EUROSUPPORT V

“Improving the sexual and reproductive health of persons living with HIV in Europe”

Institute of Tropical Medicine in co-operation with Sensoa

NEWSLETTER NR. 6

CONTENT of this Newsletter:

This project is financially supported by the European Commission's Public Health Programme, Grant agreement nr. 2004314

Brief introduction

Eurosupport V project

The Eurosupport project aimed at gaining scientific insight into newly emerging HIV-related problems by using a flexible and multidisciplinary approach. With the support of the European Commission, an international expert network had been set up to carry out targeted empirical research on the needs of persons who are living with HIV. Fourteen European countries participated. The Eurosupport initiative started in 1996. Four research projects (Eurosupport I – IV) have run since then.

The current Eurosupport V research project (2005-2008) focused on sexual and reproductive health (SRH) of persons living with HIV (PLHA), with special emphasis on secondary prevention. Appropriate tools were developed to assess problems and needs in these areas. On the basis of the results, criteria for SRH services targeting PLHA and their partners were developed. Furthermore we aimed at identifying existing service provisions centres in Europe and developed policy and service recommendations built on evidence-based-practices. Eurosupport V was coordinated by the Institute of Tropical Medicine and Sensoa, Belgium.

The Eurosupport V project ran from March 2005 until June 2008.

The final Eurosupport V newsletter: main results of the project phases

The Eurosupport Newsletter was disseminated biannually by Sensoa. Although the previous Eurosupport V newsletters included project related information as well as sexual and reproductive health related topics, this last Newsletter is fully dedicated on project related information.
A general overview of the Eurosupport V research project is described in the first part of this newsletter. In the following parts, the main results per research phase are described in more detail. Project reports are currently developed and will be available soon on the Eurosupport V website.

Subscription and more detailed information of the EUROSUPPORT project, visit the website: http://www.sensoa.be/eurosupport

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I. General overview of the Eurosupport V project

Introduction

The Eurosupport V project had been established as an expert and research network that unites HIV treatment centers and patient organizations in fourteen European countries. This expert network carried out qualitative and quantitative research on sexual and reproductive health (SRH) related problems and needs of persons who are living with HIV (PLHA).

Eurosupport V had been set up because research had shown that PLHA have many unmet needs regarding sexual and reproductive health topics. Effective HIV treatment has profoundly changed the life of PLHA. While overall mortality decreased, PLHA are facing the challenge of integrating HIV into their daily lives. Having satisfying social and sexual relationships contributes substantially to the overall quality of life. PLHA have to deal with issues such as:

- How to find a new partner?
- How to disclose their serostatus?
- How to deal with the fear of infecting a partner?
- How to integrate safer sex into a rewarding sexual relationship?
- Which family planning methods are suitable?
- What about desiring children and getting pregnant?

Project objectives

General project objectives

The project's general objective was to promote the SRH of PLHA and to prevent further transmission of HIV to their sexual partners by addressing health determinants that contribute to adopting healthy sexual lifestyles.

The project aimed at preventing transmission of HIV and other STIs from PLHA to their sexual partners. The projects general objectives were:

– To improve current strategies of secondary prevention targeting PLHA (i.e. supporting PLHA in adopting safer sex practices);

– To empower PLHA to take informed choices about fertility-related issues (such as family planning and pregnancy-related issues).

The general objectives contribute to further increasing the quality of life of PLHA. In addition, improving secondary prevention will also significantly enhance current primary prevention efforts.

Specific project objectives

(1) Identification of SRH needs of men and women living with HIV. By developing and utilising appropriate methodologies, we identified needs, as well as potential resources and barriers with respect to adopting and maintaining safer sex behaviour, taking decisions on fertility- and pregnancy-related issues.

(2) Identification and analysis of service provision across Europe that effectively address these issues and/or that effectively combine SRH programmes with HIV/Aids services.

(3) Development of policy recommendations in an integrated field of HIV/Aids and SRH, and their dissemination them among the Member States.

(4) Setting up a network of experts and expert organizations in the area of SRH and HIV/Aids in the Member States of the European Union including the acceding states.

While objective 1 and 2 refer to the actual research process carried out within the project, objective 3 refers to conclusions and recommendations based on the evidence gathered. Objective 4 finally refers to the EUROSUPORT network already existing and to be expanded within the current EUROSUPPORT initiative.

