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### Differences in perceptions on sexual and reproductive health between service providers and people living with HIV: A qualitative elicitation study

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## Differences in perceptions on sexual and reproductive health between service providers and people living with HIV: A qualitative elicitation study

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The sexual and reproductive health (SRH)-related needs of people living with HIV/AIDS (PLHA) have not been sufficiently recognised in research and clinical care. Fifteen study sites in 13 European countries participated in this qualitative study to assess differences in perceptions between service providers (SP) and PLHA on SRH-related problems and needs of PLHA. Factors influencing SRH were determined to collect evidence on how to improve service provision. Qualitative data were obtained using an interpretative ethnographical approach. Data were analysed inductively on country level; a cross country data matrix was developed to facilitate the contextual analysis. Thirty-seven FGD discussions were organised with a total of 254 participants. A short survey was distributed to assess demographic characteristics. Results revealed insufficient information and lack of behavioural skills regarding SRH issues among PLHA. Intra- and interpersonal, provider-related, and social factors were found to influence the SRH behaviours of PLHA. Although from patients' perception SRH is a prioritised issue, it rarely comes up during routine HIV clinical care. SP need adequate counseling training to tackle SRH-related issues. A better integration between HIV care programs and SRH care settings is needed to improve effective service provision.

**Keywords:** HIV/AIDS; sexual and reproductive health; service provision; prevention; elicitation research

### Introduction

With the increasing quality of life and prolonged length of life due to improved HIV treatment, the sexual and reproductive health (SRH) of people living with HIV/AIDS (PLHA) has become a focus of attention of service delivery, academic research and AIDS activists (Boonstra, 2006). Women and couples living with HIV have specific fertility-related needs, including family planning and assisted conception (Delvaux & Nöstlinger, 2007; Massad et al., 2004; Mitchell & Stephens, 2004; van Benthem et al., 2000). In addition, it has been recognised that PLHA need specific support in adopting and maintaining preventive behaviours (UNFPA, 2004; WHO, 2006) in order to protect their own health from infection with other sexually transmitted diseases (STDs) and potential

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HIV-re-infection, as well as the health of their sexual partners (Gottlieb et al., 2004; Smith, Richman, & Little, 2005).

The clinical and policy context, in which SRH-related needs and problems of PLHA are being tackled, is changing: service providers (SP) increasingly recognise the need for enhanced SRH interventions mainly driven by positive prevention efforts (CDC, 2003; Del Rio, 2003; International HIV Alliance, 2003), whereas PLHA value sexual health as a major concern affecting their overall health-related quality of life (Douaihy & Singh, 2001; Weatherburn, Anderson, Reid, & Henderson, 2002).

There is a growing body of scientific evidence on the SRH needs of PLHA (e.g. Bouhnik et al., 2007; Crepaz & Marks, 2002; Peretti-Wattel et al., 2006), but little research has been carried out on the different perceptions between PLHA and service providers in terms of their SRH-related problems and needs, as well as service provision. Focusing on such a duality may provide valuable insights for SP on how to better meet the needs of PLHA's service provision.

This study was carried out as formative work for a multicentre study (Eurosupport V) on improving the SRH of PLHA. Our research takes a comprehensive definition of SRH into account. Guiding principle is the internationally accepted definition of SRH at ICPD Cairo in 1994, including the areas of sexual health (responsible, satisfying, and safe sex life), reproductive freedom (access to information, methods, and services), and safe motherhood (safe pregnancy, childbirth and healthy children) (WHO, 2001). These areas have particular relevance for PLHA. More details on the overall project design are available at [http://www.sensoa.be/eurosupport/euro\\_support.htm](http://www.sensoa.be/eurosupport/euro_support.htm)

The elicitation research had the objective to explore in-depth the SRH-related problems and needs of PLHA, as well as to identify influencing factors on SRH in this target group. In this article we focus on the differences between service providers and clients relating to the above subjects. Other relevant aspects of the analysis, such as cross country differences or in-depth analysis of selected SRH issues, will be tackled in a forthcoming paper.

