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. 4

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 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: 15th June 2011

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

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

I. Current state of affairs

In the Eurosupport newsletter nr. 3 we gave an overview on the counseling intervention on safer sex (CISS) intervention, its basic elements and an outlook on the evaluation. In the meantime, we have completed the pilot counseling sessions and fine-tuned the intervention. All evaluation tools are available as online versions. The CISS is now ready for effectiveness testing and in some centres recruitment has started. The CISS intervention is now available for the trial study by two target groups on separate DVDs: HIV-positive men having sex with men (MSM), and HIV-positive migrants, i.e. gender-specific versions for male and female migrants. The DVD is accompanied by a pilot intervention manual for the counselors, including step-by-step instructions on how to use the CISS DVD.

The CISS - a brief overview

The CISS is a computer-assisted counseling intervention on safer sex, for people living with HIV. It consists of three sessions. Each session is guided by a specific model that leads to an individualized tailored risk reduction plan.

- Session 1: WHO AM I? Identification of the clients' and problems related to safer sex and condom use.
- Session 2: WORKING THROUGH. How to find tailored solutions for safer sex (i.e. use condoms more consistently).
- Session 3: MAKING YOUR PLAN. What are the clients' personal plans and what will help in the future to achieve the goals set (on safer sex/ condom use).

The CISS is based on empirically validated psychological theories on behavioural change (information-motivation-behavioral skills theory; stages of change; conceptulization of risk: dual-process theory of information processing in affective decision making.

In previous editions of this newsletter we gave more details on the development of the CISS. Readers, who want to have more background documentation, are invited to contact us.

To put it simply, with the CISS, we want to

- Normalize sexual (risk) behavior
- Engage people to behavioral change
- Offer feasible behavioral solutions
- Motivate clients to develop an individual 'risk reduction plan' (assisted by a counselor or other HIV service provider) and to adhere to it

Results of the pilot testing

Two centres (ITM in Belgium and AIDES in France) carried out a pilot test with selected volunteers. In these centres a selected number of 3-4 participants received the full counseling intervention. These pilots enabled us to fine-tune the intervention, and represented a good opportunity for the counselors to practice their counseling skills with the online tool. Overall we found that:

- Clients reacted very positively to the role-models, stories, images and other material presented on the CISS counseling DVD. Clients could self-identify with the presented material and it seemed to trigger certain emotions around problems with safer sex among HIV positive clients.
- The design and content of the DVD was found to be quite professional and easy to integrate into the counseling process.
- Thanks to the DVD, counselors felt able to discuss even very difficult issues (as the visual material helped clients to create their own stories and be upfront about them).
- Counselors felt that the most important advantage of using the DVD is, that it makes the feelings of the clients more explicit. The visual materials build a bridge between the clients own memories, feelings and potential barriers to safer sex, and made them more easily accessible within a rather short time.

Of course participants were selected volunteers and the pilot situation remained non-representative ,in comparison with the evaluation study, which will show the real acceptance and effectiveness of the CISS. In 'the practice behind the theory', the experience of an hiv counselor who was involved in conducting the pilot sessions, is described.

Recruitment has started

During February, recruitment has started. First at ITM and at the Infectious Disease Clinic in Munich and other centres will now follow step by step. Of course we are all keen to see how well accepted the CISS will be among the regular clients of the participating HIV/STD clinics. Participants will undergo a computerised screening procedure and will then be randomly divided into either the intervention group or the control group. If participants are selected into the intervention group, they will receive the 3 CISS sessions. If they are selected into the control group, they will receive the standard care (or 'treatment as usual') as provided at the centre. Follow-up moments with appropriate assessments on outcome

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

indicators are foreseen three and six months after completion of the intervention. Once the study will be completed, the control group participants will also be offered the intervention, if interested.

Next steps

During the next months, all our efforts will go into the mobilisation of participants in the various centres, so as to enrol. a sufficient number of participants into the trial. At the same time, we will work on improving and finalizing the manuals which will accompany the final intervention. We will also develop a set of online training tools that will support service providers in learning how to work with the CISS.

II. The practice behind the theory...

Christel Morren, a counselor of the Tropical Institute for Medicine in Belgium, tested the CISS with four clients. This was the beginning of the pilot phase in which the theory is put into practice. Before describing the general outcome of these pilots, it must be noted that the clients were very familiar with the subject and are therefore very open-minded towards sexual (health) topics. Although the overall outcome can be biased, the pilots are of great value for the counselors in question. By starting the pilots, counselors can get acquainted with the material and can gain an insight in the structure and contents of the CISS .

