Integration of sexuality into SRH and HIV/AIDS counselling interventions in developing countries: *a systematic review*

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Contents

Acronyms

AIDS	Acquired immunodeficiency syndrome
CRD	Centres for reviews and documentation
FGD	Focus group discussion
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
IEC	Information, education, communication
IPPF	International Planned Parenthood Federation
KIT	Koninklijk Instituut voor de Tropen/Royal Tropical Institute
M&E	Monitoring and evaluation
PHC	Primary health care
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
RH	Reproductive health
RTI	Reproductive tract infection
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STIs	Sexually transmitted infections
TARSHI	Talking About Reproductive and Sexual Health Issues
TASO	The AIDS Support Organization
UNFPA	United Nations Population Fund
VCT	Voluntary counselling and testing
WHO	World Health Organization

1 Executive summary

Background
In the era of HIV/AIDS, a better understanding of sexuality is critically important to improve sexual health. Despite best intentions to expand reproductive health services to the broader sexual and reproductive health (SRH) concept as prescribed in the International Conference on Population and Development (ICPD) Programme of Action, many programmes continue to struggle with the content of the 'S' or 'sexual' in SRH.

This report presents a systematic review of sexuality counselling between 2005 and 2006 as part of a larger research project. The results of the review serve two purposes:

- to review the evidence of the outcomes of integrating sexuality into SRH and HIV/AIDS counselling interventions aimed at improving the sexual health of men, women and youth; and
- to identify promising counselling projects that were found to be successful in improving people's sexual health.

The projects identified are taking part in the second phase of this research work.

Methods
Internationally accepted methods for conducting a systematic review were used in this research.

Searching: Data from existing reviews of counselling and review group expertise informed an initial scoping search that identified indexing terms and key concepts related to sexual counselling to be used in the comprehensive database searches. The reviewers and the information specialist used an iterative process to establish a matrix of key concepts and search terms to be used in the final search, and interrogated a total of eight databases. A snowball technique was used to identify additional studies. The review team identified and searched websites of organizations sponsoring or delivering sexual counselling, and examined references in identified papers to identify additional studies.

Inclusion criteria: Selected papers met the minimum criteria of reporting or addressing – either implicitly or explicitly – sexuality-related issues within their counselling sessions. The World Health Organization (WHO) working definition of sexuality was used as a guideline for what should be considered a sexuality-related issue. As the definition is broad and inclusive, the search and thus selection of studies was also ultimately rather broad. These broad criteria were purposely used to capture a larger number of studies that report some discussion of sexuality-related issues, to assist in further defining and refining the definition of sexuality-related counselling. Inclusion criteria were independently applied by two reviewers and discrepancies settled through discussion.

Data extraction and analysis: Data extraction was done by one reviewer and cross-checked by a second. Data is presented in tables and discussed in a narrative format.

Results
The search strategy identified 534 titles and abstracts. A total of 158 full papers were obtained and had inclusion criteria applied. Twenty-seven studies reported in 31 published papers met the inclusion criteria and are included in the review.

In the cases where sexuality-related counselling was included in the studies, the outcomes were reported as:

- an increase in contraceptive uptake;
- a decrease in risky sexual behaviour;
- a decrease in the number of sexual partners;
- an increase in condom use; and
- an increase in the prevention of (sexual) violence.

Information on how sexuality was addressed in the counselling sessions was generally not provided, as insufficient information was provided on the actual content of the counselling sessions. Scant (or minimal) evidence exists on studies of sexual orientation and reproductive rights in HIV settings. The conditions for effective integration of sexuality into SRH and HIV/AIDS counselling interventions vary.

The beliefs, norms and values of health providers affect the way counselling is provided and limit their own ability to discuss sexuality-related issues. At the same time, results show the interest and willingness of clients to discuss sexuality-related issues openly once the health provider offers the opportunity. Therefore, training, as well as supervision, plays a key role in the quality of counselling related to sexuality. Client-centred, comprehensive training which allows both the counsellor and the client to feel comfortable, confident, culturally consistent, sensitive and non-judgemental when discussing issues of sexuality is a necessity to create effective counselling.

There is evidence that involvement of spouses or partners is contributing to various outcomes, such as the increased emotional and tangible support, increased condom use and decreased risky sexual behaviour. Repeated counselling on contraceptive options seems to lead to an increase in consistency of use of family planning methods and thus to a decrease in unplanned pregnancies and fewer repeated abortions.

Confidentiality and privacy were noted as important aspects of counselling. Confidentiality was most prominently featured in studies carried out in an HIV or voluntary counselling and testing (VCT) service setting. Creating environments where consultations and counselling can be provided in a secure and private space is of great importance. Differences in interpersonal communication in counselling are influenced by gender. Studies showed that most men come for information, while women want to adopt, continue or change contraceptive methods. Consultations with men and couples are more than twice as long as consultations with women alone.

Four promising programmes were identified for assessment in the next phase of this research project, to document best practices and provide information for the development of guidelines for high-quality sexuality counselling.

Limitations

This review did not include an exhaustive search (particularly grey literature) and, therefore, it does not include all the studies related to this topic. However, given the consistent lack of integration of sexuality into SRH and HIV/AIDS counselling interventions in the included papers and the limited reporting of sexuality found in the studies, it is not believed that extending the search would have yielded other studies that would have changed the results or conclusions of this review.

Conclusions
The literature identified in the systematic review provided limited insights into what the content of sexuality counselling is or should be. Although frequently mentioned, the content of the counselling session was explicitly discussed in only two studies. None of the studies were designed to explicitly assess the outcome of the sexuality issues related to the counselling.

The emphasis in most studies carried out in settings where sexuality counselling is paired with other SRH and HIV/AIDS services (as identified in our review) was on measuring these services and their effects, rather than on the impact of sexuality counselling itself. The studies did not provide direct evidence for the effect of sexuality counselling on health outcomes but instead identified contributing factors to reported outcomes. Counselling offered in several SRH and HIV/AIDS health settings contributed to increased uptake of the services, increased contraceptive use, increased partner notification, increased condom use, and decreased risky sexual behaviour. Independent of the setting, the included studies suggested that sexuality counselling contributes to the overall efficacy of the programme where clients feel heard, understood and better able to request and receive the specific care, information and counselling they might need. In addition, counselling of male partners contributed to personal and behavioural outcomes. A number of studies identified that counselling needs to be ongoing and should not be seen as a one-off event.

Recommendations
This systematic literature review has identified that the integration of sexuality into SRH and HIV/AIDS counselling is an important health care issue that currently is limited by a lack of consistent definition of terms and good-quality research. There is, therefore, a need for:

- The creation of a more unified understanding as to what the integration of sexuality into SRH and HIV/AIDS counselling interventions entails. This would include a consistent definition of sexuality counselling, and the identification of key components of such counselling regardless of the setting in which it is provided.

- Good-quality empirical research on the integration of sexuality into SRH and HIV/AIDS counselling. This would include, where appropriate, randomized controlled trials but also good-quality before/after or case-study research. Areas requiring further investigation include but are not limited to: joint/partner counselling; the effect of gender on provider counselling; and gender differences and needs in counselling settings.

- Continued support for organizations to both integrate and evaluate the implementation of sexuality into SRH and HIV/AIDS counselling interventions into existing services.

- Continued development and evaluation of training programmes for health care workers providing sexuality counselling services. This may include the development of generic training protocols and monitoring and evaluation (M&E) tools to assess the impact of the integration of sexuality counselling into current service provision.

- An evaluation of programmes designed for specific marginalized groups, such as men who have sex with men, drug users, widows etc.

2 Background

This systematic review of effective integration of sexuality into SRH and HIV/AIDS counselling interventions and its contribution to improving health outcomes was conducted by the Royal Tropical Institute (KIT) and the World Health Organization (WHO).

2.1 Rationale for the review

The Programme of Action of the ICPD[1] adopted by 184 countries in Cairo, Egypt, called for a broad, integrated approach to SRH. It expanded the notion of reproductive health to include sexual health, both directly and indirectly, and called for greater attention to sexuality and a variety of aspects of power in sexual relationships. This call came after years of documentation and study of the role played by sexual and reproductive health and rights (SRHR) in the well-being of adolescents, women and men. The neglect or denial of SRHR is often found at the root of many health-related problems around the world, such as unwanted pregnancies, unsafe abortion, maternal mortality, sexually transmitted infections (STIs) including the human immunodeficiency virus (HIV), infertility, sexual dysfunction and gender-based violence.[2] As a result, renewed efforts to implement the Cairo agenda influenced countries' programmes to adopt a more expansive and holistic approach to SRH and HIV counselling services.

Despite best intentions to expand reproductive health services to the broader SRH concept as prescribed in the ICPD Programme of Action, many programmes continue to struggle with the content of the 'S' or 'sexual' in SRH. From 1990 to 2005, the global HIV epidemic has led to an average of 4.1 million new infections each year and 38.6 million people living with HIV, of which 24.5 million in sub-Saharan Africa.[3] In the era of AIDS, a better understanding of sexuality is critically important to improve sexual health, and reproductive health remains one of the best entry points.

There has been little research on the effectiveness of integrating sexuality-related issues into counselling practices in SRH and HIV/AIDS programmes and on the health system requirements for scaling up good-quality practices in primary health care. Therefore, there is insufficient understanding of the conditions that are required to integrate and sustain the quality of non-discriminatory, human rights-based counselling practices that enable primary care providers to discuss sexuality-related issues with their clients. The lack of evidence on practical and effective examples of integrating sexuality into SRH and HIV/AIDS counselling interventions further validates the need for an assessment of a number of hopeful interventions currently addressing sexuality in their programmes.

This systematic literature review aims to document the effectiveness of integrating sexuality into SRH and HIV/AIDS counselling interventions. Following the presentations of the definitions, objectives, research questions, and methods, the results will be presented.

2.2 Definition of counselling and sexuality

This systematic review of the integration of sexuality into SRH and HIV/AIDS counselling interventions investigates counselling that implicitly or explicitly raises sexuality-related issues in an effort to help individuals and couples improve their SRH and well-being.

As a result, this exploratory review remains broad, in an effort to capture the variety of direct and indirect ways in which programmes are trying, within their cultural and service delivery context, to expand their counselling services to a broad concept of SRH. In most studies

included in this systematic review the concepts of sexuality and sexual health are used interchangeably. The WHO 2002 definition of sexual health was chosen as the definition to apply in this review, because it encompasses a broad definition of sexual health. Where possible, an attempt was made to differentiate between studies referring to sexuality-related issues (i.e. issues related to sexual life, relationships or practices, etc.) and those referring to sexual health problems or concerns, such as STIs, infertility, abortion, etc. All counselling interventions conducted in SRH and HIV/AIDS service settings that implicitly or explicitly addressed sexual pain, problems, concerns, needs, pleasures, relationships, reproduction, rights, discrimination and violence are encompassed under the definition of sexual health[(4)] and thus fit into the criteria for selection of studies to be included in this review.

For our study purposes we have used the following working definitions**:**

Sexual health: Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[(4)]

Sex: Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean 'sexual activity', but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred.[(4)]

Sexuality: Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.[(4)]

Sexual rights: Sexual rights embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence to:

- The highest attainable standard of sexual health, including access to sexual and reproductive health care services;
- Seek, receive and impart information related to sexuality;
- Sexuality education;
- Respect for bodily integrity;
- Choose their partner;
- Decide to be sexually active or not;
- Consensual sexual relations;
- Consensual marriage;
- Decide whether or not, and when, to have children;
- Uptake of contraceptives
- Pursue a satisfying, safe and pleasurable sexual life.[(4)]

Rights-based approach: A rights-based approach integrates the norms, standards and principles of the international human rights system into the plans, policies and processes of development. The norms and standards are those contained in the wealth of international treaties and declarations. The principles include equality and equity, accountability, empowerment and participation. A rights-based approach to development includes the following elements: express linkage to rights; accountability; empowerment; participation; non-discrimination and attention to vulnerable groups.(5)

Counselling: Counselling on issues of sexuality can be defined as creating a climate where clients can express themselves and their concerns relating to sexual relationships and intimacy without fear of discrimination.(6)

Sexuality counselling: Counselling on issues of sexuality with the aim of creating a climate where clients can express themselves and their concerns relating to sexual relationships and intimacy without fear of discrimination. See Sexuality and also Counselling.(6)

Sexuality counselling: To facilitate individual, couple and provider's understanding of the client's sexual health concerns or needs, and desired sexuality, reproductive or contraceptive preferences.(7)[1]

[1] During this systematic review the IPPF definition of sexuality counselling (6).

International Planned Parenthood Federation. Glossary of Sexual and Reproductive Health Terms. New York: IPPF; 2006.) was used as a guideline for identifying sexuality counselling in the literature. In mid-2006 WHO created a definition of sexuality counselling. The definitions are complementary, and the use of the more recent definition would not have changed the results of this review.

3 Aims of the study

There are two general objectives of this systematic review:

- to review the evidence of the outcomes of integrating sexuality into SRH and HIV/AIDS counselling interventions, aiming at improving the sexual health (WHO, 2002) of men, women and youth; and
- to identify promising counselling projects that were found to be successful in improving people's sexual health.

Key question:
Is the integration of sexuality into SRH and HIV/AIDS counselling interventions contributing to the improvement of the sexual health of men, women and young people?

Research questions:

1. What evidence exists related to the effectiveness of integrating sexuality into SRH and HIV/AIDS counselling services in improving sexual health?
2. What are the key elements of interventions that are described as effective?
3. Where evidence of effectiveness exists, are there other outcomes?
4. What are the commonalities of the interventions that are effective?
5. Who is providing promising or effective counselling services dealing with sexuality?

4 Methods

This systematic review was conducted and is reported using internationally accepted methods for the identification, inclusion, quality assessment and synthesis of information related to evidence of best practice.[8, 9]

4.1 Literature search

Database searching

Data from existing reviews of counselling and review group expertise informed an initial scoping search. The aim of the scoping search was to identify indexing terms and key concepts related to counselling on sexuality-related issues that would be used in the comprehensive database searches. Through an iterative process the reviewers and the information specialist[10] developed a matrix of key concepts and search terms to be used in the final search. They used a combination of these terms to interrogate a total of eight databases. The details of the search strategy, including the search terms and databases accessed, are listed in Appendix 1.

In addition, a snowball technique was used to identify additional studies. The review team identified and searched websites of organizations sponsoring or delivering sexual counselling, and examined references in identified papers to identify additional studies.

The information specialist initially provided results of this search. Two reviewers (RP and AK) independently examined the list with titles and abstracts, obtained full reports of the papers and applied inclusion criteria. Discrepancies were discussed and, where necessary, a third reviewer (RD and/or AG) was consulted.

Application of inclusion criteria

The nature of the review question necessitated the use of broad inclusion criteria, and these are presented in Table 1.

