Eurosupport 6

"Developing a training and resource package to improve the sexual and reproductive health for people living with HIV in Europe"

Final Project Meeting

Antwerp, February 7-8, 2013

INSTITUTE OF TROPICAL MEDICINE ANTWERP

Executive Agency for Health and Consumers

SENSOA

EUROSupport

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Final project and dissemination meeting and training workshop

The meeting was organised and hosted by Sensoa and took place at the Institute of Tropical Medicine, Antwerp (Belgium) on 7th and 8th of February 2013. The goal of this final workshop was to present the final results of the project and its different outputs, and also to offer training workshops on the use of the tools developed within this project to participants.

1 Participants

Associated and collaborative project partners were invited. Associated partners (AP) are partners who participated in developing and testing the training and resource package (TRP), including the CISS intervention. Collaborative partners (CP) received all project-related information (such as the Eurosupport newsletters) throughout the project's lifetime, but did not actively participate in the research and development activities (R&D). In addition to the R&D component of this project, Eurosupport 6 also has maintained the previously already existing Eurosupport network on SRH and HIV. This network constitutes a forum for collaborative partners to exchange information and expertise relating to SRH and HIV. Collaborative partners also had the opportunity to provide their feedback to the TRP during the development phase.

In total 33 partners from 14 different European countries participated:

Name		Organisation	AP/CP	Country	Email
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Annex 8: Group Photo of the participants

2 Agenda of the final meeting

Venue: Institute of Tropical Medicine, Nationalestraat 155, Antwerp Thursday, 07/02/2013		
9 – 13hrs	Plenary (Room C)	
9-9.30	Coffee	
9.30 - 9.45	Welcome + overview agenda (Ruth Borms, SENSOA)	
9.45 - 10.25	Eurosupport 6: A systematic approach to intervention development (35') + questions (5') (Christiana Nöstlinger, ITM)	
10.25 -11.05	The CISS: A counselling tool for supporting people living with HIV in safer sex (35') + questions (5') (Laura Albers, ITM)	
11.05 - 11.20	Coffee break	
11.20 - 12.00	The training and resource package (TRP) (35') + questions (5'): (Ruth Borms, SENSOA)	
12.00 - 12.35	The CISS evaluation study: first results of the CISS intervention trial. Presentation (30') + questions (5') (Tom Platteau, ITM)	
12.35 - 13.00	The CISS intervention study: results of the process evaluation (presentation 20) + questions ' (5') (John Helps, CNWL)	
13.00 – 14.00	Lunch (sandwiches): (Forum)	
14.00 - 14.05	Overview agenda afternoon + practical information dinner (Ruth Borms, SENSOA (Room C)	
14.05 – 16.00	Parallel workshops (Room C and Room Broden)	
	Workshop 1: Basic CISS training: CP (Agnes Kocsis, CNWL)	Workshop 2: TRP workshop: AP (Ruth Borms, SENSOA)
19.30	Dinner: Café Imperial	

The final project meeting offered a mix of plenary lectures (to provide an update on the scientific results) and workshops, to present the intervention tools, the TRP and to provide training opportunities.

The first morning session was dedicated to presenting the research results: an overview on the systematic approach to intervention development was given, as well as results from both the outcome and the process evaluation. Participants also had the opportunity to listen to first hand impressions about working with the CISS from a counsellor, who had used the CISS tools during the evaluation study (see below summaries of the respective presentations).

In the afternoon of the first day the first workshops took place. To maximise the learning opportunities, the group of participants was divided into a group of associated partners and a group of collaborative partners. During the first day the associated partners attended the TRP workshop where the use and applicability of the TRP was demonstrated. In a parallel session the collaborative partners attended the CISS workshop. Participants not yet familiar with the CISS intervention and its underlying theoretical principles had the chance to learn about this innovative tool. During the second day, the workshops were switched, so that all participants had the opportunity to get familiar with the TRP and the CISS. For the associated partners, who already applied the CISS, we organised a specialised CISS workshop to exchange their experiences and to reflect on future ways of using the CISS in regular counselling. We completed the meeting with a plenary group discussion, brainstorming on the way forward, i.e. what is necessary to up-scale the intervention and dissemination of the TRP broadly across Europe.

In what is to follow, we provide you with short summaries of the various presentations.

2.1 Eurosupport 6: A systematic approach to intervention development

(Christiana Nöstlinger, Annex 1)

The evidence-based intervention CISS (which stands for 'computerised intervention for safer sex' or 'condom is safe and simple') is one of the main outputs of the ES 6 project. The CISS is a brief counselling intervention for clinical or community-based health care settings to support people living with HIV in their sexual and reproductive health (SRH), with a specific focus on safer sex [1]. It is embedded in a comprehensive training and resource package (TRP), and targets three main groups: HIV-positive men having sex with men and women and men living with HIV, belonging to ethnic minorities.

