10. Lessons Learned – Continued Relevance of Taking Action

In Brief

Question: Is *Taking Action* (still in 2006) the most relevant strategy for the UK to adopt to tackle HIV and AIDS in the developing world? Are there major outstanding issues that are not adequately addressed in *Taking Action* (bearing in mind that the UK is only one player among others). What are the implications for future AIDS strategy?

Taking Action is a broad strategy on HIV and AIDS that provides a menu of options. It includes both statements which reflect the UK's position on various issues and strategic choices, e.g. the establishment of a spending target on AIDS. However, it is less useful in prioritising or guiding action. Middle-income countries, such as China and Russia, do not see a strategy that focuses on HIV and AIDS in the developing world as relevant.

Overall, *Taking Action* remains a relevant strategy for the developing world, although there have been a number of developments since it was conceived in 2004. These include the push for universal access to HIV prevention, care and treatment; greater focus on the links between sexual and reproductive health and HIV and AIDS; the emergence of new global partners and initiatives; changes in the aid environment, e.g. Paris Declaration on Aid Effectiveness and UN reform agenda; development of new policy frameworks, e.g. the 2006 DFID White Paper; and new evidence on the beneficial effects of male circumcision in reducing HIV infection in men.

10.1 This Chapter provides a brief overview of *Taking Action*, progress towards international targets[214] and challenges to progress, key developments since 2004 and emerging issues. In the light of these it identifies areas of work that could be given higher priority during the remaining timeframe of *Taking Action.*

Taking Action: A Brief Review of Strengths and Gaps

10.2 *Taking Action* provided a clear statement of UK intent and is a broad framework for tackling HIV and AIDS. It is a bold strategy that fits well into DFID's poverty focus and strong championing of the Millennium Development Goals. DFID was awarded the Institute for Public Policy Research 'Oscar' for best policy of 2004 for *Taking Action*. The strategy articulates clearly the causes and effects of the epidemic; recognises the importance of international targets, partnerships and harmonisation with other donors; emphasises the need for a more comprehensive response that integrates prevention, treatment and care; gives greater prominence to the needs of women, children and vulnerable groups; and promises to place human rights at the centre of UK actions. It also highlights the importance of building an enabling environment and supporting an effective multisectoral response and of focusing on countries with concentrated epidemics as well as countries experiencing generalised epidemics.

[214] See also section 1.5-1.6 (p3) and 10.10-10.12 (p133)

10.3 *Taking Action* was the first strategy of its kind in DFID. Although an action plan[215] was developed by the GAP team it was not integrated into *Taking Action*.

10.4 *Taking Action* also highlighted a number of inter-related topics, e.g. the links between sexual and reproductive health, HIV and AIDS. The UK has given this issue considerable policy attention, e.g. influencing the EU HIV Prevention Statement to reflect this. This has enabled EU countries to take a common position on this issue in other fora. DFID recently commissioned a study to explore the policy, financing and institutional factors that enable or constrain integration of SRH and HIV programmes (Druce et al., 2006). The design of more recent country programmes has also addressed the issue of linkages between HIV and SRH more explicitly (see Box 26). However, the role of sexually transmitted infections in relation to HIV is not reflected in *Taking Action.* More generally, UNAIDS has also highlighted the lack of coordination between diagnosis and treatment of STI and HIV (UNAIDS, 2006).

Box 26 Linking HIV and AIDS to Sexual and Reproductive Health in Country Programmes

The **DRC** country case study reported that, given high levels of fertility and maternal mortality, there is considerable demand for reproductive health information and services, including contraception and family planning (Cleland and Sinding, 2005; Alexandratos, 2005). Discussions, including with HIV-positive widows, indicate significant desire for contraception. Of the 15 women living with HIV who participated in the case study focus group, 13 were widows and several had as many as seven children. There is an urgent need to link HIV prevention, treatment and care services, including PMTCT, to family planning and other reproductive health information and services.

DFID has firmly embedded HIV into reproductive health in **Zimbabwe**. The focus on women is primarily through strengthening reproductive health services, including family planning, maternal and child health and PMTCT. The new Maternal and Newborn Programme will greatly expand opportunities for women to have safe pregnancies and reduce mother to child transmission of HIV. DFID's support to the female condom programme provides an opportunity to address HIV prevention, while also strengthening women's social support networks.

