Scientific Research Publishing

Advances in Sexual Medicine, 2026, 16(2), 17-29
https://www.scirp.org/journal/asm
ISSN Online: 2164-5205
ISSN Print: 2164-5191

Relational, Emotional, and Sexual Vulnerabilities of Women Living with HIV Receiving PMTCT Care at the Military Teaching Hospital-University Hospital Center (HIA-CHU) of Parakou, 2025

Roger Klikpézo[1,2*], Lydwina Charelle Maryse Nougbodé[2], Beaudouin Jean-de-Dieu Edayé[2,3], Marius Mariano Tchêdékê Efio[1,2], Eric Kochikpa Dettin[2], Silas Sossouhounto[3], Elisabeth Vikpohouede[2], Sabine Amouzoun[2,3], Aliou Chabi[3], Awadé Afoukou Achille Obossou[1], Fanny Maryline Nouessèwa Hounkponou Ahouingnan[1], Kabibou Salifou[1], Justin Lewis Denakpo[4]

[1]Faculty of Medicine, University of Parakou, Parakou, Benin
[2]Parakou Army Training Hospital-University Hospital Center, Parakou, Benin
[3]Research Office in Epidemiology and Population Health (CaRESaP), Parakou, Benin
[4]Faculty of Health Sciences, University of Abomey-Calavi, Cotonou, Benin
Email: *kliroger@yahoo.fr

How to cite this paper: Klikpézo, R., Nougbodé, L.C.M., Edayé, B.J.D., Efio, M.M.T., Dettin, E.K., Sossouhounto, S., Vikpohouede, E., Amouzoun, S., Chabi, A., Obossou, A.A.A., Ahouingnan, F.M.N.H., Salifou, K. and Denakpo, J.L. (2026) Relational, Emotional, and Sexual Vulnerabilities of Women Living with HIV Receiving PMTCT Care at the Military Teaching Hospital-University Hospital Center (HIA-CHU) of Parakou, 2025. *Advances in Sexual Medicine*, **16**, 17-29.
https://doi.org/10.4236/asm.2026.162002

Received: November 21, 2025
Accepted: March 24, 2026
Published: March 27, 2026

Abstract

Introduction: Women living with HIV who are enrolled in Prevention of Mother-to-Child Transmission (PMTCT) programs face relational, emotional, and sexual vulnerabilities that remain poorly documented. These vulnerabilities influence their well-being, sexual lives, and reproductive plans. **Study Method:** A descriptive cross-sectional study using a mixed-methods approach was conducted between 2024 and 2025 among women living with HIV receiving PMTCT care at the Military Teaching Hospital-University Hospital Center (HIA-CHU) of Parakou. Data were collected through structured questionnaires and semi-structured interviews with 32 participants recruited exhaustively. Quantitative analyses were performed using STATA version 15, while qualitative data were analyzed thematically using NVivo. Ethical principles and informed consent were strictly respected throughout the research process. **Results:** The participants had a median age of 32 years and were predominantly married and educated. A decrease in libido during pregnancy was reported by 71.9% of participants, particularly during the third trimester, with infrequent sexual intercourse. In the postpartum period, 75% resumed sexual activity within an average period of five months. HIV affected marital rela-

tionships in 65.6% of cases, characterized by frequent non-disclosure of HIV status and emotional distancing. Fear of transmission generated anxiety, guilt, and reduced sexual desire, despite PMTCT follow-up being generally perceived as not having a negative impact and a persistent desire for motherhood among women. **Conclusion:** These findings highlight the need to integrate strengthened psychosocial support into PMTCT services in order to improve women's quality of life.

Keywords

HIV, PMTCT, Sexuality, Vulnerabilities

1. Introduction

The lived experiences of women living with HIV during pregnancy and the postpartum period represent a major public health concern [1]-[3], at the intersection of biomedical, psychological, sexual, and relational dimensions. Despite substantial improvements in obstetric outcomes and a marked reduction in the risk of mother-to-child transmission due to antiretroviral therapy, pregnancy remains for many women a period marked by persistent fears, internalized stigma, and profound reproductive ambivalence. Studies conducted in diverse settings indicate that HIV seropositivity continues to disrupt perceptions of motherhood, risk appraisal, and women's ability to envision a fulfilling sexual life [4].

