

Mar 31st, 2:30 PM - 4:00 PM

Sacrée et Inviolable: The HIV+ Mother in Ivoirian Health Policy

Amber Alaniz

University of Houston - Main

Follow this and additional works at: <http://digitalcommons.providence.edu/auchs>

 Part of the [African Languages and Societies Commons](#), [Bioethics and Medical Ethics Commons](#), [Ethics and Political Philosophy Commons](#), [Health Policy Commons](#), [Immune System Diseases Commons](#), and the [Political Science Commons](#)

Alaniz, Amber, "Sacrée et Inviolable: The HIV+ Mother in Ivoirian Health Policy" (2012). *Annual Undergraduate Conference on Health and Society*. 1.

<http://digitalcommons.providence.edu/auchs/2012/panelc1/1>

This Event is brought to you for free and open access by the Conferences & Events at DigitalCommons@Providence. It has been accepted for inclusion in Annual Undergraduate Conference on Health and Society by an authorized administrator of DigitalCommons@Providence. For more information, please contact mcaprio1@providence.edu, hposey@providence.edu.

Sacrée et Inviolable : The HIV+ Mother in Ivoirian Health Policy

Abstract

« *La personne humaine est sacrée (2)... Le domicile est inviolable. Les atteintes ou restrictions ne peuvent y être apportées que par la loi. (4) La famille constitue la cellule de base de la société. L'État assure sa protection. (5)*» *Constitution of La Côte d'Ivoire, Articles 2,4,5*¹

The Ivoirian national constitution, authored and enacted in July of 2000, while expressing a devotion to democratic thought (Preamble) and to the sovereignty of the individual (Article 2), also acknowledges the primacy of the Ivoirian family and collective identity as the basis of society and advances a moral duty on the part of the state to honor and protect them (Articles 4-5). The Ivoirian constitution seeks to embrace the Western tradition through its enshrinement of the human individual and its use of rationalist argument while maintaining fidelity to African ideals of human collectivism.

In this paper, I will situate the seropositive Ivoirian mother within the tensions of these philosophical commitments and demonstrate the ways in which ethical subjectivity and health status are mediated by them. I will describe some of the challenges of lactation in sub-Saharan countries. I will use exclusive breastfeeding, a PMTCT strategy, to explore the ways in which western public health, which conceives of mothers as independent rational actors, has not imagined African mothers in their collectivist context. Lastly, I will discuss new models for reproductive policy which address the unique problem of the seropositive mother in sub-Saharan Africa.

African Collectivism

Recent scholarship has commented extensively on the problems associated with the use of “Africa” in popular and academic discourse². First, generalizing language in popular media,

¹ From “Le peuple du côte”: Constitution du Côte d'Ivoire. 2000.

especially when coupled with vivid descriptions of poverty, civil war, hunger, and political volatility³, can give a misleading impression of the pan-African condition. For example, the use of the general term “Africa”, as opposed to, for instance, the more specific “Zimbabwe” puts the reader at risk of generalizing to all of Africa political events, economic conditions, or the health status of citizens which are unique to Zimbabwe. Similarly, data obtained from the study of one ethnic group in a particular geographical, ecological, political, and linguistic context does not yield meaningful data about another group, even if their situation is judged to be similar.

As Nkiwane¹ has explained, pan-Africanism has historical roots in a common legacy of colonization by European powers, followed by a commitment on the part of the Organization of African Unity in 1963 by liberated African states to work in solidarity with colonized states for the purpose of advancing political freedom and human rights. Thus, the pan-African identity is a construction designed to increase collective power. In the creation of the OAU, member states “embraced” pan-Africanism as a measure for both reducing inter-state discord¹ and forging a larger and more cohesive African body politic for global relations¹. Whereas the OAU’s governing principles express this collectivist ethic, it may be said that *collectivism* is a value circumscribed in numerous African cultures, both by tradition and by recent political history.