The CISS was perceived, by both the counselor as the clients, as a professional product that has been developed with great care. They immediately noticed the advantages for the client as well as for the service provider. The availability of numerous videos enhances the involvement of the client by making an obvious connection with the clients' life. Clients can identify themselves with what they see. This can give them a start to talk about sensitive subjects, such as sexual and reproductive problems. The CISS facilitates the counseling process by providing recognizable videos. The explicit images are in this respect a benefit for the counseling process. The fact that an erection is not hidden and a direct sexual language is used, contributes to a realistic reproduction of a clients' daily life. Nevertheless it must be noted that for some clients the images will be to explicit. When this is the case, it is the task of the service provider to make the client aware of this explicitness. An introduction game can function as a way to make clients feel at ease. However clients still need to be prepared before starting the CISS and service providers need to build on a trustful relationship with every client. That's why the counselor introduced the CISS by going through the informed consent form together. By doing so, clients get a clear view on the purpose and the course of the intervention.

By conducting the pilots, it became clear that time management is of crucial importance. As the visual material is very realistic, lots of emotions can come to the surface. Some clients may feel relieved to be able to talk about their sexual experiences and problems. It means that time is often too short to deal with all these issues. The service providers have the important task of identifying the main problem, for which a plan of action will be made. This often means that there is no time to deal with other related problems. When this is the case it is important to agree on this issue in advance, to ensure a follow-up or to refer the client to other experts.

It is advisable to conduct the pilots with both target groups (MSM and migrants) since every group has its own specific context. In order to successfully conduct an intervention, service providers need to create a safe environment for clients to speak freely on their sexual health. Some clients might have problems with this as there is still a taboo on sexuality and condom use, especially with Sub-Saharan African migrants. They might be shocked by the way of sexual talking and the explicit images in the video. In that case, it is important to stress that clients voluntarily participate, as agreed upon in the informed consent form. It should be mentioned to clients that they participate anonymously in the study and that all information will remain confidential. In this respect it is not advisable to take notes during the sessions, as this might frighten clients to talk freely.

The pilot shows that the CISS is made to be easily accessible for all service providers as long as they are willing to learn about new approaches and methods. By using the training and resource package (TRP) service providers get the necessary tools

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

to use the CISS, as they need some experience and skills to identify the specific problem of the client. Clients might hesitate to talk about a certain problem. It is the task of the counselor to offer the appropriate videos that address the problems of the clients. Since the CISS consists of numerous video fragments, service providers should get enough time in advance to gain an insight in the CISS before starting the pilots. It is important to have an idea of the duration and the contents of all fragments in order to be able to decide which material is appropriate for a specific client. This requires some time and effort to do so. When the counselor feels comfortable with the material, he or she can guide the client through the CISS. It is the strength of the CISS that clients can decide what is discussed during the sessions.

The three sessions were terminated in a period of two weeks. This short amount of time wasn't perceived as a disadvantage. On the contrary: when there is too much time left between the sessions, clients forget the core message. When the sessions are conducted in rapid succession, it seems that clients stick more to what has been agreed upon.

In the short term, the study will be started in different European settings. There will be thirty MSM and migrants in each country that will take part in the study. Before the start of the intervention they need to fill in a questionnaire that serves as a baseline assessment to determine behavioural? change. After the sessions there is a follow-up of each client. This study must indicate whether the CISS is an effective instrument in promoting safer sex for MSM and migrants.

Reported by Lore Declercq, Implementation manual Developer Eurosupport 6, Staff member Department of People living with hiv, Sensoa, Antwerp, Belgium

III. Meeting on Sexual Health Challenges in Europe

The WHO Regional Office for Europe, in collaboration with the Ministry of Health and Social Policy of Spain, International Planned Parenthood Federation (IPPF) European Network and the Federal Centre for Health Education (BZgA), WHO Collaborating Centre for Sexual and Reproductive Health in Cologne, Germany organized a meeting on Sexual Health in Europe, fficially called 'meeting of national counterparts in the WHO European Region: Challenges in Improving Sexual Health in Europe'. Policy-makers , researchers and various stakeholders from across the WHO European Region met in Madrid, Spain on 21–22 October 2010 to agree on a common understanding of sexual health. Due to the highly sensitive nature of this topic and the political ideologies involved, to date there is still no officially agreed upon definition of sexual health that expands beyond a traditional perception. The definition focused mostly on sexually transmitted infections and unwanted pregnancies, and did not take into account the positive aspects of sexual health, related to pleasure, general well-being and rights-related aspects. It was hoped that this meeting was a further step towards achieving a consensus definition.