## **Methodology**

We used an interpretative ethnographical approach to delineate some of the complex personal and social phenomena surrounding both patients' and providers' perceptions of SRH. The goal of our research was to identify central topics that explain how SRH is affected in a particular social context.

We chose focus group discussions (FGD) as data collection technique (Morgan & Krueger, 1998), because we aimed at understanding perceptions relating to SRH, and the social contexts that shape these views rather than assessing in-depth participants' sexual experiences. We used standardised focus group procedures, and interactive debates in the groups facilitated additional insight into the study content (Barbour & Kitzinger, 1999).

## ***Participants and data collection methods***

We conducted 37 FGD in 12 different European countries between December 2005 and June 2006. Research settings were HIV-treatment centres and community based settings providing HIV care and support. Table 1 gives an overview of the target groups addressed by country.

PLHA were recruited by SP at the study settings and participated voluntarily and anonymously, if opted for. Information about the study was distributed locally to recruit

Table 1. FGD per country.

Country	HCP medical staff	HCP psychosocial staff	PLHA heterosexuals	PLHA (MSM)	Totals
Austria	2	3	–	–	5
Belgium	2	1	3	2	8
Czech Republic	1	–	–	1	2
Germany	1	–	1	1	3
Greece	–	–	–	1	1
Hungary	–	–	–	1	1
Italy	3	1	2	–	6
Latvia	2	–	–	–	2
Poland	–	–	1	1	2
Portugal	–	–	2	–	2
Slovakia	1	1	–	–	2
UK	1	2	–	–	3
Total	13	8	9	7	37

patients, using snowball sampling (Burgess, 1991) often starting with ‘resource patients’ assumed to be willing to participate.

In addition to the 37 FGD, 20 face-to-face interviews were carried out (4 SP in Hungary, 11 SP in Spain, as well as 5 personal interviews with PLHA in Spain). To add to the multi-method approach, one e-mail discussion was conducted with men having sex with men in Slovakia.

### *Procedure and topic guides*

FGD were held separately for PLHA and SP. Within target groups, we aimed at recruiting homogenous groups (according to gender, transmission group, and ethnic origin). FGD were facilitated by trained moderators (professionals with a background in group dynamics) with an observer present in each group. To avoid bias, researchers did not act as moderators. FGD lasted about 2 h each, with 5 to 13 persons participating per FGD (7 on average). The study was approved by the institutional review board of the coordinating centre, and participants’ informed consent was obtained.

To standardise study procedures parallel topic guides for the two target groups were developed on the basis of a literature review. Four major topics were covered: HIV/STI prevention; sexual problems; fertility-related problems and needs; perceptions of SRH service provision. The topic guide was piloted with volunteers, subsequently revised, and translated. To enhance rigor of research, a detailed training manual was used, explaining the methodology, practical issues and technical details relating to e.g. the moderating style and how to handle critical group situations.

### *Analysis*

FGD were audio-taped and transcribed verbatim. Data were available as transcripts in 13 different languages. Hermeneutic analysis was employed to gain in-depth understanding of the contextual data, and a descriptive content analysis was carried out by two independent raters per setting assigning the first codes. By constantly comparing the data, common

codes were identified inductively, refined and sub-grouped as themes to answer the research questions. Each research team arrived at specific categories with their respective sub-codes. These second codes and a description of their contents were translated into English, including a back-translation to avoid translation bias. Researchers also provided a narrative interpretation of the country-specific data in English.

To facilitate the synthesis of the European data, a research data workshop with six researchers from different countries was carried out to interpret the findings and to look in-depth at cross-national differences. A data matrix for synthesising the second codes was developed. It organised the data into the following dimensions: intra- and inter-personal variables, service provider-related variables and variables relating to the wider social and policy context. All data were grouped into that grid by the coordinating research team, and subsequently validated by the country researchers. As such, the cross-country synthesis was a group process of all the researchers involved.