Table 1: Inclusion criteria

Study design	Any study reporting original findings. No research method limitations were applied. Included, therefore, are studies that are randomized controlled trials, cohort studies, case control studies, descriptive studies or programme evaluations. Exclusions: editorial letters, descriptive discussions, consensus statements or commentaries.
Study location	Studies conducted in a developing country.
Interventions	Must implicitly or explicitly include a focus on sexuality and/or sexual health within the SRH and/or HIV/AIDS counselling interventions (see discussion of sexuality-related counselling definitions above).

Data extraction and analysis
Data were extracted onto pre-determined data extraction tables. All data were extracted by one reviewer and checked by a second independent reviewer. Data included study country, setting, intervention, participants, primary outcome, definition of sexuality into SRH and HIV/AIDS counselling interventions and reported results.

Heterogeneity of the studies precluded any statistical analysis. Study data are presented in tables with subsequent narrative discussion focusing on two areas. The first focuses on the study design and quality, and the second focuses on key concepts related to definitions of sexuality into SRH and HIV/AIDS counselling interventions and programme implementation.

Study quality assessment
The quality assessment of the randomized controlled trials was conducted using criteria based on CRD Report No. 4, listed in Khan, 2001[11] and presented in Appendix 2.

4.2 Analysis
The analysis of the results of the review is presented from two perspectives. First, a summary and comments were made on the research design and quality of the included studies. Second, key aspects were identified on how sexuality or sexual health-related issues were raised or integrated into the SRH and HIV/AIDS counselling interventions within the included studies and the implementation of programmes.

4.3 Limitations of this review
As sexuality or sexual health-related counselling has not been very well documented nor described in the literature, a broad search was needed to capture the variety of ways in which the issues are raised within counselling programmes. A broad conceptual framework was thus used in the review question, which in turn required that the search strategy be very broad. This resulted in a sensitive search that, unfortunately, lacked specificity. Reviewers, therefore, had to scan a large number of publication titles. This also meant that inclusion criteria at the first stage of application were broadly applied, and a large number of full publications were examined.

The advantage of this approach is that the authors developed a very good sense of the volume and quality of the published reports in this area. The disadvantage is that the results of the application of the inclusion criteria yielded a group of studies that demonstrate significant heterogeneity.

This has not been an exhaustive search of the available literature, particularly in relation to the area of grey literature. More studies may have been undertaken on this topic, but they do not appear in the databases or other sources. However, given the consistent lack of integration of sexuality into SRH and HIV/AIDS counselling interventions in the included papers and the poor overall quality of the research found in the studies, it is not believed that extending the search would have yielded other studies that would have changed the results or conclusions of this review.

5 Results

5.1 Overview

Titles and abstracts of 534 studies from the years 1990 to 2005 were examined, and 158 full papers were obtained and had inclusion criteria applied. This resulted in the inclusion of 27 different studies reported in 31 published papers.[12-42]

One randomized controlled trial was reported in multiple publications, including a report of qualitative data analysis.[20, 21, 37, 39, 40] The study is referred to as the Voluntary HIV-1 study in the general description. However, to aid in the discussion of differing aspects and outcomes, these reports are presented as separate studies in the tables and discussion sections of the review. Therefore, at times it may appear that the number of studies in each section is inconsistent with the total number of studies in the review.

To aid in identification, all studies are subsequently referred to by the first author and the year of publication. A full reference list for included studies is presented in Appendix 3. A table of study characteristics is available in Appendix , while details related to study design are presented in Appendix 5.

5.2 Study designs

Six of the 31 published papers (covering 27 studies) were randomized controlled trials, four were controlled trial/quasi-experimental, eight of the studies included in the review were qualitative research four were programme/project reports, four were cohort studies, two case control studies, two pre-post design studies, and one is a survey (see Table 2). Numbers are based on the primary research design and, as noted above, one quantitative study also provided qualitative data collection and analysis.

Table 2: Study designs

Type of study	Number
Randomized controlled trial	6
Controlled trial/quasi-experimental	4
Qualitative studies	7
Programme/project report	3
Cohort study	3
Pre/post design	2
Survey	1
Case Case/Control	1
Total	27

5.3 Quality assessment

Results of the quality assessment of the randomized controlled trials included in the review are presented in Table 3.

Table 3: Quality assessment of randomized controlled trials

	Randomization:			Baseline comparability:				Blinding:				Withdrawals:		
	Truly Random	Allocation concealment	Number stated	Presented	Achieved	Eligibility criteria specified	Co-interventions identified	Assessors	Administration	Participants	Procedure assessed	>80% in final analysis	Reasons stated	Intention to treat
Abdel-Tawab 2000 Integrating	n/s	n/s	✔	✔	✔	✔	✘	n/s	n/s	n/s	n/s	✔	✔	✔
Abdel-Tawab 2002 Recovery	n/s	n/s	✔	✘	✘	✔	✘	✘	✘	✘	✘	✘	✔	n/s
Faxelid 1996	✘	✔	✔	✔	✔	✔	✘	✘	✘	✘	✘	✔	✔	✔
Voluntary HIV-1 2000	✔	✔	✔	✔	✔	✔	✘	n/s	n/s	n/s	n/s	✘	✔	✔
Jones 1998	n/s	n/s	✔	✘	✘	✔	✘	✘	✘	✘	✘	n/s	n/s	✔
MacNeil 1999	n/s	n/s	✔	✘	✘	✔	✘	✘	✘	✘	✘	n/s	n/s	n/s

n/s: not stated

The table shows that two studies provided enough information regarding randomization to judge whether the study was truly randomized. The first was not truly randomized, as participants in this study were stratified by symptoms and randomization was done by patients drawing lots labelled intervention or non-intervention from a box.[18] The Voluntary HIV-1 study had central randomization and used sealed envelopes, therefore, ensuring allocation concealment.[40] One study used cluster randomization (by clinic), but the method of randomization was not stated, and it was not possible to tell if the cluster randomization was taken into consideration in the analysis.[13]

Three studies provided information regarding baseline comparability.[13, 18, 40] In another two studies baseline data were presented by sex and not by randomized group.[23, 29] All trials provided information on inclusion criteria.

None of the studies indicated that there was any attempt to blind any portion of the study. In two studies it was possible to estimate drop-out rates.[13, 18] One study did an analysis on 332 participants but, since no trial flow was provided, it was not possible to calculate the drop-out rate.[23] Three studies appear to have carried out an 'intention to treat' analysis.[13, 18, 23]

In summary, the quality of the trials – or at least the trial reports – was poor. A lack of information regarding randomization and baseline comparability meant that it was not appropriate to draw any firm conclusions from these studies. The weakness of the randomized controlled trial study design in these studies raises the question as to whether randomized controlled trials are the most appropriate way to capture the effectiveness of sexuality counselling interventions, particularly where baseline sexual health status – including sexual behavioural status – is extremely difficult to measure with any accuracy, as is the cause/effect chain of a psychosocial intervention on health and behavioural outcomes.

It was not felt to be useful to conduct a formal quality assessment of the remainder of the included studies. As can be seen from the table of study characteristics, a number of reports did not have clearly stated research objectives. The primary focus of the studies, however, did relate to measurable outcomes, such as contraceptive use and decreasing rates of unprotected intercourse, or to the uptake of services. Outcomes were those that related to objective measurement (e.g. condom use, uptake of contraceptive use, etc.).

None of the studies reviewed provided a detailed definition of the counselling provided in the study. Definitions that were given of the counselling reported in the studies primarily referred to the 'information' provided to clients, failing to give in-depth, detailed accounts of the type of information and issues covered in counselling. Nevertheless, studies that stated they provided information on the broad range of sexuality or sexual health topics described in the definition section above were considered if they met the other inclusion criteria.

6 Results related to the service settings in which counselling is provided

This chapter shows the connection between the different SRH and HIV/AIDS settings where counselling on sexuality was provided and the outcomes. Chapter seven reports on the personal, behaviour, health and service delivery outcomes. Chapter eight reports the findings related to aspects addressed in counselling, such as sexual health, sexual rights, quality of counselling and health systems and environment conditions. This leads to some repetition in the presentation of the findings. However, it was considered important to give the reader an insight into the link between the setting in which counselling is provided and the outcomes.

6.1 Introduction to the presentation of the results

After a preliminary database search and reading of the studies, six main SRH and HIV/AIDS settings were identified as providing counselling on sexuality and sexuality-related issues. The six settings include:

- Post-abortion care counselling;
- Youth services;
- HIV/VCT counselling;
- Family planning counselling;
- STI counselling; and
- Counselling on sexuality-related issues.

In order to better understand the content of the counselling provided, the methods used and the outcomes achieved, information was extracted from the studies, categorized and presented in tables. Appendix presents the characteristics of the studies included in the systematic literature review. It reviews the details of the studies: design; intervention; participants; primary outcomes; definition of counselling; and reported results/conclusions in relation to the settings in which the counselling was provided.

An iterative process led to the development of a draft conceptual framework included in Appendix . The framework is based on the definitions used and the features of sexuality counselling found in the literature. With the help of this framework more detailed information was extracted from the studies and categorized in the 'Extended Literature Review Framework', included in Appendix .

Different emphasis or features of the counselling were identified and categorized according to the different health service settings where counselling was provided. These features were extracted and broadly categorized as counselling on 'sexual health', 'sexual rights', 'sexual counselling', 'training of health providers' and 'capacity of health delivery system'.

6.2 Post-abortion counselling

Post-abortion counselling showed a positive impact on the uptake of contraceptives[22, 35], demand for contraceptives[38], partner involvement in receiving information on family planning and contraceptives, post-abortion care recovery, and prevention of future abortions.[14, 38, 42] None of the studies on post-abortion counselling made reference to sexuality as an integrated component of post-abortion counselling. However, counselling on family planning methods and prevention of future abortions was understood to implicitly necessitate a discussion of sexuality-related issues. A narrow concept of counselling seems to have been applied, such as providing information on different types of contraceptives, possible side-effects, advantages and disadvantages. Of the five studies, three measured dual

protection, referring to providing information about prevention of STIs/HIV and prevention of unwanted pregnancy by means of contraceptive use.[35, 38, 42]

6.3 Youth services

Lessons learnt from sex education have relevance for counselling services, including the ways in which sexuality can be and is addressed. The five studies identified on youth services and counselling underlined the importance of sexual health programmes for young people with a focus on sex education. A number of articles studied traditional structures or institutions in society that played a significant role in sex education and counselling in the past.[17, 32] These traditional systems may still have potential to contribute to the sexual health of young people and need to be further explored as future options for programmes targeting youth. In addition, the provider's attitude, norms and self-efficacy strongly influenced the counselling intervention, as shown in Tanzania.[33]

An evaluation of nine youth centres in Ghana showed that young people felt satisfied with the level of confidentiality of services offered but would have liked the counsellors to ask more in-depth questions and allocate more time to counselling sessions.[19] In the five studies focused on youth and counselling, outcomes included an increase in demand for contraceptives,[28] an increase, although marginal, in contraceptive use[17, 28] and a decrease in risky sexual behaviour.[17] Seven of the studies addressed sexual rights and aspects of sexual rights in their services, including sexual education and choice of partner(s).

6.4 HIV/AIDS counselling

Eleven studies on HIV counselling, including couple counselling, provided evidence of a positive connection between ongoing, non-judgemental HIV counselling, sexual practices and disclosure. In most of the cases, counselling accompanying HIV services (VCT) did not explicitly address sexual relationships and sexuality. VCT counselling in the studies reviewed necessitated counselling on safe sex practices, partner communication and notification, and transmission patterns of HIV – all sexuality and sexual health-related issues. In a study on sexual risk behaviour reduction associated with VCT in HIV-infected patients in Thailand, 80% of patients reported having decreased their sexual activity, decreased their number of sexual partners and were more often using condoms during their last three incidences of sexual intercourse since receiving a positive HIV test result.[31] The same results were found in a study in Uganda, where a participatory evaluation of the counselling, medical and social services of The AIDS Support Organization (TASO) showed a positive behaviour change in sexual practices and in seeking early treatment for opportunistic infections.[24] It should be mentioned that while the studies did not explicitly emphasize their discussions in the counselling sessions on sexuality, the topics discussed and the outcomes achieved demonstrate that a more explicit discussion of HIV clients' sexual lives was likely to have been part of the content of counselling sessions. Articles found on HIV and counselling demonstrated an increase in partner involvement[23, 30] and uptake in contraceptive use. They also showed an outcome of decreased risky sexual behaviour,[23, 29, 31] increased demand for STI/HIV testing[30] and an increase in partner notification.[30, 31] Partner involvement included notification of the partner's status and/or the need to seek VCT services. Counsellors' experiences of providing HIV counselling in conjunction with testing services may have contributed to the effectiveness of the services provided and the outcomes recorded.

6.5 Family planning

Four articles on family planning counselling provided information on sexuality issues in counselling sessions. The study with the strongest methodology of all the studies reviewed

took place in Egypt. 'Integrating Issues of Sexuality into Egyptian Family Planning Counselling'[13] explicitly uses the term 'sexuality counselling'. In this study some of the health providers were trained on technical information about contraceptives and sexuality related issues. The study outcomes showed that discussing issues related to sexuality is not only acceptable but also strongly desired by clients. Once the opportunity was offered, the women in the study preferred the provider to raise sexuality-related issues. Significantly more (44% versus 18%) clients in the intervention group had a sexuality-related discussion with service providers that went beyond addressing issues related to the use of contraception. Despite the fact that providers were trained on sexuality counselling, they continued to have problems addressing sexuality issues and personal problems. This reluctance was also indicated in a study on informed choice and decision-making in family planning counselling.[25]

A study in Kenya on gender differences in counselling showed that most men came to family planning counselling for information, while women wanted to adopt, continue or change contraceptive methods.[26] Consultations with men and couples were more than twice as long as consultations with women. During their turn to speak, 66% of the men in the study communicated actively, compared with just 27% of women. Providers also contributed to the marked difference, by offering men more detailed information than women, by asking women fewer questions, by providing fewer instructions, and by responding more supportively to men than to their female clients.

Another study conducted in a family planning counselling setting focused on the method of counselling provided.[14] This study measured more positive outcomes when clients received client-centred counselling versus provider-centred counselling. Providers offering client-centred counselling not only conveyed technical expertise but also assisted clients to interpret and understand their own values and worked towards achieving a mutually acceptable decision, following with the implementation of that decision.[43] The study showed a threefold increase in the likelihood of client satisfaction and their continued use of a family planning method seven months later, as compared to those who received physician-centred counselling (the provider determines the best course of action for the patient, with the patient obeying the providers decisions and not participating in the decision-making process).

6.6 STI counselling

Five studies addressed STI counselling focusing on sexual health, in particular physical, emotional, mental and social well-being in relation to sexuality. This covered topics such as partner notification; high-risk behaviour and motivation for risk taking; information on transmission, prevention, symptoms, treatment and complications of STI/HIV; the importance of treatment and partner referral/notification; condom use demonstration; monogamy; and prevention strategies against STI transmission.

