Safe motherhood in the time of AIDS:
the illusion of reproductive ‘choice’

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Using data from research in Zambia, and drawing on the broader literature on HIV/AIDS, reproductive health, and gender, this paper examines the difficulties faced by women who wish — or are pressured — to have children, but at the same time want to protect themselves and their children against HIV infection.

'It's frightening to think that I am sitting at home while the 'old man' might be wondering, moving from woman to woman to end up bringing HIV/AIDS home to me. I feel that I would even have no children at all so as not to be exposed to the risk of being HIV infected. The only 'medicine' is to remain celibate and avoid getting married because that is the most likely situation in which a woman will get infected, considering unfaithful husbands.'

'If I suspected I were HIV-positive, I would stop having children because this would hasten my death. If I suspected my husband was promiscuous I would definitely have no more children with him.'

The comments above reflect women's anxieties about child-bearing when the prevalence of HIV infection is high and suspicions are harboured about partners' sexual behaviour. They were collected in a study carried out in Zambia in 1995, on the impact of AIDS on households in Chipapa, south of Lusaka, and Minga, in the country's Eastern Province.

Given the importance of child-bearing in many societies, and their own desire for children, women often face a stark dilemma. As Marge Berer and Sunanda Ray put it, 'Practising safer sex and trying to get pregnant are not possible at the same time, at least on fertile days, and it may take many months or years for a woman to complete her family' (Berer with Ray 1993, 77). Topouzis and du Guerny comment that, 'If, under certain epidemiological conditions, a woman runs a 25 per cent chance of HIV infection in order to conceive, it follows that if she wants four, five or six children, she runs a very high risk of contracting HIV' (Topouzis and du Guerny 1999, 13). Women repeatedly stare those risks in the face, sometimes preferring not to acknowledge them fully, but often deciding that the costs of forgoing having children are much greater than the potential costs of HIV infection. Both of the women quoted above already had children. Younger, childless women might be less prone to articulate such views so forcibly, or to act on them.
Dilemmas around bearing children are also faced by men, but they have greater immediacy for women, due to the unequal power relations which characterise intimate relationships between men and women. Men tend to have more sexual partners during their lifetime, and more extramarital encounters. Marriage – and fertility within it – is crucial to many women’s economic security. In any given setting, the way such dilemmas are constructed, understood, and worked through is affected by the accessibility of means of protection against infection and/or contraception, opportunities for women’s economic autonomy, and the level of HIV prevalence. A woman’s age, marital status, level of education, and child-bearing history also have a bearing on the extent to which HIV may jeopardise chances of ‘normal’ maternity.

Neglect of women during the AIDS epidemic

As the AIDS epidemic gathered momentum in the late 1980s and early 1990s, a number of writers began to speak out about the way women had been neglected by both the medical profession and those involved with HIV prevention. Where they had been taken into account, women tended to be depicted not so much as individuals in their own right, vulnerable to HIV or suffering from illness and needing support, but as responsible for transmitting HIV to innocent children or, in the guise of ‘blameworthy’ sex workers, to male clients (Patton 1993; Sherr 1993; Carovano 1991). Women continue today to be widely cast in the role of transmitters of the virus. The relative visibility of commercial sex workers has made them a ready target for interventions – and an attractive one, if promoting their safer behaviour allows men to continue to be sexually ‘mobile’.

Pregnant women are an even more accessible group for targeting. Throughout the course of the epidemic, the basis for estimates of HIV prevalence in populations has become surveillance testing at antenatal clinics. The increasing possibility of mother-to-child infections being prevented through medical means has added a compelling logic for pregnant women being tested for HIV on a more routine basis.

Over time, HIV/AIDS prevention campaigns have been directed at women more generally, based on an assumption that women tend to be the guardians of their families’ health. But there are limits to such strategies, as women are frequently ill-placed to ensure that prevention messages which call for a reduction in the number of sexual partners, or use of condoms, are put into practice (Hamlin and Reid 1991; Sherr 1996). Only recently has there been a more concerted shift towards targeting men, in recognition of the fact that they ‘drive the epidemic’ (Foreman 1999). Men are increasingly called on to be responsible (Rivers and Aggleton 1998; Cohen and Reid 1996), via a paternalistic version of moral guardianship of their families’ health. In Thailand, for example, male clients have been targeted alongside sex workers, and urged not so much to give up their extra-marital pursuits, as to use condoms, so as to provide some protection not just for themselves (and, incidentally, for sex workers), but also for their wives and children.

