

# Relationship dynamics, intimate partner violence, and HIV prevention practices among serodiscordant couples in Mozambique – a qualitative study

José Braz Chidassicua & Lu-Anne Swart

To cite this article: José Braz Chidassicua & Lu-Anne Swart (28 May 2026): Relationship dynamics, intimate partner violence, and HIV prevention practices among serodiscordant couples in Mozambique – a qualitative study, AIDS Care, DOI: [10.1080/09540121.2026.2670488](https://doi.org/10.1080/09540121.2026.2670488)

To link to this article: <https://doi.org/10.1080/09540121.2026.2670488>



© 2026 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group



Published online: 28 May 2026.



Submit your article to this journal [↗](#)



Article views: 89



View related articles [↗](#)



View Crossmark data [↗](#)

# Relationship dynamics, intimate partner violence, and HIV prevention practices among serodiscordant couples in Mozambique – a qualitative study

José Braz Chidassicua <sup>a,b</sup> and Lu-Anne Swart<sup>a,c</sup>

<sup>a</sup>Institute for Social and Health Sciences, University of South Africa, Johannesburg, South Africa; <sup>b</sup>Department of Inquiries and Health Surveillance, Instituto Nacional de Saúde, Maputo, Moçambique; <sup>c</sup>Violence, Injury and Social Asymmetries Research Unit, South African Medical Research Council–University of South Africa, Western Cape, South Africa

## ABSTRACT

Intimate partner violence (IPV) and HIV remain intersecting public health challenges in Mozambique, particularly among serodiscordant couples. This qualitative study explored how individuals in serodiscordant relationships described their intimate relationships following the discovery of HIV serodiscordance, and how these relationship dynamics were described in relation to engagement with HIV prevention practices. Eighteen serodiscordant couples (36 individuals) were recruited from health facilities in Gaza Province, Mozambique. Individual in-depth interviews were conducted between October and November 2022 and analysed using thematic analysis. Participants described emotional and relational responses following diagnosis, including betrayal, mistrust, uncertainty about relationship continuity. Ongoing dynamics included conflict, control, and experiences of IPV, as well as commitment, support, and communication. In some relationships, conflict, coercion, and violence limited participants' ability to negotiate condom use or avoid unprotected sex. In others, commitment and support facilitated condom use and engagement with treatment. Alcohol use was described in relation to both conflict and difficulties with safer sex. These findings highlight how HIV prevention within serodiscordant relationships is experienced in the context of relationship dynamics, including IPV. Interventions that address both relational dynamics and access to prevention may strengthen engagement with HIV prevention and care among serodiscordant couples.

## ARTICLE HISTORY

Received 19 December 2025  
Accepted 30 April 2026

## KEYWORDS

HIV serodiscordance; intimate partner violence; relationship dynamics; HIV prevention; gender-based violence; Mozambique

## SUSTAINABLE



## DEVELOPMENT GOALS

gender equality; good health and well-being; reduced inequalities

## Introduction

Intimate partner violence (IPV) and HIV represent interconnected global health challenges that disproportionately affect populations in sub-Saharan Africa (Krug et al., 2002; UNAIDS, 2023; World Health Organization [WHO], 2025). In 2024, approximately 40.8 million people globally were living with HIV, with 63% residing in sub-Saharan Africa (UNAIDS, 2025). Mozambique has one of the highest HIV burdens in Southern Africa, with an estimated adult HIV prevalence of 12.5% (INS et al., 2023). Approximately 9.6% of couples in Mozambique are serodiscordant, relationships where one partner is living with HIV and the other is HIV-negative (MISAU et al., 2019).

Serodiscordant couples face unique biomedical, behavioural, and relational risks that require specialised prevention and intervention approaches (WHO, 2012, 2021). Evidence-based prevention strategies for these couples include HIV testing and counselling, behavioural risk reduction counselling, consistent condom use, pre-exposure prophylaxis (PrEP) for the HIV-negative partner, including newer long acting injectable formulations that may overcome adherence barriers associated with daily oral regimens, and antiretroviral therapy (ART) for the partner living with HIV (Delany-Moretlwe et al., 2022; Roberts et al., 2016; WHO, 2021, 2022). When PrEP and ART are used effectively, HIV transmission within serodiscordant couples can be

**CONTACT** José Braz Chidassicua  jchidassicua@gmail.com  Institute for Social and Health Sciences, University of South Africa, Johannesburg, South Africa; Instituto Nacional de Saúde, Maputo, Moçambique

© 2026 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group

This is an Open Access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (<http://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way. The terms on which this article has been published allow the posting of the Accepted Manuscript in a repository by the author(s) or with their consent.

virtually eliminated (Cohen et al., 2016; Crepaz et al., 2016). However, in many sub-Saharan African contexts, including Mozambique, uptake and sustained adherence to these prevention strategies remains inadequate due to individual, social, and structural barriers, particularly IPV (Hatcher et al., 2015; Jewkes et al., 2010).

Globally, approximately 30% of ever-partnered women report having experienced physical and/or sexual violence by an intimate partner (WHO, 2025). In Mozambique, IPV remains a pervasive public health issue, with one in three women aged 15–49 reporting lifetime experience of emotional, physical, or sexual violence (INE & ICF, 2023). The relationship between IPV and HIV is bidirectional (Hatcher et al., 2014). In serodiscordant couples, IPV can limit communication, impede condom negotiation, reduce autonomy in decision-making, and discourage HIV testing or disclosure of serostatus, particularly for women (Were et al., 2011). Fear of violence or abandonment may lead people living with HIV, especially women, to conceal their status, thereby diminishing the effectiveness of prevention strategies (Colombini et al., 2016).

Despite the clear intersections between IPV and HIV, research that specifically examines IPV within HIV serodiscordant couples remains limited and is especially scarce in Mozambique (Were et al., 2011). Much of the existing literature treats IPV and HIV as separate domains, missing how they interact within stable, long-term relationships. Qualitative research is particularly valuable for understanding the relational and contextual mechanisms through which IPV shapes HIV prevention behaviours, revealing processes that quantitative data cannot fully capture (Hatcher et al., 2015; Kouyoumdjian et al., 2013).

The socioecological model provides a comprehensive framework to explore the dynamic interaction between individual and environmental factors, conceptualizing IPV and HIV risk as arising from factors operating at individual, relational, community, and societal levels (Heise, 1998; Krug et al., 2002; Ogolsky et al., 2026). The Theory of Gender and Power complements this by identifying how gendered structures, namely the sexual division of labour, the sexual division of power, and cathexis (affective and social norms), shape women's vulnerability to IPV and constrain their ability to engage in HIV prevention and care (Connell, 1987; Wingood & Diclemente, 2000). Together, these frameworks provide a lens for understanding how gendered power inequalities and multilevel contextual factors shape women's experiences of IPV within serodiscordant relationships and influence their ability to engage in HIV prevention and care (El-Bassel et al., 2022; Kuchukhidze et al., 2022).

