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Finally, we suggest that a next question for the field not be “do cognitive behavioural interventions for HIV prevention work?” The answer to this is, yes. We believe the question should be “how, and under what circumstances, can we produce the greatest sustainable intervention effects through the use of cognitive behavioural interventions?”

References


Social and behavioural interventions are effective in preventing HIV transmission

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EDITOR—We were disappointed to see the paragraph in This week in the BMJ for the paper by Imrie et al conclude that behavioural interventions are ineffective in reducing the risk of HIV among gay men.1 Imrie et al reported a rigorously conducted evaluation of a one day groupwork intervention targeting gay men attending a genitourinary medicine clinic. Informed by cognitive behavioural theory, the intervention aimed to help these men assess their current risk taking and act to reduce this. The intervention was not effective with regard to either behavioural or biological outcomes.

Our disappointment is not the shock of health promoters suddenly discovering that our work is not achieving its aims. Our centre has pioneered the development of rigorous methods of evaluating social and behavioural interventions. We have sometimes been labelled arch-sceptics concerning the effectiveness of behavioural interventions.2 Our disappointment results from the manner in which a very general conclusion is drawn from a very specific study. The intervention by Imrie et al was not representative of all behavioural interventions to prevent transmission of HIV, which vary in terms of approach, location, and target group. We should not generalise its results to conclude, say, that outreach work with gay men in Amsterdam or Sydney is ineffective. We should not even automatically generalise its conclusions to other group-work interventions for gay men that are based on cognitive...
We wonder whether a similarly general conclusion would have been drawn on the basis of a clinical trial. Would, for example, a study reporting the ineffectiveness of antidepressants in treating post-traumatic stress disorder be accompanied by a paragraph in This week in the BMJ announcing that pharmacological interventions are ineffective in treating mental ill health? We presume not. We suggest that the BMJ adopts the same caution in reviewing trials as that of the Cochrane Collaboration. One trial is seldom sufficient to make conclusions about effectiveness, especially where the intervention in question is atypical of the interventions under consideration.

More thorough reviews of the effectiveness of behavioural interventions in HIV prevention reveal that while some have been ineffective, many others have been effective. In the absence of effective HIV vaccines, behavioural interventions remain one of our only options for preventing HIV transmission. Comment such as the paragraphs in This week in the BMJ contribute little to an informed debate, either in drawing conclusions from trials of behavioural interventions or in establishing how best to prevent new HIV infections.

References


Authors' reply

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EDITOR—Noar and Zimmerman are correct that behavioural change is a precondition to reducing the incidence of sexually transmitted infections. But which behaviours are most important is not always
clear; the causal pathway between increased use of condoms and reduced infections proposed is not that simple. Use of condoms is not a single behaviour, nor is it certain to provide protection against infection. Our findings show a non-significant reduction in the highest risk sexual behaviours throughout the follow up, particularly at six months, but without a corresponding reduction in new infections.

Other studies have shown that the incidence of new infections may be influenced by a range of factors—for example, demographic characteristics, doubt on the efficacy of cognitive behavioural interventions, choice of partner, and consistent and correct use of condoms. This makes it difficult to predict the efficacy of an intervention in preventing a disease when the intervention is based on observed behaviour change or use of condoms alone. We know of only one study that has been able to show a causal pathway relation between adopting new behaviours and reduced incidence of sexually transmitted infections—condom use was only part of the explanation.

As public health researchers, the effectiveness of our interventions is ultimately assessed by their impact on morbidity in the population. Two of the much larger trials that Noar and Zimmerman refer to were not randomised controlled trials, and the trial by Nelson et al did not entail a specifically described cognitive behavioural intervention.

We agree that our study should not cast doubt on the efficacy of cognitive behavioural interventions themselves. But it does raise important questions about the optimal dose and formulation of intervention that is able to produce sustained change of behaviour and can feasibly be delivered within routine care. Limited resources preclude providing long term one on one interventions for every patient at risk. So far there is limited indication that there is a uniform dose of intervention that can achieve sustained change in sexual behaviour.

The question of how different therapeutic approaches and theoretically derived interventions can be optimally deployed in the different HIV prevention settings, including sexual health clinics, is still largely unanswered. As Bonell and Strange point out, this was a trial of a highly specific intervention delivered within a particular context. We agreed with them that it may be hard to make major policy generalisations from it. Its greatest value is to remind us to think carefully about the potential impact of our interventions and consider, equally carefully, how best these effects can be measured.

References