## Results

Table 1 gives an overview of FGD conducted per country. The 37 FGD involved 110 PLHA and 144 SP. Participants' socio-demographic characteristics are shown in Table 2. Table 3 provides data on their medical characteristics, and Table 4 gives some details of SP participating in this study.

### *Prioritised SRH issues*

Overall, the perceptions of both target groups were congruent with respect to the identification of salient SRH-related problems. All participants stressed that not having a sexual partner was one of the major concerns of PLHA. For some, this was deliberately chosen, as fear to infect sexual partners led to avoidance of sexual activity, for others it was attributed to loneliness and social isolation because of HIV-related stigma. For those who were sexually active, all participants identified having difficulties with HIV disclosure to sexual partners as a major problem.

In addition, sexual problems were mentioned as exerting a negative impact on the quality of sexuality: in particular, gay men reported a wide array of sexual problems, subjectively either attributed to psychological reasons or side-effects of antiretroviral treatment (ART). Major challenges were identified by both groups as difficulties to adhere on a lifelong basis to safer sex, with condom-use acting as constant reminder of HIV-status. Gender issues became clearly visible in the FGD: a substantial proportion of women identified fertility-related issues as a problem increasingly affecting their reproductive lives. Contingent on their individual situation with respect to reproductive life-cycles this was either expressed as the need for safe family planning or the desire to realise an existing child-wish. The latter was particularly important for migrant women and/or couples, and more pronounced in Southern European countries. Persistent HIV-related stigma was mentioned more often by PLHA than SP as an overall concern, hindering a meaningful re-integration of sexuality into people's daily lives.

### *Determinants influencing SRH*

The determinants found to influence the SRH of PLHA were organised along a continuum from intrapersonal, to interpersonal, provider-related and social determinants. For each of

Table 2. FGD participants, socio-demographic characteristics (PLHA).

	<i>n</i> (%)
Gender	
Female	43 (39.1)
Male	67 (60.9)
Age	
Mean (SD)	37.5 (9.1)
Median	37.2
Country of origin	
This country	93 (84.5)
Foreign country	17 (15.5)
Relationship status	
Single	40 (36.4)
Separated/divorced	9 (8.2)
Relationship with a man	54 (49.1)
Relationship with a woman	7 (6.4)
Living situation	
Alone	43 (39.1)
With partner/family	51 (46.4)
With friends	3 (2.7)
With parents	11 (10.0)
Institution/hospital	2 (1.8)
Education (completed)	
Primary school	9 (8.3)
High school	32 (29.1)
Occupational training	6 (5.5)
Senior high school	29 (26.4)
University	29 (26.4)
Other	5 (4.5)
Main source of income	
Regular employment	40 (36.4)
Self employment	10 (9.1)
Partner's income	5 (4.5)
Social benefits	44 (40.0)
Other	11 (10.0)
Total	110 (100)

these intertwined domains we established the specific barriers and facilitators to adopting healthy SRH behaviours.

#### *Intrapersonal determinants*

All participants felt that among PLHA some relevant knowledge gaps relating to SRH-related risks still existed. They referred in first instance to misconceptions on safer sex and the way HIV may or may not be transmitted, such as the notion that HIV cannot be transmitted when viral loads are below detection level. When inconsistent preventive messages or complicated technical information had been conveyed from SP to patients, PLHA weighed their own risk-benefit balance (e.g. with respect to HIV transmission risk during oral sex or between sero-concordant couples). That type of vernacular knowledge was often communicated between peers, but was not shared with SP. Finally, culturally

Table 3. FGD participants' medical characteristics (PLHA).