In Côte d’Ivoire, a more regionalized Ivoirian nationalism (*Ivoirité*) is relevant in the internal discourse as a political appeal, and has in fact been mobilized by politicians in the

² See Nkiwane, Tandeka. “Africa and International Relations: Regional Lessons for a Global Discourse.” *International Political Science Review/Revue internationale de science politique*. Vol 33, No. 3, pp. 279-290. JSTOR: University of Houston, 3/1/2012.

³ See Mwenda, Andrew. “Andrew Mwenda takes a new look at Africa.” TEDTalks. TED.com video archive. TEDGlobal 2007, June 2007. Website: accessed 3/2/2012.

http://www.ted.com/talks/lang/en/andrew_mwenda_takes_a_new_look_at_africa.html

last decade to keep Africans of non-Ivoirian origin from holding state office in the country. Additionally, local collectivist beliefs may take the form of community land ownership or of matrilineal and patrilineal traditions of kinship and social authority⁴. Many of these became incarnate in political reforms of the 1990's³, and form the foundation for the manner in which reproductive health and HIV policies are applied to Ivoirian mothers. The continental ideal of collectivism, applied in specific ways across distinct Ivoirian communities, may thus be called "African" and can be understood to apply to both African mothers generally and Ivoirian mothers specifically.

Furthermore, the World Health Organization sets Ivoirian health statistics against the contextualizing background of larger sub-Saharan statistics in order to better explain their significance⁵. For example, while the total fertility per woman in Côte d'Ivoire is 4.9 children over the course of the lifespan, the WHO average for Africa is 5.3⁵. Similarly, women's life expectancy is 47 years in Côte d'Ivoire and 49 in greater sub-Saharan Africa⁵. While maternal mortality per 100,000 live births is much smaller in Côte d'Ivoire (690) than in Africa as a whole (910), infant mortality, per 1,000 live births, is somewhat larger (118 vs. 100), perhaps due to fewer healthcare workers and lower access to antenatal healthcare in Côte d'Ivoire than in other sub-Saharan countries⁵. In 2002, HIV/AIDS was the leading cause of death among both adults and children in Côte d'Ivoire⁵.

It is with these things in mind, then, that this study uses the findings of pan-African research in collective ethical subjectivity as a reference for Ivoirian ways of thinking about sero-positivity, healthcare, and motherhood. As HIV policy and public health practice in sub-Saharan Africa is commonly funded by similar sources, such as USAID and UNAIDS, and

⁴ Toungara, Jeanne Maddox. "Inventing the African Family: Gender and Family Law Reform in Côte d'Ivoire." *Journal of Social History*. Vol 28, No. 1. Autumn 1994, pp. 37-61. JSTOR: University of Houston, 10/12/2011.

⁵ See World Health Statistics, 2006. World Health Organization: <http://www.who.int/whosis/en/>

informed by a common evidence base, programs in one African state closely resemble those in others. Moreover, because much of the existing literature covers several African programs at once, rather than covering one specifically, sub-Saharan PMTCT (prevention of mother-to-child transmission) programming is also used to describe the current ethical frameworks used in treating seropositive Ivoirian mothers.

Ethical Frameworks

A vital factor in the creation of mindful and sensitive health interventions is the proper use of a guiding ethical framework. As Moodley⁶ observes, public health practice in Africa has long been imagined within the ethical norms of western medicine, where principles such as physician beneficence and patient autonomy shape the discourse and, consequently, limit the scope of intervention. In examining the implications for future AIDS vaccine research in sub-Saharan communities, Moodley shows that, in resource-poor settings, these principles cannot assume a weight equivalent to that which they carry in more comfortable, industrialized contexts⁴.

