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Sexual health counselling by Dutch HIV care providers: A cross-sectional survey among physicians and nurses in the Netherlands

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ABSTRACT

To improve sexual health among people living with HIV, sexual health should be addressed during consultations in routine HIV care. The aim of the present study was to investigate to what extent Sexual Health Counselling (SHC) is incorporated into routine Dutch HIV care and to explore differences between physicians and nurses in their practices and views regarding SHC. A cross-sectional survey was conducted among all HIV physicians (N=110) and HIV nurses (N=82) in the Netherlands. A questionnaire assessed socio-demographic characteristics, current SHC practice, topics addressed, and factors associated with engaging in SHC. The response rate was 53.6% (N=59) among physicians and 60.0% (N=40) among nurses. SHC was performed by 26.1% of physicians and 83.9% of nurses (X^2 (1) = 27.68, p<.001). The most frequently reported barrier for SHC was the presence of a third party, endorsed by 50.9% of physicians and 60.4% of nurses. Nurses were more likely to address issues related to sexual wellbeing, while physicians mainly discussed medical topics. While, both HIV physicians and nursed felt responsible for providing SHC, nurses were more likely to address SHC that physicians. There is scope for improving SHC for PLHIV through a multidisciplinary approach based on clear guidelines for physicians and nurses.

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People living with HIV; healthcare providers; sexual health counselling; patient provider interaction

Introduction

Sex is an important human need (Maslow, 1943), and sexual health is an intrinsic part of quality of life (East & Hutchinson, 2013; Saunamäki et al., 2010; Waterhouse & Metcalfe, 1999). According to an influential definition of the World Health Organization (2006), sexual health is not only the absence of illness but is a multi-dimensional state of physical, emotional, mental and social well-being (WHO, 2006). As enshrined in the declaration of sexual rights (Kismödi et al., 2017), all people have the "right to the highest attainable standard of health, including sexual health, with the possibility of pleasurable, satisfying, and safe sexual experiences" (p. 5).

Various studies have documented evidence of multiple sexual health problems experienced by people living with HIV (PLHIV) and showed an association between HIV status and sexual health problems (Huntingdon et al., 2020; Lema, 2013; Luo et al., 2017; Russell, 2011). Since sexual intercourse is the primary route for HIV transmission, fear of transmitting the virus during sexual intercourse can negatively affect intimacy and sexuality of PLHIV (Lema, 2013; Santi et al., 2014). Studies among gay and bisexual men living with HIV found that as many as 70% of reported problems with sex in the first year after diagnosis (Bourne et al., 2012; Huntingdon et al., 2020; Sandfort et al., 2013). Among women living with HIV, sexual problems were also found to be highly prevalent (Agaba et al., 2017; Bell et al., 2006). The most commonly reported sexual health problem among men who have sex with men (MSM) living with HIV is loss of libido, followed by erectile dysfunction (Bourne et al., 2012; Santi et al., 2014). Women living with HIV most frequently report a decrease in sexual desire, as well as increased painful intercourse (Sandfort et al., 2013; Taylor et al., 2017).

Despite the clear need for sexual health counselling (SHC) for PLHIV, it is not known whether and how this is incorporated in routine HIV care, and which HIV care providers engage in SHC. The limited available research on SHC in HIV care has shown that sexual health is rarely addressed during regular consultations

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(Bell et al., 2006; Carter et al., 2014; Saunamäki et al., 2010), not even in the Netherlands, which is generally known for its open-minded attitude towards sexuality (De Munnik et al., 2017, Krouwel et al., 2015, Van Ek et al., 2018).

As of December 2019, 23.700 people were estimated to be living with HIV in the Netherlands (63% MSM, 18.5% other men, and 18.5% women), of whom 20.612 were in care (van Sighem, 2019)). In the Netherlands, HIV care is provided by a total of 110 HIV physicians and 82 HIV nurses in 24 HIV treatment centers across the country. It is not known to what extent these HIV physicians and nurses address sexual health issues in their consultations with PHIV, what issues they address and whether the extent to which physicians and nurses provide SHC and the issues they address differs. The aim of the present study was to investigate to what extent SHC is incorporated into routine Dutch HIV care and to explore differences between physicians and nurses in their views and practices regarding SHC for PLHIV.