10.5 Views differ about the purpose of *Taking Action,* in particular whether it is primarily an external position paper, a strategy to guide programming or a mix of both. *Taking Action* includes elements of DFID target strategy, policy and practice papers.

[215] Mandatory for all DFID strategies since the end of 2005

10.6 *Taking Action* has more than 130 commitments and this makes it more useful as an advocacy document to enable an external audience to understand the UK's position than as a guide to prioritise action. *Taking Action* has been considered less relevant in middle income countries, e.g. Russia and China that do not consider themselves part of the developing world. There is limited acknowledgement in the strategy of regional differences in the epidemic and in the factors that drive it (see Box 27). A related issue for DFID is that countries with the most severe or rapidly developing epidemics do not necessarily correlate well with poverty as measured by GDP per capita (DFID, 2006d).

Box 27 *Taking Action*: Relevance to National Responses to HIV and AIDS

The country case study conducted for this evaluation in **Zimbabwe** noted that *Taking Action* was seen by DFID Zimbabwe as extremely relevant to their work in a number of specific ways. It provided clarity that the UK will support ART. It also provided, together with the Country Assistance Plan, an enabling framework from which advisers could select the most relevant interventions for a particular country. However, some concerns were raised that DFID, in general, and *Taking Action*, in particular has too strong an emphasis on finances, including types of aid instruments, and therefore overlooks critical issues, such as the human resource crisis (see Box 28, p130) and the ongoing need for technical assistance. It was also noted that the strategy is less clear about how it will be implemented and how progress will be measured.

The **China** country case study noted that *Taking Action* would be more useful if it prioritised UK intentions by region or even sub-region. Currently, the strategy appears strongly focused on Africa and not all of the general principles in the strategy are appropriate to China.

10.7 With the exception of the DFID HIV Treatment and Care Policy (DFID, 2004b), *Taking Action* is not explicit about how HIV and AIDS fits with other DFID or UK Government policies and strategies, e.g. on sexual and reproductive health rights (DFID, 2004f), maternal health (DFID, 2004g), aid modalities, human resources for health (see Box 28, p130) and gender. The links between HIV, AIDS, education[216] and food security are referred to briefly, but the strategy is not explicit about how HIV and AIDS will be addressed in the work of other sectors such as livelihoods, health, social development or governance.

10.8 Review of *Taking Action* and interviews conducted for this evaluation highlighted views on issues that could be more fully covered in the strategy[217]:

- **Responding beyond the health sector** – Although *Taking Action* emphasises the importance of a strong multisectoral response to HIV and AIDS and commits DFID to comprehensive and integrated responses that address the development causes and consequences of the epidemic, the strategy does

[216] In the context of universal primary education

[217] However, if *Taking Action* is to be truly strategic, it may need to choose certain areas to prioritise and other areas to leave to others – please see Table 19, p139.

not clearly describe how this will be done. There are some concerns that *Taking Action* and this evaluation are too health-focused[218].

- **UK contribution to greater alignment and harmonisation of international response to HIV and AIDS** – although the UK has contributed strongly to improving the international response to HIV and AIDS (see from section 3.19, p15), this has mostly focused on the contribution of others, particularly multilateral agencies. There has been less focus on the extent to which UK agencies, e.g. DFID, have introduced incentives and made changes to their systems and communications to promote harmonisation and alignment[219,220].

- **Supply security** – Although supply shortages threaten progress in HIV prevention (UNFPA, 2005), there is no explicit commitment in *Taking Action* to HIV and SRH supply security. In 2005, the UK and the Netherlands commissioned a series of studies (Druce, 2006) and DFID is

Box 28 Critical Shortages of Human Resources for Health Threaten Ability to Scale-up AIDS Responses in Many Countries

In **Zimbabwe**, although data is patchy, there is strong evidence that shortages of health personnel are extremely significant. Causes are multiple and include the poor macroeconomic environment, low salaries and high rates of illness and death as a result of AIDS. This crisis is having severe effects on the health sector. For example, plans to scale up the provision of ART require significant external financing if the human resource requirements are to be met. Positive responses have been made by the Zimbabwean Government, including the creation and training of new categories of health worker, such as the primary care nurse. With the recent establishment of a Health Services Board, there are active plans to develop a comprehensive strategy for human resources for health in Zimbabwe.