Observed outcomes in the studies included an increase in contraceptive use,[15, 27, 41] a decrease in risky sexual behaviour,[15, 27, 41] a decrease in STI rates,[15, 41] an increase in STI treatment among participants,[41] and an increase in partner notification.[18, 34] One study conducted in Kenya focused its counselling on STI treatment and information, answering questions of clients and discussing the rationale for having partners seek treatment.[34] This study saw an increase in the number of partners of clinic attendees seeking STI treatment. A study in Senegal that focused on male clients of female sex workers saw a decrease in men believing condoms reduced sexual pleasure, from 58% to 6% at the two-year follow-up.[27] This same study had a decrease from 13% to 6% in men stating that condoms were too difficult to use,

and an increase from 2.2% to 42.2% of female sex workers saying they 'always use condoms' with clients. There was also increased consistent condom use and knowledge of HIV/AIDS amongst male clients.

6.7 Counselling on sexuality-related issues

One study explicitly dealing with counselling on sexuality-related issues investigated language used by callers to a sexuality and sexual health helpline in New Delhi.[16] The study stated that 82% of the calls answered were placed by males, despite this helpline being set up for everyone. As a result, the language used was very much based on male perceptions of sexual acts and bodily processes and was dominated by common male views and assumptions of sexuality and sexual relations. The helpline offered counselling on the following: sexual health; sexual rights; sexual pleasure; sexual orientation; sexual physical problems and concerns; sexual bodily integrity and sexual safety; partner communication; reproductive health issues (abortion, miscarriage, etc.); and contraceptives.

6.8 Summary

Counselling was offered in several SRH and HIV/AIDS health settings, resulting in increased uptake of the services, increased contraceptive use, increased partner notification, increased condom use, and decreased risky behaviour. Independent of the setting, several studies showed the appreciation of clients in cases where the provider addressed sexuality or sexuality-related issues during the counselling session. Despite this, it is difficult to get a clear understanding of the content of counselling sessions because few studies were explicit about if and how sexuality was addressed. The appreciation of the clients was not always consistent with the experience of the health providers who continued to face obstacles in offering good-quality counselling despite the training they had. Counsellors' own norms and values could have hindered their attitudes towards and acceptance of sexuality and sexuality-related issues faced by clients. Gender differences between providers and clients were observed in a number of studies, many resulting in a bias towards men, encouraging them to actively communicate, thereby contributing to enforcing gender roles and minimizing women's ability to address their needs.

7 Reported outcomes

In this chapter the reported outcomes of the counselling interventions are presented. These outcomes form elements of the conceptual framework (see Appendix 6) which was developed on the basis of the literature review entitled 'Integrating sexual health interventions into reproductive health services: Programme experience from developing countries'[2] and further evolved during the reading of the studies for this review. The review is not showing direct evidence between counselling and outcomes by addressing sexuality**,** but instead identifies contributing factors to reported outcomes.

7.1 Personal outcomes

Personal outcomes refer to an increased ability to express feelings and discuss issues around sexuality, increased self-esteem and increased partner involvement. Regarding personal outcomes, three studies showed an increase in satisfactory sexual relationship(s),[12, 41] and six studies showed increased partner involvement.[14, 23, 28, 30, 38, 42] Studies of partner involvement covered post-abortion counselling and VCT counselling. One study on post-abortion counselling showed that, in the intervention group of husbands who had been counselled on their wife's condition, their involvement was more likely to provide tangible, emotional or family planning support to their wife.[12]

Four of the six studies showing an outcome of increased partner involvement examined the role of the partner in different ways. Three of the studies[14, 23, 38] included the partner (in each case a male partner of a female participant) in the design of the study. Each of the studies sought consent from the counselled female before counselling her male partner. Females in all of the studies had the option to refuse counselling of their partner. Another study was a survey of a counselling programme in an HIV/VCT setting.[30] The counselling provided in this setting promoted active couple counselling and stressed the importance of receiving HIV status as a couple. Participants in this study were also able to decide whether they wanted to involve their partner, be they male or female.

7.2 Behavioural outcomes

Behavioural outcomes refer to increased contraceptive use, increased STI/HIV testing, diagnosis, treatment, decreased risky sexual behaviour, and decreased transmission in discordant couples. Regarding behavioural outcomes, two studies showed that counselling contributed to an increase in STI treatment.[29, 41] Nine studies showed decreased risky sexual behaviour,[15, 17, 23, 27, 29, 31, 41] and 13 studies showed an increase in contraceptive use.[12, 15, 17, 22-24, 27-29, 31, 35, 41]

In the 13 studies showing an increase in contraceptive use, nine of the studies provided information and featured contraceptives as an aspect of their counselling. While not all methods of contraception were introduced, condoms were discussed within the counselling in eight of the studies.[15, 22, 23, 27-29, 35, 41] Condoms were also discussed in the VCT and health information setting of the study conducted by The Voluntary HIV-1 Counselling and Testing Efficacy Study Group.[44] One study on VCT in Thailand reported that, after receiving VCT, participants more often abstained from sex and, when engaging in sexual activity, more often used condoms.[31]

A study in Zambia showed the importance of partner participation in counselling interventions in connection to sexual risk behaviour among HIV-positive women. Females who participated in same-sex group counselling interventions reported higher rates of condom use, more positive condom attitudes, safer sex intentions and less alcohol use, when their

male partners participated in the same type of high-intensity group counselling interventions.[23]

Of the studies which describe a decrease in risky sexual behaviour, three of them were conducted in an STI setting, four in a VCT counselling setting and one in a youth services setting. There was no decrease in risky behaviour seen as an outcome in post-abortion counselling, counselling on sexuality-related issues or family planning counselling settings.

7.3 Health outcomes

Health outcomes refer to decreased STI rates and decreased unwanted pregnancies. Included in health outcomes are two studies, both of which were conducted in an STI counselling setting that reported decreased rates of STIs.[15, 41] The increased condom use with sex workers and decreased STI rates are correlated with repeated counselling and focused prevention messages, acknowledging age, marital status, educational level, and previous STI history.[15] In Malawi, trained counsellors discussed ways of prevention and STIs/AIDS, as well as the use of condoms, partner notification, risk taking and motivation for change. Here, the reduction of occurrences of STIs and the mean number of sexual partners were reported among other outcomes that were not measured by the literature review (such as reduced health costs with fewer hospital visits, and increased knowledge of contraception).[41]

7.4 Service delivery outcomes

Service delivery outcomes refer to increased satisfaction with services; increased use of counselling services; increased availability of information and education materials; increased demand for contraceptives; increased demand for STI/HIV testing; increased partner notification; decreased repetitive STI infections; and increased adherence to treatment.

In service delivery outcomes as a result of counselling, two studies showed an increase in the use of health services by groups needing counselling services. One in India, through the telephone helpline TARSHI[16], and the other, Matovu[30], reported an increased demand for STI/HIV testing. Two studies reported an increased demand for contraceptives.[28, 38] These studies took place in post-abortion counselling and youth services settings. In Faxelid,[18] participants presented for STI testing and were counselled by a nurse or clinical officer of the same sex. The participants in the intervention group received information on the importance of completing treatment, abstaining from sex during the treatment period, and why and how they should inform their partners. They were also given a contact slip to notify their partner(s) of their need to seek STI testing. Participants in the control group received the same information but did not receive a contact slip to notify their partner(s). Participants then returned two weeks later for follow-up to see if they had contacted their partner(s). The study found that individual counselling of men and the provision of written information (contact slip) to give to sexual partners increased the proportion of female partners traced: with 89% of men in the intervention group notifying partners, and 64% of men in the control group notifying partners. However, the study did not see an increase in individually counselled women tracing their male partners.[18]

A survey of counselling in HIV/VCT settings in Uganda acknowledged the emphasis put on the importance of couple counselling and having a partner present when receiving HIV test results.[30] The active promotion of couple counselling was carried out by both interviewers conducting the survey and stressing the importance of receiving test results as a couple and counsellors who spoke publicly about the advantages and disadvantages of couple counselling.

8 Programmatic areas where counselling on sexuality is addressed

In this chapter, details on the content of counselling in relation to sexuality, sexual health and sexual rights are reported. The reporting follows the WHO[4] working definitions of sexuality, sexual health, and sexual rights and sexuality counselling, as described above on page 9-10. In addition, this chapter looks in detail at the description of the counselling as presented in the included studies, and the factors and conditions that are likely to have influenced the quality of counselling as presented in the conceptual framework (see Appendix 6).

The word 'mention', as used below, reflects the number of the studies that identified elements from the definition of sexuality, sexual health or sexual rights in relation to counselling. Details of how these elements were addressed are provided below, if included in the study. Some studies only mentioned the elements without detailing how they were used. As stated previously, mention of issues related to sexuality, sexual health or sexual rights may be explicit or implicit. As such, the definitions have been applied rather broadly and some assumptions have been made about whether a mention of counselling on dual protection or partner notification, for example, necessitates some, however minimal, discussion of the sexual relationship and/or other sexuality-related issues, such as power dynamics in the couple, violence or preferences.

For easier understanding of the chapter and the methodology applied, it is recommended to accompany the reading with the extended literature review framework, as presented in Appendix 7. The identified areas are further broken down into specific sub-areas as described in this chapter.

8.1 Sexual health

Fifteen studies addressed sexual health, referring to physical, emotional, mental, and social well-being in relation to sexuality.[13, 14, 16, 17, 22, 23, 27, 30, 32, 34, 38, 41] Three studies identified counselling as a positive and respectful way to address sexuality and sexual relationships, encouraging dialogue between providers and adolescents seeking health services, providing information to adolescents relating to sexual health, and respecting traditional practices and integrating them into sexual health services.[13, 16, 17] One study mentioned pleasurable and safe sexual experiences free of coercion, discrimination and violence.[16] Chandiramani referred to pleasurable sex in a gender context where more males were forthcoming on the subject of sexual pleasure and seeking information when calling the helpline reviewed in this study.[16] The studies addressing sexual health issues were spread across counselling settings. Studies that addressed a positive and respectful approach to sexuality and sexual relationships were carried out in youth services settings (one study), sexuality counselling (one study) and family planning counselling settings (one study). Three studies identified sexual problems (physical) such as contraceptive interference with sexual sensation, trouble reaching orgasm, pain during intercourse and training for providers on sexual problems of prospective patients.[13, 14, 16] Two studies mentioned harmful practices[13, 17], including female genital cutting amongst adolescents seeking services as an issue dealt within services, and discussion of female genital mutilation in training and amongst providers.

8.2 Sexual rights

Eight studies[13, 16, 17, 19, 25, 28, 32, 33] mentioned issues which can pertain to sexual rights. Five of these studies were carried out in a youth health service setting.

It is necessary to note when referring to 'sexual rights' that we have taken the WHO working definition (as previously mentioned in the definitions section) and applied it to the studies in

the review. We noted when a study *mentioned* any aspect of sexual rights. However, this does not mean that the studies in the review *understood and expressed sexual rights* or *explicitly referred* to the 'sexual rights' aspects we observed as 'sexual rights' or 'human rights' as a part of the study.

Three studies mentioned 'the right to access to SRH care',[13, 19, 28] including for youth as to how and where to access reproductive health services, counselling and contraceptive supplies. Two studies mentioned 'receive and impart information related to sexuality'.[13, 16] Chandiramani found that men who accessed the helpline were forthcoming with their thoughts on sexual pleasure and were seen as comfortable asking for information on sexual pleasure.[16] One study mentioned sexual concerns (bodily integrity/sexual safety) such as abuse.[16] Two studies identified 'the decision to be sexually active or not as a sexual right'.[16, 19] Three studies, all of which were in a family planning setting, referred to 'the right to decide on whether or not, and when to have children'.[13, 25, 26] However, providers did not go into details, discussing women's circumstances, time, etc. in relation to having children or not.[25]

Six studies mentioned 'the right to sexuality education'[16, 17, 19, 28, 32, 33], and five of the six studies addressing sexuality education were conducted in a youth services setting.

Seven studies mentioned 'pursuit of satisfying, safe and pleasurable sexual life, and sexual pleasure'.[13, 16, 17, 25, 27, 28, 32] Only one study mentioned sexual orientation.[16]

8.3 Quality of counselling with respect to sexuality and sexual health

The conditions discussed that influenced the quality of counselling with respect to sexuality, sexual health, and sexual rights included:

- confidentiality;
- privacy;
- choice;
- interpersonal communication;
- language used for counselling;
- time/duration of counselling sessions;
- client satisfaction;
- non-disclosure;
- partner involvement (couple counselling); and
- identification and addressing of sexual health needs relating to sexual identity (see conceptual framework in Appendix 6).

Eight studies gave information on the confidentiality within the counselling services under study.[12, 16, 21, 29-31] Confidentiality was created by using coding methods to review information, keeping information from a third party and following country-specific guidelines for confidentiality.[16, 30] Confidentiality was most prominently featured in studies carried out in an HIV/VCT service setting. Six of these studies took place in HIV/VCT service settings. Five studies mentioned privacy where patients were counselled in their homes or other locations away from a crowded area.[12, 19, 29, 30, 38] Counsellors voiced their thoughts on the importance of confidentiality, identifying what makes counselling unique and different from speaking with friends or family members as "confidentiality and privacy".[21] Despite this recognition, counselling was also given in situations which lacked full privacy and confidentiality. Nevertheless, clients greatly appreciated the attention and information provided to them.[12]

The aspect of choice as an element of counselling was mentioned in seven studies.[12, 14, 25, 30] The choice of whether or not to participate in individual counselling or couple counselling was raised with respect to the sensitive nature of information disclosed in counselling sessions and the conservative environment in which counselling was held.[30] In another study, women who had received post-abortion counselling were asked if they wanted their husbands to be separately counselled on post-abortion care.[12] In this study, the women who chose to have their husbands receive counselling found their husbands provided a higher level of tangible support, emotional support and support for the use of family planning than husbands who did not receive counselling at all.

Five studies demonstrated interpersonal communication within their counselling,[16, 17, 23, 26, 29] using a group format and an ongoing dialogue between the counsellor and client. A study in Kenya illustrated that most men came for information, while women wanted to adopt, continue or change contraceptive methods. Consultations with men and couples were more than twice as long as consultations with women. Providers also contributed to the marked difference. They offered men more detailed information than women, asked them fewer questions, issued fewer instructions and responded more supportively than they did for their female clients.[26]

Five studies mentioned the language used when administering counselling.[16, 23, 29] For most of the studies, this refers to the language in which counselling was provided. In MacNeil, interviews and informed consent were conducted in Kiswahili, with information translated into English.[29] Staff participating in Jones were multilingual, and interventions that took place were carried out in the participants' preferred language (Bemba, Nyanja and Nsenge).[23]

Six studies gave information on the time/duration of the counselling sessions reviewed in the studies.[12, 16, 17, 25] Two of the studies which gave information on the time/duration of their counselling were carried out in a family planning counselling setting. Counselling duration ranged from weekly counselling sessions of 90 to 120 minutes for four to eight weeks, to 10 to 30 minutes for a new family planning client.[17, 25]

Six studies mentioned client satisfaction.[12, 13, 19, 38, 42] This ranged from study participants giving positive feedback on the counselling provided,[12] to youth participants saying they wanted more time with the counsellor in sessions to discuss issues,[19] and repeated female aborters indicating that current contraceptive counselling services were not helpful enough and failing to meet their needs.[42]

Two studies mentioned non-disclosure as a feature of their counselling[12] – one in post-abortion services and the other in HIV/VCT services. Six studies described partner involvement (couple counselling) as an aspect of their counselling services[12, 26, 30, 38] with encouragement of HIV testing and results for couples, counselling of husbands and wives (separately) on the same issues relating to post-abortion care and recovery, and the vocal domination of men asking questions more than females.

