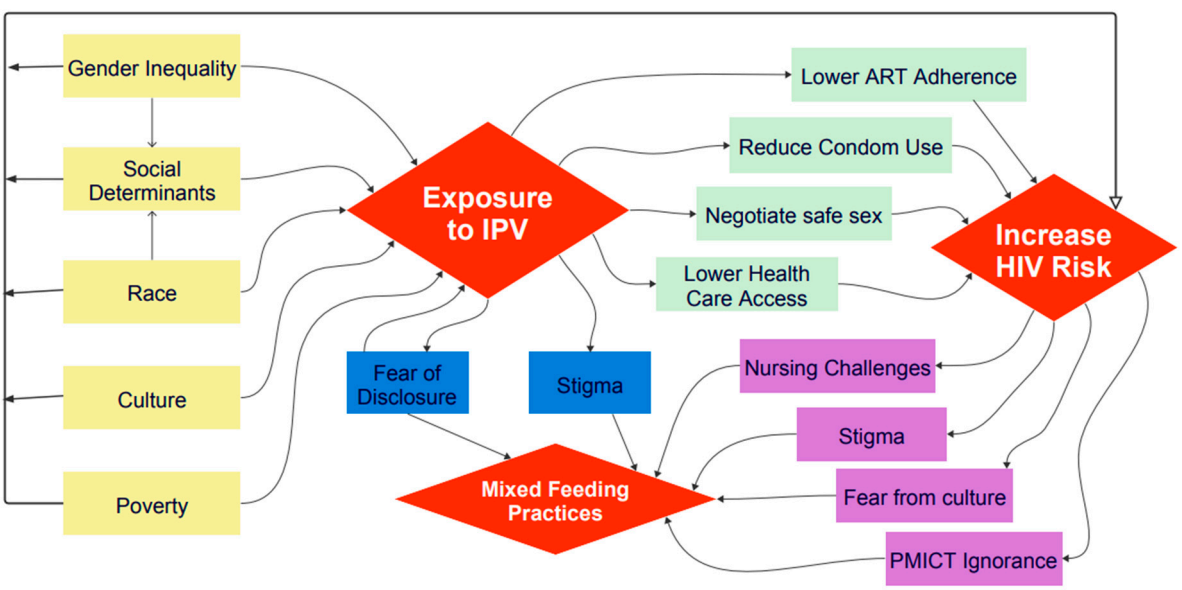

Figure 2. Causal diagram of the relationship between IPV, HIV, and mixed feeding practices. The yellow boxes indicate factors that are associated with IPV and they are also associated directly with HIV. The green boxes signify the impact of IPV and the risk factors of contracting HIV. Similarly, the purple boxes represent the impacts of HIV-positive status and the associated factors of practicing mixed infant feeding. Finally, the blue boxes represent the associated factors of mixed feeding practices as a result of experiencing IPV. Arrows indicate causal pathways between the variables.

5. Recommendations

Recommendations for addressing the impact of IPV among Black women with HIV status and its impact on their feeding practices require specific, concrete, and culturally sensitive interventions. From this review came recommendations for culturally adapted healthcare practices. Healthcare professionals need better education and training to practice culturally sensitive nursing services. For example, patient-centered approaches and interventions should be introduced for healthcare professionals as a part of their continuing education. During their first degree, healthcare providers should be trained regularly in a culturally sensitive setting for ethnic minorities such as Black women and other marginalized populations such as victims of abuse. In this context, stakeholders and healthcare providers should adapt clinical practical standards for culturally competent care to improve the care for these women. In addition, efforts to address IPV and HIV should involve collaboration among healthcare providers, social services, and community organizations. Integrated interventions that address IPV, HIV, mental health, and breastfeeding support are essential to ensure the well-being of Black women and their infants during these complex situations.

Future research on the causality and directionality of the IPV and HIV relationships should be conducted due to the lack of studies about these relationships. Although current research indicates that women may experience IPV as a result of HIV disclosure, we cannot demonstrate that HIV was the only factor that led to IPV. Other associated factors that might affect the outcome of the IPV include poverty, cultural norms, social isolation, and other social determinants.

6. Strengths and Limitations

There are several limitations in this study. First, gray literature and non-peer-reviewed publications, such as any government or policy papers, books, or dissertations, were not included in the review. Additionally, research that yielded no findings, which is less likely to have been published, was missed since this review only included the published literature. Another study limitation was limiting the review to studies that were published in English only. This may result in a language bias that excludes some non-English publications. This review focused on studies that fit the inclusion criteria, which were further limited by the paucity of existing research-based studies examining both IPV and HIV intersection and how it impacts infant feeding practices. Another limitation is due to the nature of the narrative review. This narrative review did not provide a quantitative summary of findings or statistical analyses. Narrative reviews are often less transparent and may lack standardized reporting guidelines. The selection of studies and the synthesis of findings may depend more on the authors' discretion, which can introduce subjectivity and bias. Narrative reviews provide a qualitative understanding of a topic but the evidence may not be as strong due to their potential subjectivity and lack of a structured methodology.

Another limitation of this review is that it used a general approach to study the experiences of Black women and it did not study Black women's experiences in one region or area. Our research aimed to treat all Black women's experiences equally, prevent the potential stigmatization of a specific region or group, and recognize the commonality of their experiences on a global scale. This approach seeks to promote inclusivity and a broader understanding of the issues faced by Black women without singling out any specific region for further scrutiny.

Nevertheless, this review adds much-needed analysis to the existing research by examining the crossroads of IPV and HIV and their impact on infant feeding practices. Also, it considers various studies, methodologies, and viewpoints to offer a comprehensive overview of the topic. This inclusivity ensures that the review does not favor one particular perspective or bias.

7. Conclusions

This comprehensive narrative review of existing works at the intersection of IPV, HIV, and motherhood in the context of infant feeding practices among Black women contributes

to advancing more holistic health services for this population in Canada and beyond. The evidence generated can inform programming and policy interventions to advocate for and support Black women's health (and that of their families), autonomy, and overall well-being.

The critical convergence of IPV, HIV, and motherhood is not commonly discussed especially in the context of Black women living with HIV who are already experiencing the double jeopardy of the disproportionately higher HIV burden and other inequities related to the social determinants of health. It is vital for HIV interventions—especially those seeking to prevent vertical transmission—to use a multi-pronged approach to address the multi-level factors that contribute to HIV vulnerabilities. For example, PMTCT programs should prioritize interventions aiming at identifying women in abusive relationships and offer suitable counseling and referrals among HIV-positive women. This will improve best practices for infant feeding and help prevent the spread of HIV from mother to child.

IPV against HIV-positive mothers is a major factor influencing adherence to best practices for infant feeding. Adherence to prolonged exclusive breastfeeding is significantly impacted by physical and mental abuse in particular. In addition, HIV-positive women who experience IPV often suffer from psychological and behavioral disorders that affect safe infant feeding practices as such mothers may be more inclined to initiate early mixed feeding practices. This highlights the complexity of the intersections of IPV and infant feeding practices among Black women living with HIV.

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