In **Zambia**, the Ministry of Health has developed a national strategy for addressing the situation of human resources for health, costed at US$313 million over three years. This provides a basis on which donor support can be focused to respond effectively to this crisis. Key steps are likely to include increasing pre-service training, scaling-up of retention schemes and hastening processes of public sector reform.

[218] This was raised in a consultation meeting with the UK Consortium on AIDS and Development about the draft of this final report. Specific sections cited as being too health-focused included 'doing more with less' (from section 8.14, p109); strengthening human resources for health (see Box 28); reference to women on antiretroviral therapy (section 1.6, p3) and the section on research (sections 3.39 - 3.41, p20). However, this final version of the report contains sections with a focus on issues beyond the health sector, including orphans and vulnerable children (section 3.8, p12); civil society (from section 6.40, p70); training for different groups of advisers (section 8.10, p108) and examples from the education sector (see Annex 5, Example 11, pA81). Nevertheless, the criticism is broadly accepted. However, it reflects the focus of *Taking Action* (DFID, 2004a), the terms of reference for this evaluation (DFID, 2005a) and different availability of information from different sectors, e.g. on research.

[219] Issues relating to this topic were discussed at the 9th meeting of the OECD DACWorking Party on Aid Effectiveness and Donor Practices. This included a paper on incentives for alignment and harmonisation prepared by the World Bank and DFID (OECD/DAC, 2007).

[220] Following the UNAIDS PCB meeting in December 2006, DFID country programmes were instructed to only fund joint UN programmes for HIV and AIDS which is seen as an incentive for grater country-level harmonisation and alignment (see section 3.25, p16).

planning to significantly increase its investment in improving supply security.

- **Gender** – *Taking Action* gives high priority to women but has little focus on gender issues, including male roles. A recent evaluation of DFID's gender-related policy and practice (DFID, 2006u) notes a lack of explicit guidelines on how to mainstream gender into HIV/AIDS programmes. Joint efforts are being made by a number of DFID teams[221] to address gender, HIV and AIDS more systematically. In line with commitments in *Taking Action* the GAP team has recently commissioned a review of gender-based violence and HIV.

- **Community engagement** – NGO respondents highlighted limited attention to community responses and issues such as the impact of HIV and AIDS on older people as gaps in *Taking Action*.

- **Palliative care** – Some NGO respondents also highlighted this as a gap in *Taking Action*.

- **Conflict and fragile states** - *Taking Action* does not refer to fragile states. It does commit the UK to support the work of UNAIDS in some countries[222] emerging from conflict but the UK's overall approach to HIV and AIDS in post-conflict states is not clear. Also, there have been developments in this area since *Taking Action* was launched, e.g. the publication of a new DFID White Paper (DFID, 2006c). Box 29 highlights issues related to the post-conflict setting in DRC.

- **Tuberculosis** – In most countries, TB, HIV and AIDS are inter-linked, with TB causing the deaths of many people living with HIV and AIDS. There are also particular concerns over the emergence of extensively drug resistant TB (XDR-TB). However, these issues are not addressed in *Taking Action*.

Box 29 Responding to HIV and AIDS in a Fragile, Post-Conflict State: An Example

The **DRC** country case study concludes that work with the health sector to re-establish basic health care infrastructure is essential to achieving universal access to treatment and care. However, it also finds that this alone is not sufficient. Attention to livelihoods and food security are critical, as are measures to reduce the HIV risk posed by development initiatives in other sectors, such as road rehabilitation. Integrating HIV prevention into activities such as resettlement of refugees and disarmed militias may be as important impacts as work in the health sector. Immediate efforts to improve access to preventive interventions are crucial. These are significant challenges in the absence of infrastructure and a functioning government.