Beyond medical considerations, the sexual and reproductive health priorities of women living with HIV remain insufficiently addressed. As demonstrated by a Canadian analysis, only a proportion of women feel that their sexual and reproductive health needs are genuinely acknowledged within HIV care, particularly those who have been exposed to stigma or experiences of violence [5]. This stigma—whether social, institutional, or internalized—constitutes a major determinant of healthcare utilization and may extend into everyday interactions with sexual partners and healthcare services [6].

Within this context, the relationship between sexuality, reproductive desire, and emotional well-being is inseparable from relational dynamics. Fear of stigma, the management of secrecy, and pressures surrounding disclosure expose women to significant conjugal tensions, sometimes exacerbated by unequal power relations or histories of early sexual violence [7]. These factors profoundly shape how women experience pregnancy, envision motherhood, and navigate intimacy with their partners.

It is within this framework that the present study is situated. The study aims to explore the interactions between sexuality, emotional experiences, conjugal dynamics, and reproductive intentions among women living with HIV receiving PMTCT care, in order to elucidate the mechanisms that shape their intimate and relational experiences.

2. Materials and Methods

This was a descriptive cross-sectional study using a mixed-methods approach (quantitative and qualitative), conducted between 2024 and 2025 among mothers living with HIV who were receiving Prevention of Mother-to-Child Transmission (PMTCT) services at the Military Teaching Hospital-University Hospital Center of Parakou, Benin. The mixed-methods design was adopted to capture both measurable dimensions and subjective experiences related to sexuality, conjugal relationships, and emotional well-being in the context of HIV and motherhood.

The study population consisted of women aged 18 years or older who had given birth between 2022 and 2024, whose children aged 1 to 24 months were enrolled in PMTCT follow-up, and who provided free and informed consent. Women who were minors, had severe cognitive impairments, or withdrew their consent were excluded. An exhaustive recruitment strategy led to the inclusion of 32 participants, with thematic saturation achieved.

Quantitative and qualitative data were collected using a structured questionnaire and individual semi-structured interviews. Quantitative variables included sociodemographic, obstetric, and clinical characteristics, as well as selected aspects of sexual life. The qualitative component specifically explored emotional, relational, and sexual experiences, based on predefined thematic areas (fear of transmission, guilt, psychological distress, conjugal pressure, and desire for motherhood), while allowing for the emergence of new themes throughout the interviews.

Interviews were conducted in a confidential and supportive environment by healthcare workers and community mediators who were routinely involved in the care of people living with HIV and were familiar to the participants through their antiretroviral follow-up, in order to foster trust and facilitate open discussion of sensitive topics such as HIV and sexuality. At the participants' request, the option to participate anonymously or without audiovisual recording was strictly respected. Qualitative data collection continued until data saturation, defined as the absence of the emergence of new relevant themes.

Quantitative data analysis was performed using STATA version 15, with continuous variables presented as means and standard deviations, and categorical variables as frequencies and percentages. Qualitative data were analyzed using thematic content analysis based on verbatim transcripts, which were fully transcribed and coded using computer-assisted qualitative data analysis software (NVivo). An iterative analytical process was applied, combining open coding, axial grouping, and thematic interpretation.

From an ethical standpoint, the study was conducted in accordance with the principles of the Declaration of Helsinki[1]. Ethical approval was obtained from the Clinical Research Ethics Council in the Military Setting. Confidentiality, participant an-

[1]The Declaration of Helsinki, adopted by the World Medical Association (WMA) in 1964, is the global ethical reference for medical research involving human subjects. It is available at: https://iris.who.int/bitstreams/01556cb2-cc4d-4bef-a12a-fcc2e8f9065d/download

onymity, data protection, respect for dignity, and the right to withdraw at any time without prejudice to ongoing care were ensured throughout the research process.

3. Results

The study population was characterized by a median maternal age of 32 years and a median infant age of 16 months. The majority of participants had attained secondary or tertiary education (68.8%), were married (84.5%), and were primarily engaged in income-generating activities, particularly trading (31.3%). In addition, 81.3% of the women were aware of their HIV status prior to pregnancy.

From an obstetric perspective, 71.9% of participants were classified as having a low risk of mother-to-child transmission, and modes of delivery were evenly distributed between vaginal delivery and cesarean section (50% each), Table 1.

