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. 5

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 February 2012

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

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I. Current state of affairs

During the last six months, i.e. the reporting period since the last newsletter, almost all partners have started to recruit participants for the intervention trial to test the effectiveness of the CISS. The CISS is a brief behavioural counselling intervention using computerised tools, with the aim to support HIV-positive clients in achieving safer sexual behaviour. The emphasis is on improving condom use, as CISS stands for "Condom is safe and simple" or "computerised intervention for safer sex".

The CISS is available as a beta version for the trial study for two target groups on separate DVDs (since it is currently being evaluated, only project partners have access to the intervention materials): a DVD for HIV positive men having sex with men (MSM), and two gender-specific versions for HIV-positive female and male migrants. The DVD comes with an integrated pilot intervention manual, which has been revised based on the feedback provided by the project partners.

The CISS philosophy

Our aim is to start from the person's perception of their situation and their individual barriers to being safe sexually. While theories may perfectly explain irrational sexual behaviour, as counsellors we are not here to moralise. With the CISS we aim to promote health and well being, both psychological and physical. Like the client, we want him or her to feel good. By working through the CISS, clients can achieve a feeling of well being and safety.

The CISS - a brief overview

The DVD guides counsellors and clients through three sessions, which each highlight a different aspect of working through issues relevant to safer sex.

Session One: "Who am I?"

The first session puts the main focus on exploring emotions. The goal in this session is to understand WHO the client is and to explore what motivates the client in his or her wish to be safer in sex.

Clients and counsellor will watch some of the video material together. By the end of the session the counsellor will know what motivates the client in life and towards safer sex, and what the actual barriers are. Counsellor and client will form an idea on setting personal goals for using condoms consistently.

At the end of the session, the counsellor suggests working on some areas of the DVD at home, in case the client has access to a PC and feels comfortable to watch the material at home.

Session Two: "Working Through"

The second session focuses on overcoming the personal barriers, in short: how to make using condoms simple. The goal for the second session is to explore different approaches to making safer sex simpler in the clients' individual situation and to link the solution to the values and meanings identified in the first session. By the end of the second session the client will have identified an approach, which is practical and feasible in his or her individual circumstances (e.g. taking into consideration for instance partner-related or even wider contextual factors).

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The counsellor's role is to guide the client through this process, not to impose behavioural solutions. This is done for instance by suggesting 'Working through' material for the client to work on before the next and last session.

Session Three: "Making your Plan"

The third session focuses on the concrete actions to be taken to achieve the behavioural goal, i.e. planning the practical steps to actually use condoms consistently. The goal here is for the client to leave the room with a clear idea of the next steps, however small. This means knowing WHAT he or she will do, WHEN to do it, WHERE to do it. This should be linked to session one and two, as to remind the client WHY he is doing it, from the point of view of the values and meaning the client gives to safer sex and condom use.

In this way the CISS links deep emotion (i.e. "what matters to us in life") to practical action (i.e. "what we do in life"). The client should be aware that the steps taken are personal ones that he or she has decided to take. The client should also feel that the counsellor respects and understands him as an individual and that the counsellor has really listened and appreciated his life situation.

Recruitment to the CISS trial is ongoing

Participants of the Eurosupport 6/CISS trial study, which adopts a randomised control design, undergo a computerised screening procedure on a voluntary basis and are then randomly selected to either the intervention group or the control group. If they are selected into the intervention group, they will take part in the 3 CISS sessions. If they are selected into the control group, they receive the standard care (or 'treatment as usual') as provided at the participating centre. Follow-up moments with appropriate assessments on outcome indicators and underlying determinants are foreseen three and six months after completion of the intervention. Upon conclusion of the intervention, participants fill in a post-intervention survey which assesses clients' satisfaction with the intervention. This is part of the process evaluation.

Recruitment started in February/March 2011. Up to now, just over 80 participants in total have been recruited to the study. Not all centres could start up at the same moment, so inclusion rates differ across the centres. Each centre is expected to include 32 participants per target group, with an overall of 440 participants to be enrolled. However, for the time being, only Portugal has achieved this target. Many of the other centres are lagging behind, and this was not only due to a late start.

We have observed two main barriers to recruitment: interpersonal and structural ones. With respect to the first, many clients find it difficult to admit to their service providers that safer sex is difficult for them to achieve. Although many may have a trusting relationship with their HIV physician or counsellor, it seriously hampers recruitment. We can only speculate that if service providers invite clients to participate, it may feel to them that enrolling means admitting to inappropriate unsafe sexual behaviour. With respect to the latter, i.e. the structural barriers mentioned above, a context of criminalisation has been proven to be detrimental to recruitment. There may also be an implicit effect of laws regulating HIV transmission: for instance in Slovakia, when receiving an HIV-positive diagnosis, all HIV-infected patients have to sign a declaration that they commit to not having unprotected sex with any sexual partner, in order to prevent onwards HIV infection. By signing this, patients are also informed that they could be prosecuted according to Slovakian law.