	<i>n</i> (%)
Duration since HIV diagnosis	
Mean (SD)	8.9 (6.4)
Median	8.0
HIV transmission	
Homo/bisexual	49 (44.5)
Heterosexual contact with a man	21 (19.1)
Heterosexual contact with a woman	4 (3.6)
Blood products	8 (7.3)
Intravenous drug use	15 (13.6)
Other	13 (11.9)
Antiretroviral medication (current)	
On ART	89 (80.9)
Not on ART	21 (19.1)
Total	110 (100)

Table 4. FGD participants' socio-demographic characteristics (HCP).

	<i>n</i> (%)
Gender	
Female	47 (32.6)
Male	97 (67.4)
Age	
Mean (SD)	40.9 (11.07)
Median	40.8
Job function	
Social worker	20 (13.9)
Psychologist	11 (7.6)
Physician	40 (27.8)
Nurse	44 (30.6)
Volunteer	8 (5.6)
Other	21 (14.6)
Type of organisation	
Medical hospital	30 (20.8)
Outpatient clinic	15 (10.4)
HIV-specialised clinic	51 (35.4)
AIDS service organisation	13 (9.0)
SRH organisation	17 (11.8)
Drug help organisation	6 (4.2)
Surgery	2 (1.4)
Church affiliated organisation	2 (1.4)
Other	8 (5.5)
Years of working experience in HIV field	
Mean (SD)	3.7 (1.6)
Median	4.0
Total	144 (100)

specific misconceptions about condom-use were identified particularly among migrant PLHA.

A second area of lack of information was identified with respect to reproductive health, e.g. information on and access to assisted reproduction techniques.

Quote: 'I am afraid of using condoms, it can slip and even remain inside a woman's womb and may affect the woman's health so that she never can have babies again ...' (female participant, PLHA)

Attitudes and personal norms were considered as important prerequisites for healthy sexual and reproductive behaviour. Both SP and PLHA identified two major topics as relevant: individual goal setting towards the future and having a sense of individual responsibility to not transmit HIV to sexual partners. However, SP stressed difficulties to deal with subgroups of patients who would not adopt that sense of responsibility towards sexual partners.

There was congruency in the perceived importance of feelings and emotions of PLHA as contributing factors to healthy sexual and reproductive behaviour: low self-esteem, feelings to be a-sexual, and fears to transmit HIV were felt to play a contributing role to one's capability to avoid unwanted consequences of sexual activity. Fear of prosecution was also mentioned in particular by gay men, and more often in countries with restrictive legislation in place. As a gay participant from Poland put it: '*they are petrified that someone will come forward and prosecute them for passing on the virus*'.

In addition, traumatic consequences of forced sexual experiences were mentioned. In settings targeting migrant participants, rape was revealed as a fairly common accusation leading to re-infection with STDs and unwanted pregnancies.

With respect to behavioural skills, the ability to integrate safer sex techniques into sexuality consistently was perceived by both target groups as most important. Although SP stressed the need of balanced sexual relationships to handle partner pressure, and subsequently the need to improve negotiation and communication skills, PLHA underlined the challenge of preventive behaviour during extended periods of time. They also gave deeper insight into more complex psychological mechanisms: for instance, some gay men interpreted condom use as a constant reminder of their HIV-status, which they repressed at least during moments of sexual experience allowing for total intimacy. Some attributed the occurrence of sexual problems to that impossibility of 'letting go', the anticipation of which would lead to discontinue the use of condoms, but mostly against their own aspirations of safety.

Partner-pressure was identified as an additional theme that required substantial behavioural skills to be dealt with. However, it included different types of pressures from partners such as for instance exerting direct pressure to have unprotected sex, making gender disparities visible as more women than men reported limited abilities to insist on protected sex. However, unprotected sex was also perceived as an expression of growing emotional intimacy between seroconcordant partners. This was expressed for instance in the case of uninfected partners (both heterosexual and homosexual relationships) deliberately seeking to become infected to share their HIV status with the partner.

