

FREQUENTLY ASKED QUESTIONS (FAQ)

XVII INTERNATIONAL AIDS CONFERENCE**3-8 AUGUST 2008 MEXICO CITY****Q. The numbers of those infected with HIV continue to be downgraded. How can we trust the numbers?**

A. Estimates of HIV infections have been revised because of new information as well as refined methodologies. A meeting of outside experts with UNAIDS and WHO staff was held in November 2007 to review how the estimates are generated. While all public health data have their limitations and greater investment is needed in strategic information, the estimates for HIV/AIDS published in late 2007 offer the best available information and are of higher quality than for most other major public health challenges.

The reduction of epidemiological figures published late 2007 is largely due to improved and expanded surveillance, data collection and methodologies which have allowed UNAIDS and WHO to present a more detailed and accurate picture of the global epidemic.

Information from population-based surveys has usefully complemented data from sentinel surveillance, including through antenatal care sites. Approaches and tools used to assess the global AIDS epidemic have all been published. UNAIDS and WHO do not exaggerate data for the sake of advocacy, nor are these data influenced by political or fundraising agendas. If anything, current HIV data represent among the most scrutinized data available for any infectious disease.

Q. I read in a recent WHO/UNAIDS statement that heterosexual transmission is increasing in all regions of the world on the one hand, and yet, on the other, media reports tell us that WHO experts maintain that a 'major heterosexual epidemic outside of Africa' is 'unlikely' to occur. Which one is it?

A. Self-sustaining epidemics in the general population of the same severity as seen in southern Africa have not occurred elsewhere. HIV/AIDS trends change rather slowly, so the immediate future is likely to be a continuation of what is seen today. However, some heterosexual spread is likely and in many settings the overall proportion of HIV infections that are in women and that are heterosexually transmitted may increase. Because heterosexual sex is so frequent, even low risk of exposure and transmission of infection applied to large populations can result in a high number of heterosexually infected persons.

Q. If we need to go 'where transmission occurs,' then why spend money on programmes aimed at the general population?

A. In concentrated epidemics, HIV prevention efforts should be focused on groups and settings where transmission occurs. However, prevention programmes targeting the general population programmes are still appropriate. Everyone has the right to basic knowledge about HIV/AIDS--how to prevent it, how to deal with it if infected, and how to address HIV/AIDS at a societal and personal level if confronted with it.

General programmes that convey information pertaining to sexual and reproductive health, STI prevention (including how to protect oneself and one's partner from HIV), responsible sexual behavior, and contraception to avoid unintended pregnancy are very useful regardless of whether they occur in the context of a generalized epidemic or not. These programmes are even more effective when combined with information relating to drug use and other associated issues.

More effort by the international community and countries to target interventions to those most at-risk of HIV infection would bring even greater benefits. These specific groups include men who have sex with men, injecting drug users, sex workers, their clients, and the partners of these persons. In some settings there may be a need for special programs for migrants and prisoners.

Q. Some commentators have been sharply critical of the global HIV/AIDS response. Are their contentions unfounded?

A. Many authors have contributed to healthy debate around HIV/AIDS in recent years. Many of the points raised, such as about the quality of data and their communication, or about targeting responses, have been fully dealt with by UNAIDS, WHO and cosponsors in different documents.

POPULATIONS

Q. What is the difference between a concentrated and generalized epidemic, and why is the distinction important?

A. HIV epidemics are categorized as 'concentrated' when HIV prevalence is high (e.g. >5%) in one or more sub-population (such as injecting drug users or sex workers), but the epidemic is not well-established in the general population (prevalence < 1% among pregnant women in urban areas).

The future course of the epidemic is determined by the frequency and nature of links between the highly infected sub-populations and the general population. HIV epidemics are categorized as 'generalized' when HIV is firmly established in the general population. Although sub-populations at high risk may continue to contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain an epidemic independent of sub-populations at higher risk of infection. Understanding the nature of the HIV epidemic in a country, including its determinants and trends, is necessary to design the response and set priorities. Policies and interventions in countries with generalized epidemics will differ from those where HIV infection is concentrated among specific population groups.