This practice has made it extremely difficult for patients to admit that they experience problems changing to safer sex practices. Despite of the fact that within the study confidentiality was emphasised and guaranteed, patients in the end did not volunteer to be recruited, although several people initially expressed their interest. The degree of this problem was unexpected, because an anonymous study on sexual and reproductive health and sexual risk reduction of people living with HIV (carried out in the framework of the Eurosupport 5 project; Nöstlinger et al. 2010) revealed equal levels of sexual risk behaviour among Slovakian participants compared to the overall European sample. This serves as an example, that legal measures criminalising exposure to HIV and HIV transmission risk may have an unintended negative effect on HIV prevention and public health safety. While probably induced by policy-makers as a public health measure, it may rather increase the vulnerability of people living with HIV. While Slovakia may represent an extreme example due to their specific regulations, also other participating countries are struggling with barriers in recruiting study participants. This indicates people living with HIV still may find it difficult to come forward and talk about their problems with condom use.

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Next steps

It is clear that with the low numbers of people recruited into the study so far, we need to intensify our recruitment efforts: this means adopting different recruitment techniques, like snowball sampling and using informal networks to access and invite participants. At some centres, ITM for instance, we switched to inviting every patient to the study without discussing sexuality up front, to further reduce any thresholds as described above. We do this by means of a personalised invitation, which emphasises confidentiality and our counselling approach of normalising problems with safer sex. However, especially with migrants, critical barriers remain in place. In addition, we will try to recruit at additional sites, however, administrative requirements often do not allow for sufficient flexibility to integrate new partners into the project.

Interview with Sónia Dias, PhD (International Health), Assistant Professor (International Public Health Unit, Institute of Hygiene and Tropical Medicine, Universidade Nova de Lisboa) and coordinator of the Portuguese Eurosupport 6 team.

- **In Lisbon, you have done a really good job in recruiting migrants living with HIV into the CISS evaluation study? Can you describe which recruitment approach you took?**

The first step was the careful preparation of the recruitment process. We scheduled working meetings with partner NGOs, prior to participants' enrolment. At these meetings we presented the standard operating procedures (SOP) for recruitment and the CISS study procedures, as well as the CISS materials. We also discussed the specific tasks for the follow up phase. So all the NGOs were well prepared and knew what was ahead of them. Each NGO then made a list of patients who were eligible for screening (based on the study's inclusion criteria).

With regards to the recruitment process, each partner NGO made a first approach to possible participants by contacting them personally and providing general information about the study.

Then the second approach was carried out by the counsellor. Each participant received information about the study goal, purpose, the procedures involved and in particular the informed consent procedures. The counsellor clarified questions and doubts and then proceeded with participant enrolment.

- **Why would you say that it was successful?**

Mainly, this approach was successful due to the intense collaboration between the Institute of Hygiene and Tropical Medicine (IHMT) and the partner NGOs during the preparation of the recruitment process and the intervention itself, which was already initiated some time before we started to actually enrol participants. Also, the great efforts and support of the counsellor and participating organisations regarding the contact of possible participants contributed, as well as information on the overall ES6 project. This raised the awareness to the importance of this study/intervention. However, the NGOs' long experience with the migrant population was definitely an added value throughout the recruitment process. Also, the general interest and will of participants to support research/intervention studies was a major positive aspect.

- **What are the advantages and disadvantages of this approach? (e.g. were there any problems, and if so, how did you overcome them?)**

The main advantages were, of course, that the approach of close cooperation with NGOs, who were already experienced in dealing with the specificities of this population, facilitated access to possible participants. The fact that these NGOs followed them on a regular basis, enabled possible participants to feel more confident concerning study procedures and counselling sessions; in addition, this may have also facilitated empathy with the counsellor.

The main problem was that some participants missed appointments, and this was mainly due to contextual factors and specific characteristics of the migrant population. We had to re-schedule appointments various times and occasionally we even had to use the NGO's home support services for transport.

- **Were participants concerned about confidentiality? How did you deal with this?**

In general this issue was not raised, but a few participants had indeed questions about the confidentiality of data. All questions were calmly answered and we went through the consent form with each participant as many times as needed. However, since participants in general were confident about the services the NGOs provided, they gave also credit to the external counsellors.

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- **What are some of the lessons learned when working with the CISS?**

First of all, it was important to summarise and give an overview of the contents of the DVD - those relevant to each session and participant.