While the 2004 WHO Global Strategy on Reproductive Health is based on human rights principles and outlines that - to ensure that these rights are respected - policies, programmes and interventions must promote gender equity, give priority to vulnerable population groups and provide special support to the countries that bear the largest burden of reproductive and sexual ill health. Nevertheless achieving full sexual health for all remains a challenge in many countries. The WHO strategy states that one of the five core aspects of reproductive and sexual health care is promoting sexual health (resolution WHA57.12). However, on the country level, many people cannot enjoy their sexual health and rights, be it because they are disabled, HIV-infected, have migrated from one country to another, belong to a sexual minority, or simply because they belong to younger or older age categories. Sexual health requires more analysis and exchange of best practices to meet the goals of the 21st century. Therefore, the purpose of this meeting was to contribute to improving the understanding of sexual health in a health systems framework. The objectives of the meeting were to discuss key concepts related to sexual health, to examine specific barriers to promoting sexual health for different target groups and to propose appropriate and effective strategies for promoting sexual health. The specific thematic focus for this meeting was to discuss and critically review:

- The existing sexual health strategies and policies in the WHO-Euro area;
- The sexual health challenges of adolescents and young people (including sexual education), older

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

people, migrants, people living with HIV and people with disabilities.

Background papers were presented, focusing on specific situation analyses with respect to sexual health of these population groups. In addition, country experiences reflected on best practise examples. One of the background papers, i.e. on sexual health of people living with HIV, was written by a Eurosupport team member (C. Nöstlinger, in cooperation with GNP+, the Global network of People Living with HIV). In addition, a representative from Sensoa (S. Van den Eynde) gave a best practice documentation on Flemish field experiences in working with migrants around issues relating to sexual health.

The audience consisted of the WHO-Euro national counterparts in sexual and reproductive health from 36 Member States in the European Region, representatives from WHO and other United Nations agencies and other international partners, including civil society organizations, and civil servants.

Based on a joint review of country experiences and scientific evidence, further discussions on challenges, achievements and developments took place. In working groups, the participants developed recommendations for further improving sexual health. Cross-cutting issues of these recommendations referred to the need of a consensus definition of sexual health, which could greatly support stakeholders in their local, regional and national efforts to strengthen the sexual health of vulnerable populations. Also the need for better documentation and monitoring of the sexual health status of key affected populations and the need for greater recognition of community involvement and the civil society contribution to improvising sexual health was discussed.

It was recognized that only very few countries have a national sexual health strategy that can be monitored and evaluated (Spain for instance has recently implemented one). Great sexual health disparities between Eastern and Western European regions were recognized and the importance of health systems strengthening in closing this gap was emphasized.

A report summarizing the presentations and the following discussions as well as the recommendations issued at the meeting will be available soon at the WHO-Euro website.

Reported by Christiana Nöstlinger, **PhD, Department of Microbiology/Health Promotion, Institute of Tropical Medicine, Antwerp, Belgium.**

IV. Hepatitis C in HIV positive MSM. The rise of a silent epidemic

Hepatitis C is a virus that causes inflammation of the liver which in turn can lead to liver diseases, including cirrhosis, liver cancer or liver failure. Contrary to hepatitis A and B, there is no vaccination available that can protect against the acquisition of the hepatitis C virus (HCV).

At the end of the previous millennium, clinicians recorded a remarkable increase of the number of HCV infections in HIV-positive MSM. Although it has long been thought that the virus was mostly transmitted by injected drug use, blood transfusions or unhygienic tattoos, there is now growing evidence that the virus can be spread by sexual behaviour. It is not clear how this transmission exactly takes place, but through deduction it has been put in relation with sexual practices that involve contact with blood. A recent study showed that HCV is only detectable in very low levels in the semen of a minority of HIV-positive MSM co-infected with both viruses. This study adds to the weight of evidence that transmission of HCV during sex happens through blood, not via semen. Regarding the risk factors for hepatitis C infection, investigators suggest that the practice of rough sexual techniques such as fisting, unprotected anal sex and the sharing of sex toys or anal showers can facilitate blood-to-blood contact by damaging the mucosal barrier of the anus. Further analysis restricted to HIV-positive men, revealed three major factors that significantly increased the risk of transmission: injecting drug use, fisting and the use of the party drug GHB. The use of the latter has an indirect impact on the rapid spread of HCV, as this might create an unrestrained atmosphere that can encourage unprotected and rough anal sex with different partners.

