EUROSUPPORT 6

"Developing a Training and Resource Package to improve the Sexual and Reproductive Health of People Living with HIV"

Institute of Tropical Medicine, in co-operation with Sensoa vzw, Antwerp, Belgium

NEWSLETTER NR. 3

CONTENT of this Newsletter:

This project is financially supported by the European Commission's Public Health Programme, Grant agreement nr. 2008 1204

Brief introduction

Eurosupport

The Eurosupport project is a long standing European Health Promotion initiative, addressing psychosocial issues in HIV care. With the support of the European Commission, an expert network has been set up to carry out empirical research on the needs of people living with HIV/AIDS (PLHA). Ten EU countries are participating in the current project. The Eurosupport initiative started in 1996. This is the 6th Eurosupport research project to run since then.

Eurosupport 6 (2009-2012) focuses on the development of an evidence based training and resource package (TRP) for sexual risk reduction and fertility-related issues. The project builds on the evidence accumulated during the previous Eurosupport 5 project, which collected evidence on sexual and reproductive health (SRH) needs of PLHA, as well as on existing gaps in actual service provision.

Eurosupport 6 used this and other current evidence on sexual risk taking to develop and evaluate brief counselling interventions for clinical and community based HIV care settings. The TRP will support service providers in their daily work to address SRH and positive prevention with HIV positive service users.

Eurosupport 6 is coordinated by the Institute of Tropical Medicine, Antwerp, Belgium.

The Eurosupport 6 newsletter

The Eurosupport Newsletter is distributed biannually by Sensoa. Project related information and SRH related topics are being disseminated beyond the Eurosupport 6 study group, to maximise the transfer of knowledge between member states and create windows of learning opportunities.

We would like to ask you to forward this newsletter to other interested organisations in the field of HIV, sexual health, and family planning.

We would also like to remind you that we are always interested in receiving relevant information that can be included in future newsletters. The Eurosupport newsletter is meant as an interactive exchange medium, so please feel free to contribute. Mail to: **Ruth.Borms@sensoa.be**

Deadline next newsletter: 10th January 2010

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

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I. Current state of affairs

An essential milestone of the Eurosupport 6 project is the evaluation of our recently developed computerized intervention for safer sex (CISS). The CISS is a brief counselling intervention for HIV clinical care and community-based settings available on a DVD. The development of the 3 DVDs (which contain different versions for MSM, Migrants/men, Migrants/women), and the translation of each version into 9 EU languages was a complex task. When finalizing this newsletter, the project reached the phase of pilot testing the feasibility of the counselling intervention in 4 selected centres in Europe.

CISS is a novel intervention to support consistent condom use among people living with HIV (PLHIV). It will be evaluated using a combined evaluation approach, consisting of a process evaluation and an outcome evaluation. The latter will adopt an experimental research design with random allocation of participants to either working with the CISS or have 'treatment as usual'. The total study population for the trial will be at least 440 (220 migrants and 220 MSM), of which half will be exposed to the CISS.

Study participants will be followed up 3 and 9 months respectively after completing the intervention, to assess effectiveness of the CISS.

For the evaluation study, we developed a study protocol, and received ethical clearance by the coordinating centre's institutional review board and the University of Antwerp. Some partners obtained their own ethical approval.

Interested PLHIV will be screened for eligibility, and eligible participants will fill in a baseline questionnaire on a computer; study participants in the intervention group will receive three semi-structured counselling sessions with a counsellor, using the material on the DVD as guidance to the session. In the first session, the participants will select topics relevant to the existance of his/her sexual risk behaviour. During the second session, the counsellor and the participant will set specific goals in changing the sexual behaviour towards more consistent condom use. In the last session, an individual risk reduction plan will be developed where the pathway towards the behavioural change is shown.

The novelty of the intervention lies in the use of video- and audio material, supporting the counselling. The material uses triggers to create similarities with real-life sexual situations, thereby targeting an underlying and almost unconscious sexual decision making system. This is not targeted in 'regular' counselling sessions, which usually focuses more on the cognitive, rational decision-making system.

If CISS turns out to be effective, it will be disseminated throughout Europe as part of a training and resource package. This will be presented at the final project workshop, where partners and stakeholders will receive training to implement CISS in their own settings, or train healthcare professionals of their respective countries.

