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8

Counselling and Caring for an HIV-Positive Woman

Case Study

Dr GH finds that a clinic patient, Mrs JK, who is eight weeks pregnant, tested HIV positive. Her husband also tested positive. The pregnancy is Mrs JK's first. She asks Dr GH about the risk to herself and her child, because she wants the pregnancy to continue, and whether she can have treatment that will protect the child before birth. What medical, ethical, legal, and human rights considerations should guide Dr GH's response?

1. *Background*

Twenty years after the first clinical evidence of acquired immunodeficiency syndrome was reported, AIDS has become the most devastating disease humankind has ever faced. Since the epidemic began, more than 60 million people have been infected with the virus. HIV/AIDS is now the leading cause of death in sub-Saharan Africa. Worldwide, it is the fourth-biggest killer. At the end of 2001, an estimated 40 million people globally were living with HIV. In many parts of the developing world, the majority of new infections occurs in young adults, with young women especially vulnerable. About one-third of those currently living with HIV/AIDS are aged 15–24. Most of them do not know they carry the virus. Many millions more know nothing or too little about HIV to protect themselves against it.[1]

HIV infections are concentrated in the developing world, mostly in countries least able to afford to care for infected people. Of the 40 million estimated to be living with HIV/AIDS as at the end of 2001, 28.1 million are in sub-Saharan Africa and 6.1 million are in South-East Asia (see Table III.1.1 for country data on prevalence of HIV/AIDS among pregnant women).

[1] UNAIDS, *AIDS Epidemic Update: December 2001* (Geneva: UNAIDS, 2001), UNAIDS/01.74E-WHO/CDS/CSR/NCS/2001.2, at 1–2.

2. *Medical Aspects*

No established guidelines exist for defining access to fertility care for individuals infected with HIV. However, UNAIDS and the World Health Organization published a review of what is known about HIV in pregnancy, providing suggestions on the appropriate management of HIV-positive women during pregnancy, delivery, and post-partum care, breastfeeding and infection control and safe working conditions with regard to HIV in pregnancy.[2] The United States Centers for Disease Control have issued Revised Recommendations for HIV Screening of Pregnant Women.[3]

The WHO report explains that most studies show that pregnancy does not have a major adverse effect on the evolution of HIV. However, a number of African studies have reported adverse pregnancy outcomes for HIV-infected women, and studies from some Central African countries show AIDS has become a leading cause of maternal mortality.[4]

A primary concern for this patient is her life expectancy and the risk of viral transmission to the offspring. Depending on Mrs JK's nutritional status and concurrent infections, pre-term delivery and low birth weight might be factors for consideration. Combination anti-retroviral therapy has produced radical improvements in life expectancy and quality of life for both children and adults infected with HIV in developed countries.[5] Current estimates suggest that a disease previously associated with certain death is compatible with a life expectancy of at least twenty years from time of diagnosis, if one has access to anti-retroviral therapy.

In the overwhelming majority of cases, children acquire the HIV infection from their mothers before or around the time of birth, or through breast milk. An equally great majority lives in the developing world. The gap between rich and poor countries in terms of transmission of HIV from mother to child has been growing. In France and the USA, for instance, fewer than 5 per cent of children born to HIV-positive women in 1997 were infected with the virus.[6] In developing countries, the average was between 25 and 35 per cent. Judicious use of combination anti-retroviral therapy during pregnancy and labour,

[2] J. McIntyre and P. Brocklehurst, *HIV in Pregnancy: A Review* (Geneva: UNAIDS and WHO, 1999), WHO/CHS/RHR/99.15; UNAIDS/99.35E.

[3] Centers for Disease Control and Prevention, 'Revised Guidelines for HIV Counselling, Testing, and Referral and Revised Recommendations for HIV Screening of Pregnant Women', *Morbidity and Mortality Weekly Report*, 50 (2001), No. RR-19, 1–85. Also available at www.cdc.gov/hiv/ctr, last accessed 6 May 2002.

[4] McIntyre and Brocklehurst, *HIV in Pregnancy*, 7.

