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# Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations

Policy brief



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## Key populations for HIV, viral hepatitis and STIs

The [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations July 2022](#) outline a public health response to HIV, viral hepatitis and sexually transmitted infections (STIs) for five key populations (men who have sex with men, sex workers, people in prisons and other closed settings, people who inject drugs and trans and gender diverse people). The guidelines present and discuss new recommendations and consolidate a range of recommendations and guidance from current WHO guidelines which are summarised here in this policy brief.

Key populations in the HIV response are also critical to the achievement of the global elimination goals for viral hepatitis and STIs. This is for the following reasons.

- The structural barriers which limit the five key populations' access to HIV services also limit their access to viral hepatitis and STI services.
- HIV risk behaviours, such as condomless sex and unsafe injecting, which in general are more common in key populations, are also among those that increase risk of acquiring viral hepatitis and STIs; therefore, integrating a response to address these risk behaviours brings greater efficiency both for people and for public health.
- Many of the interventions recommended for HIV prevention also have an impact on transmission of viral hepatitis and STIs.

In most countries, inadequate coverage and often poor quality of health services for key populations continue to undermine responses to HIV, viral hepatitis and STIs. All countries should prioritize reaching these key populations for greatest impact and supporting key population communities to lead the response and provide equitable, accessible and acceptable services.

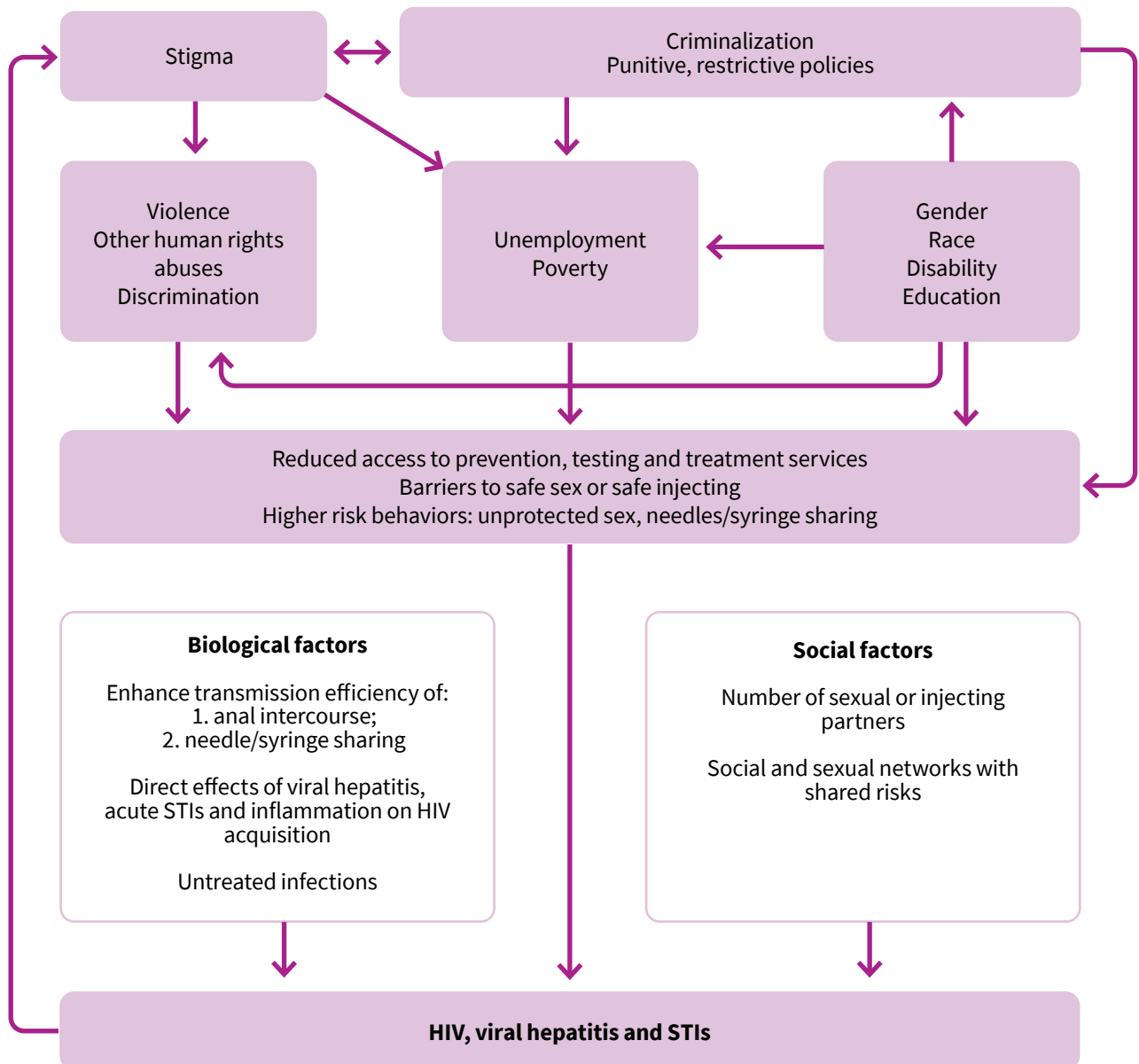
These guidelines are developed with the following principles:

- human rights
- gender equality
- equity and inclusion
- medical ethics
- universal health coverage
- evidence-based public health
- key population community-led response.

## Structural barriers

Particularly for key populations, social, legal, structural and other contextual factors both increase vulnerability to HIV, viral hepatitis and STIs, and obstruct access to health and other essential services. In many settings, one or more aspects of key population members' behaviour, work or gender expression are criminalized, and members are subject to punitive legislation and policing practices. Stigma and discrimination from/by the general population and health workers and law enforcement officials are perpetuated by criminalization, which also means that legal or policy change is more difficult to achieve. Stigma and discrimination in health care settings are common experiences among key populations, and create significant barriers to achieving universal health coverage. Stigma and discrimination are related to unemployment and poverty as well as violence and human rights abuse. Violence and other human rights abuses are exacerbated by criminalization, making key population members less likely to report abuses and increase vulnerability to such abuses. In combination, these reduce access to HIV, STI, viral hepatitis and other health services; can lead to poorer uptake and inconsistent use of prevention methods, such as condoms, pre-exposure prophylaxis (PrEP) and post exposure prophylaxis (PEP) for HIV and sterile injecting equipment, and to delayed diagnosis and poorer linkage and retention in treatment programmes (see Fig. 1.).

Fig. 1. Factors contributing to HIV, STIs and viral hepatitis in key populations



## Responding to HIV, viral hepatitis and STIs in key populations

Sustainable Development Goal (SDG) 3 and related target 3.3 are: “By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases”. This can only be achieved by prioritizing the prevention, diagnosis and treatment of these infections in key populations and focusing on impact. Fig. 2. describes a theory of change for meeting these global targets by 2030 and is detailed in the text below.

To prevent, diagnose and treat infections, key populations need equitable access to services at an adequate scale to have impact. The Joint United Nations Programme on HIV/AIDS (UNAIDS) set HIV coverage targets for 2025 as part of its global strategy to end AIDS (1), which applies to all populations: 95% use combination prevention; 95% of people living with HIV know their HIV status; 95% of people living with HIV who know their status initiate treatment; 95% of people on HIV treatment are virally suppressed and 95% of women access HIV and sexual and reproductive health services.

Global targets for viral hepatitis include 90% of people living with HCV or HBV diagnosed and 80% treated (HBV) or cured (HCV) by 2030. For STIs targets are that by 2030 >90% of priority populations are screened for gonorrhoea or syphilis and >95% treated if positive. Few countries reach this proportion of key populations with services, contributing to ongoing epidemics.

Access to services for key populations to have an impact on HIV, viral hepatitis and STIs can only be improved if structural barriers are removed, such as stigma and discrimination, criminalization, restrictive policies and violence and other human rights abuses, and if enabling environments exist (please see Chapter 4 on enabling interventions for references).

The global response to HIV, STIs and viral hepatitis has not reached adequate numbers of young key populations. Young key populations' lower access to prevention, diagnosis and treatment is due to a range of factors: misconceptions about risks; lack of knowledge and accurate age-appropriate information; lack of comprehensive sexuality education; low awareness of available, friendly health services; and barriers to access and uptake of services (including legal and policy barriers around consent requirements).