To enhance dissemination of information we also developed a CISS flyer in extension of our Eurosport 6 folder. Both documents are available at www.sensoa.be/eurosupport

CISS

Computerised Intervention for Safer Sex

CISS is a DVD based intervention to support HIV positive migrants and gay men in finding their way to personalized 'safer sex' solutions. Using film material and engaging slide shows it allows HIV service providers to discuss delicate emotional and sexual issues with their clients, working with them to achieve an individually tailored approach.

The CISS is evidence-based, facilitating clients in bridging the rationale-cognitive divide so as to achieve success in affective decison-taking in sexual situations. Clients are encouraged to continue working with the DVD alone, for example at home. Three counseling sessions are given to complete the three sections of the CISS.

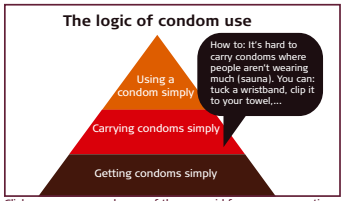
Who am I?

In this first session clients are encouraged to articulate their values around safer sex and their personal needs . Video clips of HIV+ people talking or interacting with lovers are used for emotional engagement to stimulate discussion with the counselor on factors that may play a part (e.g. mood, relationship needs, drugs and alcohol).

Richard Georgio Sam

Working through solutions

The second session aims to set concrete goals, using further materials which stimulate the client to consider new approaches which meet his or her needs.



Click your mouse on layers of the pyramid for more suggestions

Today and tomorrow

In this session clients are enabled to formulate an individual risk reduction plan. This includes concrete steps to achieve their long-term goal. If desired, this plan can be worked out using the planning tool 'goal enforcer' to visualise the concrete steps.

Evaluation Research

The CISS is being evaluated in a European multicentre study. Effectiveness is determined using an experimental design, while its feasibility for HIV care settings is assessed through a process evaluation. If found to be effective, the CISS will be disseminated as part of an integrated training and resource package.

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II. Highlights of the XVIII International Aids Conference 2010

The XVIIIth International AIDS Conference took place in Vienna, Austria from July 18th-23rd, 2010, with over 19.000 participants present stemming from more than 190 countries. The overall conference theme was 'Rights here, right now' and focused on the application of Human Rights, especially - but not exclusively - in the field of HIV and drug use.

With more than 6000 abstracts accepted, divided over approx. 250 sessions, 19 plenary speeches, and more than 200 satellite meetings in addition to the official conference program, AIDS2010 clearly was a mega-event. Conference participants were offered an overwhelming number of sessions, posters, and poster discussions. While a great variety of topics was covered by the different scientific tracks (i.e., basic science/clinical, science/epidemiological, prevention/social, behavioral science/economic, health systems, operational research/human rights and political science) and the global village program, for this ES6 newsletter we summarize the main events related to topics such as positive prevention, serodifference and treatment as prevention, as they directly relate to sexual and reproductive health of people living with HIV.

After Bill Cinton's keynote address on Monday morning, a plenary presentation given by Vuyseke Dubula (South Africa) addressed positive health, dignity and prevention. In her presentation, she explained this comprehensive approach to support people living with HIV in their prevention and social needs through individual and community empowerment with dignity. This approach recognizes the importance of health promotion and access, sexual and reproductive health and rights, reduction of stigma and discrimination, gender equity on the prevention of transmission and access to treatment and support services. She called on PLHIV, governments, NGOs, and civil society to envision new ways to ensure that human rights are strongly considered when working towards treatment and prevention goals.

The issue of infectiousness while on antiretroviral treatment remained an important issue at this conference, as it has specific implications for behavioural initiatives and advice to discordant couples. Bernard Hirschel (Switzerland) presented models on the potential impact of treatment on prevention. Such models provide different scenarios, and also point to the importance of early investment for future prevention gains. However, Hirschel also pointed out that one has to consider potential slips between protocols of randomized controlled trials, which usually investigate the efficacy of treatment as prevention, and reality, with considerations of factors such as attrition, harm versus benefit, and cost versus sustainability.

How to deal with infectiousness in real life situation has practical implications for couples with different serostatus. This topic was dealt with in various sessions, i.e., a symposium, skills building workshop, and a bridging session.