[1] For a more detailed description of the CISS, we refer to the Eurosupport newsletter nr. 5, which can be downloaded from the Eurosupport website: www.eurosupportstudy.net

At the end of such a labour-intensive project –after all, it took us four years to finalise this project– it is worthwhile to look back and give you some information on the approach we took in developing the intervention, the behavioural theories underlying the intervention, the problems we encountered, and the steps we took to solve them.

The systematic intervention development was guided by the intervention mapping method (IMM) [2], an evidence-based health promotion planning tool. IMM provides guidance through six distinct steps:

Needs assessment

The result of the previous project Eurosupport 5 (ES5) provided a comprehensive needs assessment. In ES5, we had documented the SRH needs of people living with HIV from various perspectives (qualitative research with both people living with HIV and health care professionals) [3]; an anonymous self-reported survey among people living with HIV [4], and an online survey with service providers about the integration of SRH and HIV services across Europe [5].

Defining the intervention's objectives

IMM requires that planners develop an intervention logic model, which is useful for conceptualising the intervention's theoretical methods adopted, the determinants hypothesised to influence behaviour change (e.g. information, attitudes, motivation self-efficacy, behavioural skills and social and community norms); the performance objectives (i.e. specific behavioural sub-goals needed to achieve the outcome behaviour, like accurate risk assessment, adoption of less risky sexual practices, negotiation skills, etc.), and finally the outcome behaviour (in our case measured as increased condom use over time).

[2]Bartholomew LK, Parcel GS, Kok G, Gottlieb NH (2006). Planning Health Promotion Programs. An Intervention Mapping Approach. Second Edition. Jon Wiley & Sons, San Francisco.

[3]Nöstlinger C, Gordillo V, Borms R, et al. (2008). Differences in Perceptions on Sexual and Reproductive Health between Health Care Providers and People Living with HIV: A Qualitative Elicitation Study. *Psychology, Health & Medicine,* (5): 516-528.

[4]Nöstlinger C, Nideröst S, Platteau T et al. (2011). Sexual Protection Behavior in HIV-positive Gay Men: Testing a Modified Information-Motivation-Behavioral Skills Model. *Archives of Sexual Behaviour.* DOI 10.1007/s10508-010-9682-4

[5]Borms R. et al. and the Eurosupport Study Group (2008): What do Sexual and Reproductive Health Services offer to People living with HIV in Europe. Abstract nr. MOAX0540.Oral presentation at the XVII. International AIDS Conference (IAS), Mexico City, August 3-8, 2008.

Choosing theoretical methods and tools

The CISS intervention is based on empirically validated behavioural theories, such as the Information Motivation-Behavioural-Skills Model [6,7], the Stages of Change Theory [8,] and the dual process theory on affective decision making [9]. We see the latter as the missing link that could explain the gap between rational decision making ('slow thinking') and the affective, intuitive decision taking in sexual or other value-loaden situations ('fast thinking'). Research has shown that these processes are located in different brain areas and that we need to learn to link them better if we want to achieve behaviour change in emotionally driven situations, like sexual ones. Recently, there has been growing interest in the dual process model of decision making in basic behavioural research, but so far there has been little application to HIV risk behaviour. Sexual decision-making can be thought to result from the interplay of consciously and unconsciously mediated processes (which are supported by distinct but interacting neural systems). [10]These theories have guided the choice of the practical tools needed for implementing the CISS: one the one hand evidence-based counselling techniques such as client-centered strategies, elements of motivational interviewing and cognitive-behavioural therapy , and on the other hand the use of audio and more importantly video-material depicting role-models in specific relationship and sexual situations.

Developing the intervention

Linking fast and slow thinking to enable people living with HIV to understand how they take decisions in sexual situation and to practice skills to change their behaviour effectively, led us to develop a computer-technology based intervention. Research evidence shows that such interventions can be as efficacious as counselling interventions. [11] The scripts in the stories shown in video-clips were developed, based on clinical experiences. They help to target the intuitive, affective level, while developing an individual risk reduction plan to achieve the desired outcome addresses the level of rational thinking, as behaviour change always requires planned action. The latter is facilitated by an empathic, non-judgmental counsellor in three face-to-face counselling sessions. The material was

[6]Fisher, W. A., & Fisher, J. D. (1993). A General Social Psychological Model for Changing AIDS Risk Behavior. In J. Pryor & G. Reeder (Eds.), *The social psychology of HIV infection* (pp. 127-154). Hillsdale: Erlbaum.

