Sous la direction de :
Fatié OUATTARA

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Présentation de la revue

Sous l'impulsion de M. Fatié OUATTARA, Professeur titulaire de philosophie à l'Université Joseph KI-ZERBO, et avec la collaboration d'Enseignants-Chercheurs et Chercheurs qui sont, soit membres du Centre d'Études sur les Philosophies, les Sociétés et les Savoirs (CEPHISS), soit membres du Laboratoire de philosophie (LAPHI), une nouvelle revue vient d'être fondée à Ouagadougou, au Burkina Faso, sous le nom de « Revue LES TISONS ».

Revue internationale des Sciences de l'Homme et de la Société, la Revue LES TISONS vise à contribuer à la diffusion de théories, de connaissances et de pratiques professionnelles inspirées par des travaux de recherche scientifique. En effet, comme le signifie le Larousse, un tison est un « morceau de bois brûlé en partie et encore en ignition ».

De façon symbolique, la Revue LES TISONS est créée pour mettre ensemble des tisons, pour rassembler les chercheurs, les auteurs et les idées innovantes, pour contribuer au progrès de la recherche scientifique, pour continuer à entretenir la flamme de la connaissance, afin que sa lumière illumine davantage les consciences, éclaire les ténèbres, chasse l'ignorance et combatte l'obscurantisme dans le monde.

Dans les sociétés traditionnelles, au clair de lune et pendant les périodes de froid, les gens du village se rassemblaient autour du feu nourri des tisons : ils se voient, ils se reconnaissent à l'occasion ; ils échangent pour résoudre des problèmes ; ils discutent pour voir ensemble plus loin, pour sonder l'avenir et pour prospecter un meilleur avenir des sociétés. Chacun doit, pour ce faire, apporter des tisons pour entretenir le feu commun, qui ne doit pas s'éteindre.

La Revue LES TISONS est en cela pluridisciplinaire, l'objectif fondamental étant de contribuer à la fabrique des concepts, au renouvellement des savoirs, en d'autres mots, à la construction des connaissances dans différentes disciplines et divers domaines de la

science. Elle fait alors la promotion de l'interdisciplinarité, c'est-à-dire de l'inclusion dans la diversité à travers diverses approches méthodologiques des problèmes des sociétés.

Semestrielle (juin, décembre), thématique au besoin pour les numéros spécifiques, la Revue LES TISONS publie en français et en anglais des articles inédits, originaux, des résultats de travaux pratiques ou empiriques, ainsi que des mélanges et des comptes rendus d'ouvrages dans le domaine des Sciences de l'Homme et de la Société **:** Anthropologie, Communication, Droit, Écologie, Économie, Environnement, Géographie, Histoire, Linguistique, Philosophie, Psychologie, Sociologie, Sciences politiques, Sciences de gestion, Sciences de la population, etc.

Peuvent publier dans la Revue LES TISONS, les Chercheurs, les Enseignants-Chercheurs et les doctorants dont les travaux de recherche s'inscrivent dans ses objectifs, thématiques et axes.

La Revue LES TISONS comprend une Direction de publication, un Secrétariat de rédaction, un Comité scientifique et un Comité de lecture qui assurent l'évaluation en double aveugle et la validation des textes qui lui sont soumis en version électronique en publication (ligne et papier).

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Les textes soumis à la Revue LES TISONS doivent avoir été écrits selon les NORMES CAMES/LSH adoptées par le CTS/LSH, le 17 juillet 2016 à Bamako, lors de la 38è session des CCI.

Pour un article qui est une contribution théorique et fondamentale : Titre, Prénom et Nom de l'auteur, Institution d'attache, adresse électronique, Résumé en Français, Mots clés, Abstract, Key words, Introduction (justification du thème, problématique, hypothèses/objectifs scientifiques, approche), Développement articulé, Conclusion, Bibliographie.

Pour un article qui résulte d'une recherche de terrain : Titre, Prénom et Nom de l'auteur, Institution d'attache, adresse électronique, Résumé en Français, Mots clés, Abstract, Key words, Introduction, Méthodologie, Résultats et Discussion, Conclusion, Bibliographie.

Les articulations d'un article, à l'exception de l'introduction, de la conclusion, de la bibliographie, doivent être titrées, et numérotées par des chiffres (ex : 1. ; 1.1.; 1.2; 2.; 2.2.; 2.2.1; 2.2.2.; 3.; etc.).

Les passages cités sont présentés en romain et entre guillemets. Lorsque la phrase citant et la citation dépassent trois lignes, il faut aller à la ligne, pour présenter la citation (interligne 1) en romain et en retrait, en diminuant la taille de police d'un point.

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Exemples :

En effet, le but poursuivi par M. Ascher (1998, p. 223), est « d'élargir l'histoire des mathématiques de telle sorte qu'elle acquière une perspective multiculturelle et globale (...), d'accroitre le domaine des mathématiques : alors qu'elle s'est pour l'essentiel occupé du groupe professionnel occidental que l'on appelle les mathématiciens (...) ».