The symposium on serodifference covered various types of challenges that serodifferent couples are facing, including social, sexual and reproductive health challenges. It was started off by lived experiences vividly presented by a serodifferent couple, who highlighted among other things the need to conceive safely and have children (R. Ruranga and E. Nkoba Kanyiginya, Uganda). Next, epidemiological evidence from sub-Saharan Africa was presented, where data show that in some countries up to 16% of all couples are serodifferent. Prevention challenges include knowing ones´HIV status to start with, how to protect the uninfected partner, and challenges to consistent and correct condom-use; barriers relating to the latter are situated both on the individual and couple level, as well as on the community/structural level, including HIV-related stigma (K. Dunkle, US). Research carried out by GNP+ using a mixed method approach also identified stigma as one of the major challenges that serodifferent couples have to deal with, including double stigma for men having sex with men; findings also showed that continuous discussions about sexuality and other challenges helped to reduce tensions within the couple dyad (K. Moody, NL). Qualitative longitudinal research from Australia showed that decision on sexuality and sexual (risk) practices often are not shaped by risk calculation or medical evidence (such as the Swiss statement), but by complex dynamics around intimacy, stigma, gender and reproductive desires (A. Persson, Australia). Overall conclusions drawn in this session pointed to the need of interventions focusing on the couple, the need for policy guidelines for better support of serodifferent couples in making informed choices, and the urgent need for more research on the psychosocial issues surrounding serodifference.

In relation to this symposium, a skills building workshop focusing on sex and intimate relationships was organized for PLHIV and counselors. It offered the opportunity to persons living in serodifferent relationships and to counselors working with serod-

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ifferent couples to exchange experiences and learn new skills in a protected environment. Serodifferent couples reported on living, loving, and flourishing in serodifferent relationships. The results from Monday's social science symposium on serodifference were fed back to the participants to provide the evidence on biomedical and psychosocial issues, such as disclosure, condom-use and safer sex, HIV-transmission risk, reproductive desires, and the implication sof the Swiss consensus statement on HIV transmission. Medical experts, counselors and advocates were present to facilitate Q&A sessions in small groups.

Main concerns raised by people living in serodifferent relationships referred to issues of self-stigma and transmission risk, and child desire. Main issues raised by counselors were the need for tools that support them in enabling clients to make informed choices about these issues. Counselors stressed that serodifferent couples need to be empowered to make fully informed decisions; while being supported in putting their decisions in practice through professional counseling in a non-directive way. The need for policy guidelines was also stressed.

On Wednesday, a bridging session on reproductive choices (jointly organized by the scientific, the community and the leadership and accountability programme committee) focused on options and availability for PLHIV to realize their reproductive choices ranging from family planning to options to conceive safely. The panel tried to bridge personal experiences, medical research as well as social factors affecting the reproductive choices of people living with HIV.

Lilian Mworeko (Kenya) talked about problems and fears encountered by HIV+ women when it comes to pregnancy. Mandatory HIV-testing for pregnant women is often accompanied by unwanted disclosure, forced sterilizations are one way of preventing positive women from having children. With the negative attitude towards pregnancy in HIV+ women and little information on their reproductive options, many seek unsafe abortions. Emphasizing that the provision of PMTCT is not enough, Heather Boonstra from the Guttmacher Institute (US) suggested enhanced counseling to HIV+ women about childbearing and their reproductive rights, integrated in other HIV services, and to work towards legal and safe abortions. Gynecologist Laurent Mandelbrot presented the medical options available to support HIV+ people in having children, for example sperm washing and assisted reproduction (eg IVF). Natural conception, the most common approach across the world, is now a lot safer with new generations of HAART, which are able to decrease not only the viral load in the blood, but also in the genital fluids. Most importantly: HIV+ people should not feel neglected and opposed by doctors when they have reproductive desires, or they will not seek help and might resort to risky modes of conception. Annabel Desgrees-du-Lou from France/Cote d'Ivoire talked about operational and social factors that are important in providing reproductive health care to HIV+ people, and criticized that many HIV interventions fail to address sexuality and pregnancy in positive people on the level of the couple.