The Western principle of patient autonomy is generally used to avert medical paternalism by privileging patient voices, concerns, and desired health outcomes. In reproductive medicine, autonomy requires that the provider suspend subjective values in order to better serve the life goals and ethical interests of the patient⁷. Under autonomy, providers are bound to seek understanding of a patient's perspectives while maintaining

⁶ Moodley, K. "HIV Vaccine Trial Participation in South Africa: An Ethical Assessment." *Journal of Medicine and Philosophy*. Vol 27, Issue 2, pp. 197-215. PubMed: University of Houston, 10/11/2011.

⁷ Chervenak, Frank A, MD and McCoullough, Lawrence B, PhD, "Ethics of Research in Perinatal Medicine", *Seminars in Perinatology*, Volume 33, Issue 6 (December 2009), pp. 391-396. JSTOR: University of Houston, 3/2011.

ideological fidelity to biomedical training and to counsel patients with the biomedical advice best suited to their circumstances⁵.

Chervenak and McCollough⁵ apply autonomy to reproductive medical practice by advancing trust in the moral soundness of patient desires. They take for granted that a woman seeking reproductive treatment is a rational decision-maker and is capable, with physician guidance, of critically interpreting medical information⁵. Upon full disclosure as to her treatment options, an autonomous pregnant woman, for instance, should be able to make sane and “rational” assessments of biomedical knowledge and apply them in a clinically acceptable manner.

A physician is responsible for disclosing all safe, tested, available, and feasible treatments for her condition and should restrict his/her role to offering information and answering clinical questions with evidence-based counsel⁵. The ethical subjectivity of the physician is made ancillary to that of the patient⁵. The assumption here is that when such a position is taken by the physician, biomedical knowledge can be made available to and instrumentalized by those in a provider’s care to serve their own ethical ends. The patient, understood as the primary moral agent in this interaction, is given full responsibility for her healthcare decisions.

In industrialized practice, reproductive medicine often encounters this principle relative to conversations about contraception and abortion. Here, a physician may hold religious beliefs about the inception of life that, if shared uncritically with patients, might limit options and skew healthcare counseling in favor of their tenets. Because the physician’s opinion is most frequently given greater ideological gravity, the use of autonomy as a principle serves to balance clinical interests by placing greater trust and agency in the patient. In the context of contraception and abortion, the physician in question would set aside his or

her religious perspectives and use biomedical knowledge in service of a patient's wishes. The only cases in which the physician might take back the privileged voice without violating the principle of autonomy would be when either 1) patient decision could be shown to contradict favorable health outcomes or 2) the patient could not be reasonably deemed a rational moral agent in her own healthcare process⁵.

Two problems arise when using autonomy as a guiding moral framework in African healthcare, particularly if the recipients of care belong to socially marginalized groups (in this paper, HIV+ mothers and their infants). The first of these concerns biomedicine as an implicit ideology embedded in the social context of all clinical practice. The next concerns the construction of the patient as an independent moral actor, whose rational healthcare decisions reflect and uphold the Western canon. In African healthcare, across multiple regions with varying levels of development, neither biomedicine nor the independent rational actor should be considered *de facto*. By contrast, several researchers have pointed out that traditional medicine, with all of its attendant metaphysics, is still a valued method of health maintenance in African communities⁸. Additionally, African notions of selfhood may indeed transcend the individual and the rational, and thereby render conventional methods of medical decision-making imperfect⁹.

As a method of constraining physician power in the clinical encounter, autonomy is rather narrow in its scope. While, if used rigorously, it effectively restricts the imposition of physician religious beliefs and social privilege onto patient healthcare choices, it does not require that physicians also circumscribe their belief in biomedicine, which has been called a

⁸ See Van Niekerk, 2005.

⁹ Roux, as cited in Van Niekerk, #9

“religion” of its own¹⁰. Though it prioritizes patient desires and experiences, autonomy is subordinated in the discourse to biomedical models of health and disease, and patient voices are taken into account in the context of these models. As a result, providers are only required to suspend *some* of their subjective values while actually showing partiality toward others. In fact, the use of suspension for the demonstrably religious or political affiliations that a physician might have only serves to obfuscate the reality that biomedicine is its own kind of creed, and carries within its many of the limitations and assumptions of religion. Autonomy, as such, does not provide protection against the shortcomings of biomedicine as a system of understanding health, disease, and patient personhood and is therefore dangerous as an ethical framework.

