Issues Surrounding Reproductive Choice for Women Living with HIV in Abidjan, Côte d'Ivoire

H Aka-Dago-Akribi, A Desgrées Du Loû, Philippe Msellati, R Dossou, C Welffens-Ekra

The vast majority of women living with HIV in Africa are unaware of their HIV status and are usually first tested for HIV in the course of a pregnancy. This paper analyses the reproductive choices made by women attending an antenatal clinic in Abidjan, Côte d'Ivoire who learned their HIV-positive status during their last pregnancy. It documents the ways in which the women's desires and views, their relationships and reproductive behaviour, and their intentions about having further children were altered by this knowledge. Sexual behaviour depends upon emotional and relational factors which are often more important than health issues; this holds true when it comes to reproductive choices, which are closely related. The health of an individual or a couple and the risk of giving birth to an infected child can be less important than meeting social and familial obligations. This balancing of risks needs to be taken into account by AIDS and family planning programmes in their prevention messages, so that more than health-related factors in the narrow sense are addressed in the discussion of HIV-positive women's reproductive decisions.

HIV was first identified in Côte d'Ivoire in 1985, and the country currently has the highest rate of HIV infection in West Africa. The main route of transmission is heterosexual and women in the 20-29 age group are most affected. Roughly 10 per cent of adults are infected; in 1995, HIV prevalence in pregnant women was around 14 per cent in Abidjan.[1] The vast majority of women living with HIV in Africa, and more generally in developing countries, are unaware of their HIV status.[2] This means that most women living with HIV in Africa are unaware that they are infected when they begin a pregnancy. Woman are usually first tested for HIV in the course of a pregnancy; in Abidjan, as in a number of other cities in Africa, HIV testing is systematically proposed to pregnant women only in the context of clinical trials which are aimed at reducing mother-to-child transmission of HIV.[3] Because most women do not seek antenatal care until the third trimester of pregnancy, the proposal to test for HIV generally comes only after the sixth month of pregnancy, making it too late to consider even an illegal abortion.

Since 1998, the UNAIDS drug access initiative has made perinatal AZT more generally available for pregnant women in Côte d'Ivoire: the woman must pay US$5 and the state pays the remaining US$95 to cover the cost.

Although there are no official directives to this effect, there has been, until recently, a general feeling in Côte d'Ivoire among health professionals, the general population and even among people living with HIV, that when a woman is HIV-positive, she should not have further children; women are therefore often advised to avoid any further pregnancies. The concern behind this advice is to prevent the risk of a more rapid progression of HIV infection in the woman, which might occur as a result of pregnancy; the risk of transmission of HIV to the infant during pregnancy, delivery or breastfeeding; and the risk of any child (HIV-positive or not) becoming an orphan in the medium term. This counselling, although directive, is intended to protect the

woman and her infant. However, this consensus is now being challenged in some quarters; this paper has been written, in part, to contribute to that debate.

In Africa, as elsewhere, women's desire to have children is strong; women achieve social status through having children to survive them and perpetuate the lineage. Pregnancy shows that a woman can be a 'good mother' and can give birth to a healthy child;[4,5] it can also revive age-old conflicts surrounding procreation and parenthood. Abidjan is characterised by a high fertility level. The mean number of children is 5.7 and less than 20 per cent of women of reproductive age use a modern contraceptive method.[6]

Nevertheless, despite the fact that abortion is still illegal in the country, among women aged 20 or less, one in three has already had at least one abortion, which implies both that there is a lack of access to family planning services in this city[6] and that many pregnancies are unwanted. In fact, pregnancy is only welcomed by women as well as by the family if the father is recognised socially and accepted by the family, and if the couple (or at least the future mother) enjoy a certain amount of economic and social independence.

In a previous study, we compared the obstetric histories of HIV-positive women who were unaware of their serostatus and those of HIV-negative women, and we found no major differences in their fertility.[7] In this paper, we analyse the reproductive choices made by women from the same cohort attending an antenatal clinic in Abidjan who learned their HIV-positive status during their last pregnancy. Using observational data and approaches from clinical psychology and social demography, we document the ways in which the women's desires and views, and their relationships and reproductive behaviour, were altered by this knowledge. Finally, we explore what the women felt about having further children. We found that very restricted psychological and social mechanisms were available to women for dealing with this virus openly and without fear in the context of what pregnancy means for women's lives in Africa.