This study addresses critical gaps by exploring how HIV serodiscordance affects relationship dynamics and how these dynamics relate to engagement with HIV prevention and care among serodiscordant couples in Mozambique, with attention to IPV as an important relational dynamic. Guided by the socioecological model and Theory of Gender and Power, we specifically examine: (1) how individuals in serodiscordant relationships described their intimate relationships following the discovery of HIV serodiscordance, including initial responses and relational dynamics such as conflict, controlling behaviours, communication, and commitment; and (2) how these relationship dynamics, including experiences of IPV, were described as influencing engagement with HIV prevention practices, such as safer sex negotiation and the use of biomedical strategies (PrEP and ART).

## Methods

### *Study design and setting*

This qualitative study was conducted in the Xai-Xai district, Gaza Province, Mozambique, between October and November 2022. Gaza has one of the highest HIV prevalence rates in Mozambique (24%), with approximately 7.9% of couples being serodiscordant (INS et al., 2023). The study employed an interpretive qualitative approach using individual in-depth interviews with members of serodiscordant couples.

### *Participants and recruitment*

Participants were serodiscordant couples recruited from the Xai-Xai Provincial Hospital HIV clinic through purposive sampling. The clinic serves approximately 2,500 people living with HIV annually. Eligibility criteria included: (1) men and women aged 18–49 years, (2) currently in a serodiscordant relationship, (3) both partners fully aware of their discordant status, and (4) willingness to participate. Individuals with cognitive impairments that might hinder informed consent were excluded.

All potential participants were contacted by their regular ART provider and invited to participate. Those who expressed interest were subsequently contacted by the researcher to schedule interviews. In total, 46 individuals (from 23 serodiscordant couples) were approached through their ART providers; 38 expressed interest and were contacted by the researcher; and 36 individuals (18 couples) were scheduled for and completed interviews. Two individuals who initially expressed interest withdrew after initial contact, citing time constraints.

Data saturation was determined through ongoing data collection and analysis, with transcripts reviewed and coded alongside interviews. Saturation was reached after 36 interviews (18 men and 18 women from 18 serodiscordant couples), when no new themes or substantive insights were emerging.

### **Data collection**

Individual semi-structured interviews were conducted separately with each partner in Portuguese by the lead researcher in private office space provided by the hospital. Each interview lasted 45–60 min. The interviews formed part of a larger study that focused on the prevalence and contributing factors of IPV and its influence on HIV risk among serodiscordant couples in Mozambique. The interview guide was developed from the literature and study objectives and was organised around four broad topic areas: participants' understanding of HIV serodiscordance and the discovery of their serodiscordant status, including initial responses; relationship experiences in the context of serodiscordance, including communication, decision-making, and conflict; HIV prevention strategies, including safer sex practices and biomedical approaches; and perceived support needs for couples in serodiscordant relationships. This analysis focuses on participants' descriptions of relationship experiences following the discovery of their serodiscordance, including initial responses and relational dynamics, and how these dynamics were described in relation to engagement with HIV prevention practices.

All interviews were audio-recorded with participants' permission. Covid-19 safety precautions, including hand hygiene, face masks, and physical distancing, were observed throughout data collection.

### **Data analysis**

Interview recordings were transcribed verbatim and translated from Portuguese to English by the lead researcher, a native Portuguese speaker fluent in English. To enhance accuracy, selected transcripts were checked against the original audio recordings. While some loss of nuance is possible in translation, care was taken to preserve the meaning and cultural context of participants' accounts.

The data were analysed using thematic analysis (Braun & Clarke, 2006). Transcripts were imported into MAXQDA 2020 to support data management and coding. Coding was conducted by the lead researcher using an inductive approach. Initial codes were developed through repeated close reading of the transcripts, with attention to participants' language and meanings. Codes were iteratively refined, compared across transcripts, and organised into a codebook reflecting emerging patterns in the data. The developing codebook and interpretations were discussed with a co-author to clarify code definitions, reduce overlap, and strengthen analytic consistency.

Codes were then grouped into broader themes capturing patterns related to relationship experiences, including responses to serodiscordance, relationship dynamics (including conflict and IPV), and engagement with HIV prevention and care. Themes were reviewed and refined to ensure coherence and distinction, and final theme definitions were agreed through discussion among the authors. While the analysis was primarily inductive, it was informed by the Socioecological Model and the Theory of Gender and Power, which sensitised the analysis to relational, social, and structural influences on participants' experiences.

Direct quotations are attributed using anonymised codes indicating gender (M/F), HIV status (+/–), and couple number (e.g., M+, 05 for the male partner living with HIV from Couple 05).

### **Trustworthiness**

Credibility was enhanced through verbatim transcription, member checking at the end of interviews, and providing adequate supporting data using participants' words. Dependability was established through

detailed documentation of research procedures and use of interview guides. Transferability was supported by providing detailed descriptions of the study setting and participant characteristics. Confirmability was strengthened through reflexive field notes and direct quotations supporting conclusions.

### **Ethical considerations**

Ethical approval was obtained from Eduardo Mondlane University's Faculty of Medicine Bioethics Committee (Reference number: CIBS FM&HCM/021/2022) and University of South Africa's College of Human Sciences Research Ethics Committee (NHREC registration: 240816-052). All participants provided written informed consent after receiving verbal and written information about the study in Portuguese and were given the opportunity to ask questions. Participation was voluntary, and participants could withdraw at any time without consequences to their medical care. Interviews were conducted in private, and partners were interviewed separately to ensure confidentiality and minimise potential risk. Confidentiality was maintained through use of pseudonyms, separate interview spaces, and secure password-protected data storage. Given the sensitive nature of IPV and HIV disclosure, all participants received contact information for psychological counselling services available at Xai-Xai Provincial Hospital.

## **Findings**

### **Participant characteristics**

The study included 18 serodiscordant couples (36 individuals: 18 men and 18 women). Six couples (33.3%) were married and 12 (66.7%) were cohabiting. Male partners were generally older than female partners, with 77.8% of men aged 30 or older compared to 61.1% of women. Men had higher educational attainment, with 66.7% having completed secondary education compared to 33.3% of women. Employment disparities were evident, with 77.8% of men employed versus 33.3% of women. Regarding HIV status, 72.2% of men were living with HIV compared to 27.8% of women. A minority reported having additional sexual partners (22.2% of men and 5.6% of women).

### **Overview of findings**

Findings are organised into three themes: (1) betrayal, trust, and uncertainty following the discovery of serodiscordance; (2) conflict, control, and experiences of IPV; and (3) commitment and communication in coping with serodiscordance (Table 1). These themes capture how participants described their intimate relationships following the discovery of serodiscordance. While Theme 1 reflects initial relationship disruption, Themes 2 and 3 illustrate relationship dynamics in the context of serodiscordance, including conflict, control, IPV, and, in some cases, commitment and communication, and how these were described as influencing how couples engaged with HIV prevention practices.