[5] D. H. Watts and R. C. Brunham, 'Sexually Transmitted Diseases, Including HIV Infection in Pregnancy', in K. K. Holmes, P. F. Sparling, P. Mardh, P. Piot, and J. N. Wasserheit (eds.), *Sexually Transmitted Diseases* (New York: McGraw-Hill, 3rd edn., 1999), ch. 80, 1089–1132.

[6] UNAIDS/WHO, *Report on the Global HIV/AIDS Epidemic—June 1998* (Geneva: UNAIDS, 1998), UNAIDS/98.10-WHO/EMC/VIR/98.2-WHO/ASDF/98.2, at 48.

delivery by Caesarean section, and avoidance of breastfeeding are proven measures which have potential to reduce the risk of vertical transmission to less than 2 per cent.[7] Potential teratogenic effects of anti-retroviral drugs taken during pregnancy remain an unresolved issue. Serious adverse effects appear rare, although damage to intercellular cytoplasmic components, particularly mitochondria leading to neonatal death, has been documented.[8]

In developing countries, it is estimated that between one-third and a half of all HIV infections in young children are acquired through breast milk. According to UNAIDS, more than nine out of ten HIV-positive women in developing countries have no idea that they are infected.[9] Breastfeeding protects the infant against a range of other infections. In many developing countries, a year's supply of artificial milk for the infant will cost more than the country's per capita gross domestic product (GDP).

Reproductive assistance to HIV discordant couples can make a significant impact in preventing viral transmission. The female partner of an HIV-positive man runs a 0.1–0.2 per cent risk of acquiring HIV in an act of unprotected intercourse, and attempting to conceive naturally carries a serious risk to the uninfected woman and her child.[10] Where artificial insemination is feasible, a highly significant reduction in the risk of viral transmission is achieved if spermatozoa are first washed free of seminal plasma and non-sperm cells before insemination into the woman during the time of ovulation. Prevention of viral transmission from an infected woman to an uninfected man is less sophisticated and relies on timed artificial insemination by husband.[11]

3. *Ethical Aspects*

The International Federation of Gynecology and Obstetrics (FIGO) Committee for the Ethical Aspects of Human Reproduction and Women's Health issued a statement on Ethical Aspects of HIV Infection and Reproduction noting that HIV infection has 'profound social and psychological implications for the woman, her partner and her family as well as for the health care team and society'.[12] An HIV-positive woman is entitled to the full ethical respect due to all patients, including her right to refuse testing and to appropriate care without discrimination due to her HIV-positive status. She is accordingly entitled to autonomous choice of available medical care.

[7] C. Gilling-Smith, jun., and A. E. Semprini, 'Editorial. HIV and Infertility: Time to Treat', *British Medical Journal*, 322 (2001), 566–7.

[8] Ibid. [9] UNAIDS/WHO, *Report*, 48.

[10] Gilling-Smith and Semprini, 'Editorial'. [11] Ibid.

[12] FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health, *Recommendations on Ethical Issues in Obstetrics and Gynecology* (London: FIGO, 2000), 33.

Counselling must be non-directive as to pregnancy continuation or termination when lawful. If she decides to continue a pregnancy, the ethical entitlements of the child she intends to deliver must be considered. The WHO Report identified the following issues in counselling HIV-positive pregnant women in order that they can make informed decisions about their pregnancy.

- the effect of pregnancy on HIV infection;
- the effect of HIV infection on pregnancy: risks of adverse pregnancy events;
- the risks of coitus during pregnancy and the particular risks of STDs acquired during pregnancy;
- the risk of transmission to the foetus during pregnancy, delivery, and breastfeeding;
- termination of pregnancy options;
- treatment options during pregnancy;
- interventions available to attempt to prevent mother-to-child transmission;
- infant feeding options: the advantages and disadvantages of breastfeeding;
- disclosure of results to male partners and/or to other significant family or community members: advantages and risks;
- the need for follow-up of both mother and child;
- future fertility and contraceptive options.[13]