Pour dire plus amplement ce qu'est cette capacité de la société civile, qui dans son déploiement effectif, atteste qu'elle peut porter le développement et l'histoire, S. B. Diagne (1991, p. 2) écrit :

> Qu'on ne s'y trompe pas : de toute manière, les populations ont toujours su opposer à la philosophie de l'encadrement et à son volontarisme leurs propres stratégies de contournements. Celles là, par exemple, sont lisibles dans le dynamisme, ou à tout le moins, dans la créativité dont sait preuve ce que l'on désigne sous le nom de secteur informel et à qui il faudra donner l'appellation positive d'économie populaire.

Le philosophe ivoirien a raison, dans une certaine mesure, de lire, dans ce choc déstabilisateur, le processus du sous-développement. Ainsi qu'il le dit :

> Le processus du sous-développement résultant de ce choc est vécu concrètement par les populations concernées comme une crise globale : crise socio-économique (exploitation brutale, chômage permanent, exode accéléré et douloureux), mais aussi crise socio-culturelle et de civilisation traduisant une impréparation sociohistorique et une inadaptation des cultures et des comportements humains aux formes de vie imposées par les technologies étrangères. (S. Diakité, 1985, p. 105).

Les sources historiques, les références d'informations orales et les notes explicatives sont numérotées en série continue et présentées en bas de page.

Les divers éléments d'une référence bibliographique sont présentés comme suit : NOM et Prénom (s) de l'auteur, Année de publication, Zone titre, Lieu de publication, Zone Editeur, pages (p.) occupées par l'article dans la revue ou l'ouvrage collectif. Dans la zone titre, le titre d'un article est présenté en romain et entre guillemets, celui d'un ouvrage, d'un mémoire ou d'une thèse, d'un rapport, d'une revue ou d'un journal est présenté en italique. Dans la zone Editeur, on indique la Maison d'édition (pour un ouvrage), le Nom et le numéro/volume de la revue (pour un article). Au cas où un ouvrage est une traduction et/ou une réédition, il faut préciser après le titre le nom du traducteur et/ou l'édition (ex : 2nde éd.).

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Biopsychosocial repercussions of HIV seropositivity in pregnant women treated at the Yopougon Santé Urban Health Center, Ivory Coast

Répercussions biopsychosociales de la séropositivité au VIH chez les femmes enceintes traitées au Centre de santé urbain Yopougon Santé, Côte d'Ivoire

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Abstract: This exploratory and descriptive study, conducted at the Yopougon Santé Urban Health Center (CSU) in Abidjan, Côte d'Ivoire, analyzes the biopsychosocial repercussions of HIV infection in 30 HIV-positive pregnant women receiving prenatal care (CPN). Using a quantitative approach, the study examines the sociodemographic characteristics, knowledge, attitudes, and psychological and social impacts of HIV-positive status. The results reveal a predominance of anxiety disorders (56.66%) and depression (36.66%), exacerbated by stigma, rejection (33.33%), and a reluctance to share HIV status. Despite good adherence to antiretroviral (ARV) treatment (86.66%), participation in support groups remains low (23.33%). These results highlight the need for enhanced psychosocial care, integrating psychotherapy and community awareness to improve the quality of life of HIV-positive pregnant women.

Keywords: HIV, pregnant women, biopsychosocial repercussions, stigmatization, PMTCT, Ivory Coast.

Résumé : *Cette étude exploratoire et descriptive, menée au Centre de Santé Urbain (CSU) de Yopougon Santé à Abidjan, Côte d'Ivoire, analyse les répercussions biopsychosociales de l'infection à VIH chez 30 femmes enceintes séropositives suivies en consultation prénatale (CPN). À travers une approche quantitative, l'étude examine les caractéristiques sociodémographiques, les connaissances, les attitudes, ainsi que les impacts psychologiques et sociaux de la séropositivité. Les résultats révèlent une prédominance de troubles anxieux (56,66 %) et dépressifs (36,66 %), exacerbés par*

la stigmatisation, le rejet (33,33 %) et une réticence à partager le statut sérologique. Malgré une bonne observance des traitements antirétroviraux (ARV) (86,66 %), la participation aux groupes de soutien reste faible (23,33 %). Ces résultats soulignent la nécessité d'une prise en charge psychosociale renforcée, intégrant psychothérapie et sensibilisation communautaire pour améliorer la qualité de vie des gestantes séropositives.

Mots-clés : *VIH, femmes enceintes, répercussions biopsychosociales, stigmatisation, PTME, Côte d'Ivoire.*

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Introduction

Pregnancy, perceived as a period of fulfillment and well-being, is often marked by psychological distress, which can be confused with the normal physiological manifestations of this condition. These difficulties are particularly pronounced in pregnant women living with HIV, whose experience is complicated by the psychological and social repercussions of their HIV status.

This situation is part of a worrying epidemiological context, characterized by the increasing feminization of the HIV pandemic. According to UNAIDS (2023), approximately 37 million people worldwide are living with HIV, with a notable prevalence in sub-Saharan Africa, where 70% of new infections affect young women aged 15 to 24. In Côte d'Ivoire, HIV prevalence among adults (aged 15-64) stands at 2.9%, with a rate of 4.1% among women compared to 1.7% among men, and an alarming resurgence among young people aged 15 to 25 (Ciphia, 2018; RFI, 2024).