Table 1. Distribution of sociodemographic and obstetric characteristics of mothers living with HIV receiving PMTCT care at the Military Teaching Hospital-University Hospital Center of Parakou, 2025 (N = 32).

	n	(%)
Educational level		
▪ No formal education	09	28.1
▪ Primary education	01	03.1
▪ Secondary education	14	43.8
▪ Tertiary education	08	25.0
Marital status		
▪ Married	27	84.5
▪ Unmarried[2]	05	15.5
Occupation		
▪ Trader	10	31.3
▪ Housewife	08	25.0
▪ Hairdresser	03	09.4
▪ Civil servant	03	09.4
▪ Secretary	02	06.2
▪ Other[3]	06	18.7
Timing of HIV diagnosis		
▪ Before pregnancy	26	81.3
▪ During pregnancy	06	18.7
Risk of mother-to-child transmission		
▪ Low	23	71.9
▪ High	09	28.1
Mode of delivery		
▪ Vaginal delivery	16	50.0
▪ Cesarean section	16	50.0

[2]**Marital status - other categories:** Divorced (2); Cohabiting (2); Widowed (1).
[3]**Occupation - other categories:** Site manager (1); Seamstress (2); Medical representative (1); Nurse (1); Audiovisual technician (1).

Sexual life during pregnancy

A decrease in libido attributed to HIV status was reported by 23 women (71.9%). Sixteen participants (50.0%) stated that they had actually experienced a reduction in sexual desire during pregnancy. This decrease in libido was more frequently reported during the third trimester by 14 women (43.7%) (Figure 1).

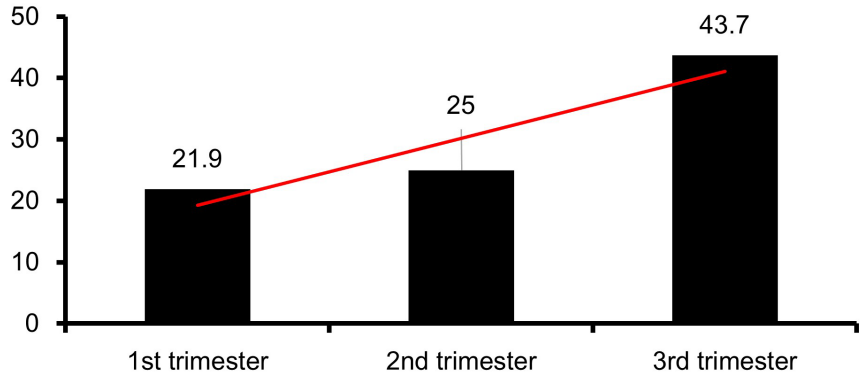


Figure 1. Distribution of decreased libido by pregnancy trimester among women living with HIV receiving PMTCT care in Parakou, 2025.

During pregnancy, four women (12.5%) reported having regular sexual intercourse, whereas 28 (87.5%) reported infrequent sexual activity. In addition, 17 participants (53.1%) indicated that their sexual satisfaction had been influenced by their HIV serostatus.

Sexual life in the postpartum period

During PMTCT follow-up, 24 women (75.0%) resumed sexual activity within nine months after delivery. The mean time to resumption of sexual activity was five months postpartum. Eight women (25.0%) had not resumed sexual activity at the time of the survey.

Emotional and relational experiences

An influence of HIV on the conjugal relationship was reported by 21 participants (65.6%). Two cases of divorce were recorded during the follow-up period. Fourteen women (43.7%) reported not having disclosed their HIV status to their partner. Some participants described the gradual emergence of emotional distancing within the couple.

Impact of PMTCT follow-up

Twenty-eight women (87.5%) reported that PMTCT follow-up had no negative impact on their sexual life, whereas four participants (12.5%) reported an adverse effect during this period.

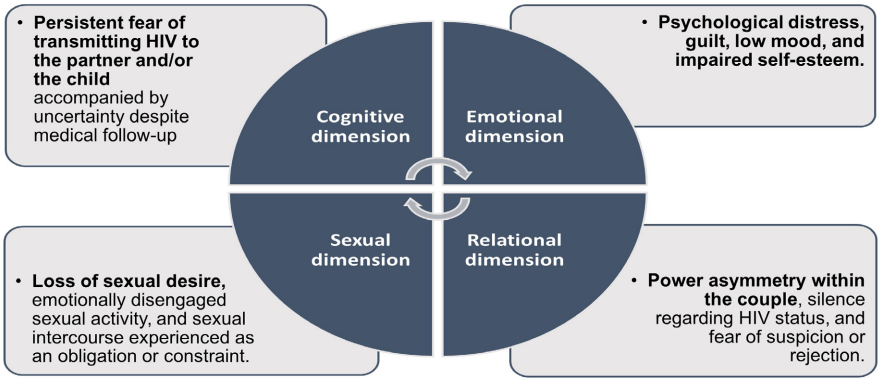
Reproductive intentions

Nineteen women (59.4%) expressed a desire for future motherhood, while 13 participants (40.6%) did not plan another pregnancy at the time of the survey.