[7]Fisher, J.D., Fisher, W.A., Cornman, D.H., Amico, R.K., Bryan, A., & Friedland, G.H. (2006). Clinician intervention during routine clinical care reduces unprotected sexual behavior among HIV-infected patients. *Journal of Acquired Immune Deficiency Syndromes*, 41, 44–52.

[8]Prochaska JO, DiClemente CC, Norcross JC. (1992). In search of how people change: applications to addictive behaviors. American Psychologist, 47(9):1102-114.

[9]Slovic P, Peters E, Finucane ML, MacGregor DG (2005). Affect, Risk and decision making. Health Psychology, 24 supplement (4): S3-S40.

[10] Ames SL, Grenard JL, Stacy AW (2013). Dual process intercation model of HIV risk behaviors among druig offenedrs. aids and Behavior, 17:914-925.

[11]Noar SM (2009). Efficacy of computer technology-based HIV prevention interventions: a meta-analysis. AIDS, 2;23(1):107-15. doi: 10.1097/QAD.0b013e32831c5500.

developed using feedback from affected communities, mainly based in the UK, and the Eurosupport network partners.

The CISS was originally planned for internet based use, but on request of the implementing partners, who feared technical problems with an online intervention, we worked with a DVD for the time of the implementation phase(see below).

Intervention adoption

Since this project was to be carried out within an initial timeframe of three years, adoption and evaluation phase had to be combined. Nine Eurosupport 6 partners (Belgium, France, Germany, Italy, the Netherlands, Poland, Portugal, Spain, the United Kingdom) implemented the CISS between February 2011 until – during the meanwhile extended timeframe- November 2012) with the three above-mentioned target groups. Using a randomised controlled study design (see below), implementation was preceded by screening for sexual risk behaviour, and followed up by a post-intervention assessment, and a three- and six months follow up session to assess medical and behavioural data. Unfortunately, it was much more difficult to recruit study participants than anticipated. Two main reasons accounted for that: barriers in admitting to sexual risk behaviour in the clinical settings and structural barriers such as HIV-related stigma and criminalisation of HIV-transmission (for instance, in the case of Slovakia). The difficulties in recruitment necessitated a one year no-cost project extension, which enabled us to enroll more than 190 study participants. During this year, we strategically adapted our recruitment strategies trying to involve community-based settings wherever possible.

Evaluation

We used a combined evaluation approach, i.e. process and outcome evaluation. Effectiveness was measured three months after completing the intervention comparing both an intervention and a control group in terms of condom use and its underlying determinants. In addition, six months follow-up date were also assessed. The process evaluation looked at indicators such as satisfaction with the intervention, and a qualitative analysis of the patient documentation forms. Overall, people living with HIV who participated in this study were generally satisfied with the intervention, and a brief summary of the study's results in terms of the CISS' effectiveness at the three months follow-up is given below.

Conclusion

IMM has proven to be a useful guidance in developing this intervention. It helped us to take steps to adapt to the challenges of conducting a trial study in real life conditions, such as the low uptake of our sexual risk reduction intervention. We need to acknowledge that in general research is a slow undertaking, and while we started out to plan it even before the release of the Swiss Statement in

2008 [12], during the project's life-time the reality of positive prevention has seen swift changes, among which a growing recognition of sexual harm reduction strategies, especially among affected MSM communities. Low uptake of behavioural interventions has been seen also in other studies, for instance in the UK [13].Our hope would be that when implementing the CISS outside of a study design, barriers to its uptake would be less challenging. Thus, it could become a tool, developped in Europe for European people living with HIV, that helps them to live happier and healthier sexual lives.

2.2 The CISS: A counselling tool for supporting people living with HIV in safer sex

(Laura Albers, Annex 2)

This presentation focused on the counsellors' experience of using the CISS.

In Belgium, people living with HIV who were interested to participate in the intervention study, were usually quite motivated. They wanted to have safer sex to protect their sexual partners and themselves. Participants who were offered the CISS counselling sessions found them very effective. Watching the video-material decreased their thresholds to talk about something very personal like sexuality. The same observation can also be made for the counsellors: also for them the CISS helps to decrease potential barriers in talking about sexuality in only three sessions, focusing on sexuality right from the beginning. In the first session clients identified their personal barriers that made safer sex and condom use difficult; in the second session participants and counsellors worked on potential solutions, i.e. they got tips on making condom use easier, women were explained how to use a female condom, communication barriers with sexual partners were identified, and so on. People discovered what was the most important to them and how they could reach their goals. In the third session, participants - with the help of the counsellor - created a personalised plan to reach their own goal, and identified the specific steps necessary to achieve it.
However, finding study participants to take part in the intervention was not always easy. Although we invested a lot in promoting the CISS intervention, people had different reasons for not wanting to participate; mostly because they found it difficult to admit to having had unsafe sex, but also time commitment was an issue. Clients with busy professional lives sometimes found it difficult to come to three additional sessions on top of their regular medical check-ups. Some people were simply not motivated as they felt no need to change their behaviour.