**Table 1.** Analytic areas, themes, and subthemes.

Themes	Subthemes
Relationship strain and uncertainty following the discovery of serodiscordance	Betrayal, confusion and questioning of trust Guilt, responsibility and uncertainty about relationship continuity Multiple partnerships as a driver of mistrust
Relationship dynamics conflict, control, and experiences of IPV	Jealousy, suspicion, and controlling behaviours Verbal, physical, and sexual violence Alcohol use and IPV escalation Constraints on HIV prevention
Commitment and communication in coping with HIV serodiscordance	Commitment and support Communication and mutual understanding Shared responsibility and support for HIV prevention Contextual influences on engagement with biomedical prevention

**Source:** Prepared by the authors

### **Theme 1: relationship strain and uncertainty following the discovery of serodiscordance**

HIV serodiscordance was experienced as placing strain on intimate relationships, as reflected in participants' accounts of uncertainty and their initial emotional responses at the time of discovery. Participants described feelings of betrayal and confusion, as well as guilt and concerns about the future of the relationship, with these responses differing by HIV status.

#### **Betrayal, confusion and questioning of trust**

Betrayal and confusion were commonly described by participants, particularly those who were HIV-negative, following the discovery of their serodiscordant status. These feelings were closely linked to participants' questioning of how HIV was acquired, often involving suspicions of infidelity and concerns about inconsistent condom use. As one HIV-negative woman explained:

I felt a profound sense of betrayal and confusion as I pondered why he chose not to use protection. It baffled me that he would risk not only his health but mine, bringing a disease into our home. In a world where my autonomy feels constantly undermined, it felt like a direct assault on my safety and trust. (F-, 03)

This account reflects how participants described feelings of betrayal and confusion in relation to trust, as well as perceptions of risk and vulnerability within the relationship. Women's accounts often emphasised emotional distress and confusion, alongside concerns about personal safety, trust, and their sense of worth within the relationship. Another woman similarly described emotional distress and questioning following her partner's diagnosis, linking feelings of betrayal to concerns about fidelity and her own sense of worth within the relationship:

My heart raced with fear as I confronted the reality of the situation. Tears flowed freely, and I felt a deep sense of anguish. I couldn't help but question everything, "How did he end up with this disease?" I felt wronged and betrayed by my partner, especially as a woman who has always valued her fidelity. It was as if my worth was diminished in the shadow of his choices. (F-, 09)

HIV-negative male participants also described feeling betrayed, with a focus on suspicions of infidelity rather than personal risk or vulnerability, as illustrated in the following quote:

In that moment, a rush of thoughts flooded my mind ... How did she come to contract HIV? Was her infidelity the cause? With whom could she have betrayed me, and what on earth compelled her? I found myself on the brink of deciding to cast aside my wife. (M-, 02)

These accounts suggest that serodiscordance is understood not only as a biomedical condition but also as a relational event shaped by concerns about fidelity and trust. Suspicions of infidelity were described as disrupting trust and producing feelings of betrayal, confusion, and uncertainty about the relationship.

#### **Guilt, responsibility and uncertainty about relationship continuity**

Participants living with HIV described feelings of responsibility and concern about the future of the relationship following diagnosis. Uncertainty about whether partners would remain in the relationship was commonly expressed:

Upon finding out that my partner is HIV negative, I had moments of uncertainty, doubt, fear, and insecurity about our marital relationship. I felt bad, wondering if he would stay with me despite our different HIV statuses. I worried if he could still avoid the worst outcome. I felt guilty, thinking that maybe he would want to leave and avoid the risk of getting infected by me. (F+, 02)

Men also described feelings of guilt and responsibility, often linked to concerns about their partner's potential risk of HIV infection and their role within the relationship. One man explained:

When I found out I had contracted HIV, I felt guilty and distressed, with countless doubts swirling in my mind. I felt as though I had put my wife's life at risk, and that burden was nearly unbearable. I wanted to shield her from my reality because it seemed unjust for her to contract HIV due to my irresponsibility. (M+, 05)

Another male participant described how living with HIV led him to question his role within the relationship and whether he could continue to meet his partner's expectations:

Being HIV-positive challenges my understanding of what it means to be a man in a relationship. I frequently question whether I am sufficient for her or if I can still bring her happiness while carrying this burden (M+, 17).

These accounts suggest that serodiscordance and living with HIV were understood in relation to partners and the relationship, with participants describing feelings of guilt and responsibility linked to their partner's risk of infection and uncertainty about relationship continuity. While both women and men expressed these concerns, men additionally described how living with HIV challenged their sense of masculinity and their perceived role within the relationship.

### ***Theme 2: relationship dynamics conflict, control, and experiences of IPV***

Theme 2 focuses on relationship dynamics characterised by conflict, control, and experiences of IPV within serodiscordance relationships. The subthemes that follow examine these dynamics in more detail, including jealousy, suspicion and controlling behaviours; experiences of violence; the role of alcohol use, and constraints on HIV prevention.

#### ***Jealousy, suspicion, and controlling behaviours***

Participants described jealousy, suspicion, and controlling behaviours within relationships, often linked to concerns about fidelity and relationship stability in the context of serodiscordance. In some accounts, particularly from women whose partners were described as persistent and affecting the relationship. As one HIV-negative woman explained:

Every passing day is getting worse. I believe it is an unhealthy possessiveness, far from being normal. He is excessively possessive, and this flaw greatly affects our relationship. (...) He constantly suspects that I am being unfaithful with other men or that I will leave him because I am HIV-negative. (F-, 03)

This account shows how jealousy and suspicion linked to HIV status were expressed through controlling behaviours, with ongoing concerns about infidelity and relationship stability shaping interactions in the relationship.

#### ***Verbal, physical, and sexual violence***

Participants described experiences of IPV, including verbal, physical, and sexual violence, within their relationships, both at the time of discovering their serodiscordance status and thereafter, as part of an ongoing relationship dynamic. Verbal aggression was described by both men and women and was often linked to concerns about fidelity and relationship tensions. One male participant described verbal aggression from his partner:

My wife shouts at me regardless of the setting whether there are strangers around, our children are present, or we are in private (...) It hurts me deeply because it undermines my authority as a man and as a father, especially when she shouts in front of our children (...) Most times started with jealousy, she thinks that I will continue betray her. (M+, 03)

One woman acknowledged engaging in verbal aggression as a means of expressing dissatisfaction:

I sometimes get angry to intimidate him and show that I am not happy with his behaviour. Whenever I get angry and start shouting loudly, he never steps out of the house and simply remains indoors (F-, 16).

Here, anger and shouting were described as a way of expressing dissatisfaction and influencing a partner's behaviour, reflecting how verbal aggression could function as a form of control within the relationship.

Accounts of physical and sexual violence were described primarily by female participants, including both women living with HIV and those who were HIV-negative. Violence was described as an a reaction to perceived infidelity following discovery of serodiscordance status and as an ongoing mechanism of control, often linked to concerns about HIV status and relationship stability. One woman living with HIV described how accusations of infidelity following disclosure were accompanied by threats, physical violence, and forced sex:

When we arrived home, it was the worst day. My husband started accusing me of betraying him and became physically abusive. He took a pair of scissors and threatened, "I will kill you. Tell me who your lover is!" (...)