Emergent interrelated dimensions

The analysis highlighted an integrated process in which persistent fear of HIV

transmission forms the central core, generating chronic anxiety that disrupts women's emotional balance, weakens conjugal relationships, and transforms sexuality into an experience that is often constrained and devoid of desire. Cognitive, emotional, relational, and sexual dimensions do not operate in isolation but interact in a reinforcing cycle of guilt, secrecy, and affective disengagement.



4. Discussion

Sociodemographic and obstetric profile of participants

The study population was characterized by a median maternal age of 32 years, a median infant age of 16 months, a high level of education in nearly 70% of women, a large proportion of married participants (84.5%), and a majority of women who were economically active, particularly in trade. Moreover, over 80% of women were aware of their HIV status prior to pregnancy, and most were classified as having a low risk of mother-to-child transmission. This profile, marked by relatively high educational attainment and a degree of conjugal stability, contrasts with other contexts in which women living with HIV accumulate greater socioeconomic vulnerabilities. Several studies have shown that social and economic trajectories profoundly influence how women experience seropositivity, their sexuality, and reproductive health [8] [9]. Similarly, the influence of relational and familial factors, particularly in managing obstetric risk and disclosure, has been documented in diverse settings [10]. However, even when socio-educational indicators appear favorable, emotional dynamics, perceived stigma, and risk perceptions persist and strongly influence sexual and relational behaviors, as highlighted by the qualitative data collected.

Decrease in libido during pregnancy

The majority of participants reported a reduction in sexual desire during pregnancy, often attributed to their HIV status, with the effect being particularly pronounced in the third trimester. This phenomenon aligns with studies showing that fear of transmission to the partner, guilt, and the psychological burden associated with HIV profoundly affect sexual desire [11]. Some participants expressed this explicitly: "I feel discouraged because of my status during intercourse," "I have no desire at all." These experiences are consistent with the observations of Comfort *et al.*, who reported that seropositivity can act as an almost complete barrier to

intimacy, especially among women who associate sexuality with potential risk to others [8]. Furthermore, several studies suggest that relational context, fear of disclosure, and concern about stigma also contribute to reduced libido [12]. The convergence of quantitative and qualitative findings underscores the importance of addressing emotional factors and risk perception in the care and counseling of women during pregnancy.

Infrequent sexual activity during pregnancy

The low frequency of sexual activity during pregnancy reported by the majority of women aligns with dynamics previously described in the literature. Pervasive fears—"I am afraid of infecting him…"—reflect a sense of relational insecurity, also observed among women living with HIV in other contexts, where sexuality becomes a space of constant vigilance [11]. Analyses by Kabir *et al.* indicate that the sexual health of women living with HIV is frequently constrained by stigma and fear of judgment [13]. Similarly, the study by Hamilton *et al.* highlights the limited attention given to women's sexual needs, leading to heightened risk perception and voluntary restriction of sexual activity [14]. These convergences illustrate a dynamic in which sexuality during pregnancy loses its affective function and becomes primarily a strategy to manage perceived risk.

Impact of HIV on sexual satisfaction

More than half of the participants reported that HIV had negatively influenced their sexual satisfaction. Verbatim accounts reveal ongoing intimate distress: "I can't think about it anymore; only if he wants…" These observations are consistent with several studies documenting a forced redefinition of sexuality, characterized by guilt, fear of rejection, and loss of pleasure [4] [11]. In some contexts, sexual activity may even be experienced as a conjugal duty, particularly when women fear the consequences of refusal—a dynamic also described by Krüsi *et al.*, who highlight how HIV status reshapes power relations within the couple [12]. Taken together, these findings suggest that sexual satisfaction is inextricably linked to the emotional climate, internalized stigma, and gendered power dynamics.