Research questions to be addressed in the framework of the project

(1) What are predictors of sexual high-risk behaviour among PLHA?

(2) Taking a comprehensive definition of SRH into consideration, what are specific support needs of PLHA (e.g. contraceptive needs and family planning; avoiding relapse behaviour and maintaining safer sex behaviours, etc.)

(3) How can optimal strategies for delivering risk reduction counselling in HIV care settings be defined (based on assessed evidence of SRH-needs of PLHA)?

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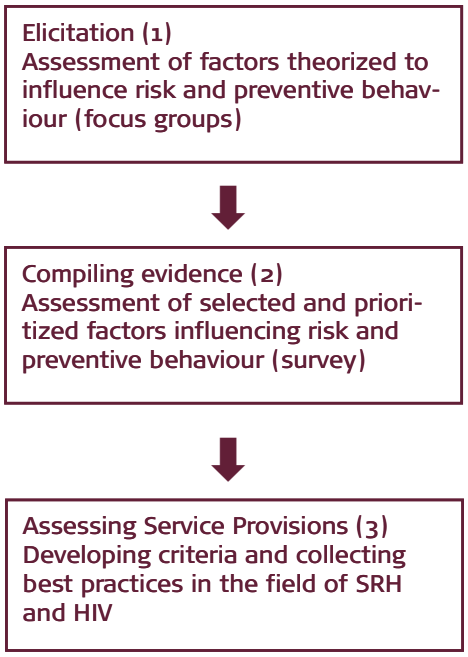
Methodology

Figure 1: Involving three steps of data assessment



Data assessment step 1: Elicitation research using focus groups

Previous EUROSUPPORT methodologies used only quantitative data collection methods such as self reported questionnaires. In order to assess accurately the research topic, which included sensitive and ambivalent issues such as dynamics of risky sexual behaviour, and its inter- as well as intrapersonal dimensions, as well as socially undesirebale behaviour (e.g. unprotected sexual activity) the Eurosupport V project started with an elicitation research phase adopting qualitative research methods such as focus groups.

Using focus group methodology, issues relevant to SRH needs of PLHA and to prevention for positives were addressed in various settings and with various target groups, such as homosexual men and heterosexual women. A series of focus groups was also carried out among health care workers to determine the feasibility of prevention for positives within clinical care settings and the preparedness of the providers.

For these target-groups a common focus-group guideline was developed containing general questions as well as target-group spefic questions. The guideline was drafted in English and translated into the different languages. A manual was developed to support the study group members in conducting focusgroups and to achieve comparable data throughout the participating countries.

Focus group sessions were audiotaped and transcribed, to enable subsequent analytic induction and comparative analysis.

Data assessment step 2: Compiling evidence in general populations of PLHA using quantitative data collection

Based on the results of the focus groups a self-reported questionnaire was developed to assess data cross-sectionally. Using this questionnaire, a survey was carried out to assess the problems and needs related to SRH among PLHA.

Objectives of the self-reported questionnaire corresponded to the above mentioned research objectives. Two areas were emphasised, i.e. sexual risk reduction behaviour and contraceptive behaviour. Contingent on the outcome of the qualitative data assessment in both areas questions were framed according to the three identified factors contributing to behavioural change, i.e. information about sexual risk reduction/contraceptive behaviour and fertility, motivation and intentions about related behaviour change, behavioural skills and obstacles to consistent use of safer sex means and contraception. In addition, variables on sociodemographic characteristics, psychological factors and some selected medical parameters relating to HIV and diseaese progression were collected.

Data obtained reflect a more general picture of sexual risk behaviours, its determinants, as well as feasible ways of reducing them in the context of professional HIV-care and support. Questionnaires were drafted in English, translated by the participating teams.. This instrument was piloted in a sample of HIV+ patients, adapted on the basis of the pilot results and subsequently used within the general population of PLHA being followed at the various HIV-tretament centres represented in the Eurosupport network.

Ethical approval on the organisational level (dependent on the respective institutational requirements of the participating centres) was obtained. Every respondent gave informed consent and received an anonymous, self-reported questionnaire from their treating physician. They were asked to fill it in, and send it back to the co-ordinating centre. By the end of the data-collection period, 1212 questionnaires were returned.

