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Funding the fight to end the AIDS epidemic: instructions from a time of austerity

Introduction

The AIDS movement currently finds itself in the throes of an unconscionable paradox. Global funding for HIV has stagnated at the very time when we are experiencing transformative developments in science that hold the potential to reverse the epidemic.

Several donors have now substantially decreased their funding to AIDS programmes, with limited or no political consequences in their home countries but with devastating impact in countries where most people are living with HIV and AIDS. These cuts have taken place against the backdrop of unprecedented developments in the science of HIV treatment, care and prevention.

We can begin to end AIDS, but countries must focus harder on the interventions we know to work. These include earlier access to HIV treatment for clinical and prevention benefit; prevention of vertical transmission to newborns; voluntary medical male circumcision; harm reduction; targeted behavioural interventions; and broader access to condoms.

| So why is funding for AIDS programmes on the wane?

As austerity measures have swept across Europe, the European Union has held fast to its requirement that member states produce balanced budgets. Consequently, a number of development budgets have been significantly reduced and HIV funds





have been flatlined since 2008. In the United States (US), funding cuts have dogged the bilateral AIDS programme, threatening major gains in expansion of treatment coverage. Governments typically beg political sentiment as the reason for their cuts. Yet recent surveys of Americans show that while general foreign aid expansion is not supported, foreign aid to tackle diseases generates greater support.

These decisions by developed countries to diminish or flat fund HIV investments have triggered some criticism and protest among a small number of activists. But the power of civil society to help reverse these trends is not yet strong enough. Meanwhile, the stakes could not be higher. These funding decisions have literally life and death consequences for communities most affected by HIV in places where resources are needed the most.

This essay looks at what might have happened in the last few years if civil society capacity for highly effective campaigning – including the confrontational tactics sometimes required to carry the message directly to distracted and antagonistic decision-makers – had actually been put to use in key countries. Would funding levels have been pushed up to ensure that the scientific advancements had a chance to work at scale? Would the political commitment of donor governments to truly ending the AIDS response be different today if activists had been able to anticipate and mobilise to counteract the current crisis?

These questions are critical for civil society groups as they face a post-Millennium Development Goal funding landscape that could further shrink the pot of resources.

They are also vital for the growing number of foundations and non-profit actors that exist outside the traditional donor world, who are investigating possible high-impact investments. And leveraging state resources better, especially in high-burden middle-income countries such as South Africa, India and Brazil, requires that civil society groups be supported, nurtured and strengthened through sufficient funding.

First we won in the streets: confrontational tactics in the 1990s

Starting in 1999, with activism by a new social movement populated by HIV, health, human rights and social justice activists in the global South and North, AIDS advocacy began to generate victories the world had thought were impossible. Treatment activists pushed for bigger budgets, compelling the world's richest nations to spend billions in additional funding to provide lifetime HIV treatment and prevention to millions around the world. They also provoked the development of new and lasting global health initiatives, including the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) and UNITAID.

Because of their advocacy, AIDS programmes saw a decade of substantial annual funding increases in donor and domestic budgets. Throughout the early 2000s, civil society's advocacy was consequential in determining the levels of funding committed by donor governments, as well as through national health and disease programmes.

While rich countries had resources, they also had multiple priorities. They were patently disinterested in funding treatment programmes for poor people in developing countries who were suffering from a largely sexually transmitted infection. Many governments were even less supportive of financing programmes aimed at men who have sex with men, people who inject drugs, prisoners, migrants and other populations vulnerable





to HIV infection. Significant coordinated pressure from activists around the world was needed to ensure that funding was made available to avoid needless deaths.

Long-term financial commitments were made in the early years of the new millennium because activists fought hard-won political battles for these resources. The cases of the Treatment Action Campaign in South Africa, who forced a belligerent government to accede to their demands and in the process forced donor agencies to begin to resource advocacy and activism, is but one example. The Indian Lawyers Collective, and their sterling work on bringing down the cost of drugs by using legal strategies and exploiting the loopholes in TRIPS, is another. At the global level, alongside others, activist groups from rich countries fought for better and bolder funding for activist groups from the board of the Global Fund. In lesser-known but still important battles, activists insisted that programmes promoting condom use, targeting young people and working on gender equality were supported financially as part a broad understanding of what it would take to 'end' AIDS.

In essence, activists throughout the 1990s made sure that the price of donor inaction was simply too high to ignore.

But funding programmes about issues that mattered was not the only terrain of battle.