Although foetuses as such are not usually considered in law to be persons, ethical responsibilities apply to future persons, whether or not they are yet conceived. The prospect of the child to be HIV infected at birth, and to succumb to AIDS shortly afterwards, must therefore be included in the information given, together with the implications of continuation of pregnancy for a woman's own health and care. Information and counselling should also address the advantages and disadvantages of breastfeeding for the woman and her infant, given the resources available to Mrs JK. The FIGO Ethics Committee notes that: 'In societies where safe, affordable alternative methods of infant feeding are available, it may be unethical for an HIV infected mother to breastfeed her child. Where the risks of alternative infant feeding are high, the balance of risk to the infant may favor making breastfeeding ethically justified.'[14]

Ethical and legal challenges can arise for the health care provider regarding the patient's serostatus. Cases may arise where health care providers have competing obligations: on the one hand to protect the patient's confidentiality and on the other hand to disclose test results in order to prevent substantial harm to third parties. The FIGO Ethics Committee has explained that:

[13] McIntyre and Brocklehurst, *HIV in Pregnancy*, 31.
[14] FIGO Ethics Committee, *Recommendations*, 34.

> Every effort should be made through counselling to convince individual patients of their responsibility to others including the importance of allowing such information to be used to protect sexual partners and health care workers. If in spite of every effort, consent [to release of information] is not obtained and the risk of transmission is high in certain circumstances, with consultation, it may be justified to override patient confidentiality.[15]

The American College of Obstetricians and Gynecologists (ACOG), in a Committee Opinion, explained that 'a breach of confidentiality may be ethically justified for purposes of partner notification when 1. there is a high probability of harm to the partner, 2. the potential harm is a serious one, 3. the information communicated can be used to prevent harm, and 4. greater good will result from breaking confidentiality rather than maintaining it'.[16] This Committee Opinion explains that, when a breach of confidentiality is contemplated, the negative consequences of breaking confidentiality need to be carefully weighed. The Committee Opinion explains that these consequences may include:

- Personal risks to the individual whose confidence is breached such as serious implications for the person's relationship with family and friends, the threat of discrimination in employment and housing, domestic violence, and the impact on family members
- Loss of patient trust, which may reduce the physician's ability to communicate effectively and provide services
- A ripple effect among cohorts of women that may deter other women at risk from accepting testing and have a serious negative impact on the educational efforts that lie at the heart of attempts to reduce the spread of disease.[17]

The facts of Mrs JK's case explain that her husband has tested positive, so the health care provider will not have competing obligations regarding whether to notify him, but the issue of confidentiality regarding Mrs JK's serostatus might arise regarding health care workers. As a general matter, the ACOG Committee explains that 'Confidentiality should not be breached solely because of perceived risk to health care workers. Health care workers should rely on strict observance of standard precautions to minimize risk. The patients' HIV serostatus, however, should be transmitted to other health care professionals to ensure optimal medical management.'[18] Of course, health care workers to whom information of a patient's HIV-positive status is disclosed

[15] Ibid. 33–4.
[16] American College of Obstetricians and Gynecologists (ACOG), 'Human Immunodeficiency Virus Infection: Physician's Responsibilities. Committee Opinion Number 255, April 2001', in *Ethics in Obstetrics and* Gynecology (Washington, DC: ACOG, 2002), 43–7 at 45.
[17] Ibid. [18] Ibid.

for their own protection are bound by the ordinary duties of confidentiality not to disclose the patient's status to anyone else who is not at direct risk of exposure to the patient's body fluids.

4. *Legal Aspects*

When an HIV-positive woman decides to continue her pregnancy, she is entitled to the legal standard of care in prenatal care and childbirth. She must also be advised on breastfeeding and alternative options, including whether local law and child welfare agencies regard breastfeeding by HIV-positive mothers to present an unacceptable risk to the child, constituting child abuse.

Neither the woman nor her child should suffer discrimination on the ground of their HIV-positive status, although transfer to a conveniently accessible birthing centre that is specially equipped for HIV-positive patients will not be discriminatory. Legal duties are owed to the mother, and to her child once it is born alive, including for the quality of prenatal, delivery, and postnatal care and advice given.

