

Promoting the ‘B’ in ABC: Its Value and Limitations in Fostering Reproductive Health

By Susan A. Cohen

It is probably fair to say that at the beginning of the pandemic, preventing HIV/AIDS was all about “C”—for Condom use. Several years ago, however, social conservatives began promoting “A”—for Abstinence—as the central component of a global HIV/AIDS prevention strategy. And more recently, public health experts have begun extolling the value of “B”—for Be faithful, or “partner reduction”—as the indispensable but forgotten middle child of the “ABC” approach.

As the political popularity of individual interventions has lurched from C to A to B, it is now obvious that no one-size-fits-all approach to HIV/AIDS prevention can ever succeed for all people at all times in all countries. Nevertheless, it is clear that attaining higher levels of B—which can range from absolute mutual monogamy inside or outside of marriage to simply having fewer sexual partners, especially fewer *concurrent* sexual partners—has the greatest potential to reduce the HIV/AIDS infection rate in a population overall.

Notwithstanding its epidemiological impact, however, B alone—in whatever form it may take—has its limitations when it comes to reducing an *individual’s* risk of HIV or other sexually transmitted infections (STIs). Moreover, even in its purest form, B offers no protection at all against unintended pregnancy.

Lowering STI and HIV Rates

“It seems obvious, but there would be no global AIDS pandemic were it not for multiple sexual partnerships,” wrote U.S. Agency for

International Development (USAID) scientist James Shelton and his colleagues in the April 10, 2004, issue of the *British Medical Journal*.

Indeed, it is a simple truth that the greater the number of sexual relationships individuals have, the more likely it is that STIs, including HIV, will spread. Having concurrent partnerships, as opposed to consecutive ones, or “serial monogamy,” can increase these rates exponentially.

Relationships that overlap over long periods of time link “sexually active people up in a giant network, not only to one another but also to the partners of their partner’s partners...via a web of sexual relationships that can extend across huge regions.” So wrote Princeton

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University’s Helen Epstein in a July 2004 *New York Times Magazine* article, “The Fidelity Fix.” In contrast to serial monogamy, Epstein suggests, concurrency carries much greater risk “because it permits the virus to spread to others quickly, rather than trapping it in a single relationship for months or even years.” The prevalence of HIV infection in Sub-Saharan Africa, she concludes, is not due to the fact that people in that region have more sex-

ual partners than people in Asia or in western countries; rather, they are more likely to have ongoing simultaneous sexual relationships within a small circle of partners.

From Uganda, where HIV prevalence plummeted between the late 1980s and the mid-1990s, there is now strong evidence that positive changes occurred in all three of the A, B and C behaviors. Experts are coalescing around the conclusion, however, that most of the decline in the overall national HIV infection rate was attributable to partner reduction—both men and women having fewer casual sexual relationships. The same pattern can be seen in Thailand, which also experienced a dramatic turnaround in HIV prevalence and where the proportion of men reporting that they had engaged in casual and, especially, commercial sex dropped dramatically in the early 1990s. A similar partner-reduction dynamic seems to have occurred among gay men during roughly the same period in Europe and the United States.

Despite the moralistic overtones of terms such as “be faithful” and “practice fidelity,” the epidemiological fact of the matter is that changes in any of a wide range of B behaviors can significantly affect the rate of STIs and HIV/AIDS in a given population. Indeed, B can mean lifelong monogamy, serial monogamy, faithfulness within a polygamous marriage or an overall reduction in the number of one’s casual sexual partners, especially sexual partners who are themselves at high risk. Increases in any of these behaviors can make a large contribution to lowering the rates of STIs and HIV/AIDS at the population level.

Lowering STI and HIV Risk

Of course, a single individual may practice any number of variations on the B theme over the course of his or

her sexual life. But while even modest increases in the practice of any of them among a given population group will reduce that group's rate of disease infection, even perfect practice of the most restrictive B behavior is insufficient, by itself, to absolutely eliminate an individual's risk of exposure. True, practicing abstinence until marriage and mutual fidelity within that marriage presents the theoretical possibility of eliminating the risk of STIs and HIV. (The possibility is only theoretical, since one can only be certain of one's own behavior, not the behavior of one's partner.) For everyone else, however, the practice of B alone is insufficient to eliminate, or even necessarily substantially reduce, risk of infection.

A woman who has remained abstinent until marriage and is faithful to her husband, for example, but whose husband is either HIV-infected or is

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sexually active outside the marriage, is in fact at high personal risk of HIV infection herself, notwithstanding her own monogamy. Likewise, individual sexually active men and women can significantly slow the spread of HIV/AIDS in their community by reducing the number of sexual partners they have. Unless these individuals use condoms correctly and consistently, however, even reducing all the way to one cannot protect them from the risk of infection. These facts lead Shelton and his colleagues to conclude that "it seems important and feasible to promote monogamy and partner reduction alongside abstinence and use of

condoms." Put another way, when one no longer practices A, one must practice B and C together in order to reduce the risk and the rate at the same time.