Finally, on the conference's last day, a session focused on abortion and unplanned pregnancy. It is worthwhile to mention that it was the first time that such a panel was organized at an international AIDS conference, due to the great taboo surrounding this issue. The issue was presented linked to maternal health, indicating that according to WHO data (2006) one woman or girl still dies every minute due to maternal death. It was highlighted that while there is a great need to legalize abortion services in many countries in order to make termination of pregnancy available to women in need, and abolish unsafe terminations leading to a high number of maternal deaths, legalization does not automatically translate in overall accessibility for women living with HIV, as the case of South-Africa has shown. There, abortion services are available, but privatized, and thus only affordable to the economically wealthy. A good-practice example (E. Lopez-Uribe, Mexico) showed that even in countries where abortion is only available under very restricted circumstances, good quality services can be offered to women.

Also in this field and of interest to PLHIV and counselors was the workshop on Positive Parenting: Building Capacities of Health Care Providers to Address Emerging Issues in Parenting. This was a mini 'training of trainers' for health providers and counselors, exploring parenting challenges when there is HIV in the family, including disclosure, planning for the future and preparing an HIV-positive child for long-term treatment. The workshop aimed at building health providers' skills to address an emerging issue in health care: the difficulties of parenting when there is HIV in the family. It dealt with physical, psychosocial and economic impacts of HIV and AIDS, whether the parents, children, or both were infected. Vital issues included disclosure, planning for the future and preparing an HIV-positive child for prolonged treatment. Participants put themselves 'in the shoes' of parents and children dealing with HIV and AIDS by reading stories of real families then writing a 'day in the life' diary about potential challenges. The group also explored specific interventions to address the multiple challenges of parenting with HIV, while being sensitive to cultural expectations, the often highly conflicting goals of different family members, and the need for open and

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supportive communication between parents and children.

One may say that the main groundbreaking news of the conference in terms of prevention, however, was delivered by the CAPRISA trial, which investigated the safety and effectiveness of 1% Tenofovir Vaginal Microbicide Gel in South African women.

CAPRISA 004 was a Phase IIb, double-blind, randomized, placebo-controlled trial to test the effectiveness and safety of 1% tenofovir gel, an antiretroviral microbicide, for the prevention of HIV infection in women at increased risk of HIV. The study involved 889 women (ages 18-40 years) in urban and rural KwaZulu-Natal, South Africa who were randomised to receive tenofovir gel (N=445) or placebo gel (N=444). Each woman was asked to apply the first dose of the assigned study gel within 12 hours before anticipated sexual intercourse, and to insert the second dose as soon as possible after intercourse. In the intent-to-treat analysis women in the tenofovir gel group had a 39% lower risk of becoming infected with HIV than women who used the placebo gel (P=0.017). Tenofovir gel was 54% effective among women who adhered to the dosing regimen at least 80% of the times, 38% effective among women who adhered to the regimen from 50-80% of the times, and 28% effective among women who adhered to the regimen less than 50% of the times. The effectiveness of the gel declined after the first 18 months in the study as the amount of gel being used by the participants decreased. Tenofovir gel also had a 51% protective effect against the acquisition of herpes simplex virus (HSV-2). Tenofovir gel was found to be safe and no drug resistance was found in women who acquired HIV infection during the study follow-up. As this trial was designed to be a proof of concept for effectiveness of microbicide gel, additional studies will be required to confirm and preferably improve the level of effectiveness observed in this trial. If this protective effect is confirmed, this gel could save millions of lives, especially in sub-Saharan Africa where women are the most affected group.

For more information on these and other topics you can visit the official conference website, which also offers video-coverage of the most important sessions and the rapporteur summary session:

http://www.aids2010.org/ and scroll down to the rapporteur summary sessions;

The conference has also been covered by:

www.aidsmap.com/vienna2010
Kaiser's complete conference coverage:
globalhealth.kff.org/AIDS2010

**Reported by Christiana Nöstlinger, PhD,
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III. Anal HPV infection and anal cancer in HIV positive MSM

Recently it has been observed that anal cancer is a growing problem in many developed countries. Like cancer of the cervix, it is caused by the human papillomavirus (HPV types 16 and 18). Anal HPV infection is most commonly acquired through anal intercourse, but it can also be acquired from other infected genital areas through sexual skin-to-skin contact. Since condom use only partially reduces the risk of transmission, all sexually active individuals, both men and women, are at risk. This makes anogenital HPV the most common viral sexually transmitted infection. As an example, supporting serological studies indicate over 50% of sexually active North Americans have antibodies indicative of previous exposure to anogenital HPV. However, in the general population only a fraction of people with anal HPV infection will develop a lasting case of abnormal cellular growth in and around the anus, and even fewer will develop anal cancer (2:100.000).