Q. Why are there so few data on access by vulnerable populations, and what is being done to improve the situation?

A. Work is ongoing to strengthen country capacity to collect the necessary information of this kind. One of the first requirements is to obtain estimates of the size of at-risk populations, such as sex workers and their clients, men who have sex with men (MSM), and injecting drug users. Obtaining data from outreach services or services delivered by civil society groups is often difficult due to logistical challenges and the difficulty of consistent record-keeping and of obtaining accurate data. Another issue hampering data collection and research is the fact that many at-risk populations are stigmatized for real or perceived illegal behavior.

Q. What is the WHO position on safe injection sites? Does WHO recommend them as a useful harm-reduction strategy?

A. WHO states that there is not enough evidence for WHO to provide global guidance to Member States on safe injection facilities. WHO does recommend harm reduction activities.* Safe injecting sites are not a new intervention but simply a repackaging of existing WHO-recommended interventions such as needle exchanges, etc. They enable known, WHO-recommended harm reduction interventions to be delivered and used in a safe environment with the aim of reaching the most marginalized and vulnerable of injecting drug users.

WHO supports a comprehensive package of harm reduction interventions that include access to sterile needles, syringes and other injecting equipment, HIV risk reduction information and education through outreach. WHO also recommends drug dependence treatment including opioid substitution treatment, HIV testing and counselling, and HIV/AIDS treatment and care for drug users.

* This clarification was added 7 August 2008.

Q. What is WHO doing to help the health sector reach prisoners?

- A. While a number of countries have introduced HIV programmes in prisons since the 1990s, many are small in scale or exclude highly effective interventions such as needle and syringe programmes. In 2007, WHO commissioned the report “Evidence for Action: A comprehensive review of interventions to address HIV in prisons” (technical papers at www.who.int/hiv/ivdu/prison/en/index.html). This review provides extensive evidence that needle and syringe programmes, STI treatment, condom distribution, opioid substitution therapy and other drug dependence treatment programmes in prison are feasible and effective. The report forms the basis for WHO’s ongoing advocacy to expand the provision of HIV prevention, treatment and care in prisons.

WHO, UNODC and UNAIDS have developed a policy statement regarding HIV testing and counselling in prisons and other closed settings. The aim of this policy statement is to increase access to HIV testing in prisons in a way that respects the rights of the prisoners, does not lead to stigma and discrimination and promotes a comprehensive response to HIV in prison settings.

Q. What is WHO doing to help the health sector reach men who have sex with men (MSM)?

- A. WHO is making recommendations to countries to integrate interventions for MSM as an essential component of national response and to develop MSM-friendly sexual health and HIV services as needed. UNDP and other UNAIDS cosponsors are focusing increased attention on MSM, and WHO will be holding a consultation later in 2008 to review what the health sector should be doing in order to reach this group more effectively.

Q. There have been media accounts about one or two high-profile cases where HIV-positive men intentionally infected others. In the interests of public health, what is the WHO position on incarceration?

- A. Intentional transmission of HIV, fortunately, is very rare but when it is proven to occur is an issue that should be dealt with by the law covering general criminal offences. It is not considered appropriate or necessary to have specific criminal legislation relating to HIV transmission. In general, attempts to characterize HIV transmission in legal rather than public health terms complicate efforts to reach most at-risk and vulnerable populations and are not supported by any legitimate public health rationale.

Q. What is WHO doing to reach out to sex workers and their clients?

- A. Data from HIV sentinel surveillance and studies conducted in several countries in Asia, Latin America, and sub-Saharan Africa, have shown that HIV prevalence among people with high rates of partner change such as sex workers and their clients are much higher than among the general adult population aged 15-49 years. Moreover, with high rates of partner change, the potential for onward transmission from an HIV-positive sex worker may be more than 100 times greater than from other populations.