[221] Including the Global AIDS Policy Team, the Reproductive and Child Health Team and the Gender Team

[222] Angola, DRC, Somalia and Sudan

10.9 Issues that are given priority in *Taking Action* but which have received less attention in practice include[223]:

- **HIV prevention and young people** – While *Taking Action* takes a strong position on the importance of a comprehensive approach to prevention and DFID has taken a leading role internationally in advocating for comprehensive approaches, this position is not always reflected in country programming (see Box 30).

Box 30 Approaches to Young People in National Programmes

In **Zimbabwe**, DFID has addressed the needs of young people in a realistic and comprehensive way, providing a counterweight to other agencies that stress a more simplistic 'ABC' approach to behaviour change. However, this has been on a relatively small scale and some NGOs feel this is not being done vigorously enough[224]. In the national response, prevention initiatives for young people have been influenced by particular agendas, e.g. an emphasis on promoting abstinence before marriage.

Similarly, in **Zambia**, the HIV prevention strategy for young people outlined in the National HIV/AIDS/STI/TB Intervention Strategic Plan emphasises sexual abstinence, and the JAPR documents that HIV prevention among young people is now strongly focused on promoting an abstinence-only agenda. Apparent effects of this approach include delayed sexual debut[225] but reduced condom usage at last sex with a non-regular partner[226].

In December 2005, the IDC expressed concern that 'Universal access to HIV/AIDS treatment will only be achieved if treatment programmes are accompanied by scaling up of evidence-based HIV prevention programmes. Given the increasingly moralistic tone of prevention programmes implemented by the US and their preference for bilateral donor relations, DFID has crucial role to play as a leader in the wider global response to HIV/AIDS.'

- **Human rights, stigma and discrimination** – *Taking Action* gives high priority to these issues and makes a commitment to ensure the human rights of marginalised and vulnerable groups are given proper attention, including supporting legislative reform and working with the formal justice sector. A recent audit of stigma and discrimination conducted by the GAP team concludes that, 'DFID has been tackling HIV and AIDS related stigma and discrimination in a variety of ways. However, given its importance in slowing and reversing the epidemic, it is not receiving the level of attention required or that was committed to in the UK's strategy *Taking Action'* (DFID, 2006v).

[223] Also see section 3.2, p8

[224] For example, a leaflet produced by PSI with USAID and DFID endorsement focused on HIV prevention and young people emphasised abstinence particularly strongly under the heading 'sex can wait' (USAID et al., undated)

[225] By 1.5 years for young women and 2.5 years for young men

[226] For example, this declined among young women from 35% in 2003 to 26% in 2005

The Wider Context

Progress and Constraints in Tackling HIV and AIDS

10.10 In 2001, global targets for HIV and AIDS were set for 2005 as part of the UNGASS Declaration of Commitment. Such global targets play an important role in mobilising action and provide a basis for tracking whether commitments made have been honoured. *Taking Action* committed the UK to continue to work towards all internationally agreed HIV and AIDS targets. Progress towards a selection of global targets is shown in Table 18[227]. However, global targets also have some limitations[228]. Because of these limitations and particularly its commitment to country-led approaches, the UK has been a strong advocate of national rather than international targets.

10.11 Despite progress, there is still a significant gap between these targets and the current situation. Prevention and treatment services remain inadequate. Less than 50% of young people have comprehensive knowledge of HIV and AIDS. Only 9% of men who have sex with men and less than 20% of injecting drug users receive HIV prevention services. Only 10 of 24 countries reporting data for sex workers have achieved at least 50% coverage of this population with prevention services. Only 9% of pregnant women are covered by services to prevent HIV infection in infants. Globally, antiretroviral drugs only reach one in five of those who need them, and the treatment needs of vulnerable groups, including sex workers, injecting drugs users, men who have sex with men, refugees and prisoners are poorly addressed (UNAIDS, 2006). Many countries have made patchy progress. Some have expanded access to treatment but made little progress in scaling up prevention programmes, while others have succeeded in prevention but made fewer gains in making treatment available.

