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"Just Like A Person": How Clinician Interactions Impact Healthcare Experiences of Women Living with HIV

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ABSTRACT
Between July 24 and August 23, 2023, researchers set out to better understand the sexual and reproductive health (SRH) care needs of women living with HIV (WLHIV) in Vermont. In-depth interviews were conducted with women receiving HIV care through the University of Vermont Health Network to explore their experiences and identify ways to improve SRH care. Inductive and deductive methods were used to analyze the interview data. The participants ranged in age from 29 to 67, and 20% identified as African American or Black. A recurring theme in the interviews was the importance of the relationship between patients and their healthcare providers. Many women emphasized that how they were treated by their providers shaped their perceptions of care quality. They expressed a strong desire to be seen as whole individuals, not solely defined by their HIV status. A particularly challenging issue was the disclosure of HIV status to intimate partners, which many women found to be a significant source of stress. They voiced a need for more guidance and support from clinicians when navigating these deeply personal conversations. The study concluded that affirming and supportive interactions between healthcare providers and WLHIV are crucial for fostering positive experiences with SRH care. Based on these findings, it should be emphasized that HIV care providers play a vital role in addressing the SRH needs of WLHIV. To do this effectively, providers should receive training on HIV-specific SRH issues and learn strategies for facilitating safe and supportive discussions about HIV disclosure with intimate partners.

KEYWORDS: HIV-related stigma, patient-centered care, rural health, women's health

Women living with HIV (WLHIV) in rural America, and their healthcare experiences, have long been understudied in medical literature. However, this population is significant. Understanding the experiences of WLHIV is critical for informing providers about their unique needs and improving healthcare delivery, particularly in underserved rural regions where resources are scarce and stigma may be heightened. Women account for nearly one-fifth (18%) of new HIV infections in the United States, with 86% of new cases attributed to heterosexual contact (Centers for Disease Control and Prevention, 2021). Black and African American women represent the

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majority of WLHIV in the U.S. as well as the majority of new infections (Centers for Disease Control and Prevention, 2021); however, national trends indicate rising incidence in populations aged 55 and older and white (Centers for Disease Control and Prevention, 2021). Furthermore, while cases of HIV tend to be concentrated in urban areas, cases are on the rise in some rural areas and can approach those in urban areas, especially in the South (Sullivan et al., 2021). This trend in rural areas has been attributed to poor healthcare access, increased injecting drug use, in part due to the opioid epidemic, socioeconomic factors like poverty, and HIV-related stigma that can be accentuated in smaller, more tight-knit communities (Sullivan et al., 2021).

More than 40 years into the HIV epidemic, it is well documented that stigma affects clinical care. The adverse sequelae of stigma is compounded by gender, with women experiencing greater impacts than men (Maragh-Bass et al., 2020).While research has explored the impacts of stigma on WLHIV, studies have tended to focus geographically on urban populations and underrepresented the experiences of rural WLHIV. An abundance of biomedical HIV research is also focused on the viral treatment of WLHIV, with a minority of studies addressing healthcare experiences, particularly with sexual and reproductive health (SRH) care. The populations of WLHIV primarily studied are Black urban Americans and Black rural Africans, and thus the data are shaped by the inextricable intersection of marginalized race and gender. Rural and predominately white populations in America are largely absent from the literature, making it more difficult to ascribe findings in the medical literature to populations of rural WLHIV. The underrepresentation of this population is accentuated by the elimination of demographic information regarding WLHIV from the Centers for Disease Control and Prevention's website in early 2025.