Since that day, he has begun forcing me to have sex, even when I do not desire it. He argues that I must have been with other men because I do not have enough sex at home. (F+, 18)

This account illustrates how suspicion and accusations related to HIV status and fidelity were expressed through coercion and violence at the time of disclosure, described by the participant as “the worst day,” and how this violence continued thereafter, as reflected in her statement “since that day.” Forced sex was described as a means of asserting control and “proving” fidelity, constraining women’s autonomy and limiting their ability to refuse sex.

Another female participant, who was HIV-negative, described violence that had occurred prior to diagnosis but was perceived to have intensified following her partner’s diagnosis:

I have experienced physical violence from my husband, driven by his deep-seated insecurities. Even prior to his HIV diagnosis, alcohol would often trigger his aggressive outbursts. However, since he found out about his status, his behaviour has intensified. He’s terrified that I might cheat or abandon him because my HIV-negative status feels like a threat to his masculinity. (F-, 14)

This account highlights how participants understood violence as rooted in insecurity, jealousy, and gendered power, and in some cases described it as becoming more frequent or severe in the context of serodiscordance. Alcohol use was also described as contributing to the escalation of conflict and violence.

### *Alcohol use and IPV escalation*

Alcohol use was described as aggravating conflict and violence. Some women explained that their partners were kind when sober but became hostile when intoxicated. One participant explained:

When he doesn’t drink, he is a good person, kind, caring, and super intelligent. However, when he consumes alcohol, he undergoes a complete transformation, becoming rude and occasionally violent (F-, 01).

Similarly, another woman noted:

When he drinks too much, he becomes irrational. On one occasion, he even slapped me and falsely accused me of cheating on him, even suggesting that I intend to give him HIV. (F+, 11)

In these accounts, alcohol use was described as linked to increased aggression and, in some cases, sexual coercion, often in relation to accusations of infidelity and relationship conflict.

### *Constraints on HIV prevention*

Conflict, coercion, and violence were described by some women in ways that limited their ability to negotiate safer sex practices. Disagreement about condom use was described as a source of conflict. In some cases, refusal to use condoms occurred alongside pressure or coercion:

Because when we wanted to have sexual intercourse, I asked him to at least use a condom. He sometimes denied it ... that was the most difficult part because he denied using a condom and forced me to have sexual intercourse without [one] (F-, 03).

Some women described situations where violence and forced sex further limited their ability to engage in prevention:

Sometimes when he’s drunk, he beats me up and forces me to have sex (...) and this psychologically breaks me down because I could also be infected (F-, 15).

Alcohol was also mentioned in relation to condom use:

Alcohol consumption makes us men forget that condoms are a safety measure to avoid infection with other diseases, including HIV and AIDS (M+, 09).

These accounts show how, in some relationships, condom use was not agreed or could not be insisted upon, showing how conflict, coercion, and violence were described as limiting the use of condoms and engagement with HIV prevention.

### **Theme 3: commitment and communication in coping with HIV serodiscordance**

Despite the challenges described, some participants emphasised commitment, emotional support, and communication within their relationships. Theme 3 describes how these dynamics were reported following the discovery of HIV serodiscordance, including commitment and support, communication and mutual understanding, and shared responsibility in relation to HIV prevention, as well as broader contextual factors that shaped engagement with prevention and treatment.

#### **Commitment and support**

Participants described providing and receiving support within their relationships following diagnosis. In several accounts, HIV-negative partners, often women, described offering emotional support, including reassurance and encouragement, and continued presence during periods of distress:

The first thing that came to my mind was to give him strength because he wanted to commit suicide. I gave him strength; I told him that this is not a disease that kills; all you have to do is comply with the treatment. (F-, 04)

In the first days, he was bad, really bad. He wanted to die. When he was at his lowest, I made sure he'd see that I would never abandon him. Love means being there, especially when times are tough. (F-, 08)

Male participants also reflected on receiving support from their partners, describing how this support reduced feelings of isolation and reinforced continued commitment:

At that moment, with my positive test result in hand, I wished I had never cheated on my wife. Interestingly, after she discovered that I had tested positive while she tested negative, she continued to provide me with strength and support, making me feel that I am not alone in this struggle (M+, 09).

These accounts show how commitment and support were described in maintaining connection within relationships and suggest gendered patterns in how support was enacted, with women frequently positioned as key sources of emotional support.

#### **Communication and mutual understanding**

Participants described communication as an important part of how some couples coped with serodiscordance following diagnosis. HIV-negative women described efforts to understand their partner's experiences and maintain connection:

Since I learned that he is HIV positive, I started to give him strength and support and tried to understand his fears because it is not easy living with this illness (F-, 08).

Another participant emphasised shared commitment and joint decision-making:

Although my husband is HIV positive and I am HIV negative, we have chosen to support one another because we vowed at the altar to remain together in both sickness and health (F-, 09).

Participants also reflected on expectations within relationships and the roles they took in supporting their partners:

People expect men to be strong and invulnerable, but we know that when they are sick, we are all vulnerable and need support to move forward. My role as a wife is to provide him with support, even though sometimes, particularly when he drinks, he exhibits poor behaviour (F-, 01).

Communication was described as helping partners understand one another's experiences and maintain connection. These narratives illustrate how commitment and communication supported coping within relationships challenged by HIV serodiscordance.

#### **Shared responsibility and support for HIV prevention**

In contrast to accounts where conflict and coercion limited prevention, some participants described how prevention was supported through mutual support, shared responsibility, and cooperation within relationships.

Several participants described fidelity as a way of reducing HIV risk and maintaining commitment within the relationship. One male participant reflected on his decision to remain faithful following diagnosis:

I decided to be faithful to my wife; she put up with my betrayals, took care of me during my illness when I was diagnosed as HIV positive, and yet she remained HIV negative (M+, 03).

A female participant similarly described fidelity as a personal commitment:

Since I met my husband, I have not known another man. I am faithful. He is the man that God has given to me (F-, 01).

Participants also described condom use as an important prevention strategy, sometimes adopted following medical advice:

Following the doctor's advice during our hospital visit, we decided to use condoms (M+, 09).

However, in some accounts, condom use required discussion and agreement:

Initially, I felt my heart racing, and as my anxiety subsided, I began to contemplate how I would navigate the relationship and coexist with him. Ultimately, we found a way to incorporate condom use ... Although he was initially resistant to the idea, he ultimately agreed to use condoms. (F+, 02)

Another woman described asserting her position:

I told him in a slightly aggressive voice, "If you want to have sex with me, use a condom. I don't want any more unprotected sex." I frightened him ... I had to do that to scare him and make it clear (F-, 16).

Partner support was also described as important for ART adherence. One woman noted:

Having the support of my partner has been crucial in my adherence to treatment. It makes a significant difference in staying on track (F+, 02).

Participants also described a sense of responsibility towards their partners and families as motivating engagement with prevention and treatment:

My wife is not employed, and my children are in the process of growing up. What will become of them if I were to pass away? I cannot afford to stop taking my medication (M+, 03).