Under occupational health and safety laws, health care facilities owe duties of care to staff members. For instance, a doctor must ensure that colleagues delivering prenatal, childbirth, or postnatal care to an HIV-positive woman and her baby are informed of and adequately safeguarded against the risks to them due to her HIV infection. Staff members have no legal right of conscientious objection to involvement in care of the woman or her child, but any who can show unreasonable risk to themselves or others, perhaps such as a pregnant nurse at risk of needle-prick exposure, might be excluded from duties of care if safely replaceable.

The treating physician bears no legal liability if anti-retroviral drugs or other necessary or desirable products for the care of the woman and her baby are unavailable due to causes outside the physician's control. Doctors may have a legal duty of reasonable advocacy, however, to request that others who control access to such products make them available in such cases.

5. *Human Rights Aspects*

An HIV-positive woman's rights to life and survival, under the International Covenant on Civil and Political Rights (the Political Covenant), and to the highest attainable standard of health, under the International Covenant on Economic, Social and Cultural Rights (the Economic Covenant), which includes her physical, mental, and social well-being, reinforce her legal rights to continue or terminate her pregnancy. If the choice is continuation of

pregnancy, her human right to anti-retroviral medication is protected by the Convention on the Elimination of All Forms of Discrimination against Women (the Women's Convention), which requires the provision of 'appropriate services in connexion with pregnancy, confinement and the postnatal period, granting free services where necessary' (Article 12(2)). The right of the woman to appropriate services is reinforced by the child's right to appropriate care. The Convention on the Rights of the Child (the Children's Convention) requires states to ensure the provision of 'appropriate pre-natal and post-natal health care for women' (Article 24(2)). National courts and human rights tribunals have ruled that denial of medically indicated resources and care for those infected with HIV violates the right to life, the right to security of the person, and the right to health,[19] and the right to be free from inhuman and degrading treatment.[20]

In some communities, there can be subtle and not so subtle inducements for a pregnant woman with HIV/AIDS to have an abortion. Such inducements, even if indicated on medical grounds, might be a violation of Mrs JK's right to found a family, her right to decide the number and spacing of her children, and more broadly her rights to privacy and to liberty and security of her person.[21] Alternatively, where a pregnant woman with HIV/AIDS has chosen to terminate her pregnancy, she is legally entitled to do so in countries where abortion is permitted for reasons of preservation of health or where it is permitted for reasons of HIV/AIDS status.

6. *Approaches*

6.1. *Clinical duty*

Medical care of Mrs JK, and the well-being of a child she intends to deliver, will be affected by her access to short-course anti-retroviral drugs that reduce the risk of vertical HIV transmission. Dr GH should know or discover whether such drugs can be obtained through an agency, such as a Ministry of Health, that will bear the cost or reduce it sufficiently to ensure Mrs JK's treatment at

[19] *Cruz Bermudez, et al.* v. *Ministerio de Sanidad y Asistencia Social (MSAS)*, Case No. 15789 (1999) (Supreme Court of Venezuela), http://www.tsj.gov.ve/, last accessed 6 Sept. 2001); R. J. Cook and B. M. Dickens, 'Human Rights and HIV-Positive Women', *Int. J. Gynecol. Obstet.* 77 (2002), 55–63.

[20] *D. v. United Kingdom* (1997) 24 EHRR 423 (European Court of Human Rights).

[21] United Nations, *HIV/AIDS and Human Rights: International Guidelines: The Results of the Second International Consultation on HIV/AIDS and Human Rights, 23–25 Sept. 1996* (Geneva: UN, 1998), HR/PUB/98/1, 47; for summary see Pt. III, Ch. 7. Reprinted in UNAIDS and Inter-Parliamentary Union (IPU), *Handbook for Legislators on HIV/AIDS and Human Rights* (Geneva: UNAIDS/IPU, 1999). Available at: http://www.unaids.org/publications/documents/human/index.html, last accessed 6 May 2002.

least in late pregnancy. Dr GH has an ethical and legal duty of reasonable advocacy on behalf of Mrs JK if she cannot afford and has no assured access to such drugs.

