CHALLENGES OF SEXUAL HEALTH (SH) AMONG PEOPLE LIVING WITH HIV (PLHIV) IN EUROPE

Introduction
The increasing effectiveness of HIV treatment has enabled PLHIV to remain sexually active after their HIV diagnoses for many years. However, in many parts of Europe, PLHIV cannot fully enjoy their SH and rights. This article, based on the background paper developed for the WHO European Regional Counterparts’ Meeting on ‘Challenges in improving SH in Europe’ (Madrid, October 21-22, 2010) deals with the specific SH challenges PLHIV may encounter in Europe today.

Two notions serve as starting points: Firstly, while the SH needs of PLHIV are quite similar to those of their uninfected counterparts, there are also some important biological, psychosocial and contextual differences, such as the role of other sexual transmitted diseases (STIs) as co-morbidities, HIV-related stigma or difficulties with disclosure of HIV status. Secondly, there is a great diversity with respect to HIV in Europe. Underlying factors that drive the epidemic, and its epidemiological outcomes, differ largely across the countries. For instance, countries in eastern Europe now have the fastest-growing HIV epidemic in the world, and the number of HIV-positive people almost tripled between 2000 and 2009 in this region (1). There are important social, cultural and epidemiological differences among the most affected key populations including men who have sex with men, migrants from regions with endemic regions (1). Migrants often present late for HIV testing, already at advanced stage of HIV disease. This jeopardizes their health prognosis, and is a missed opportunity for HIV prevention. Asylum-seekers and refugees may have specific needs in relation to SRH, such as their culturally grounded desire to have children, or unmet family planning needs when arriving from their country of origin. Culturally-sensitive and migrant-friendly SRH services should be scaled up and community mobilization efforts strengthened, since migrants often have difficulties accessing health systems in their host countries due to their vulnerable socio-economic position, HIV-related stigma and specific language and cultural barriers.

People who use drugs
Intravenous drug use (IDU) is a driving factor behind the HIV epidemic in many European countries, especially in eastern Europe where 45% of all HIV cases are due to IDU (1). Most relevant for good SH of HIV positive people who use drugs is access to HIV treatment and opioid substitution therapy, both of which has been shown to be restricted. While IDUs have comprised up to 80% of all HIV cases in some eastern European countries, they constituted less than 40% of those receiving treatment (1). PLHIV who use drugs also need specific SH support, such as treatment of STIs, support for safer sex, family planning, and harm reduction measures.

Sex workers
Sex work has become an increasingly important factor in the HIV epidemic in some regions in eastern Europe. Sex workers may face multiple risks: transactional sex for supporting drug use may link HIV infection, drug use and sexual transmission. In addition, sex workers may have an increased risk of sexual violence or may have been forced into sex work because of their migration status. To meet their SH needs, sex workers need access to HIV testing and HIV treatment, when diagnosed HIV-positive, but also to comprehensive and integrated services, such as psychosocial and psychosexual support and medical check-ups for STIs.

Young people
Eastern European countries are faced with much higher numbers of young PLHIV than western Europe, due to inequity in access to HIV treatment, among other reasons. In Bulgaria, for instance, almost two thirds of all people living with HIV are between 15 and 29 years old (1).
Young PLHIV are confronted with specific SH challenges at a very sensitive time of their development: developing a sexual identity while having to cope with HIV. This poses challenges mainly for care facilities, such as adherence to medication, clinic visits, disclosure to peers and sexual partners, condom use and family planning. Besides quality HIV care, that should integrate SRH issues relevant to the adolescent transition period, young PLHIV should be able to experience the same gender-specific, developmentally appropriate sexuality education as all young people.

**Recommendations**

The following recommendations arose from the working group discussions during the meeting.

- **International organizations** should promote SH for key affected populations. More than 15 years after the International Conference on Population and Development in Cairo (1994), there is still no consensus definition of SH. A jointly agreed definition of SH and rights would greatly support many stakeholders. There are many international evidence-based guidance documents and tools available that aim at SH promotion for PLHIV, but they need to be disseminated more widely, and translated into local languages.

- On the level of **service provision**, the need for integrated services was confirmed. SH check-ups (e.g. for human papillomavirus infection and related cancers, as well as for other STIs), and SH counselling should become an integral part of routine service provision. For instance, a minimum set of validated standard questions to assess patients’ SH could be helpful. Integrating SH counselling in routine service provision requires improved capacity, training of service providers and stronger interdisciplinary cooperation between different professions. Currently, many service providers deliver ‘positive prevention’, but very rarely does it encompass a comprehensive, rights-based definition, nor does it involve PLHIV in determining how these services are delivered. Problems identified also relate to reproductive health. Across Europe, PLHIV do not all receive the same treatment and cannot exert the same rights as people who are (assumed to be) HIV negative. Gaps were noted in areas such as assisted reproduction, infertility treatment, and sexual counselling for safe and satisfying sex lives.

- Since many contextual components influence SH, recommendations for governments and policy-makers closely relate to legal conditions. Governments should be supported not to criminalize PLHIV. In this sense, the Swiss statement has delivered supportive evidence, but has not yet significantly impacted national legal frameworks. All regulations of mandatory HIV testing should also be removed; testing and counselling should be scaled up in the eastern European regions, however, not pursuing HIV detection alone, but as a tool to achieve universal access to HIV treatment and care. As stigma and discrimination are of widespread concern throughout Europe, issues of solidarity with PLHIV should be supported instead, for instance by targeted public awareness campaigns.

- Finally, recommendations for the **civil society** referred to the needed recognition that non-governmental organizations (NGOs) have an important role in advocacy, especially in confronting stigma and discrimination, and the criminalization of HIV transmission. This recognition must also be reflected in government support, since the NGO sector in the HIV field has been fighting for financial survival. Yet, civil society plays a vital role in the psychosocial support, which enables PLHIV to take better control of their SH and well being.

**References**