Some accounts described shared routines and practical strategies that supported adherence, including synchronising medication use and mutual support in collecting treatment:

Although my wife is HIV-negative, she has supported me in collecting my medication from the hospital. When she visits to obtain her PrEP prescription, she also picks up my medication, and we take them together every day at 8 PM before going to bed (M+, 09).

Some participants also described using PrEP as a way of managing risk within the relationship, although it was not always presented as a shared or mutually negotiated practice:

I take PrEP to reduce my risk of contracting HIV (F-, 01).

My husband is HIV-positive, and I take PrEP as a precaution ... if the condom breaks, I must protect myself (F-, 09).

These accounts describe how prevention practices were, in some relationships, supported through cooperation between partners, including shared responsibility and support.

### **Contextual influences on engagement with biomedical prevention**

In addition to relationship dynamics, some participants described broader factors that affected their engagement with HIV prevention, particularly in relation to PrEP and ART. These included concerns about stigma, beliefs about medication, and material constraints.

Accounts relating to PrEP reflected uncertainty about taking medication in the absence of illness, as well as beliefs about immunity:

Why do I have to take these pills if I am not sick? The one who is sick is my husband (F-, 17).

My blood is good because it's type O. I don't need to use a condom or take these medications (PrEP) (M-, 18).

In relation to ART, one participant described avoiding health services due to fear of being seen:

My husband avoids going to the hospital due to the fear of being seen by others and concerns that he will be ridiculed (F-, 01).

Material constraints were also described as affecting treatment adherence:

Taking medication every day is a significant challenge; there are moments when I feel inclined to give up. The treatment requires a nutritious diet, but unfortunately, there are times when we struggle to find enough food (M+, 17).

These accounts indicate that engagement with PrEP and ART was, in some cases, shaped by concerns about stigma, individual beliefs about medication, and broader living conditions, rather than by relationship dynamics alone.

## Discussion

This qualitative study provides insight into how HIV serodiscordance is experienced within intimate relationships and how these relational dynamics relate to engagement with HIV prevention and care among serodiscordant couples in Mozambique. The findings highlight three interrelated patterns: initial relationship disruption characterised by mistrust and uncertainty; relationship dynamics marked by conflict, control, and IPV, as well as commitment and support; and the ways in which these dynamics were described as shaping engagement with HIV prevention practices. Together, these findings suggest that HIV prevention within serodiscordant relationships is embedded within everyday relational processes, shaped by power, communication, and broader contextual influences. The discovery of serodiscordance was experienced as a disruption within relationships, characterised by betrayal, confusion, and uncertainty about relationship continuity. These responses were closely tied to questions about how HIV was acquired, with participants, particularly those who were HIV-negative, describing suspicions of infidelity and concerns about trust. Similar patterns have been reported in studies across sub-Saharan Africa, where disclosure of HIV status has been associated with mistrust, accusations of infidelity, and relationship instability (Bhatia et al., 2017; Emusu et al., 2009; Kairania et al., 2010; Medley et al., 2004; Sanga et al., 2023).

Participants living with HIV described feelings of guilt and responsibility, particularly in relation to the perceived risk posed to their partners and uncertainty about whether the relationship would continue. These accounts reflect concerns about rejection and relationship dissolution that have been widely documented in the context of HIV-related stigma across sub-Saharan Africa (Alhassan et al., 2022; Audet et al., 2010), but in this study they were described in relation to immediate relational experiences following diagnosis. Some accounts also suggest that living with HIV was interpreted through gendered expectations within relationships. Male participants, in particular, described questioning their adequacy and ability to fulfil expected roles, consistent with evidence that masculine norms shape how men experience illness and vulnerability and may discourage health-seeking and preventive behaviours (Audet et al., 2016; Sikweyiya et al., 2015). Together, these findings suggest that serodiscordance was experienced not only as a source of relational uncertainty, but also as a challenge to identity and role expectations within intimate relationships. The study also documented how HIV serodiscordance was described in relation to conflict, controlling behaviours, and IPV within relationships. While it is not possible to determine whether these dynamics were present prior to diagnosis, some participants described conflict and violence as becoming more frequent or more severe following the discovery of serodiscordance, often in relation to HIV status, trust, and fidelity. Similar patterns have been documented in sub-Saharan Africa, where HIV disclosure has been associated with increased relationship conflict and IPV (Colombini et al., 2016; Shamu et al., 2014).

The findings further show how prevention practices are negotiated within these relational contexts. In situations characterised by coercion or violence, participants described being unable to insist on condom use or avoid unprotected sex. These findings reinforce existing evidence on the relationship between IPV and HIV risk by illustrating how control and violence are linked to difficulties in condom negotiation and engagement with prevention within serodiscordant relationships in this setting. This is consistent with broader evidence on the gendered nature of sexual negotiation in sub-Saharan Africa, where male dominance and female subordination constrain women's ability to advocate for protection (Closson et al., 2018; Muessig & Cohen, 2014).

Gendered patterns were evident in how these experiences were described. Accounts of physical and sexual violence, as well as difficulties negotiating condom use or avoiding unprotected sex, were described by women. These accounts highlight how violence and coercion limited women's ability to influence sexual decision-making within relationships. Verbal conflict, including shouting and expressions of anger, was described by both men and women. These patterns are consistent with the Theory of Gender and Power, which highlights how gendered power relations shape decision-making within intimate relationships, particularly in relation to sexual practices (Connell, 1987; Wingood & Diclemente, 2000).

Alcohol use further intensified these dynamics. Women described how male partners' alcohol use contributed to conflict, aggression, and forced or unprotected sex, while men described forgetting or abandoning condom use when intoxicated. This aligns with existing evidence showing that alcohol use is associated with increased IPV and sexual risk behaviours (Coldiron et al., 2008; Shuper et al., 2009) and suggests that substance use compounds relational constraints on HIV prevention.

In contrast to these accounts, some couples described commitment, communication, and mutual support in ways that enabled coping with serodiscordance and, in some cases, supported engagement with HIV prevention. HIV-negative partners, especially women, described providing reassurance, encouragement, and efforts to sustain the relationship during periods of distress. Men also described receiving this support, showing how some couples maintained connection and navigated the challenges associated with serodiscordance. These findings align with evidence that partner support and dyadic coping can facilitate adjustment to HIV and improve engagement with care (Patel et al., 2012; Stoebenau et al., 2011).

Communication also appeared to be important in supporting prevention. In relationships, condom use, fidelity, and treatment engagement were discussed and negotiated, even where agreement was not immediate and required discussion over time. This reflects broader evidence that safer sex practices within couples are shaped through interaction rather than individual decision-making alone (Closson et al., 2018; Muessig & Cohen, 2014). Support within relationships was also described in relation to treatment, with some participants linking adherence to encouragement from partners, shared routines, and a sense of responsibility towards family members, consistent with evidence that social support plays an important role in sustaining ART adherence (Patel et al., 2012; Stoebenau et al., 2011).