However, despite the fact that the position of wives as innocent victims of AIDS has been increasingly highlighted, there is still a large gap between the health and welfare needs of women in the face of AIDS and the attention and protection they actually receive. Their situation can be further complicated, and their ability both to control their fertility and to achieve truly safe motherhood can be jeopardised, when approaches to family planning discourage married women from using condoms as contraception in favour of more effective, hormonal means. On the
other hand, in situations in which sexual abstinence and condom-use are designated as the primary means of protection from AIDS, women who wish to have children are frequently left 'with no options at all' (Carovano 1991, 136).

**Limits on women's ability to choose**

If one considers societal norms about fertility, together with the agendas of family-planning organisations and AIDS-protection campaigns, one can see the dilemmas of women very clearly. The language of choice, preference, planning, and decision-making, often used by health providers, emphasises the reproductive rights that all should enjoy. But these terms often misrepresent what actually occurs. Their use obscures the complexity of a process of negotiating – or failing to negotiate – the nature of sexual activity, which is grounded in power relations, convention, the heat of the moment, and, sometimes, gender violence.

Both men and women may feel aggrieved that they have less control than they might like over fertility 'outcomes', but women typically have far less control than their partners, in spite of terminology which labels many contraceptives 'women-controlled' (Lutalo et al. 2000). Many couples do communicate about having children and about the number of children they would like to have, but as Wolff et al. (2000) demonstrate with reference to a study in Uganda, they often experience difficulty in talking about such issues, use unspoken or indirect cues, or frequently misinterpret their partner's preferences, with men having a greater tendency than women to underestimate their partner's desire to stop having children. Nor, when they discuss such issues, does this necessarily imply equal participation or joint decision making (see also Bauni and Jarabi 2000). It may rather serve as a basis for men to enforce their preferences.

Women typically have even less control over their fertility when accessibility to contraceptives is limited, as is more likely to be the case in rural than urban areas, or where contraceptive use is discouraged by religious dictates. There are considerable differences between countries, reflecting in part the varying scope of national or voluntary-sector family-planning programmes. For example, in 1994, 43 per cent of women aged 20-49 in Zimbabwe reported that they were currently using 'any contraceptive method', while the figure in neighbouring Zambia in 1996 was just 23 per cent (Blanc and Way 1998; Central Statistical Office et al. 1997).

**HIV protection within marriage**

Across most of Africa and many other parts of the developing world, however, the majority of women do not use 'modern' means of contraception, or indeed any means (Blanc and Way 1998). This amounts to a substantial unmet need for effective fertility control. Many women similarly have limited ability to protect themselves from HIV, not least within marriage, and especially during its early years when families are being built. The power relations which operate in this context are not absolute, and vary from place to place and according to other factors, such as the level of education of partners. But they typically serve to put women at a disadvantage. In the mid-1990s in Zambia, 65 per cent of married women considered themselves to be at risk of getting AIDS, as against 54 per cent of those formerly married and 35 per cent of those never married. Almost all of those married women who considered themselves at risk of AIDS, but for those who perceived the risk to be
Condoms are a particular issue of contention, as they can be used for both family planning and protection from sexually transmitted infection, but are associated in much of Africa (as elsewhere) with casual encounters or commercial sex. This association has been strengthened by slogans used in AIDS-prevention campaigns in many African settings, which call for abstinence prior to marriage and fidelity within it, and for any lapses through pre-marital or extra-marital encounters to be protected through the use of condoms. In Thailand and India, there have been similarly strong messages promoting the use of condoms outside marriage. The success of such campaigns makes it increasingly difficult for the condom to be promoted as a viable means of protection in sex within marriage. Meanwhile, advocacy of its extra-marital use serves in turn to reinforce the expectation that men (in particular) are liable to stray, and to underline the distinction not so much between what is moral or immoral sex (although that certainly applies in the minds of some), but between reproductive and recreational sex, the former increasingly associated with marriage and the latter with extra-marital encounters. This presumes there to be a difference between men's and women's sexual needs, with men's needs dictating the nature of sexual encounters and the roles which partners assume within them (Holland et al. 1998; Giffin 1998).

Women often emphasise their difficulty in persuading their husbands to use condoms (Bauni and Jarabi 2000; Baylies and Bujra 2000), because a request of this nature implies lack of trust. It may be easier to negotiate the use of condoms as a contraceptive, which then offers a secondary benefit of protection from HIV. But once again, the association of condoms with illicit sex can make even this problematic. Both in attempting to secure protection and trying to control fertility,
women may resort to secret means. As a woman in Baumi and Jarbi’s (2000) study in Kenya commented, such methods were essential, given that husbands only wanted sex and had little interest in family planning. Female condoms would seem to be a possible remedy, since they are ‘in the hands of’ women. In practice, however, even if they were readily accessible, it is highly unlikely that female condoms could be used without the knowledge of partners; negotiation will still be required. Moreover, in the minds of some, the female condom connotes the same association with ‘extra-marital’ sex as does the male condom (Kaler 2001). Microbicides which are also spermicides – or which provide protection against infection while permitting pregnancy – may be more promising.