Data were entered and analysed centrally by the coordinating centre. The data-base will be made available to all interested study group participants upon request and after approval of the ES V study group.

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The following data-analysis procedures were performed: a descriptive analysis of the SRH-needs assessed, a bivariate analysis of demographic, psychosocial and HIV disease factors associated with specific outcomes (e.g. sexual risk behavior, unintended pregnancies, desire to have children...), a multivariate analysis (logistic regression) to predict the selected outcome variables.

Data assessment step 3: Assessing Service provisions and developing policy recommendations

The third phase focused on collecting data on sexual and reproductive health service provision (SP) for PLHA. Main task of this work package is to provide an overview of the existing services who are working on Sexual and Reproductive Health (SRH) topics. To assess which sexual and reproductive services were offered to PLHA and in what manner these topics were included into the services. Criteria for assessing service provision in an integrated field of SRH were developed on the basis of the qualitative research, and have been used to develop a service provision (SP) questionnaire. These qualitative criteria, were used to identify those SRH services in the field of HIV that most adequately meet the sexual and reproductive health needs of PLHA.

II. Main results data assessment step 1: Elicitation research

15 study sites from 12 Western and Central European countries participated in this qualitative research on how to improve sexual and reproductive health (SRH) of PLHA. Results presented here stem from the first phase in the above described three step research . These data were used to conceptualize the quantitative data assessment (development of a self-reported instrument) as well as to develop criteria to assess Service provisions in the field of SRH.

Research Questions

1. What are major problems of PLHA relating to their sexual and reproductive health?

2. What are determinants of the adoption of protective SRH-related behaviours (prevention of HIV and STDs and fertility-related decision-making)?

3. What are barriers with respect to adequate service provision to PLHA in the field of SRH?.

Methodology

Methodology of grounded theory[1] was used. Data were collected using focus group technique with both health care workers (HCW) and service providers (SP) and PLHA. A common topic guide was developed and used in all countries, also a manual for standardized data collection procedure was developed. Primary data analysis was done on country level in the different languages, either manually or using software packages. Qualitative data were provided as second codes (including a detailed description of the categories). These data plus a short narrative interpretation were translated into English (including back translation for validity check) for further data synthesis. Meta-ethnography[2] was applied to arrive at a cross country synthesis. An analytical matrix for cross country analysis was prepared during a data workshop with country teams present to develop the line of argument; subsequently, data were validated by all study group members. Results constituted an in-depth analysis of SRH-needs of PLHA, and served for further hypothesis building and questionnaire development for subsequent quantitative data collection (see point III).

Findings

A total of 37 focus groups (21 with SP and 16 with PLHA) were conducted; as some countries encountered substantial difficulties in recruiting FG participants due to HIV-related stigma and organizational problems, a total of 20 additional face-to-face inter-

1 Strauss A & Corbin J (1990). Basics of Qualitative Research: Grounded Theory Procedures and Techniques. Newbury Park, CA: Sage

2 Noblit GW, & Hare RD (1988). Meta-ethnography: Synthesizing Qualitative Studies. Qualmitative research methods series 11. Newbury Park, CA: Sage

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views were carried out. To add to the multi-method approach, one country (Slovakia) organized an e-mail discussion with PLHA.

Data were analyzed looking at differences between service providers and PLHA, as well as looking at similarities and differences across the countries.

Major problems of PLHA relating to sexual health

- Gaps in knowledge on HIV transmission, in particular in relation to undetectable viral loads, and specific sexual practices
- Gaps in information about STIs (sexual transmitted infections) other than HIV
- Individual sense of responsibility for protective behaviors and safer sex norms
- Lack of communication skills about sexuality
- Difficulties with HIV disclosure
- Lack of intimacy and sexual abstinence (difficulties to find a sexual partner)
- Lack of sexual communication and negotiation skills (gender-differences!)
- Sexual problems (reduced libido, problems in sexual arousal, erectile problems, reduced sexual pleasure, sexual aversion, pain during sex) in relation to duration of HIV-infection and/or medical treatment