Getting to B

If B is an important outcome, then as with A and C, the real challenge is to identify effective strategies and interventions for achieving it. And while it may seem counterintuitive, those relationships are not necessarily always direct. In the United States, for example, a growing body of research indicates that encouraging teens to abstain *and* teaching them about contraception and prevention of STIs can effectively lead them both to postpone sexual intercourse and to reduce their risk of pregnancy and disease when they do initiate sex. By contrast, most abstinence-only programs and strategies have yet to demonstrate effectiveness in delaying teens' sexual initiation or in reducing the frequency of intercourse and number of sex partners ("Legislators Craft Alternative Vision of Sex Education to Counter Abstinence-Only Drive," *TGR*, May 2002, page 1).

In Uganda, the trend toward people having fewer sexual partners that took hold in the early 1990s appears to be attributable to multiple factors and messages. President Museveni took a direct approach, urging Ugandans—mainly men—to practice "zero grazing." At the same time, Uganda billboards exhorted people to "love carefully," which carries multiple messages. Further, Uganda reinforced its ABC approach with numerous other societal initiatives, including promoting the status of women and discouraging gender violence and sexual coercion. Ultimately, according to an analysis by USAID's HIV Behavior Change Advisor Daniel Halperin, it was a combination of interventions that contributed toward breaking down some of the sexual networks that

had been fueling the epidemic, and thus increasing B behaviors.

Thailand, facing a more concentrated epidemic, achieved the same end by following a different path. That country's "100% Condom Program" requires condom use in every act of commercial sex. In fact, condom use increased rapidly starting in 1988 to become almost universal at brothels by 1993. Interestingly, as Norman Hearst and Sanny Chen explain in a March 2004 article in *Studies in Family Planning*, although "the government did not directly discourage commercial sex, ...mandatory condom use and the awareness of risk caused many men to give up paying for sex. Thai men also reduced the numbers of their unpaid casual partners." The result of encouraging condom use in Thailand, therefore, was to increase both C and B, which ultimately led to a sharp decline in the HIV infection rate.

Fidelity and Fertility

Controlling fertility is a process that can span over 30 years of a woman's life. This is a reality that is ongoing and universal, whether that woman lives in a high HIV prevalence country or a low-prevalence one. B behaviors may be epidemiologically significant in reducing STI and HIV rates within her community or country, and may be critical to reducing her own risk of disease, but they do nothing to help her time and space pregnancy. She needs C—not just condoms for HIV prevention, but condoms or other methods of contraception for family planning.

Indeed, some 700 million women—more than half of all women in developing countries—are at risk of unintended pregnancy. About 200 million of these women want to postpone, space or avoid future births but do not have access to effective contraceptive services. They account for the vast majority of the

76 million unintended pregnancies that occur in the developing world each year. Many of these pregnancies are high risk: More than a half-million women die each year of pregnancy-related causes, 13% of the deaths being attributable to unsafe abortion. Many hundreds of thousands more survive pregnancy but suffer lifelong debilitating illnesses or conditions as a result. Possessing the ability to determine the timing and spacing of one's children increases the likelihood that pregnancy can occur when it is safest and healthiest for the woman and her child.

Against the backdrop of the scourge of HIV/AIDS, however, even sustaining, let alone increasing, support for family planning services has been receding as a global health priority. This is unsupportable on its own terms. As reported in *Adding It Up*, a joint report by The Alan Guttmacher Institute and the United Nations Population Fund (UNFPA), closing the gap so that every woman at risk of unintended pregnancy has access to modern contraceptives would save the lives of an additional 1.5 million women and children annually, reduce induced abortions by 64%, reduce illness related to pregnancy and preserve 27 million years of healthy life—at a cost of just \$144 per year of healthy life.

Further, as the report notes, starving reproductive health programs of resources is also self-defeating in the fight against HIV/AIDS. As more and more HIV-positive women and men receive treatment and live longer lives, they will need access to family planning services to help them live healthier ones. Without access to condoms, for example, they risk spreading the disease to their partner. Without access to other contra-

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ceptives, women risk an unintended pregnancy that may compound the threat to their own health and life and may result in an HIV-infected infant.

Given that, at least in Sub-Saharan Africa, approximately 90% of all new HIV infection is sexually transmitted, the need for more and better linkages between STI/HIV prevention interventions and unintended pregnancy interventions is clear (see related story, page 7). Family planning providers have decades of experience in responding to the needs of women, and increasingly men, across a world of cultures. These

providers may have unique capacities, such as an expertise in dealing with the sensitivities around sexuality and confidentiality, that can benefit and inform confidential HIV testing and counseling. Likewise, developments in HIV prevention strategies involving behavior change techniques may generate new and improved ideas for helping people to use condoms and other contraceptives correctly and consistently and over a sustained period of time—an age-old challenge intrinsic to human nature that now faces new urgency.

Yet, social conservatives, including those within the Bush administration, continue to view HIV prevention and pregnancy prevention narrowly, simplistically and in a segmented way. The facts show, and reality dictates, that no single HIV prevention approach in isolation—A, B or C—is likely to work for most individuals over a lifetime. And the battle against HIV/AIDS is unlikely to be won so long as it is viewed in a vacuum, without recognizing and taking into account the everyday challenges of everyday people—millions of whom are trying to avoid HIV and other STIs *and*, at the same time, to control when and whether to have children. ☹