Methods

Study design and participants

All PLHIV who are in care in the Netherlands receive treatment in one of the 24 dedicated HIV treatment centers across the country, with consultations alternating between HIV physicians and HIV nurses who address patients' medical needs with, monitor general health and provide additional care and support, as required. A cross-sectional survey was conducted among all HIV physicians and nurses in the Netherlands. They were approached via the member list of the Netherlands Association of HIV Physicians (NVHB) and the Netherlands Professional Association of HIV nurses (VCH). Paper-and-pen questionnaires were sent to physicians between April and June 2017, together with a prepaid return envelope. Nurses received a link to an online questionnaire via their work e-mail between April and June 2018. A reminder was sent to both groups after four weeks.

Ethical considerations

Informed consent was obtained from all physicians and nurses who participated in the study. HIV physicians and nurses were advised that participation was voluntary and anonymous, and that they could withdraw at any time. This study is exempt from formal medical ethics review as stipulated in the Medical Research Involving Human Subjects Act of the Netherlands, as no patients were included and the study did not involve medical or behavioural interventions.

Measures

The questionnaire was adapted from a questionnaire used in previous studies assessing SHC by healthcare providers of patients with chronic illness (Krouwel et al., 2015; Van Ek et al., 2018). The questionnaire was pilot tested with six HIV physicians and two HIV nurses and amended based on their feedback, as required. The final questionnaire consisted of 40 questions (see Supplementary materials for the complete questionnaire).

Participant characteristics: We included questions concerning demographic characteristics and work-related characteristics (i.e., Age, professional role, and years of work experience).

Readiness for providing SHC: HIV care providers indicated whether they felt competent to offer SHC (yes/no). Self-perceived knowledge on sexual health was assessed by asking how well informed HIV care providers perceived themselves to be about sexual health issues and counselling, with responses given on a 5-point scale (1 = not well informed, 5=well informed) and then dichotomized (1-3=not/somewhat informed, 4-5=sufficiently/well informed). Participants also indicated who they thought was responsible for SHC, with various options provided, of which the five most frequently chosen options are reported. Furthermore, participants indicated whether they were aware of the guidelines on sexual health counselling for PLHIV developed by STI AIDS Netherlands (SANL), the Dutch center of expertise on HIV and other STI, and whether they were interested in training to strengthen their knowledge of SHC.

Provision of SHC: we asked how often HIV care providers addressed sexual health with PLHIV in (1) the first consultation after HIV diagnosis and (2) during routine (follow-up) consultations. Responses were given on 5-point scales (1=never, 5=always, and subsequently dichotomized 1-3=infrequently, 4-5=frequently). We also asked participants to indicate which of 15 sexual health topics (multiple answers were possible) were addressed in SHC (for example fatigue, lack of experienced pleasure, loss of libido). In addition, we assessed 23 possible barriers for the provision of SHC, with responses given on a 5-point scale (1=fully disagree, 5=fully agree). Participants who selected response options 1 or 2 were classified as experiencing a specific barrier. The three most experienced barriers are reported, as well as the total number of barriers HIV care providers experienced.

Data analysis

Descriptive statistics were calculated for demographic characteristics and views and practices regarding SHC. Univariate analyses were conducted to assess differences between physicians and nurses, consisting of Chi-square tests for categorical variables and independent sample t-tests for continuous variables; p-values of ≤ 0.05 were considered significant. Data analysis was performed using SPSS version 23 (SPSS Inc., Chicago, IL, USA).

Results

Participant characteristics

In total, 59 of 110 physicians (53.6%) and 48 of 82 nurses (58.5%) completed the survey (see Table 1). Age of physicians and nurses did not differ significantly ($p = .61$), nor did their years of work experience ($p = .65$). Gender did differ significantly ($p = .002$) between groups; more physicians (52.2%) than nurses (22.9%) were men.

Readiness for providing SHC

Most HIV care providers felt competent in providing SHC (physicians: 84.7%, nurses: 95.8%, $p = .06$). All nurses (100%) and most physicians (72.9%) considered their own professional group to have responsibility for providing SHC to PLHIV. Overall, most physicians as well as most nurses considered nurses to be responsible for SHC, followed by physicians, patients, the patient's general practitioner and the patient's partner. About half of both physicians and nurses were aware of the SHC guideline developed by SANL. About 60% of nurses and 40% of physicians indicated a need for additional training to build their capacity to provide SHC.