In addition, enhanced efficiency of HIV transmission between commercial sexual contacts associated with higher prevalence of ulcerative STI cofactors (including chancroid and HSV-2) has been described, particularly in settings where men are uncircumcised.

Together, these factors may contribute to a very high differential HIV transmission potential compared to lower-risk populations. Yet, there is little evidence that transmission of HIV or of other STIs in sex work settings has been controlled in much of Africa. If not, transmission from sex workers to clients and clients of sex workers to their sexual partners likely remains a driving factor in the spread of HIV even in mature HIV epidemics.

WHO along with UNFPA and UNAIDS is working on promoting interventions for prevention of sexual transmission of HIV and other STIs and care and treatment for sex workers in various settings, including biological and behavioral surveillance, size estimations and mapping.

Q. Research has indicated that Africans and those of African descent may be more biologically susceptible to HIV infection owing to genetic variations that originally evolved to protect against *Plasmodium vivax*. Has the Global HIV response overemphasized culture and sexual practices and under-emphasized the impact of biology?

A. Scientists have long recognized and commented on the genetic predisposition to protection or susceptibility to a variety of infectious agents (i.e. malaria, tuberculosis) and it is a subject of increasing scientific study. For HIV-1, scientists have recognized that specific genetic predispositions may confer relative protection against infection (eg delta-32 deletion in the gene for CCR5 receptor) or the opposite. This research is relatively new and requires further verification because the study in question points to an increased susceptibility in a specific racial or ethnic group. In addition, more work in Africa will be required to confirm the distribution of this genotype and its association or lack of it with regards to HIV-1 infection.

If correct, findings such as these will result in a significant impact on basic science and potentially, for future drug and vaccine development. Immediate public health implications are very limited and results do not influence what is required for scaling up HIV prevention, treatment, care and support for universal access.

Finally, if correct, results of such studies do not suggest that genetic predisposition is the main reason that sub-Saharan Africa is so disproportionately affected by HIV/AIDS, but rather, that it is a contributing factor.

Although WHO contends that culture and sexual practices have not been overemphasized in the context of AIDS, this discussion is a useful reminder that HIV/AIDS epidemiology, as for all infectious diseases, reflects the complex interaction of factors relating to the host (man), the agent (HIV), and the broader environment.

WOMEN AND THE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT)

Q. We hear from a number of UN agencies and other partners that the HIV/AIDS epidemic is becoming 'feminized', but from other quarters we hear that no, it is not. Could you please comment?

A. 'Feminization' of the epidemic refers to the increasing proportion of women among persons living with HIV. We try to avoid using the term "feminization" because it has caused confusion.

- Globally, approximately 50% of HIV infections are in women, and this figure has been stable for several years.
- In sub-Saharan Africa, more women are infected than men (ie "feminization" has already occurred). Women account for approximately 60% of HIV infections in sub-Saharan Africa, and that figure has also been stable for several years. Sub-Saharan Africa accounts for approximately 80% of all HIV infections in women worldwide.
- Whether women make up an increasing proportion of new infections with HIV depends on the incidence trends in men and women in the particular setting being considered. In some Latin American countries, women are accounting for a slowly increasing proportion of infections. In some other settings, sex-specific trends seem relatively stable and have even declined. However in some countries, e.g. in the United States, the proportion of women affected has increased substantially during the last 25 years..
- More men than women are infected in many concentrated epidemic settings because (i) men who have sex with men are heavily affected; (ii) the majority of injecting drug users are men; (iii) clients of sex workers are overwhelmingly men.
- Women are vulnerable because they tend to have only limited control over the risk behaviour of their partners and therefore, of their own.
- Treatment scale-up in low- and middle-income countries has resulted in treatment coverage in women that is at least as high, and sometimes higher, than in men.
- A major concern is that pregnant women are not being adequately assessed for their own need for treatment quite apart from preventing transmission to their children. Increasing numbers of HIV-positive pregnant women are accessing PMTCT services, but too few are being treated for their own health.