Gendered patterns were also evident in these supportive dynamics. Women were often described as providing emotional and practical support, particularly to partners living with HIV, while men described engagement with treatment in relation to responsibility for family wellbeing. These patterns reflect gendered expectations around care, responsibility, and authority, consistent with the Theory of Gender and Power (Connell, 1987; Wingood & Diclemente, 2000). Within a broader socioecological context, these dynamics are shaped by gender norms and economic constraints that influence how support is enacted and whose needs are prioritised (Ogolsky et al., 2026). While women's roles in sustaining relationships may facilitate engagement with treatment, they may also limit women's ability to prioritise their own prevention needs.

At the same time, engagement with biomedical prevention was not shaped by relationship dynamics alone. Some participants described broader factors that affected engagement with PrEP and ART, including stigma, beliefs about medication, and material constraints such as food insecurity. Accounts relating to PrEP reflected uncertainty about taking medication in the absence of illness, while ART adherence was described as affected by concerns about being seen at health facilities and by economic constraints. These findings align with evidence showing that uptake and adherence to biomedical prevention are shaped by stigma, misconceptions about prevention, and structural barriers, including poverty and access to care (Ahmed et al., 2018; Bogart et al., 2016; Corneli et al., 2014). Within the socioecological framework, these findings highlight how individual, relational, and structural factors interact to shape engagement with HIV prevention and care.

### **Strengths and limitations**

This study provides qualitative insights into how relationship dynamics are experienced and described in relation to HIV prevention among serodiscordant couples in Mozambique. However, several limitations should be considered. Participants were recruited from a single health facility and were already engaged in HIV care, which may underrepresent the experiences of couples who are less connected to services or

who experience more severe relationship instability. The sensitive nature of IPV and HIV may have influenced reporting, with some participants potentially underreporting experiences of violence or conflict or presenting their relationships in more socially acceptable ways. In addition, the study captures participants' accounts at a single point in time, which limits the ability to assess how relationship dynamics evolved or to determine the nature of relationships prior to the discovery of serodiscordance.

## Conclusions

This study found that HIV serodiscordance was experienced as a relational disruption that influenced relationship dynamics and, in turn, engagement with HIV prevention and care among couples in Mozambique. Conflict, control, IPV, and alcohol use were described as constraining safer sex negotiation and engagement with prevention, while commitment, communication, and partner support enabled some couples to manage HIV risk and treatment together. These findings highlight that HIV prevention among serodiscordant couples in Mozambique and similar settings requires approaches that address both biomedical and relational dimensions. Interventions should incorporate IPV screening and support within HIV services and strengthen couple-based counselling approaches, which have shown promise in improving prevention engagement among couples (Crepaz et al., 2015; Morton et al., 2017). Addressing gendered power imbalances, integrating alcohol reduction strategies, and expanding access to user-controlled prevention options, such as long-acting PrEP, may further support engagement. Future research should examine how relationship dynamics evolve over time and evaluate interventions that address both relational and structural drivers of HIV risk within serodiscordant partnerships.

## Acknowledgments

The authors wish to acknowledge Universidade Eduardo Mondlane for funding JBC's doctoral studies at the University of South Africa through the SIDA/SAREC Programme. We thank all participants who generously shared their experiences. We acknowledge the support of Xai-Xai Provincial Hospital staff and the Provincial Health Department for facilitating recruitment. We thank the counsellors who provided psychological support services to participants. Jose Braz Chidassicua, Lu-Anne Swart: Conceptualization; Jose Braz Chidassicua: Data curation; Jose Braz Chidassicua, Lu-Anne Swart: Formal analysis; Jose Braz Chidassicua: Funding acquisition; Jose Braz Chidassicua: Investigation; Jose Braz Chidassicua, Lu-Anne Swart: Methodology; Jose Braz Chidassicua, Lu-Anne Swart: Project administration; Jose Braz Chidassicua: Resources; Lu-Anne Swart: Supervision; Jose Braz Chidassicua, Lu-Anne Swart: Validation; Jose Braz Chidassicua, Lu-Anne Swart: Writing – original draft; Jose Braz Chidassicua, Lu-Anne Swart: Writing – review & editing

## Author contributions

CRediT: **José Braz Chidassicua**: Conceptualization, Data curation, Methodology, Project administration, Resources, Validation, Writing – original draft, Writing – review & editing; **Lu-Anne Swart**: Conceptualization, Formal analysis, Methodology, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing.

## Disclosure statement

No potential conflict of interest was reported by the author(s).

## Funding

This research was supported by the Swedish International Development Cooperation Agency (SIDA) through the SIDA/SAREC Programme at Universidade Eduardo Mondlane, which funded doctoral studies for JBC at the University of South Africa. The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

## Data availability statement

The qualitative data supporting this study's findings are not publicly available due to participant confidentiality and ethical restrictions, as data contain sensitive personal health information. De-identified interview transcripts may be available from the corresponding author upon reasonable request and with appropriate ethical approval.