This oversight can undermine our efforts to understand and address healthcare-related barriers to HIV prevention and treatment in rural WLHIV, who tend to get diagnosed later and experience worse treatment rates and health outcomes than WLHIV in urban areas (Bono et al., 2023). Published research reveals that while HIV may negatively affect the healthcare experiences of WLHIV, there may also be valuable clinical opportunities to innovate care. Research in Peru, for example, demonstrated that community-engagement focused on key practical messages (for example, HIV that is undetectable is untransmittable), can both add to clinical care and critically reduce prejudice and shame (Nunez et al., 2025). Additionally, studies exploring father daughter sexual health dialogue illuminate how communication patterns influence risk perception and decision making in health contexts (Kachingwe, 2023). Similarly, work on provider approaches to behavioral health care highlights how clinician cultural perspectives shape clinical engagement and patient trust, suggesting parallels for HIV and SRH care environments (Gill & Mauriello, 2025).

Our research question seeks to bridge this important knowledge gap and explore the SRH health care experiences as well as barriers to, and facilitators of, meeting SRH needs in a rural northeastern American population living with HIV. In the current study, we present findings from a qualitative study that was nested within a mixed-method cross-sectional study Vermont enrolled in HIV care in a university health network. The parent study aimed to quantitatively assess cervical Papanicolaou (Pap) smear frequency among cisgender WLHIV compared with cisgender HIV-uninfected women engaged in primary care. The current study qualitatively explores WLHIV's experiences with and perceptions of their SRH care. In a separate study (unpublished), we also qualitatively assessed the SRH knowledge of clinicians who care for this population, comprised mostly of physicians trained in infectious diseases. Results are being used to inform clinical care recommendations to improve SRH care for WLHIV receiving care at the university health network.

Researcher Positionality Statement

There are three researchers for this study; two identify as white Americans, and one identifies as South Asian American. We were motivated to undertake this research because WLHIV is an underserved population, especially in our small, rural state of Vermont, and we wanted to learn about this population's gaps in SRH care so that we could suggest improvements at the clinical delivery level. We received a small grant for clinical care innovation research to conduct this study. None of us are living with HIV nor do we have lived experience in rural American settings, which may have influenced our interpretations of the data. To mitigate our biases, we engaged in bracketing, via both personal reflection and collective verbal discussion, to regularly reflect on and maintain awareness of our own assumptions, beliefs, and knowledge that we may bring to this study. One researcher acknowledges that her experience as an infectious disease doctor working with patients living with HIV helped her make meaning of the text and emergent themes. She did not conduct the interviews with respondents, some of whom she provides care for, in order to avoid influencing the interview dynamics or responses.

Methods

Research Design and Setting

The parent study was conducted at University of Vermont Health Network (UVMHN) clinics in Burlington, St. Johnsbury, Brattleboro, Berlin, and Rutland, Vermont, from July 24 – August 23, 2023. Funded by the federal Ryan White HIV/AIDS program, the UVMHN has developed a network of HIV Comprehensive Care Clinics (CCC) statewide that provide antiretroviral treatment for all stages of HIV/AIDS as well as primary and specialty care for people living with HIV.

Investigators received an Innovations in Clinical Care Research Grant to explore potential SRH disparities among cisgender WLHIV engaged in HIV care at UVMHN to identify potential opportunities within UVMHN to improve its delivery of evidence-based, patient-centered, and women-focused HIV specialty care. Population data were extrapolated from CAREWare, a secure, centralized, web-based software application that supports client-level data from the Ryan White HIV/AIDS programs (Health Resources and Services Administration [HRSA], n.d.). Compared to much of the U.S., Vermont has a relatively low number of people living with HIV (PLHIV), which currently numbers at approximately 650-700 known cases (Health Resources and Services Administration [HRSA], n.d.). Most PLHIV in Vermont are engaged in medical care and virally suppressed, with greater than 90% of the enrolled patients carrying an HIV-1 viral load of less than 200 copies/mL. Of the 553 active patients engaged in care through the UVMHN, 14.8% identify as cisgender women (Health Resources and Services Administration [HRSA], n.d.). Vermont is the country's second least populated state and is predominantly rural. Adult HIV care in Vermont, from its inception in 1987 as the UVMHN's CCC, demonstrated an inventive and bold program by establishing rural satellite clinics to extend services beyond Burlington. UVMHN infectious disease (ID) clinicians regularly travel to these sites or engage in telehealth services to address topics ranging from antiretroviral adherence to primary care, substance use, and sexual partnerships.