Q. Why are men more infected with HIV than women, even though the latter are more biologically susceptible?

- A. HIV prevalence is high among men, especially in regions where HIV transmission rates are high among men who have sex with men (MSM), such as in Latin America and the Caribbean, North America, and Western and Central Europe. Men who have sex with men continue to represent the largest population living with HIV in most high-income countries. In Eastern Europe and Latin America, HIV transmission among men who have sex with men appears to be greatly underreported. The HIV epidemic among MSM in other parts of the world, including sub-Saharan Africa, is poorly documented; however recent studies show that high risk behaviours occur among MSM.

Q. Why aren't more women receiving treatment for PMTCT getting it for their own health?

- A. A minority of pregnant women, in the range of 20-30%, might be expected to require antiretroviral therapy (ART) for their own health. The reason why pregnant women have difficulty accessing ART is because of weak health systems in general.

Currently, pregnant women receive prophylaxis while accessing antenatal care and maternal and child care services. Once a pregnant woman is identified as needing ARV for her own health, she needs to be referred to ARV clinics or other care and treatment centers.

Delivering HIV testing and counselling for pregnant women and the short course antiretroviral treatment for preventing transmission to infants is simpler than doing the necessary medical assessment required prior to the more complex antiretroviral drug regimen used for treatment of HIV disease.

The weakness of many developing country health systems means that women in need are rarely referred to the appropriate services and that the required links between maternal health services and ART programmes are not in place. Furthermore, once the pregnant woman attends an ARV clinic, she may face delays owing to long waiting lists.

Pregnant women requiring ART for their own health need to be given priority treatment. This is to ensure that the mother stays healthy, lower the risk of HIV transmission, and prevent children from being orphaned. WHO and partners are increasingly focusing on the well-being of the entire family, and it is hoped that family-centered care will bring benefits to all family members.

Q. WHO recommends that lactating HIV-positive mothers engage in 'exclusive breastfeeding' for six months after the child is born and yet HIV can be transmitted through breast milk. What is the rationale behind this WHO recommendation?

- A. The most appropriate infant feeding option for an HIV-infected mother depends on her individual circumstances, including her health status, the local situation, health services available, and the counselling and support she is likely to receive.

When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected women is recommended.

Among HIV-infected women, exclusive breast feeding for up to six months was associated with a significantly decreased risk of transmission of HIV compared to non-exclusive breast feeding in different international studies. Mixed feeding, it is thought, may damage the infant's intestinal mucosa and thus facilitate HIV transmission from breast milk.

Exclusive breast feeding is recommended for HIV-infected women for the first 6 months of life unless replacement feeding is acceptable, feasible, affordable, sustainable and safe.

At six months, if replacement feeding is still not acceptable, feasible, affordable, sustainable and safe, continuation of breast feeding is recommended with additional complementary foods. All breast feeding should stop once a nutritionally adequate and safe diet without breast milk can be provided.

Q. Family planning is a critical component of PMTCT. What is the WHO position on family planning as it relates to HIV?

A. Prevention of HIV infection in girls and women of childbearing age and of unintended pregnancies among those women infected with HIV are the most cost-effective ways to prevent HIV infection of infants.

The UN considers primary prevention of HIV infection in women and prevention of unintended pregnancies as critical components of an integrated approach to preventing mother-to-child transmission of HIV.

Q. Is rapid scale-up being overemphasized at the cost of monitoring and targeting treatment to those most likely to benefit?

A. National governments, WHO and partners are all operating in an emergency situation, trying to scale up access to vital medication for millions of people who need it immediately, and who will likely die in the coming months or years without treatment.