Provision of SHC

Nurses (78.9%) were more likely to provide SHC during regular consultations than physicians (26.1%). The topics that physicians and nurses addressed in SHC with PLHIV are shown in Table 2. The most frequently addressed topic, both by physicians and nurses, was fear of HIV transmission. Loss of libido was the second most discussed issue that was also addressed equally frequently by physicians and nurses. HIV stigma, lack of experienced sexual pleasure, altered self-image, uncertainty about the future, fatigue, and inability to reach orgasm were discussed less frequently and relatively more often by nurses than physicians. Erectile dysfunction was addressed relatively frequently and more often by physicians. The three most reported barriers for not providing SHC were having insufficient time, which was more often indicated by physicians than by nurses ($p < .001$), presence of a third party, and patients not initiating discussions on sexual health themselves.

Factors associated with providing SHC

As can be seen in Table 3, chi-square tests showed that nurses provided SHC more often than physicians. Work experience and self-perceived competence in SHC were

Table 1. Characteristics, Knowledge, Competency, Responsibility, Practice and Experienced Barriers Regarding Addressing Sexual Health of Physicians (N = 59) and Nurses (N = 48) in the Netherlands.

		Physicians		Nurses		
		N	%	N	%	Statistical test
Age in years Mean (SD)		46.5	9.2	47.4	10.0	t (105) = -.51, $p = .612$
Gender	Men	31	52.5	11	22.9	χ^2 (1) = 9.74, $p = .002$
Experience in year	1–2	8	13.6	9	18.8	χ^2 (4) = 2.45, $p = .654$
	3–5	5	8.5	6	12.5	
	6–10	15	25.4	7	14.6	
	11–15	11	18.6	10	20.8	
	> 15	20	33.9	16	33.9	
Knowledge (self perceived)	Low	39	66.1	20	41.7	χ^2 (1) = 6.39, $p = .011$
	High	20	33.9	28	58.3	
Competency	Yes	50	84.7	46	95.8	χ^2 (1) = 3.53, $p = .060$
Sexual health counselling is the responsibility of ….	Physician	43	74.1	37	77.1	χ^2 (1) = .12, $p = .726$
	Nurse	56	96.6	48	100.0	χ^2 (1) = 1.69, $p = .194$
	Patient	37	63.8	37	77.1	χ^2 (1) = 2.20, $p = .138$
	General practitioner	19	32.8	31	64.4	χ^2 (1) = 10.67, $p = .001$
	Partner of patient	17	29.3	23	47.9	χ^2 (1) = 3.87, $p = .049$
Addressing sexual health	Infrequently	51	86.4	18	37.5	χ^2 (1) = 27.68, $p < .001$
	Frequently	8	13.6	30	62.5	
Top 3 barriers	Insufficient time	35	61.4	11	22.9	χ^2 (1) = 15.68, $p < .001$
	Presence of a third party	30	54.6	29	60.4	χ^2 (1) = .36, $p = .548$
	Patients do not initiate …	23	41.1	4	8.3	χ^2 (1) = 14.41, $p < .001$
Aware of guideline	Yes	25	46.3	29	53.7	χ^2 (1) = 3.15, $p = .076$
Wish to increase knowledge by training on sexual health counselling	Yes	29	39.7	44	60.3	χ^2 (1) = 22.07, $p < .001$

Table 2. Factor Associated with Frequency of Sexual Health Counseling as Indicated by Chi-square Tests Among Dutch Health Care Providers.