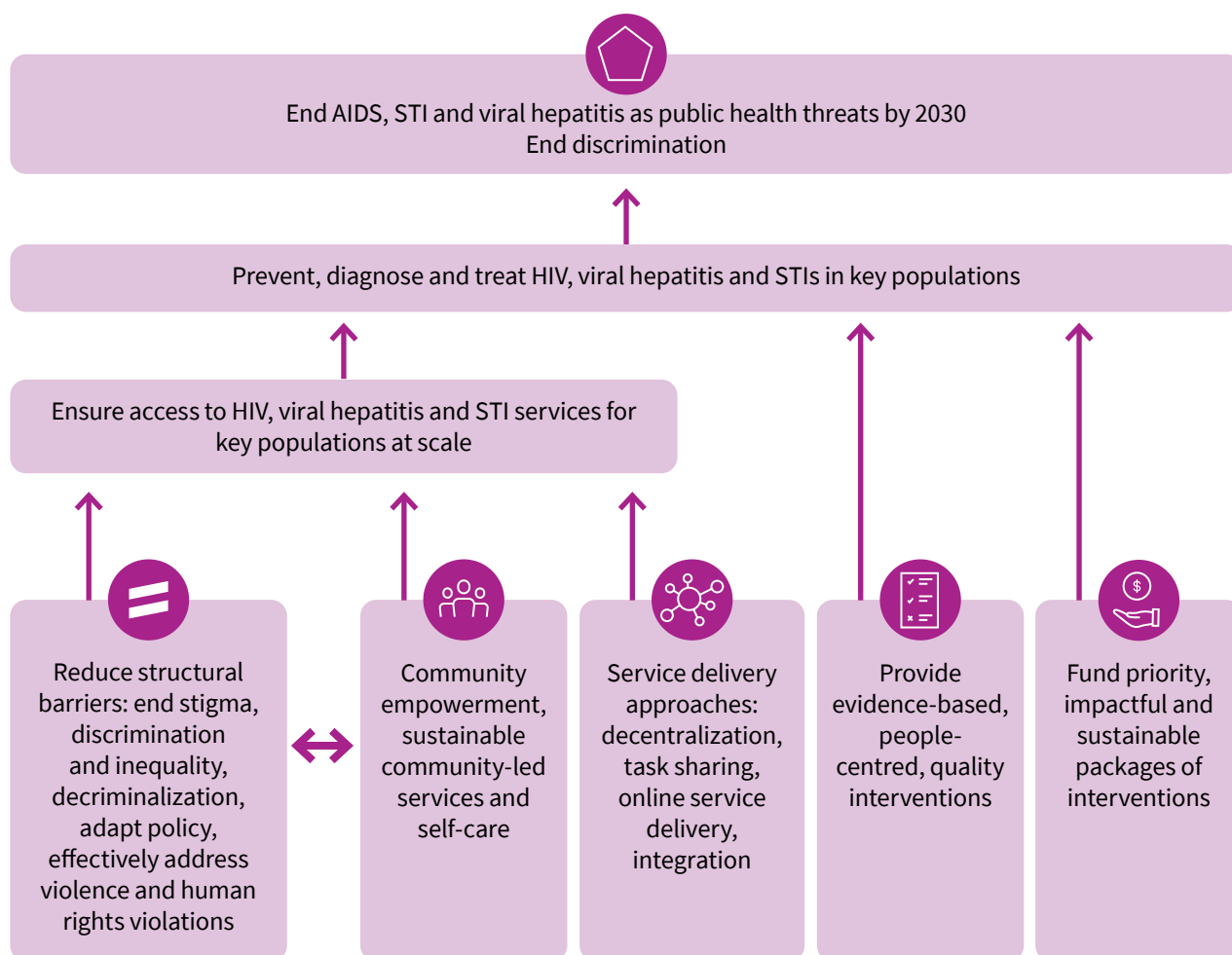
Women who belong to key populations, as well as women who are partners of key population members, experience alarmingly high risks of acquiring HIV and are less likely to access services. The UNAIDS global strategy to end AIDS (1) includes 2025 targets related to structural barriers: less than 10% of countries have punitive laws and policies that deny or limit access to services, less than 10% of people experience stigma and discrimination and less than 10% experience gender inequality and violence. Relatedly, community empowerment is needed to both increase access and coverage and to support necessary structural changes.