While rapid scale-up remains an absolute priority, we are now receiving information that points to steps that can be taken to not only expand access, but also to improve patient outcomes. Late diagnosis is a significant negative influence on patient outcomes, as is insufficient monitoring, counselling and support for patients beginning ART. WHO actively supports efforts to expand testing and counselling in order to increase earlier diagnosis of HIV infection, and is working with governments and treatment programmes to improve patient monitoring and follow-up, with the objective of increasing patient retention in treatment and improving outcomes.

Q. What is the relationship between the Universal Access target, the Millennium Development Goals (MDGs) and the UNGASS Declaration of Commitment?

A. In September 2000, world leaders meeting at the United Nations Millennium Summit unanimously agreed to a concerted global effort to reduce poverty and improve lives and issued the eight Millennium Development Goals (MDGs). MDG 6 calls for combating AIDS, and beginning to reverse the spread of HIV/AIDS by 2015. Achieving other MDGs, such as eradicating extreme poverty and hunger (#1); reducing child mortality (#4); and improving maternal health (#5) will all depend, in part, on significantly reducing the impact of HIV/AIDS.

The following year, at the historic June 2001 United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, Member States agreed to the Declaration of Commitment — a strong, practical blueprint designed to achieve significant progress in 10 priority action areas with an aim towards reducing the HIV epidemic, from prevention to treatment to funding.

At the General Assembly High Level Meeting on HIV/AIDS in 2006, Member States reviewing progress towards the 2001 Declaration of Commitment goals unanimously endorsed the goal adopted earlier that year by the G-8 nations to achieve universal access to prevention, treatment, care and support by the year 2010. The provision of universal access to basic HIV services is seen as key to accomplishing the Millennium Development Goals by the target date of 2015.

Q. Should more attention be paid to North Africa and the Middle East and South/South-East Asia, all of which have lower rates of coverage than sub-Saharan Africa?

A. Universal access is required everywhere. Some of the areas mentioned, such as North Africa and the Middle East, have some of the lowest coverage rates internationally although they also have lower numbers of persons living with HIV. Scale-up has emphasized high burden countries, but equity requires HIV prevention, treatment and care to be accessible everywhere.

Q. What is the public health approach to scaling up antiretroviral therapy?

A. The public health approach seeks to greatly expand ARV access by emphasizing the principles of simplification, standardization, decentralization, equity, and patient and community participation. The approach utilizes standardized regimens and simplified formularies, along with simplified clinical decision-

making and standardized treatment monitoring. This approach seeks to provide the best quality of care for the largest number of people, recognizing the financial and human resource constraints facing many developing world health systems.

Q. What is the impact of conflict or other social disruptions on ARV access?

- A.** One of the greatest challenges to providing large-scale access to ART in low- and middle-income countries is overcoming the obstacles posed by poor infrastructure and/or social or political unrest.

Northern Uganda, for example, is affected by a long-running civil conflict, the breakdown of the health system, and HIV prevalence that is higher than the national average. Working together in this region since 2004, the Ministry of Health, local government institutions, international donors, UN agencies and NGOs have increased access to ARV therapy from 1261 patients in 2004 to 10,450 in 2007—a more than eight-fold increase, which now covers 39% of people in need of ART in the Northern Uganda and Karamoja regions. This effort is one of several that demonstrate that with the support of all players, especially of the national government, ARV therapy can be delivered and sustained even in regions experiencing significant social unrest.

Q. Who will pay for treatment scale up to universal access?

- A.** It is not realistic to think that low-income countries can cover the full cost of universal access—not even if they deliver on their pledge to mobilize 15% of revenue for the health sector (a pledge made at an Abuja conference in 2001). This is a global responsibility.

TREATMENT AS PREVENTION

Q. Recent research shows that HAART can reduce viral load to such an extent that HIV is no longer transmissible. What is the WHO the position regarding treatment as prevention?