Major problems of PLHA relating to reproductive health

- Gaps in knowledge on mother-to-child transmission
- Desire to have children
- Access to assisted reproductive technologies to plan pregnancies while reducing the potential risk of HIV-infection to sexual partners (in case of sero-discordant couples) and the unborn child
- Contraceptive needs and prevention of unplanned pregnancies
- Contraceptive failures leading to abortion
- Difficult access to family planning services

The following section summaries the main emerging topics for determinants influencing the adoption of "healthy" sexual behaviors:

This qualitative study provided insight in the problems of PLHA relating to their SRH, as they need to adhere to safer sex on a life-long basis. In addition, fertility-related needs were high on the agenda for all heterosexual PLHA. Next to adherence to complex medical regimens, which by many was perceived as influencing sexuality, dealing with SRH-issues constitutes a major challenge in coping with HIV disease.

Factors influencing the adoption of protective sexual behaviours, either in relation to oneself or to protect the health of one's sexual partner, were summarized on a continuum from intrapersonal, interpersonal, provider-related , to social factors.

Respondents participating in this study perceived information as a necessary prerequisite to protective behavior, and gaps with respect to knowledge and information were identified. However, providing sufficient information did not remove fear and concerns among PLHA about infecting sexual partners. Instead, taking responsibility for protecting a sexual partner and oneself was more directly related to adopting safer sex practices, and so was social support (by the partner, a specific peer group, or lifestyle related community). In addition, healthy and constructive coping styles were also associated with protective behaviours.

HIV-disclosure was another determinant of healthy sexual behaviors, as it may enable partner to communicate about precautions to be undertaken in a sexual context. Some FG participants reported deliberate decisions not to disclose, as they placed equal responsibility on the partner. In general, disclosure seemed to be closely linked to the partner's sero-status.

Gender-specific as well as cultural determinates influenced the individuals' ability to negotiate protective behaviours. Whereas for gay men SRH-decisions constituted a choice, it was rather defined as a risk for migrant women, which they poorly could control. In addition, fertility-related desires compromised safer sex choices, if there was no access provided to accurate information and adequate reproductive services.

Stigma and HIV-related discrimination were perceived as factors influencing the ability of PLHA to address SRH on various levels, be it the sexual partner, the family, the community, or the health care providers. While normalization of HIV has occurred to various degrees across the European countries, this did not translate into personal behaviors.

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With respect to barriers in service provision, policy issues both on the organizational level as well as on the level of health care policies played a role. While service providers perceived themselves as not sufficiently trained to provide SRH services, PLHA expected them to address these issues as an integrated part of a comprehensive bio-psycho-social care model.

Discussion and conclusion

Prioritized problems and needs relating to SRH, as they merged in this formative research, were quantified in the next research phase of the EUROSPPORT V project. In addition, conclusions were drawn on the basis of the qualitative findings:

Tailored approaches are needed that assist PLHA in their choices relating to healthy sexual behaviors and fertility related decisions. SRH-needs may vary throughout different stages of HIV-disease, relating to the progression of the disease (e.g. diagnosis, starting with ARV-therapy, occurrence of periods of illness, etc.) and the psychosexual adaptation to living with HIV.

Our data show that there is need for including counseling on SRH in standard HIV care in Europe. While intensified sexual counseling among HIV care providers is considered necessary, service providers working in an integrated field of SRH and HIV require training to better understand the SRH-related needs of PLHA. A stronger integration of HIV- and reproductive health services should improve care for women and couples living with HIV.

Speaking of HIV and reproduction techniques, not only family planning and counseling have to be addressed, but also the possibility of safe termination of unwanted pregnancy. Unsafe abortions need to be eliminated. This includes that women should have free access to all existing medical structures, that they can decide freely and that counseling should also include the issue of pregnancy termination.

Some people find the news of a pregnancy very confusing, especially if a pregnancy was not planned. Some people find out that they are pregnant while knowing their HIV diagnosis, others learn only that they are HIV-positive during antenatal care. Confronted with such situations, women (and couples) have to take difficult decisions within a short span of time. People who find themselves in similar situations (e.g. the future mother, father or both) need to be prepared to face different emotions, from deciding whom to tell about the pregnancy to coping with the often contradicting reactions from people close to them and others. For instance, because many people still hold prejudices against PLHA who want to have children. This means that creating a good support system for persons with HIV (or the couple) is of utmost importance.