One of the most effective strategies of activists in the 1990s and 2000s was the strong focus on scientific enquiry. Early activism in the 1980s focused on the importance of people living with AIDS understanding the virus and the effects it had on their bodies. In the 1990s activists built on this, insisting that research money and resources be allocated to 'finding a cure'. The global vaccine movement was lobbied; drug companies were persuaded to dedicate research and development funds; and global foundations began to make large grants aimed at science. A decade into the new millennium, these investments began to pay off.

Then we won in the lab: AIDS activism leads to scientific breakthroughs

In 2011, a randomised controlled clinical trial showed that when HIV-positive people had earlier access to HIV treatment, they were 96% less likely to transmit HIV to a negative sex partner. The compelling preventive benefit associated with viral suppression, along with the clinical impact of earlier treatment, was further affirmed in cost-effectiveness studies, with models in South Africa showing that earlier treatment initiation could be cost-saving in as few as five years.

In 2013, after a protracted process, the World Health Organization (WHO) released updated HIV treatment guidelines recommending a change in clinical eligibility to CD4 <500 from CD4 <350, based on the clinical as well as preventive benefit of treatment, along with initiation regardless of CD4 count for serodiscordant couples, children under five years old, pregnant women, and people co-infected with tuberculosis. WHO also recommended incorporating routine viral load monitoring into treatment programmes to increase the clinical and preventive impact of antiretroviral treatment.

At the 2012 International AIDS Conference in Washington, leading HIV researchers told the media that the evidence on treatment as prevention was decisive, and that implications for policy decisions should be "as decisive as the scientific evidence".

The modeling data argue that countries equipped to scale up aggressively now are much more likely to get ahead of new infections, while countries that continue





scale up at the same or a slower pace will remain on an unsustainable pathway, constantly playing catch up, with some falling behind.

The gains won in the streets in the 1990s, and followed up by wins in the labs in the 2000s, were both dramatic and important. But they cannot be converted into a lasting reversal of the epidemic without money. Despite important reductions in incidence among most of the highest burden countries, many countries, particularly in Eastern Europe and Central Asia, are facing rising rates of new infection alongside extremely low treatment coverage among sex workers, people who use drugs, men who have sex with men, and transgender women. These marginalised, excluded and criminalised populations require precisely the human rights- and evidence-based approaches to prevention and treatment that governments have too often refused to adopt, and they need the resources to roll those programmes out.

The game-changing benefits of earlier initiation with improved regimens have been proven. But countries have been largely unable to implement these guidelines due to flatlined or shrinking budgets. In December 2013, for example, Zimbabwe and Uganda adopted the new guidelines in their national programmes, widening their treatment gap substantially. To match the commitments made by these governments, an infusion of resources was needed to bridge the widening treatment and prevention gaps. Furthermore, crucial resources were required to support advocacy for treatment as prevention among key policymakers.

Two years later, relatively little has changed despite the science. Tragically, HIV programme managers in many high-burden countries are debating whether to expand medical male circumcision programmes or to expand adult and paediatric treatment or to expand programmes to eliminate vertical transmission or to scale up prevention and treatment for key populations such as sex workers or men who have sex with men. They are rationing services at a time when the evidence in favour of aggressive scale up on all fronts could not be more compelling.

The risk civil society faces on entering the third decade of the AIDS crisis is that we miss the opportunity to surge forward with bold scale up of proven interventions in the highest-burden communities and actually end the AIDS epidemic. The financial downturn, combined with lack of political will among many donors and insufficient investment in the kinds of nimble and fast-moving civil society advocacy needed to challenge the received wisdom that budget expansion could not be possible in a time of austerity, have created a perfect storm.

Then they pushed back: investment talk not matched by action

In the aftermath of the gains of the 1990s and 2000s, donors and governments that had lost a number of battles with activists began to push back in a more forceful and concerted manner. For many years, activists had urged institutional actors to focus on scaling up investments for populations most at risk of HIV infection and facing chronic gaps in treatment coverage, and to address the structural drivers of the AIDS epidemic. They pushed for interventions focused on the most difficult issues, and insisted on ambition and boldness in planning. These were precisely the types of approaches that countries with the resources to invest had stubbornly resisted.

Beginning in 2008, the assault on human rights, AIDS funding increases and, indeed, AIDS activism began to take more focused shape. One manifestation of this is that those who continue to push for bigger budgets and bolder programmes to enrol greater numbers of people are accused of not understanding the economic





constraints that donors now face.