Positive prevention for MSM, such as raising awareness on the risks and internationally widespread routine testing for HIV/STIs, are needed to minimize further spread of HCV among MSM. MSM need more counseling about the risk of (re-) acquiring

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

HCV infection and testing for HCV should be reinforced in the six months after STD diagnosis. Guidelines from the UK recommend that all HIV-positive patients should be tested for HCV at least once, with subsequent tests for people at higher risk or with unexplained liver disease. This is needed for a variety of reasons. First of all, the virus is a major public health problem, as an estimated number of 180 million people are infected worldwide. It is almost impossible to give accurate figures on this, since a great amount of people is not aware of their infection with HCV. 80 to 90% of all acute infections occur without any clear symptoms. Without obvious symptoms, people are unaware of their infection and they become a chronic carrier of the virus. This is one of the reasons of the rapid spread of the disease. Therefore it is crucial that persons most at risk get tested for HCV (and other STIs).

Hiv-positive MSM are especially susceptible to infection by the virus. In the STD clinic of Amsterdam, prevalence of HCV among HIV-negative MSM was very low (0,4%), while prevalence among HIV-positive MSM was quite high (18% in 2008). It is not clear how the virus could occur as a STI in such a short period of time. As mentioned above, it can be related to rough sexual practices that involve blood contact. HIV can also lead to a higher viral load of HCV in the blood, which makes an infection more likely. It is plausible that very soon after the HIV infection, the immune system of the intestine isn't working properly. Furthermore, serosorting can contribute to a rapid spread of HCV among HIV-positive MSM. With this HIV risk reduction strategy, MSM want to avoid the spread of HIV by selecting HIV positive sexual partners.

Secondly, the prevalence rate of HCV among HIV-positive MSM remains high. Approximately a quarter of HIV-positive patients in France are co-infected with HCV. At the recent International Congress on drug therapy in HIV infection, German researchers stated that HCV prevalence in HIV-positive men remained high (15%). A study from Amsterdam, presented at the Vienna International AIDS conference, on the contrary found acute hepatitis C cases decreasing after January 2008. Studies conducted in France, the UK, Germany and the Netherlands with 200 HIV-positive MSM, indicated that MSM are infected with very similar variants of the virus, that differ completely from the variants that occur in HIV-negative persons. Therefore, researchers concluded that the virus spreads rapidly in a big European network of sexually active MSM that are HIV-positive.

Thirdly, treatment in the acute phase has the best chance of success, but may be less successful if initiated soon after the infection. This makes it crucial to detect HCV in an early stage of the infection, although this does not guarantee a cure. Treatment for HCV is not life-long, but has severe side-effects. Relapse occurs in over a third of individuals who are co-infected with HIV and HCV and almost always occurs within the first twelve weeks after discontinuation of treatment. Most occurrences beyond twelve weeks are reinfections. Furthermore mortality rates are high among patients co-infected with HIV and HCV. In France, over 40% of deaths were directly attributable to the HCV virus. A chronic infection can lead to liver cirrhosis or liver cancer. Evolution to liver fibrosis was rapid in a substantial proportion of diagnosed MSM during a Belgian study. Researchers concluded that the majority contributor to mortality among co-infected patients during the HAART (highly active antiretroviral therapy) era is likely to be liver disease, although there was no difference in the risk of progression to AIDS. Nevertheless people living with HIV should avoid co-infection with HCV, as co-infected people are twice as likely to develop an AIDS-defining illness than individuals who are only infected with HIV.

This strengthens the need for careful follow-up of both HIV-positive MSM to prevent infection with HCV and of co-infected people. An effective programme must include preventive methods, such as testing, prophylaxis and vaccination of preventable diseases (e.g. hepatitis A and B). Although further research concerning the transmission of HCV and the influence of the virus on people living with HIV is necessary, the prevention message should be clear. Positive MSM are most at risk of co-infection with HCV and should therefore be encouraged to practice safer sex during counseling. They should use condoms with every sexual partner and use a new condom for every partner. Furthermore they should be motivated to use latex gloves during fisting and avoid using shared sex toys and anal showers. HIV-positive MSM should get tested every six months for STIs. Only these precautions concerning sex can tackle the rapid spread of the virus.