It has been shown to be effective to pause the video-clips at specific moments and discuss important aspects with the participant. Main challenges related to the fact that the video-material was not dubbed, which caused difficulties for some participants. To overcome this issue it was necessary to stop the videos more often and translate on the spot, in order for all contents to be correctly perceived.

In order to address each participants' issues concerning his/her sexuality, it was important to explore in-depth all DVD contents because for some participants it was difficult to draw parallels between the videos and materials available and their own situation.

- **What would you recommend to other project partners, how could they improve recruitment?**

While each context and target group may differ, the first contact and approach by professional service providers from the centre/clinic seems to be important (i.e. when the person who will enrol participants and deliver the counselling sessions is not known in the centre/clinic).

Some other relevant aspects that also should be taken into account: In our case, in some situations participants were more sympathetic when they knew that enrolment, follow up and CISS was to be delivered by an external counsellor. Gender issues (matching participant-counsellor) may also be an important factor influencing participants' decision to participate in the study. Time and availability of team members to respect each participants' availability to take part in the study, could be an additional issue (e.g. flexible timetables, scheduling several appointments, managing non-attendance, etc.)

Development of the Training and Resource Package (TRP)

The finalised version of the CISS, adapted on the basis of the evaluation, will consist of the training and resource package to support people living with HIV in improving their sexual and reproductive health. While the CISS focuses on condom use, as one selected outcome behaviour, the TRP is more comprehensive and focuses on positive prevention in an overall context of sexual and reproductive health and rights. It has constantly been developed through the work-packages led by Sensoa, with contributions of other project partners (CNWL, ITM). The TRP consists of the following elements:

The CISS and the accompanying intervention manual (see above); this will be complemented by online tools to show best practice using the CISS for specific topics;

The reference guide: a handbook on positive prevention to provide an overview on the state of the art of positive prevention research;

The implementation manual: describing how to work with the CISS in different settings and the institutional and policy requirements to work locally with this intervention;

The trainer's manual: describing how to train service providers in working with the material developed, which contains both elementary sexual health counselling skills referencing the CISS.

For finalising the TRP, we will organise a consultation with our collaborative partners as to ensure a broad community involvement. Those organisations, benefiting from the material developed, will get a chance to give their input, and on the basis of this we will revise and finalise the materials. The collaborative partners will be contacted early November 2011.

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

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III. Reports on Conferences and Scientific Meetings

Annual Meeting of the Academy of Sex Research

The meeting was hosted by the University of California - Los Angeles (UCLA). The UCLA-campus is impressive and includes multiple sports, leisure, and other facilities.

This four-day conference focuses traditionally on a variety of aspects in sex research. This broad variety was reflected in the different symposia, including 'Neuroimaging of men's object preferences', 'Female cosmetic genital surgery', and 'Sexualities and people living with intellectual disabilities'.

While the range of topics was broad, the focus was primarily on biomedical-oriented, fundamental research. Clinical research projects were only sporadically presented. Nevertheless, the quality of presentations and findings was high, and the atmosphere relaxed. During the four days of the conference, a poster session (including reception), a social excursion, and a banquet were organised. These side activities facilitated networking and exchanging ideas with some of the leading researchers in the field.

A first lecture I would like to highlight, was on 'How to think about bare-backing' given by Tim Dean (www.acsu.buffalo.edu/~tjdean), Professor of English literature at Buffalo University. He gave an insiders' view on the subculture of bare-backing among men having sex with men. He explored the scene, and wrote down his reflections in book form: "Unlimited Intimacy". (press.uchicago.edu/ucp/books/book/chicago/U/bo6485469.html)

Another interesting presentation was given by Susan Cochran (www.stat.ucla.edu/~cochran), professor in Epidemiology. She provided an overview of findings on mental health of lesbian, gay, bisexual and transgender (LGBT) populations. She concluded that the LGBT populations suffer from more mental health problems than their heterosexual counterparts.

Currently there is an important switch to be observed in sex research and this was reflected by the programme: sexuality has always been prominently considered as an individual behaviour. Sexual risks, and sexual problems are mostly studied as intrapersonal issues. But as sex is dyadic (i.e. sexual relationships involve two people), sexual partners influence sexual patterns. The importance of the sexual partners' role is therefore increasingly acknowledged in the study of people's sexual behaviour.

Next year's IASR-meeting will be held in Lisbon (Portugal) from July 8-12, 2012. As I gave my feedback to this year's meeting (somewhat too biomedical oriented) to some members of the organising committee, they assured me that next year's meeting will include more clinical aspects. But of course, it all depends on what people submit. So let this be a call to check the website of the academy (www.iasr.org), submit an abstract, and attend next year's meeting.