Being told that you are HIV-positive is a traumatic shock. It has significant psychological and social consequences. The literature emphasizes that this news causes emotional shock. It often leads to disorders such as fear, guilt, shame, anger, or social isolation. Psychiatric disorders may also appear, such as anxiety (31.5% of people living with HIV in Côte d'Ivoire), depression (9.7%), denial,

or, more rarely, psychosis (Afrapedia, 2023; Belz-Celia, 2013; Ferenczi, 2018).

These disorders are exacerbated in pregnant women by the fear of transmitting the virus to their child, a risk of 15-35% without prophylaxis (WHO, 2023), and by social stigmatization. This stigmatization can lead to rejection by the family, abandonment by a spouse, or loss of social status (Martin, 2018). Furthermore, biologically, HIV affects the central nervous system, causing neuropsychiatric complications (encephalopathy, dementia) and iatrogenic disorders related to antiretroviral treatments (*idem).*

In Côte d'Ivoire, efforts to prevent mother-to-child transmission (PMTCT) have reduced HIV prevalence from 4.7% in 2010 to 1.8% in 2023, thanks to the integration of prenatal screening, ARV treatment, and postnatal follow-up (Spectrum, 2022). However, obstacles remain, including delays in testing and stigma, which hinder the effectiveness of these interventions. Globally, the WHO (2020) reports an increase in HIV-related mental disorders, with a 27.6% rise in major depressive disorders and a 25.6% rise in anxiety disorders, particularly among women, young people, and people with a history of health problems. Physical or sexual violence, which is common among HIV-positive women, increases the risk of depression, anxiety, unplanned pregnancies, and sexually transmitted infections (UN Women, 2023).

Despite significant progress in HIV prevention of mother-to-child transmission (UNAIDS, 2021), the psychosocial issues related to motherhood in this context remain under-explored. HIV status disrupts identity, social and family relationships, and creates a negative outlook on the future, amplifying isolation and emotional distress (Vincent, 1978; Martin, 2018).

In this context, a fundamental question arises: how does HIV seropositivity influence the experiences and social relationships of pregnant women? By exploring these dimensions, this work aims to contribute to improving perceptions of pregnant women with HIV and to the development of appropriate care strategies for them.

1. Methodology

1.1. Type of study and survey period

This is an exploratory and descriptive study using a quantitative approach. It was conducted from September 16 to October 31, 2024, at the prenatal consultation service (CPN) of the Yopougon Santé Urban Health Center (CSU) in Abidjan.

1.2. Data collection techniques

Data was collected using a questionnaire. The questionnaire survey targeted pregnant women diagnosed as HIV-positive during their pregnancy. This method made it possible to analyze the sociodemographic characteristics of the participants, their knowledge and attitudes towards their HIV status, the biopsychosocial and repercussions, and the changes in values following the announcement of their HIV status during pregnancy.

Participants were selected using a non-probabilistic, reasoned sampling method specifically designed to include pregnant women who tested HIV-positive during pregnancy. This methodological approach is particularly relevant for vulnerable populations, as it allows for targeted and appropriate selection. The inclusion criteria were as follows: a diagnosis of HIV-positive status established during pregnancy and voluntary consent to participate in the study.

1.3. Size and processing of the corpus

The study sample consisted of 30 pregnant women diagnosed as HIV-positive, selected during prenatal consultations. Given the sensitivity of the subject matter, participants were interviewed individually. The sample size was determined based on the principle of empirical saturation, according to which the inclusion of new interviews ceases to provide significantly new data to enrich the analysis (Pires, 1997). The informed consent of the participants was obtained after a detailed presentation of the study objectives and assurances of the confidentiality of the information collected.

1.4. Data analysis

Statistical analysis was used to process the data collected. The data were grouped by quantifiable variables and presented in terms of numbers, frequencies, and percentages in tables and graphs.

2. Study results

This part of the study is organized into three different sections: sociodemographic characteristics of HIV-positive pregnant women, knowledge and attitudes of pregnant women towards HIV, and the psychosocial repercussions and changes in values of HIV-positive pregnant women.

2.1. Sociodemographic characteristics of HIV-positive pregnant women

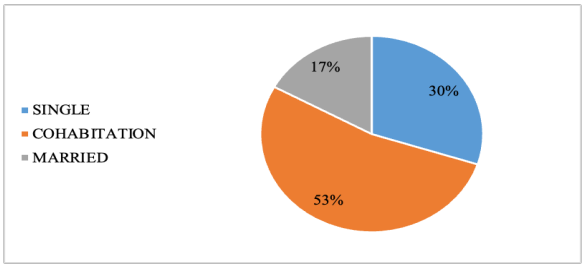
2.1.1. Age of HIV-positive pregnant women

Table I: Distribution of respondents by age group

Age range	Number	Percentage
16-25 years old	6	20%
26-35 years old	19	63.33
35-45	5	16.66

The distribution of pregnant women by age group shows a predominance of women aged 26 to 35 (66.33%), followed by younger women aged 16 to 25 (20%). These results suggest that women of optimal reproductive age (generally considered to be between 20 and 35) represent the population most affected by HIV infection among pregnant women.

2.1.2. Marital status of HIV-positive pregnant women



Graph 1: Distribution of respondents by marital status

The distribution of pregnant women by marital status reveals a predominance of women living with a partner (53%), followed by single women (30%) and married women (17%).

