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ARVs and 'sex disinhibition' in SA's 7.9 million patients battling HIV

COMMENT

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THERE are currently more than 7.9 million people living with HIV in South Africa – and it is estimated that close to 4 500 more get infected every week.

Since HIV is transmitted predominantly through sex, prevention programmes are mostly designed to reduce the "riskiness" of sex or of passing on the virus during intercourse.

Unsurprisingly, the intimacy and relationship dynamic context in which sex happens remains underexplored.

More than 5 million South Africans receive anti-retroviral therapy (ART). People who are on ART effectively – meaning the virus has been suppressed in their bodies – can expect to live healthy lives.

Being virologically suppressed also means a much smaller chance of transmitting HIV on to others.

There is growing evidence that if all people living with HIV were on ART and virally supressed, there would be so many fewer new cases of HIV that we would (with time) be able to end the epidemic altogether.

As ART becomes more available, and people become more aware that being on ART can prevent onward transmission, some public health specialists raised concerns that people would engage in more frequent sex, with more partners, and all other forms of HIV prevention (such as condoms) would be eschewed.

Collectively, this increase in risky sex is known as sexual disinhibition. There were fears that this might lead to an increase in new HIV cases. The question was: does ART availability factor into people's decisions around how often to have sex, who to have sex with, and what additional protective measures they take when they were having sex (e.g. condoms)?

As part of my recent doctoral study at Stellenbosch University, I explored how women negotiate sex and intimacy in this changing HIV landscape. As receptive partners, women are biologically more at risk of HIV.

Socially, they are often disempowered and socio-economic dependence on men reduces their ability to negotiate safe sex. There are more than 4.8 million adult women living with HIV in South Africa.

My research, conducted with more than 80 households and 300 participants over 18 months, was nested in an HIV prevention trial in the Western Cape. In study communities, HIV treatment was made available to all people living with HIV, prior to changes in the South African National HIV Treatment guidelines. This research offered an understanding into how the availability of ART features in the intimate lives and relationships of women in places where HIV is most prevalent.

As an early exploration of the impact of increased access to HIV treatment on people's sexual lives, the study showed that readily available HIV testing and treatment has not yet shaped the sexual relationships of women in South Africa. The findings indicate that when women consider having sex, including who to have sex with, how often, and whether to use other forms of prevention, decisions are made primarily concerning the quality of their relationships, not HIV.

Women in my study described consensual sex as being about the well-being of intimate relationships and not about physical health and the well-being of bodies. HIV in general, and HIV treatments as prevention (TasP) specifically, did not feature as part of this intimate decision-making process.

Despite fears related to "behavioural disinhibition", there is no evidence to suggest that it was, at least at this early stage, the case. Moreover, despite their increased risk of acquiring HIV, women did not factor this into their sexual decision-making. It was also evident that they were unaware of the benefits of treatment-based prevention methods and were not yet capitalising on these new available preventative measures.

Given the findings, it is clear that there is a gap in engaging women in prevention programmes that target their needs and lives. Sexual disinhibition is not a concern, and more emphasis should be placed in engaging women in relevant interventions.

The findings indicate also that HIV as a health issue is not included in the way that women make decisions around sex.

The successful implementation of effective treatment-based prevention, when considered in conjunction with other behavioural prevention methods, will therefore require a different approach.

We need dedicated and sex-positive couples counselling and improved adherence support for people living with HIV. Other types of counselling support, including improved communication support and relationship counselling to address issues such as infidelity, trust, and sexual satisfaction for both men and women should also be considered.

It is only when people receive the necessary support that programmes, such as expanded access to HIV testing and treatment, can be rolled out and those most at risk will be able to benefit.

In many ways, the prevention benefits of ART access contradict the accepted and standing health narratives and the assumption that treatment is for making you feel "less sick", not for prevention, and that ART should therefore only be taken by those who are feeling ill. This means that health programmes need to invest in time and effort to adapt the messaging around the acceptance of HIV treatment and prevention.

In order for women to access the health and prevention benefits of HIV treatment, health implementers would need to actively engage in more intensive programmes to effectively inform communities of changes in treatment guidelines and the mechanisms of TasP.

The findings of my study suggest that a more active facility-based and media campaign might be necessary to spread the message of the preventive benefits of HIV treatment more widely because most people had not yet heard of TasP.

Previous HIV preventio approaches have been extensively promoted through massive public education campaigns and have thus become part of the accepted language around HIV.

Newer biomedical approaches to HIV prevention have not received nearly the same investment in public education or media campaigns. At the time of my study, the prevention benefits of ART were not yet well-known in sub-Saharan Africa.

TasP centred on sexual liberation and individual choice could have the potential to transform sexual decision making. If the message is embraced, women living with HIV, in particular, and their communities in general, could reconceptualise treatment as a means to ensure safe sex in partnerships and to secure broader community protection.

The efficacy of HIV TasP has been proven and accepted. For communities to really benefit from TasP, researchers will need to explore how other prevention modalities, with appropriate TasP awareness campaigns, and couples counselling can best be incorporated into national health programmes.

As we go forward to find effective treatments to curb the epidemic, it is essential we find ways to better serve and support those most vulnerable – as clients, as partners and as people seeking, using, and enjoying sex.

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