Putting key populations at the centre of health systems – by organizing services around people's needs rather than around diseases, and by promoting integrated patient-centred approaches and linkages with primary health care services – is key to ending these epidemics. Different service delivery approaches, including task shifting to key population peers as health workers, decentralizing provision of services to key population community-led programmes, providing services online and service integration are also needed to increase access to and availability of HIV, viral hepatitis and STI services for key populations (2).

Prevention, diagnosis and treatment of STIs, viral hepatitis and HIV can only be achieved if people are provided with correct and evidence-based interventions with consideration for their individual health needs through providing person-centred care. This requires understanding of what works to prevent, diagnose and treat these conditions (see Fig. 2.).

Finally, several effective interventions which prevent and treat HIV, STI and viral hepatitis in key populations are cost effective and cost saving (3–6), especially when combined and provided in an integrated manner, but without adequate funding their impact cannot be realized. Funding needs to be sustainable, predictable and focused on supporting communities.

Fig. 2. Theory of change: addressing HIV, viral hepatitis and STIs in key populations



The [Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations](#) consolidates WHO recommendations relevant to these population groups.

The interventions have been categorized as follows:

**1. Essential for impact: enabling interventions**

This includes all interventions recommended to reduce structural barriers to health services' access for key populations.

**2. Essential for impact: health interventions**

This includes health sector interventions that have a demonstrated direct impact on HIV, viral hepatitis and STIs in key populations.

**3. Essential for broader health**

This includes health sector interventions to which access for key populations should be ensured, but do not have direct impact on HIV, viral hepatitis or STIs.

**4. Supportive**

This includes health sector interventions which support the delivery of other interventions, such as creating demand, and providing information and education.



## Recommended package

Note that these interventions are not in order of priority.

It is important to note that while we have provided recommended packages of interventions separately for each key population, people can be members of more than one key population group or have more than one behaviour that increases their vulnerability to HIV and/or viral hepatitis and STIs, and some people may have risk behaviours without identifying as members of a particular group. Therefore, a person who injects drugs, including those that belong to another key population group, should have access to harm reduction interventions, and any trans or gender diverse person, whether they also belong to another key population group or not, should have access to gender-affirming care, and so on.

### Essential for impact: enabling interventions

	MSM	PWID	TGD	SW	PRIS
Removing punitive laws, policies and practices	x	x	x	x	x
Reducing stigma and discrimination	x	x	x	x	x
Community empowerment	x	x	x	x	x
Addressing violence	x	x	x	x	x

### Essential for impact: health interventions

#### Prevention of HIV, viral hepatitis and STIs

Harm reduction (needle and syringe programmes (NSPs), opioid agonist maintenance therapy (OAMT) and naloxone for overdose prevention)		x			x
Condoms and lubricant	x	x	x	x	x
PrEP for HIV	x	x	x	x	x
PEP for HIV and STIs	x	x	x	x	x
Prevention of vertical transmission of HIV, syphilis and HBV		x	x	x	x
Hepatitis B vaccination	x	x	x	x	x
Addressing chemsex	x	x	x	x	x

#### Diagnosis

HIV testing services	x	x	x	x	x
STI testing	x	x	x	x	x
Hepatitis B and C testing	x	x	x	x	x

#### Treatment

HIV treatment	x	x	x	x	x
Screening, diagnosis, treatment and prevention of HIV associated tuberculosis (TB)	x	x	x	x	x
STI treatment	x	x	x	x	x
Hepatitis B virus and hepatitis C virus treatment	x	x	x	x	x

## Essential for broader health: health interventions

	MSM	PWID	TGD	SW	PRiS
Anal health	X		X	X	X
Conception and pregnancy care		X	X	X	X
Contraception		X	X	X	X
Gender-affirming care			X		
Mental health services	X	X	X	X	X
Prevention, assessment and treatment of cervical cancer		X	X	X	X
Safe abortion		X	X	X	X
Screening and treatment for hazardous and harmful alcohol and other substance use	X	X	X	X	X
TB prevention, screening, diagnosis and treatment <sup>1</sup>		X		X	X

## New recommendations

As part of the development of these guidelines, certain new or updated recommendations and good practice statements were developed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology. Four new recommendations and two good practice statements are detailed below (for full details on the supporting evidence, please see Chapter 9 in the [full guidelines](#)).