[12]Vernazza P et al. (2008). Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitment antirétroviral efficace ne transmettent pas le VIH par voie sexuelle. *Bulletin des médecins suisses,* 89 (5), 2008.

[13]Desai M et al. (2013). Audit of HIV testing frequency and behavioural interventions for men who have sex with men: policy and practice in sexual health clinics in England. *Sexually Transmitted Infections,* published online first, doi:10.1136/sextrans-2012-050679.

It is encouraging that some participants who were assigned to the study's control group also wanted to be supported by these sessions. Currently, we are implementing these sessions as well.

From the experience during the study, the CISS could be useful to offer a fourth session to our clients, when working with the CISS in the future; an additional follow-up session could be used with the clients to discuss whether or not the risk reduction plan has actually been helpful and to focus on current problems. This would ensure a good follow-up and would boost the intervention's effect.

Questions and remarks:

What are reasons for not participating? Do you think that fear of being judged or judged on failure is a resistance for participation?

- The outpatient department talked to all clients, the time consuming process (3 counseling sessions)was usually the reason for refusal. Idem for the 6 months' follow-up.
- Another reason for not participating, was the role of the doctor. A doctor was seen as 'mother' by clients, and you don't discuss sex with your 'mother'. In some countries unprotected sex is a penal act, talking about unprotected sex therefore is very difficult.
- Other AP's also mentioned the cost of transport to the venue as a reason for not participating. It was too expensive for patients to pay for 3 extra visits.
- Fear of being judged is for some indeed a reason for not participating
- Some clients have no sex life, while others didn't like the introduction. They felt that there was too much polarisation on 'bad' (not using condoms), and 'good' (using condoms).
- Other clients said that they were not familiar in using a computer, so they weren't comfortable with the tool.

2.3 The Training and Resource package

(Ruth Borms, Annex 3)

The training and resource package (TRP) consists of the CISS intervention, and of four additional accompanying manuals to enhance the capacity of service providers to support people living with HIV effectively in their SRH. While the CISS focuses on supporting people living with HIV in safer sex and 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.

Working with the CISS implies having both sufficient knowledge and skills relating to sexual counselling, HIV and positive prevention[14]. Therefore a rather large part of this TRP, i.e. the Reference Guide, provides detailed background information on topics related to positive prevention. Furthermore, working with the CISS requires skills in sexual counselling. However, Europe is a heterogeneous region, implying that sexual counselling is not automatically integrated to the same degree into services towards people living with HIV. Consequently, a large part of this TRP focuses on how to build skills, needed for delivering effective sexual counselling (i.e. the Trainer Manual).

The TRP consists of four different manuals, which serve different goals.

Reference Guide: provides all the background information related to sexual and reproductive health and positive prevention for people living with HIV. The aim of this guide is to increase the knowledge of service providers on these topics.

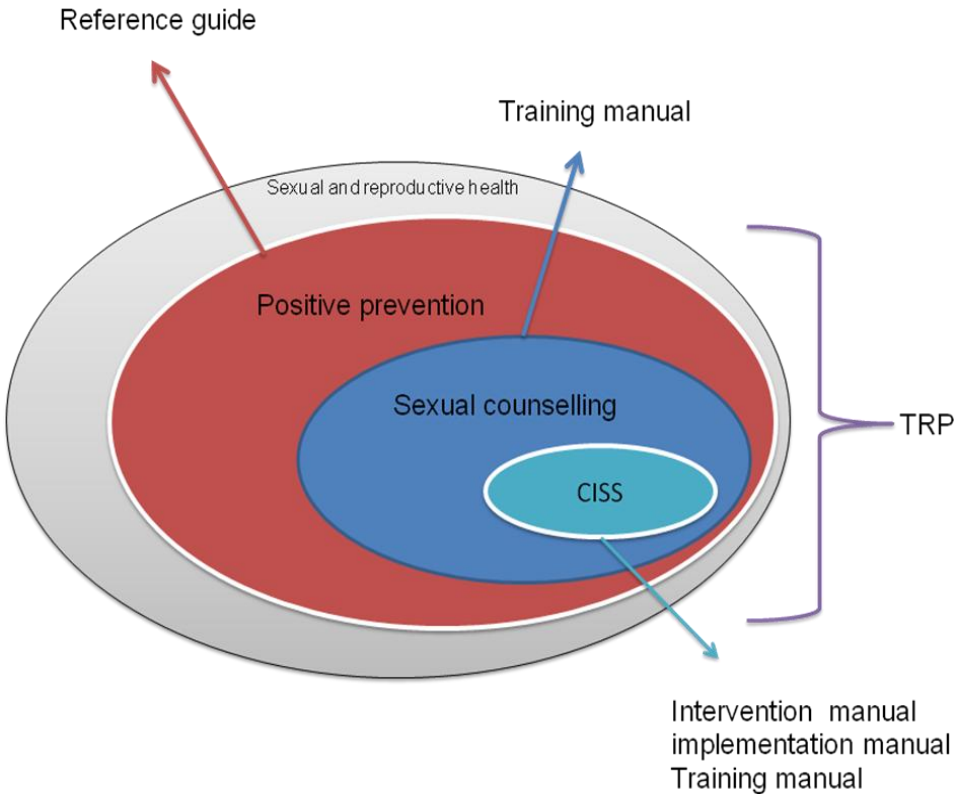
Intervention Manual: guides the individual service provider through the computerised intervention (CISS).