Reported by Tom Platteau, **Sexologist, Department of Microbiology/Health Promotion, Institute of Tropical Medicine, Antwerp, Belgium.**

Conference Report: 10th AIDS Impact conference in Santa Fe, US

From September 12-15, 2011, the 10th AIDS Impact conference took place. This year, more than 400 international delegates met in Santa Fe, USA, the capital city of New Mexico, labelled as "land of enchantment". Nestled in the Rocky Mountains, Santa Fe is one of the oldest state capital cities in the USA. The city has a very distinct "adobe" architecture inspired by historic Indian pueblos, many of which could be visited in close vicinity to the conference venue.

AIDS Impact 2011 highlighted recent advances in HIV/AIDS prevention, treatment and care. It also focused on remaining and emerging challenges for HIV prevention and care among at risk populations. In what is to follow, we focus mainly on some selected contributions and presentations of delegates pertaining to prevention and behavioural research, and sexual and reproductive health of people living with HIV, as this is also the focus of the Eurosupport 6 project.

The conference started off with a commemorative symposium in honour of the work of Marty Fishbein, a longstanding supporter of AIDS Impact and member of the international organising group. It was a tragic event when Marty Fishbein died in 2010 during one of the preparatory meetings of the committee. The symposium 'the Work of a Lifetime' offered the opportunity to work in detail through the Theory of Reasoned Action' (TRA) and the 'Integrated Model', two important theoretical contributions by Fishbein to a better understanding of how people change behaviour. International scholars working with these models discussed the theories' empirical validation as well as their application to

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various fields in health promotion and HIV prevention; for instance the project RESPECT, one of the largest behavioural trials ever conducted, was based on the TRA and showed that good quality counselling can be successful in changing behaviour. Fishbein's work is highly relevant for HIV prevention planners, as he showed the importance of defining one (!) specific behavioural goal to be reached (i.e. safer consistent condom use with one partner as compared to just adopting safer sex) and the importance of psychosocial mediators such as beliefs, attitudes, and intentions and how they influence behavioural outcomes. The latter is particularly important as with small effect sizes to be expected in actual behaviour change, changes in intentions can be practically meaningful and should therefore always be measured. One important paper published by Fishbein in 2008 describing a health promotion approach based on his integrated model is available online (open access): 'A reasoned Action Approach to Health Promotion' (Med Decis Making 2008, 28:834-844):

mdm.sagepub.com/content/28/6/834.full.pdf+html

During the regular conference programme, much attention was given to topics such as treatment as prevention, mental health and quality of life of people living with HIV, and sexual health. In the opening plenary, Kevin Fenton from CDC (Centers for Disease Control, Atlanta, US) presented the new approach CDC is taking in promoting sexual health within the US. While this approach is largely based on WHO's working definitions of sexual health, it is still quite remarkable for a policy framework developed in the US, to explicitly mention sexual pleasure as an important part of sexual health. More information on the new strategy can be found at: www.cdc.gov/sexualhealth/docs/SexualHealthReport-2011-508.pdf

A session on mental health and well-being focused on factors that promote resilience among target groups as diverse as AIDS-orphaned children (L. Cluver at al., abstract nr. 151), love and sex life of people living with HIV 50 years and over (Wallach et al., abstract nr. 173), and presentation of a model for an over 50-clinic (Ward et al., abstract nr. 110). The latter reported mainly on how to assess for neurocognitive disorders in aging people living with HIV.

An interesting study presented by Shela Tariq from the London City College showed that women living with HIV in the UK are more than twice as likely to present late for antenatal care, compared to HIV-negative women. Just over 50% present after the first trimester, 25% after 17 weeks, and 5% after 28 weeks, while UK guidelines advise that all pregnant women should have their first appointment at 13 weeks of pregnancy. In women diagnosed with HIV during pregnancy, the risk of late booking was higher for women of African ethnicity (AOR 2.85: 95% confidence interval (CI) 1.49, 5.45; p=0.001). When the mother knew her HIV status prior to becoming pregnant, the risk of late booking was also raised for women of African ethnicity (AOR 1.61; 95% CI 1.03, 2.54; p=0.038). The study pointed to the fact that women presenting late for antenatal care miss the opportunity of early screening for HIV and other conditions, which may have an adverse effect on obstetric and maternal health outcomes (S. Tariq et al., abstract nr. 90).