8.4 Health systems and environment

8.4.1 Providers

Eleven studies made reference to the role of the provider as that of providing information and as a facilitator of information.[12-16, 18, 23, 28, 30, 34, 45] Seventeen studies made reference to attributes of the provider, such as knowledge, skills and attitude, and give information on the

provider, such as the relative importance of their knowledge, attitude and skills related to sexuality and sexual health issues, problems and concerns.[12-16, 19, 21, 25, 26, 30, 32-34, 36, 38, 42]

Provider attitudes were shown to have a possible limiting effect on the content of counselling in connection to sexuality-related issues. Their own beliefs, norms and values did affect the way they were counselling and limit their own ability to discuss sexuality-related issues.

Five studies identified the sex of the provider giving counselling.[13, 16-18, 25] In Egypt, female clients in the study preferred a female to counsel them, specifically a female doctor.[13] In another study, women with repeated abortions did not specify the sex of the provider but requested a doctor to counsel them about contraception.[42]

Eight studies identified either the lack of continuity of service by the same provider as a missing aspect of the services offered or stressed the importance of continuity of service by the same provider.[15, 18, 24, 25, 30, 38, 42] Four studies mentioned the age of the provider giving counselling.[13, 14, 16, 19] One study in Egypt stated that although a client-centred style of communication was associated with positive client satisfaction, results of this study showed that clients were more likely to be satisfied if the doctor was 35 years or older.[14]

8.4.2 Training

Fourteen studies gave information about training of health providers involved in counselling.[13, 14, 16, 17, 19, 21, 23, 27, 28, 30, 34, 36, 38] Five of these studies took place in an HIV/VCT setting, four studies took place in post-abortion counselling settings, and four in youth health services settings. Seven studies on training covered reproductive health issues.[13, 16, 17, 28] These studies were all carried out in service settings except for HIV/VCT counselling and post-abortion counselling. Two studies mentioned training on abortion/miscarriage.[16, 38] Seven studies mentioned training on contraceptives.[13, 16, 21, 27, 28, 38] One of the studies took place in a post-abortion counselling setting, and another study took place in a family planning counselling setting.

Three studies discussed the importance of training on gender roles/power,[13, 16, 17] one study mentioned training on violence[16], two studies mentioned training on negotiation,[13, 27] seven studies mentioned training on RTI/STI/HIV,[13, 16, 17, 27, 34, 36] and three studies mentioned training on physiological aspects of sexual health and sexuality in relation to counselling.[13, 16, 17] Studies undertaken in a post-abortion counselling setting did not mention gender roles/power, violence, negotiation, RTI/STI/HIV, or psychological and physiological aspects in their training of health providers.

Eight studies made reference to the duration/time of the counsellor training, which differed in programme content and intensity.[13, 16, 17, 21, 27, 34, 38] Six studies mentioned the importance of follow-up given to trained health providers,[13, 16, 27, 36, 38] and seven studies indicated the importance of the supervision that trained health providers received in their counselling services.[13, 16, 21, 34, 36, 38] Self-assessment and peer review were considered key elements of supervision which helped to maintain providers' performance after training and prompt continuous quality improvement.[38] The method of training was shown to have an impact on the attitudes and perceptions of health providers and the execution of their job.[19] Reference was made in three studies to the importance of communication skills and a client-centred approach contributing to behaviour and health outcomes.[14, 21, 38]

8.4.3 Capacity of health delivery system

Three studies mentioned an unnamed information or data collection system functioning in the health system in which they were operating,[16, 27, 30] two studies gave background information on the environment of the health system in the country where the study took place,[12, 30] and three studies described drugs they had for patients.[18, 24, 34] Twelve of the studies mentioned that health providers granted referrals.[13, 14, 16-18, 22, 24, 27, 29, 35, 42] Referrals mentioned in five studies took place in a post-abortion counselling setting. One study mentioned the type of equipment available in the services,[38] and three studies mentioned access as part of their health system.[19, 29, 30] Eight studies mentioned the supplies available in their setting.[15, 21, 22, 25, 28, 35, 38, 42] Half of these studies were in a post-abortion counselling setting.

The studies provided scant information on contextual and structural factors which enabled integration or expansion of the counselling provided to better address sexuality or sexual health issues. The managerial policy or regulatory context was not detailed in the studies and, therefore, no conclusion can be drawn on which of these factors facilitated or impeded integration or expansion of counselling services. Further studies should better investigate and document the contributing factors which often play a significant role in scaling up programme interventions.

9 Discussion

Sexuality, sexual health and sexual rights include more aspects than just those such as safe sex methods, family planning and treatment for STIs. The idea of sexuality as part of life is generally not acknowledged by SRH services. This literature review demonstrates that reports currently available lack a consistent definition of sexuality in relation to counselling.

In addition, there are numerous interpretations of what 'integration of sexuality into SRH and HIV/AIDS counselling interventions' entails. Without a clearer understanding of what the integration of sexuality is, implementation will vary across and within programmes. It may also mean that issues which are hard to introduce, to address and measure (i.e. masturbation, sexual identity, increased pleasure in sexual relationships, etc.), will not be addressed or recognized as components of sexuality.

The review identified six randomized controlled trials that demonstrated an effect on health services delivery and patient behaviour. For ethical reasons it may be considered difficult to conduct randomized controlled trials related to sexuality counselling.[46] Even with well designed randomized controlled trials it may be difficult to attribute positive sexual health or other outcomes to discussions of sexuality and sexual relations in a counselling session. The randomized controlled trials in this review were not designed to assess the issue of the integration of sexuality into counselling but do demonstrate that it is possible to conduct good-quality empirical research in this complex field.

This should not be interpreted to mean that only evidence from randomized controlled trials should be included in a review such as this. As pointed out by other articles, literature reviews need to be realistic and pragmatic to be useful to policy makers and programme implementers.[47, 48] The case studies and programme evaluations included in the review identified key areas for consideration when designing and implementing programmes such as these.

Evidence of the effectiveness of counselling in general is mixed.[49-51] Positive findings in some reviews mean that further investigation is required. However, such research is difficult. The majority of studies included in the review addressed sexuality or sexual health in counselling. However, the reports did not provide specific in-depth information on the content of counselling provided. The primary objective of the research was not intended to measure the aspects of sexuality integrated into the counselling. The emphasis, in studies carried out in settings where sexuality counselling is integrated into other SRH and HIV/AIDS services, related to these services and their effects, rather than on the impact of sexuality counselling itself. In addition, it is difficult to measure the effects of counselling in isolation from other aspects, for example the effect of VCT on risk behaviour.

This review demonstrates a lack of a consistent definition of sexuality and sexuality counselling across settings. This is not surprising, given the state of the literature on this topic to date. The perspective from which the counselling settings address sexuality filter what issues are perceived as relevant and useful. For instance, HIV counselling places a greater emphasis on safe sex practices and methods, abstinence, partner notification, and motivations for risky behaviour change throughout their counselling services than post-abortion care services. Where the focus is on HIV/AIDS (in a VCT centre, for example) the counsellor (and even the client) may perceive specific issues as more relevant than others, particularly as they

relate to HIV/AIDS. In this case, the focus is thus often limited to sexual behaviour, sexual methods and partner notification. The differences in perspective are appropriate; however the general concepts of sexuality counselling are relevant across settings.

In a recent WHO study, the elements of integrated sexual health counselling were listed as:

- Discuss matters related to contraceptive choice
- Discuss matters related to prevention of mother-to-child transmission (PMTCT) at risk, pregnancy and child care
- Discuss measures for protection against STI/HIV
- Conduct STI assessment adapted for the local situation
- Propose HIV testing (VCT)
- Discuss concerns, fears and values related to sexuality, sexual function and sexual and reproductive health[2]

From the studies included in this review it emerged that counsellors most frequently focused on the first five bullet points and less on the final critical aspect. The studies appeared to view sexuality counselling as discussing safe sex methods, STIs and abstinence and remain on the surface of sexuality. Only two studies explicitly used and applied the term 'sexuality counselling' in reference to the counselling they provided. None of the studies in this review mentioned aspects of sexuality counselling such as the exploration of sexual dysfunctions, or sexual desires which underpin some behaviours (i.e. why does a person have a desire to have unprotected sex? Is it due to circumstances beyond their control?).

It needs to be acknowledged that the content and focus of counselling is not static but changes in line with changes in reproductive health technologies. For example, as antiretrovirals (ARVs) become more available, counselling sessions are likely to change, with increased demands and inquiries about how to have a 'normal' sexual life despite being HIV positive. The improved health and longer-term survival of people living with HIV/AIDS influence their sexual identity. Therefore, health providers and counsellors will need to be able to respond to these changing identities and needs. These issues were also discussed at a recent expert meeting on HIV/AIDS that focused on preventive counselling.[52]

Results of the review indicate that clients were interested and willing to openly discuss sexuality-related issues once the provider offered the opportunity. One well designed randomized controlled trial identified that the benefits of integrating sexuality into counselling are not only important for avoiding pregnancy and infections, but also enable couples to enjoy sexuality and have a healthy sexual relationship.[12]

How choice is accommodated in the studies varies, as does the willingness of the programmes to address some of the more sensitive or difficult issues, such as sexual preferences, orientation and pleasure. Respect for sexual rights in counselling implies that clients have a right to be informed about all their choices and possibilities without discrimination or bias. However, such issues were only addressed in three studies in the context of family planning sessions. Reproductive choices of HIV-positive men and women were hardly addressed in any of the studies. Sexual orientation came up in one study. [16] How counselling sessions will begin to grapple with these more sensitive but critical issues is now becoming ever more urgent to understand. Recent international interest in providing sexual health guidance for people living with HIV/AIDS should help.[7]

None of the studies mentioning sexual rights were conducted in an HIV/VCT counselling setting, STI setting or post-abortion counselling setting. Topics under the heading of sexual rights, such as choice of partner(s), consensual sexual relations and decision to be sexually active, were only addressed in youth services settings and through the services of the telephone helpline in India.[16]

9.1 Key issues for consideration

Despite the lack of a consistent understanding to what 'integration of sexuality into SRH and HIV/AIDS counselling interventions' means, there are similarities across the studies. Twelve studies included a focus on training and supervision of providers in relation to their behaviour, attitudes and technical skills. Health providers who received behaviour change training as part of their professional education were more likely to report counselling young people on safe sex practices than their colleagues who had not received the training. In addition to training and supervision, follow-up and prevention of burn-out were important aspects of a conducive counselling environment in one study. Counsellors were encouraged to discuss their calls with other staff in order to provide peer monitoring and support and prevent burn-out.[16]

Clients receiving counselling at intervention sites where the provider had received a sexuality training course were more likely to report having had a sexuality-related discussion not dealing with family planning with their service provider.[13]

The studies observed strong associations between health workers' counselling behaviour and their perceived norms, attitudes and self-efficacy. There was consensus that counselling should not be a one-off occurrence but a repeated 'process' with emphasis on specific issues or topics. This has been raised as an issue in training, but from the included studies there was evidence indicating that provider attitudes had a limiting effect on the content of sexuality-related issues in counselling,[30] and increased training changes provider attitudes. This may translate into improved counselling and better health outcomes. This cause and effect chain of training to reported outcomes should be further studied if we are to know the relative value of repeated training on counsellors' effectiveness.

Client-centred counselling and counselling that takes the characteristics of clients into consideration were considered appropriate in this area. Clients receiving client-centred counselling – as opposed to provider-centred counselling – were likely to produce better outcomes (i.e. continuation of use of family planning method).[14] Clients were more likely to return for follow-up counselling if they perceived their provider to be caring and respectful.[37]

Inclusion of partners in counselling – either joint couple counselling or in a separate session – emerged as another way of influencing clients' sexuality and sexual health. There was evidence that the involvement of husbands/partners in separate counselling sessions led to an increase in emotional support and support by husbands for the use of family planning methods,[12] reduced risk behaviour and increased communication[23] and disclosure of HIV-positive status.[44]

Confidentiality was most prominently featured in studies carried out in an HIV/VCT service setting. Studies ensured the confidentiality of counselling by following government policy,[30] stressing the importance of confidentiality and privacy in trainings provided to their counsellors,[21] and utilising mechanisms where clients were only identifiable by codes and

numbers.[29] Despite this recognition, counselling was also given in situations which lacked privacy and confidentiality.[14] Confidentiality was also of concern to patients with some of them preferring 'to avoid outside referrals to preserve confidentiality when having to be treated for a stigmatizing condition (STD or HIV-related health problems)…'.[37]

Gender issues are important and need to be addressed within sexuality counselling. Men and women have different expectations of a counselling session. In one study, men came for information, while women wanted to adopt, continue or change contraceptive methods, and asked fewer questions.[26] In addition, providers also seemed to treat male and female clients differently. They offered men more detailed information than women, asked them fewer questions, issued fewer instructions and responded more supportively. By implication, male and couple sessions take longer than sessions with women only.[26] Power relationships, although not emphasized in the studies included in this review, play an important role in the effect counselling can have on sexual behaviour. Sangiwa et al identified that women are often less powerful than men in negotiating sexual practices.[37] The inclusion of men in the counselling process (either joint counselling or individual) resulted in an increased uptake in changes in sexual practices.[12, 13]

In Chandiramani,[16] counselling was conducted through a helpline in Hindi and English. The study into the language used by callers brought up some interesting contextualized gendered notions of sexuality. For example, the language of male callers indicated that they perceived women as sexual objects instead of sexual beings, while the language used by women when calling demonstrated feelings of subordination to males in sexual relations.

An interesting side note to this study is that all counselling at this sexual health helpline was provided by females. It was found that both male and female callers were more comfortable discussing sexual issues with female counsellors. In the initial stages of this programme it was found that more time and investment in training and monitoring had to be taken for male counsellors than for female counsellors. The implications of this study are that the gender of the counsellor plays a role in the way issues around sexuality are elicited and addressed and needs attention in the training of counsellors and the service provision.

The review identified that the sex of the provider can have an effect on client satisfaction with the counselling provided. In one study, female clients preferred a female to counsel them, specifically a female doctor.[13] In another study, women with repeated abortions did not specify the sex of the provider but requested a doctor to counsel them about contraception.[42] There does not seem to be a consistent point of view in this area, and local assessment of client perceptions is, therefore, required when making decisions regarding the gender of workers providing sexuality counselling.