- A.** Although viral load is the major risk factor for HIV transmission, low viral loads do not guarantee that transmission cannot occur. WHO therefore recommends that all persons living with HIV, including those on antiretroviral therapy, should take additional measures to prevent transmission to others such as correct and consistent use of condoms during sexual intercourse.

REGIMENS

Q. If 90% of patients are on regimens compliant with WHO guidelines, what are the other 10% getting, and why?

- A.** The other 10% may be receiving a variety of regimens, some efficacious and some contra-indicated. Potential reasons include lack of familiarity of practitioners with WHO recommendations and inconsistent supply of drugs.

Q. Aren't some of the most frequently used first-line regimens considered outdated by developed world standards? Why doesn't WHO recommend newer, more easily-tolerated regimens?

- A.** WHO has reviewed and pre-qualified 178 antiretroviral formulations, of which 56 originate from innovator companies and 122 from generic companies. All WHO-approved regimens are effective against HIV.

As with any other medicines, some ARV regimens have clinical advantages over others related to their effectiveness, durability of response against HIV, and toxicity. While different treatment programmes use different regimens, based on the needs of their treatment populations and the resources available, improved efforts to control toxicities would likely benefit patient retention and treatment outcomes.

A major topic of current discussion concerns the desirability of moving away from use of stavudine and adopting more tolerable drugs such as tenofovir. WHO is actively working with countries and programmes to facilitate introduction of less toxic drugs and regimens.

PRECAUTIONS

Q. Why are universal precautions on blood safety not yet in place in all countries? What is WHO doing to advance this and other efforts to reduce infection in health-care settings?

A. The incomplete or insufficient implementation of universal precautions places both patients and health-care workers at risk of HIV infection through unscreened or improperly screened blood transfusions, unsafe injections, or accidental sharps injuries. WHO priorities include achieving 100% screening of blood and reducing unnecessary blood transfusions, increasing access to sterile injection equipment (nearly 40% of all injections in low- and middle-income countries are given with equipment that is unsafe), and increasing precautions to reduce accidental sharps injuries.

TESTING

Q. What is the benefit of an HIV test?

A. Knowing your HIV status can have two important benefits:

- If you learn that you are HIV positive, you can take the necessary steps before symptoms appear to access treatment, care and support, thereby potentially prolonging your life for many years.
- If you know that you are infected, you can take precautions to prevent the spread of HIV to others.

Q. Testing among young men seems particularly low. What is behind this, and how can it be corrected?

A. Men tend to have different health care seeking behavior than women, who have more contact with health services for reasons relating to maternal and child health care. Innovative approaches need to be developed to reach out to men through different types of services, including youth-friendly adolescent services, encouraging couple testing and counselling, increasing emphasis on partner testing and counselling in the context of PMTCT, etc. Scale up of male circumcision services in countries with generalized epidemics offers another opportunity to reach men.

Q. Why are testing rates for sex workers, injecting drug users (IDUs) and men who have sex with men (MSM) so much higher than for the population at large? Are these tests voluntary?

A. A number of countries have made and continue to make focused efforts to reach populations at particularly high risk for HIV infection with prevention education and access to prevention services, including testing and counselling. This is a sound strategy in many regions of the world in which the epidemic is largely concentrated among certain populations at particularly high risk. WHO, UNAIDS and UNICEF consistently emphasize the need for testing and counselling to be completely voluntary and informed. UN agencies also emphasize the need to resist stigmatization of HIV and of communities at elevated risk, by guaranteeing their full legal rights and equality.

Q. What has been the impact of the new guidelines for provider-initiated testing?

A. The vast majority of people who could benefit from HIV prevention, treatment and care still do not know their HIV status. WHO and UNAIDS issued guidance in 2007 that supports increasing access to and uptake of HIV testing by having health care providers recommend testing to all patients in generalized epidemic areas, as well as patients that present with what may be signs of HIV disease, and men seeking circumcision as an HIV prevention strategy. The guidance also recommends testing for patients receiving antenatal care or care related to tuberculosis or sexual health, and to those who are part of most-at-risk populations in areas with concentrated and low-level HIV epidemics. The guidance emphasizes that provider-initiated testing must be voluntary, confidential and undertaken with the patient's consent.