Autonomy also requires that its subject see herself as an independent rational actor in her healthcare experience⁹. As Van Niekerk asserts¹¹, African individual selfhood can be better understood in terms of collective experience and identity than in terms of personal goals and desires.

Groves, et al¹² found in a study on informed consent and antenatal HIV testing in South African women that Western notions of what constitutes adequate provision of knowledge to patients and subsequent autonomous decision-making do not align with the social realities of motherhood in their lives. A majority of women interviewed in the study

¹⁰ Lunstroth, John, LLM, MPH. Medicine and Society lecture, Health and Human Rights. November 14, 2011. Honors College, University of Houston. Here, biomedical models of health and disease were described as “religious” in that they represent a distinct set of “philosophical commitments” or “metaphysical claims” about causality and the nature of truth.

¹¹ Van Niekerk, Anton. “Mother to Child Transmission of HIV/AIDS in Africa: Ethical Problems and Perspectives.” *Ethics and AIDS in Africa: The Challenge to Our Thinking*. Left Press Coast: Walnut Creek. 2005

¹² Groves, A.K. et al. « South Africa : Durban’s Ante-natal Clinic Environment and its Impact on a Woman’s Choice to test for HIV During Pregnancy.” *HIV/AIDS Policy Law Review*. Vol 15, No 1 (October 2010). JSTOR: University of Houston, 10/ 09/2011.

revealed that they felt pressure from their providers to undergo testing and, further, that women who were tested (HIV positive *or* negative) placed themselves at greater risk for social stigma and isolation from community support systems¹⁰. The authors postulate that, as a vulnerable population, African women are more likely to subordinate individual health understandings, goals, and desires (if indeed these can be said to exist in this context¹³) to the larger will of the family and community and also to the more esteemed will of the physician¹⁰. Roux¹⁴ corroborates this argument and advances that African women consenting under the twin pressures of community and physician will are also less likely to disclose a positive test result to their loved ones and receive support in seeking treatment for their condition.

Lactation and its Challenges

November 2009, the World Health Organization made revisions to its recommendations regarding infant feeding strategies for HIV+ mothers in African countries. Reflecting recent data that demonstrate elevated risk of bacterial and parasitic infections in exclusively formula-fed African infants¹⁵, heightened danger of HIV infection due to intestinal lesions and bacterial infections from unsafe water sources in infants receiving mixed feedings¹⁶, and both decreased incidence of infection and improved health and survival outcomes in exclusively breastfed infants whose mothers receive HAART (highly active anti-

¹³ As cited in Van Niekerk, 2005.

¹⁴ As cited in Van Niekerk, 2005.

¹⁵ Doherty, Tanya, et al. "Implications of the new WHO guidelines on HIV and infant feeding for child survival in South Africa". *Bull World Health Organ*, 2011; 89: pp. 62-67. Additionally, there have been numerous prior revisions to these guidelines. They are expected to change according to shifts in the epidemiological dynamics of HIV-1 and 2 in Africa and according to

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3040019/pdf/BLT.10.079798.pdf>. University of Houston: accessed September 21, 2011.

¹⁶ White, Edith. *Breastfeeding and HIV/AIDS: The Research, the Politics, and the Women's Responses*. McFarland & Company: Jefferson, SC, 1999.

retroviral therapy) in late pregnancy and during lactation¹, these recommendations, while ambitious and ethically worthy, pose several implementation problems for HIV+ mothers in Africa.