Sources

Turner J et al. (2010) Hepatitis C viral load in semen of HIV-positive men during acute and chronic hepatitis infection, 2nd Joint BHIVA/BASHH Conference in Manchester. Cairns G. (2010) Hepatitis C virus in semen unlikely to explain transmission, 27 April 2010, www.aidsmap.com/news/Hepatitis-C-virus-in-semen-unlikely-to-explain-transmission/page/1438576

Urbanus A.T. et al. (2009) Hepatitis C virus infections among HIV-infected men who have sex with men: an expanding epidemic, AIDS 23: F1-F7. Carter M. (2009) Hepatitis C spreading rapidly amongst HIV-positive

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

men in Amsterdam, 5 August 2009, www.aidsmap.com/page/1435517

Florence E, et al. (2008) Acute hepatitis C infection in a cohort of HIV-infected patients in Belgium, Journal of the International AIDS Society, 11 (Suppl 1), 10 November 2008, p 270.

Hepatitis C, Diagnosis and monitoring, www.aidsmap.com/resources/Diagnosis-and-monitoring/page/1273017/

Ghany M G, et.al. (2009) Diagnosis, management and treatment of Hepatitis C: An update, The American Association for the study of Liver diseases, April 2009, www.hivandhepatitis.com/hep_c/news/2009/HCVUpdates.pdf

Van Laar T and Urbanus A T (2009) Hepatitis C als SOA bij hiv-positieve mannen die seks hebben met mannen, SOAAIDS 6 (3), September 2009, www.soaaids.nl

Loko M et al. (2010) The French national prospective cohort of patients co-infected with HIV and HCV: early findings, 2006-2010, BMC Infectious Diseases, 10.

Stellbrink H et al (2010) Increasing numbers of acute hepatitis C infections in HIV-infected MSM and high reinfection rates following SVR, 10th International Congress on Drug Therapy in HIV infection, Glasgow.

Fierer D.S. , et al (2008) Liver fibrosis in an outbreak of acute HCV in HIV-infected men: a prospective cohort study, Mount Sinai study, September 2008.

Medrano J. et al. (2009) Rate and time of hepatitis C virus relapse after a successful course of pegylated interferon plus ribavirin in HIV-infected and HIV-uninfected patients, Clin Infect Dis 49, p 1397-1401. Carter M. (2009) Relapse common in HIV/HCV co-infected patients after treatment for HCV, 19 October 2009, www.aidsmap.com/page/1436488/

Carter M (2010) High hepatitis C mortality and low clearance rates in HIV/HCV co-infected patients in France, 29 October 2010, www.aidsmap.com/news/High-hepatitis-C-mortality-and-low-clearance-rates-in-HIV-HCV-co-infected-patients-in-France/page/1526828

Chen T et al. (2009) Meta-analysis: increased mortality associated with hepatitis C in HIV-infected persons is unrelated to HIV disease progression, Clin Infect Dis 49 (10), p 1606-1615.

Monteforte A et al. (2009) Risk of developing specific AIDS-defining illnesses in patients coinfected with HIV and hepatitis C virus with and without liver cirrhosis, Clin Infect Dis 49, p 612-622.

Reported by Lore Declercq, Implementation manual Developer Eurosupport 6, Staff member **Department of People living with hiv, Sensoa, Antwerp, Belgium**

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

V. Dates to keep in mind: upcoming conferences

BHIVA 'Best of CROI' Feedback Meetings

These meetings will take place in various locations across the UK. All of our feedback meetings will provide an independent, unbiased and impartial review of the key presentations which will be held at the CROI conference in Boston from 27 February - 2 March 2011.

Dates and locations

Monday 14 March 2011, Royal College of Physicans, London
Tuesday 15 March 2011, Birmingham
Wednesday 16 March 2011, Haydock, North West England
Thursday 17 March 2011, Edinburgh
Monday 21 March 2011, Gateshead

3rd National Conference: Current Issues in Sexual Health 2011

24 – 25 March 2011
London, United Kingdom

17th Annual Conference of the British HIV Association

6–8 April 2011
Bournemouth International Centre,UK

HIV in European Region - Unity and Diversity Conference

25-27 May 2011
Talinn, Estonia

7th International Workshop on HIV & Hepatitis Co-infection

1-3 June 2011
Milan, Italy

5TH SA Aids Conference

7-10 June 2011
ICC Durban- South Africa

1ST International HIV Social Sciences and Humanities Conference

11-13 June 2011
Durban, South Africa

AIDSimpact

12-15 September 2011
Sante Fe, NM, United States

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

VI. Interesting literature

Behavioural interventions for HIV positive prevention in developing countries: a systematic review and meta-analysis