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An article based on these data is currently in press:

Nöstlinger C, Gordillo V , Borms R , Murphy C, Bogner JR, Csépe P, Colebunders R and the EUROSUPPORT Study Group (2008): Differences in Perceptions on Sexual and Reproductive Health between Service Providers and People Living with HIV: A Qualitative Elicitation Study. Psychology, Health & Medicine. In press.

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III. Main results data assessment step 2: Understanding sexual risk behaviour among people living with HIV

Introduction

There is both clinical and empirical evidence that sexual risk behaviour among people living with HIV/AIDS (PLHA) is more prevalent than several years ago (Williamson et al., 2006). More specifically, there has been an increase in incidence of HIV and STI's (Janier, 2005). It could be concluded that safer sex practices have been adopted to lesser degrees then before.

Several causes can be postulated for this behaviour, such as: a higher prevalence of HIV (increasing the chance that people have sex with a HIV-positive person), HIV-prevention fatigue, therapy-optimism (reduction of the fear to contract HIV due to the availability of affective antiretroviral treatment), other factors relating to antiretroviral treatment (in instances where they may cause sexual problems which in turn may lead to unsafe sex), limited knowledge on the health risk of specific sexual practices in the general population, as well as peer-group pressure in specific sub-cultures (Walsh, 2005).

Several variables are known to influence sexual risk behaviour. Biological, psychological and contextual factors may contribute to the onset and maintenance of this behaviour.

Within the Eurosupport V project we examined the correlates of sexual risk behaviour by concentrating on factors that are potentially modifiable in a clinical setting. On the basis of the evidence on factors determining sexual risk behaviour, tools can be developed to support PLHA to practice safer sex, and sustain it over time. The latter, however, is subject of a pending project proposal for a follow-up. Moreover, research on factors that make PLHA specifically vulnerable to high risk sexual practices will make it possible to detect persons with a higher risk earlier (secondary prevention task) and support them more adequately.

Methods

In order to select relevant variables, a literature review was conducted to detect the related factors to sexual risk behaviour.

A cross-sectional retrospective design was used. An anonymous standardized self-reported questionnaire was developed, pre-tested and distributed to consecutive patients in all participating treatment sites. Filling in the questionnaire was voluntary and done on an anonymous basis. Ethical approval was received at the coordinating centre (Institute of Tropical Medicine in Antwerp, Belgium) and informed consent procedures were applied contingent on the respective requirements of the participating centres.

Variables assessing sexual risk behaviour and specific aspects related to it stemmed from to the "Information-Motivation-Behavioural skills model" (IMB; Fisher at al. 2002) with some added variables identified on the basis of previous elicitation research outcomes (mental health, social support, service provision). Where appropriate, the questionnaire contained validated scales: for measuring depression, anxiety and stress, the DASS 21-item version was used (Lovibond, P.F. & Lovibond, S.H, 1995; Brown et al., 1997; Antony et al., 1998) and for social support the SSI (Timmerman, Emanuels-Zuurveen & Emmelkamp, 2000).

In total, about 300 variables were assessed. The following sections will focus on the significant results.

Results

The sample included 1212 HIV-positive respondents. Of these respondents, 24% were female, and 76% male (18% heterosexual men, 58% men having sex with men or MSM). Response rate was 39%.

Sample characteristics

The mean age was 39.1 years for women, 42.1 years for heterosexual men and 43.5 years for MSM (p=.000). The groups also differed significantly with respect to 'living status', as significantly more MSM lived single: of women, 27.7% lived single, of heterosexual men 24.6% and of MSM 46.7% (p=.000). When looking at the financial situation, 51.5% of women had financial problems, versus 35.1% of heterosexual men and 31.5% of MSM (p=.000).

Focusing on health-related variables, 17.5% of women used illicit drugs within the past 3 months. Twenty-six percent of heterosexual men and 36% of MSM used them (p=.000). The desire to have a child differed significantly between the groups: 43.9% of women, 41.1% of heterosexual men and 10.4% of MSM feels this desire (p=.000).

Having fewer partners as strategy to reduce the sexual risk was adopted by 11.7% of women, 12.8% of heterosexual men and 24.6% of MSM (p=.000).