## ORCID

José Braz Chidassica  <http://orcid.org/0000-0001-5131-0349>

## References

- Ahmed, S., Autrey, J., Katz, I. T., Fox, M. P., Rosen, S., Onoya, D., Bärnighausen, T., Mayer, K. H., & Bor, J. (2018). Why do people living with HIV not initiate treatment? A systematic review of qualitative evidence from low- and middle-income countries. *Social Science & Medicine*, 213, 72–84. <https://doi.org/10.1016/j.socscimed.2018.05.048>
- Alhassan, Y., Twimukye, A., Malaba, T., Myer, L., Waitt, C., Lamorde, M., Colbers, A., Reynolds, H., Khoo, S., & Taegtmeier, M. (2022). 'I fear my partner will abandon me': The intersection of late initiation of antenatal care in pregnancy and poor ART adherence among women living with HIV in South Africa and Uganda. *BMC Pregnancy and Childbirth*, 22(1), 566. <https://doi.org/10.1186/s12884-022-04896-5>
- Audet, C. M., Burlison, J., Moon, T. D., Sidat, M., Vergara, A. E., & Vermund, S. H. (2010). Sociocultural and epidemiological aspects of HIV/AIDS in Mozambique. *BMC International Health and Human Rights*, 10(1), 1–10. <https://doi.org/10.1186/1472-698X-10-15>
- Audet, C. M., Chire, Y. M., Vaz, L. M. E., Bechtel, R., Carlson-Bremer, D., Wester, C. W., Amico, K. R., & Gonçalvez-Calvo, L. (2016). Barriers to male involvement in antenatal care in rural Mozambique. *Qualitative Health Research*, 26(12), 1721–1731. <https://doi.org/10.1177/1049732315580302>
- Bhatia, D. S., Harrison, A. D., Kubeka, M., Milford, C., Kaida, A., Bajunirwe, F., Wilson, I. B., Psaros, C., Safren, S. A., Bangsberg, D. R., Smit, J. A., & Matthews, L. T. (2017). The role of relationship dynamics and gender inequalities as barriers to HIV-serostatus disclosure: Qualitative study among women and men living with HIV in Durban, South Africa. *Frontiers in Public Health*, 5, 1–9. <https://doi.org/10.3389/fpubh.2017.00188>
- Bogart, L. M., Naigino, R., Maistrellis, E., Wagner, G. J., Musoke, W., Mukasa, B., Jumamil, R., & Wanyenze, R. K. (2016). Barriers to linkage to HIV care in Ugandan fisherfolk communities: A qualitative analysis. *AIDS and Behavior*, 20(10), 2464–2476. <https://doi.org/10.1007/s10461-016-1331-z>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Closson, K., Dietrich, J. J., Lachowsky, N. J., Nkala, B., Palmer, A., Cui, Z., Chia, J., Hogg, R. S., Gray, G., Miller, C. L., & Kaida, A. (2018). Gender, sexual self-efficacy and consistent condom use among adolescents living in the HIV hyper-endemic setting of Soweto, South Africa. *AIDS and Behavior*, 22(2), 671–680. <https://doi.org/10.1007/s10461-017-1950-z>
- Cohen, M. S., Chen, Y. Q., McCauley, M., Gamble, T., Hosseinipour, M. C., Kumarasamy, N., Hakim, J. G., Kumwenda, J., Grinsztejn, B., Pilotto, J. H. S., Godbole, S. V., Chariyalertsak, S., Santos, B. R., Mayer, K. H., Hoffman, I. F., Eshleman, S. H., Piwowar-Manning, E., Cottle, L., Zhang, X. C., & Fleming, T. R. (2016). Antiretroviral therapy for the prevention of HIV-1 transmission. *New England Journal of Medicine*, 375(9), 830–839. <https://doi.org/10.1056/nejmoa1600693>
- Coldiron, M. E., Stephenson, R., Chomba, E., Vwalika, C., Karita, E., Kayitenkore, K., Tichacek, A., Isanhart, L., Allen, S., & Haworth, A. (2008). The relationship between alcohol consumption and unprotected sex among known HIV-discordant couples in Rwanda and Zambia. *AIDS and Behavior*, 12(4), 594–603. <https://doi.org/10.1007/s10461-007-9304-x>
- Colombini, M., James, C., Ndwiga, C., Team, I., & Mayhew, S. H. (2016). The risks of partner violence following HIV status disclosure, and health service responses: Narratives of women attending reproductive health services in Kenya. *Journal of the International AIDS Society*, 19(1), 1–7. <https://doi.org/10.7448/IAS.19.1.20766>
- Connell, R. W. (1987). *Gender and power: Society, the person and sexual politics*. (Politics Press (ed.)). Blackwell Publishers.
- Corneli, A. L., Deese, J., Wang, M., Taylor, D., Ahmed, K., Agot, K., Lombaard, J., Manongi, R., Kapiga, S., Kashuba, A., Van Damme, L., Atingu, W., Ambia, J., Asewe, J., De Baetselier, I., Chetty-Tulsee, S., Chiduo, S., Crucitti, T., Fransen, K., & Wong, C. (2014). FEM-PrEP. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 66(3), 324–331. <https://doi.org/10.1097/QAI.000000000000158>
- Crepaz, N., Tang, T., Marks, G., Mugavero, M. J., Espinoza, L., & Hall, H. I. (2016). Durable viral suppression and transmission risk potential among persons with diagnosed HIV infection: United States, 2012–2013. *Clinical Infectious Diseases*, 63(7), 976–983. <https://doi.org/10.1093/cid/ciw418>
- Crepaz, N., Tungol-Ashmon, M. V., Vosburgh, H. W., Baack, B. N., & Mullins, M. M. (2015). Are couple-based interventions more effective than interventions delivered to individuals in promoting HIV protective behaviors? A meta-analysis. *AIDS Care*, 27(11), 1361–1366. <https://doi.org/10.1080/09540121.2015.1112353>
- Delany-Moretlwe, S., Hughes, J. P., Bock, P., Ouma, S. G., Hunidzarira, P., Kalonji, D., Kayange, N., Makhema, J., & Mandima, P. (2022). Cabotegravir for the prevention of HIV-1 in women: Results from HPTN 084, a phase 3, randomised clinical trial. *The Lancet*, 399(10337), 1779–1789. [https://doi.org/10.1016/S0140-6736\(22\)00538-4](https://doi.org/10.1016/S0140-6736(22)00538-4)
- El-Bassel, N., Gilbert, L., Witte, S., Wu, E., Chang, M., Hill, J., & Hunt, T. (2022). Intertwined epidemics: Progress, gaps, and opportunities to address intimate partner violence and HIV among key populations of women. *The Lancet HIV*, 9(3), e202–e213. [https://doi.org/10.1016/S2352-3018\(21\)00325-8](https://doi.org/10.1016/S2352-3018(21)00325-8)