2.1.3. Educational level of HIV-positive pregnant women

Table II: Distribution of respondents by educational level

Level of education	Number	Percentage
No schooling	13	43.33
Primary	9	30
Secondary	5	16.66
Higher	3	10

This table provides an overview of the socio-educational profile of pregnant women. This breakdown of pregnant women by level of education reveals a predominance of women with no schooling (43.33%) and primary education (30%). This reflects a low level of literacy in this population.

This finding is significant in the context of HIV infection, as lack of education is often associated with limited understanding of medical information, reduced adherence to antiretroviral (ARV) treatment, and increased vulnerability to stigma.

2.1.4. Employment status *of HIV-positive pregnant women*

Table III: Distribution of respondents by occupation

Activities	Number	Percentage
Informal activities	15	50
Housewife	3	10
Student	1	3.33
Student	2	6.66%
Shopkeeper	5	16.66
Private sector worker	2	6.66
Civil servant	2	6.66

The distribution of pregnant women according to professional activity shows a predominance of informal activities (50%), followed by shopkeepers (16.66%) and housewives (10%). There are also small proportions of pupils, students, private sector workers, and civil servants (3.33% to 6.66%).

The high proportion of pregnant women engaged in informal activities reflects the precarious socioeconomic context in which these women live.

2.1.5. Religious affiliation of HIV-positive pregnant women

The majority of respondents identified as Muslim (63%), followed by Christian (30%), while 7% identified with other religious denominations or spiritual traditions.

2.2. Knowledge and attitudes towards HIV among HIV-positive pregnant women

2.2.1. Primigravida HIV-positive pregnant women

Table IV: Distribution of respondents according to parity (number of previous pregnancies)

Parity	Number	Percentage
1st pregnancy (G1)	12	40
2nd pregnancy (G2)	7	23.30
3rd pregnancy (G3)	5	16.66
4th pregnancy (G4)	4	13.33
^{5th} pregnancy or more (G5+)	2	6.66

The distribution of pregnant women according to parity shows a predominance of primigravidas (40%), suggesting a high proportion of women pregnant for the first time. They are followed by secundigravidas (23.33%) and tertigravidas (16.33%), while multiparous women (G4 and G5) represented the minority.

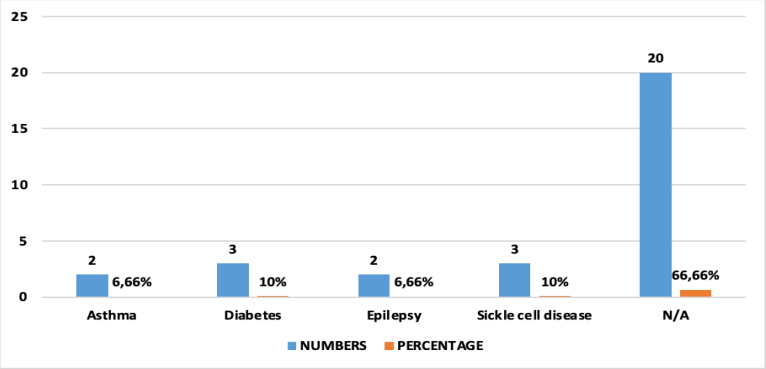
2.2.2. Average gestational age of HIV-positive pregnant women

Table V: Distribution of respondents according to gestational age

Gestational age	Number	Percentage
3 months	5	16.66
4 months	8	26.66%
5 months	2	6.66%
6 months	10	33.33%
7 months	3	10
8 months	1	3.33%
9 months	1	3.33

The distribution of pregnant women according to their gestational age shows a significant concentration of prenatal consultations between the third and sixth months of pregnancy. In fact, the majority of pregnant women attended consultations in the sixth month (33.33%), followed by the fourth month (26.66%) and the third month (16.66%). This trend suggests that the majority of pregnant women begin or continue their prenatal care in the second trimester of pregnancy.

2.3. HIV-positive pregnant women with other conditions

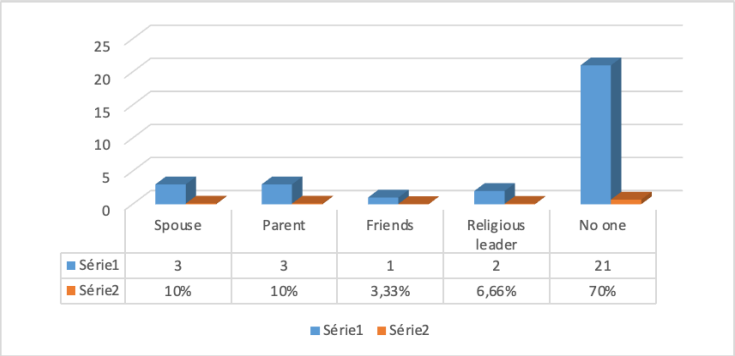


Graph 2: Distribution of respondents with other pathologies

The data collected on the medical history of HIV-positive pregnant women reveal a predominance of cases with no reported medical history, representing 66.66%. This significant proportion of women without comorbidities suggests relative clinical stability in terms of somatic health. However, 33.34% of pregnant women have

associated chronic conditions, including diabetes, sickle cell disease, asthma, and epilepsy.