The study: methods

From September 1995 to February 1998, we carried out a clinical trial in two antenatal clinics, one in Abidjan, Côte d'Ivoire and one in Bobo-Diolassou, Burkina Faso, aimed at reducing mother-to-infant transmission of HIV.[8] The regimen was shown to be effective in Thailand, and from then until September 1998, our recruitment continued but as an open, observational study. The women attending the Abidjan clinic come from socio-economically poor and very poor backgrounds. For those who test HIV-positive who agree to participate, the trial involves taking zidovudine (AZT) perinatally and they are advised and given support not to breast-feed. Medical care is offered free of charge for both the woman and her infant when it is born, including obstetric, gynaecological and paediatric care, medicines, family planning, and hospital and laboratory services.

Most women do not know their HIV status; hence, each woman who attends for the first time is asked in the course of her first antenatal visit whether she might care to consider having an HIV test. The decision to take the test is up to the woman, and women who agree to be tested must give their written consent. Blood samples and medical records are anonymised. The results of the HIV test are communicated to the woman, and only to her, two weeks later. In this way, to date, 350 women attending the antenatal clinic in Abidjan who agreed to be tested during pregnancy have learned that they are HIV-positive and have been followed-up on a regular basis. Their observations and ours, noted in the course of this study, form the basis of the discussion that follows.

In 1998, a weekly psychology clinic was set up for the women, which has enabled them to get support with any problems and talk through what to do about them, if and when they need and want it. Consultations are free of charge. The women can also attend with their partners if they wish. The clinical case approach takes into account the African socio-cultural context;[9-11] an individual history of each woman who attends is taken, along with clinical case notes. The psychologist is also the facilitator for a self-help group initiated by some of the women who attended the clinic.

In a two-month period in the first part of 1998, the first 21 women attending consecutively for the follow-up part of the clinical trial were invited to participate in an interview. All of them agreed. Semi-qualitative interviews were carried out on

issues related to reproductive choice, the desire to have another child and notification of their partners of their HIV status. They were interviewed first in May and June 1998 and again one month later. All of them had delivered more than six months previously.

During the first interview, the women were asked about their reproductive histories, their experience of weaning their last child, whether they had notified their partners of their HIV-positive status and their future intentions as regards having another baby. During the second interview, questions went into more depth about relationships with their partners, partner notification, the partner's reaction to learning the woman was HIV-positive and his attitude towards having an HIV test for himself. They were asked again about their own and their partner's desires for another child, contraceptive use and contraceptive intentions in future, and sexual behaviour, including the length of post-partum sexual abstinence, condom use and communication with their partner on these issues. All the women agreed to answer all these questions.

Demographic characteristics are detailed elsewhere.[8] The mean age of the 21 women was 28 (range 20-42). Six had not gone to school, four had had less than six years of schooling, three had completed primary school and eight were at secondary school. Our observations arising from these 21 interviews and the women's own responses, and the case histories of two additional women who were attending the psychology clinic, will be described and discussed in this paper.

A woman learns of her seropositivity during her pregnancy

Our experience in this clinical trial and the psychology clinic is that it is traumatic for a woman to learn of her HIV-positive status during pregnancy, and that giving her information about possible risks to the child she is carrying is equally traumatic. It gives rise to a sense of loss: loss of motivation for the future and eventual loss of those she loves (partner, family), including perhaps the child she is carrying.

'Perhaps it is AIDS. But if it is that I would prefer to die. I am not going to eat any more or drink, and then I will die.'

There is at first a kind of incomprehension, shock and hesitation, and then a feeling of being torn between her partner's and her own desire for a child and her fears for her own and the child's future, which inevitably call into question how she feels about her pregnancy. With certain women, the sense of guilt at giving birth to a child who will suffer is particularly strong. In an attempt to re-establish some psychological balance,[12] and in the face of the multiple threats that HIV presents, some women try to deny the terminal nature of AIDS.[13] ('Medicines' in the following quotes refers to the perinatally administered AZT, which although it protects most infants from becoming HIV infected, confers no benefit for the woman.)

'They are going to give me medicines to cure my illness.'

'If I am asked to take the test again, I won't hesitate because the medicines will have killed the germs in my body.'