Participants

We purposely sampled cisgender WLHIV who are enrolled in HIV care in UVMHN's Ryan White HIV/AIDS CCCs (N=98). Inclusion criteria included correspondence between female gender identity and birth sex, being 18 years or older, ability to speak English, being present in

Vermont during the study period, and being willing and able to give informed consent. Patient participants that completed telephone health surveys in an earlier part of the parent study were recruited for in-depth-interviews. To mitigate undue inducement to participate, the recruitment materials asked participants to notify their clinician or check-in staff only if they agreed to being contacted by the study team, allowing them to easily choose not to participate without directly communicating this decision with their clinician or clinic staff. The study team contacted interested participants by phone to provide information about the study and to conduct screening. For those found to be eligible, an in-person visit was arranged at a UVMHN clinic of the participant's choice to complete consent procedures and an in-depth interview.

Data Collection

In-depth interviews were conducted in-person by a female interviewer trained in conducting research with vulnerable populations and concerning sensitive SRH topics. Interviews were conducted in English in a private office at a designated UVMHN clinic or CCC location. Interviews were audio recorded after verbal and signed informed consent was received from the participant. Audio files were deleted after they were transcribed by a trained transcriptionist. Participants were assigned a unique study identification number to protect their privacy. Digital computer files containing interview transcripts and participant demographic data were transferred into electronic storage hosted on UVMHN servers and were only accessible to the study team.

Our research question was shaped by the concept of person-centered care, which "asserts that patients are persons and should not be reduced to their disease alone, but rather that their subjectivity and integration within a given environment, their strengths, their future plans and their rights should also be taken into account" (Ekman et al., 2011). At the core of this concept is the patient acting as an active participant and decision-maker regarding their medical care, rather than being a passive recipient of care. This model is understood to improve care and patient outcomes, particularly for patients with chronic diseases, including HIV (Chinyandura et al., 2022). Guided by this conceptual understanding of health care delivery, the study team developed a semi-structured interview guide that was informed by a review of the literature and the principal investigator's clinical care experiences at UVMHN. The guide used open-ended questions with probes to explore SRH care received since the participant's HIV diagnosis including: the types, quality, and privacy of services and what experiences were perceived to be especially good or bad; the participant's perceived SRH needs as a WLHIV, including whether there have been unmet needs; participants' experiences engaging with healthcare providers about SRH issues, including contraception, sexual and romantic relationships, fertility desires, and pregnancy; and perceived barriers to meeting the SRH needs of WLHIV.

Ethics

The parent study, including the qualitative sub-study, received human subjects research approval from the Institutional Review Board (approval number 00000485) of the University of Vermont. All members of the study team maintained up-to-date certifications for human subjects research training during the study. Hard copies of study documents and consent forms were stored in a locked filing cabinet in the principal investigator's locked office on the UVMHN campus. Each participant voluntarily provided written, informed consent prior to completing the in-depth interview and received a $20 gift card to a local grocery store for their participation.

Analysis

Our analysis was informed by content analysis methods and used an inductive-deductive approach (Bradley, Curry, & Devers, 2007; Krippendorff, 2013). To enhance analytic rigor, we adopted inter coder agreement strategies consistent with contemporary qualitative methodology, which help ensure coding reliability and interpretive validity across interview transcripts (Halpin, 2024). Two core members of the research teams developed an initial codebook based on a priori codes informed by the research questions, which was iteratively revised during a review of transcripts to include inductive codes that reflected identified emergent themes. Code applications and perceptions of emergent themes were regularly discussed until core members of the research team reached consensus around the final codebook. All interview transcripts were then double coded by these two researchers, and coding applications were reviewed to ensure an inter-coder reliability of at least 80% agreement. Coded transcripts were then iteratively reviewed and analyzed. Thematic reports were created that identified and described key themes, including descriptions of common and divergent experiences and perspectives and illustrative quotes representing these perspectives. Key themes were reviewed by the core members of the study team, and discrepancies were resolved through discussion and consensus. In the results that follow, participant quotes are anonymously identified by race/ethnicity and age.