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Experiences with SRH service provision

Experiences with HIV-related discrimination were not significantly different between women, heterosexual men and MSM (p=.109). Satisfaction with organisations that offered sexual and reproductive health-related services (score range 1-10), however, was significantly different between women (mean score 6.24; median 7), heterosexual men (mean score 6.49; median 7) and MSM (mean score 6.83; median 8) (p=.048). Complaints about these services were not different between the groups. Main complaints were (1) "Caregiver doesn't ask actively enough about sexual- and reproductive health-related issues" (24.6%) and (2) "There's not enough time" (20.1%).

Sexual risk behaviour

Sexual risk behaviour was operationalised as a dichotomous variable. It was defined as 'unprotected vaginal or anal intercourse within the past 6 months'. Overall, thirty-two percent of the sample displayed sexual risk behaviour. This differed significantly between women (31%), heterosexual men (25%) and MSM (37%).

The main difference in sexual risk behaviour between MSM, women and heterosexual men, was found in sexual risk behaviour with casual partners (MSM 25%, women and heterosexual men 6%).

Using bi-variate statistical analysis, sexual risk behaviour was tested in the 3 groups: women, heterosexual men and MSM. For each variable within these groups, we checked if it was significantly related to sexual risk behaviour. For women, unprotected sexual activity was mainly explained by having a child wish (p=.001) and by being younger (p=.005), for heterosexual men by being less educated (p=.006) and having a decreased anxiety level (p=.046), and for homosexual men by use of different kinds of illicit drugs (p=.000) and erection-enhancing medication (p=.000).

Conclusions

Our data show the huge need for including diversified counselling strategies on sexual risk behaviour in standard HIV care in Europe, as different risk factors explain unprotected sexual behaviour among women, heterosexual men and MSM respectively. Counselling tools should take the diversity of risk factors and vulnerability into account and should be tailored to the individual and couple context. A better integration of HIV- and reproductive health services should improve care for women and couples living with HIV.

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IV Main results data assessment step 3: Service provision

Introduction

Within the framework of the Eurosupport V project, focusing on improving the sexual and reproductive health of PLHA, we aimed at making some recommendations on how to improve sexual and reproductive health service provision in HIV care. As a first step in compiling these recommendations, an overview of what services are offering at that moment was gathered by means of a questionnaire in the third research phase of Eurosupport V (ES V).

Methods

‚A Service Provision (SP) Questionnaire based on the results of the elicitation phase (ES V), was developed to identify which sexual and/or reproductive health services were offered by HIV and family planning centers. We focused on the level of the actual service provision, often located at smaller units or departments within larger scaled organizations, such as hospitals. The SP questionnaire was drafted in English, sent to study group members to provide feedback, and pre-tested. Heads of departments were contacted by the Eurosupport study group members, informing them about the study and motivating them for cooperation. The SP questionnaire was made available online, but there was also the opportunity to fill in a paper version. After five follow-up interventions and data cleaning, the analysis included 61 departments. On a total of 184 departments being asked to cooperate, a response rate of 33.1 % was obtained (61 departments). These departments were subdivided into three categories: medical organizations, sexual health and family planning organizations and support organizations.

Results

In general, departments invest most of their time on medical issues. When we compare time spent on sexual health issues and reproductive health issues, we see that departments dedicate substantially more time on sexual health issues (18.5%) compared to reproductive health issues (9.6%). Although most departments perceive their time allocation as more or less ideal, almost a quarter of the departments believe changes in time allocation had to be considered. They would like to spend more time on sexual health in general, HIV testing, reproductive health issues and psychological issues.
Shortage of staff, lack of specialized staff, time pressure and lack of an integrated approach are identified as hindering factors in achieving a more ideal time allocation. Furthermore, grey areas legal issues (i.e. conception and abortion) make it difficult to include (more) reproductive health issues.

Sexual health topics, mentioned most often by service providers as being included in SRH services to PLHA, include the protection of the PLHA, i.e. not contracting another STI or treatment resistant HIV strains. However, responsibility issues related to the protection of the partner(s) are also frequently included in the services to prevent onwards HIV transmission. When HIV disclosure was included as a topic in counseling and care, it related mainly to support in disclosing the HIV status to the main partner (72%) compared to disclosing to occasional partners (57%).