One key factor was not addressed in the identified studies. In many resource-poor settings, integration of sexuality into existing programmes will be hampered by a host of problems related to the shortcomings of the health system. Under-funding and poor management of public sector services in much of the developing world cause many of these problems. The infrastructure of health facilities often does not ensure privacy for confidential interviews and examination of patients. Shortages of personnel and medical supplies hamper the delivery of quality services.[2] Even where integration is a priority and the necessary resources have been made available, results suggest that service capacity and quality of care are not sufficient. An absence of monitoring and evaluation systems and the availability of drugs was the most common observation in the studies reviewed. Counselling on sexual and reproductive health

requires time, human resources, space, commitment and money – all of which many resource-poor settings lack or have trouble establishing. The idea that the performance of public health services and the functioning of a health system as a whole is at stake was not expressed. The need for scaling up sexuality counselling services provided by non-government organizations (NGOs) and the private sector was not mentioned.

10 Conclusions

Five research questions guided the extraction of data and data analysis in order to identify and assess the effectiveness of integrating sexuality into SRH and HIV/AIDS services. These are discussed here.

10.1 What evidence exists related to the effectiveness of integrating sexuality into SRH and HIV/AIDS counselling services in improving sexual health?

None of the identified studies explicitly included the integration of sexuality into counselling. The studies included in the review demonstrated that researchers had identified some elements of sexuality which were being provided within services. Because counselling was provided alongside SRH and HIV/AIDS services, the effect of the counselling was not independently measured.

10.2 What are the key elements of interventions that are described as effective?

The literature identified in the systematic literature review provided limited insights into what the content of counselling is or should be. It was frequently mentioned that the counselling had been client-centred and the client should define the contents of the session. However, only two of the studies discussed the content of the counselling. Therefore, it was not possible to get a clear idea of how sexuality-related issues were addressed in counselling sessions.

As would be expected, the role of health care providers is critical. Interventions that had an effect on outcomes were related to specific services where providers had received in-depth training (i.e. technical skills and communication skills). A key component identified in a number of studies relates to the need to consider the attitude and values of the provider (i.e. being open and non-judgemental, and offering client-centred counselling). Other attributes of the provider that may influence the structure and contents of counselling include the sex and age of the counsellors.

Inclusion of partners (if applicable) in counselling – either joint couple counselling or in a separate session – has been shown to effect clients' behaviour.

There was consensus that counselling should not be a one-off occurrence but an ongoing 'process' with emphasis on specific issues or topics.

10.3 Where evidence of effectiveness exists, are there other outcomes?

There is evidence that the inclusion of partners in counselling led to increased partner involvement. Client-centred counselling – rather than physician-centred counselling – led to increased contraceptive method continuation rate at follow-up, as well as increased client satisfaction.

There is also evidence that repeated counselling on specific issues or topics led to increased contraceptive use and increased concern for a partner's health. While not all methods of contraception were introduced, females who participated in group counselling interventions where condoms were covered reported higher rates of condom use and a decrease in risky sexual behaviour when their male partner participated in the same type of group counselling intervention. The influence of male partners on female risk behaviour demonstrates the benefits to sexual health outcomes when male partners are engaged and presented with the opportunity to broaden communication channels related to sexual health within their relationships. Despite this, changes were not consistent between the different service settings identified.

10.4 What are the commonalities of the interventions that are effective?

Interventions which involved partners in counselling showed an outcome of increased condom use and decreased risk behaviour. In-depth training and supervision in sexual health issues and sexuality for providers were shown to increase providers' acceptability of and comfort in discussing issues of sexuality with clients. This was found in projects which demonstrated increased partner involvement and demand for contraceptives.

10.5 Who is providing promising or effective counselling services dealing with sexuality?

The studies included in the review provide valuable insight into the key elements in counselling related to sexuality, sexual health and rights. The type of outcomes and background information contributed to the identification of a number of promising projects.

The systematic literature review was conducted to assist in the identification of potential programmes to be included in the second phase of the research. Four organizations were selected. Reports from three of these projects are included in the review.[16, 24, 26] One other organization was identified and selected: a pioneer programme in the Latin America region in the area of sexuality counselling as both a standalone intervention and as part of its other SRH interventions.

Therefore, the following four organizations will participate in the next stage of this important research:

- **TASO** (The AIDS Support Organization) in **Uganda** provides HIV/AIDS counselling interventions to HIV-positive patients as well as serodiscordant couples. Its counselling is provided in an HIV context, discussing sexual pleasure, masturbation and family planning, etc. while taking into account the HIV-status of its clients. TASO provides couple and individual counselling as well as home-based counselling for patients. TASO's emphasis on sexuality issues faced by HIV-positive clients or people affected by HIV shows its understanding of the importance and need to address sexuality in the context of HIV.[24]

- Discussing sexuality-related issues is part of the telephone counselling service of **TARSHI** (Talking About Reproductive and Sexual Health Issues) in **New Delhi, India.** The service is provided through an anonymous telephone helpline where people call in to discuss any issue relating to sexuality. Callers are also able to seek information about referral to medical services and information centres. This is done in an anonymous setting, where conversations with callers are not recorded, and the only identification is a caller number for calls that the client may place to TARSHI again in the future.[16]

- **FHOK** (Family Health Options Kenya, formerly FPAK, Family Planning Association of Kenya) has a focus on young people (aged 10 to 24) which has lead it to address the sexual and reproductive needs and rights of youth in Kenya. An IPPF affiliate since 1962, FHOK has counselling centres (two of which are youth specific) and referral systems to their medical services located in government hospitals. FHOK's peer education and peer counselling programmes have established themselves either directly in the community or at one of the two youth-specific centres. FHOK counsellors work with teachers to provide training and information, giving teachers

the capacity to distribute condoms, and provide sexual and reproductive health information to students in the school setting without being biased or judgemental towards young people seeking information and counselling. Using different settings to provide counselling services demonstrates a great possibility to scale up services in other settings in Kenya.[26]

- **The Coletivo Feminista Sexualidade e Saúde in São Paulo, Brazil** was founded in 1981 to promote and provide integrated health and sexuality-related services for women. Working from a rights perspective, the Coletivo is one of the leading women's health activist organizations in Brazil that provides direct ambulatory SRH services, specific mental health services (private individual and couples counselling), workshops for diverse populations (male and female sex workers, gay men and lesbians, young people, older women, rural workers, etc.) and training and capacity building for other organizations aiming to work on sexuality specifically within their own service setting. For all of their services, they have developed training materials and other tools to improve individual and community knowledge of the issues. The Coletivo provides private subsidized services for individuals and couples. Its training and education services are provided to the State and Municipality of São Paulo's public health system, the Catholic Church's pastoral support services, police and judiciary training organizations and associations (related to violence), and other organizations dealing with a variety of populations and sexual health issues facing women, men and young people.[53]

11 Recommendations

This systematic literature review has identified that the integration of sexuality into SRH and HIV/AIDS counselling is an important health care issue that is currently limited by a lack of consistent definition of terms and good-quality research. There is, therefore, a need for:

- The creation of a more unified understanding as to what the integration of sexuality into SRH and HIV/AIDS counselling interventions entails. This would include a consistent definition of sexuality counselling and the identification of key components of such counselling, regardless of the setting in which it is provided.

- Good-quality empirical research on the integration of sexuality into SRH and HIV/AIDS counselling. This would include, where appropriate, randomized controlled trials but also good-quality before/after or case-study research. Areas requiring further investigation include but are not limited to: joint/partner counselling; the effect of the gender of provider on counselling; gender differences and needs in counselling settings.

- Continued support for organizations to both integrate and evaluate the implementation of sexuality into SRH and HIV/AIDS counselling interventions into existing services.

- Continued development and evaluation of training programmes for health care workers who provide sexuality counselling services. This may include the development of generic training protocols and monitoring and evaluation tools to assess the impact of the integration of sexuality counselling into current service provision.

- An evaluation of programmes designed for specific marginalized groups, such as men who have sex with men, drug users, widows, etc.

12 Appendices:

12.1 Appendix 1 Quality assessment

Indexing terms related to sexual counselling:

Counselling	Reproductive Counselling
Sexuality	Contraceptive Counselling
Sexual Education	Abortion Counselling
Sex Education	Talking Therapy
Sexuality Education	Mother to Child Transmission
Sexual Pleasure	AIDS
Sexual Health	HIV
Sexual Rights	Population Control
Sexual Orientation	Family Planning
Sexual Pleasure	Maternal Health
Sexual Concern	Services and Youth
Sexual Problems	Services and Adolescents
Psychological Interventions	Voluntary Counselling and Testing
Psychosocial Interventions	Information Education Communication

Searches conducted 2004 to 2006, and studies included in the review from 1990 to 2005.

Bibliographic sources

The Cochrane Library
The Cochrane Library is a source of reliable and up-to-date information on the effects of interventions in health care, published on a quarterly basis. The Cochrane Library consists of a regularly updated collection of evidence-based medicine databases. The databases hold primarily systematic reviews.
Search results on most relevant keywords:
Sexual Counselling: 3 hits
Sex Counselling: 1 hits
Sexuality Counselling: 0 hits
Sexuality: 1 hit
Sexual Pleasure: 6 hits
Sexual Education: 9 hit
Sexuality Education: 8 hits
Sex Education: 7 hits
Reproductive Counselling: 0 hits
Contraceptive Counselling: 1 hit
Sexuality and Youth: 7 hits

PubMed
PubMed is a service of the US National Library of Medicine that includes citations from MEDLINE and other life science journals for biomedical articles.
Search results on most relevant keywords:
Sexual Counselling: 54 hits
Sex Counselling: 19 hits
Sexuality Counselling: 4 hits

Sexuality: 3613 hits
Sexual Pleasure: 133 hits
Sexual Education: 128 hits
Sex Education: 662 hits
Sexuality Education: 154 hits
Reproductive Counselling: 26 hits
Contraceptive Counselling: 77 hits
Sexuality and Youth: 171 hits

ScienceDirect
ScienceDirect is a large electronic collection of science, technology and medicine full-text and bibliographic information. The following journals are included, among others: Social Science & Medicine; The Lancet; Patient Education and Counselling; Nurse Education in Practice; Reproductive Health Matters; Journal of Counselling Psychology.
Search results on most relevant keywords:
Sexual Counselling: 90 hits
Sex Counselling: 524 hit
Sexuality Counselling: 11 hits
Sexuality: 5553 hits
Sexual Pleasure: 161 hits
Sexual Education: 152 hits
Sex Education: 4382 hits
Sexuality Education: 20 hits
Reproductive Counselling: 42 hits
Contraceptive Counselling: 136 hits
Sexuality and Youth: 575 hits

SwetsWise
SwetsWise provides a comprehensive source of electronic publications on a very broad range of subjects. The following journals, among others, are part of the collection: Culture, Health and Sexuality; Health Policy and Planning; Aids Care.
Search results on most relevant keywords:
Sexual Counselling: 2 hits
Sex Counselling: 2 hits
Sexuality Counselling: 0 hits
Sexuality: 794 hits
Sexual Pleasure: 17 hits
Sexual Education: 18 hits
Sex Education: 112 hits
Sexuality Education: 32 hits
Reproductive Counselling: 3 hits
Contraceptive Counselling: 11 hits
Sexuality and Youth: 40 hits

PsycINFO
PsycINFO is an abstract database of psychological literature.
Search results on most relevant keywords:

Sexual Counselling: 1 hit
Sex Counselling: 0 hits
Sexuality Counselling: 0 hits
Sexuality: 106 hits
Sexual Pleasure: 2 hits
Sexual Education: 0 hits
Sex Education: 20 hits
Sexuality Education: 20 hits
Reproductive Counselling: 1 hit
Contraceptive Counselling: 7 hits
Sexuality and Youth: 5 hits

SocioFile
SocioFile is an abstract database with literature in sociology and related disciplines.
The KIT subscription to SocioFile stopped in 2002.
Search results on most relevant keywords:
Sexual Counselling: 2 hits
Sex Counselling: 1 hit
Sexuality Counselling: 0 hits
Sexuality: 6 hits
Sexual Pleasure: 1 hit
Sexual Education: 43 hits
Sex Education: 28 hits
Sexuality Education: 3 hits
Reproductive Counselling: 0 hits
Contraceptive Counselling: 6 hits
Sexuality and Youth: 5 hits

Campbell Collaboration
The Campbell Library consists of systematic reviews of studies on the effects of policies and practices in education, and the social and behavioural sectors. In this database it appeared to be impossible to select the records by year of publication. One hundred records were examined by hand.
Search results on most relevant keywords:
Sexual Counselling: 0 hits
Sex Counselling: 0 hits
Sexuality Counselling: 0 hits
Sexuality: 7 hits
Sexual Pleasure: 0 hits
Sexual Education: 0 hits
Sex Education: 7 hits
Sexuality Education: 0 hits
Reproductive Counselling: 0 hits
Contraceptive Counselling: 0 hits
Sexuality and Youth: 1 hit

The WHO Reproductive Health Library No.7
The WHO Reproductive Health Library is a collaborative project between the World Health Organization, the Cochrane Collaboration and collaborating institutions and scientists in developing countries as part of the WHO programme to map best reproductive health practices.
Search results on most relevant keywords:
Sexual Counselling: 0 hits
Sex Counselling: 1 hit
Sexuality Counselling: 0 hits
Sexuality: 2 hits
Sexual Pleasure: 0 hits
Sexual Education: 2 hits
Sex Education: 3 hits
Sexuality Education: 0 hits
Reproductive Counselling: 0 hits
Contraceptive Counselling: 2 hits
Sexuality and Youth: 0 hits

Websites
The following websites were used:
United Nations Development Programme (UNDP; www.undp.org)
United Nations Population Fund (UNFPA; www.undp.org)
Family Health International (FHI; www.fhi.org)
International Planned Parenthood Federation (IPPF; www.ippf.org)
International Planned Parenthood Federation European Network (IPPF EN; www.ippfnet.ippf.org)
Population Action International (PAI; www.pai.org)
The Alan Guttmacher Institute (www.agi-usa.org)
Population Services International (PSI; www.psi.org)
Marie Stopes International (www.mariestopes.org.uk)
Synergy Project (www.synergyaids.com)
Pathfinder International (www.pathfind.org)
Talking about Reproductive and Sexual Health Issues (TARSHI; www.tarshi.org)
Eldis Gateway to Development Information (www.eldis.org)
Department for International Development (DfID; www.dfid.gov.uk)
Reproductive Health Outlook (RHO; www.rho.org)
United Nations Development Fund for Women (Unifem; www.unifem.org)
United Nations Children's Fund (Unicef; www.unicef.org)
World Bank (www.worldbank.org)
International Labour Organization (ILO; www.ilo.org)
Population Council (www.popcouncil.org)
Entre Nous, The European Magazine for Sexual and Reproductive Health (www.euro.who.int)
Healthlink Worldwide (www.healthlink.org.uk)

The number of keywords was reduced by searching on websites. It became clear that some of the keywords were not useful, because no relevant documents were found using them. On some websites there were no search options for keywords. In that case, relevant themes were explored. Websites were consulted in January to February 2005.