Implementation Manual: focuses on the organisational policy level and gives information on the different steps needed to be taken within specific organisational environments when implementing the CISS: e.g.: what are the requirements to work with the intervention, how do policy contexts influence working on SRH/HIV-related issues, task division and training needs. This manual includes a separate toolkit. These tools are user-friendly instruments, which can guide a successful implementation.

Trainer Manual: Working with the CISS requires being competent in providing sexual counselling to people living with HIV. This manual supports the individual service provider in training other service

[14] Positive Prevention is an overarching term used to describe prevention activities towards and in collaboration with people living with HIV to prevent the further spread of HIV and other sexually transmitted infections (STIs), but also to prevent unwanted pregnancies and mother to child transmission (MTCT), and overall, to increase quality of life of people living with HIV (Reference guide, Chapter 4).

providers to provide sexual counselling to HIV-positive clients. The manual facilitates the organisation of a training. The main part of this manual describes exercises that can be used in a training workshop to improve sexual counselling.



This Training- and Resource Package, developed within the context of European Public Health project 'Eurosupport 6 (ES6), is focusing on sexual and reproductive health, tailored to the specific positive prevention needs of two target groups, men having sex with men and migrants. The counselling tools, as well as the information and skills building provided focus also on these target groups. The tools or parts of it may also be used for other target groups such as heterosexual men and women living with HIV or intravenous drug users. The package, however, does not include specific strategies tailored to the specific (drug related) needs of these groups. While within the framework of this project it has not been possible to create a training and resource package focusing on specific needs and approaches for the many subgroups that exist within the communities of people living with HIV, the underlying general counselling principles and the relevant background information on positive prevention may certainly benefit a larger target group.

The materials and tools provided in the TRP have been tested, evaluated and improved based on the feedback provided by project partners and other community-based organisations, which makes us confident that the TRP will meet the needs of service providers.

In conclusion, the TRP provides individual service providers with information and tools not only to integrate the CISS into their services, but also be able to train other service providers in sexual counselling and working with the CISS.

Questions: No questions

2.4 The CISS intervention: First results of the evaluation study

(Tom Platteau, Annex 4)

During the CISS evaluation study, 192 participants were enrolled, of which 112 gay men or MSM (58%), and 80 migrants (42%). The study population consisted of 148 men (77%), and 44 women (23%). The mean age of all participants was 40.5 years (ranging between 22 and 66 years), and was slightly higher among migrants (41.4 years), compared to the MSM group (39.8 years), although this difference was not statistically significant.

We compared the baseline data (i.e. assessed before the intervention) between the two groups enrolled in the CISS evaluation study (MSM and migrants), and we found some interesting results on several domains: socio-demographic aspects, health, mental well-being, and issues related to sexuality.

Migrants are more likely to be involved in a relationship compared to MSM (64% vs. 45.5%). More MSM than migrants are employed (65% vs. 34%); this is reflected in financial difficulties, which are more prevalent among migrants, compared to MSM (87% vs. 45%). All these differences were significantly different between these two groups.

The majority of all study participants report no physical complaints (65%, without distinction between the groups), and report an undetectable viral load (65% overall; 68% among MSM and 61% among migrants). However, migrants are far more likely to say they do not know their viral load (27.5%) compared to MSM (4%). Thirty-five percent of the MSM and 6% of the migrants report that they had received a diagnosis of a sexually transmitted disease, which reflects a statistical significant difference. Such a diagnosis can be taken as a proxy for sexual risk behaviour.

We found no significant differences between severity of symptoms related to depression, and anxiety between the two groups. However, migrants take significantly more antidepressants (25% vs. 14%) and anxiety-reducing medication (27.5% vs. 15%), compared to their MSM-counterparts.