Despite strong international and local advocacy against it, mothers in African countries are still likely to practice mixed feeding for their infants, which is to say that they mix breastfeeding with bottle feeding, porridge, tea, dairy milk, and other foods¹⁷. In HIV-endemic countries, public and private-sector clinics use breastfeeding promotion according to WHO guidelines and advocate exclusive breastfeeding during the first six months of infant life in order to prevent HIV transmission while guarding against bacterial infections from unsafe water sources. However, medical difficulties¹⁵, legal inequalities¹⁸, and differing social constructions of breastfeeding¹⁹ contribute to anxiety, reticence, and unwillingness on the part of the mother to practice exclusive breastfeeding.

Medical difficulties, particularly among young mothers, constitute a significant challenge to exclusivity¹⁴. In 2007, Naanyu¹⁴ found that delayed milk production, sore or cracked nipples, small nipples, uterine contractions, leaking or “engorged” breasts, and maternal illness were used as reasons for cessation among mothers under the age of twenty at the birth of their first infant. In the same study, Naanyu also found that exclusivity in months increased with maternal age, perhaps as a result of having successfully navigated medical

¹⁷ Naanyu, Violet. “Young Mothers, First-Time Parenthood, and Exclusive Breastfeeding in Kenya.” *African Journal of Reproductive Health/La Revue Africaine de la Santé Reproductive*. Vol 12, No 3 (December 2008). JSTOR : University of Houston, 10/14/2011.

¹⁸ Thairu, Lucy N, et al, “Sociocultural Influences on Infant Feeding Decisions among HIV-Infected Women in Rural in Kwa-Zulu Natal, South Africa.” Stanford University: website.
<http://www.stanford.edu/~thairu/THAIRU%20writing%20sample%20MCN.pdf>. Accessed 10/11/2011.

¹⁹ Seidel, Gill. “Re-conceptualizing Issues Around HIV and Breastfeeding Advice: Findings from Kwa-Zulu natal, South Africa.” *Review of African Political Economy*. Vol 27, No 86 (December 2000), pp. 501-518. JSTOR: University of Houston, 10/11/2011.

difficulties in the past or as a result of a different set of maternal expectations and life experiences¹⁴. In the context of healthcare access, it may also be possible that exclusivity in months could be increased by better provision of post-natal health services and skilled clinical breastfeeding support.

Maternal age and infant care can also be circumscribed in the social ecology of the family. A study in Kwa-Zulu Natal revealed that younger mothers living with older family members felt more pressure to supplement breastmilk with solid foods and porridge¹⁵. Because the meanings of infant crying and health beliefs about what constitutes sufficient nutrition vary according to generation in their community, young mothers often succumb to the infant care wishes of their elders, even when such wishes run counter to the advice of their healthcare professionals. Injunctions from elders to offer more than breastmilk to infants can also be combined with expressions of concern for a mother's health and for her nutritive status. As one mother stated in her interview:

“[Older people] at home they wish to see the baby eating. [...] they like to see the baby eating every time [...] they believe if the baby is crying [you should] give him something to eat.”¹⁵

That breastfeeding advice from family and community is couched in the language of care for both maternal and infant health (and is surely offered with sincerity!) may make it difficult for a young mother to claim authority and assert power in infant feeding decisions. As her own wellbeing and social support comes from this community, she is likely to trust it more than biomedicine. Moreover, if she did choose to place her trust in the advice of healthcare professionals over that of family members, she may face hurdles in confronting a balance of numbers that places her opinion in the minority. Finally, even in cases where a woman asserts her wishes to exclusively breastfeed, she may be poorly understood by her elders, who do not conceptualize health and wellbeing in the terms available to her through the biomedical explanation. There is, therefore, a need for public health to address PMTCT

at the community and family level, and to supply a language for expressing risk and benefit that is comprehensible to all.