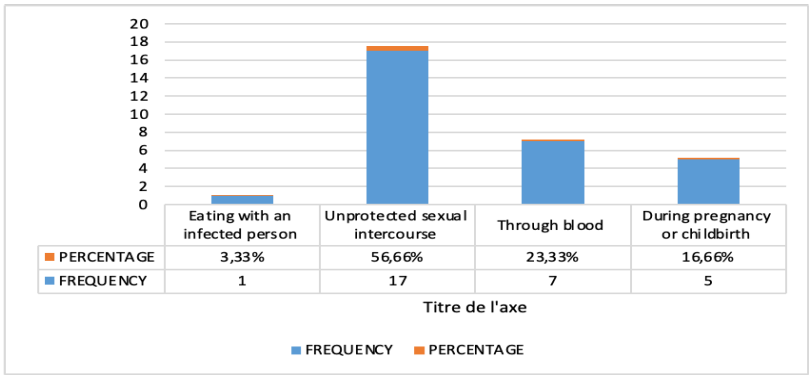
2.4. People informed of the HIV status of pregnant women



Graph 3: Distribution of respondents according to people informed of their status

The graph presents data related to the disclosure of HIV status among HIV-positive pregnant women. 70% of respondents did not inform anyone of their HIV status. This majority reveals a tendency to withdraw into oneself. The proportions of those who shared their status with a spouse or parent were both 10%, while 6.66% confided in a religious leader and 3.33% in a friend.

2.5. Mode of HIV/AIDS transmission



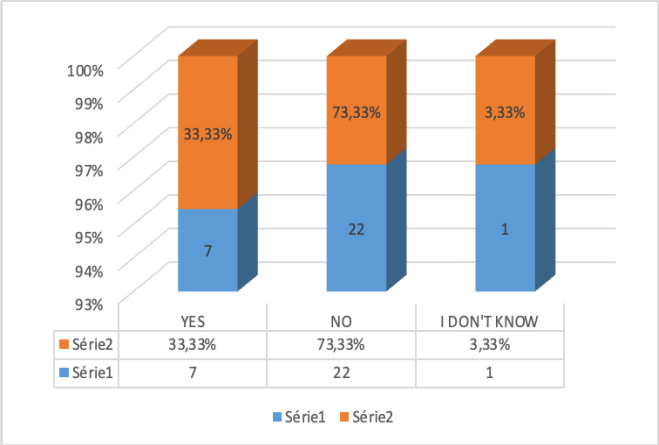
Graph 3: Distribution of respondents according to their knowledge of the mode of transmission of HIV/AIDS

This graph highlights the perceptions of HIV-positive pregnant women regarding mother-to-child transmission of HIV. Analysis of the data reveals that the majority of participants (56.66%) identify unprotected sexual intercourse as the main mode of HIV transmission. However, 23.33% mention blood transmission, and 16.66% mention vertical transmission, i.e., during pregnancy or childbirth.

2.5.1. Responses relating to HIV/AIDS prevention

The data reveal that the majority of pregnant women (63.33%) identify condom use during sexual intercourse as an effective method of prevention, and 36.66% of pregnant women mention the individual use of personal items (toothbrushes, razors, blades, etc.).

2.5.2. Possibility of a cure for HIV/AIDS



Graph 4: Distribution of respondents according to whether or not HIV/AIDS can be cured

This graph illustrates the perceptions of pregnant women regarding the possibility of curing HIV/AIDS. Twenty-two pregnant women (73.33%) believe that it is not possible to cure HIV/AIDS, compared to seven pregnant women (33.33%) who believe that it is possible to cure it. These results show that nearly

three-quarters of respondents recognize that there is currently no cure for HIV.

2.6. Strategies for managing HIV infection

Table VI: Distribution of respondents according to their HIV management strategies

Responses	Number	Percentage frequency
Prayers	25	83
Antiretrovirals (ARVs)	20	67
Traditional medicines	5	17
Compliance with health guidelines	10	33

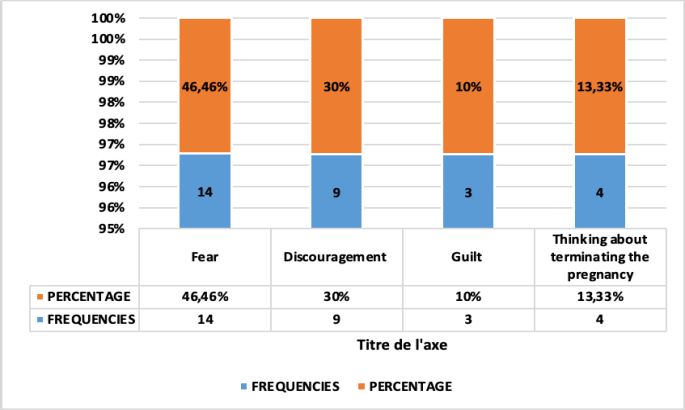
The distribution of HIV infection management strategies reveals a predominance of prayer practices (83%) and ARV use (67%), followed by compliance with guidelines (33%) and the use of traditional medicines (17%) each. This predominance of ARV use reflects substantial adherence to recommended biomedical protocols for HIV management.