More migrants than MSM have a main sexual partner (64.9% vs. 43.8%). While the proportion of study participants who have an HIV-positive main partner is around 40% in both groups, migrants are more likely to be unaware of their main partner's HIV-status (28% vs. 12%). The vast majority (90%) of both migrants and MSM have disclosed their HIV-positive status to their main partner. Sexual

activity with casual partners during the previous three months is more common among MSM (86%)compared to migrant participants (29%).

While a substantial part of both MSM and migrants report to never or almost never having used condoms in the past 30 days, it is encouraging that 22 % of the migrant participants said that they always used condoms during this period, and 78% report that they were planning to use condoms consistently (compared to 49% of the MSM) in the future.

In order to evaluate the effectiveness of the CISS-intervention, participants were randomly assigned to the CISS or control group. Because the main characteristics between intervention- and control group participants did not differ at baseline, we can assume that any change in sexual behaviour (assessed after the intervention at three and six months follow-up measurements) can be attributed to the intervention itself. Among the participants from the control group, risk of unprotected intercourse reduced with 0.7% between baseline and 3 months post-intervention. Among participants who were allocated to the CISS-intervention, this risk decreased much more, with 30%.

This clear-cut difference in reduction of unprotected sexual intercourse demonstrates the effectiveness of the intervention.

When looking at the indicator 'condom use at last intercourse', the likelihood that participants of the CISS group would not use a condom was much lower than of the controls ($p< 0.04$; OR: 0,08 95% CI [0,01;0,90]). A mediation analysis shows that this increase in condom-use can be partially attributed to more positive attitudes towards condom-use (56%) and to improved self-efficacy in safer sex and using condoms.

Questions and remarks:

- How many people have reached the 6 months' follow-up?
  Not certain at this point in time, because not all clients have reached this stage. They are still in month 4 or 5 … We will have the figures of drop out when every participant has completed the CISS 6 months' follow-up.
- What's the impact of the CISS per target group? Is this different for MSM and migrants? What kind of numbers do we need to have a robust result ? What are we analysing when we combine both groups?
  If numbers allow meaningful results, an analysis per target group will be carried out.
- What is the definition of migrant? What is their background? In the study, the following definition was used: "Seropositive migrants from high endemic regions having migrated to Europe, also including other migrants who are vulnerable to HIV due to their migration background. While even Sub-Saharan African migrants are an ethnically heterogeneous group, as migrants living in Europe they do share some common pan-African cultural elements, which justifies development of a common framework for a culturally sensitive intervention. Since access to health care differs across European countries, migrants with different resident status may be enrolled in the intervention trial."

2.5 Process evaluation: Feedback from participants and counsellors on quality and effectiveness of intervention

(John Helps, Annex 5)

Summary of Conclusions

1. The CISS intervention had good levels of acceptability for people living with HIV as well as for the counsellors giving the intervention.

   The CISS was regarded as relevant and helpful by participants;

   _ The CISS was regarded as positive in building empathy and enabling action plans to be developed by counsellors.

2. There was satisfaction amongst both intervention groups, but there was a trend for greater benefits for the migrant group.
3. There was positive feedback on the combination of counselling with the DVD.
4. The feedback provided some measurable outcomes:

   _ 80% of participants who experienced the intervention felt confident in being able to have safe sex in the future;

   84% of counsellors said they would use the CISS with similar patients in the future.

5. There are some limitations to this analysis and the conclusions that can be drawn:

   _ This analysis only comprised the CISS intervention group and so there is no comparison with the control group in this presentation.

   _ The analysis is based on self report which may be overly generous?

Questions and remarks:

⊥ Some patients mentioned that there were too few sessions. An extra follow-up session would be helpful to increase motivation. The counselor of ITM also experienced this.

⊥ **What is the definition of migrants**, what about a migrant MSM, in which group is he added? People could divide themselves into groups by filling in the questionnaire. Migrants mostly participated in the migrant group, due to the ethnically more appropriate material, but they could also participate in the MSM group, if they clearly self-identified as MSM.

- **Why did people drop out?** The final drop-out rate has to be defined after the completion of the data analysis. As some partners are still trying to conclude the 6 months' follow-up, we don't have the final and accurate drop-out rate yet. However, some people will have dropped out and several reasons may account for this:

  1) Some participants found it burdensome to come to the extra counseling sessions, or to return for the follow-up assessments.

  2) Technical problems with the online questionnaires which sometimes occurred , could have contributed. Participants were given the opportunity to fill in the follow-up questionnaires online from home, and in several cases data were either not submitted or did not reach us for other reasons, although participants did report that they filled in the questionnaires.

  3) Some participants could not be traced, and several attempts to contact them failed. Therefore, we cannot assess what the reason for drop-out is; however, migrants for instance are a highly mobile population and tend to move easily for various reasons (legal or economic).