Social and economic progress, which have increased mean levels of education, and therefore professional opportunities, for women in endemic communities have also impacted the maternal experience¹⁴. With more young mothers seeking work outside the home, exclusive breastfeeding becomes less of a priority¹⁴. In addition to scarce provision of space, time, and equipment to lactate and store milk in the workplace, exclusivity is also interrupted by the use of supplemental foods by caregivers who watch the baby while mothers are working. Though many African women cite cost of formula as a benefit of exclusive breastfeeding¹⁵, younger mothers feel empowered by their ability to provide income for their families and wish to exercise their right to work outside the domestic sphere.

Indeed, the rights discourse in recent years has commented on the manner in which breastfeeding advocacy in Africa continues to subordinate a woman's extra-domestic capabilities to the rhetoric of a patriarchal body politic²⁰. In this context, the lactating mother is constructed as a "natural resource" of the state¹⁷ and is ethically bound to both her infant and her community to breastfeed. Her role as a mother, of which exclusive breastfeeding is an implicit part, trumps all other roles, responsibilities, desires, and capacities¹⁷.

As expressed by Gill Seidel¹⁷, this construction of motherhood sacrifices economic and social advancement for women, binding their worth and value to the physical sustenance she can give to her family. Her ethical subjectivity is thus made dependent upon the political identity of the collective in which she exercises political will. Here, power relations with healthcare providers who encourage breastfeeding are laden with a second level of coercion in which self as an independent rational actor is eclipsed by the ethical ends of the whole.

The problem of instrumentalizing the lactating mother is made clear in this argument. While Seidel calls for a liberation of African mothers' power of choice from the political milieu, one might also view collective identity as a strength, and seek ways to expand individual capacity to contribute to collective ethical ends within its scope. If African countries are to accept WHO guidance as normative, then public discourse might mobilize the nobility of the lactating mother and the importance of a healthy state as ideological incentive for employers to allow space and storage for lactation breaks on the job and for families of working mothers to find ways to prolong exclusivity.

A Rights-Based Perspective on PMTCT

The biomedical model of PMTCT has de-politicized patient treatment and dismissed the health beliefs and African philosophies of being which are central to the public health environment. A study of the social obstacles to exclusive breastfeeding and highly active anti-retroviral therapies (HAART) is useful, but has limited power when applied only at the level of healthcare delivery. Rights-based approaches to human health are informed by social struggles and legal inequalities and operate at the level of policy to produce just outcomes.

A rights-based approach to seropositive maternal care in Côte d'Ivoire will take into account the political obstacles to healthcare access for HIV+ pregnant women and HAART while addressing knowledge and education gaps at the community level. Concurrently, it will privilege the "embodied"²¹ experience of African motherhood and examine the social obstacles to exclusive breastfeeding while constructing policy to encourage it.

²¹ See Traina, CLH. *Erotic Attunement* (2010) and others for an elucidation of embodiment theory appropriate to the breastfeeding relationship. Embodiment as a theory of relationship focuses on the physical and social realities of role fulfillment and expresses knowledge as embedded in human experience. In the case of African motherhood, an embodied perspective would take into account both the "body" of the maternal subject *and* the collective ethical subjectivity of which her embodied knowledge is a part.

If PMTCT is conceptualized as a political activity embedded in the context of public health, then it could use a distributive justice framework to reflect its mindfulness of these values as it performs public health procedure. Using this framework, access, education, and power relations within the collective relative to age, gender, and ethnicity would be seen as human quantities whose current allocation is unjust. The project, then, would be to determine right allocation of these quantities and to advance a procedure standardized to meaningful ethical norms in context for distributing them²².