One woman, who appeared to take in the painful reality of her diagnosis, became accusing and demanding of her partner and blamed him for the situation. Others searched for possible causes for the infection in everyday life. Some who accepted the news of their HIV status attempted to overcome their anguish through the determination to have a healthy child and to survive at whatever cost.[14] Others were primarily concerned with their partners' feelings and avoided facing up to the reality of the virus for themselves; they focused only on having a healthy child.

HIV is often not mentioned out of fear that in naming it, it will become real and will result in symptoms.[15] The expressions commonly used instead were: 'The illness that kills', 'My blood is dirty', 'I have germs in my blood'.

Some of the women put the responsibility for their having the virus and for their feelings of guilt about giving birth to a baby who will suffer on the project research team: they blamed the team because it was a team member who told them they were HIV-positive. The project initiatives were seen by them as a 'debt' and the medical assistance that was offered as the possibility of being cured. The child they were expecting became synonymous with hope, because it gave

the mother access to medical care that she hoped could cure her.

Furthermore, within their own social circles the women never said anything about having HIV, and indeed they would lie about it, if necessary, in order to avoid ostracism, rejection and abandonment. Often the simplest solution for them was to act as if they were in good health, i.e. using the pretext of pains in their breasts or an insufficient milk supply to explain why they had stopped breastfeeding.

Whatever their responses, there was never indifference.[16] Using various strategies, they protected themselves from becoming seriously disturbed and managed to carry on despite everything.

Brigitte's story

Brigitte (not her real name) is a 22-year-old trader who was educated up to third year of secondary school. She is not in paid work and her current partner is a student.

Brigitte's plans and desire to have a child are consistent with those of her partner. She already has a child of six, whose father she did not marry because of her parents' opposition. The birth of that child forced her to stop going to school because her father refused to continue paying for it. With her current partner, Brigitte has already had one pregnancy. Out of fear of her parent's reactions and with the agreement of her partner, she opted for an abortion through the use of traditional medicines from a traditional doctor, to whom she was sent by her friends. After taking this treatment, she began haemorrhaging, which alerted her mother to her condition. Her mother warned her against getting pregnant again. However, when her most recent pregnancy occurred (the one which brought her to our antenatal clinic), Brigitte and her partner decided not to seek a termination. Her partner was happy at the idea of having a child, and began planning for the future. Brigitte was still living with her parents, who were very reproachful, especially her father, who stopped speaking to her. He refused to accept the new relationship because of the young man's ethnic group. No one in the house spoke about the pregnancy as they considered it a subject of shame and dishonour.

At five and a half months of pregnancy, during an antenatal consultation, an HIV test was offered to her. She accepted because 'you never know'. The result came as a great surprise to her: 'I was not expecting such results at all. I immediately got a bad stomach ache. The doctor gave me some medication and that gave me some relief. But I could not sleep at night because I was thinking so much. Afterwards, I said to myself that the child and the happiness of my boyfriend were more important. I did not think about AIDS anymore.'

Brigitte did not inform anyone else of her positive status, even her partner, because she was afraid that he would abandon her. After a difficult pregnancy, she gave birth to twin girls. She did not know she was carrying twins as she had not had an ultrasound, owing to her lack of money. Unfortunately, the twins both died two days later. Her partner, who was informed late about the delivery, was not able to see his daughters. Brigitte felt guilty because she had not been able to take the babies to the emergency ward, despite the advice of the doctor, who thought he detected respiratory distress: she had been alone and without assistance. The deaths occurred during the night; the actual cause is unknown. Brigitte's father took care of the burials; she did not want to know how or where these were carried out.

Today, she feels responsible for her partner's grief, and life is difficult for her. Nobody in her family speaks about it, and the relationship with her father is still conflictual. She feels that if the twins had survived, it would have helped to resolve the situation by giving her parents a reason to accept her partner and their marriage plans. All of that is now very uncertain. Even though her pregnancy had progressed normally, the spectre of HIV and AIDS has now reappeared: 'Perhaps AIDS is responsible [for the infants' deaths], perhaps it is a warning and I will soon follow my children. I no longer eat or sleep, I think about AIDS. I make an effort not to cry in front of my boyfriend, but it is very hard. I no longer believe in anything, I no longer want anything, I ask myself what is going to happen to me.' Brigitte does not understand that the AZT treatment could not have saved her daughters nor shield her from the devastating effects of AIDS, which had been her hope.

