CORRIGENDA

Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach

ISBN 978-92-4-003159-3 (electronic version)
ISBN 978-92-4-003160-9 (print version)

Page xi, lines 24–27

Delete: WHO also acknowledges the contributions of David Back, Alison Boyle, Sara Gibbons, Saye Khoo and Fiona Marra (University of Liverpool, United Kingdom) as well as Catia Marzolini (University Hospital Basel, Switzerland) for developing and providing technical input for the drug–drug interactions in Chapter 4.

Insert: WHO also acknowledges the contributions of David Back, Alison Boyle, Sara Gibbons, Saye Khoo and Fiona Marra (University of Liverpool, United Kingdom), as well as Catia Marzolini (University Hospital Basel, Switzerland), for developing and providing technical input for the drug–drug interactions in Chapter 4. In addition, WHO acknowledges the contributions of the WHO Global HIV Quality of Care Technical Working Group members, who provided writing support and technical input for section 7.12.

Page xv, lines 3–4

Delete: The ★ symbol represents recommendations or good practice statements developed between 2020 and 2021.

Insert: The ★ symbol represents recommendations or good practice statements developed between 2020 and 2021.

Critical enablers

Good practice statements
Laws, legal policies and practices should be reviewed and, where necessary, revised by policy-makers and government leaders, with meaningful engagement of stakeholders from key population groups, to allow and support increased access to services for key populations.

Countries should work toward decriminalization of behaviours such as drug use/injecting, sex work, same-sex activity and nonconforming
gender identities, and toward elimination of the unjust application of civil law and regulations against people who use/inject drugs, sex workers, men who have sex with men and transgender people.

Countries should work towards implementing and enforcing antidiscrimination and protective laws, derived from human rights standards, to eliminate stigma, discrimination and violence against people from key populations.

Key population-led groups and organizations should be made essential partners and leaders in designing, planning, implementing and evaluating health services.

Violence against people from key populations should be prevented and addressed in partnership with key population-led organizations. All violence against people from key populations should be monitored and reported, and redress mechanisms should be established to provide justice.

**Page xx, lines 2–6**

**Delete:**

3.2 Pre-exposure prophylaxis for preventing the acquisition of HIV
3.2.1 Oral pre-exposure prophylaxis for preventing the acquisition of HIV

Oral pre-exposure prophylaxis (PrEP) containing TDF should be offered as an additional prevention choice for people at substantial risk of HIV infection\(^\text{a}\) as part of combination HIV prevention approaches (strong recommendation, high-certainty evidence).

\(^\text{a}\) See Box 3.2 for reflections on the definition of substantial risk of HIV infection.

**Insert:**

3.1 Combination HIV prevention

**Condoms**

The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and STIs (strong recommendation, moderate-certainty evidence).

**Harm reduction**

All individuals from key populations who inject drugs should have access to sterile injecting equipment through needle and syringe programmes (strong recommendation, low-certainty evidence).

All people from key populations who are dependent on opioids should be offered opioid substitution therapy in keeping with WHO guidance, including those in prison and other closed settings (strong recommendation, low-certainty evidence).
All key populations with harmful alcohol or other substance use should have access to evidence-based interventions, including brief psychosocial interventions involving assessment, specific feedback and advice (conditional recommendation, very-low-certainty of evidence).

People likely to witness an opioid overdose should have access to naloxone and be instructed in its use for emergency management of suspected opioid overdose (strong recommendation, very-low-certainty of evidence).

**Voluntary medical male circumcision**

Voluntary medical male circumcision (VMMC) should continue to be promoted as an additional efficacious HIV prevention option within combination prevention for adolescents 15 years and older and adult men in settings with generalized epidemics to reduce the risk of heterosexually acquired HIV infection (strong recommendation, high-certainty evidence).

The use of WHO-prequalified male circumcision devices is recommended as additional methods of male circumcision in the context of HIV prevention for males ages 15 years and older (conditional recommendation, moderate-certainty evidence).

### 3.2 Pre-exposure prophylaxis for preventing the acquisition of HIV

#### 3.2.1 Oral pre-exposure prophylaxis for preventing the acquisition of HIV

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**a** See Box 3.2 for reflections on the definition of substantial risk of HIV infection.