MTCT-Plus! Models

As described earlier, maternal HIV care in sub-Saharan Africa has historically been characterized by structural and idealistic challenges, many of which are attributable to dissonances between Western public health and African theories of personhood. Additionally, as richer case studies become available, clinical and management challenges are revealed²³. For instance, because the incidence of cervical cancer and HPV-related health events is increased among sero-positive women, HIV care must now include both preventative services and HIV-specific treatment algorithms²⁴. New cases of other STDs, as well as vulvo-vaginal candidiasis and other reproductive tract infections, among HIV positive women require specialized clinical care while recent measures of the economic and social burden of HIV on the lives of African mothers suggest the need for psychosocial support and counseling²⁵. Attention has also been directed toward the values and attitudes of clinicians. Research in this area emphasizes problems such as paternalistic behavioral counseling in sexual health

²² Lunstroth, John, LLM, MPH. "Health and Human Rights". Lecture, University of Houston, 11/16/2011. Just outcome vs. just procedure are discussed in terms of Aristotle (outcome) and Rawls (procedure).

²³ Myer, Landon, et al. "Focus on Women: Linking HIV Care and Treatment with Reproductive Health Services in the MCTC Plus Initiative." *Reproductive Health Matters*, Vol. 13, No. 25, May 2005. pp. 136-146.

²⁴ Cronje, HS, and Cejtin, HE, as ctd. in Myer, 2005.

²⁵ Baingana, G, as ctd. in Myer, 2005

settings and the strong recommendation of drastic procedures, such as sterilization, for seropositive women that undermine their own fertility choices²⁶. With regard to fertility in particular, research has found that condom use in Côte d'Ivoire is both sporadic and poorly understood²⁷ and that hormonal contraceptive methods may increase the risk of HIV transmission from women to their uninfected partners²⁸. Future programming must, therefore, integrate such features as multidisciplinary healthcare management, appropriate and sensitive contraceptive counseling, patient advocacy, and an understanding of African health beliefs and ethics.

In response to these critiques, African MTCT-Plus! initiatives attempt to integrate reproductive and sexual health services for seropositive women using a mother-centered, family approach to care. Using antenatal clinic visits and subsequent enrollment in PMTCT services as an entry point, MTCT-plus programs include reproductive choice advocacy, patient-sensitive contraceptive management, HAART therapy for pregnant women, psychosocial services, and referrals for other HIV+ family members¹⁹. Additionally, seropositive women and their family members in MTCT-Plus programs have the clinical advantage of receiving treatment from the same physician¹⁹. Organizational features of MTCT-Plus programs include collaboration among academic, NGO, and government entities, streamlined patient databases, standardized, research-based treatment algorithms for clinical case management, and advanced training for healthcare workers¹⁹.

To date, there is one such program active in Côte d'Ivoire, based in Abidjan, at the Formation Sanitaire Urbaine de Yopougon-Attié¹⁹. Identified obstacles to implementing MTCT-Plus as the preferred model of care involve donor biases against reproductive care for

²⁶ Chen, JL, as ctd. in Myer, 2005

²⁷ Martin, H and Lavreys, L, as ctd. in Myers, 2005.

²⁸ Martin, H, as ctd. in Myer, 2005

HIV+ individuals, the recruitment and training of dual-specialty clinicians, and inter-organizational transfer of healthcare records¹⁹. Further considerations might look to macro-level issues such as political instability, domestic violence against seropositive mothers, legal inequalities of women, funds allocation, and international aid regulations, such as the Global Gag Rule²⁹, which might limit healthcare access among vulnerable families or impede the flow of resources to programs providing a full complement of reproductive services.

Conclusion

Lactation in an African context, as an embodied exchange between members of the family, reifies the symbolic and relational complications of using a strictly biomedical model to implement PMTCT programming. As the whole family is considered party to the mother-child relationship, public health programming for seropositive mothers might do well to include all of its members. Whereas considerations such as family planning, contraception, PMTCT, and economic roles of family members are evolving conversations taking place in community contexts, healthcare that seeks to address them must also take place at the community level. Furthermore, because seropositive mothers in Côte d'Ivoire are participants in a developing society with roles beyond the domestic sphere, PMTCT programs would do well to supplement HIV and reproductive care with psychosocial services to advance a holistic model of wellbeing for seropositive women and their families.