12.2 Appendix 2 Quality assessment

Randomized controlled trials were assessed using the following criteria, based on CRD Report No. 4. [11]

- Was the method used to assign participants to the treatment groups really random? *(Computer-generated random numbers and random number tables will be accepted as adequate, while inadequate approaches will include the use of alternation, case record numbers, birthdates or days of the week)*
- Was the allocation of treatment concealed? *(Concealment will be deemed adequate where randomization is centralized or pharmacy-controlled, or where the following are used: serially numbered containers, on-site computer-based systems where assignment is unreadable until after allocation, other methods with robust methods to prevent foreknowledge of the allocation sequence to clinicians and patients. Inadequate approaches will include: the use of alternation, case record numbers, days of the week, open random number lists and serially numbered envelopes, even if opaque)*
- Was the number of participants who were randomized stated?
- Were details of baseline comparability presented in terms of treatment-free interval, disease bulk, number of previous regimens, age, histology, and performance status?
- Was baseline comparability achieved for treatment-free interval, disease bulk, number of previous regimens, age, histology, and performance status?
- Were the eligibility criteria for study entry specified?
- Were any co-interventions identified that may influence the outcomes for each group?
- Were the outcome assessors blinded to the treatment allocation?
- Were the individuals who administered the intervention blinded to the treatment allocation?
- Were the participants who received the intervention blinded to the treatment allocation?
- Was the success of the blinding procedure assessed?
- Were at least 80% of the participants originally included in the randomization process followed up in the final analysis?
- Were the reasons for any withdrawals stated?
- Was an 'intention to treat' analysis included?

Items were graded in terms of ✓ **yes** (item adequately addressed), ✗ **no** (item not adequately addressed), ✓/✗ *partially* (item partially addressed), **?** **unclear** (unclear or not enough information), **NA** (not applicable) or **NS** (not stated).

12.3 Appendix 3 Included studies

Abdel-Tawab, N., Huntingdon, D., Osman, E., Youssef, H. & Nawar, L. (2002) *Recovery from abortion and miscarriage in Egypt: does counseling husbands help?*

Abdel-Tawab, N., Nawar, L., Youssef, H. & Huntington, D. (2000) *Integrating issues of sexuality into Egyptian family planning counseling*. Washington, US Agency for International Development (USAID).

Abdel-Tawab, N. & Roter, D. (2002) The relevance of client-centred communication to family planning settings in developing countries: lessons from the Egyptian experience. *Social Science & Medicine,* 54**,** 1357-1368.

Bentley, M., Spratt, K., Shepherd, M., Gangakhedkar, R., Thilikavathi, S., Bollinger, R. & Mehendale (1998) HIV testing and counseling among men attending sexually transmitted disease clinics in Pune, India: changes in condom use and sexual behavior over time. *AIDS,* 12**,** 1869-1877.

Chandiramani, R. (1998) Talking about sex. *Reproductive Health Matters,* 6**,** 76-86.

Erulkar, A. S., Ettyang, L. I. A., Onoka, C., Nyaga, F. K. & Muyonga, A. (2004) Behavior change evaluation of a culturally consistent reproductive health program for young Kenyans. *International Family Planning Perspectives,* 30**,** 1-15.

Faxelid, E., Tembo, G., Ndulo, J. & Krantz, I. (1996) Individual counseling of patients with sexually transmitted diseases: a way to improve partner notification in a Zambian setting? *Sexually Transmitted Diseases,* 23**,** 289-292.

Glover, E., Erulkar, A. & Nerquaye-Tetteh, J. (1998) *Youth centres in Ghana*. Population Council.

Grinstead, O., Gregorich, S., Choi, K., Coates, T. & Voluntary Hiv-1 Counselling and Testing Efficacy Study Group (2001) Positive and negative life events after counseling and testing: the Voluntary HIV-1 Counselling and Testing Efficacy Study. *AIDS,* 15.

Grinstead, O. A., Van Der Straten, A. & Group, T.V.H.-C.A.T.E.S. (2000) Counsellors' perspectives on the experience of providing HIV counselling in Kenya and Tanzania: the Voluntary HIV-1 Counseling and Testing Efficacy Study. *AIDS Care,* 12**,** 625-642.

Johnson, B., Ndhlovu, S., Farr, S. & Chipato, T. (2002) Reducing unplanned pregnancy and abortion in Zimbabwe through postabortion contraception. *Family Planning,* 33**,** 195-202.

Jones, D., Ross, D., Weiss, S., Bhat, G. & Chitalu, N. (1998) Influence of partner partipation on sexual risk behaviour reduction among HIV-positive Zambian women. *Journal of Urban Health: Bulletin of the New York Academy of Medicine,* 82 (Supp 4)**,** iv92-iv100.

Kaleeba, N., Kalibala, S., Kaseje, M., Ssebbanja, P., Anderson, S., Van Praag, E., Tembo, G. & Katabira, E. (1997) Participatory evaluation of counselling, medical and social services of The Aids Support Organization (TASO) in Uganda. *AIDS Care,* 9**,** 13-26.

Kim, Y., Kols, A. & Mucheke, S. (1998) Informed choice and decision-making family planning counseling in Kenya. *International Family Planning Perspectives,* 30**,** 4-11.

Kim, Y., Kols, A., Mwarogo, P. & Awasum, D. (2000) Differences in counseling men and women: family planning in Kenya. *Patient Education and Counseling,* 39**,** 37-47.

Leonard, L., Ndiaye, I., Kapadia, A., Eisen, G., Diop, O., Mboup, S. & Kanki, P. (2000) HIV prevention among male clients of female sex workers in Kaolack, Senegal: results of a peer education program. *AIDS Education and Prevention,* 12**,** 21-37.

Lou, C.-H., Wang, B., Shen, Y. & Gao, E.-S. (2004) Effects of a community-based sex education and reproductive health service program on contraceptive use of unmarried youths in Shanghai. *Journal of Adolescent Health,* 34**,** 433-440.

Macneil, J., Mberesero, F. & Kilonzo, G. (1999) Is care and support associated with preventive behaviour among people with HIV. *AIDS Care,* 11**,** 537-46.

Matovu, J., Kigozi, F., Nalugoda, F., Wabwire-Mangen, F. & Gray, F. (2002) The Rakai Project counselling programme experience. *Tropical Medicine and International Health,* 7**,** 1064-1067.

Muller, O., Sarangbin, S., Ruxrungtham, K., Sittitrai, W. & Phanuphak, P. (1995) Sexual Risk behaviour reduction associated with Voluntary HIV Counselling and testing in HIV infected patients in Thailand. *AIDS Care,* 7**,** 567-572.

Muyinda, H., Kengeya, J., Pool, R. & Whitworth, J. (2001) Traditional sex counselling and STI/HIV prevention among young women in rural Uganda. *Culture, Health & Sexuality,* 3**,** 353-361.

Ngomuo, E., Klepp, K., Rise, J. & Mnyika, K. (1995) Promoting sager sexual practices among young adults: a survey of health workers in Moshi Rural DIstrict, Tanzania. *AIDS Care,* 7**,** 501-507.

Njeru, E., Eldridge, G., Ngugi, E., Plummer, F. & Moses, S. (1995) STD partner notification and referral in primary level health centers in Nairobi, Kenya. *Sexually Transmitted Diseases,* 22**,** 231-5.

Rasch, V., Massawe, S., Yambesi, F. & Bergstrom, S. (2004) Acceptance of contraceptives among women who had an unsafe abortion in Dar es Salaam. *Tropical Medicine and International Health,* 9**,** 399-405.

Rohleder, P. & Swartz, L. (2005) 'What I've noticed what they need is the stats': lay HIV counsellors' reports of working in a task-oriented health care system. *AIDS Care,* 17**,** 397-406.

Sangiwa, M., Van Der Straten, A., Grinstead, O. & Voluntary Hiv-1 Counseling and Testing Efficacy Study Group (2000) Client's perspective of the role of voluntary counseling and testing in HIV/AIDS prevention and are in Dar Es Salaam, Tanzania. *AIDS and Behavior,* 4**,** 35-48.

Solo, J., Billings, D., Aloo-Obunga, C., Ominde, A. & Makumi, M. (1999) Creating linkages between incomplete abortion treatment and family planning services in Kenya. *Studies in Family Planning,* 30**,** 17-27.

Voluntary Hiv-1 Counseling and Testing Efficacy Study Group (2000) Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania, and Trinidad: a randomised trial. *The Lancet,* 356**,** 103-112.

Voluntary Hiv-1 Counseling and Testing Efficacy Study Group, Kamenga, M., Sweat, M., Zoysa, D. & Dallabetta, G. (2000) The voluntary HIV-1 counseling and testing efficacy study: design and methods. *AIDS and Behavior,* 4**,** 5-14.

Wynendaele, B., Bomba, W., M'manga, W., Bhart, S. & Fransen, L. (1995) Impact of counselling on safer sex and STD occurrence among STD patients in Malawi. *International Journal of STD and AIDS,* 6**,** 105-9.

Xinh, T., Binh, P., Phuong, V. & Goto, A. (2004) Counseling about contraception among repeated aborters in Ho Chi Minh City, Vietnam. *Health Care for Women International,* 25**,** 20-39.

12.4 Appendix 4 Study characteristics table

Results of the first screening of titles and abstracts using the following inclusion criteria:

1) studies should report original findings (e.g., the article should not be an editorial, letter, discussion of clinical practice, overview, consensus statement, opinion piece or commentary);
2) studies were conducted in developing countries;
3) studies focusing on counselling related to sexuality within HIV/AIDS and/or SRH context

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
1. Post-abortion counselling						
Abdel-Tawab 2002[12] Egypt Date of study not provided In-hospital post- abortion services Recovery From Abortion and Miscarriage in Egypt: Does Counselling Husbands Help?	Randomized controlled trial Follow-up interviews conducted among women in intervention group to learn about their recovery and what they thought of the counselling they received (and their husband received).	Intervention group: improved care and counselling for women, and their husband received separate counselling Control group: improved care and counselling for women only In-depth interview of random selection of husbands	Women who experienced pregnancy loss N= 366 completed Intervention N=136 Control N=157 Husband in- depth interview N=15 Note: large proportion of husband counselling	Husband support for wives (tangible, emotional, FP use) Use of FP	Women's counselling included: educational information – physical recovery, nutrition, warning signs, FP) Miscarriage counselling Men's counselling included: educational information – women's needs, physical recovery, fertility, FP, referral	Husbands in intervention group more likely to provide tangible, emotional or FP support to wives (50%, 30%, 60%) Women whose husbands provided a high level of support for their use of FP were almost six times more likely to use/intend to use contraceptives Counselling was well received by husbands and wives and had a measurable and positive effect on husbands' behaviour and their wives' recovery. Husbands who participated suggested elaborating on the information provided in the counselling sessions about the resumption of sexual activity and use of family planning.

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
			provided in the hallway in five minutes			
Johnson 2002[22] Zimbabwe 1996-1997 Hospital Harare (intervention) Bulawayo (control) Reducing unplanned pregnancy and abortion through post-abortion contraception	Control trial Subject interviews Pregnancy tests Follow-up Q3 months to 12 months	Post-abortion family planning counselling	Women after incomplete abortion Intervention N=1355 Control N=873	Contraceptive use Unplanned pregnancies Repeat abortion	Counselling on contraceptive options	Results presented only for women who wished to delay pregnancy Intervention N= 316 Control N=320 Increased use of effective family planning (82% vs 58%) Decrease in unplanned pregnancies (15% vs 35%) Fewer repeat abortions (2.5% vs 5%)
Solo 1999[38] Kenya 1995-1997 Hospital ward and FP clinic Creating linkages between incomplete abortion treatment and family planning services	Pre/post intervention Three models: Ward (by ward staff) Ward (by ward and MCH-FP staff) FP clinic (MCH-FP staff)	Post-abortion family planning counselling Provided staff training, equipment and re-organization of services	Patients: Pre N=481 Post N=319 Staff: Pre N=140 Post N=106 Partners Post N=93	Contraceptive use Method of contraceptive	Information on contraceptives – counselling not specifically addressed	Improvement: FP counselling received (7% vs 68%) Decide to use FP (22% vs 68%) Received method (3% vs 70%) Provision on ward by ward staff was the preferred model An unanticipated benefit to offering services on the gynaecological ward occurred in terms of men's potential access to these services.
Rasch 2004[35]	Project report	Contraceptive	Women	Post-abortion	Counselling on	High proportion of women accepted

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
Tanzania 2001-2002 Hospital – ward and out patient Acceptance of contraceptives among women who had an unsafe abortion in Dar es Salaam		counselling	attending ward N=1085 Unsafe abortion N=523 Women attending outpatient clinic with unwanted pregnancy N=265	contraception use	contraception and risk of STIs/HIV	contraception post abortion (90%) Single women were significantly more likely to use condoms.
Xinh 2004[42] Vietnam 2001 Hospital Counselling about contraception among repeated aborters in Ho Chi Minh City	Qualitative semi-structured in-depth interviews	None	Women with history of abortion N=30	To investigate the factors that influence the demand for abortion, the need for contraceptive counselling, the ideal time, types, location, and context of the counselling		Women had very little knowledge about contraceptive use. They prefer face-to-face discussion with a physician at a hospital using leaflets and pictures.
2. Youth services						
Erulkar 2004[17] Kenya 1997-2001	Quasi-experimental Intervention and control sites	Culturally consistent reproductive health programme	1997 survey N=1544 2001 survey N=1865	Behavioural changes: delay sexual initiation,	Not defined Culturally consistent programme provided	Demonstrated only marginal difference in delay in sexual initiation in control district. All data presented as aggregate of the two groups.

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
Community base Behaviour Change Evaluation of a Culturally Consistent Reproductive Health Program for Young Kenyans.	Pre-test/post-test survey	One-month training programme for councillors	Unable to identify number of participants in the two sites separately	prevention of STI and unwanted pregnancies		
Muyinda 2001[32] Uganda Date of study not provided Traditional sex counselling and STI/HIV prevention among young women in rural Uganda.	Qualitative In-depth interviews Focus groups Simulation games	None	Interview Women N=60 Opinion leaders Women N=7 Male N=5	Assess potential of traditional ways (senga) of passing sexual knowledge from adult to younger women for STI/HIV prevention	Counselling (and education) by senga on menses, hygiene, maintain virginity until marriage, how to elongate her labia minora, how to handle a husband socially and sexually, and how to generally prepare for womanhood and marriage	Senga model has potential to improve access to and quality of sex education for adolescent girls Content of sex education should be diversified to include clearer focus on STIs/HIV and family planning techniques Two-way communication should be strengthened
Lou 2004[28] China 2000 Suburban Shanghai Effects of a community-based	Quasi-experimental intervention and control towns Follow-up 20 months (92%)	Youth-friendly intervention – counselling (information and skills) and services related to sexuality and reproduction Tables indicate that less than a third actually had counselling	Unmarried youth Intervention N=1220 Control N=1007	Contraception and condom use	Interaction with young people in supportive, non-judgemental, friendly and confidential ways to assist in dealing with sex-related issues, to choose appropriate contraceptives, and to avoid high-risk behaviours	Sexual activity increased in both groups Intervention group more likely to use contraception and to make joint decision related to contraception

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
sex education and reproductive health service program on contraceptive use of unmarried youths in Shanghai.						
Glover 1998[19] Ghana 1998 location not provided Youth Centres in Ghana: Assessment of the Planned Parenthood Association of Ghana Programme (9 of 12) Youth Centres	Programme evaluation Situational analysis Interviews, retrospective analysis of clinical records and IEC client attendance Equipment Cost	Counselling services at youth centres	Client interviews N=291 Staff interviews N=21	Programme usage and attendance Quality of services	All youth centres offer counselling services Counselling not defined	Interviews: 55 (19%) had received counselling from either a nurse or a counsellor 95% felt that the counsellor would keep information confidential 27% found counsellors were embarrassed 43% found counsellors to be judgemental 22% had questions that remained unanswered 27% had issues that were not discussed 35% would have liked more time
Ngomuo 1995[33] Tanzania 1993 District health centre Promoting safer sexual practices among young adults: a survey of health	Survey self-administered questionnaire	None	Rural health workers (government and volunteers) N = 342 (participation rate 68.4%)	Attitudes towards safer sex promotion Perceived norms regarding counselling Perception of health workers	Not defined	Strong associations between participating health workers' reported counselling behaviour and their perceived norms, attitudes and self-efficacy. Subjects who had behaviour change training were more likely to report counselling young people regarding safe sex.