3 Workshops

3.1 TRP Workshop

(Ruth Borms, Annex 6)

Goal

The main goal of the workshop was to inform the partners on how they can use the TRP and get everybody started in thinking how the TRP can be of use for them. Because training is a large part of the TRP, each step of the workshop was also emphasised as an example on how to give a training/workshop.

Warming-up

After setting out some ground rules and an introduction round, we started with a warming-up question. The AP's were asked how they implemented the CISS and how they experienced it. The CP were asked what they thought necessary to implement the CISS in their organisation, setting?

Analysing the current situation

Based on the first handout; partners were asked to start thinking and analysing their current (SRH) services for people living with HIV.

Every partner was led to the question on how he/she would summarise the sexual counselling services towards people living with HIV; 'No or minimal sexual counselling', 'sexual counselling' or 'specialised sexual counselling'.

Set a realistic goal

Handout 2 helped the partners to set out a realistic goal. The CISS is a specialised tool to counsel people living with HIV, but in a setting where there is minimal or no sexual counselling offered, implementing the CISS will not be a great idea. In some settings, the next step will be to introduce the importance of positive prevention or convince the service providers why people living with HIV need sexual counselling. In other settings, the goal could be to train service providers in sexual counselling of people living with HIV.

The main conclusion of this step is to identify a realistic achievable goal for your organisation (starting from what's already available).

TRP as multifunctional tool

In the following step, the TRP was presented in all its aspects. The partners were invited to think about ways to use the TRP manuals, depending on their goal setting. Handout 3 provided some ideas on how to use the manuals of the TRP.

Organising a training

Training will be a large part of enhancing sexual counselling skills and capacities of service providers. At the end of the workshop, the different steps of a training were briefly discussed and we looked more in-depth at the trainer manual. The development of excercises, what you need andpossible combinations… Finally we did some excercises from the trainer manual ourselves.

3.2 CISS workshop

(Christiana Nöstlinger, Annex 7)

All partners have participated in a workshop focused on the use of the CISS. To tailor the workshop to the needs and the experience of the participants, the whole group was divided into two separate workshops: one for collaborative partners and one for associated partners. The collaborative partners participated in an introductory workshop on the CISS materials. The goal of this workshop was to familiarise them with the CISS tools and to train them in using the CISS in a counselling session.

For the associated partners we organised a workshop to give feedback on the implementation of the CISS during the trial study with a specific emphasis on how the associated partners envisage the regular use of the CISS in their clinical environments.

As an introduction, the Spanish partner gave a presentation on a clinical case and demonstrated how she sued used the CISS with this patient (see slides). The Spanish partner had also organised a

training with a small group of doctors and psychologists to train them in using the intervention material, and the slide presentation was also part of this training.

There was a particular suggestion from Spain to make the materials relating to "'the meaning of condoms" accessible for both target groups. Experience has shown that this topic is also relevant for the migrant group. Preferably this should work with different images.

Also other partners reported as on how they had trained colleagues in the use of the CISS, for instance in Germany, role-play was used for the training. All partners agreed that training is an essential requirement to be able to work effectively with the CISS material, in order to know the content well enough to guide clients through the material, handle the material during the counselling sessions without interruptions, and use it with the right counselling attitude and skills.

Germany, as well as other countries, encountered problems with the recruitment. It appeared to be easier to work with clients who were in discordant relationships, or patients with a recent STI diagnosis. In general, people with undetectable viral load were often more hesitatant to participate, especially if they were less motivated to work on behaviour change or if participation was hampered by e.g. long travel times to the clinic, or long working hours.

In Poland recruitment was easier, since the project was supported by a highly motivated doctor with apparently very good personal relationships with HIV-positive patients. In addition, patients already visit the clinic on a monthly basis, therefore coming to the sessions was easier. However, because of the stigma attached to HIV, patients still sometimes preferred not to meet in the clinic, and sessions could take place privately. In Poland, medical doctors, felt that they gained a lot in terms of their own skills in discussing sexuality when they worked with the CISS,, and that they perceived the materials as helpful to do so.

The French partner was more critical towards the material and found in general that the CISS worked better with migrants than with gay men. With respect to the French gay subculture the participant found some of the video material not fully adapted, such as a gay couple who are shown in bed wearing T-shirts instead of being naked. This could have influenced the degree to which clients were able to identify themselves with the scenes that are shown. Emphasis was also put on the selection of the service providers delivering the intervention, i.e.: it is important to choose counsellors who can identify with the intervention.

Slovakia reported on the existence of a new NGO, and hoped that working with the CISS would be a possibility for this NGO. The coordinator is committed to promote the intervention.

In Belgium, ideas focused around a potential use of the CISS for primary prevention purpose, i.e. HIV-negative people with risk behaviour, although it is clear that as an evidence-based tool it has only been evaluated in the target group of people living with HIV.