With respect to counselling interventions, S.M. Noar (University of Kentucky, US) gave an overview on computer-technology based interventions, which came to the conclusion that CBI are effective in changing behaviour (such as condom use) and the underlying determinants (like self-efficacy and attitudes), but that they are more efficacious if they include individually tailored components (Plenary 3.3, no abstract available). The Eurosupport Project was also presented: "Systematic development of a computerised sexual risk reduction intervention with people living with HIV" (by C. Nöstlinger). An interesting contribution was also a meta-analysis of sexual risk behaviour reduction using the counselling technique known as motivational interviewing (MI), which found little evidence of efficacy, which was attributed to the fact that sexual risk was a decision shared between two people, and the psychosocial theories underlying techniques such as MI assume that risk behaviours are under the control of the individual – as they are when the individual is trying to do something like stop drinking. (see also literature overview).

From the last day's plenary, we would like to highlight the presentation on Disclosure of HIV-status to children, given by F. Amolo Okeru, who presented WHO's work on compiling guidelines for pediatric HIV disclosure, which will be published soon. The final closing plenary was devoted to "Learning from theory-based interventions". R. Wolitski (CDC) gave an overview on the strength and weaknesses of existing behavioural interventions, highlighting the trend towards formulating new prevention goals induced by the shift to treatment as prevention and other recently prioritised biomedical prevention interventions: Achieving viral suppression will require more attention for prevention goals such as avoiding missed opportunities for HIV screening, better linkages to care, retention in care, improved adherence - which can be summarised as improving health outcomes for people living with HIV. However, one may want to conclude, whether it is about condom use, people using a microbicide, pre-exposure prophylaxis or antiretroviral treatment as prevention,

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in the end it's all about human (and often sexual) behaviour, and the more acceptable interventions are to people, the more likely they will use them.

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

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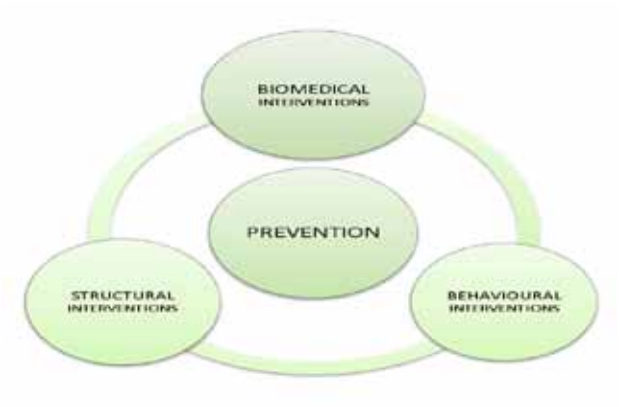
IV. Combination Prevention – some considerations

Combination prevention - a model based on combined biomedical, structural and behavioural interventions, in order to prevent the transmission of HIV and other sexually transmitted infections (STI), has been around for a while now but still is the buzz word on many congresses. This was also the case at the 19th Biennial Conference of the International Society for STD Research. Many presentations focused on the results of biomedical interventions, as for instance the successful results of the HTPN 052 study (Cohen, 2011). This study showed that serodiscordant heterosexual couples could significantly lower the risk of HIV transmission when the HIV-positive partner received effective on antiretroviral therapy. Whether these results can be applied to a MSM community in resource-rich settings, is still unclear.

The figure below is a schematic representation of the combined prevention model.



Examples of the biomedical interventions are for instance: delivery of vaccines and topical microbicides, use of new diagnostic tests, use of PEP and PrEP and Treatment (with ART); examples for structural interventions range from integrated STI care and test facilities (i.e outreach) targeting the community level, to improving clinical environments (i.e. increasing partner notification, screening), to promotion of community empowerment and protecting human rights and other legal measures. Promoting healthy behaviours (e.g. safer sexual and health seeking behaviour, increasing condom use) and behaviour and practice change interventions (counselling for improving risk reduction skills) are behavioural interventions. This model underlines the difficult and complex multi-facetted actions needed for prevention of HIV and STIs.

On a regular basis, new study results are added to the range of developments in the biomedical field increasing the range of prevention instruments. Biomedical, structural and behavioural interventions do not only influence the outcome of the prevention as such, they also influence each other. However, it is still unclear how exactly the different approaches influence each other, how these intertwined effects are achieved and which combinations would be most beneficial for which target groups. For instance, investment in treatment as prevention or pre-exposure prophylaxis, might lead to budgetary limitations in other structural efforts such as investing in low threshold testing facilities for STIs. One could also hypothesise that, for instance, the delivery of the current successful results in biomedical prevention studies were achieved mainly in strongly controlled trial settings (i.e medical and counselling follow up). What remains unclear is how these successful trials can be translated to real life settings and how most affected groups and key populations will perceive such interventions and integrate them in their daily lives. As all such biomedical interventions have a behavioural component in that they entail human behaviour when delivered to people, biomedical interventions still will need counselling for safer sex behaviour and adherence during and after the intervention delivery.