This story shows very clearly the difficulties that pregnancy represents for a young woman who is economically dependent on her parents (she

stopped her schooling, had an abortion in unsanitary conditions, with the inherent dangers this presents), but also how, despite social difficulties, pregnancy can still be a desired event (as it made her partner happy). In the face of her father's opposition, with the child as proof of their love, the marriage with her partner might have been a possibility.

When Brigitte was informed of her HIV infection during the course of the pregnancy, and after the first shock had worn off, she quickly sublimated the information and adapted. She seemed to have forgetten the reality of HIV/AIDS and did not express any anguish. This pregnancy, whatever its consequences, had been wanted and was part of a life plan that the news of her positive status had just shattered. When the infants died, all her plans and hopes were, at least in the short term, destroyed.

The deaths of the twins brought her back to reality. For Brigitte, there was at first denial and then secrecy, followed by the trauma of the loss of the twins, feelings of isolation and a loss of self-esteem. She became very afraid that she might not be desirable to her partner anymore and that she might not be able to give him a healthy child. She became very anxious and began to feel unwell. She was exhausted and listless and did not know how to react in the face of what she knew about the ravages of AIDS. Her partner, still not informed that Brigitte had HIV, was dealing with another pain – the loss of his daughters – and was not able to support her at this difficult time. Brigitte kept telling herself that the medical treatment she was receiving would destroy the virus in her blood to justify her continuing desire to give birth to a healthy child.

Desire for another pregnancy in women who know they are HIV-positive

Among 21 women we interviewed, even though they were repeatedly advised not to have more children because of their infection, and even though all of them were aware of the risk of mother-to-child transmission of HIV, the desire to have another child continued to be paramount.

Six of the women had given birth to only one child at the time of interview and all of them declared that they wanted another child. Two of the six had lost those only children, one died at 9 months and the other at 15 months. One of the two was trying to get pregnant at the time of writing. She had not revealed her HIV status to her partner as she wanted to get pregnant again before telling him. The other was left by her partner when their baby died. Apart from any desire for another child, this woman was afraid of starting a new relationship because of her serostatus; she did not know how she would reveal this to a new partner and feared she would be rejected again. She was also afraid that a new pregnancy might threaten her health, so she now has a lot of questions about her ability to have children.

Nine of the women had had two or three children each at the time of interview. Only three of these women did not want any more children. One of the three, although she felt that she did not have enough children, also felt that another child would bring her too much anxiety. She did not yet know the serostatus of her last baby and felt very anxious about it. The second one affirmed that she did not want more children so as to protect herself and to avoid having an infected child. Nevertheless, she asked a lot of questions about having another child and the risk of mother-to-child transmission. The third preferred not to have another child but her partner wanted another one: she had had two children with another man and this baby was her first with this man. He was aware of his wife's HIV status; he was tested too and was himself HIV-positive, but he denied the reality of HIV.

The remaining six women had four children or more. None of them wanted any more children, but one declared that if her husband insisted, she would get pregnant again. (This woman's husband had not been informed of her serostatus.)

Hence, overall the desire to have more children had remained strong among this group of HIV-positive women: the ones who did not want to get pregnant again were mostly those who had had all the children they felt were enough, i.e. mostly four or more. The others expressed, more or less clearly, a desire for new children, even though this desire was often underpinned by fear (fear for their own health, fear of having an infected child). Sometimes it was a result of or sustained by pressure from the family (mainly husband, mother-in-law, mother).

BÖRJE TOBIASSON/PANOS PICTURES

Contraceptive use was very low among the eight women who did not want to become pregnant again: only three were using a contraceptive method (two were using condoms, one a progestogen injectable); two were not using any method, and two were already pregnant again. One was not having sexual relations.

For the two women who were already pregnant again at the time of interview, the pregnancy had not been wanted and had been a surprise because it had started before the end of their post-partum amenorrhoea. Both of them would have preferred to have an abortion but they had discovered their pregnancies too late (at about four months).

In terms of their relationships with their partners, nine of the 21 women had not divulged their seropositivity to their partners for fear of being abandoned or rejected. Twelve women had chosen to inform their partners; in most of these cases (eight of the 12), the husband had reacted well and brought financial and psychological support to his wife. In three cases, the husband denied the reality of HIV and one husband left his wife when he learned she had HIV. Even when informed, most partners do not accept to be tested themselves and do not agree to use condoms. Only four of the 21 women said they were regularly using condoms.

