

Changes in sexual behaviours to prevent HIV

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Published in:

The Lancet

(www.thelancet.com)

See original article in Journal's web page:

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2806%2969712-2/fulltext#article_upsell

Cite as:

De Irala J, Alonso A. **Changes in sexual behaviours to prevent HIV**. *Lancet* 2006;368:1749-1750.

In today's *Lancet*, John Cleland and Mohamed Ali¹ offer interesting results on behaviours about HIV sexual transmission in women from different African countries. Their study is valuable for epidemiologists and public health practitioners, and has important strengths. Cleland and Ali use information from all countries in sub-Saharan Africa that have had two or more Demographic and Health Surveys since 1990 to estimate behaviour trends. Reliable information on number of sexual partners of these women was unfortunately not available, but having multiple sexual partners is a well known risk factor for HIV transmission² In fact, in different places in Africa where UNAIDS suggests HIV has declined, the success seems to be mainly attributed to the reduction of multiple sexual partners.^{3,4} If the effect of any HIV prevention strategy has to be accurately assessed, precise information about all factors determining the risk of HIV transmission is necessary. Data about the number of sexual partners is also crucial in relation to the hypothesis of risk compensation. Briefly, this hypothesis suggests that the introduction of new technological approaches to prevention could reduce the perception of risk and thus worsen the compliance with other basic preventive behaviours. In the end, higher risk taking could off set the protective benefits theoretically associated with the new approach. For example, risk compensation was cited for the initial failure of seat-belt laws to prevent road accident deaths because drivers presumed that wearing a seat belt would protect them from their riskier driving.⁵ Others have extended risk compensation to HIV prevention.⁶ Campaigns mainly focusing on condom use at the population level could paradoxically lead to an increase in risky behaviours, such as the number of sexual partners if the population perceives condoms to be absolutely safe, irrespective of sexual behaviour. The overall effect of such an intervention could be off set by riskier behaviours at the population level and thus hinder the targeted decrease of HIV incidence.⁷ A community trial in Uganda

suggested this paradoxical effect.⁸ Discussions on the ABC approach (Abstinence, Be faithful, use Condoms) for HIV prevention are regularly surrounded by controversy. Some groups or governments advocate abstinence-only programmes. At the other end of the debate, others regard promoting the delay of sexual debut and mutually monogamous sex as too naive and favour condoms as the only practical measure to prevent sexually transmitted HIV.

Beyond this debate, we are convinced that each of the three components of the ABC approach share common difficulties in their implementation.⁹ Specifically, if we think about young women in Africa or elsewhere, the same reasons that could make the implementation of delayed sexual debut and mutual monogamy programmes unfeasible also hinder the consistent use of condoms. Indeed, women's subordinate status, including violence and sexual subordination, or inequities, such as the economical inequities between men and women, are powerful determinants in the sexual spread of HIV. Preventive programmes could benefit from being comprehensive and taking the specific needs of different target groups into account.¹⁰ Cleland and Ali propose to concentrate and improve condom promotion by using the pace of change and acceptance gained by promoting condoms for contraceptive use in Africa because it seems more difficult for women to argue in favour of condoms for the prevention of sexually transmitted infections. However, as stated in a report on the feminist perspective on the ABC strategy, behaviours such as the delay of sexual debut, mutual monogamy, and condom use can be considered as "outcomes of prevention strategies" rather than "strategies in themselves".¹¹ Women and men should be empowered to make free and better reproductive choices. Policies should help improve women's status and help men reconsider cultural roles and choices that harm their health. There might be advantages in promoting later sexual debut and mutual monogamy even in settings 0

where they theoretically seem unfeasible. If the A and B risk-avoidance behaviours of the message are emphasised as more effective, perhaps those who choose risk-reduction behaviours, such as condom use, could be better informed and more aware of the slippery slope of risk compensation.

The evolving doctor

The values of medicine are not moral monuments, sculpted millennia ago, fixed and inert. They are refreshed in each generation by doctors who seek to keep their practice in tune with prevailing social mores. The new edition of *Good Medical Practice* by the UK's General Medical Council (GMC),¹ which comes into effect on Nov 13, offers a radical reinterpretation of what it calls "medical professionalism in action". It is a document of exemplary clarity and insight, a substantial improvement on its 2001 predecessor, which had quickly become out-of-touch and a hindrance to emerging new ideas about professionalism.² Sadly, the reception of this revised guidance to doctors has been unnecessarily sensationalised.³ Instead, it deserves serious and forensic reflection. *Good Medical Practice* is actually two documents rolled into one. First, it is a list of the duties of a doctor (panel). Second, it provides a longer narrative explanation of what it means to be a good doctor. The duties of a doctor do have an underpinning foundation that is reasonably firm across time. Doctors should always put their patients first, maintain a good standard of care, show respect, be honest and trust worthy, and keep up-to-date in their knowledge and skills. But the 2006 doctor must now and in the future think differently from his or her earlier counterpart. They should explicitly "protect and promote" individual and public health. The nature of the connection between patient and doctor is now a partnership, not a relationship. The doctor should

do, more to support self-care. And doctors will always be held to be personally accountable for their actions. These are the new elements in a doctor's duties. But subtle reworkings of older commitments reveal still further the profound extent of the doctor's shifting role. Doctors must not only recognise but also "work within" the limits of their competence. They must "respond to" patients' preferences, not merely respect those preferences. They must give patients the information they ask for, not only what the doctor thinks they want or need. Patients should be part of the process of reaching decisions about care and treatment, rather than only being involved in those decisions. And the threshold at which a doctor should act if he or she, or a colleague, is underperforming is now lowered. The test is not whether a doctor is "fit to practise"—a significant and burdensome judgment to make about a colleague—but whether that doctor "may be putting patients at risk".

The second part of the GMC's guidance—an explanation of what good medical practice means—also signals a dramatic alteration in balance between the doctor, the patient, and the State. The GMC defends the idea of medical professionalism, not only "in action", but also as being a defining set of ideas that supports the probity of a medical practitioner. Indeed, it is the "goodness" of the doctor, and not an abstract and disengaged manifesto for good medical practice, that is put at the centre of the GMC's thinking.

Disclosure of interests

We declare that we have no conflict of interest.

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