For MSM in general and MSM with HIV in particular, the perspective is unfortunately remarkably different. Anal HPV is present in approximately 65% of HIV negative MSM and 95% of MSM who are HIV positive.

Although HAART (highly active antiretroviral therapy) has decreased overall mortality from HIV, it has not reduced the incidence of anal cancer. Stronger even, the incidence has continued to increase since the beginning of HAART. For MSM, the incidence climbs to about 35 in 100.000. HIV positive MSM are even twice as likely to get anal cancer than MSM who are HIV negative, which approaches the risk of cervical cancer for unscreened women living in developing countries.

Although many men have no obvious symptoms, possible symptoms are abnormal discharge from the anus, bleeding from the rectum and anus, anal itching, pain or pressure around the anus, and anal sores that do not heal.

What can be done? Prevention and treatment perspectives

As stated above, condom use only partially reduces the risk of transmission of the HPV infection. In the last decade two types of vaccines have been marketed in the prevention of cervical cancer, caused by the same HPV types causing anal cancer. Currently, both products have been approved as a prophylaxis against HPV and cervical cancer for girls between the ages of nine and 26, resulting in large scale campaigns and even government supported implementation of the vaccines. The best form of prevention of anal cancer may be the vaccination against HPV infection. However, little consequence has been given up to date to the preliminary research showing that vaccination was effective for boys in the prevention of anal cancer in later life. Even less has been considered how to help preventing anal cancer in men older than 26 years old or HIV-positive MSM.

Some practitioners advocate the use of both marketed HPV vaccines for use in MSM who have already been infected with HIV and/or HPV. To this date, this would be considered an "off label" use of the vaccines. Clinical trials are being conducted, however, to see what benefits the vaccines might have for HIV-positive people.

In terms of treatment, anal cancer can be successfully treated if diagnosed early. Although a consensus on an accepted method for screening HIV positive MSM for anal pre-cancer to reduce the morbidity and mortality due to anal cancer is lacking, it is recommended to perform an anal pap smear as means of screening tool. The anal pap is a test similar to the pap test in women. A sample of cells is collected from the anus and rectum, and tested for structural cell changes. These changes are precursors to anal cancer and can be treated.

A growing number of gay physicians and health activists now believe that routine screening, using an anal pap smear, could reduce the incidence of anal cancer as dramatically as it has cervical cancer in women. They recommend that all MSM, especially those who are HIV-positive, be tested every one to three years, depending on their immunological well-being and CD4 count.

Even though standards of care are still lacking, it's wise for people living with HIV to bridge these health conversations with their providers and vice versa. Accordingly a discussion can be opened on what's needed in order to screen for detecting and/or resolving these conditions before they advance to cancer. Internationally, this advice has already lead to good practice examples in anonymous MSM sexual health clinics where visitors where offered a range of sti screening opportunities and risk reduction counseling.

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Still, carefully controlled studies remain necessary to further evaluate the screening and treatment of abnormal anal cell growth in HIV-positive MSM to prevent anal cancer, and also evaluate favorability of even HPV screening for all MSM since HPV enhances susceptibility to HIV infection.

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Reported by Sandra Vanden Eynde, psychologist-sexologist, Coordinator of Department Research and Development, Sensoa vzw, Antwerp, Belgium

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Think Positive, Love Positive and Act Positive

‘Live Positive’ is a campaign by Sensoa and will run until the beginning of 2011. The campaign for gay men is visible in the gaybars and –clubs, on the internet and on gay events. It consists of 14 posters, an hiv-folder, condoms and stickers. The campaign will be launched in five different parts, three of which have already been launched: Think Positive, Love Positive and Act Positive. Talk Positive and Live Positive will be launched in September and November. The messages behind the different parts are about prevalence, condoms, testing, talking about hiv and, ultimately, living with hiv (in the broad sense).

You can visit the website (in Dutch) on www.mannenseks.be/livepositive and follow the campaign on www.facebook.com/livepositive.