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**Page xxxviii, lines 35–43**

**Delete:**

**Good practice statement**

HIV programmes should:

- provide people-centred care that is focused and organized around the health needs, preferences and expectations of people and communities, upholding individual dignity and respect, especially for vulnerable populations, and engage and support people and families to play an active role in their own care by informed decision-making;
- offer safe, acceptable and appropriate clinical and non-clinical services in a timely fashion, aiming to reduce morbidity and mortality associated with HIV infection and to improve health outcomes and quality of life in general; and
- promote the efficient and effective use of resources.
Good practice statement
HIV programmes should:

- provide people-centred care that is focused and organized around the health needs, preferences and expectations of people and communities, upholding individual dignity and respect, especially for vulnerable populations;
- engage and support people and families to play an active role in their own care by informed decision-making;
- offer safe, acceptable and appropriate clinical and non-clinical services in a timely fashion, aiming to reduce morbidity and mortality associated with HIV infection and to improve health outcomes and quality of life in general; and
- promote the efficient and effective use of resources.

Good practice statement
Health-care workers should receive appropriate recurrent training and sensitization to ensure that they have the skills and understanding to provide services for adults and adolescents from key populations based on all persons’ right to health, confidentiality and non-discrimination.

Page 11, line 1

Delete: Fig. 2.1 Addressing critical enablers for HIV testing services programmes

Insert: Fig. 2.1 Addressing critical enablers

Page 66, lines 27–28

Delete: Needle and syringe programmes are highly effective in reducing HIV transmission through injecting drug use (4).

Insert: Needle and syringe programmes are highly effective in reducing HIV and hepatitis C transmission through injecting drug use (4).

Page 66, lines 35–37

Delete: WHO is developing new recommendations on behavioural interventions to reduce the risk of transmission of HIV, hepatitis and sexually transmitted infections through chemsex, which may include injecting drug use.

Insert: “Chemsex” is an increasingly common phenomenon where individuals engage in sexual activity, typically involving multiple participants while taking drugs (often multiple drugs, usually stimulants, including injecting drug use), over a prolonged time. Addressing chemsex requires a comprehensive, non-judgemental and person-centred approach. This can include integrated sexual health, mental health and substance use services with linkages to evidence-based prevention interventions.
Page 67, lines 37–43

Delete: These messages encourage people to reduce behaviour that may increase the risk of acquiring HIV and increase behaviour that is protective (such as safer drug use, delaying sexual debut, reducing the frequency of unprotected sex, using male and female condoms correctly and consistently and knowing your and your partner’s HIV status). Recognition is growing that social media and mobile technology are important tools that can be integrated in HIV prevention programmes and can be particularly critical in informing about and providing prevention services to populations such as men who have sex with men.

Insert: Recognition is growing that social media and mobile technology are important tools that can be integrated in HIV prevention programmes and can be particularly critical in informing about and providing prevention services to key populations.

Page 75, lines 42–45

Delete: Older individuals, especially those over 50 years, with baseline creatinine clearance of <90 mL/min and with kidney-related comorbidities such as diabetes or hypertension, had a higher probability of declining to abnormal levels of creatinine clearance.

Insert: Older individuals, particularly those over 50 years, individuals with a baseline creatinine clearance of <90 mL/min, and individuals with kidney-related comorbidities such as diabetes or hypertension had a higher probability of declining to clinically significant levels of creatinine clearance.

Page 76, lines 32–36

Delete: Clinical relapse did not occur during or after PrEP use in trials that included people with chronic hepatitis B infection (62,63) and are considered very rare. Hepatitis B infection is not a contraindication for daily oral PrEP use, but event-driven use of oral PrEP is inappropriate for individuals with chronic hepatitis B infection. Daily oral PrEP can be initiated before hepatitis B testing results are available.

Insert: Clinical relapse did not occur during or after PrEP use in trials that included people with chronic hepatitis B infection (62,63) and is considered rare. Most cases of relapse are asymptomatic. Hepatitis B infection is not a contraindication for daily oral PrEP use and daily oral PrEP can be initiated before hepatitis B testing results are available.
Page 77, lines 23–24

Delete: WHO will release revised guidance on this topic in 2021–2022.

Insert: WHO will release revised guidance on safely starting and stopping oral PrEP use for all populations in 2022.

Page 77, lines 44–46

Delete: Operational research is especially needed in diverse settings to generate demand for prevention services among adolescents and young people and support effective PrEP use.