Also, the prevention targets of the different intervention levels might interfere. The San Francisco Surveillance Report (Das, PloS, 2010) showed a decrease of new HIV infections but a rise in STI infections (syphilis, gonorrhea, chlamydia) after an intervention focusing on serosorting and treatment as prevention.

It also remains unclear whether the availability of PrEP as a biomedical intervention might have a negative impact on condom use behaviour with expected higher levels of certain STIs (and possibly easier transmission of HIV) as an outcome. While this would be an unintended effect in real life settings, so far the controlled studies have shown no effect of risk compensation or behavioural disinhibition, which is at least promising.

Another example of unintended intervention effects could be observed when flooding a gay community with condoms, it might in the long run build the image that anal sex is an essential element in sex between men having sex with men, whereas other forms of sexuality may be rather neglected. This may contribute to higher levels of anal sex (safe or

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unsafe). In this way an intervention can influence the choice of sexual practices. Also, with the availability of different biomedical and other interventions, safe(r) sex messaging (and risk reduction behaviour) becomes more disperse.

This multifaceted model of prevention has already been labelled in different ways. Whether we call it 'combination prevention', 'multidisciplinary prevention', or 'interdependent prevention, the model should take into careful consideration the influences (both desired and undesired) that the different disciplines of intervention might have on each other. Combination prevention will only lead to better results in the field of prevention, if full attention is being paid to the interaction between all different measures. However, it is a promising approach in that it allows for choices in prevention. In drawing a parallel with treatment for HIV, we may conclude that one magical bullet does not do the job in treatment either, however, a combination of different medications, also with prevention a combination of different prevention approaches, tailored to the target groups' specific needs and prerequisites, will be beneficial and a first step into the right direction. On a global level, for every two new patients put on treatment, about five new HIV infections occur, which means that the search for effective prevention should still be high on the agenda.

Sources

Cohen, M et al. "Antiretroviral therapy for the prevention of HIV: where are we now and where are we going?" Special Plenary Session, July 11, 2011 16:15, Congress: 19th Biennial Meeting of the International Society for Sexually Transmitted Diseases Research.

www.informed-scientist.org/presentation/antiretroviral-therapy-for-the-prevention-of-hiv-where-are-we-now-and-where-are-we-going

Reported by Sandra Van den Eynde, psychologist/ sexologist**, head of department 'Vulnerable Groups', Sensoa, Antwerp, Belgium**

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V. Dates to keep in mind: upcoming conferences

13TH European AIDS Conference / EACS

12 – 15 October 2011
Belgrade, Serbia

2ND International Workshop on HIV & Aging

27 to 28 October 2011
Baltimore, Maryland, United States of America

The Future of European Prevention 2011 (FEMP)

10 - 11 November 2011
Stockholm, Sweden

The overall objective of the conference is to challenge and change the increasing trends of HIV and other sexually transmitted infections among men having sex with men. Innovative and evidence-based prevention methods and best practices will be presented. The conference aims to facilitate an exchange between the different actors and stakeholders in the prevention field, such as academics, prevention workers, and the community, and policy makers. It will be good opportunity to network and update your knowledge on HIV prevention with MSM.

You can still register and come to the conference. For more information please go to: www.femp2011.eu

HIV/AIDS Law and Practice: Rights Protection through Representation

20 to 21 July 2012
Washington, DC, United States of America

19th International Aids Conference

22-27 July 2012
Washington DC, United States of America

IUSTI Europe Congress

27-29 September 2012
Antalya, Turkey

13TH International Union against Sexually Transmitted Infections Congres (IUSTI)

15 - 17 October 2012
Melbourne, Australia

11TH International Congress on Drug Therapy in HIV Infection

11 to 15 November 2012
Glasgow, United Kingdom

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VI. Interesting literature

EU Health Programme

Joining Together to Tackle HIV/AIDS in Europe

EAHC website ec.europa.eu/eahc/projects/database.html, on the DG SANCO Health-EU Portal health.europa.eu and on SANCO Web Site ec.europa.eu/health

The Executive Agency for Health and Consumers (EAHC) implements the EU Health Programme, the Consumer Programme and the Better Training for Safer Food initiative.

AIDS Behav. 2011 Aug;15(6):1171-9.

Depression is associated with sexual risk among men who have sex with men, but is mediated by cognitive escape and self-efficacy.

Alvy LM, McKirnan DJ, Mansergh G, Koblin B, Colfax GN, Flores SA, Hudson S; Project MIX Study Group.