In general, the following points were mentioned as negative experiences during the trial implementation:

- Some partners mentioned difficulties in working on line with the goal enforcer, they had to switch to a paper and pencil version.
- Occasional technical problems with the data-base, which worked demotivating and frustrating both for counsellors and clients, e.g.: data not getting submitted, and in particular the coupling of the IAT condom game with the questionnaires, which made it necessary to repeat the IAT, which was already considered as lasting too long.

Overall, partners were committed to try to complete the 6 months follow-up data as much as possible (Germany, Poland, Belgium, UK). CNWL promised to deliver an updated overview of the data, so that we know what can be achieved within the next three to four months.

In addition, all partners were reminded to send in their updated contact information and information related to the resource section included in the DVD (i.e. other support organisations, further country-specific information, etc.), which will be included in the CISS dissemination website.

4 Way forward: Up-scaling and future dissemination

(Ruth Borms, Christiana Nöstlinger)

4.1 Feedback from the partners

At the end of the meeting, the partners were asked to share their thoughts and ideas towards the use of the tools. Both AP's and CP's were very enthusiastic about the CISS as well as the manuals included in the TRP. Some CP's expressed their gratitude and were proud to be part of the Eurosupport 6 project. They saw a lot of possibilities to use and implement the materials. The majority of CP's wanted to use the CISS also for other target groups; HIV negative people, peers, high risk groups or Latin American migrants. The CISS could help them to start consultations with HIV negative partners in sero-different couples. Language was mentioned as a potential challenge, especially for migrant populations, who often speak English or Frenchonly as a second language. While the CISS is also available subtitled in different languages, reading subtitles can be difficult for some migrants. Some partners expressed being interested to have the (English) spoken language in the CISS film clips dubbed in the local language. Some partners expressed the need for a minimal CISS evaluation tool, which could be integrated in the future CISS website (cfr 4.2) on the basis of the research tools that were developed for the CISS trial study. It was discussed whether or not to make training an essential requirement before a professional would be allowed to use the CISS, in order to safeguard quality standards of the intervention. The importance of implementing the CISS respecting its underlying theory base as well as the counseling approach was emphasised, but making a specific

CISS training mandatory was seen as not feasible, in particular because the project funding has come to an end.

The manuals of the TRP are hands-on tools that can be used in other contexts than only related to the CISS intervention. Some of the collaborative partners expressed their commitment to organising courses and training programmes in their region, using the TRP, relating to sexual and reproductive health. They mentioned that the trainer manual especially will help them to develop training sessions in a structured and refreshing way. CPs saw possibilities to use it in counselling and health care trainings, peer support trainings, group sessions, LGBT (lesbian, gay, bisexual and transgender) community trainings, trainings for volunteers, student courses, to train counsellors in HIV test centres to discuss sexual topics, to train doctors in counselling skills, a.o. Partners perceived the TRP as a useful framework to get a clear view on their current sexual and reproductive health services towards people living with HIV. It can help them to start discussions with counsellors about topics that should be included into their services and to create a common guideline on how to counsel HIV positive people. At national level, the TRP can be used to train the trainers themselves, or to motivate NGOs to include positive prevention in their services.

In conclusion, the partners agreed that the materials are very comprehensive, that they support organisations to look critically at their own SRH services to HIV positive people, and that they can help to improve current services in a feasible way.

4.2 New CISS website: Presentation of the CISS (draft) website

The UK partner (Agnes Kocsis) presented a beta version of the website. This 'CISS' website will be used to disseminate the materials of this project towards professionals as well as towards people living with HIV. The CISS was available on a DVD during the trial, but to maximise the use and the implementation of the intervention, it will be disseminated through a website. Besides the CISS, e-learning tools and the manuals of the TRP will be added on the website. To provide some kind of quality control on the use of the CISS, future users will be guided through a demo version and have the opportunity to train themselves by using the e-learning tools.

Suggestions were made to make the website as easy-to-use as possible. To maintain the attention of the surfer, different text elements to explain the goal of the CISS, its background and the overall TRP, should be added on the website.

A basic CISS website for dissemination purpose will be available at the end of March 2013.

5 Next steps

Although the project has ended, there are some next steps to take to maximise the implementation of the CISS and the TRP.

Some ideas:

- Searching for extra funding to implement the materials. An option is to apply for an 'operational grant' (EAHC grant) but due to the deadline (22nd March 2013), it will not be realistic to apply for it this year but it should be kept in mind for a next call.
- Looking for national funding to translate the materials. Each partner can look for national funding possibilities to implement the tools? Or looking for funding to translate the tools.
- Every partner should give an update on the resources in their country/region that can be added on the CISS website, for instance links to local support organisations and positive prevention campaigns (see 'resources' section on the DVD).

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