
New good practice statement on counselling behavioural interventions for key populations to prevent HIV, viral hepatitis and STIs

Policy brief



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Summary

A new good practice statement about counselling behavioural interventions for key populations was developed by the World Health Organization (WHO) in 2022 (1). The good practice statement reflects a lack of evidence that certain behavioural interventions, as outlined below, have an impact on HIV, viral hepatitis and sexually transmitted infections (STIs).

It is important to understand that the behavioural interventions reviewed as part of this new good practice statement are quite specific and may not reflect all behavioural interventions. The evidence relates to counselling interventions that aim to change behaviours such as reducing the number of sexual partners, reducing drug use, increasing use of condoms and increasing safe injecting practice. These interventions are different from those that aim to educate or inform people, for example, by demonstrating how to use a condom, describing to a patient how to correctly take medicine or by giving details of the nearest place to get an HIV test. These types of interventions give information and education, without judging and while accepting people's behaviour. They are not the subject of this new good practice statement, and they remain important as part of providing information to people about HIV, viral hepatitis and STIs and how to prevent, diagnose and treat these.

The implementation of this good practice statement may require a shift in the way service providers work and plan programmes for key populations. Providers and planners need to focus less on trying to change behaviours, which is difficult to do and can be a very long-term goal for many, and more on giving non-judgemental and practical advice, information and education based on a client's needs, as well as providing access to a range of evidence-based biomedical interventions for the prevention of HIV, viral hepatitis and STIs. Key to all work with key populations is encouraging peer-support mechanisms and the reduction of structural barriers, including reducing stigma and discrimination.

Good practice statement: When planning and implementing a response for HIV, viral hepatitis and sexually transmitted diseases (STIs), policy-makers and providers should be aware that counselling behavioural interventions aimed 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/syringe 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 that 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 and freedom from torture, and fosters cruel, inhuman and degrading treatment.

Background

Key populations (men who have sex with men, people who inject drugs, sex workers, trans and gender diverse people and people in prisons) are at increased risk of and disproportionately affected by HIV, viral hepatitis and sexually transmitted infections (STIs). This is due to several interconnected factors, primarily criminalization of one or more aspects of key population members' behaviour, work or sexual orientation; gender identity and gender expression; punitive legislation and policing practices; as well as stigma and discrimination. Risk behaviours such as unsafe sex and unsafe injecting that may be more common in key populations, when combined with poor access to prevention interventions, can lead to increased risk of acquiring HIV, viral hepatitis and STIs.

In 2022 WHO published *Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations* (key population guidelines), which outlines a public health response to HIV, viral hepatitis and STIs for the five key populations. The guidelines recognize that achievement of the global targets for HIV, viral hepatitis and STIs will not be possible without both prioritizing reaching key populations for greatest impact and supporting key population communities to lead the response, and providing equitable, accessible and acceptable services.

As part of the development of the key population guidelines, several areas were identified that required a review of evidence to answer key questions and allowed the development of new or updated recommendations. One of these research questions was about behavioural interventions and their impact on risk behaviours and incidence of HIV, viral hepatitis and STIs.

Behavioural interventions that aim to reduce transmission of HIV, STIs and viral hepatitis by changing risk behaviours such as condomless or other unprotected sex, sharing needles/syringes or illicit drug use are often included in key population programmes. In order to change these behaviours, the interventions can use different approaches, including counselling, education or empowerment. This policy brief focuses on counselling behavioural interventions; these can be provided by health care workers, by peers, can be one time or multiple sessions, can be brief or long, can be provided in groups, individually, online or face-to-face.

Evidence of lack of impact of counselling behavioural interventions

In order to answer the question **Do counselling behavioural interventions reduce risk behaviours associated with transmission or acquisition of HIV, STIs and viral hepatitis?** a systematic review was commissioned by WHO. The systematic review identified nine eligible randomized control trials published from 1 January 2010 to 1 March 2021.

The intervention of interest was counselling behavioural interventions that aim to change risk behaviours compared to no intervention or a different intervention. Outcomes of interest were changes in frequency of unsafe sex (for example, condomless sex, sex without lubricant or sex without pre-exposure prophylaxis (PrEP)), needle/syringe sharing and HIV, viral hepatitis or STI incidence.

A systematic review of published evidence found that counselling interventions that aim to change behaviours such as unprotected sex and injecting among key populations do not change behaviours or reduce new HIV, viral hepatitis and STI infections.

The studies that were eligible for inclusion in the systematic review and meta-analysis employed different counselling interventions, aiming for different outcomes. Examples of counselling behavioural interventions included the following:

- enhanced HIV voluntary counselling and testing, which included extra counselling, reminders for safe sex and development of a safer sex action plan; the objective was to reduce unprotected anal intercourse among men who have sex with men in order to reduce HIV incidence (2);
- personalized comprehensive PrEP counselling, which also included sexual risk reduction counselling; the objective was PrEP initiation and safer sex in order to reduce HIV incidence (3);

- interactive injection and sexual risk reduction intervention including videos, motivational interviewing and role-play that aim to reduce unsafe sex and injecting (4); and
- counselling for key population individuals and couples to reduce unsafe sex and unsafe injecting (5-9).

Together the included articles indicated with moderate certainty that counselling behavioural interventions probably do not have impact on the following:

- HIV incidence in key populations (2-4, 7, 8, 10, 11)
- viral hepatitis incidence in key populations (7)
- STI incidence in key populations (2, 4-6, 8, 10, 11)
- unsafe sex (2, 3, 6-8, 10, 11)
- needle/syringe sharing (7, 8).

The systematic review did not include the following interventions; therefore we did not assess whether they have any impact on any of the risk behaviours, HIV, viral hepatitis or STI incidence:

- counselling that DID NOT aim to change risk behaviour but had another intended outcome;
- provision of education and information;
- demand creation.

Values and preferences qualitative research that was undertaken for the development of the key population guidelines indicated that key populations value counselling interventions when provided by peers and through community based organisations.

Harms may occur when counsellors or counselling behavioural interventions promote abstinence from drug use, rehabilitation, cessation of sex work or so-called cures for homosexuality, which can discourage key population members from accessing lifesaving health interventions.

Implementation considerations

Given that a systematic review did not find any effect of counselling behavioural interventions on incidence of HIV, viral hepatitis or STIs or on risk behaviour, they have not been included in the essential package in the current guidelines. **The choice to include counselling behavioural interventions in packages of interventions for key populations should be made with an understanding of the potential limitations on outcomes and related cost.**

While we did not review other types of counselling interventions, key population groups who took part in values and preferences research that informed this good practice statement, as well as experts from the key populations guidelines development group, stated that counselling interventions could have additional benefits, such as engaging with key populations and building caring relationships between key population members and health care providers.

If counselling behavioural interventions are implemented, ongoing training for peers and health care workers is needed to ensure quality, as well as urgently addressing stigmatizing attitudes within the health system and structural barriers.

If implemented, counselling behavioural interventions should be tailored to specific key population groups and individuals, recognizing that people are in different life stages, have different priorities and some people may currently be unable to change their risk behaviours or may not want to make changes. This should be accepted without judgement and as a component of a comprehensive approach, one that combines behavioural strategies with biomedical and structural interventions.

Counselling interventions that promote abstinence, rehabilitation, cessation of sex work or a so-called cure for homosexuality (for example, conversion therapy) create barriers to key population service access and are not recommended.

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