Results

We interviewed 10 participants, with interviews that lasted 30 minutes on average with participants that ranged in age from 29 to 67 years old (median 55 years old). One-fifth of the participants were African American, and the remaining were white.

Most participants did not understand the term “sexual and reproductive healthcare”; in nearly every interview, the interviewer had to qualify what that meant by giving examples (e.g., Pap smears, contraception, or birth control). Pap smears and pregnancy care were the most common SRH care participants said they received since their HIV diagnosis. A minority of women also mentioned being tested for sexually transmitted infections, receiving contraceptives, and undergoing mammograms. No participants described being unable to speak with their clinicians about any SRH issues that they had.

Pap smears, if done at all, were typically described as being monitored and requested by clinicians and not by participants (“they gonna bug me about it”). Women were more likely to say they did not undergo Pap smears due discomfort and disliking it, rather than because they had HIV. Regular engagement with clinicians for HIV care therefore meant that women were more likely to get reminded about their Pap smears and to follow through with getting them. One participant said,

> You know, there’s just, I mean, no woman wants that, right? And there’s all this anxiety and discomfort and embarrassment and just, oh my God. And so [participant’s HIV doctor] would just like, pop it on me and, um, but I would either get it from her or get it from my primary care doctor, but she often just sprung it on me. (Age 51, white)

A good relationship with their clinician facilitated participants’ willingness to get Pap smears completed when it was recommended to them. For example, one participant described going to her women’s health clinic for her annual Pap smear thanks to her clinician’s encouragement and despite her strong dislike of getting this service done.

> …[A]lthough I hate going to, um, the Women’s Health Clinic, [participant’s HIV doctor] is usually on my back about it every time. It’s just I hate going, so that's…although I hate it, it's really nice to have

> someone who's encouraging me to get there. Cuz otherwise I definitely wouldn't go. (Age 29, white)

This participant also pointed out that her good rapport with her HIV clinician meant that she was open to receiving information about other SRH services available to her beyond Pap smears. She said her HIV clinician, "really touches everything. And, even if it's not something I'm…interested in at the time, she lets me know what's available for me."

Interpersonal dynamics between patients and providers thus emerged as an important enabler of good SRH care, in that clinicians who made participants feel seen, cared for, and treated with respect were also perceived as those who helped participants get the SRH care they needed in an acceptable way. Notably, the converse was also true, in that a bad healthcare experience could be a deterrent for future healthcare-seeking behaviors. One 60-year-old white participant's negative experiences being diagnosed with HIV while living in another state "made it really hard to come to doctors when [she] did get to Vermont", though she'd had very good experiences since then. Participants tended to describe good-quality SRH care as care that met a particular need of theirs, encouraged them to get the necessary care they needed to be healthy, and made them feel safe because their confidentiality and privacy were respected. Consistent with this, they frequently described wanting clinicians to treat their patients with positivity and a lack of judgment – just like a "normal person" not exclusively defined by their HIV status. One 41-year-old African American participant described her clinicians approvingly as, "…they are lovely…and caring, and they explain everything to me." Two participants described similarly positive treatment by their clinicians, including while pursuing assisted reproductive technology to achieve pregnancy, which added to the positive perception overall of the care they received.