Reported by Leen Van de Velde, staff member prevention team MSM, Sensoa vzw, Antwerp, Belgium

Live Positive team at the Belgian Pride in Brussels

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IV. Interesting literature

Reports

Sexuality and counselling: building evidence of good practice

Anke van der Kwaak, Kristina Ferris, Louise Dekker

Exchange on HIV and AIDS, sexuality and gender, 2010, No. 1, pages: 1-16

In this special issue on sexuality counselling, the contributors argue that HIV and AIDS as a facet of sexuality is an area seeking more attention. It cannot be adequately addressed through traditional health promotion or sexuality education programmes. It requires the nuanced personalized attention of sexuality counselling.

The issue contains the following articles: Sexuality and counselling: building evidence of good practice; Counselling men to end partner violence in Indonesia and South Africa; Spotlight on fears of Kenyan youth; Feminist approach to sexuality counselling; Contextual sexuality challenges among people living with HIV: TASO's response; Helpline to address sexuality needs.

Available to download at
www.kit.nl/net/KIT_Publicaties_output/ShowFile2.aspx?e=1634

Relative safety II: Risk and unprotected anal intercourse among gay men with diagnosed HIV

Adam Bourne, Catherine Dodds, Peter Keogh et al.

London: Sigma Research, 2009

This study explores the experience of unprotected anal intercourse amongst homosexually active men living with diagnosed HIV. It draws on interview data from forty-two homosexually active men in England and Wales, spanning a range of years since diagnosis, and living in areas of differing HIV prevalence.

ISBN: 1 872956 98 X

Available at
www.sigmaresearch.org.uk/files/report2009d.pdf

Articles

Family-based HIV prevention and intervention services for youth living in poverty-affected contexts: the CHAMP model of collaborative, evidence-informed programme development

Arvin Bhana, Mary M McKay, Claude Mellins, Inge Petersen, Carl Bell

Journal of the International Aids Society, Volume 13 (Suppl 2), S. 8

Family-based interventions with children who are affected by HIV and AIDS are not well established. The Collaborative HIV Prevention and Adolescent Mental Health Program (CHAMP) represents one of the few evidence-based interventions tested in low-income contexts in the US, Caribbean and South Africa. This paper provides a description of the theoretical and empirical bases of the development and implementation of CHAMP in two of these countries, the US and South Africa. In addition, with the advent of increasing numbers of children infected with HIV surviving into adolescence and young adulthood, a CHAMP+ family-based intervention, using the founding principles of CHAMP, has been developed to mitigate the risk influences associated with being HIV positive.

The Collaborative HIV Prevention and Adolescent Mental Health Program (CHAMP) is an example of a family-focused, developmentally timed programme targeting pre- and early adolescents (9-13 years), providing a model of primary and secondary HIV prevention programme development and one that has been tested in numerous studies in the United States, sub-Saharan Africa, the Caribbean and South America.

The CHAMP+ intervention represents an adaptation of the CHAMP primary prevention programme to meet the needs of HIV-positive youths and their adult caregivers. The intervention protocol focuses (amongst other issues) on: family communication about puberty, sexuality and HIV and parental supervision and monitoring related to sexual possibility situations and sexual risk-taking behaviour; helping youth manage their health and medication.

This article is available via
www.ncbi.nlm.nih.gov/pmc/articles/PMC2890977 and has been published as part of Journal of the International AIDS Society Volume 13 Supplement 2, 2010: Family-centred services for children affected by HIV and AIDS. The full contents of the supplement are available online at
www.jiasociety.org/supplements/13/S2.

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Books

Unlimited intimacy: Reflections on the subculture of barebacking

Tim Dean

Chicago: The University of Chicago, 2009

This book investigates barebacking – gay men deliberately abandoning condoms and embracing erotic risk - and the distinctive subculture that has grown around it. The publication is not a manifesto but an extensively researched analysis about how intimacy works in the twenty-first century. A highly theorized interpretation of bareback sex that challenges mainstream understanding ment for everyone who whishes to become better acquainted with the topic of barebacking.

ISBN 978-0-226-13939-5

What do gay men want? An essay on sex, risk and subjectivity

David M. Halperin

Ann Arbor: University of Michigan Press, 2007

Unlike most writers on the topic of barebacking (condomless sex), David Halperin rejects psychology's claim to hold the keys to human subjectivity. He argues that psychology, which is grounded in a highly prejudicial opposition between the normal and the pathological, between healthy and unhealthy behavior, masks a set of dubious moral assumptions about "good" and "bad" sex.

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