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
workers in Moshi Rural District, Tanzania				perception of their own counselling behaviour		
3. STI service counselling						
Njeru 1995[34] Kenya 1992 Urban outpatient clinic MCH/FP N=5 STD partner notification and referral in primary level health centres in Nairobi, Kenya.	Pre/post study	5-10-minute counselling session Staff training 2days Medical student training 3 days with twice-weekly supervision	MCH/FP staff Medical students (one per clinic) Patients presenting for STI treatment N=254 Follow-up – 1 week N=93	Impact of counselling Partner notification	5-10 minutes of additional counselling from a senior medical student trained in STI counselling. Provided information and answered questions about STI treatment, reviewed treatment instructions, stressed rationale for referring all sex partners for treatment.	Effects of counselling not reported Partners presented for treatment Pre=15% Post=40%
Faxelid 1996[18] Zambia 1992-3 Urban health centre Individual	Randomized controlled trial No information on what intervention was given to the control group	Individual counselling and notification cares	Patients with STD N=396 Intervention N= 196 Female= 46 Male= 150 Control	Partner treatment Note – it was clinic policy to only treat patients who brought a partner	One-to-one discussion Females treated female patients, males treated males 10-20 minutes including discussion of STIs, how to notify a partner, health education	Partner treatment Male: intervention versus control (1.8 vs 1.2) Female: no difference Individual counselling of men with STIs improved partner notification. Those that received individual counselling and a contact slip (for partner notification) were

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
Counselling of Patients with Sexually Transmitted Diseases: A way to Improve Partner Notification in a Zambian Setting?			N= 200 Female= 54 Male= 152		(transmission, treatment, complications, prevention of STIs), importance of completing treatment, not having sex during treatment period, why patients should notify their partners.	more likely to notify partners of the past three months. It cannot be said whether providing a contact slip for partner notification or individual counselling was more effective in notifying partners. NOTE: It is not possible to tell from the study if both groups got notification slips
Wynendaele 1995 [41] 1991 Malawi Hospital (2) Impact of Counselling on Safer Sex and STD Occurrence among STD Patients in Malawi.	Control group design Clinical observation Questionnaires	STI counselling	Control Hospital N=154 Intervention N=155 Participants N= 454	Knowledge, condom use, risk behaviour	Trained counsellors discussed modes of transmission and prevention of STIs/AIDS, condom demonstration, symptoms and treatment of STIs, partner notification, risk taking and reasons for doing so, motivations for behaviour change	Follow-up poor Less then 50% of respondents in each group did the post test Counselling Reduced: occurrence of STDs, mean number of partners, health costs, hospital visits. Increased: concern for sexual partners, knowledge about and use of condoms
Bentley 1998[15] India 1993-97 STI clinic Testing and Counselling Among men Attending	Longitudinal cohort 4 years	HIV testing, STI counselling and condom promotion 3-month follow-up	N=1628 Men previously screened negative for HIV	Condom use Sex with sex workers STI rates	Pre-test counselling included: routes of transmission of HIV, high-risk behaviours, prevention strategies, demonstration of condom use and repeat by patient.	Increased condom use with sex workers 6, 18 and 24 months – 2.6, 3.6 and 4.7 times more likely to use condom Men with history of STI more likely to use condom Sero conversion less likely in men who used condoms. Older and married men less likely to use

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
Sexually Transmitted Disease Clinics in Pune, India: Changes in Condom Use and Sexual Behaviour Over Time.					Counselling at each visit focused on reinforcing monogamy, condom use with sexual partners and provision of government-provided condoms Initial counselling done by masters-level social workers	condoms with sex workers Married men living with spouse less likely to visit sex workers after counselling Low condom use correlated with low levels of education and knowledge of HIV Findings in study indicate that counselling prevention messages should be more focused, acknowledging participants' age, marital status, education and previous STI history, instead of general counselling methods.
4. Counselling on sexuality-related issues						
Chandiramani 1998[16] India Not applicable Talking about sex, TARSHI's Telephone Help line in New Delhi.	Qualitative Analyses of data from helpline calls	Observation and description of counselling provided via helpline calls	Helpline calls N = 15,000 Male=82.3 % Female=18.3 %	Not stated	Not stated	Males = 82% of calls Callers' perceptions of sexual acts and bodily processes appear to be based on and restricted to male-centred and male-defined assumptions.
5. HIV/AIDS and counselling						
Kaleeba 1997[24]	Participatory evaluation of TASO	Observation and description of	TASO clients N=324	Evaluation of counselling,	Ongoing one-to-one counselling. Initial	

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
Uganda 1993-94 Participatory evaluation of counselling, medical and social services of The Aids Support Organization (TASO)	programme Home visits and interviews Case-study Focus groups Informant Interviews Observation of counselling session	counselling services and methods provided to HIV-positive patients, and others coming for counselling and testing	Care giver interviews N=232 Case-study N=2 Focus groups 24 informants Counselling sessions observations N=49	medical and social services offered by The AIDS Support Organization (TASO).	dialogue between a counsellor and a client discussion of coping strategies. Ongoing monthly counselling.	
Grinstead 2001a [20, 21, 37, 39, 40] Kenya, Tanzania and Trinidad Public clinics Positive and negative life events after counselling and testing: Voluntary HIV-1 Counseling and Efficacy Study	Randomized controlled trial with cross over	VCT versus basic health information	Individuals and couples seeking HIV-related services not known to be HIV positive N=3120	Rates of unprotected intercourse for individuals and couples	Not defined, counselling given was VCT (VCT included pre-test counselling, HIV antibody testing, and two weeks later post-test results and counselling. Condom information and supplies were also given with the understanding that participants could return for more condoms if they needed).	For individuals with HIV, their positive status was associated with increased support from health professionals, the break-up of marriage and being neglected or disowned by family. Serodiscordant couples where the woman was HIV positive were most likely to report a break-up of marriage and the break-up of a sexual relationship. Disclosure of status was linked to the strengthening of a sexual relationship except for HIV-positive women.
Grinstead 2000[21] Additonal report to study above Kenya and Tanzania	Qualitative Focus groups Interviews	Interviewing counsellors on their perspectives of counselling and VCT.	Counsellors and counsellors supervisors N = 11	To investigate counsellors' roles and experiences providing HIV-related counselling	Providing information, protecting confidentiality and being non-judgemental	Counsellors' stress might be reduced and their effectiveness and retention improved by: 1. Allowing work flexibility 2. Providing supportive, non-evaluative supervision 3. Offering alternatives to client behaviour change as the indication of

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
Public clinics Counsellors' perspectives on the experiences of providing HIV counselling in Kenya and Tanzania						counsellor performance 4. Acknowledging and educating about 'emotional labour' in counselling. 5. Providing frequent information updates and intensive training 6. Encouraging counsellor participation in the development of research protocols.
Sangiwa 2000 (Sangiwa et al., 2000) Tanzania 1995-1997 Dar es Salaam Client's Perspective of the Role of Voluntary Counselling and Testing in HIV/AIDS Prevention and Care in Dar Es Salaam, Tanzania: The Voluntary Counseling and Testing Efficacy Study	Randomized qualitative study This study is part of a larger study (see Grinstead 2001) Clients randomized to receive either health information or VCT on sexual behaviour, psychological status and knowledge about HIV/AIDS and STIs (see Grinstead 2001)	Interviews (short interviews 10-15 minutes; long interviews 1hr) at six-month follow-up. VCT (pre-test counselling, HIV antibody testing, and two weeks later post-test results and counselling) versus health information (a 15-minute video about HIV transmission and prevention and questions answered by a health educator) randomly assigned to participants	81 study participants at the Tanzania study site (part of larger study see Grinstead 2001)	Importance of HIV/AIDS in the context of other significant life issues identified by clients	Not defined VCT included pre-test counselling, HIV antibody testing, and two weeks later post-test results and counselling	Issues identified: Poverty and access to services; economic dependency of women; presence of endemic diseases; community perception of HIV/AIDS. Reasons and motivation for coming to the VCT centre: Sero-status specific motivations; motivation to return for either additional counselling or for the first follow-up. Experience with and consequences of receiving VCT: Health changes; emotions and feelings; changes in emotional support. Role of VCT in prevention and risk reduction strategies: Increased awareness and knowledge of prevention and care; perceived vulnerability; promotion of behavioural change; condom use; beliefs and attitudes.
The Voluntary HIV-1 Counseling	Randomized controlled trial	VCT (pre-test counselling, HIV	3120 individuals	Decrease in unprotected sex	VCT included pre-test counselling, HIV	Reported unprotected sex declined from baseline to first follow-up among those

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
and Testing Efficacy Study Group 2000 (The Voluntary HIV-1 Counseling and Testing Efficacy Study Group, 2000) Kenya, Tanzania and Trinidad 1995-1998 Efficacy of Voluntary HIV-1 Counselling and Testing in Individuals and Couples in Kenya, Tanzania and Trinidad: a randomized trial**.**		antibody testing, and two weeks later post-test results and counselling) versus health information (a 15-minute video about HIV transmission and discussion about HIV-1 transmission and condom use led by a health-information officer) randomly assigned to participants	and 586 couples enrolled, aged 18 years and older.	seen among people having received VCT.	antibody testing, and two weeks later post-test results and counselling. It also included a personalized risk assessment, and development of a personalized risk reduction plan for each client.	receiving VCT versus health information. These results maintained at second follow-up as well. Data supports efficacy of HIV-1 VCT counselling in supporting behaviour change.
The Voluntary HIV-1 Counseling and Testing Efficacy Study Group et al., 2000 (The Voluntary HIV-1 Counseling and Testing Efficacy Study Group et al., 2000)	A description of the design and methods (including recruitment, consent, randomization, intervention, assessment, follow-up, training, and quality assurance) of a randomized	No intervention in this sub-study. A description of the design and methods (including recruitment, consent, randomization, intervention, assessment, follow-up, training, and quality assurance) of a randomized clinical trial study.	Participants in this sub-study taken from earlier study (Grinstead 2001a) using 3120 individuals and 586 couples	Ideas for future studies assessing the design and methods of VCT and its effects on communities were discussed. No health outcomes were	VCT included pre-test counselling, HIV antibody testing, and two weeks later post-test results and counselling	Ideas for future studies including: Further follow-up data assessing cost-effectiveness may be useful in evaluating sustainability of services. Population-based survey studies to assess the community-level impact of HIV testing, counselling and services being available in the area.

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
Kenya, Tanzania and Trinidad 1995-1998 The Voluntary HIV-1 Counseling and Testing Efficacy Study: Design and Methods	clinical trial study.		enrolled in the primary study	recorded or reported.		
Rohleder 2005[36] South Africa Khayelitsha District Date not provided HIV counsellors working in a task-oriented health care system	Qualitative focus groups interviews	Specially trained volunteer counsellors	Counsellor interviews N=16 Focus groups N=13 A total of 29 counsellors interviewed	Counsellors' role in sexual counselling	HIV/AIDS counselling is about a confidential and intimate relationship between client and counsellor, where emotionally loaded topics, such as sex, death and dying are discussed	Identification of a need to address workplace issues when planning and providing VCT. Counsellors feel unappreciated or not given due recognition. Counsellors find difficulties working with a health team. Identified capacity problems.
Leonard 2000[27] Senegal 1995 - 1997 HIV-prevention among male clients of female sex workers in Kaolack, Senegal: Results of a peer education programme.	Cohort Two-year follow-up	Male peer education programme Local transport workers trained	Female sex workers N=45 Male transport workers N= 260	Male knowledge of condom use and sexual pleasure	No specific counselling Education and information provided Focus on ideas of change in attitude to behaviour and addressing sexual behaviour which believes pleasure is decreased due to contraceptive use	

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
Müller1995 [31] Thailand 1993-94 Community/clinic Sexual Risk behaviour reduction associated with Voluntary HIV Counselling and testing in HIV infected patients.	Retrospective case/control cross-sectional survey	VCT	Control clinic N=300 Case clinic N=300	To study the association between HIV VCT and sexual risk behaviour (number sex partners and condom use) in HIV-positive patients to Thai Red Cross Society services in Bangkok, Thailand.	Not defined	Report benefits in the study group related to sexual activity, etc. Unable to draw conclusions as control group measured before they knew their HIV status
Jones 1998[23] Zambia Influence of Partner Participation on Sexual Risk Behaviour Reduction Among HIV-positive Zambian Women	Randomized controlled trial	High- and low-intensity gender concordant group interventions for partners of HIV-positive women All women attended group sessions Follow-up after one year	Participants = 332 Over 17 years of age, sexually active HIV-positive individuals and partners Female N=180 Male N=152	Use of sexual protection	Participants received cognitive behavioural skill training on HIV/STI prevention and transmission, reproductive choice and mother to child transmission, communication, conflict resolution, sexual negotiation and an educational/experiential programme (visual, auditory, and experiential) aimed at increasing use of sexual barriers. Participants were introduced to male	Sexual protection 'all of the time' 83% increase among males 94% increase among females Coping strategies for both male and female participants improved Increased AIDS-related knowledge Decreased negative (alcohol) coping strategies Increased positive coping strategies were associated with decreased risk behaviour. Both male and female participants stated that they felt they benefited from group (interventions) session. Male participants felt that it provided an

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
					and female condoms and vaginal lubricant products.	opportunity to ask questions without feeling foolish in front of their spouses (partners). Female participants felt free to share strategies with each other to achieve gender equity within their relationships.
MacNeil 1999[29] Tanzania 1996 Hospital clinics Is Care and Support Associated with Preventive Behaviour Among People with HIV?	Randomized controlled trial Follow-up at three and six months	Experimental: enhanced care and support. Control: standard care from health services	Newly diagnosed HIV-positive individuals. Experimental N=77 Control N=77 Female = 102 Male = 52	Self-reported risk behaviour HIV status disclosure Reproductive health and psychosocial support	Enhanced care included counselling that included ongoing dialogue and relationship between the counsellor and the client. Also included problem solving, family education and condom provision during monthly session.	Decrease in both groups in relation to risk behaviours at three and six months. Extra care and support did not lead to a greater degree of risk reduction.
Matovu 2002[30] Uganda Ongoing Counselling centre The Rakai Project Counselling Programme Experience	Cohort	HIV (VCT) testing and results/services HIV results administered in people's homes by resident counsellors	15,091 people consented to interviews. 77.6% (11,709) of participants provided blood sample Male= 5127	Proportion of participants requesting results	Not defined All participants who gave blood had free unlimited access to VCT and could participate as couples or individuals. Counsellors addressed priority issues such as abstinence, condom use, couple counselling, partner notification, HIV	90% (10,480) requested results of the test. Males more likely to request test results than females (91% vs 88%) 94% of adolescents requested results – but fewer received them (56.9%) 64.5% who requested HIV results were given them. 17% (1149) of those who received results were counselled as a couple.