> …they're very positive about [participant's HIV diagnosis]; you're not judged. I don't think any of them looked at it differently. And the clinic where I received care for my doing the IVF and all of that, they, they were very nice people. I mean, I think they were all very positive people about it, and especially the clinic outside being…they were very very helpful in explaining things and just being positive about it even if I have HIV. (Age 44, African American)

> It's really been really great. There are even people who I know who work at the clinic and I know from, um, growing up in the community and it's all been really…nice because I felt safe, and…I'm super confidential with the people that I've run across and at the women's health clinic here and in this office here. (Age 29, white)

Participants often emphasized the importance of a more personal interaction with their clinicians. One 51-year-old white participant described her HIV clinician as being "like a mother to [her]" because she regularly reminded her about her Pap smears and other available SRH services. Some spoke of wanting to be "supported and cared for" by clinicians, including by being assisted with navigating basic needs like housing, financial assistance, and Medicaid or other health insurance. Pregnancy was a particularly sensitive area that women perceived as requiring good engagement with a range of healthcare providers. Having HIV was one of many difficult issues to weigh when deciding to have a baby, and a good clinician was seen to help women navigate these.

> My [primary OB/GYN physician] was amazing…I went to UVM, and [my primary OB/GYN] was also in, um, contact with the doctor there so that they were kind of doing it together. And…he was very much…participating in this, in my whole pregnancy. And then when I was in the hospital, because he was worried that, maybe, I wouldn't be treated as well as I should be because of my diagnosis, he came to the hospital and made sure

> I was being treated, you know well, like a normal patient, and so that was great..that was just wonderful.(Age 55, white)

HIV status alone changed the management of pregnancy-related care for some participants. Abortion, contraceptive measures, and number of desired children were factors that multiple women being important to consider when family planning with a known HIV diagnosis.

> "The primary reason [for choosing tubal ligation after delivering my baby] was that I had so much stress, so much anxiety during my pregnancy. So much fear for my baby; I just was never going to put myself through that with the nature of the diagnosis." (Age 51, white)

One participant also spoke of how having an engaged clinician really shaped how she experienced her pregnancies, even more than the HIV status itself.

> Um…in the beginning it was a little scary, because of the doctor. But… since then I've had another child, and between…my doctors here, the Children's Hospital, and high risk pregnancies; it was wonderful. (Age 54, white)

Given how much participants privileged strong interpersonal dynamics with their providers, a team-based approach to prenatal care may not be as good for women with HIV, who may benefit from/prefer the one-on-one relationship with one provider.

> …so I would say the difference in my pregnancy was that I had a different OBGYN every time I came to the hospital. Like you don't get the same person every time, so you don't get that relationship; your birth experience is…not in a relationship type of thing. …I got good care, but it was definitely depersonalized...I think that's the best way I can say it. (Age 51, white)

Some participants spoke of their clinicians suggesting that they have an abortion; only in one case was the context perceived as positive and supportive rather than coercive. A 54-year-old white participant spoke about being told to have an abortion by a physician when she discovered she was pregnant: "…when I first found out I was pregnant with my son, the doctor told me that it was in my best interest to abort him. And I refused to do that." Another participant spoke about how a social worker suggested that she get an abortion:

> I got pregnant, but I was very very dif…I had my mental health, I don't have control over myself, so the social worker over there decided to get a…an abortion. And my baby dying, was giving me a hard time. It disturbed me, I can't, I can't handle it, and they said they don't want me…they don't want me to get worse than this, and want me to get an abortion. So, they did it. (Age 41, African American)

In one case, a participant described bringing up an abortion with her doctor, and the doctor didn't recommend the procedure one way or the other but instead supported the participant to decide for herself. To that end, the participant's doctor referred her to a therapist at the clinic, with whom the participant discussed the decision, ultimately declining to have the abortion.