Mrs JK should be informed of the duties that Dr GH owes to the health care team members attending her, and that they have to be aware of her HIV-positive status. That is, Mrs JK must be informed that Dr GH's colleagues must know her HIV status in order to take universal precautions to protect themselves and other patients who may be at risk, but also that they will protect her confidentiality to the maximum extent possible. 'Universal precautions' are not uniform, but are related to the degree of risk of exposure. For instance, those exposed to spurting blood require masks and eye protection, whereas those only handling tubes of body samples require little more than gloves. In this case, precautions will be needed to prevent, for instance, contamination of equipment used in the patient's care, such as for natural or Caesarean delivery.

Dr GH should review the capacity of the clinic to treat an HIV-positive patient to ensure the safe care of Mrs JK, of clinic staff, and of the baby Mrs JK will deliver. If a clinic to which Mrs JK has convenient access has been specially equipped and staffed to care for HIV-infected patients, Dr GH may offer her the option to be transferred there. If Mrs JK remains Dr GH's patient, Dr GH should provide her with information and counselling relevant to her choice to continue the pregnancy. Dr GH should address means to provide Mrs JK with at least a short course of anti-retroviral medication in late pregnancy and around delivery, and counsel her regarding breastfeeding and alternatives to be considered following childbirth. Dr GH should also counsel Mrs JK regarding her future contraceptive care.[22]

Mrs JK should be advised of the advantages to herself and to the child of finding alternatives to breastfeeding. While further research is needed, concerns about the effect of breastfeeding on maternal health in HIV-positive women include the potential effects of breastfeeding and resultant weight loss on the immunity and long-term prognosis of the mother.[23] Given the increased risk of HIV transmission through breastfeeding, the feasibility of potential modifications of infant feeding practices should be discussed with Mrs JK. They include complete avoidance of breastfeeding, early cessation, pasteurization of breast milk, and avoiding breastfeeding in the presence of breast abscesses or cracked nipples.[24]

There might be social pressures on Mrs JK to breastfeed because, in many communities, if women do not breastfeed, they are suspected of having

[22] W. Cates, 'Use of Contraception by HIV-Infected Women', *International Planned Parenthood Federation (IPPF) Medical Bulletin*, 35 (2001), 1–2.

[23] McIntyre and Brocklehurst, *HIV in Pregnancy*, 26.

[24] Ibid.

HIV/AIDS. If Mrs JK decides to be open about her HIV status, and for example decides not to breastfeed, she should be encouraged to find the support she needs, through AIDS networks, in dealing with the stigma of being HIV positive.

6.2. *Health care systems obligations*

Dr GH should treat the access that Mrs JK and her baby have to necessary resources, including anti-retroviral drugs and safe alternatives to hazardous breast milk, as representative of how the health system responds to pregnancy among women with HIV/AIDS. If resources are adequate, Dr GH's effort is to maintain them. If they are not, effort, energy, and advocacy must be directed to influence the personnel and agencies able to bring them to the necessary level favourably, in order to maximize Mrs JK's potentials for survival and health, and the similar potentials of her child. Dr GH must consider how such influence can be generated and maintained, including by collaboration with colleagues, medical associations, HIV-advocacy groups, and comparable non-governmental agencies.

Laws that prohibit discrimination on grounds of disability require that Mrs JK be treated even though she is HIV positive. However, Dr GH and colleagues involved in her care should be appropriately educated and equipped for their own protection against exposure to her body fluids in her prenatal care and in continuation of her pregnancy leading to childbirth. If the local health care system concentrates treatment of HIV-positive patients in centres where universal precautions are provided, Dr GH may refer Mrs JK to the centre most conveniently available to her.

In addition to ensuring that Mrs JK has access to appropriate services to prevent the development of complications and sequelae, Dr GH might join with other colleagues to review how the national STD/HIV/AIDS prevention and control programme might be improved to ensure that women in Mrs JK's situation do not contract HIV/AIDS. They might start by examining whether their national programme is widely supported by the national leadership and wide spectrum of civil society and whether it meets the guidelines for comprehensive national STD programmes developed and revised regularly by the World Health Organization and UNAIDS.[25] A comprehensive public health package includes the following:

- health promotion to reduce risk of exposure to infection and adoption of safer sex practices, including the use of condoms and the maintenance of safe behaviours;

[25] WHO, *Management of Sexually Transmitted Diseases* (Geneva: WHO, 1994), WHO/GPA/TEM/94.1; WHO, *Policies and Principles for Prevention and Care of Sexually Transmitted Diseases* (Geneva: WHO, 1996); UN, *HIV/AIDS and Human Rights*.