It is not through secretive agency that women are likely to gain genuine control, but rather through challenging and transforming the gender relations which put them at risk in the first place. Without this, and without a change in men’s behaviour, the problem of reconciling desired fertility with protection will remain.

Fertility among women who are HIV-positive

Many women do not know whether they or their partners are HIV-positive, and often, with much imprecision, use their children’s health as a marker of their own. The anxiety a woman feels may not necessarily impact on her child-bearing, but she may wish to hedge her bets by having fewer children (Bayfies 2000; Gregson et al. 1997, 1998) or, as one woman in Minga, Zambia explained, by having them more quickly so that if she becomes ill she will already have completed her family. But what of the situation of those who wish to have children when they already know that they are living with HIV or AIDS?

The situation may have changed substantially for some women elsewhere over recent years. But in Zambia, where few women have access to technical means of conceiving safely or to medication which could prolong lives, there are strong views that HIV-positive women should not have children. As one woman in Chipapa, Zambia, said, ‘I would not have any more children if I found that I was positive. What is the point when they will end up dying?’ While it overestimates the probability of HIV transmission from a woman to her children, this is a view deeply felt and often repeated, sometimes supplemented with the rationale that the woman’s health would deteriorate should she become pregnant and she would also die ‘soon’. Such sentiments reflect strong feelings of guilt about children being brought into the world only to face a quick death, and a sensitivity to the costs borne by wider society, even if their lives are short.

Yet even where there is little or no access to new therapies, such is the combination of pressure on women to have children and their own desire to conceive that many women who are aware that they are HIV-positive continue to become pregnant, especially those who are younger or in new relationships (Kryder et al. 2000; Santos et al. 1998). In many cases this is a consequence of a deeply felt need. Reporting on a small study of 21 women in Côte d’Ivoire diagnosed as HIV-positive during pregnancy, Aka-Dago-Akribi et al. (1999) note that even though the women were ‘warned’ about the possible consequences, their desire for another child remained very strong, except among those who already had at least four. All six who had given birth to only one child wanted another, as did two-thirds of those with two or three children. Only four of the 21 were using condoms. A study of women living with HIV in France found those with African backgrounds more likely to express a desire for more children and to have a child after a positive diagnosis than Caucasian women (Bungener et al. 2000).
A larger study of HIV-positive women in Europe found a higher rate of abortions and lower birth rates among them than within the general population, but a greater chance of pregnancy among those younger and born outside Europe, underlining the extent to which reproductive behaviour is related to cultural and social attitudes (van Berthel et al. 2000). Earlier in the epidemic, Bury (1991, 47) noted that decisions about pregnancy taken by women who are living with HIV are determined by a range of factors other than their own health and that of the child. ‘She may wish to have a baby as it may be the only creative thing she has ever done. Knowledge of her HIV status and the realisation that she may die soon may be added reasons for wanting to fulfil herself in some way before she dies, and to leave something of herself after she is gone.’ Hepburn (1991, 62) commented along similar lines that while some would prefer not to risk the possibility of a child being infected with HIV, ‘Others consider having a child so important that any level of risk would be acceptable’, with cultural, moral, or religious factors exerting a strong influence over considerations about contraception or termination.

Women who become pregnant when they are aware of their HIV status may be exercising choice, and, in the relatively rare cases where technical means permit, may be able to do so while their partners remain safe from infection. Where drug therapies are available, they can also minimise the probability of HIV transmission to their children. In many cases, however, factors associated with the context in which women live mean there is no possibility of ‘choice’ or ‘control’ over fertility or its outcomes. Fear of abandonment may make women reluctant to inform partners of their HIV status, let alone change their fertility behaviour. In a study in Burkino Faso, for example, this anxiety lay behind the fact that fewer than one-third of women who had been diagnosed with HIV told their partners about the diagnosis (Issiaka et al. 2001; see also Keogh et al. 1994; Ryder et al. 1991; Aka-Dago-Aribi et al. 1999; Santos et al. 1998). Marriage or customary unions may be based on affection, but are typically also entered into and sustained for reasons of economic security, which become all the more pressing when women are pregnant, newly delivered, or have a number of young children.