These observations lead to the question: Is it possible in Abidjan to decide not to have any more children for women who are seropositive, when this 'choice' exposes them to the risk of being rejected by husbands and families who expect them to have more? We are currently collecting data to find out how the women in our cohort would answer this question.

However, it is clearly extremely difficult for the women to explain within their social networks that a pregnancy is not wanted, unless the couple already have as many children as they would like. Even women who hide their HIV status still run the risk of being labelled sick and barren if they no longer get pregnant. Further, a new pregnancy is not only reassuring in terms of the woman's social network, but is also an indicator to her of her own continuing health and fertility.

Finally, for seropositive women who have not yet had as many children as they would like,

making a decision not to have any more children is seen as a form of denial of the future. This adds to the anxiety about dying, triggered by the knowledge of their infection, and seems an insurmountable obstacle.

Dominique's story

Dominique (not her real name), age 29 and a trader, is the mother of a three-year-old seronegative little girl. Dominique was found to be seropositive during her pregnancy with this daughter. She has a good relationship with her seronegative partner, and they have protected sexual relations. Nevertheless, the relationship with her in-laws is difficult. For some time she has noticed, from various remarks that her husband has made that he would like to have another child. Although he is aware of her serostatus, he does not speak openly about it with her. Dominique thinks he is manipulated by his mother. 'You were not married to be a mirror in the house.' As a Muslim, his mother is prepared to propose another wife to her son to alleviate Dominique's apparent difficulties getting pregnant. Dominique feels she must try for another child in order to avoid being asked too many questions about her health. Thus, she would be redeeming herself, denying death, redeeming the relationship with her in-laws, and being recognised in her status as wife and mother. The longer her daughter goes on growing without any major health problems and she herself continues blossoming despite her seropositivity, the more she wants another child. The couple are mutually supportive and her husband has suggested to her that she find out about having children by other methods (insemination with his semen) because they practice safe sex. Thus, Dominique is caught up in the dynamics of wanting to please, giving pleasure, and being loved by proving that she is in good health. Nevertheless, she knows there are many worries about the health of a future child.

Discussion

The women who attended our clinical trial and psychology clinic described what they go through as an emotional roller-coaster. Each of them is trying to please others and at the same time, focusing their own need for a future as represented by having a healthy baby. Yet they have no reassurance that any child will be born without HIV, making this situation particularly anxiety-ridden.[17] Thus, the women wonder whether their seropositive status still gives them the right to want to have a child or the right to assert their own womanhood through a child. This ambivalence is expressed through both resignation and rebellion.[18]

These findings are comparable to those of other studies on women and couples who are living with HIV/AIDS.[19] In particular, a study carried out in an urban area of Rwanda[20] also showed that advice given to seropositive women not to have any more children was to no avail. In that study, 1,458 women of childbearing age were tested for HIV, received in-depth counselling and were given information about HIV transmission, particularly mother-to-child transmission. During counselling, the risks that pregnancy presents both for the woman and for her child were explained to each of the 460 seropositive women, and oral contraceptive use was advised. Despite this, half of the seropositive women who began using oral contraception were no longer doing so a year later. During the two years of follow-up, 43 per cent of the seropositive women had become pregnant. Among them, as in our study, the women who had less than four children at the time of the test were significantly more inclined to begin a new pregnancy than the others. Those who had fewer than four children were impatient to have another child, as if they had to achieve an ideal number of children.[20,21] Pregnancy was a means of continuing a normal life despite the infection and reduced the risk of being rejected by husband and family.

Induced abortion is more common in Abidjan than it was even ten years ago. But helping seropositive women to prevent unwanted pregnancies will not become possible until there are better links between HIV/AIDS programmes and family planning services. First, however, for seropositive women to choose not to have more children, they must enjoy the support of the whole community.