2.7. Psychosocial repercussions and changes in values

2.7.1. Reactions following disclosure of HIV status

The distribution of pregnant women upon disclosure of their HIV status highlights a marked immediate psychological impact, characteristic of the post-diagnosis shock phase. All expressed sadness, while 50% and 33% reacted with crying and emotional shock, respectively.

2.7.2. Reactions of HIV-positive pregnant women to their pregnancy



Graph 5: Distribution of respondents according to their reaction directly related to pregnancy

Fear was the predominant reaction, expressed by 46.46% of respondents (14/30). This feeling is indicative of acute anxiety linked to fears for their own health and that of their unborn child. Discouragement came in second place, reported by 30% of participants (9/30). Feelings of guilt (10%) and the idea of terminating the pregnancy (13.33%) were among the other reactions expressed by respondents.

2.7.3. Sharing information about HIV status with the partner

Of the 30 HIV-positive pregnant women surveyed, nine (30%) said they had shared their HIV status with their partner, while 21 (70%) chose not to.

2.7.8. Impact of HIV status

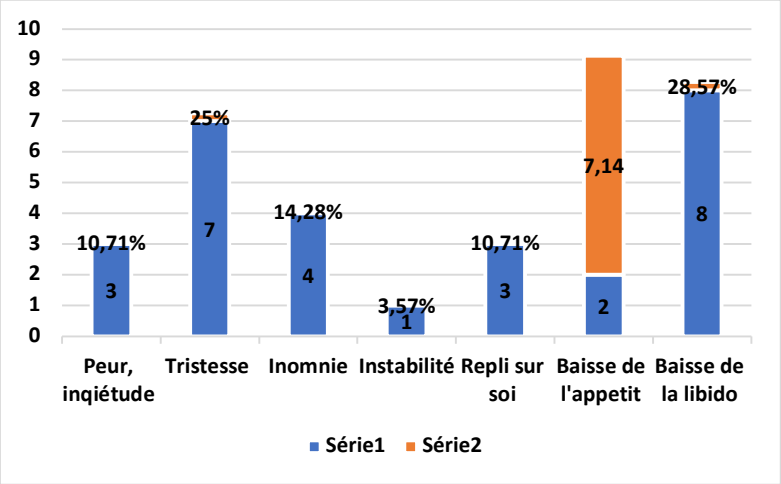


Figure 6: Distribution of respondents according to the repercussions of HIV status

The graph reveals a variety of psychophysiological manifestations associated with the disclosure and management of HIV status among pregnant women. A decrease in libido, reported by 28.57% of pregnant women (8 cases), emerged as the most common impact. This was followed by sadness (25%), fear/anxiety (10.71%), and withdrawal (10.71%), reflecting significant psychological distress among the respondents.

2.7.9. Attitudes of informed individuals towards HIV-positive pregnant women

Table VII: Distribution of respondents according to the attitudes of people informed of their status

Reactions	Number	Percentage
Acceptance	8	26.66%
Rejection	10	33.33
Support	7	23.33
Fear	5	16.66%

The distribution of HIV-positive pregnant women according to the attitudes of those informed of their HIV status reveals a predominance of rejection (33.33%), followed by acceptance (26.66%), support (23.33%), and fear (16.66%).

2.8. Relationship to support groups

Table VIII: Distribution of respondents according to their knowledge of and membership in a support group

Pregnant women aware of the existence of a support group	**Number**	**Percentage**
Yes	30	100
No	0	0
Pregnant women belonging to a support group	**Number**	**Percentage**
Yes	7	23.33
No	23	76.66

The distribution of pregnant women according to their relationship with support groups shows that they are fully aware of the existence of support groups. However, only 23.33% of pregnant women report belonging to a support group, while 76.66% do not participate in one.

3. Discussion of study results

3.1. Sociodemographic characteristics and vulnerability of HIV-positive pregnant women

Analysis of the results confirms the high vulnerability of HIV-positive pregnant women receiving antenatal care at the Yopougon Santé Urban Health Center, characterized by their young age (26-35 years). These results suggest that women of optimal reproductive age (generally considered to be between 20 and 35 years old) represent the population most affected by HIV infection among pregnant women.

These results corroborate the observations of Kakou (2020), who notes a similar age (27 years) and a predominance of women in cohabiting relationships. This trend is consistent with global epidemiological data on HIV prevalence, where women of

childbearing age are often the most vulnerable due to biological factors (increased susceptibility during sexual intercourse), social factors (exposure to multiple partners, gender-based violence), and economic factors (financial dependence or limited access to prevention) (UNAIDS, 2023).

The World Health Organization (2021) highlights the vulnerability of pregnant women aged 20-35 to HIV infection, particularly in low- and middle-income countries, due to economic factors (limited access to prevention) and social factors (financial dependence), including data on heterosexual transmission as the main mode of infection. Desgrées-du-Loû et *al.* (2009) showed that in the Ivorian context, specifically in urban areas such as Abidjan, women aged 26-35 are overrepresented among HIV-positive pregnant women, due to biological factors (period of high reproductive activity) and social factors (exposure to risks in informal unions).