Moreover, some pregnancies among women with HIV may result from pressure from their partners, even when women’s partners are informed about their HIV status (Bungener et al. 2000). Among the 45 per cent of HIV-positive women studied by Keogh et al. (1994) who gave birth over a three-year follow-up period, slightly fewer than half of pregnancies were ‘planned’, with four of these having been wanted by the male partner only. Lutalo et al. (2000) suggest that the couples they studied in Uganda appeared motivated to have children largely in order to meet social obligations, despite risks of transmission, and speculate that this might reflect the patrilineal culture of the area. Although some were using contraception, fewer than half were using condoms. Similar instances of unprotected sex have been found in other studies (Hira et al. 1990; Keogh et al. 1994; Santos et al. 1998) of couples where one or both had been diagnosed with HIV, in some cases as a consequence of their partners’ opposition to using protection.

However, this pattern is neither uniform nor universal. While a third of women in Keogh et al.’s study were not using condoms, many of the others were. Moreover, there is some evidence of condoms being used for protection, alongside negotiated attempts to conceive in as much safety as possible. Thus, Ryder et al. (2000) report on predominantly safe pregnancies among 24 couples (albeit involving one new HIV infection) where women tried to restrict instances of unprotected sex to times when they considered themselves most fertile.
But this was a case involving a high level of support from research and medical teams, which is unavailable to most couples.

**Particular problems for young, unmarried women**

Particularly complicated dilemmas arise in respect of sexual relations among unmarried young people, not least because this is an area beyond the boundaries of what many regard as ‘legitimate fertility’ (Garenne et al. 2000). Data from Health and Demographic Surveys conducted during the 1990s indicate that many – in some age groups most – young people in developing countries are not sexually active (Blanc and Way 1998) and a relatively small minority have multiple partners. Moreover, the age of sexual initiation is rising in many societies. However, the gap between age of sexual initiation and age at first marriage is increasing, marking not just the possibility of pregnancy but also the extent of potential danger of HIV infection where sex is unprotected (Blanc and Way 1998). Young women are especially susceptible to HIV infection, in consequence of physiological immaturity, higher susceptibility to other STDs, and vulnerability to non-consensual sex (UNAIDS 1999; Baden and Wach 1998).

Young people are often left in the lurch, targeted by AIDS-prevention campaigns exhorting them to abstain from sex, given incomplete sex education by schools, parents, or traditional educators, and largely excluded from family-planning campaigns (Baylies and Bujra 1999; Garenne et al. 2000). They inhabit a milieu of rapidly changing, contradictory sexual norms with mixed messages from parents, peers, and AIDS campaigners. Significantly, they are often left with limited access to means of either contraception or protection against HIV. Their first sexual encounters are almost always unprotected, and they are more likely than older people to experience contraceptive failure (Blanc and Way 1998).

For young women, choice in respect of both child-bearing and ensuring protection may be particularly problematic. Social pressures may bear heavily upon them, albeit in contradictory ways. Nyanzi et al. (2000) describe how tensions between traditional attitudes towards female chastity and modern notions of sexual freedom complicate the lives of adolescents in Uganda. Gage (1998) notes that, in several African societies, girls are under pressure on the one hand to avoid having children, and on the other to prove their fertility, whether to secure a relationship or to demonstrate themselves to be a desirable partner. Many young people are adopting protective practices, but this is less true of women than men, and, as Baggaley et al. (1997) show in their study of university students in Zambia, it is more likely to occur during casual encounters than with regular partners. Frequently, young people face the future with a high level of fatalism, adopting what appears to their parents to be a brazen attitude, but to their peers a sophisticated realism. They frequently misperceive risks and harbour false confidence about their safety. As Hulton et al. (2000) note in reference to a Uganda study, boys often see sex as natural and predominantly for pleasure and pregnancy as accidental. Adolescent girls may contrive ingenious means of dealing with potential sexual partners, yet show reluctance to introduce condoms into their sexual negotiations, conceding when their partners reject protection on grounds that it hinders male pleasure (Nyanzi et al. 2000).

**The possibility of more positive outcomes**

The dilemmas facing women who wish to bear children in safety are many and multi-faceted. A few may choose to forego the great satisfaction of having children.
Some will be fortunate enough to secure responsible partners. But most will take risks with their lives, whether after weighing up the odds and deciding that the potential rewards are greater than the probable costs, or preferring to take a more fatalistic stance. However, once women have had one or two children, they may approach the future more cautiously.