Kennedy, Caitlin E / Medley, Amy M / Sweat, Michael D / O'Reilly, Kevin R

Bulletin of the World Health Organization, 88 (8), p.615-623, Aug 2010

Systematic review and meta-analysis of papers on positive prevention behavioural interventions in developing countries published between January 1990 and December 2006. Aimed to assess the evidence for a differential effect of positive prevention interventions among individuals infected and not infected with human immunodeficiency virus (HIV) in developing countries, and to assess the effectiveness of interventions targeted specifically at people living with HIV.

www.ncbi.nlm.nih.gov/pubmed/20680127?dopt=Abstract

Mental health treatment to reduce HIV transmission risk behavior: a positive prevention model

Sikkema, Kathleen J / Watt, Melissa H / Drabkin, Anya S / Meade, Christina S / Hansen, Nathan B / Pence, Brian W

AIDS and behavior, 14 (2), p.252-262, Apr 2010

Secondary HIV prevention, or "positive prevention," is concerned with reducing HIV transmission risk behavior and optimizing the health and quality of life of people living with HIV/AIDS (PLWHA). The association between mental health and HIV transmission risk (i.e., sexual risk and poor medication adherence) is well established, although most of this evidence is observational. Further, a number of efficacious mental health treatments are available for PLWHA yet few positive prevention interventions integrate mental health treatment. We propose that mental health treatment, including behavioral and pharmacologic interventions, can lead to reductions in HIV transmission risk behavior and should be a core component of secondary HIV prevention. We present a conceptual model and recommendations to guide future research on the effect of mental health treatment on HIV transmission risk behavior among PLWHA.

www.ncbi.nlm.nih.gov/pubmed/20013043?dopt=Abstract

Perceptions of audio computer-assisted self-interviewing (ACASI) among women in an HIV-positive prevention program

Estes, Larissa J / Lloyd, Linda E / Teti, Michelle / Raja, Sheela / Bowleg, Lisa / Allgood, Kristi L / Glick, Nancy

PloS one, 5 (2), p.e9149, Jan 2010

This exploratory qualitative analysis aimed to better understand the experience and implications of using ACASI among HIV-positive women participating in sexual risk reduction interventions in Chicago (n = 12) and Philadelphia (n = 18). Strategies of Grounded Theory were used to explore participants' ACASI experiences.

www.ncbi.nlm.nih.gov/pmc/articles/PMC2818842/

Positive Prevention Toolkit

This toolkit aims to assist global training of HIV/AIDS caregivers. It was created to assist health care providers and counselors in delivering effective Positive Prevention messages during their routine interactions with HIV-infected clients. The range of resources contained herein enables caregivers to choose the approaches that will work best in their individual settings and to develop skills for effec-

tively implementing new programs.

positiveprevention.ucsf.edu/

Online Sex-Seeking Behaviors of Men Who Have Sex With Men in New York City

Grosskopf, N. A. / Harris, J. K. / Wallace, B. C. / Nanin, J. E.

American Journal of Men's Health, Aug 2010

The ongoing HIV epidemic among men who have sex with men (MSM) in New York City and the increased use of Internet sexual social networking websites by MSM fosters a need to understand the characteristics and sex-related behaviors of this group. The authors conducted an online survey of 195 MSM who use sexual social networking websites in New York City. Demographic characteristics, sexual sensation seeking, and HIV optimism–skepticism were compared among participants reporting sex with and without condom use (safe sex and high-risk sex, respectively) with partners met online. There was no difference in income, education, race, or employment status between the groups. The groups differed significantly in age, sexual sensation seeking, and HIV optimism–skepticism. In a multivariate logistic regression

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

both HIV optimism–skepticism ($p < .05$) and sexual sensation seeking ($p < .05$) were significant predictors of high-risk sexual behavior (pseudo-$R^2 = .24$). This information should be considered when developing interventions for this group. For example, to reach those with high sexual sensation seeking, public health professionals should design sex-positive prevention messages for online distribution that highlight safer sex without condemning risky sexual practices.

jmh.sagepub.com/content/early/2010/06/24/1557988310372801.abstract

EUROSUPPORT 6
is financially supported
by the European Commission
Grant Agreement Nr. 2008 1204.

"This newsletter arises from the project Eursupport 6; grant agreement 2008 1204, which has received funding from the European Union, in the framework of the Health Programme"

ALSO SPONSORED BY

GILEAD

Abbott
A Promise for Life