- adequate management of patients with STD and their partners;
- intensified interventions in population groups with highest rates of risk behaviours;
- case finding and treatment of syphilis in antenatal populations;
- treatment to prevent eye infection in newborns.[26]

If the national programme does not meet these guidelines, Dr GH might work with other colleagues and the Ministry of Health to ensure the development, dissemination, and implementation of new guidelines.

6.3. *Social action for underlying conditions*

Dr GH may face the greatest professional challenge in resolving the obstacles to Mrs JK and her baby having access to the quality of products and care enjoyed by families in the best of developed countries. Dr GH must be engaged with medical and associated professional bodies, even at national and international levels, and with governmental and comparable agencies, to gain patients' access to affordable drugs. Collective approaches may be made to commercial and generic drug manufacturers to determine how patent laws and enlightened commercial practices can stimulate innovation in drug and vaccine therapies, and ensure affordable and equitable access to patients in need. Dr GH may focus initially on how the national government and commercial institutions in the country in which Dr GH practises can be mobilized in this effort, and how they may be inspired to international efforts to provide relief in addition to other countries and populations affected by HIV infection.

Dr GH might also explore working with women's health advocacy groups to:

- decrease the risk of contracting HIV/AIDS;
- decrease the vulnerability to contracting HIV/AIDS;
- decrease the impact of HIV/AIDS.[27]

Risk reduction strategies focus on particular behaviours and their modifications, and the remedy of situations where there is risk of HIV infection. Behaviour modification includes abstinence, partner reduction, mutual monogamy, male and female condom use, and the avoidance of high-risk sexual practices, such as anal sex and reduction of use of infected injecting equipment. Improvements in situations focus on where there is a risk of HIV infection,

[26] C. Johannes van Dam, G. Dallabetta, and P. Piot, 'Prevention and Control of Sexually Transmitted Diseases in Developing Countries and Resource Poor Settings in Industrialized Countries', in Holmes *et al.* (eds.), *Sexually Transmitted Diseases*, ch. 100, pp. 1381–90.

[27] UNAIDS, Programme Coordinating Board, *Framework for Global Leadership on HIV/AIDS* (Geneva: UNAIDS, 2000), UNAIDS/PCB(10)00.3.

such as the prevention of HIV transmission through blood and blood products, and prevention or reduction of situations where anyone is forced or induced into having unsafe sex.

An individual's or a community's vulnerability to HIV/AIDS is a measure of the ability to control the risk of infection. Factors that influence individual vulnerability include:

- particular characteristics and the overall empowerment of the individual (negotiation and refusal skills, avoidance of sexual abuse in childhood, knowledge and information),
- design and implementation of essential health services (the degree of availability of and access to services and their acceptability) for those who are most vulnerable to HIV/AIDS, including groups marginalized by such factors as stigma, poverty, race and ethnicity, and age,
- social and legal norms, such as the ability of individuals to talk frankly about sex and their ability to negotiate safe sex,[28] the degree of condemnation, acceptance, and practice of abusive or coerced sex, extra-marital sexual practices and unions, equality of men and women especially in family life, such as the legality of polygamy, and the degree of respect and protection of human rights.[29]

Individuals, families, communities and nations face the challenge of decreasing the impact of the HIV/AIDS epidemic. Impact mitigation strategies at the individual and family level include increased support for children orphaned by AIDS, and improved access to treatment for those living with HIV/AIDS, including legal services for the protection of their human rights. Impact mitigation strategies at the community level include the improvement of the capacity of organizations to carry out their activities, including outreach and the provision of care and social support to affected families. Strategies to mitigate impact at the national level include strengthening national AIDS programming and coordination across all sectors of government, external investments in health, education, and social services, and improved access to essential drugs and commodities through price or trade concessions.