Quote: 'He simply wants to be as close as possible, surmount all boundaries between us and share this experience with me. As a proof for his true love, however, a foolish one ...' (female participant, PLHA)

*Interpersonal determinants*

Disclosure of HIV-status was identified by both target groups as a major barrier to the adoption of healthy sexual and reproductive behaviour. PLHA often would not disclose their status to partners, families, and service providers other than the specialised HIV treatment facility. They worried about relationship break-down, enacted stigma, discrimination, and criminalisation. Both SP and PLHA perceived this as a barrier to receiving appropriate care or advice from general practitioners or family planning clinics. PLHA emphasised in particular the difficulty to find the right moment to disclose to sexual partners.

Quote: 'At which moment one should tell? In the very beginning or after some time? When we tell in the very beginning, we feel afraid to be rejected. When we tell later, when we have made him or her love us, he or she will not understand why we have not told this before. This creates mistrust in a relationship. This appears to be a vicious cycle...' (male participant, PLHA)

African migrants living with HIV perceived disclosure as particularly problematic. Some PLHA from African origin stated that they could consider HIV-disclosure to their sexual partner only if that person were also believed to be HIV positive.

Communication about prevention of any unwanted consequences of sexuality was considered to be a relevant behavioural skill of PLHA, which, however, has to be viewed in the context of the sexual relationship: partner-pressure to have unsafe sex, even in discordant relationships, was mentioned frequently by PLHA. This can be triggered by the wish to have a child (more frequently reported for African females), by the wish to dissolve borders to of intimacy between the partners, or by peer pressure in specific sexual sub-cultures (e.g. sexual venues for MSM such as sex parties or dark rooms).

Quote: 'I was once in a gay club, and people would talk about my HIV-status. There was this guy who insisted on having sex with me. I asked why, whether he was not afraid ... he said I want it because my life sucks and so on ... he simply wanted to commit suicide in velvet gloves. I had the impression he wanted to do it the fashionable way ...' (male participant, PLHA)

Quote: 'If you are going out to have sex, you are not actually looking for a relationship. You go out because you want to feel good about yourself, and have some fun, and then you get hot, and you end up having casual sex. In such a situation, I would not tell that I am positive, but I would play it safe. This is much better than telling about your HIV-status. In such moments I feel like a "normal person"...' (male participant, PLHA)

Social support was perceived by both target groups as an important resilience factor. Fear of HIV-disclosures was described as reducing access to otherwise existing social support and thus rendering it ineffective for many PLHA, in particular for migrants. There was agreement that the 'invisibility' of HIV, aggravated by its medicalisation, made it more difficult to access adequate social support. Most PLHA had not had sufficient access to self-help, community-based support or advocacy. Although PLHA felt that their needs for organised social support such as patient support groups were not met, some SP appeared not to fully support this notion.

Quote: 'It would be so important for me to have the chance to meet other people who go through the same experience; we are silenced all the time, it just feels good to participate in this group and learn that others experience similar things' (female participant, PLHA)

*Provider-related determinants*

A recurring issue in many FGD was SP' definition of professional roles: their perception, in particular of those with a medical background, was primarily that SRH issues did not really concern them. They felt that they either were not adequately trained, did not have enough time to 'be able to delve deeply' or did not have sufficient knowledge about available services.

Lack of resources was identified as a common theme coming back in all FGD. SRH services not being available or not easily accessible to PLHA locally, included:

- Fertility checks for both partners to assess fertility before assistance in conception by natural means.
- The need for sperm washing at affordable prices to facilitate safe conception for HIV negative women with positive partners.
- Sexual health clinics for specific sexual problems such as erectile dysfunction: when available (in the UK for instance), long waitinglists were reported. However, in most investigated settings a complete lack of specialised services was described.
- Psychosexual counseling: Although great need was stated by PLHA and SP, only few clinics offered this service.
- Family planning and contraceptive advice: provided only in some settings, hardly ever on a routine basis, and almost always only on direct request of female patients. Dual protection, i.e. protecting against HIV/STI transmission by means of condoms and protecting against unwanted pregnancies by means of other contraceptives such as hormonal methods, was mentioned by SP as a high need of many women of reproductive age living with HIV; however, it was rarely integrated in service delivery.