Table 18. Progress towards Global Targets for HIV and AIDS in 2005

Global Targets 2005	Global Results 2005	Comment
Total annual expenditure: US$7-10 billion	US$7.5-8.5 billion (estimated range)	Global target achieved
Percentage of youth aged 15-24 who correctly identify ways of preventing HIV transmission and reject major misconceptions about HIV transmission: 90%	Male: 33% (country range 7-50%) Female: 20% (country range 8-44%)	No country achieved this
Percentage of HIV-positive pregnant women receiving antiretroviral prophylaxis: 80% coverage	9% (country range 1-59% coverage)	No country achieved this
Percentage of people with advanced HIV infection receiving antiretroviral therapy: 50% coverage; 3 million people on treatment	20% (country range 1-100% coverage) 1.3 million people on treatment	21 countries achieved 50% coverage target; global target for number of people on treatment not achieved. All PSA countries apart from Sudan have data on this indicator. Of those, all but Nepal have

[227] Data source for this table and most of the information in sections 10.10 to 10.13 is UNAIDS, 2006

[228] For example, the absence of baseline information against which to measure overall progress in reducing HIV prevalence

Global Targets 2005	Global Results 2005	Comment
		comparative data for 2003 and 2005. In all of them, except Pakistan, provision of ART has increased. In some cases, Kenya, Lesotho, Malawi, Rwanda, South Africa, Uganda, Zambia, Cambodia, China, Indonesia and Vietnam, this increase is very considerable. Nine PSA countries have more women on ART than might be expected[229], while six have less[230]. All PSA countries have fewer children on ART than might be expected. There are particular concerns over the lack of data on ART access for the most vulnerable populations.
Percentage of young males and females aged 15-24 who are HIV infected: 25% reduction in most affected countries	Males: 1.4%[231]; Females: 3.8%[232]; No comparable data on this age cohort is available from 2001. Progress towards target can only be measured in individual countries	6 of the most affected countries achieved this. In particular, HIV prevalence rates among 15-24 year olds have declined in four African PSA countries[233], remained static in eight[234] and increased in three[235,236].
Estimated percentage of infants born to HIV-infected mothers who are infected in 2005: 20% reduction	26% of infants born to HIV-infected mothers were also infected; In 2001, approximately 30% of infants were infected. There has been an estimated 10% reduction in HIV transmission between 2001 and 2005	11 of the most affected countries achieved this

10.12 The main challenges to achieving the Millennium Development Goal for HIV and AIDS, the six UNGASS targets and national HIV and AIDS objectives have been identified as: financing; implementation; co-ordination; technical capacity and infrastructure; leadership; social barriers; and the involvement of people living with HIV and AIDS (UNAIDS, 2005b). Specific constraints identified more recently include (UNAIDS, 2006):

- HIV prevention – diminishing support for prevention in some regions; inadequate supplies of condoms; untreated STI and poor coordination of STI and HIV services.
- Care, support and treatment – out-of-pocket costs to patients; concentration of treatment sites in urban areas; high cost of second-line

[229] Malawi, Nigeria, Rwanda, South Africa, Tanzania, Zambia, Zimbabwe, Cambodia, China

[230] Ethiopia, Ghana, Kenya, Uganda, India, Vietnam

[231] Measure of uncertainty 1.1-1.8%

[232] Measure of uncertainty 3-4.7%

[233] Ethiopia, Kenya, Rwanda and Zimbabwe

[234] Ghana, Lesotho, Malawi, Nigeria, Sierra Leone, Tanzania, Uganda and Zambia

[235] Mozambique, South Africa and Sudan

[236] Insufficient data in DRC

antiretroviral drugs; inadequate coverage of HIV testing services; stigma; shortages of human resources for health; weak supply management; and lack of integration of HIV care with other health services.

- Human rights – lack of, or failure to enforce, laws and regulations protecting people living with HIV from discrimination; policies and laws that prevent access to prevention and treatment services e.g. laws prohibiting access to condoms and needles for prisoners or criminalising sex between men.