The particular design of these strategies, whether aimed at the reduction of risk, vulnerability, or impact, will vary according to local and national circumstances, and will need to be tailored to particular groups, whether they

[28] G. R. Gupta, E. Weiss, and P. Mane, 'Talking about Sex: A Prerequisite for AIDS Prevention', in L. D. Long and E. M. Ankrah (eds.), *Women's Experiences with HIV/AIDS: An International Perspective* (New York: Columbia University Press, 1996), 333–50.

[29] S. Gruskin and D. Tarantola, 'HIV/AIDS, Health and Human Rights', in P. Lamptey, H. Gayle, and P. Mane (eds.), *HIV/AIDS Prevention and Care Programs in Resource-Constrained Settings: A Handbook for the Design and Management of Programs* (Washington, DC: Family Health International, 2001).

be women or men, adolescents, groups marginalized by race, ethnicity, income, or stigma. For example, care and thought are needed in understanding how social constructions of gender and sexuality affect HIV/AIDS strategies. Gender is not the same as sex. Gender refers to the widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics, and roles. Understanding how gender attitudes are specifically constructed by a culture is also important, as there can be significant differences in what women and men can or cannot do in one culture in contrast to another.[30]

Understanding the pervasive and distinct nature of gender differences, how sexuality is constructed, and how gender and sexuality interact with poverty in a community is essential in tailoring any intervention strategy to ensure the highest probability of effectiveness.[31] Gender differences exist, for example, in sexual behaviour, communication, and negotiation skills, and in partner management, in susceptibility and transmission of STDs/HIV/AIDS, in health care-seeking behaviour and access to health services, and in detection of, and in adverse health outcomes of, STDs/HIV/AIDS.[32]

Sexuality is distinct from gender yet intimately linked to it. Sexuality is the social construction of a biological drive. An individual's sexuality is defined by whom one has sex with, in what ways, why, under what circumstances, and with what outcomes. It is more than sexual behaviour; it is a multidimensional and dynamic concept. Implicit and explicit social rules, influenced by one's gender, power differences between the sexes, age, social demands for procreation often influenced by economic and social status, can influence an individual's sexuality.[33]

Constructions of women as 'good women' who are expected to be ignorant about sex and passive in sexual interactions make it more difficult for women to learn about sex and develop refusal and negotiation skills. Constructions of men assume they are knowledgeable about sex, making it more difficult for men to admit their lack of knowledge and to obtain essential information. Moreover, social norms that require men to have multiple sex partners make it more difficult for them to have monogamous relationships.[34]

Programme strategies that address gender imbalances in sexual interactions include:

[30] G. R. Gupta, *Gender, Sexuality and HIV/AIDS: The What, the Why, and the How, Plenary Address XIIIth International AIDS Conference, Durban, South Africa* (Washington, DC: International Center for Research on Women, 2000).

[31] P. Farmer, M. Connors, and J. Simmons (eds.), *Women, Poverty and AIDS: Sex, Drugs and Structural Violence* (Monroe, Me.: Common Courage Press, 1996).

[32] G. Bolan, A. A. Ehrhardt, and J. Wasserheit, 'Gender Perspectives and STDs', in Holmes *et al.*, *Sexually Transmitted Diseases*, ch. 8, pp. 117–27.

[33] Gupta, *Gender*. [34] Ibid.

- gender-neutral approaches that promote messages such as 'be faithful' or 'keep to one partner'—these are helpful because they do not reinforce gender stereotypes like using macho images to sell condoms;
- gender-sensitive approaches that begin to respond to the gender-specific needs of men and women, for example, by promoting female condoms and in so doing recognize that many women cannot require that their partners use a male condom;
- approaches, such as games, role plays, and group discussions, that attempt to transform gender roles to facilitate healthy, respectful sexuality among young men;
- empowerment approaches that try to free individuals from the effects of destructive gender and sexual norms. Examples of such approaches include empowering women with information, skills, and services relevant to sexual protection and to encourage their participation in group decision-making that fosters group identity and empowerment.[35]

[35] Ibid.