- Emusu, D., Ivankova, N., Jolly, P., Kirby, R., Foushee, H., Wabwire-Mangen, F., Katongole, D., & Ehiri, J. (2009). Experience of sexual violence among women in HIV discordant unions after voluntary HIV counselling and testing: A qualitative critical incident study in Uganda. *AIDS Care*, 21(11), 1363–1370. <https://doi.org/10.1080/09540120902883077>
- Hatcher, A. M., Smout, E. M., Turan, J. M., Christofides, N., & Stöckl, H. (2015). Intimate partner violence and engagement in HIV care and treatment among women. *Aids (London, England)*, 29(16), 2183–2194. <https://doi.org/10.1097/QAD.0000000000000842>
- Hatcher, A. M., Woollet, N., Pallitto, C., Mokooatle, K., Stocl, H., MacPaill, C., Delany-Moretlwe, S., & Garcia-Moreno, C. (2014). Bidirectional links between HIV and intimate partner violence in pregnancy: Implications for prevention of mother-to-child transmission. *Journal of the International AIDS Society*, 17(1), 1–9. <https://doi.org/10.7448/IAS.17.1.19233>. Research.
- Heise, L. (1998). Violence against women. *Violence Against Women*, 4(3), 262–290. <https://doi.org/10.1177/1077801298004003002>
- INE & ICF. (2023). *Inquérito Demográfico e de Saúde 2022-2023*.
- INS, MISAU, INE, & CNCS. (2023). *Inquérito Nacional Sobre o Impacto do HIV e SIDA em Moçambique* (Issue Insida 2021). <http://ins.gov.mz>
- Jewkes, R. K., Dunkle, K., Nduna, M., & Shai, N. (2010). Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: A cohort study. *The Lancet*, 376(9734), 41–48. [https://doi.org/10.1016/S0140-6736\(10\)60548-X](https://doi.org/10.1016/S0140-6736(10)60548-X)
- Kairania, R. M., Gray, R. H., Kiwanuka, N., Makumbi, F., Sewankambo, N. K., Serwadda, D., Nalugoda, F., Kigozi, G., Semanda, J., & Wawer, M. J. (2010). Disclosure of HIV results among discordant couples in Rakai, Uganda: A facilitated couple counselling approach. *AIDS Care*, 22(9), 1041–1051. <https://doi.org/10.1080/09540121003602226>
- Kouyoumdjian, F. G., Findlay, N., Schwandt, M., & Calzavara, L. M. (2013). A systematic review of the relationships between intimate partner violence and HIV/AIDS. *PLoS One*, 8(11), e81044–25. <https://doi.org/10.1371/journal.pone.0081044>
- Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (2002). *World report on violence and health*. World Health Organization. <https://www.who.int/publications/i/item/9241545615>.
- Kuchukhidze, S., Panagiotoglou, D., Boily, M.-C., Rönn, M., Looker, K. J., Braithwaite, S., Delany-Moretlwe, S., Eaton, J. W., & Baggaley, R. F. (2022). The effects of intimate partner violence on women’s risk of HIV acquisition and engagement in the HIV treatment and care cascade: A pooled analysis of nationally representative surveys in sub-Saharan Africa. *The Lancet HIV*, 10(2), e107–e117. [https://doi.org/10.1016/S2352-3018\(22\)00305-8](https://doi.org/10.1016/S2352-3018(22)00305-8)
- Medley, A., Garcia-moreno, C., McGill, S., & Maman, S. (2004). Rates, barriers and outcomes of HIV serostatus disclosure among women in developing countries : implications for prevention of mother-to-child transmission programmes. *Bulletin of the World Health Organization*, 03(03), 299–307.
- MISAU, INE, & ICF. (2019). Inquérito de Indicadores de Imunização, Malária e HIV/SIDA em Moçambique (IMASIDA) 2015 Relatório:Relatório Suplementar Incorporado os Resultados de Biomarcadores de Antiretrovirais.
- Morton, J. F., Celum, C., Njoroge, J., Nakyanzi, A., Wakhungu, I., Tindimwebwa, E., Ongachi, S., Sedah, E., Okwero, E., Ngure, K., Odoyo, J., Bulya, N., Haberer, J. E., Baeten, J. M., & Heffron, R. (2017). Counseling framework for HIV-Serodiscordant couples on the integrated use of antiretroviral therapy and Pre-exposure Prophylaxis for HIV Prevention. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 74, S15–S22. <https://doi.org/10.1097/QAI.0000000000001210>
- Muessig, K. E., & Cohen, M. S. (2014). Advances in HIV prevention for serodiscordant couples. *Current HIV/AIDS Reports*, 11(4), 434–446. <https://doi.org/10.1007/s11904-014-0225-9>
- Ogolsky, B. G., Hardesty, J. L., & Carter, M. L. (2026). The social-ecological framework for understanding intimate partner violence. *Current Opinion in Psychology*, 68, 102256. <https://doi.org/10.1016/j.copsyc.2025.102256>
- Patel, R., Ratner, J., Gore-Felton, C., Kadzirange, G., Woelk, G., & Katzenstein, D. (2012). HIV disclosure patterns, predictors, and psychosocial correlates among HIV positive women in Zimbabwe. *AIDS Care*, 24(3), 358–368. <https://doi.org/10.1080/09540121.2011.608786>
- Roberts, S. T., Haberer, J., Celum, C., Mugo, N., Ware, N. C., Cohen, C. R., Tappero, J. W., Kiarie, J., Ronald, A., Mujugira, A., Tumwesigye, E., Were, E., Irungu, E., & Baeten, J. M. (2016). Intimate partner violence and adherence to HIV Pre-exposure prophylaxis (PrEP) in African women in HIV serodiscordant relationships: A prospective cohort study. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, 73(3), 313–322. <https://doi.org/10.1097/QAI.0000000000001093>
- Sanga, E., Nampewo, Z., PrayGod, G., & Wringe, A. (2023). HIV positive status disclosure to sexual partners: A qualitative study to explore experiences and challenges among clients attending HIV care services in north-western Tanzania. *AIDS Care*, 35(7), 953–960. <https://doi.org/10.1080/09540121.2021.2012555>
- Shamu, S., Zarowsky, C., Shefer, T., Temmerman, M., & Abrahams, N. (2014). Intimate partner violence after disclosure of HIV test results among pregnant women in Harare, Zimbabwe. *PLoS One*, 9(10), e109447–8. <https://doi.org/10.1371/journal.pone.0109447>
- Shuper, P. A., Joharchi, N., Irving, H., & Rehm, J. (2009). Alcohol as a correlate of unprotected sexual behavior among people living with HIV/AIDS: Review and meta-analysis. *AIDS and Behavior*, 13(6), 1021–1036. <https://doi.org/10.1007/s10461-009-9589-z>

- Sikweyiya, Y. M., Jewkes, R., & Dunkle, K. (2015). Impact of HIV on and the constructions of masculinities among HIV-positive men in South Africa: Implications for secondary prevention programs. *Global Health Action*, 7(1), 1–13. <https://doi.org/10.3402/gha.v7.24631>
- Stoebenau, K., Nixon, S. A., Rubincam, C., Willan, S., Zembe, Y. Z. N., Tsikoane, T., Tanga, P. T., Bello, H. M., Caceres, C. F., Townsend, L., Rakotoarison, P. G., & Razafintsalama, V. (2011). More than just talk: The framing of transactional sex and its implications for vulnerability to HIV in Lesotho, Madagascar and South Africa. *Globalization and Health*, 7(1), 34–15. <https://doi.org/10.1186/1744-8603-7-34>
- UNAIDS. (2023). *The path that ends AIDS: UNAIDS global AIDS update 2023*. Geneva: UNAIDS.
- UNAIDS. (2025). FACT SHEET 2025. Global HIV statistics. In *Unaid*s (pp. 1–6). UNAIDS. <https://www.unaids.org/en/resources/fact-sheet>
- Were, E., Curran, K., Delany-Moretlwe, S., Nakku-Joloba, E., Mugo, N. R., Kiarie, J., Bukusi, E. A., Celum, C., & Baeten, J. M. (2011). A prospective study of frequency and correlates of intimate partner violence among African heterosexual HIV serodiscordant couples. *Aids (london, England)*, 25(16), 2009–2018. <https://doi.org/10.1097/QAD.0b013e32834b005d>
- Wingood, G. M., & Diclemente, R. J. (2000). Application of the theory of gender and power to examine HIV-related exposures, risk factors, and effective interventions for women. *Health Education & Behavior*, 27(5), 539–565. <https://doi.org/10.1177/109019810002700502>
- World Health Organization. (2012). Guidance on couples HiV TesTinG and counsellinG includinG anTireTroViral THERapy for TreaTmenT and preVenTion in serodiscordanT couples. *World Health Organization*, April, 54. <http://www.who.int/hiv/pub/guidelines/9789241501972/en/index.html#>
- World Health Organization. (2021). *Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: Recommendations for a public health approach*. Geneva: World Health Organization.
- World Health Organization. (2022). *Guidelines on long-acting injectable Cabotegravir for HIV prevention*. Geneva: World Health Organization.
- World Health Organization. (2025). *Violence against women prevalence estimates, 2023: Global, regional and national prevalence estimates for intimate partner violence against women and non-partner sexual violence against women*. Geneva: World Health Organization.