> …[participant's HIV doctor] just came in, and talked to me and told me calm...she told me to breathe, and that it was going to be okay and that, umm you know, it's not the end of the world, and it's not what it used to be, and, um, she can help me make informed decisions because I was like, "what do I do? Do I have an abortion? I don't want my baby to be sick"… I don't want this man's baby anyway because the man is violent and dangerous and threatens to kill me and hurts me and I just wanted all

> contact like, I just didn't even know if I was going to live or die. (Age 51, white)

In addition to supportive healthcare providers and clinic staff, some participants spoke of the need for emotional support from other women as well. While the CCC offers mentorship opportunities, targeting individuals with longstanding HIV with those with newer diagnoses or with individuals experiencing HIV-associated challenge, multiple women named interest in support groups for women, which are not currently available to them.

> …when I was going through my pregnancy, and I was in the worst state of being that I could have been in, in my life, I didn't have another woman to talk to, who had been through my experience. And at the time there literally was no one. And I've offered over the years to be someone that is willing to talk to another woman who's HIV positive and pregnant, and to give them that kind of support and I feel like, that people should have the option of having that type of resource because I think that would have meant the world to me at that time. (Age 51, white)

A final theme that emerged as an important factor shaping the SRH wellbeing of participants was that of HIV disclosure to intimate partners, whether sexual, romantic, or both. Women widely perceived talking to partners as very difficult and an important barrier to their ability to navigate and meet their SRH needs. Participants spoke often of the dangers of revealing their diagnosis because of uncertainty of how someone would react, and some participants sought support from clinicians in how to navigate these disclosure conversations with their sexual and romantic partners. One participant positively described bringing her partners into the clinic to speak with clinicians alongside her about her HIV diagnosis and SRH topics:

> I could bring partners here. And, and, and you know, have them sit down with me and, you know, they, we would talk with, like, support and the different people here, so that my partners could learn how, you know, how they could be a help to me, and how we could be safe as a couple, and everything. They've always been great about that. (Age 60, white)

Another important role for a clinician is in helping women navigate when, and who, to share their HIV diagnosis with. One 29-year-old white participant described how it was difficult for her to decide on the timing and types of partners she disclosed to, and how this negatively affected her relationships overall by preventing her from initiating intimate connections with others.

> …when I was younger, it felt like something that I needed to share with people? Um, so I was really needing strangers who had no way to find out who I was, who my friends were, who my families were, because I was worried that people were gonna, you know talk or anything like that. So, when I was younger, especially, it just ended in like, failed…um, not even bad relationships, just didn't end up with me meeting anyone. I got a little older and I did a little bit more research for myself; I decided it wasn't something that I needed to share anymore. So it hasn't really affected me much since then.
>
> …to help them figure out how to have conversations with people in their life that they either want, those people to know? Or you know, if their partner and they eventually come to a point where they need them to know; I think it's something that a lot of people struggle with…trying to figure out the words for it.

> …I think it's really hard trying to figure out how to…live their life, and talk to people, and figure out your relationships. And someone who can help coach you through that or give you the resources on other people to talk to on how to…kinda get yourself through that? I think that's probably the main thing. For everyone.

Discussion

The researchers of this study endeavored to learn in-depth patient experiences to help inform clinical care and SRH healthcare training. Some of the collected experiences conveyed a clear strength of particular HIV clinicians in engaging into HIV care with empathy. This appeared to be a meaningful strength in building trust and creating a culture of comfort in approaching SRH topics, including difficult conversations about disclosing HIV to an intimate partner or navigating an unintended pregnancy. The importance of supportive patient-provider relationships is found in the literature, with findings of increased adherence to HIV care when clinicians are felt to be trustworthy, supportive, knowledgeable and non-judgmental (Marks, Hayes, Amos, Moore, & Dark, 2023).