Insert: Operational research is especially needed in diverse settings on how to generate demand for prevention services and support effective PrEP use among adolescents and young people.

Page 85, lines 13–17

Delete: Unlike oral PrEP, no creatinine monitoring or hepatitis B testing is required for the safe use of the dapivirine ring.

Insert: Use of the dapivirine ring does not affect kidney function, so no kidney function monitoring is necessary. Unlike TDF-based oral PrEP, use of the dapivirine ring by people living with hepatitis B infection is not associated with an increased risk of virological and clinical relapse of hepatitis B, although PrEP services including the dapivirine ring offer a good opportunity to screen for hepatitis B infection.

Page 94, Fig. 3.1

Please replace figure with corrected version below.
Page 117, Table 4.2, column 1, lines 8–11

_Delete:_ Adults, adolescents and children being treated for HIV-associated TB (including multidrug-resistant TB)

Insert: Adults, adolescents and children being treated for HIV-associated TB

Page 119, Box 4.1, lines 8–14

_Delete:_ ART should be delayed by 4–6 weeks of ART following initiation of treatment for cryptococcal meningitis. Use of steroids is not recommended.¹

Insert: ART should be delayed by 4–6 weeks of ART following initiation of treatment for cryptococcal meningitis. Use of steroids is not recommended.¹

ART should be delayed at least four weeks (and initiated within eight weeks) after treatment for TB meningitis is initiated. Corticosteroids should be considered adjuvant treatment for TB meningitis.²


Insert: ART should be delayed by 4–6 weeks of ART following initiation of treatment for cryptococcal meningitis. Use of steroids is not recommended.¹

The expert opinion of the guidelines development group was that ART should be delayed by at least four weeks (and initiated within eight weeks) after treatment for TB meningitis is initiated due to safety concerns.²

Corticosteroids should be considered adjuvant treatment for TB meningitis.³


Page 155, Table 4.12, column 1, line 9

_Delete:_ Sensitivity (copies/mL)

Insert: Specificity (copies/mL)
Everyone entering or re-entering care should receive a CD4 test at treatment baseline and as clinically indicated for people who are severely ill, clinically unstable or have advanced HIV disease. A person receiving ART is considered clinically stable based on the following criteria: receiving ART for at least six months, no current illnesses, good understanding of lifelong adherence and evidence of treatment success within the past six months (such as all viral load measurements <1000 copies/mL).

All children younger than five years living with HIV are considered as having advanced HIV disease, although those who are established on ART and older than two years should not be considered to have advanced disease and should be eligible for multimonth dispensing.

When performed after a positive WHO-recommended four-symptom screen, C-reactive protein with a cut-off of >5 mg/L was found to be as sensitive as the WHO-recommended four-symptom screen, with a sensitivity of 78% (95% CI 70–85%) but with significantly higher specificity (73%; 95% CI 66–79%) than the WHO-recommended four-symptom screen, which had a sensitivity of 84% (95% CI 75–90%) and specificity of 37% (95% CI 25–50%).

People who use drugs may experience a range of disorders related to drug use, including drug dependence, intoxication, withdrawal and overdose. Injecting drug use is associated with a range of diseases and
infections, including HIV, viral hepatitis, TB, septicaemia and bacterial endocarditis.

WHO, UNODC and UNAIDS recommend a comprehensive package of interventions for HIV prevention, treatment and care for people who inject drugs, including needle and syringe programmes, opioid substitution therapy, HIV testing and counselling, ART, preventing and treating sexually transmitted infections, condom programmes, targeted behaviour change communication, preventing and treating viral hepatitis and preventing, diagnosing and treating TB.

Insert:

6.12 Drug use
People who use drugs may experience drug dependence, intoxication, withdrawal and overdose. Injecting drug use is associated with a range of diseases and infections, including HIV, viral hepatitis, TB, septicaemia and bacterial endocarditis.

WHO, UNODC and UNAIDS recommend a comprehensive package of interventions for HIV prevention, treatment and care for people who inject drugs, including needle and syringe programmes, opioid substitution therapy, HIV testing and counselling, ART, preventing and treating sexually transmitted infections, condom programmes, preventing and treating viral hepatitis, and preventing, diagnosing and treating TB.

Page 288, lines 29–34

Delete: Although the focus with HIV has been injecting opioids, a link is becoming more evident between using other drugs such as amphetamine-like stimulants and sexual risk and transmission of HIV (214).