### Virtual interventions



GRADE recommendation

Online delivery of HIV, viral hepatitis and STI services to key populations may be offered as an additional option, while ensuring that data security and confidentiality are protected (*conditional recommendation, very low certainty of evidence*).

#### Remarks

- Choice is important, and online services should form a part of a menu of interventions, not stand-alone interventions, and should not be a replacement for face-to-face services.
- Efforts should be made to increase equitable access to the internet, improve literacy and provide appropriate training for key population members where needed.
- Consideration should be given to the preferences of different key population groups, given the current lack of published evidence from sex workers and people who inject drugs.

<sup>1</sup> In high TB burden settings TB services could be considered across all populations.

## Peer navigators



GRADE  
recommendation

Peer navigators are recommended to support people from key populations to start HIV, viral hepatitis or STI treatment and to remain in care (*conditional recommendation, very low certainty of evidence*).

Remarks

- A peer navigator's role is to assist key population members to access health services, navigate these services and stay in care.
- Peer navigators require adequate remuneration, recognition, training and other support to fulfil their role.
- Peer navigators are often highly valued by their peers.

## More frequent HCV testing for people at ongoing risk



GRADE  
recommendation

People at ongoing risk and a history of treatment-induced or spontaneous clearance of HCV infection may be offered 3–6 monthly testing for presence of HCV viremia (*conditional recommendation, very low certainty of evidence*).

Remarks

- Testing should be voluntary and not be used to further stigmatize any populations at ongoing risk.
- Testing should be offered alongside primary prevention services that are evidence-based and reduce transmission risks, and in combination with appropriate treatment access and linkage.
- To detect presence of viremic infection, the use of quantitative or qualitative nucleic acid testing (NAT) for detection of HCV RNA, or alternatively an assay to detect HCV core antigen, can be performed.

## HCV treatment for people at ongoing risk



GRADE  
recommendation

Pan-genotypic direct-acting antiviral (DAA)-HCV treatment should be offered without delay to people with recently acquired HCV infection and ongoing risk (*conditional recommendation, very low certainty of evidence*).

Remarks

- Individuals with recently acquired infection must have the option to make an informed choice about starting treatment immediately or delaying treatment initiation.
- Treatment for recently acquired infection should be offered alongside additional, evidence-based interventions to reduce HCV risk and primary prevention services.

## Behavioural interventions



Good practice statement

When planning and implementing a response for HIV, viral hepatitis and STIs, policy-makers and providers should be aware that counselling behavioural interventions, which aim to change behaviours to reduce risks associated with these infections for key populations, have not been shown to have an effect on HIV, viral hepatitis and STIs' incidence nor on risk behaviour such as condom use and needle sharing. Counselling and information sharing, not aimed at changing behaviours, can be a key component of engagement with key populations, and when provided it should be in a non-judgemental manner, alongside other prevention interventions and with involvement of peers.

Remarks:

- Addressing structural and social barriers is critical to create environments which permit supportive and impactful counselling.
- Counselling interventions which promote abstinence from drug use, rehabilitation or cessation of sex work or drug use, or a so-called cure for homosexuality or gender incongruence (for example, so-called conversion therapy)\* are not recommended, and create barriers to key population service access.

\* Compulsory, or involuntary, treatment for drug dependence, so-called conversion therapy or rehabilitation of sex workers is against human rights and medical ethics principals of consent, freedom from arbitrary arrest, access to quality health, freedom from torture and cruel, inhuman and degrading treatment.

## Addressing chemsex



Good practice statement

Addressing chemsex\*, especially for key populations and their sexual partners, requires a comprehensive, non-judgemental and person-centred approach. This can include integrated sexual and reproductive health, mental health, access to sterile needles/syringes and OAMT services with linkages to other evidence-based prevention, diagnostic and treatment interventions.

It is acknowledged that in some settings the definition for chemsex may vary and that it may take place in the context of other harmful drug and alcohol use.

\* Chemsex for the purpose of these guidelines is defined as when individuals engage in sexual activity, while taking primarily stimulant drugs, typically involving multiple participants and over a prolonged time.

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