Resumption of sexual activity in the postpartum period

The relatively early resumption of sexual activity—on average five months postpartum—reflects multiple realities. Some women resume sexual activity to meet conjugal expectations, as expressed in statements such as: "I had to do it so he wouldn't suspect anything." This form of pressure is also described in the work of Krüsi *et al.*, highlighting that relational pressures continue to affect women living with HIV, particularly when they have not disclosed their status [12]. Conversely, other studies indicate that for some women, resuming sexual activity serves as a means of reaffirming their feminine identity after childbirth [8]. This contrast underscores the plurality of trajectories shaped by risk perception, conjugal relationships, and access to appropriate counseling.

A quarter of participants had not resumed sexual activity at the time of the survey. This phenomenon appears to reflect persistent anxiety related to transmis-

sion, as expressed in: "I often tell myself that I will infect him…" The literature extensively documents this enduring fear as a major barrier to intimacy, even after delivery [8] [11]. Qualitative syntheses further indicate that women with prior experiences of stigma or rejection are particularly likely to delay resumption of sexual activity [10]. Thus, the absence of postpartum sexual activity often reflects an emotional space marked by doubt, fear, and a lack of integrated psychological support within follow-up care.

Impact of HIV on the conjugal relationship

The majority of participants reported a negative impact of HIV on their relationship, with some cases resulting in divorce. Verbatim accounts such as "I was psychologically destroyed…" or "An emotional distance set in" reflect experiences similar to those described in other contexts, where HIV undermines affective relationships due to secrecy, stigma, and tensions surrounding risk [11]. Figueroa-Cosme highlights that even in parental relationships, communication about sexuality and HIV remains difficult, reinforcing silences and emotional distancing [4]. Moreover, social pressures and expectations surrounding female sexuality may exacerbate relational fragility, particularly when women attempt to reconcile conjugal expectations with fear of transmission [14].

Non-disclosure of HIV status to the partner

Nearly half of the women had not disclosed their HIV status, a phenomenon widely documented in the literature. Multiple studies show that fear of rejection, violence, or relationship dissolution constitutes a major barrier to disclosure [12]. Verbatim statements confirm this: "I had to do it so he wouldn't suspect anything." Non-disclosure is also associated with unwanted or coerced sexual activity, a phenomenon observed in studies of relational dynamics in serodiscordant couples [15]. Huertas-Zurriaga *et al.* note that disclosure represents a socially risky and emotionally costly act, often avoided to preserve the conjugal bond [10]. These converging findings highlight that non-disclosure is not an isolated choice, but an expression of structural and relational vulnerability.

Psychological sexual pressure and constrained sexuality

Sexual activity experienced as an obligation—"Yes, but it means nothing to me"—reflects a disjunction between desire, consent, and conjugal expectations. This issue aligns with findings from several studies describing the sexuality of women living with HIV as largely shaped by gender norms, power dynamics, and male control [12]. Hampton *et al.* also highlight how internalized stigma leads some women to engage in sexual activity despite emotional distress, for fear of losing the relationship [11]. Wielding *et al.* further demonstrate that gender-based violence and relational pressures are common among women living with HIV, directly impacting their sexual health and autonomy [9]. Thus, constrained sexuality appears as an indirect but profound consequence of the interaction between HIV, social norms, and stigma.

Perception of PMTCT follow-up

The vast majority of participants did not perceive a negative impact of PMTCT

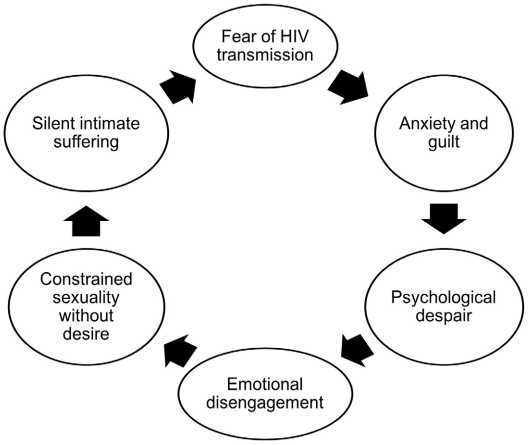
follow-up on their sexuality. This positive perception may be explained by a sense of security provided by medical follow-up, as illustrated in the statement: "If I follow the program correctly, he will not be infected, right?" Several studies indicate that access to information and counseling reduces anxiety related to transmission and enhances confidence in risk management [8]. The integration of sexual health services, described as beneficial, also improves the quality of follow-up and women's sense of control over their reproductive health [16]. These findings suggest that PMTCT programs play a stabilizing role, even though emotional and relational dimensions remain sensitive.