The critical connection between clinicians and their patients feels exceptionally relevant in building and bolstering trust with WLHIV. Prior research that emphasizes safety, relationships and health rights resounds in some research out of sub-Saharan Africa focused on the care of WLHIV and testing of their partners (Barnighausen K et al. 2024). The bulk of HIV clinicians in Vermont are physicians that pursued formal fellowship training in infectious diseases. Beyond that core role as an infectious disease provider, HIV clinicians are obliged to continue to meet the expansive and comprehensive care of WLHIV and serve as important teachers to healthcare colleagues in the SRH field. Other published qualitative studies have found that negative experiences of WLHIV receiving SRH care occurred primarily with providers who are not HIV specialists (Buseh & Stevens, 2006; Cuca & Rose, 2016; Peltzer, Domian, & Teel, 2016). It is well documented that clinicians often contribute to the stigma and discrimination that WLHIV experience related to their HIV status, particularly of those seeking SRH (Greene et al., 2017; Sommer & Barroso, 2023). Larger studies throughout Canada and Europe report that WLHIV felt that clinicians discouraged them from pregnancy due to their HIV status (Kelly et al., 2014; Toupin et al., 2019). The provider-recommended abortions that women reported in our study echo this larger theme experienced by WLHIV elsewhere. Consistent with broader qualitative evidence on the centrality of communication and relational dynamics in health care, our findings suggest that the quality of interactions—not simply clinical content—can shape WLHIV's engagement in SRH services (Kachingwe, 2023; Gill & Mauriello, 2025). Additionally, how individuals interpret and navigate their experiences in other qualitative studies highlights the importance of supporting WLHIV's perspectives during clinical encounters (Gilbert et al., 2025).

There may be opportunities for HIV clinicians to educate healthcare colleagues, especially clinicians who provide SRH care, on how to convey a new HIV diagnosis to a woman given the experiences of stigma, isolation and trauma reported by some participants. As national guidelines continue to support HIV screening/testing to occur at any number of timepoints, including annual gynecological care and other sexual health clinical encounters, HIV providers have an opportunity to train primary care colleagues on appropriate and sensitive language surrounding HIV. HIV providers typically also have an opportunity to offer avenues to primary care practices on how to connect women with a new HIV diagnosis with other WLHIV in the community and relevant social supports. Additionally, the need to better explain and explore the SRH needs of WLHIV with reproductive healthcare colleagues (obstetrician-gynecologists, for example) and navigate planned

pregnancies with approaches to management of abortion care has been elucidated in our study. This study's research team plans to add SRH content to continuing medical education and routine HIV clinical conferences available to HIV clinicians and their allies across Vermont.

Stigma is most commonly reported in qualitative studies that describe the experiences of WLHIV, including how stigma influences patients' HIV status disclosure to medical providers, family, friends, and sexual partners (Cuca & Rose, 2016; Herron et al., 2022; Marks et al., 2023). Our findings align with contemporary qualitative evidence that stigma is not only persistent but also deeply embedded in social and clinical interactions, affecting care engagement, disclosure negotiations, and mental well being in WLHIV (Sommer & Barroso, 2023). Mixed-method research, specifically qualitative work, provides valuable opportunities to explore this in WLHIV. One qualitative metasynthesis conducted on this topic in 2023 covered qualitative research over two decades. The findings conveyed the importance of intersectionality of both experienced and enhanced stigma (Sommer & Barroso, 2023). Findings from our study echo those of larger studies that report increased fear and discrimination described by WLHIV regarding status disclosure. This stems largely from the stigma associated with HIV due to the historical oppression of highly affected populations. Our study included interviews with a notable number of African American women, which was a unique experience in a very white, rural state. Themes of rejecting and navigating relationships alongside processing sexuality help inform sexual health and intimacy among some African American women that reside in upstate New York (Hampton C et al. 2022). Disclosure carries obvious public health implications, but also risks, for many WLHIV including isolation, ostracism and, worse, violence. Though Vermont is not one, there are still thirteen US states that require people with HIV who are aware of their status to disclose that information to sex partners, even if their viral load is undetectable and they are using barrier protection (The Center for HIV Law and Policy, n.d.). Though people living with HIV in Vermont have the right to keep their status confidential, they are sometimes unaware of this. WLHIV in Vermont who are early in the course of a new diagnosis are encouraged to bring their sexual/romantic partners and/or other core family members into a clinic visit. When providers engage in open conversations surrounding disclosure of status with patients, it is also advisable that they inform patients of their choice for confidentiality. For some WLHIV interviewed, confidentiality meant safety. For another, it meant sexual liberation and the autonomy to choose who gets to know her personal medical information and who does not. Regardless of their choice to share or not, WLHIV deserve to have accurate information and trusted advocates they can rely on to help them make informed decisions and guide conversations surrounding disclosure of HIV status.