Evidence suggests that provider-initiated testing and counselling results in considerable increases in testing uptake, and does not deter clients from seeking health services. Evidence from both high- and low-income

settings points to the fact that patients benefit from increased testing and counselling. This includes the earlier diagnosis of HIV infection, earlier treatment, and a concomitant positive impact on subsequent HIV risk behavior.

Q. Is WHO/UNAIDS guidance on provider-initiated testing being followed? Have there been any problems?

- A. Provider-initiated testing and counselling is undoubtedly contributing to the scale-up of testing in populations such as pregnant women and tuberculosis patients, and is key to making progress towards universal access. Monitoring and evaluation of scale-up of provider-initiated testing and counselling is required to ensure WHO/UNAIDS guidance is followed, but to date no large scale problems have been detected.

Q. Syphilis is considered a reportable disease and health-care authorities engage in partner-tracing and notification in order to track down those who might have been exposed. Does WHO recommend partner tracing for HIV and if not, why not?

- A. Two processes for informing partners of an individual's HIV infection are disclosure and partner notification. Disclosure (also called beneficial disclosure) refers to voluntary actions by individuals themselves to notify their partners of their serostatus. WHO strongly supports disclosure, but emphasizes that for this to occur there needs to be a safe social and legal environment that provides care, treatment and support, and that protects against stigma, discrimination, and other adverse outcomes.

When a person with HIV who has received counselling is unable or unwilling to notify partners, and after careful ethical weighing of the potential harms involved, it may be necessary for health-care workers to notify sexual and needle-sharing partners that an individual is infected with HIV. As far as possible, partner notification should be performed with the informed consent of the HIV-infected person and maintain the confidentiality of the source client. Individuals should be protected from stigma, discrimination or physical abuse that may result from partner notification.

Notified partners of infected persons should be encouraged to seek HIV voluntary counselling and testing and appropriate medical referral.

IMPACT

Q. Are universal access efforts having a demonstrable positive impact on health systems?

- A. The impact of disease-specific programs on health systems is a topic of current intense study and debate. Specific examples point to the fact that health systems may be enhanced from HIV/AIDS service scale-up. It may be easier to demonstrate benefit for some specific components of the health system, such as strengthening of laboratory capacity or procurement systems, than for others. Overall, we need general strengthening of health systems as well as disease-specific interventions for major killers such as malaria, tuberculosis and HIV/AIDS.

Q. I have recently heard that condom programming and other prevention activities are not as effective as circumcision and partner reduction. Why do we continue to fund these activities if they don't work?

- A. WHO is committed to a comprehensive approach to HIV prevention, rather than emphasizing one approach over another, since different interventions have different relevance depending on the context. For example, condom promotion and control of sexually transmitted infections are important interventions for sex workers. WHO recognizes the importance of and supports male circumcision for the prevention of heterosexual acquisition of HIV by uncircumcised men in areas where male circumcision rates are low, HIV prevalence is high and transmission is predominantly heterosexual. Because high transmission settings and populations are characterized by high rates of overlapping partnerships and change, partner reduction is also an important prevention strategy.

Q. I have heard that the amount of funding for HIV is drawing scarce resources away from malaria and diarrhoeal and respiratory infections that kill more people than HIV. Is HIV funding distorting public health delivery?

A. HIV causes more deaths than any other single pathogen. Universal access requires long-term sustainable financing. The answer to funding shortages for other health priorities such as safe water is to increase funding to these other areas, not take money away from AIDS.

Q. Does HIV/AIDS still constitute a major global health emergency?

A. With an estimated 33 million people living with HIV, and an estimated 2.7 million new HIV infections and 2 million AIDS deaths in 2007, HIV remains the leading infectious disease challenge in global health.