Men who have sex with men (MSM) show high rates of HIV infection, and higher rates of depression than non-MSM. The authors examined the association between depression and sexual risk among "high risk" MSM. Evidence has been mixed regarding the link between depression and risky sex, although researchers have rarely considered the role of psychosocial vulnerabilities such as self-efficacy for sexual safety or "escape" coping styles. In a national sample (N = 1,540) of HIV-positive and HIV-negative MSM who reported unprotected sex and drug use with sex partners, the authors found evidence that depression is related to HIV transmission risk. Self-efficacy for sexual safety and cognitive escape mediated the link between depression and risk behavior, suggesting that psychosocial vulnerability plays an important role in the association of depression with sexual risk. These findings may help to construct more accurate theories regarding depression and sexual behavior, and may inform the design of sexual safety interventions.

AIDS Behav. 2011 Aug;15(6):1161-70.

Persons newly diagnosed with HIV infection are at high risk for depression and poor linkage to care: results from the Steps Study.

Bhatia R, Hartman C, Kallen MA, Graham J, Giordano TP.

Little is known about the prevalence and impact of depression in persons newly diagnosed with HIV infection. The Steps Study is a prospective, observational cohort study of persons newly diagnosed with HIV infection. Participants were administered a battery of instruments, including the CES-D. Linkage to care was defined as attending at least one clinic appointment in each of the first two 90-day intervals following diagnosis. Of 180 participants, 67% screened positive for depression. In multivariate analysis, depression was associated with female sex, income <$25,000, recent substance abuse, baseline poor access to medical care, and low self-efficacy. Fifty-six and sixty-eight percent of depressed and not depressed participants linked to care, respectively. In multivariate analysis, depression was a borderline significant predictor of poor linkage. Depression is very prevalent in persons newly diagnosed with HIV infection. Interventions targeting linkage to care should address depression, substance abuse, and barriers to care.

Health Educ Res. 2011 Jun;26(3):443-55. Epub 2011 Mar 16.

Implementation intentions for buying, carrying, discussing and using condoms: the role of the quality of plans.

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Forming implementation intentions (i.e. action plans that specify when, where and how a person will act) could be effective in promoting condom use on a large scale. However, the technique implies that people are able to form high quality implementation plans that are likely to induce behaviour change. Young single females, aged 16-30 years old, were asked to form either an implementation intention for the target behaviour using condoms (n = 159) or preparatory implementation intentions for buying, carrying, discussing and using condoms (n = 146). Condom preparations were assessed at follow-up 2 months later. The implementation intentions that participants formed were rated on quality. In general, it appeared hard for young women to form high quality general implementation intentions for the target behaviour condom use. Implementation intentions for the preparatory behaviours were of better quality than general implementation intentions. Females who formed strong implementation intentions in the preparatory behaviours condition were more committed to these plans and perceived them as more useful. Plan commitment and perceived usefulness predicted condom preparations at follow-

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up. The authors conclude that it is important to ask individuals to form implementation intentions for the preparatory behaviours rather than for the target behaviour alone.

AIDS Behav. 2011 Jul;15(5):885-96.

Group motivational interviewing to promote adherence to antiretroviral medications and risk reduction behaviors in HIV infected women.

Holstad MM, DiIorio C, Kelley ME, Resnicow K, Sharma S.

This article presents the results of a clinical trial that tested the efficacy of using motivational interviewing (MI) in a group format to promote adherence to antiretroviral medications and risk reduction behaviors (RRB) in 203 predominately African American HIV infected women. It was compared to a group health promotion program. Participants were followed for 9 months. Adherence was measured by MEMS(®); and RRB by self-report. Controlling for recruitment site and years on ART, no significant group by time effects were observed. Attendance (≥7/8 sessions) modified the effects. Higher MI attendees had better adherence at all follow-ups, a borderline significant group by time effect (p = 0.1) for % Doses Taken on Schedule, a significantly larger proportion who reported abstinence at 2 weeks, 6, and 9 months, and always used protection during sex at 6 and 9 months. Though not conclusive, the findings offer some support for using MI in a group format to promote adherence and some risk reduction behaviors when adequate attendance is maintained.

AIDS Behav. 2011 Jul;15(5):1045-57. Epub 2009 Aug 14.

Application of the attitude-social influence-efficacy model to condom use among African-American STD clinic patients: implications for tailored health communication.

Noar SM, Crosby R, Benac C, Snow G, Troutman A.