10.13 UNAIDS recommends the following to ensure that countries can deliver the promises made in 2001:

- Sustain and increase commitment and leadership
- Sustain and increase financing
- Aggressively address AIDS-related stigma and discrimination
- Strengthen HIV prevention
- Build treatment access
- Strengthen human resources and systems
- Ensure available and affordable products for HIV prevention and treatment
- Invest in research and development for drugs, microbicides and vaccines
- Counter the impact of AIDS

Developments since 2004

10.14 Key developments since *Taking Action* was launched include:

- **Increased funding** – including commitments to double development aid made by the G8 and EU in 2005 and increased financing for HIV and AIDS through PEPFAR and the Global Fund.
- **Changes in the aid environment** – including the Paris Declaration on Aid Effectiveness in March 2005[237], which commits DFID and other donors to reform the way in which aid is delivered, with a focus on country ownership, harmonisation, alignment, results and mutual accountability (High Level Forum, 2005); the increased focus on UN reform; the emergence of new development partners such as the Bill and Melinda Gates and Clinton Foundations; and the launch of new aid instruments, such as UNITAID.
- **New policies and agendas** – including the launch in 2006 of the UK Government's White Paper (DFID, 2006e) and the endorsement in 2005 by the G8 industrialised countries, the UN World Summit and the African Union of the 'universal access' goal.
- **Developments in the epidemic** (see Box 31, p137) – including growing diversity between and within regions (Moses et al., 2006); increasing feminisation of the epidemic[238]; growing recognition of the need to expand access to paediatric treatment (UNICEF, 2006; WHO, 2006; Clinton Foundation, 2006) and evidence from two major trials of the protective effect of male circumcision in relation to HIV transmission among men (NIAID, 2006).

Priority Issues

10.15 Documents that have explored future scenarios and emerging issues (Barnett, 2004; UNAIDS, 2005c; UNAIDS, 2006) indicate that the following are likely to be priority issues in the next few years:

- **Sustaining momentum[239]** – including ensuring the donor community meets existing commitments, in face of the likely risk of 'AIDS fatigue' as attention focuses on other issues, such as climate change.
- **Increasing financing** – including providing long-term and sustainable funding, meeting the funding gap (see section 3.5, p10), and providing the additional financing required to meet the 'universal access' goal.
- **Strengthening health and social systems** – including addressing human resource shortages, especially in sub-Saharan Africa (see Box 28, p130), supporting the role of non-state actors in service delivery, and strengthening social safety nets for affected communities and families.

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[237] Following up on the Rome declaration

[238] Women between 15-24 account for 60% of people with HIV and AIDS in Sub Saharan Africa. Young women aged 15-24 years in this region are three times more likely to be HIV positive than young men (UNAIDS, 2006)

[239] These headings are used as the structure for Table 19, p139.

- **Working in fragile and post-conflict states** – including the need for effective HIV/AIDS programming in these challenging settings, which have one sixth of the total population in developing countries but account for a third of those living with HIV in the developing world (DFID, 2006d)
- **Addressing prevention and treatment challenges** – including identifying effective approaches to behaviour change, ensuring evidence-based prevention programming, increasing resistance to first-line antiretroviral drugs and need for more expensive second- and third-line treatment, and implications of the spread of extensively drug resistant TB (XDR-TB) (UNAIDS and WHO, 2006)
- **Tackling underlying causes** – including effective efforts to improve the status of women and girls, address stigma and discrimination and protect the rights of vulnerable and marginalised population groups.

Box 31 Snapshot of the HIV and AIDS Epidemic

Based on the 2006 Epidemic Update (UNAIDS and WHO, 2006):

- 39.5m people were living with HIV in 2006. Of these, 37.2m were adults and 2.3m children under 15
- 4.3m adults and children were newly infected with HIV in 2006
- The most striking increases in the number of people living with HIV have occurred in East Asia, Eastern Europe and Central Asia
- In sub-Saharan Africa, the epidemic is highly diverse – e.g. HIV prevalence has declined in Zimbabwe, Kenya and urban Burkina Faso but the epidemic continues to grow in Mozambique, South Africa and Swaziland
- Women are disproportionately affected. For every 10 men there are 14 women living with HIV
- In Asia, there is evidence of HIV outbreaks among MSM in Cambodia, China, India, Nepal, Pakistan, Thailand and Vietnam; India, which has more than two-thirds of people in the region living with HIV, has a highly diverse series of epidemics
- In Eastern Europe, injecting drug users represent two-thirds of people infected with HIV. Most people living with HIV in the region are in Russia and Ukraine
- In Latin America, the largest epidemics are in the countries with the largest populations, such as Brazil and Mexico. Unprotected sex between men is a central feature of epidemics in most Latin American countries
- The Caribbean remains the second-most affected region in the world, despite a decrease in infection levels in the Bahamas and urban Haiti and stabilisation in Barbados and the Dominican Republic
- In Oceania, Papua New Guinea is experiencing a rapidly increasing and serious epidemic
- In the Middle East, Sudan accounts for 80% of people living with HIV in the region