Although PLHA mainly observed the lack of time during consultation to address SRH, SP also mentioned lack of other resources, such as training in sexual communication, guideline/protocols to tackle such issues, and adequate referral options (to either psychologists, sexologists, or sexual health advisors).

An interesting difference in perception between SP and PLHA was noted with respect to patients' expectations in terms of who should address SRH-related issues during consultation. Most PLHA clearly expected their providers to do so. Although psychosocial staff seemed to be more comfortable with bringing such issues to the table, physicians tended to wait for patients to address it.

*Social determinants*

Here we refer to factors deeply engrained in society, culture and/or religion of the people affected, and rooted in socio-economic disparities between different target-groups of PLHA. HIV-related stigma was mentioned by both SP and PLHA as one such structural barrier to the adoption of healthy sexual and reproductive behaviour. This was clearly more pronounced in FGD held in the new Member States than in Western European settings.

Quote: 'I was simply rejected by everybody. I used to live alone for many years. Now I have come to the conclusion that I probably don't need anybody. And I function just as well'. (male participant, PLHA)

Although some statements from PLHA during the FGD clearly showed the impact of the legal context on individual behaviour (see above: fears relating to prosecution in relation to sexual activity), SP did not raise the issue to the same extent.

Lack of general HIV prevention campaigns in recent years was mentioned by SP as another relevant policy context, which resulted in decreasing public awareness of HIV further adding to HIV-related stigma and contributing to the invisibility of HIV.

## Discussion

### *Limitations to the study*

There are some limitations to this study. Recruitment of participants required significant effort. Within the time boundaries of the EUROSUPPORT V project, we may have recruited mainly SP and PLHA who had a special interest in SRH. In some countries (e.g. Austria, Hungary, Latvia), and in some sub-populations, getting PLHA to attend a FGD was too difficult due to the fear of being labeled as someone living with HIV patient. Although efforts were invested to reach migrant target groups and include other socially disadvantaged people, we may have missed those with diminished social capital. However, given the representation of different target groups throughout the study settings, we assessed a sufficiently broad range of age, ethnicity, and professional backgrounds of care providers to reflect an overall picture of European HIV-care settings. Further research in this area should look into the potential of employing participatory community research strategies to improve access to marginalised groups (Pitts & Smith, 2007).

This article constitutes an effort to report on the overall complexity of SRH-related problems and needs of PLHA, and as such it cannot tackle all issues raised in depth. In the same context we have interviewed a broad range of service providers and target groups, allowing us to incorporate multiple experiences in the field.

### *Relevance to the literature*

Our qualitative findings are corroborated by existing literature. Many of the factors described in the currently prevailing AIDS behavioural theories of risk and vulnerability have been confirmed (e.g. Bandura, 1986; Fisher & Fisher, 2000). This qualitative study adds the relative importance of emotions and feelings in order to explain motivational deficits in taking action towards avoiding unwanted consequences of sexual activities. In addition, social isolation and both internal and external HIV-related stigma (Calin, Green, Hetherington, & Brook, 2007; Castro & Farmer, 2005; Wilson & Miller 2003) may add to feelings of low self-esteem and low degrees of self-efficacy in adopting or maintaining healthy sexual behaviour. Although we did not focus on investigating complex psychological phenomena relating to sexual dynamics in sero-concordant or discordant couples, data assessed show that both intrapersonal and interpersonal issues relating to sexuality and intimacy are relevant determinants influencing sexual risk taking behaviour. Subconscious dynamics in sexual relationships call for a recognition of more subtle influences than cognitive and motivational factors alone, such as issues of intimacy and partner pressure. Issues that relate to personal norms of responsibility for prevention were also identified by previous qualitative studies, e.g. the role of contextual influences on responsibility and behaviour in HIV-positive MSM (van Kesteren et al., 2005) or the dyadic emotional shifts in couples living with HIV (Beckerman, 2005).