		Providing sexual health counselling				
		Frequently		Infrequently		Chi-square/
		N (%)		N (%)		
Role	Physician	8	(21.1)	51	(73.9)	χ^2 (1) = 27.68, p <. 001
	Nurse	30	(78.9)	18	(26.1)	
Experience	<5 years	12	(31.6)	16	(23.2)	χ^2 (1) = 0.89, p = .345
	>5 years	26	(68.4)	53	(76.8)	
Competency	Yes	37	(97.4)	59	(85.5)	χ^2 (1) = 3.74, p = .053
	No	1	(2.6)	10	(14.5)	
Knowledge	Low	13	(34.2)	46	(66.7)	χ^2 (1) = 10.44, p < .001
	High	25	(65.8)	23	(33.3)	
Count of barriers	0–1	15	(39.5)	9	(13.0)	χ^2 (2) = 10.05, p = .007
	2–5	17	(44.7)	41	(59.4)	
	>6	6	(15.8)	19	(27.5)	
Responsible	Yes	36	(97.3)	55	(79.9)	χ^2 (1) = 6.13, p = .013
	No	1	(2.7)	14	(20.3)	

not associated with providing SHC, but HIV care providers with less self-perceived knowledge of SHC were less likely to offer SHC than providers who considered themselves more knowledgeable. Those who felt responsible for SHC were more likely to provide SHC. Also, a higher number of experienced barriers was associated with a lower frequency of providing SHC.

Discussion

Our study aimed to provide new insights into the extent to which SHC is incorporated into HIV care in the Netherlands, and to assess the similarities and differences in readiness for providing SHC and provision of SHC in regular consultations among HIV physicians and nurses. Overall, HIV care providers felt competent in providing SHC, with nearly all nurses expressing perceived competence as well as the majority of physicians. Also, all nurses and three-quarters of physicians considered their professional group to be responsible for SHC with PLHIV. Nevertheless, only about half of the HIV care providers were aware of current Dutch guidelines for SHC with PLHIV, and only about one-third of physicians and over half of nurses felt knowledgeable of SHC for PLHIV. About one third of physicians and nearly two-thirds of nurses indicated an interest in further training on SHC to build their capacity.

While nearly two-thirds of nurses frequently provided SHC, this was done by only slightly more than one in ten physicians. Our study also shows that nurses are more likely to address sexual risk behavior and prevention of HIV transmission, while physicians are more likely to discuss biomedical issues with PLHIV. A study among 400 HIV physicians in the US similarly found that they discussed biomedical issues more frequently with PLHIV than transmission risk reduction Gartner et al. (2008). As the standard number of HIV consultations in the Netherlands has been reduced from four to two times per year as HIV care has become more routine, and as consultations alternate between physicians and nurses, the already limited opportunity for SHC, particularly by physicians, may have been further reduced. This can lead to missed opportunities to address sexual health issues. HIV physicians and nurses should hence be encouraged to include SHC in regular

Table 3. Topics Discussed during Sexual Health Counselling.

	Physicians		Nurses		
	N	%	N	%	Chi-square
Erectile dysfunction	53	59.6	36	40.4	χ^2 (1) = 4.160, p = .041
Fatigue	13	23.2	24	50.0	χ^2 (1) = 8.091, p = .004
Lack of experienced pleasure	25	44.6	42	87.5	χ^2 (1) = 20.71, p < .001
Loss of libido	49	87.5	43	89.6	χ^2 (1) = .11, p = .740
Painful intercourse	28	50	24	50.0	χ^2 (1) = .00, p = 1.000
Inability to reach orgasm	7	12.5	14	29.2	χ^2 (1) = 4.46, p = .035
Sexual arousal problems	12	21.4	22	45.8	χ^2 (1) = 7.00, p = .008
Physical changes	15	26.8	11	22.9	χ^2 (1) = .21, p = .650
Altered self-image	21	37.5	32	66.7	χ^2 (1) = 8.80, p = .003
Uncertainty about future	15	26.8	24	50.0	χ^2 (1) = 5.94, p = .015
Hormonal changes	8	14.3	13	27.1	χ^2 (1) = 2.63, p = .105
Medication side effects	15	26.8	17	35.4	χ^2 (1) = .90, p = .342
Fear of transmitting HIV to partner	52	92.9	46	95.8	χ^2 (1) = .42, p = .516
Fear of talking about HIV with partner	44	78.6	40	83.3	χ^2 (1) = .38 p = .539
HIV stigma	37	66.1	41	85.4	χ^2 (1) = 5.16, p = .023

HIV care, and ensure that the diversity of potential sexual health issues is addressed.