There is evidence that some women (and some men) may consider limiting the size of their families, not just in the interests of their own and their partner’s safety, but in order to maximise the welfare of their children (Baylies 2000). HIV/AIDS creates uncertainty about parents’ ability to survive long enough to ensure their children’s welfare. The fewer those children, the greater the chance that they might be reasonably well looked after by relatives. There is also evidence that some women are now choosing to leave husbands suspected of engaging in risky behaviour. In the Zambia research, a young woman in Chipapa, near Lusaka, who was living in her parents’ home and looking after her small child, first answered a question about how the threat which HIV poses might affect her child-bearing behaviour by saying she was frightened of getting HIV, and if she felt her spouse was endangering her by being promiscuous, she would not only stop bearing his children, but promptly leave him. But then she elaborated, moving from the hypothetical to the intensely personal: ‘In fact, I am divorced, because my ex-husband wanted to have two wives and brought in another woman. I am not interested in a polygamous marriage, and would sooner remain single than risk my life.’

The choice to leave a marriage is bound up with economic considerations, and is influenced by the number and age of the children. In some cases, older children are able to assist their mothers to ensure subsistence, especially in agricultural communities. In other cases, the fewer the children a woman has, the more likely she is to be able to support her family as a lone parent. The mother of a young child in Zambia’s Copperbelt explained to a research colleague how she had gone to stay with her mother at the time of the birth. On her return, she discovered that her husband had taken up with a girlfriend, who had been ‘taken home for illegally sleeping with him’. He pleaded with his wife for forgiveness, whereupon she demanded that he have an HIV test. When he refused, she left him. ‘It is better to be divorced now, when we have only one child, than when we have a lot of children,’ she said. Her friend agreed, noting that many women who might otherwise wish to do so ‘fail’ to leave their husbands because they are concerned about the future of their children (Chabala, field notes, 25 February 1999). The more children they have, the greater their sense that their children’s welfare depends on the material security which marriage affords.

In conclusion, sexual practices and identities, which contribute so fundamentally to a sense of cultural stability, often appear to be ‘permanent and natural’ (Herdt 1997, 8). Yet radical change is possible. HIV presents a challenge to sexual practices and identities, exposing their dangers. There is a certain intransigence in this area, and not a little fatalism; arguments of ‘naturalness’ and male ‘need’ prop up structures of inequitable power and privilege. Yet the sexual practices and identities of women and men are continuously undergoing change. The negative and positive potential of this change process is sharply illuminated in the face of AIDS. While young people are placed in particular danger, the greater autonomy they strive for can set the stage for a more considered approach to their future mutual survival. But perhaps the issue can be most forcefully addressed by the generation adjacent to them, and particularly by women who already have at least some children. If their husbands fail to behave ‘responsibly’, such women may determine
that for their own safety and the ultimate welfare of their children, they must go their own way. But they must, in turn, do so responsibly. Of necessity, the HIV/AIDS epidemic forces a sober look at sexual practices and identities, and the power relations which inform them. It has brought some change - although admittedly also some return to older practices. But it will require not just change in behaviour, but much more fundamental change in the nature of gender relations if conceiving children is to be safe for both women and men in future, and for their offspring.

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Notes

1 The project involved small surveys, each with 150 participants, focus group discussions, and in-depth interviews with a sub-set of the initial sample. The study was funded under the UK Government's Overseas Development Administration's (now Department for International Development) Links between Population and the Environment Research Programme. Among those involved in the research and its administration deserving particular mention are Veronica Manda, Mbozi Haimbe, Oliver Saasa, Beatrice Liatto-Katundu, Mary Zulu, Epiphano Phiri, Bornwell Maluluka, Edwin Cheelo, and Melanie Ndzinga.

2 While the primary objective of such testing is prevention of paediatric AIDS, in countries where wealth and political will exists, women found to be living with HIV infection may enjoy a secondary, fortuitous benefit via access to antiretroviral drugs. This is not only the case for women in Europe and North America, but also in countries such as Brazil (see Bergenstrom and Sherr 2000; Santos et al. 1998).

3 The studies by Bungener et al. (2000) and van Benthen et al. (2000) were conducted in the mid-1990s. It is possible that the increased life expectancy that antiretroviral regimes offer will alter HIV-positive women's calculations about having children, offering hope for more 'normal' maternity. But there is insufficient data to know how far this will be the case.

References


Santos, N., Ventura-Filipe, E., and V. Palva (1998) 'HIV positive women, reproduction and sexuality in Sao Paulo, Brazil', Reproductive Health Matters, 6(12)


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References

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