The one-sidedness of an approach that is designed only to persuade HIV-positive women not to have any more children is questionable, however. Women at the asymptomatic stage of infection, who constitute the vast majority of seropositive pregnant women in Abidjan, have a 70 to 80 per cent chance with each pregnancy of

giving birth to a healthy baby, one who is not infected with HIV[22] even without the intervention of perinatal AZT treatment. Women who have access to AZT perinatally reduce the risk of having an infected child by an additional 30 to 50 per cent. Their chances of having an uninfected child reach 85 to 90 per cent, depending upon the infant feeding method they use (breastfeeding or an alternative).[8,23]

In fact, there is recent, but as yet unpublished evidence from several developed countries, presented at the 12th World AIDS Conference in Geneva in 1998, that the availability of perinatal AZT may be having the effect, at least among some women, of reducing the rate of induced abortions and making the intention to try for a pregnancy and the decision to continue an existing pregnancy less frightening for HIV-positive women.

In a society in which fertility is highly valued and where women who do not have an acceptable number of children find themselves marginalised and rejected, this is a risk worth taking. This is all the more true in the context of the strong family ties which exist in Côte d'Ivoire, even though these are slowly changing. Some women know that they can leave their child with one of their relatives to raise, and that the child would not be abandoned and alone if they were to die.

Conclusions

From a public health perspective, HIV infection calls for, even demands, behavioural changes which impinge on intimate relationships and important life choices. When a woman is aware of her HIV-positive status, there is a change in her perceptions of herself, her pregnancy, her children and her relationship. There are problems of denial, and of anguish and fear throughout pregnancy and delivery about the state of health of the unborn child. HIV-positive women are advised to give up (prolonged) breastfeeding and unprotected sexual relations. A mother who creates life is not prepared to face death. Yet HIV-positive women are expected to give up what being a woman represents and what gives her status in her society: being a mother and being able to breastfeed.[24]

What remains of the desire to have a child after the changes and disruptions that take place following the news of HIV seropositivity? Contrary to what certain researchers claim,[25] seropositive African women clearly express the desire for children from an individual and social point of view. How is it possible to make sense of the desire for a child when, within the context of HIV/AIDS, it is prohibited? The unborn child represents a lot more than is first apparent: it allows the mother to be seen as a 'good mother' as well as a woman in good health who is able to give life to a healthy child.

Thus, a woman who knows that she is infected by HIV frequently hides it from her partner and family for fear of being rejected. For economically dependent women, the risk of transmission of the infection to the partner may be considered less serious than the risks of not having any more children, the break-up of the couple and the family and abandonment.[26,27]

This also holds true for discordant couples (where only one partner has HIV) in which both partners are aware of each other's HIV status, but who together choose to have one or more new children, despite the risk of transmission of the virus to the uninfected partner and to future children. The desire for a child is a determining factor in people's behaviour generally, and this desire can be made even stronger with the knowledge that a woman is HIV positive.[28] This fact has received little attention, particularly with respect to discordant couples, yet it is important in Africa, where having children is a vital social, family and individual concern.

In terms of reproductive choices and protection against AIDS, the individual must confront risks which are often contradictory and opt for the ones considered least risky. Their choices may be in direct opposition to those advised by health programmes. It is therefore important for such programmes to provide the fullest possible information to women living with HIV concerning the risks in relation to pregnancy so as to allow them, with or without their husbands and partners, to reach a decision with full knowledge of the facts.

With reproductive choices, the same tension exists as between a person's knowledge of HIV risk and their willingness to change their sexual behaviour; knowledge alone does not bring about behaviour change.[29,30] Sexual behaviour depends upon emotional and relational factors which are often more important than health

issues; this holds true when it comes to reproductive choices, which are closely related. The health of an individual or a couple, and the risk of giving birth to an infected child, can be less important than meeting social and familial obligations.

This balancing of risks needs to be taken into account by AIDS and family planning programmes so that prevention messages take into account factors that are not only health-related in a narrow sense, in the discussion of reproductive choices. In the end, it is up to women living with HIV and couples to make their own decisions about whether or not to have a child on the basis of the fullest possible information.

Acknowledgements

We thank Professor Brunet-Jailly (IRD, Abidjan) for his critical reading of a previous version of this article and Gill Seidel for her patient translation.