Looking at reproductive health topics, the most salient issue is HIV transmission during conception. This is almost always (by 93%) discussed and implemented by departments that include reproductive health issues into their services. In addition, information concerning HIV transmission to the (un)born child is also frequently part of the services for PLHA within these departments, i.e. not passing HIV to the child during pregnancy, conception, labor and after birth.

In addition, we observe a trend to include general reproductive health-related information. However, this information is rarely tailored to cultural differences in the patient population of the service. Topics relating to conception, contraceptives and abortion are frequently covered. However, only a minority of the departments informed on the financial consequences (costs) for PLHA related to these medical interventions, i.e. costs of assisted conception, cost of contraceptives and cost of an abortion.

To include sexual and reproductive health topics into the services of the department, the majority of the departments discussed these during a face to face consultation with the client. In addition many departments distribute flyers or brochures on these topics to PLHA.

In most departments, health care providers as well as PLHA take the initiative to discuss sexual and reproductive health topics. Even though taking the initiative seems to be viewed as a shared responsibility in most departments, sexual health topics (44.2 %) are more often discussed on initiative of the health care provider than reproductive health topics (11%).

More than ¾ of all departments believe the initiative to talk about sexual and reproductive health topics, should be taken by both the health care provid-

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ers and the PLHA. A minority of the departments believes only PLHA should be responsible for putting sexual health topics (3.8%) and reproductive health topics (5.4%) on the counseling agenda.

Guidelines

Our data reveal that the majority of the departments did not use a guideline or a state-of-the-art protocol to implement sexual health topics (almost 80%) and reproductive health topics (82.35%) into their service provision. However, using guidelines can help departments in taking on an evidence-based integrated approach to optimize sexual and reproductive care and support to PLHA.

Three guidelines are mentioned in our study by departments who did use a guideline to implement SRH topics. Due to this small number of identified guidelines in the research, a literature study is conducted to identify additional existing guidelines. In total 8 guidelines are examined. The additional guidelines (or topics within the guidelines) are selected on the following criteria: relate to sexual and/or reproductive topics; or relate to more organizational aspects of service delivery. Another aim in including guidelines in our search is to combine guidelines on HIV in pregnancy, sexually transmitted infections in people living with HIV, syphilis and HIV and on post-exposure prophylaxis. The guidelines are intended for use by healthcare staff in various disciplines, including gynecologists and staff in primary care, fertility experts and all those involved in the care of HIV positive individuals. They can also be of use to a wider audience including policy makers or public health specialists, as they also refer to structural levels. Last but not least they are also of use for communities or individuals living with and/or affected by HIV, who ultimately, are the target group for these guidelines and should benefit of improvements achieved by evidence-based practice. Guidelines thus cover principles and policy actions on different levels. Additional SRH guidelines focus on human rights and empowerment, infrastructure, financial and scientific aspects, individual topics such as psychological aspects, sexual dysfunctions, risk behaviour ..., but also PEP, disclosure, antenatal care, Family Planning and Conception, termination of pregnancy issues, counseling etc. Guidelines also raise more context related issues such as criminalization.

Guidelines that were examined:

- "Are you being served: New tools for measuring service delivery", The International Bank for Reconstruction and Development / The World Bank, Edited by Samia Amin, Jishnu Das, Markus Goldstein, 2008 www.worldbank.org
- "The Role of Reproductive Health Providers in Preventing HIV", In Brief – 2004 series, Guttmacher Institute and the Joint United Nations Programme on HIV/AIDS (UNAIDS) - Advancing sexual and reproductive health worldwide through research, policy analysis and public education, New York 2004 (Reprinted January/2007) www.guttmacher.org
- "Hiding in Plain Sight: The Role of Contraception in Preventing HIV", Guttmacher policy review, by Susan A. Cohen
- "Recommended standards for NHS HIV services", The medical Foundation for AIDS & Sexual Health (MedFASH)
- "Recommended standards for Sexual health services", The medical Foundation for AIDS & Sexual Health (MedFASH) – for all settings providing NHS-funded sexual health services including general practice, hospital and community based clinics, pharmacies, voluntary and independent sector organizations.
- "2007 UK guidelines for the management of Sexual and Reproductive health (SRH) of people living with HIV infection" – produced jointly by the British HIV association (BHIVA), the British Association for Sexual Health & HIV (BASHH) and the Faculty of Family Planning & Reproductive Health Care, A. Fakoya et al., May 2007.
- "2006 United Kingdom National Guidelines on the Sexual Health of People with HIV: Sexually Transmitted Infections", Rak Nandwani on behalf of the Clinical Effectiveness Group of the British Association for Sexual Health and HIV (BASHH), April 2006.
- "Sexual and Reproductive Health of women living with HIV/AIDS – guidelines on care, treatment and support for women living with HIV/AIDS and their children n resource-constrained settings", World Health Organization 2006