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
			Female= 6582		results interpretation, family planning, proper and prompt medication, MTCT of HIV and nutrition Active couple counselling was promoted by interviewers and counsellors.	This study suggests that providing home delivery of HIV testing and counselling could create high proportions of acceptance and uptake of VCT among this rural population.
6. Family planning counselling						
Abdel-Tawab 2002[14] Egypt FP clinics (31) The relevance of client-centred communication to family planning settings in developing countries: lessons from the Egyptian experience	Qualitative audio-taping of consultation Client exit interviews Home visits Physician questionnaire Client questionnaire	None	Physicians N=34 Clients N=112	Client satisfaction	Client-centred counselling	Client-centred consultation associated with threefold increase in client satisfaction and use of FP at seven months
Abdel-Tawab 2000[13]	Randomized controlled trial Interviews	Inclusion of sexuality issues in family planning Provider training	Family planning clinics	Client and provider acceptance of		Sexuality counselling acceptable to clients Sexuality-related problems common in client group

Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
Egypt Family planning clinics (6) Integrating Issues of Sexuality into Egyptian Family Planning Counselling	Focus groups		Intervention N=3 Control N=3 Interviews Female clients N=503 Service providers N=25	inclusion of sexuality issues in FP counselling sessions		Training of counsellors is feasible Training had positive impact on attitudes of counsellors and quality of counselling service
Kim 2000[26] Kenya FP clinics (25) Differences in counselling men and women in family planning	Qualitative Audio taping of counselling sessions	Family planning counselling	Family planning counselling sessions N=358 Family planning sessions with males and couples N=78 (two years later)	To explore possible difference in communication patterns	Not provided	Distinct gender differences found. Women less likely to speak and communication more likely to be considered passive then men Male and couple sessions took twice as long and included more information sharing and questions from clients Men came for information, while women wanted to adopt, continue or change contraceptive methods Providers offered men more detailed information than women, asked them fewer questions, issued fewer instructions, and responded more supportively.
Kim 1998 [25]	Qualitative Structured	Observation No intervention	Family planning sessions	Key counselling behaviours and	Not applicable	Results suggest that counsellors could have played a more active role in counselling sessions by relating information and assisting

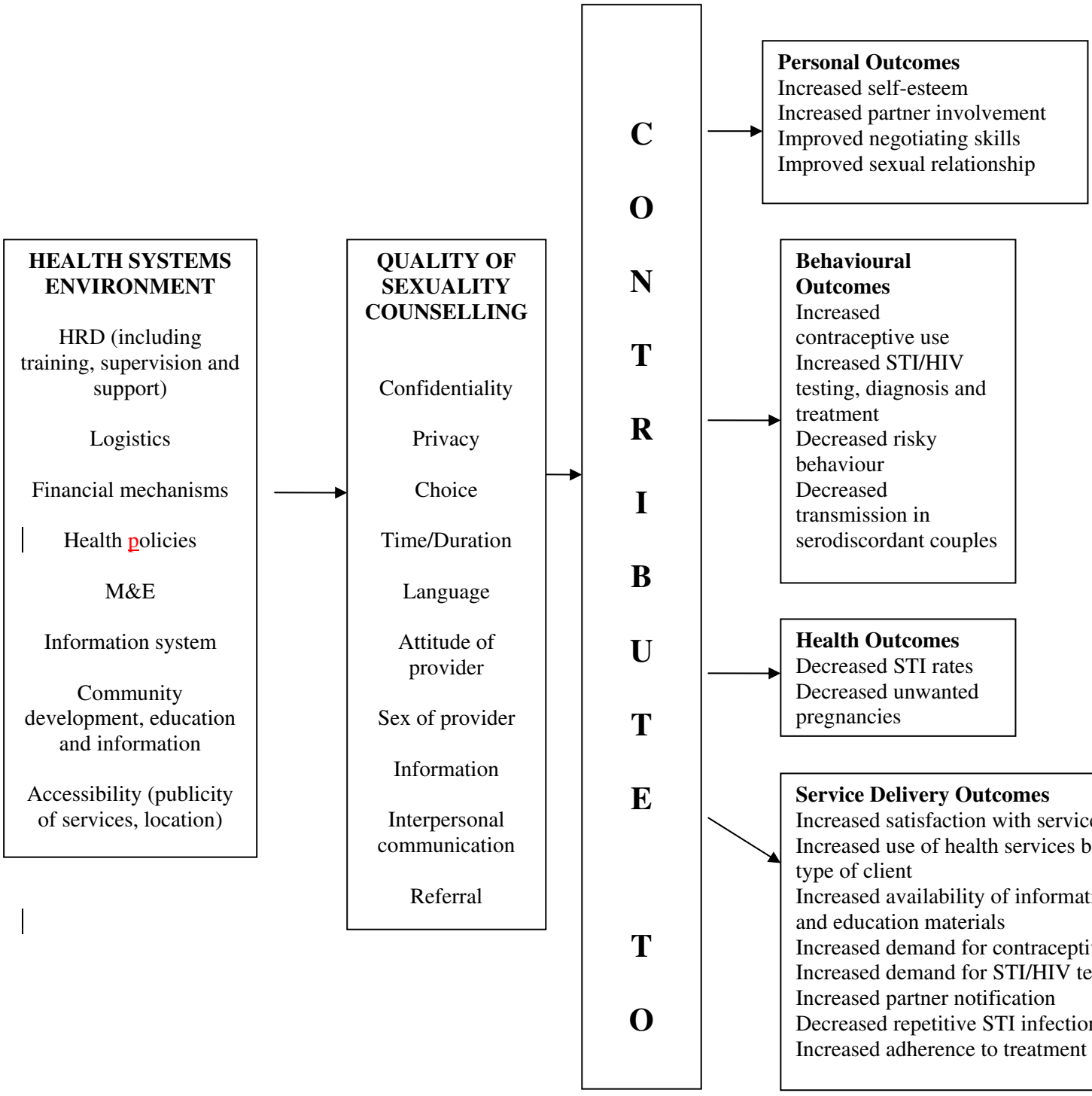
Study author(s), Year published, Country, Year of study, Location, Title of study	Design	Intervention	Participants	Primary outcomes	Definition (sexuality) counselling	Reported results/conclusions
Kenya 1993 Clinics – urban and community(25)1993 Informed choice and decision-making family planning counselling in Kenya	observations and client interviews		N=358	completeness of provided information		women in decision-making process

12.5 Appendix 5 Included study list by design

Type of study	Study Name
Randomized controlled trial	Abdel-Tawab 2002 [12] Faxelid 1996 [18] Jones 1998 [23] MacNeil 1999 [29] Abdel-Tawab 2000 [13] Voluntary HIV-1[20, 21, 37, 39, 40]
Controlled trial/quasi-experimental	Johnson 2002 [22] Erulkar 2004 [17] Lou 2004 [28] Wynendaele 1995 [41]
Qualitative research	Xinh 2004 [42] Muyinda 2001 [32] Grinstead 2000 [21] (qualitative data from randomized controlled trial) Rohleder 2005 [36] Chandiramani 1998 [16] Abdel-Tawab 2002 [14] Kim 2000 [26] Kim 1998 [25]
Programme/project report	Rasch 2004 [35] Glover 1998 [19] Kaleeba 1997 [24]
Cohort study	Leonard 2000 [27] Bentley 1998 [15] Matovu 2002 [30]
Survey	Ngomuo 1995 [33]
Case Case/control	Müller1995 [31]
Pre/post design	Solo 1999 [38] Njeru 1995 [34]

12.6 Appendix 6 Conceptual framework

Conceptual framework for counselling on sexuality-related issues



12.7 Appendix 7 Extended literature review framework

EXTENDED LITERATURE REVIEW FRAMEWORK– SEXUAL COUNSELLING

	Post-abortion counselling	**Youth services**	**STI counselling**	**Counselling on sexuality-related issues**	**HIV/AIDS counselling**	**Family planning and counselling**
Aspects addressed in sexuality						
SEXUAL HEALTH						
Physical, emotional, mental and social well-being in relation to sexuality	Solo 1999 Johnson 2002	Muyinda 2001 Erulkar 2004	Njeru 1995 Leonard 2000 Wynendaele 1995	Chandiramani 1998	Jones 1998 Matovu 2002 Sangiwa 2000 The Voluntary HIV-1 Counseling and Testing Efficacy Study Group 2000 Kamenga 2000	Abdel-Tawab 2000 Abdel-Tawab 2002
Positive and respectful approach to sexuality and sexual relationships		Erulkar 2004		Chandiramani 1998		Abdel-Tawab 2000
Pleasurable & safe sexual experiences free of coercion, discrimination & violence				Chandiramani 1998		
Sexual rights respected, protected and fulfilled						
SEXUAL RIGHTS						
All persons free of coercion, discrimination and violence						
Access to sexual and reproductive health care		Glover 1998 Lou 2004				Abdel-Tawab 2000
Highest attainable standard of sexual health						
Seek, receive and impart information related to sexuality				Chandiramani 1998		Abdel-Tawab 2000
Sexuality education		Ngomuo 1995 Muyinda 2001 Lou 2004 Glover 1998 Erulkar 2004		Chandiramani 1998		

	Post-abortion counselling	**Youth services**	**STI counselling**	**Counselling on sexuality-related issues**	**HIV/AIDS counselling**	**Family planning and counselling**
Respect for bodily integrity				Chandiramani 1998		
Choice of partner (s)						
Decision to be sexually active or not		Glover 1998		Chandiramani 1998		
Consensual sexual relations						
Consensual marriage						
Decision of whether or not, and when, to have children						Kim 1998 Abdel-Tawab 2000
Pursuit of a satisfying, safe and pleasurable sexual life		Erulkar 2004 Lou 2004		Chandiramani 1998		Abdel-Tawab 2000 Kim 1998
Quality of counselling with respect to sexuality and sexual health (services)						
SEXUAL COUNSELLING						
Sexual violence						
Harmful traditional practices		Erulkar 2004				Abdel-Tawab 2000
Sexual health	Johnson 2002 Rasch 2004	Lou 2004 Muyinda 2001 Glover 1998 Erulkar 2004	Njeru 1995 Wynendaele 1995	Chandiramani 1998		Abdel-Tawab 2000
Sexual rights		Erulkar 2004		Chandiramani 1998		
Sexual pleasure		Muyinda 2001		Chandiramani 1998		Abdel-Tawab 2000
Sexual orientation				Chandiramani 1998		
Sexual physical problems/concerns				Chandiramani 1998		Abdel-Tawab 2000
Sexual bodily integrity/sexual safety			Wynendaele 1995	Chandiramani 1998		
Partner communication			Njeru 1995	Chandiramani 1998		
Partner notification			Njeru 1995 Wynendaele 1995			
Reproductive health issues (abortion, miscarriage, etc.)	Rasch 2004			Chandiramani 1998		
Contraceptives	Rasch 2004 Johnson 2002	Lou 2004 Glover 1998	Wynendaele 1995	Chandiramani 1998	Kaleeba 1997	Kim 1998 Abdel-Tawab 2000 Abdel-Tawab 2002
Health systems and environment						

	Post-abortion counselling	**Youth services**	**STI counselling**	**Counselling on sexuality-related issues**	**HIV/AIDS counselling**	**Family planning and counselling**
TRAINING OF HEALTH PROVIDERS						
Duration/time	Solo 1999	Erulkar 2004	Njeru 1995 Leonard 2000	Chandiramani 1998	Grinstead 2000 Kamenga 2000	Abdel-Tawab 2000
Follow-up	Solo 1999		Leonard 2000	Chandiramani 1998	Rohleder 2005 Kamenga 2000	Abdel-Tawab 2000
Supervision	Solo 1999		Njeru 1995	Chandiramani 1998	Grinstead 2000 Rohleder 2005 Kamenga 2000	Abdel-Tawab 2000
Topics covered:						
Reproductive health issues		Erulkar 2004 Lou 2004		Chandiramani 1998		Abdel-Tawab 2000
Abortion/miscarriage	Solo 1999			Chandiramani 1998		
Contraceptives	Solo 1999	Lou 2004	Leonard 2000	Chandiramani 1998	Grinstead 2000 Kamenga 2000	Abdel-Tawab 2000
Gender roles/power		Erulkar 2004		Chandiramani 1998		Abdel-Tawab 2000
Violence				Chandiramani 1998		
Negotiation			Leonard 2000			Abdel-Tawab 2000
RTI/STI/HIV/AIDS		Erulkar 2004	Njeru 1995 Leonard 2000	Chandiramani 1998	Rohleder 2005 Kamenga 2000	Abdel-Tawab 2000
Psychological						
Physiological		Erulkar 2004		Chandiramani 1998		Abdel-Tawab 2000
Service delivery outcomes:						
CAPACITY OF HEALTH DELIVERY SYSTEM						
Expansion of counselling services						
Integration of SRH services into PHC/general clinics						

12.8 Appendix 8 Definitions

Counselling	A process of communication by which a person is helped to identify her or his sexual and reproductive health needs and to make the most appropriate decisions about how to meet them. Counselling is characterised by an exchange of information and ideas, discussion and deliberation. [6]
Sexuality	A central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors. [4]
Sexual health	Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. [4]
Sex education	Basic education about reproductive processes, puberty, sexual behaviour, etc. Sexual education may include information, for example about contraception, protection from STIs and parenthood.[6]
Sexual violence	Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work. [4]
Sexuality counselling	Counselling on issues of sexuality with the aim of creating a climate where clients can express themselves and their concerns relating to sexual relationships and intimacy without fear of discrimination. See Sexuality and also Counselling.[6]
Sexuality counselling	To facilitate individual, couple and provider's understanding of the client's sexual health concerns or needs, and desired sexuality, reproductive or contraceptive preferences (World Health Organization, 2006)
Sexual Rights	Embrace human rights that are already recognised in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence to: • The highest attainable standard of sexual health, including access to sexual and reproductive health care services; • See, receive and impart information related to sexuality; • Sexuality education; • Respect for bodily integrity; • Choose their partner; • Decide to be sexually active or not; • Consensual sexual relations; • Consensual marriage;[4]

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