Desire for future motherhood

The majority of participants expressed a desire for future motherhood, despite concerns regarding transmission. This desire is consistent with studies showing that motherhood remains a central element of feminine identity, particularly among women living with HIV [10]. Comfort emphasizes that motherhood can be perceived as a way to reclaim a positive identity despite stigma [8]. Qualitative syntheses confirm that reproductive intentions are shaped by a tension between desire, fear, available information, and conjugal or medical support [10]. These findings also align with studies documenting the diversity of post-diagnosis reproductive trajectories [17].

Conversely, a substantial proportion of women did not wish for another pregnancy, primarily due to persistent fears of transmission and the psychological burden associated with living with HIV. This observation is consistent with studies showing that HIV can lead to reproductive renunciation driven by fear, stigma, and emotional uncertainty [11]. In several contexts, women report that lack of conjugal support or relational instability reduces their desire for pregnancy [15]. Qualitative syntheses further indicate that reproductive ambivalence is common and depends as much on structural as on psychological factors [10].

A clear model emerges from the thematic analysis of our study. The theoretical model highlights fear of HIV transmission to the partner or child as the central core, situated within a context of HIV-related stigma, limited discourse on female sexuality, conjugal pressure, and predominantly biomedical PMTCT follow-up.



This fear generates chronic anxiety and persistent guilt, leading to psychological despair, emotional disengagement, and weakening of conjugal relationships. Sexuality consequently becomes constrained and devoid of desire, embedded in enduring and often silent intimate suffering.

Interventions to restore postpartum sexuality and conjugal well-being among women living with HIV: identification of key determinants

The study highlights that postpartum sexuality among women living with HIV is frequently characterized by fear, anxiety, and constraint, despite effective biomedical PMTCT follow-up. A detailed analysis identifies three major, interacting categories of factors contributing to this issue: psychosocial factors (fear of transmission, guilt and internalized stigma, emotional stress and psychological distress), relational and gender-related factors (non-disclosure of HIV status, unequal power dynamics within the couple, social and conjugal pressures), and PMTCT follow-up-related factors (biomedically focused follow-up and lack of integrated interventions addressing sexual health and conjugal well-being) Figure 2.

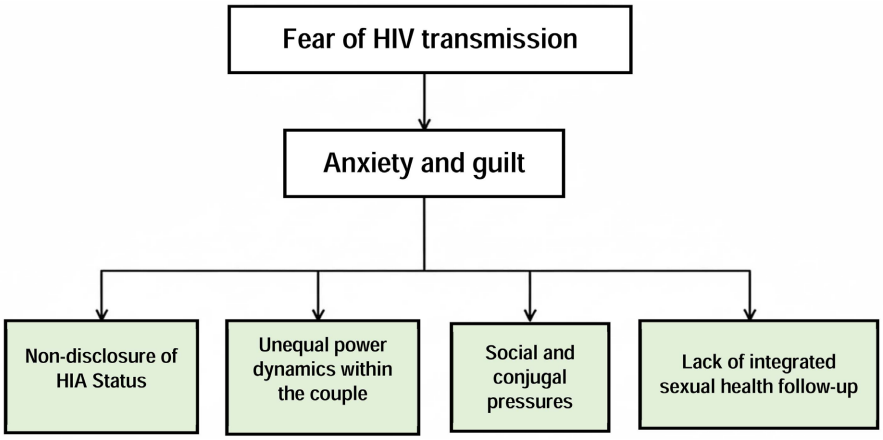


Figure 2. Problem tree illustrating the psychosocial, relational, and PMTCT follow-up factors contributing to constrained postpartum sexuality among women living with HIV.

Integrated approach: Constrained sexuality among postpartum women living with HIV results from a complex interaction between transmission-related anxiety, power dynamics within the couple, and limitations in biomedical follow-up. Effective intervention requires an integrated approach combining:

- psychological support,
- couple counseling and the promotion of gender equity,
- integration of sexual health into PMTCT follow-up.

Such an approach directly targets the key factors identified in the problem tree and has the potential to break the cycle of constrained sexuality, improve quality of life, and enhance the overall effectiveness of PMTCT programs.