The purpose of this investigation was to apply the attitude-social influence-efficacy (ASE) model to achieve a theory-based understanding of condom use among low income, heterosexually active African-American STD clinic patients. N = 293 participants were recruited from a large, publicly-funded metropolitan STD clinic in the South eastern United States and surveyed using an ACASI computer program. Results indicated that several ASE variables exhibited meaningful relationships with condom stages of change in univariate analyses, replicating patterns found in previous research. Fewer variables remained significant in multivariate analyses, however. There was also some support for the proposition that early stage movement (e.g., Precontemplation to Contemplation) is based more upon perceptions of condom use (e.g., pros, perceived norms), whereas later stage movement (e.g., Preparation to Action/Maintenance) is based more upon perceived and actual skills acquisition (e.g., condom self-efficacy, negotiation strategies). Results varied with regard to main and casual condom stage of change. Implications for developing tailored HIV prevention interventions with heterosexual African-Americans are discussed.

AIDS Care. 2011 Jun;23(6):663-70.

Theory development for HIV behavioral health: empirical validation of behavior health models specific to HIV risk.

Traube DE, Holloway IW, Smith L.

In the presence of numerous health behavior theories, it is difficult to determine which of the many theories is most precise in explaining health-related behavior. New models continue to be introduced to the field, despite already existing disparity, overlap, and lack of unification among health promotion theories. This paper will provide an overview of current arguments and frameworks for testing and developing a comprehensive set of health behavior theories. In addition, the authors make a unique contribution to the HIV health behavior theory literature by moving beyond current health behavior theory critiques to argue that one of the field's pre-existing, but less popular theories, Social Action Theory (SAT), offers a pragmatic and broad framework to address many of the accuracy issues within HIV health behavior theory. The authors conclude this article by offering a comprehensive plan for validating model accuracy, variable influence, and behavioral applicability of SAT.

Abstract #102, 10th AIDS Impact Conference.

Effectiveness of Motivational Interviewing on HIV risk behaviors among men who have sex with men: A systematic review of the best available evidence

Berg, R (The Norwegian Knowledge Centre for Health Services), Ross M, Tikkanen R.

In most areas of the world, despite the small size of their community, men who have sex with men (MSM) continue to be the population most affected by HIV. Among this group, the principal risk practice for HIV infection is unprotected anal intercourse (UAI), often engaged in under the influence of alcohol and other substances. Both behaviors are targeted through

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Motivational Interviewing (MI), a harm reduction approach that has been used to prevent HIV risk behaviors among this group for more than a decade, without its effectiveness having been systematically studied. The authors conducted a systematic review (SR) according to the Cochrane Handbook for Systematic Reviews of Interventions investigating the effectiveness of MI on HIV risk behaviors for MSM.

Nine electronic databases were searched: Google scholar, databases of websites and newsletters relevant to MI, literature lists of 22 relevant reviews, and contacted experts. Two reviewers independently appraised records and full-text papers for inclusion. They extracted data using a pre-designed data recording form, performed risk of bias assessment using Cochrane's risk of bias tool, and used the instrument Grading of Recommendations Assessment, Development and Evaluation (GRADE) with GRADE-Profiler to assess the extent to which we could have confidence in the estimate of effect. Finally, Mantel-Haenszel random effects meta-analyses for dichotomous outcomes and inverse-variance random effects meta-analyses for continuous outcomes were used to pool results.

The searches yielded 255 unique records, of which 10 randomized controlled trials were included. Risk of bias was generally moderate or low. With the exception of one study from the Netherlands, all were from the U.S. In total, they included 6,051 participants at baseline. Nine outcomes were sufficiently similar to compute meta-analyses. The quality of these outcomes was judged as moderate (GRADE). There was no significant difference between the group receiving MI and the control group for seven sexual behavior outcomes: unprotected anal intercourse (UAI) with non-primary partner (RR=1.06, 95%CI= -4.71, 6.84), UAI with primary partner (RR=1.02, 95%CI= -6.43, 8.48), number of sexual partners (MD=0.34, 95%CI= -0.91, 1.58), UAI at short term follow up (MD=0.13, 95%CI= -0.15, 0.40), UAI at medium term follow up (MD=-0.09, 95%CI= -0.49, 0.31), UAI at long term follow up (MD=-0.08, 95%CI= -0.33, 0.17), condom use (MD=-0.06, 95%CI= -0.32, 0.20). The meta-analysis for drinks per day at short term follow up was significant (MD=-1.24, 95%CI= -2.04, -0.43), but failed to reach significance at long term follow up (MD=-0.29, 95%CI= -0.74, 0.16). None of the meta-analyses showed statistically significant heterogeneity (max I2= 36%).
The effectiveness of MI as a prevention strategy for unsafe sexual and substance use behaviors among MSM does not appear promising. However, to dismiss MI as an intervention for all HIV risk behaviors among all groups of MSM, however, is premature. The results of this SR demonstrates that crafting suitable HIV prevention programming for MSM remains a challenge for today's health promotion community.

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