Taking Action in the Context of Current and Future Priorities

10.16 There are many competing priorities clamouring for the UK's attention in regard to HIV and AIDS. Factors to consider when making choices include areas where the UK has had success to date (see Table 19, p139), major gaps in the international response and the UK's comparative advantage in different areas (see Box 32). Table 19 (p139) and the conclusions of the health zero based review (see Box 33) identify where the UK might focus its efforts until 2008, and in its subsequent HIV and AIDS strategy. It also highlights issues that could be left to other agencies. Recommendations are presented in the Executive Summary (pxxi) and further issues to consider in Chapter 14 (p179).

Box 32 Areas of UK Comparative Advantage in Responding to HIV and AIDS

Areas in which the UK has a proven comparative advantage in responding to HIV and AIDS include:

- Policy dialogue and exerting influence
- International and national leadership and experience on issues relating to Paris Declaration on Aid Effectiveness, including harmonisation
- Willingness to take a stand on and tackle contentious issues
- Support for sexual and reproductive health and rights
- Innovative approaches
- Flexibility and responsiveness to national priorities
- Informed and high quality sectoral engagement and technical assistance
- Capacity to strengthen the evidence base

The most valued characteristic of DFID support in **Zimbabwe** is its flexibility. DFID staff are seen as constructive and willing to communicate openly on a range of issues. DFID has supported contentious issues, such as humanitarian aid to those affected by Operation Murambatsvina. In **DRC**, while its financial contribution is relatively small compared to those of others, DFID's flexibility, ability to respond to urgent needs and willingness to provide multi-year funding are valued. The UK has a stronger commitment to harmonisation than many other donors and can play an important role in DRC and other post-conflict settings where governments are weak and donor collaboration is critical.

Box 33 Health Zero Based Review (DFID, 2006d)

The DFID Zero Based Review: Health Case Study highlights the need for health systems that can ensure a regular supply of drugs, an efficient network of facilities and laboratories and well-qualified staff to achieve the health MDGs and provision of HIV treatment. It states the need to increase funding to meet the recurrent costs of recruiting, training and retaining health workers; expanding and maintaining physical infrastructure; improving drug procurement and distribution systems; and building core management skills at central and peripheral levels.

Table 19. Areas where UK has Had Most Success in Responding to HIV and AIDS in the Past and Suggested Future Priorities

Issue[240]	Comments
Sustaining momentum:	
Relevance to middle-income countries★	*Taking Action* emphasises tackling HIV and AIDS in the developing world. It also highlights the importance of epidemics in middle-income countries, where HIV and AIDS is largely concentrated in vulnerable and marginalised groups such as injecting drug users and sex workers. Decisions to close DFID offices in countries including Russia, Ukraine and China have implications for how the UK and DFID will continue to support efforts to tackle HIV and AIDS in these contexts and how DFID's significant achievements in areas such as harm reduction will be sustained. The stated strategy is to encourage multilaterals to address the HIV and AIDS epidemics in middle-income countries more effectively. Country case studies in Russia and China raised questions about how effectively these agencies can address the needs of vulnerable and marginalised groups or encourage governments to do so, and the extent to which they will continue to support innovative work by civil society organisations. Any future strategy should consider the potential contributions that could be made by NGOs, networks, foundations and, in Eastern Europe specifically, the EC and how DFID can support and monitor the effectiveness of these contributions. The role of the FCO in countries where DFID does not have a presence also needs to be considered.
Commitment and leadership★	The UK should continue its active role in promoting international commitment and strong national leadership.
Increasing financing:	
Meeting the funding gap★	The UK needs a clear position with regard to its role in addressing the funding gap for meeting 'universal access' goals and more specifically in financing drugs to sustain and expand treatment.
Long-term, predictable funding★	The UK should continue its leadership on long-term, predictable financing.
Strengthening health and social systems:	
Security of supplies★	Commitment from DFID and others will be crucial to ensure growing emphasis on new technologies is not at the expense of existing interventions. The UK should take forward plans to increase investment in SRH supplies.
SRH (including STI) and HIV linkages★	The UK should continue existing efforts to strengthen SRH and HIV linkages. Areas of focus could include PMTCT and improved SRH for HIV positive women; improved HIV prevention in pregnancy; linking of HIV and SRH supply management and reproductive health rights of PLWHA and members of vulnerable populations.
Human resources for health★	The UK should build on lessons learned to date in supporting national governments to address critical shortages of healthcare professionals.
Supply management	The UK could leave this to other agencies that focus on logistics and supply chain issues such as the US Government, UNFPA and UNICEF, which is the lead agency on this issue under the UNAIDS cosponsor division of labour.
Service delivery by non-state actors★	DFID should continue its support for civil society partners to play this role.
Social safety nets★	DFID should continue to focus on social protection for affected communities and families, including the elderly and vulnerable children, through social transfers and safety nets programming.