Limitations

Although this study provides valuable insights into postpartum sexuality and

conjugal well-being among women living with HIV, certain limitations should be acknowledged for scientific transparency. In particular, much of the data relies on self-reporting, which may introduce recall or social desirability biases, especially regarding sexual frequency, libido, and sexual satisfaction. Nevertheless, the combined use of quantitative data and qualitative verbatim strengthens the credibility of the findings and allows for the identification of meaningful trends that remain informative for guiding PMTCT interventions.

5. Conclusions

This study highlights a complex reality in which, despite the biomedical effectiveness of PMTCT, women living with HIV experience a profoundly challenging journey marked by fear of transmission, emotional distress, and frequently imbalanced conjugal relationships. Sexuality, far from being a space for fulfillment, is often experienced as a silent obligation, shaped by anxiety, guilt, and social pressure, while emotional experiences remain largely invisible in clinical follow-up.

These findings indicate that the success of PMTCT cannot be fully achieved without an integrated approach that recognizes, listens to, and supports the relational, emotional, and sexual dimensions of women's lives—a critical requirement for sustainable and truly person-centered prevention.

Ethics Statement

This study was approved by the Ethics Committee for Clinical Research in Military Settings. It was conducted in accordance with the ethical principles of the Declaration of Helsinki. Written, voluntary, and informed consent was obtained from all participants prior to data collection. Confidentiality, anonymity, respect for the dignity of participants, and the right to withdraw at any time without affecting their care were strictly ensured.

Author Contributions

All authors made substantial contributions to the study design, data collection, analysis, and interpretation of results, as well as to the drafting and critical revision of the manuscript. All authors have read and approved the final version submitted for publication.

Data Availability Statement

The data from this study contain sensitive information related to HIV and participants' sexual lives. For ethical and professional reasons, they cannot be made publicly available but can be provided upon reasonable request to the corresponding authors, subject to approval by an ethics committee.

Consent for Publication

All participants provided informed consent for the use and publication of anonymized data derived from questionnaires and qualitative interviews.

Compliance with Scientific Standards

This research was conducted in accordance with current scientific and methodological best practices for quantitative and qualitative research, particularly for studies involving vulnerable populations and sensitive topics such as HIV and sexuality.

Acknowledgments

The authors sincerely thank the staff of the **Cabinet of Research in Epidemiology and Population Health (CaRESaP → https://www.caresap.org/)** for their methodological support and technical and organizational assistance. They also extend their gratitude to the staff of the HIV care site at the **Military Teaching Hospital-University Hospital Center of Parakou**, whose dedication and collaboration were essential for the completion of this study. Finally, special recognition is given to all participants and to all individuals who, in various ways, contributed to conducting this research despite challenges encountered during the initial phases of the project.

Conflicts of Interest

The authors declare that they have no financial or non-financial conflicts of interest related to the conduct or publication of this study.

References

[1] Bule, V., Pitkevica, I. and Lazdane, G. (2022) Contraception among HIV-Positive Women in Latvia—Knowledge, Experience and Factors Influencing the Choice. *The European Journal of Contraception & Reproductive Health Care*, **27**, 390-396. https://doi.org/10.1080/13625187.2022.2088730

[2] Carlsson-Lalloo, E., Berg, M., Mellgren, Å. and Rusner, M. (2018) Sexuality and Childbearing as It Is Experienced by Women Living with HIV in Sweden: A Lifeworld Phenomenological Study. *International Journal of Qualitative Studies on Health and Well-Being*, **13**, Article ID: 1487760. https://doi.org/10.1080/17482631.2018.1487760

[3] Mathews, K., Swann, S.A., Campbell, A.R., Lee, M., Pang, D., Tognazzini, S., *et al.* (2025) Sexual Activity, Pleasure, and Testosterone: A Biopsychosocial Analysis of Women Living with and without HIV in British Columbia, Canada. *The Journal of Sex Research*, 1-15. https://doi.org/10.1080/00224499.2025.2503896

[4] Figueroa-Cosme, W.I., Miranda-Díaz, C., López-Córdova, N.M., *et al.* (2018) The Birds and the Bees: Do Puerto Rican Mothers and Daughters Talk about Sex? *Archives of Clinical and Medical Case Reports*, **2**, 190-205. https://doi.org/10.26502/acmcr.96550043