The three most important barriers to SHC noted by both physicians and nurses were insufficient time, patients not asking for advice on sexual health issues, and the presence of a third party. Not having enough time is an expected barrier given the average consultation time of 10–15 min for an HIV physician and 30 min for a nurse, as also found in other research among HIV care providers (Carter et al., 2014; Flickinger et al., 2013). Insufficient time due to the limited duration of consultations is also reported as a barrier to SHC by health care providers in other medical domains, including surgical oncologists and dialysis nurses (Krouwel et al., 2015; van Ek et al., 2018).

The importance HIV care providers attach to patients initiative for SHC is in line with the findings of research from the perspective of HIV patients, which found that they wanted to start the conversation about sexual health problems (Sandfort et al., 2013). The presence of a third party as a barrier to SHC likely reflects HIV care providers' perceived sensitive and private nature of the sexual health issues. At the same time, HIV care providers are also attribute responsibility to partners for raising sexual health issues. Whether the third party present during a consultation is a partner or someone else may explain why previous research on the role of the presence of others in SHC has yielded mixed results (Bell et al., 2006; De Munnik et al., 2017; Krouwel et al., 2015).

Our findings show that both HIV physicians and nurses address sexual health issues with PLHIV. Optimal SHC for PLHIV hence requires effective collaboration between HIV nurses and physicians so that sexual health-related issues are actually addressed during (each) regular HIV consultations and that effective care is provided, and ensuring that consultations for the same patient effectively build on each other. Furthermore, our findings suggests scope to strengthen the readiness of HIV care providers to address sexual health issues with PLHIV, building on their perceived responsibility to do so. To strengthen this readiness, it is important to develop and promote awareness of guidelines for SHC with PLHIV that indicate which topics to address, as well as more importantly, how to address these issues, what care to provide and when to refer PLHIV to which care provider.

Our findings show that many issues related to the sexual health of PLHIV, in particular psychosocial issues such as stigma and uncertainty about future, and subjective experiences, such as sexual arousal problems and altered self-image, are mostly discussed with HIV nurses or are discussed equally frequently by HIV nurses and physicians (e.g., Fear of HIV transmission, physical changes). This underscores the importance of ensuring that any guidance regarding SHC for PLHIV recognizes and strengthens the role of HIV nurses, who can provide integrated care combining medical and nursing perspectives. HIV physicians also have an important role to play in SHC for PLHIV and, at a minimum, need to be aware of the importance of SHC during regular consultations, have basic knowledge of prevalent sexual health issues and know who to refer patients to, including an HIV nurse already providing regular consultations. We recommend that SHC for PLHIV provided by HIV physicians and nurses encompasses psychosocial, experiential as well as medical issues. While HIV physicians as well as nurses participating in our study indicate feeling responsible for providing SHC to PLHIV, they also indicate a need to engage in further training. Such training should be part of a comprehensive toolkit for optimal SHC for PLHIV, which also included evidence-based guidelines reflecting professional consensus.

Strengths and limitations

To the best of our knowledge, this is one of the first studies to assess the readiness and provision of SHC by both HIV physicians and nurses. Furthermore, this study provides new insight into the barriers HIV care providers experiences with respect to SHC. Some limitations also need to be considered. Data were collected using self-reports, and may be affected by memory and social desirability biases. Also, due to the relatively low number of physicians and nurses involved in HIV care in the Netherlands, the power of our study is limited. The response rate was nevertheless high, and results likely provide a good indication of the views and practices regarding SHC by HIV care providers in the Netherlands. Furthermore, while the research findings may not be fully generalizable beyond the Dutch HIV care setting, they may however be informative for HIV care providers more broadly.

Conclusion

In contrast to the sense of responsibility among Dutch HIV care providers to address SHC in regular consultations with PLHIV, there is substantial variation in the readiness and provision of SHC between HIV physicians and HIV nurses. Overall, there is substantial room for improvement in SHC provided in regular HIV care, and HIV care providers need to be aware of the importance of addressing sexual health problems for the quality of life of PLHIV. To improve SHC for

PLHIV, a multidisciplinary approach may be needed, encompassing guidelines for HIV physicians and nurses, additional training tailored to the needs of specific types of HIV care providers, establishing adequate referral systems and, where possible enabling sufficient consultation time to discuss sexual health.

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