The study also shows that the majority of HIV-positive pregnant women live with a partner (53%) and have not received formal schooling (43.33%), reflecting a low level of literacy among the pregnant women surveyed. Cohabitation, often characterized by informal unions, can lead to varying levels of social and emotional support. In the context of HIV infection, pregnant women in cohabiting relationships may face specific challenges, such as relationship instability or increased stigma, particularly if the partner is not informed or involved in the management of the disease. This situation can exacerbate psychosocial repercussions, such as anxiety, depression, or social isolation.

The high proportion of pregnant women who have not attended school is significant in the context of HIV infection, as lack of education is often associated with limited understanding of medical information, reduced adherence to antiretroviral (ARV) treatment, and increased vulnerability to stigma. Pregnant women who have not attended school may also have limited access to health resources and limited decision-making power, exacerbating psychosocial impacts such as anxiety, fear of disclosure of HIV status, or social isolation (World Health Organization, 2021). This observation was highlighted by UNAIDS (2016), which emphasizes that the lack of information on HIV prevention and the inability to use such

information in sexual relationships, including in the context of marriage, compromise women's ability to negotiate condom use and engage in safer sexual practices.

With regard to the activities carried out by pregnant women, the study shows that the majority of pregnant women (50%) are engaged in informal activities, a sector often characterized by a lack of social security, irregular incomes, and precarious working conditions. In the context of HIV infection, this situation can increase psychosocial vulnerabilities, such as financial stress, stigmatization in the workplace, and difficulties in accessing care due to economic constraints. This trend is similar to that observed by Traoré (2022), who found that the high rate of pregnant women in informal work reflects the greater vulnerability of women without financial resources or living in precarious conditions to HIV infection.

As for the religious affiliation of the respondents, the results showed that 63% were Muslim. On the subject of Islam, Chrystelle (2009) stated that the misinterpretation of certain Islamic texts associated with certain African customs can have the opposite effect if it affects the age at which people first have sex. Girls are generally sent into marriage in their teens, and the age gap between spouses is quite significant, another factor that favors the transmission of the virus during sexual intercourse.

3.2. Pregnant women's knowledge and attitudes towards HIV: progress and limitations

The results show a predominance of primigravidas (40%), suggesting a high proportion of women who are pregnant for the first time. This category may be particularly vulnerable to the psychosocial repercussions of HIV due to their inexperience with motherhood, the lack of previous references for managing a pregnancy complicated by a chronic infection, and possible increased stigmatization in a context where HIV-positive status is newly diagnosed.

Psychological stress, anxiety, or fear of mother-to-child transmission may be more pronounced among these primigravidas. This is shown by Rochat et *al.* (2013) when they examine the psychosocial repercussions among HIV-positive mothers, including

primigravidas. They emphasize that maternal inexperience and initial stigmatization amplify psychological stress and anxiety, particularly the fear of mother-to-child transmission. The delay in the first prenatal care visit (average gestational age of 6 months) indicates that many pregnant women are monitored in the early third trimester. At this stage, HIV-related complications, such as viral suppression or prevention of mother-to-child transmission (PMTCT), become critical.

Psychologically, this period can heighten anxiety about the approaching delivery, particularly if the HIV diagnosis is recent, leading to challenges such as stigma or fear for fetal health. HIV testing in pregnant women is mainly carried out during pregnancy, which highlights the persistence of a still vague, even mythical, perception of the issues related to mother-to-child transmission of the virus. This situation raises questions about the effectiveness of awareness campaigns and counseling, testing, and communication (CTC) sessions, which are supposed to inform pregnant women about the risks of HIV transmission to their children and the importance of early screening.

Despite the implementation of these measures, some women remain reluctant to undergo screening, or, when they do consent, do not return to collect their results, which significantly compromises early treatment. Furthermore, although 66.66% of the pregnant women surveyed had no associated medical conditions, a significant proportion (33.34%) suffered from comorbidities (diabetes, asthma, sickle cell disease, epilepsy) that could increase their vulnerability to HIV. These chronic conditions, in combination with HIV infection, can further compromise the overall health of pregnant women, making their medical follow-up even more complex.

The fact that all pregnant women (100%) are aware of HIV demonstrates the effectiveness of awareness campaigns in Côte d'Ivoire, particularly through the media and medical consultations. As for the modes of transmission of the virus, the majority of participants (56.66%) identify unprotected sexual intercourse as the main mode of HIV transmission. 23.33% mentioned blood transmission, and 16.66% cited vertical transmission, i.e., during pregnancy or childbirth. These responses, which are consistent with biomedical data, show a relatively accurate understanding of the

main vector of virus transmission. These results, together with those of Touré et *al.* (2005), who report a high level of knowledge of modes of transmission among a school population in Abidjan. However, the emphasis on sexual and blood-borne transmission in campaigns may marginalize awareness of mother-to-child transmission, as evidenced by the low rate of voluntary prenatal testing (70% tested during pregnancy) (UNAIDS, 2022).

With regard to HIV prevention methods, the data reveal that 63.33% of pregnant women identify condom use during sexual intercourse as an effective prevention method, and 36.66% of pregnant women mention the non-use of potentially infected shared injection equipment (needles, razors, blades, etc.) as a means of prevention. These results are scientifically relevant, as condoms are one of the most reliable means of reducing sexual transmission of HIV. These majority responses demonstrate a good understanding of prevention messages.