The aim of this elicitation research was to explore in-depth how different areas of intra-, interpersonal and structural factors influence SRH behaviour. Social determinants such as

gender-norms or a given policy context influence intrapersonal characteristics and behavioural skills to a large extent.

Our data showed that adopting healthy SRH is a major concern of PLHA in their search for a satisfying and fulfilled sexual life. Many PLHA participating in this study perceived onward HIV transmission as a highly unwanted consequence of sexual activity, sometimes even leading them to choose an a-sexual lifestyle. Criminal prosecution for HIV exposure and transmission (such as in the UK, Austria, and Poland for instance) have been perceived by PLHA as another barrier to disclose HIV, and subsequently may also contribute to more stigma and sexual risk behaviour. As others did (Peretti-Wattel et al., 2006), we view sexual risk behaviour as a social construct, and our data stress that the determinants found to influence 'risky behaviours' possess a large variety of intrapersonal and interpersonal variability. At the same token, social and cultural issues remain the overarching challenges to effectively meet the SRH needs of PLHA. Boonstra (2006) identified the set of interlocking social issues that impede access to services: sexual taboos, gender inequality, and stigma and discrimination around HIV itself. Our data stress the need for services to enable PLHA to make informed choices about their SRH behaviours, and for SP and policy makers to further reduce the structural barriers that PLHA have to cope with.

### *Policy implications*

This study highlighted important gaps in service provision, which were acknowledged by both SP and PLHA. However, participants shared also information on what they perceived as working well in service provision. One might start here to recommend on how to achieve a better fit between patients' expectations and the resources available.

Patients clearly opted for a comprehensive care model, in which patient-centered care is of key importance. They want to be understood as individuals embedded in a social context with a life history shaping current experiences related to their illness. SP pointed out that multidisciplinary teams with defined roles within teams have proven to be an effective way of providing such comprehensive care for PLHA. Identified gaps in service provision, such as specific sexual health counseling, or the need for intensified family planning counseling, could be plugged in with additional 'visitor' staff providing the requested services, or with specific services being rolled out to a network with other local service providers. The need for enhanced SRH counselling in HIV clinical care setting is evident. Nevertheless, although the clinical care setting presents an ideal context for targeting sexual risk behaviour (Fisher et al., 2004; Fisher, Fisher, & Cornman, 2006; Ward, 2007), clinician's efforts to intervene systematically have been rare. The qualitative evidence provided here and elsewhere (Ashton, Cook, & Wiesenfeld, 2002) shows that many SP would see family planning and prevention counseling as a time consuming additional task. The challenge lies in how to integrate these tasks in busy HIV care clinics.

From a service delivery point of view, different models of integration can be identified (Askew & Berer, 2003; Family Health International, 2004; Kane & Colton, 2005): HIV services as entry point for family planning and diverse SRH services, as well as SRH services with specialisation in HIV-specific care. Also the involvement of primary care facilities for generalised services including SRH could be an option. While different settings will have different capacities to meet the needs of PLHA, such as dual protection needs (Mantell, Hoffmann, Exner, Stein, & Aykins, 2003) from a clients' perspective a one-stop-shop provision of services may have advantages (IAG, 2004; IPPF, 2007).

For all types of services, it has been argued convincingly that integration will require a re-thinking of the patient-provider interaction, using a client centered risk assessment

(Rietmeijer, 2007). This seems a relevant clinical task, given the changing needs of PLHA, who – according to our data – expect SP to more actively address SRH-related topics in routine HIV care. Participatory approaches should be used to develop innovative concepts on integrating family planning and prevention counseling, eventually adapting theory-based behaviour change strategies proven to be effective elsewhere to the needs and standards of European HIV care settings.

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