Correspondence

Philippe Msellati,
E-mail: msellati@bassam.orstom.ci

References

1. Sylla-Koko F, Anglaret X, Traore-Anaky M et al. Séroprévalence de l'infection par le VIH dans les consultations prénatales d'Abidjan, Côte d'Ivoire 1995. *Med Mal Infect* 1997; 27:1-2.
2. Msellati P. Proposition systématique du dépistage aux femmes enceintes. In: Desclaux A, Raynaut C (eds). *Le dépistage VIH et le conseil en Afrique au sud du Sahara, aspects médicaux et sociaux*. Karthala, 'Coll Economie et Développement', Paris, 1997.
3. Cartoux M, Meda N, Van de Perre P et al. Acceptability of voluntary HIV testing by pregnant women in developing countries: an international survey. *AIDS* 1998 ; 12:2489-95.
4. Revault d'Allones C. *Etre, faire et avoir un enfant*. Paris, Petite Bibliothèque Payot, 1994.
5. Collomb H, Valantin S. Famille africaine (afrique noire). In: *L'enfant et la famille*. Eds Anthony EJ, Koupernik C. Masson, Paris 1970.
6. Desgrées du Lou A, Msellati P, Viho I, Welffens Ekra C. L'évolution du recours à l'avortement provoqué à Abidjan depuis 10 ans. *Population* 1999 (in press).
7. Desgrées du Loû A, Msellati P, Yao A et al. Impaired fertility in HIV-1 infected pregnant women. A clinic based survey in Abidjan, Côte d'Ivoire, 1997. *AIDS* 1999; 13:517-21.
8. Dabis F, Msellati P, Méda N et al. Six month efficacy, tolerance and acceptability of a short regimen of oral zidovudine to reduce vertical transmission of HIV in breast-fed children in Côte d'Ivoire and Burkina Faso: A double-blind placebo controlled multicentre trial. *Lancet* 1999; 353:786-92. For details of another clinical trial in Côte d'Ivoire see also: Wiktor SZ, Ekpini E, Karon JM et al. Short-course oral zidovudine for prevention of mother-to-child transmission of HIV-1 in Abidjan, Côte d'Ivoire: a randomised trial. *Lancet* 1999; 353:781-85.
9. Mongeau A. Psychiatrie transculturelle ou interculturelle ? Entre théorie et pratique. In: *L'évolution psychiatrique* T45 Juillet-Sept 1980; 3:477-91.
10. Cornaton M. Les avatars de la psychologie africaine. *Nouvelle revue d'Ethnopsychiatrie* 1987; 7:113-33.
11. Ortigues MC et E. *Oedipe africain*. Plon, Paris, 10:18, 1976.
12. Nasio JD. Qu'est ce que la douleur psychique ? Conference, Cité Universitaire Paris 1994.
13. Ruszniewski M. *Face à la maladie grave. Patients, familles, soignants*. (Préface de Robert Zittoun). Paris, Dunod, 1995.
14. Seidel G, Sewpaul V and Dano B. Experiences of breastfeeding and vulnerability among a group of HIV-positive women – discussions with a peer support group of HIV positive mothers at King Edward Hospital, Durban, Kwazulu-Natal, South Africa. *Health Policy and Planning* 1999. (in press)
15. Vidal L. Le temps de l'annonce (Abidjan). Séropositivités vécues à Abidjan. *Psychopath Afric* 1994; 26(2):265-82.
16. Freud A. *Le moi et le mécanisme de défense* (1949). Paris, 1982, Presses Universitaires de France.
17. Funck-Brentano I. Le couple parents-enfants face à la maladie. *Le journal du sida*. août- septembre 1994, 64-65:48-52. See also: Cornaton M. Les avatars de la psychologie 'africaine'. *Nouvelle Revue d'Ethnopsychiatrie* 1987; 7:113-33.
18. Guerin A. Le désir d'enfant, otage du discours social. *Le journal du sida*. août- septembre 1994, 64-65:30-32.
19. Desgrées du Loû A. Sida et santé de la reproduction en Afrique : enjeux et défis. *Population* 1998; 4:701-30.
20. Allen S, Serufilira A, Gruber V et al. Pregnancy and contraception use among urban Rwandan women after HIV testing and counseling. *American Journal of Public Health* 1993; 83(5):705-10.
21. Keogh P, Allen S, Almedal C et al. The social impact of HIV infection on women in Kigali, Rwanda: a prospective study.