Recommendations and conclusions

To offer state-of-the-art and optimized sexual and reproductive care to PLHA, we recommend service provisions and HIV centers to use sexual and reproductive guidelines. For some departments (or organizations) it may not be feasible to implement existing guidelines as described in the literature. Therefore we identify - on the basis of the previous research phase of Eurosupport V - some essential factors (criteria) that could be taken into account when delivering SRH services. These criteria are based on major sexual and reproductive health needs of PLHA:

- Provide information about sexual and reproductive topics: e.g. information on contraceptives, transmission risks to partner and child, STI, responsibility issues
- Enhance behavioral skills: enhance communication skills to talk about sexuality, safer sex negotiation, disclosure...

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- Offer psychological support to help PLHA cope with sexual and reproductive topics: e.g. support related to HIV disclosure, difficulties to find a partner, desire to have children, pregnancy termination, (lack of) support from the PLHA personal environment (e.g. relatives, friends, partners,...)
- Discuss available personal resources and how they can be accessed (e.g. presence of a support system).
- Make specific care more available: e.g. access to assisted reproductive technology, access to family planning, access to specialized staff, availability of interdisciplinary care...

All evidence gathered in this research phase and the overall project-related activities of Eurosupport V show that sexual and reproductive health issues for PLHA need to be tackled by using a tailored individual approach and by addressing all relevant sexual and reproductive health topics (which may change over time). Special attention should be given to individual meanings of "objective facts" interfering in the patient-health worker relationship, such as 'grey areas' of current evidence, existence of vernacular knowledge, cultural differences, language issues, life style differences, and other factors affecting individual coping with SRH-related needs and problems.

However all departments include sexual and/or reproductive health topics into their services to PLHA, the data also show that shortage of (specialized) staff, lack of integrated approach, specific legal situations and time pressure are the main factors responsible for not achieving a more integrated and balanced sexual and reproductive health service. This implicates that policy makers on organizational and governmental level should focus on and support organizations in offering integrated sexual and reproductive health care services to PLHA.

Ruth Borms en Koen Block

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V. Looking forward: Eurosupport VI: PHEA Call 2008

The coordinating centre, Institute of Tropical Medicine (Antwerp), is currently preparing a new project proposal to submit to Second programme of community action in the field of health (2008-2013) by Public Health Executive Agency (PHEA). The follow-up project proposal is titled: 'Eurosupport VI: Developing a training and resource package for improving the sexual and reproductive health of people living with HIV/AIDS in Europe'. The overall objective of this project is to improve the SRH of PLHA by supporting service providers in HIV care settings to deliver adequate sexual and reproductive health related services. The project aims at designing, implementing, evaluating and disseminating a theory–guided and evidence based training and resource package, in cooperation with service providers in the field and PLHA using a participatory approach.

The deadline for the call for proposals is 23th of May. The Public Health Executive Agency will publish the evaluation results not before the end of September 2008. If Eurosupport VI will be selected for funding, the new project will start in January 2009. In this event, the Eurosupport newsletters will continue to be disseminated twice a year.

VI. Thank you

Since this is the last newsletter in the Eurosupport V research project, we would like to thank you for subscribing to this newsletter. We hope that this newsletter delivered some interesting and relevant information about sexual and reproductive health issues in the field of HIV.

We would also like to thank all contributors to the Eurosupport newsletters, and we hope to be able to

contact you with a new issue of a Eurosupport VI newsletter in 2009.

The Eurosupport project team

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