[240] Priorities for the UK and DFID are marked ★

Issue[240]	Comments
Community responses	DFID should continue its support for civil society partners to play this role.
Strengthening systems in fragile states★	Better evidence concerning effective approaches to working in post-conflict settings is required. The role that conflict plays in HIV needs to be better understood and planned for in any future HIV and AIDS strategy if DFID continues to expand its support to post-conflict countries. DFID is developing a conflict policy and this represents an opportunity to ensure that HIV and AIDS is considered as well as to inform future HIV and AIDS strategy and ensure greater internal policy coherence. Support to ensure that fragile states can access available resources also needs to be addressed. Fragile states, such as DRC and Sudan, where there is less in-country capacity to put together proposals, though individual grants perform as well as grants in other states, have a higher failure rate for proposals, which leads to low levels of additional funding and unbalanced portfolios.
Addressing prevention and treatment challenges:	
Evidence base for comprehensive approaches to prevention★	DFID should concentrate on contributing to the evidence base. Technical agencies such as UNAIDS, WHO and UNFPA should be encouraged to produce guidance on effective approaches to prevention in the context of increasing access to treatment and growing numbers of sero-discordant couples, and on preparing for access to new prevention methods as these become available.
Treatment access★	This should include: consideration of DFID's role in countries that are not Global Fund or PEPFAR recipients; ensuring that the needs of vulnerable and marginalised groups are not neglected in the drive to 'universal access' and supporting alternative models of service delivery in contexts where such groups are unlikely to be reached by public sector services. DFID could leave leadership on paediatric treatment to other organisations focusing on this issue, such as UNICEF, MSF and the Clinton Foundation.
Palliative care	A forthcoming review of HIV, AIDS and palliative care (HLSP, 2007) is likely to recommend that DFID focus its attention on a number of areas including working with other agencies to ensure that palliative care is recognised in the broad continuum of prevention, treatment and care; and supporting improved access at country level to medicines needed to manage pain, other symptoms and opportunistic infections. In particular, this may include policy dialogue on over-restrictive laws on opioids for pain relief and drug substitution therapy.
Drug resistance	Action to address technical challenges such as drug resistance should be left to agencies such as the WHO.
Drug pricing and second-line treatment★	The UK should continue to focus efforts on strengthening the capacity of developing country governments to engage on TRIPS issues and on global efforts to address variations in the prices of antiretroviral drugs, in line with recommendations of the IDC in December 2005 (IDC, 2005) that DFID should work to expand the capacity of developing countries to utilise flexibilities in the TRIPS agreement to gain access to affordable medicines, and of the Public Accounts Committee report on DFID 2005.
Tackling underlying causes:	
Gender★	DFID should build on its experience and comparative advantage in gender work. More emphasis could be given to support civil society partners to identify effective approaches to working with men and boys and to address women's legal and property rights and the underlying causes of gender inequalities.
Stigma and discrimination★	The UK should focus on policy dialogue and support for civil society partners.
Rights of vulnerable and marginalised groups★	The UK should focus on policy dialogue and support for civil society partners.