The predominance of ARV use (66%) and compliance with health workers' instructions are very positive findings, as they reflect majority adherence to the treatment strategy recommended by WHO. This reflects a certain accessibility to treatment and successful awareness-raising among the majority of pregnant women. This situation could be explained by the application of methods for the prevention of mother-to-child transmission (PMTCT) and the quality of care provided to pregnant women from screening to delivery (Tshabu, 2014).

3.3. Psychosocial repercussions and changes in values

The study highlights major psychological disorders following the discovery of HIV status in pregnant women, with 56.66% of pregnant women presenting with anxiety disorders and 36.66% with depressive disorders. These figures, which are slightly higher than those reported by Kouakou (2020), who found 53% for anxiety disorders and 30% for depressive disorders, confirm the traumatic impact of the announcement of HIV-positive status, which is perceived as a threat to survival and identity (Grochcinki, 2010). As for their reaction to the announcement, fear (46.66%) and

discouragement (30%) dominate the initial reactions, while 13.33% consider terminating the pregnancy.

These reactions indicate deep psychological distress, often reinforced by the internalization of social stigma associated with HIV, and even cultural and moral norms, a fact also highlighted by Rabi et *al.,* cited by Traoré (2022). These reactions fit into a theoretical framework in which the announcement of a chronic illness triggers defense mechanisms such as denial, guilt, or isolation (Belz-Celia, 2013).

On a social level, the reluctance to inform one's spouse (70%) highlights the persistence of stigma. The fact that the majority of pregnant women did not disclose their HIV status to their spouse reflects a climate of fear, stigma, or rejection, often fueled by negative social representations associated with HIV. This situation constitutes a major obstacle to breaking the chain of transmission. Furthermore, although the majority claim to have a normal sex life, there is a decrease in libido (53.57%), reflected in a period of lack of sexual desire following the discovery of HIV-positive status and a disruption of instinctual desires, corroborating Delor's (1997) observations on the impact of HIV on quality of life.

Disclosing one's HIV status to a third party sometimes elicits a variety of psychological reactions ranging from rejection to acceptance, fear, and support. The rate of rejection (33.33%) and fear (16.66%) felt by respondents reflects a stigma that is still deeply rooted in social representations of HIV. This situation highlights the ethical issues and rights of individuals regarding confidentiality, privacy, and the right to a protected pregnancy, while emphasizing the need for a more inclusive and supportive approach towards women living with HIV. Acceptance and moral support from loved ones could be a coping mechanism that helps pregnant women deal with the disease. These data contrast with those of Traoré (2022), who found that supportive behavior was what motivated informed individuals.

The fact that all pregnant women surveyed were on ARV treatment reflects the successful integration of PMTCT (Prevention of Mother-to-Child Transmission) policies into prenatal care services. This demonstrates satisfactory accessibility and acceptability of antiretroviral treatment. High treatment adherence

(86.66%) and the use of ARVs for PMTCT (50% of treatments) reflect progress in medical care, reducing the risk of mother-to-child transmission. However, adherence to treatment is influenced by several psychosocial factors (the weight of the diagnosis, lack of family or spousal support, side effects of ARVs, stigmatization). These factors, perceived as constraints by some pregnant women, highlight the need for psychological support to prevent treatment discontinuation (Soro, 2005).

Furthermore, low participation in support groups, despite awareness of their existence, reflects psychological barriers (fear of being recognized, lack of confidence in the confidentiality of the groups) and logistical barriers (lack of time, distance, cost), contrasting with the results of Kouakou (2020), where 82.50% were unaware of these groups. These discrepancies suggest contextual differences in access to information and awareness.

Conclusion

This exploratory and descriptive study highlights the profound psychosocial repercussions of HIV infection in HIV-positive pregnant women. Using a quantitative approach, it drew on a sample of 30 HIV-positive pregnant women monitored at the Yopougon Santé CSU in Abidjan. Data were collected using a questionnaire and analyzed using descriptive statistics (number, frequency, percentage). The study enabled us to understand the social and psychological impacts on women who discover their HIV status during pregnancy. The analyses confirm the vulnerability of pregnant women, amplified by sociodemographic factors such as young age, low level of education, and economic insecurity in the face of HIV infection.

The results also reveal a good knowledge of HIV but late testing and high adherence to ARVs. They also show predominant psychological disorders (anxiety, depression), marked by fear, sadness, discouragement, and a reluctance to share one's HIV status. Furthermore, stigmatization and rejection exacerbate social isolation and low participation in support groups, while the desire to have children persists despite the risks, reflecting deep-rooted African cultural values (Yoro, cited by Kouakou, 2020).

Furthermore, these results also highlight the biopsychosocial impact of HIV, where individual (anxiety and depression, denial), relational (spousal rejection, decreased libido), and systemic (delays in PMTCT, side effects of ARVs) factors interact to weaken pregnant women. To improve care, it is imperative to strengthen the training of mental health caregivers, intensify awareness campaigns to reduce stigma, and integrate psychotherapy into follow-up protocols. These measures, combined with early prenatal screening, could improve the quality of life of HIV-positive pregnant women and reduce mother-to-child transmission.

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Table des matières