A primary intention of this study was to explore SRH elements in HIV primary care including pregnancy and fertility. This study thus largely presents stories and narratives from when women were of reproductive age. There are likely considerable psychosocial burdens associated with aging with HIV, manifesting as depression, anxiety and social isolation. There is an opportunity to integrate exploration of these experiences into HIV clinical care (Folorunsho S et al. 2025). CCC's leadership plans to expand Ryan White HIV/AIDS support groups to include sessions exclusively for women. Future studies should explore elements of aging among WLHIV including, for some, peri- and post-menopausal health challenges and navigating growing older without the support of partners/spouses and children. Some qualitative work conducted in England focused on women's health spanning ages 40-65 years revealed lack of health and well-being prioritization among midlife women, knowledge deficits, and stigma as themes that challenged pursuit of comprehensive sexual healthcare (Simmons et al., 2025; Hamoda & Moger, 2022). There is some quantitative research from the early 2000s that focuses on the medical impacts of HIV and its related comorbidities on menopause, but there is a lack of qualitative research describing patient experiences of WLHIV on aging (Enriquez et al., 2008). Given recent data reporting a relative

increase in life expectancy for people living with HIV with advancements in antiretroviral therapy, the need to study aging WLHIV is more pertinent than ever before (Wing, 2017).

There is immense benefit in pursuing mixed-method research to better understand the healthcare priorities of WLHIV across rural landscapes. Earlier findings in our parent study demonstrated that clinicians fall short in meeting the SRH clinical needs of this population (Hahn et al., 2026). Our study population is primarily rural white WLHIV, given the demographic profile of the Vermont population, which may limit its generalizability to other populations and locations. We described the study context and methods in detail to assist readers in determining whether results can be applied to other settings. Our results are also subject to social desirability bias, given the sensitivity of SRH topics. Despite these limitations, this study addresses important gaps in the qualitative literature on the SRH experiences of WLHIV, especially in rural areas, and offers new directions for future studies, including aging-related health among WLHIV.

Conclusion

HIV clinicians are more likely to be associated with positive patient experiences by WLHIV, thus resulting in increased adherence to care. They can better healthcare delivery for WLHIV by acting as educators for non-HIV-specialized SRH providers, especially in rural areas where specialists are limited, and by fostering collaborative, patient-centered care across disciplines. There is a particular need to better explain and explore the SRH needs of WLHIV with reproductive healthcare colleagues to navigate planned pregnancies and abortion care safely and respectfully. There is a need for community support groups that are exclusively for WLHIV. Peer mentorship could help address isolation, provide emotional support, and improve coping skills, especially for newly diagnosed WLHIV. Future research is needed to further explore the healthcare experiences of WLHIV in rural settings and aging-related SRH issues such as menopause, loneliness, and the psychosocial impacts of long-term HIV management.

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Ethics

This study was approved by the International Review Board (approval number 00000485) with protocol number STUDY00001711 on 08/31/21. All participants provided written informed consent prior to enrollment in the study.

Author Contributions

Angela E Russo, MD: Investigation, Data Curation, Formal Analysis, Writing
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Data Availability

The datasets analyzed during the current study are available from the corresponding author upon reasonable request.

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Disclosure Statement

The authors have declared no conflict of interest.

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