A form of sexualized drug use is also seen in subgroups of men who have sex with men, often referred to as chemsex, with increased risk of HIV and sexually transmitted infections, including HCV transmission.

Insert: Although the focus with HIV has been injecting opioids, a link is becoming more evident between using other drugs such as amphetamine-like stimulants and sexual risk and transmission of HIV (214, 355–357).

A form of sexualized drug use referred to as chemsex increases the risk of HIV and sexually transmitted infections, including HCV transmission.
Page 289, lines 18–25

Delete: For sex workers and their clients in low- and middle-income countries (2012)
We suggest offering periodic screening for asymptomatic sexually transmitted infections to female sex workers (conditional recommendation, low-certainty evidence).

We suggest offering female sex workers, in settings with high prevalence and limited clinical services, periodic presumptive treatment for asymptomatic sexually transmitted infections (conditional recommendation, moderate- to high-certainty evidence).

Insert: For sex workers and their clients in low- and middle-income countries (2012)
We suggest offering periodic screening for asymptomatic sexually transmitted infections to female sex workers (conditional recommendation, low-certainty evidence).

Page 292, lines 41–43

Delete: Anorectal symptoms and anorectal sexually transmitted infections are prevalent among men who have sex with men, female sex workers, transgender people and heterosexual women who engage in anal sexual intercourse.

Insert: Anorectal symptoms and anorectal sexually transmitted infections are prevalent among people who engage in anal sexual intercourse.

Page 363, lines 32–34

Delete: Other key services for people living with HIV who use drugs, such as needle and syringe programmes and drug substitution therapy, provide further opportunities to support adherence.

Insert: Other key services for people living with HIV who use drugs, such as needle and syringe programmes and opioid substitution therapy, provide further opportunities to support adherence.

Page 474, Table 8.1, column 3, lines 19–21

Delete: AV.3 People living with HIV who have suppressed viral load

Insert: AV.3 People living with HIV who have suppressed viral load (defined as viral load < 1000 copies/mL)
Page 514, Table A1.7

Replace table with corrected version below.

<p>| Table A1.7 Simplified age-based ARV drug dosing for administering enhanced and prolonged postnatal prophylaxis* |
|-------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|</p>
<table>
<thead>
<tr>
<th>Drug</th>
<th>Strength</th>
<th>0–6 weeks</th>
<th>6–12 weeks</th>
<th>12 weeks–6 months</th>
<th>6–9 months</th>
<th>9–24 months</th>
<th>9–24 months</th>
<th>9–24 months</th>
<th>9–24 months</th>
<th>9–24 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>AM</td>
<td>PM</td>
<td>AM</td>
<td>PM</td>
<td>AM</td>
<td>PM</td>
<td>AM</td>
<td>PM</td>
<td>AM</td>
</tr>
<tr>
<td>NVP^</td>
<td>50-mg scored dispersible tablets</td>
<td>0.5</td>
<td>–</td>
<td>0.5</td>
<td>–</td>
<td>0.5</td>
<td>–</td>
<td>0.5</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>NVP</td>
<td>10 mg/mL</td>
<td>1.5 mL</td>
<td>–</td>
<td>2 mL</td>
<td>–</td>
<td>2 mL</td>
<td>–</td>
<td>3 mL</td>
<td>–</td>
<td>4 mL</td>
</tr>
<tr>
<td>AZT</td>
<td>10 mg/mL</td>
<td>1.5 mL</td>
<td>1.5 mL</td>
<td>6 mL</td>
<td>6 mL</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

*In special circumstances with stock-outs of NVP and/or AZT, alternative ARV drugs could be used: RAL with treatment dosing, 3TC or LPVr based on evidence gathered through the PROMISE trial (3TC was administered as follows: 2.5 mg once daily for neonates weighing 2 to <4 kg, 15 mg once daily for infants weighing 4 to <8 kg and 50 mg once daily for children weighing more than 8 kg; LPVr was administered twice daily after the first week of life according to the following dosing scheme: 45/10 mg once daily for neonates weighing 2 to <4 kg and 80/20 mg once daily for infants weighing more than 4 kg.

This simplified dosing was developed with a WHO generic tool based on previously established NVP prophylactic targets.

These corrections have been incorporated into the electronic file.