Soc Sci Med 1994; 38(8):1047-53.
22. Dabis F, Msellati P, Dunn D et al. Estimating the rate of mother-to-child transmission of HIV. Report of a workshop on methodological issues. Ghent (Belgium), 17-20 February 1992. *AIDS* 1993; 7:1139-48.
23. Shaffer N, Chuachoowong R, Mock PA et al. Short course zidovudine for perinatal HIV-1 transmission in Bangkok, Thailand: a randomised controlled trial. *Lancet* 1999; 353:773-80.
24. Bensaid-Mrejen D et Moreigne JP. Grossesse et période périnatale. Colloque 'Maternité et séropositivité VIH', Paris, 4 juin 1995; 45-51.
25. Stora B. Ces représentations qui donnent du sens à la maladie. Un entretien avec Tobbie Nathan et Serge Bouznah. *Le journal du sida* août-septembre 1994; 64-65:34-35.
26. Coulibaly-Traore D, Msellati P, Desgrées du Loû A et al. Le vécu des femmes d'un essai thérapeutique visant à réduire la transmission mère-enfant du VIH-1 à Abidjan, Côte d'Ivoire en 1997 (essai ANRS 049). Xème Conférence Internationale sur le SIDA et les Maladies sexuellement transmissibles en Afrique, 7-11 décembre 1997, Abidjan, Côte d'Ivoire.
27. Dozon JP, Vidal L (eds). *Les sciences sociales face au sida: cas africains autour de l'exemple ivoirien*. ORSTOM, 1995, Paris.
28. Rwegera D. Représentations et vécu des familles touchées par l'infection à VIH/sida en Côte d'Ivoire. Atelier 'Synthèse des recherches menées en sciences de l'homme et de la société sur le sida en Afrique', ANRS - ORSTOM 1995, Paris, septembre 1995.
29. Bajos N, Bozon M, Giami A et al. *Sexualité et Sida*, ANRS 1995, Paris.
30. Calvez M. La sexualité dans les recherches sociologiques sur le sida : des questions de prévention à la construction d'une approche. In: *Sexualité et Sida*, Bajos N, Bozon M, Giami A et al (eds). ANRS, Paris 1995; 143-58.

Résumé

La grande majorité des femmes qui vivent avec le VIH en Afrique n'ont pas conscience de leur séropositivité et sont habituellement testées pour la première fois lors d'une grossesse. Cet article analyse les choix en matière de reproduction exercés par des femmes fréquentant un dispensaire prénatal à Abidjan, Côte d'Ivoire, qui ont appris leur séropositivité pendant leur dernière grossesse. Il analyse comment les désirs et les opinions des femmes, leurs relations et leurs comportement génésique ainsi que leurs intentions à propos de futures naissances ont été modifiés par cette nouvelle. Le comportement sexuel dépend de facteurs psychologiques et relationnels qui sont souvent plus importants que les questions de santé; cela demeure vrai quand il s'agit de prendre des choix en matière de procréation, qui sont étroitement liés. La santé d'un individu ou d'un couple et le risque de donner naissance à un enfant contaminé peuvent revêtir moins d'importance que la satisfaction des obligations sociales et familiales. Cette analyse des risques doit être prise en compte par les programmes de lutte contre le SIDA et de planification familiale dans leurs messages de prévention, afin que la discussion des décisions en matière de procréation de la part des femmes séropositives dépasse les facteurs liés à la santé au sens étroit.

Resumen

La gran mayoría de las mujeres que viven con VIH en Africa no saben que están infectadas con el virus. Generalmente se les hace una prueba de detección por primera vez en el curso de un embarazo. El presente trabajo analiza las opciones reproductivas escogidas por mujeres que asisten a una clínica antenatal en Abidjan, Costa de Marfil, quienes supieron de su calidad de VIH-positivas durante su último embarazo. Documenta las formas en que este conocimiento alteró los deseos y perspectivas de estas mujeres, además de sus relaciones y su comportamiento reproductivo, y sus intenciones de tener más hijos. El comportamiento sexual, igual que las opciones reproductivas, depende de factores emocionales y relacionales que son a menudo más importantes que la salud. La salud de un individuo o una pareja, y el riesgo de dar a luz a un bebé infectado, puede ser menos importante que cumplir con las obligaciones sociales y familiares. Al elaborar sus mensajes de prevención, los programas del SIDA y planificación familiar deben tomar en cuenta este esfuerzo por equilibrar los riesgos, para así abordar más que los factores relacionados estrictamente con la salud en la discusión de las decisiones reproductivas de las mujeres portadoras del VIH.