Works Cited

²⁹ Though this regulation had been repealed by the Obama Administration at the time of this study, versions of the rule have been reintroduced in potential legislation and still exist as funding restrictions from entities other than the United States government.

Chervenak, Frank A, MD and McCoullough, Lawrence B, PhD, "Ethics of Research in Perinatal Medicine", *Seminars in Perinatology*, Volume 33, Issue 6 (December 2009), pp. 391-396. JSTOR: University of Houston, 3/2011.

Doherty, Tanya, et al. "Implications of the new WHO guidelines on HIV and infant feeding for child survival in South Africa". *Bull World Health Organ*, 2011; 89: pp. 62-67.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3040019/pdf/BLT.10.079798.pdf>. University of Houston: accessed September 21, 2011.

Groves, A.K. et al. « South Africa : Durban's Ante-natal Clinic Environment and its Impact on a Woman's Choice to test for HIV During Pregnancy." *HIV/AIDS Policy Law Review*. Vol 15, No 1 (October 2010). JSTOR: University of Houston, 10/ 09/2011.

Lunstroth, John, LLM, MPH. "Health and Human Rights". Lectures, University of Houston, 11/14/2011 and 11/16/2011.

Moodley, K. "HIV Vaccine Trial Participation in South Africa: An Ethical Assessment." *Journal of Medicine and Philosophy*. Vol 27, Issue 2, pp. 197-215. PubMed: University of Houston, 10/11/2011.

Myer, Landon, et al. "Focus on Women: Linking HIV Care and Treatment with Reproductive Health Services in the MCTC Plus Initiative." *Reproductive Health Matters*, Vol. 13, No. 25, May 2005. pp. 136-146.

Mwenda, Andrew. "Andrew Mwenda takes a new look at Africa." TEDTalks. TED.com video archive. TEDGlobal 2007, June 2007. Website: accessed 3/2/2012.

http://www.ted.com/talks/lang/en/andrew_mwenda_takes_a_new_look_at_africa.html

Naanyu, Violet. "Young Mothers, First-Time Parenthood, and Exclusive Breastfeeding in Kenya." *African Journal of Reproductive Health/La Revue Africaine de la Santé Reproductive*. Vol 12, No 3 (December 2008). JSTOR : University of Houston, 10/14/2011.

Nkiwane, Tandeka. "Africa and International Relations: Regional Lessons for a Global Discourse." *International Political Science Review/Revue internationale de science politique*. Vol 33, No. 3, pp. 279-290. JSTOR: University of Houston, 3/1/2012.

Seidel, Gill. "Re-conceptualizing Issues Around HIV and Breastfeeding Advice: Findings from Kwa-Zulu natal, South Africa." *Review of African Political Economy*. Vol 27, No 86 (December 2000), pp. 501-518. JSTOR: University of Houston, 10/11/2011.

Thairu, Lucy N, et al, "Sociocultural Influences on Infant Feeding Decisions among HIV-Infected Women in Rural in Kwa-Zulu Natal, South Africa." Stanford University: website.

<http://www.stanford.edu/~thairu/THAIRU%20writing%20sample%20MCN.pdf>. Accessed 10/11/2011.

Toungara, Jeanne Maddox. "Inventing the African Family: Gender and Family Law Reform in Côte d'Ivoire." *Journal of Social History*. Vol 28, No. 1. Autumn 1994, pp. 37-61. JSTOR: University of Houston, 10/12/2011.

Van Niekerk, Anton. "Mother to Child Transmission of HIV/AIDS in Africa: Ethical Problems and Perspectives." *Ethics and AIDS in Africa: The Challenge to Our Thinking*. Left Press Coast: Walnut Creek. 2005

White, Edith. *Breastfeeding and HIV/AIDS: The Research, the Politics, and the Women's Responses*. McFarland & Company: Jefferson, SC, 1999.

World Health Statistics, 2006. Website: World Health Organization: <http://www.who.int/whosis/en/>