[5] Zhang, L.J., Shannon, K., Tibashoboka, D., Ogilvie, G., Pick, N., Kestler, M., *et al.* (2021) Prevalence and Correlates of Having Sexual and Reproductive Health Priorities Met by HIV Providers among Women Living with HIV in a Canadian Setting. *Sexual & Reproductive Healthcare*, **30**, Article ID: 100666. https://doi.org/10.1016/j.srhc.2021.100666

[6] Daniels, J., van der Merwe, L.L., Portle, S., Bongo, C., Nadkarni, S. and Petrus Peters, R. (2025). *JMIR Research Protocols*, **14**, e52121. https://doi.org/10.2196/52121

[7] Lee, C., Low, A., Kreniske, P., Mugurungi, O., Ndagije, F., Tenthani, L., *et al.* (2024) HIV Outcomes among Women Living with HIV Who Experienced Early Sexual Violence across Four Sub-Saharan African Countries. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, **97**, 253-260. https://doi.org/10.1097/qai.0000000000003489

[8] Comfort, L., Watnick, D., Peskin, M., Gutierrez, J., Abadi, J. and Atrio, J. (2022) Reproductive Health Perspectives of Young Women with Perinatally and Behaviourally Acquired HIV: A Qualitative Study. *Reproductive, Female and Child Health*, **1**, 42-50. https://doi.org/10.1002/rfc2.9

[9] Wielding, S. and Scott, A. (2016) What Women Want: Social Characteristics, Gender-Based Violence and Social Support Preferences in a Cohort of Women Living with HIV. *International Journal of STD & AIDS*, **28**, 486-490. https://doi.org/10.1177/0956462416654046

[10] Huertas-Zurriaga, A., Palmieri, P.A., Edwards, J.E., Cesario, S.K., Alonso-Fernandez, S., Pardell-Dominguez, L., *et al.* (2021) Motherhood and Decision-Making among Women Living with HIV in Developed Countries: A Systematic Review with Qualitative Research Synthesis. *Reproductive Health*, **18**, Article No. 148. https://doi.org/10.1186/s12978-021-01197-6

[11] Hampton, C.J. and Gillum, T.L. (2021) "It Changes Everything": The Impact of HIV-Related Stigma on Sexual Health and Intimacy among African American Women. *Culture, Health & Sexuality*, **24**, 1619-1633. https://doi.org/10.1080/13691058.2021.1990411

[12] Krüsi, A., Ranville, F., Gurney, L., Lyons, T., Shoveller, J. and Shannon, K. (2018) Positive Sexuality: HIV Disclosure, Gender, Violence and the Law—A Qualitative Study. *PLOS ONE*, **13**, e0202776. https://doi.org/10.1371/journal.pone.0202776

[13] Kabir, P., Shannon, K., Kestler, M., Thompson, C., Zhou, H. and Deering, K. (2025) Socio-Structural Barriers to Mental Health Services among Women Living with HIV in Metro Vancouver, Canada. *AIDS Care*, **37**, 1221-1232. https://doi.org/10.1080/09540121.2025.2534115

[14] Hamilton, R.A., Wells, Y. and Higgs, P. (2022) A Retrospective Cohort Study of Women and Men Living with HIV, Attending an HIV Clinic in Australia. *Women's Health Reports*, **3**, 915-923. https://doi.org/10.1089/whr.2022.0038

[15] Hahn, A.L., Corcoran, J., Fontalvo, S., Gure, S., Snyder, C., McDonald, V., *et al.* (2025) "We Can't Help Who We Love": The Impact of Relationship Dynamics on Women's HIV Prevention Strategies. *Culture, Health & Sexuality*, **28**, 259-274. https://doi.org/10.1080/13691058.2025.2523330

[16] Carter, A., Greene, S., Money, D., Sanchez, M., Webster, K., Nicholson, V., *et al.* (2019) Love with HIV: A Latent Class Analysis of Sexual and Intimate Relationship Experiences among Women Living with HIV in Canada. *Archives of Sexual Behavior*, **48**, 1015-1040. https://doi.org/10.1007/s10508-019-1418-5

[17] Hernando, V., Alejos, B., Montero, M., Pérez-Elias, M., Blanco, J.R., Giner, L., *et al.* (2017) Reproductive History before and after HIV Diagnosis: A Cross-Sectional Study in HIV-Positive Women in Spain. *Medicine*, **96**, e5991. https://doi.org/10.1097/md.0000000000005991