Yet it is clear that the global recession was not the sole, or even the primary, reason for the shrinking of AIDS budgets that began in 2008. While it may be appealing to believe that fiscal externalities are to blame, the decline in funding has deeper political roots. A powerful, well-organised and strategic civil society is needed precisely because, thus far, the diagnosis of the funding problem has been superficial. Without activist intervention at the level of analysis, the solutions for the funding crisis we now face will not be forthcoming, and a range of interventions and people will continue to be sidelined.

One of the most interesting and pernicious ways in which donors have pushed back against activists' gains is at the level of rhetoric.

A compelling example of rhetorical gamesmanship (and there are many) is evident in the language of 'investing' that has characterised AIDS policy discussions since 2010.

International agencies, led by the Joint United Nations Programme on HIV/AIDS (UNAIDS), have argued forcefully since 2010 for donors and implementing countries to consider a response to HIV modeled on a strategic investment framework. The value proposition in this investment approach is that increased and sustained impact can be achieved as a result of additional funding for key prevention and treatment interventions. The idea is that big investments now pay off far into the future. If an increase in funding commitments for high-impact intervention is allocated now, the need for continual funding – the perpetual financing cycle that donors fear – is thus diminished.

By 2008, the analysis generated by technical agencies through modeling, clinical trial outcomes and operational findings from HIV programmes in high-burden countries was aligning to indicate strongly that a surge in high-impact prevention and treatment would mean the world had a fighting chance at 'bending the curves' of the epidemic – the curves of new infections, of disease progression and mortality, and, ultimately, of costs. Coincidentally, this new information was emerging precisely when the financial crisis began to be felt.

One might be forgiven for thinking that the donor response to the evidence outlined above would be to make strong arguments for further funding. The idea of protecting existing gains and bending the epidemic's curves even further would make rational sense. Instead, donor resistance to genuinely investing in ambitious AIDS programmes ratcheted up. Around 2009, in order to justify odious funding decisions, donors began tactically deploying a range of concepts that civil society organisations were not always ready to challenge.

In principle, donors accepted the findings. Yet they did nothing to act. Knowledge of the facts did not trigger the intellectually honest (albeit sometimes ruthless) response that is second nature in the world of investors: when a compelling value proposition is made, investors mobilise the additional capital needed in order to make long-term profits. The donor governments responsible for funding the AIDS response failed to heed sound advice.

But donors were not the only problem. In the countries most affected by the epidemic, national governments stubbornly – and some would say hypocritically – did not (and still have not) change course to push bolder agendas and urge donors to act. In fact, in some cases, additional barriers to scale up have been promoted by the governments of poor countries.





These barriers include the passage of draconian new laws that further criminalise not only sex between lesbian, gay, bisexual and transgender people (LGBT) but also public health and advocacy efforts to reach LGBT communities with prevention, treatment and other life-saving services. Such efforts, for example, under Uganda's new Anti-Homosexuality Act, could be considered "promoting" homosexuality or "aiding and abetting" homosexuality, punishable by seven years' imprisonment, hefty fines and de-registration of organisations found guilty.

The refusal to base programmes on evidence in some countries has been compounded by donor stasis. The intensified resistance by donors to committing funding for middle-income countries, and sluggish or non-existent increases in funding for evidence-based HIV interventions by middle-income country governments themselves, are creating a perfect storm for increases in incidence in countries that have a real chance of putting the epidemic behind them.

Were we too slow to react? Rhetorical traps and distractions

As indicated above, donor and government insistence on using the language of investment (even as they divested) was not the only arena of rhetorical battle. The terms 'efficiency' and 'country ownership' began to surface more frequently. So too did the idea that it was time to make 'a shift from emergency to sustainability'. Devoid of political context, these are each highly desirable features of any HIV programme, whether in the developing or developed world.

Yet after the financial crisis hit, these concepts were too often used by politicians as excuses not to fund AIDS programmes, even in the face of facts that indicated that substantial increases in short-to-medium investments would have long-term benefits. Often, this language was introduced to reinforce refusals by funders to keep funding promises or to soften the ground for announcements of budget cuts in the near future.

Why? In many respects, policymakers and donors saw AIDS programmes as soft targets. The success of activists in raising the issues and insisting on larger budgets made it seem to some in donor countries as if there were more funding available to fight AIDS than was actually needed. Those involved in AIDS activism, as well as donor agencies themselves, understood that this had never been the case. Despite this fact, the combination of new language designed to promote 'efficiency' and new tactics to promote a perception that there was a large amount of money supporting programmes (often at the expense of other diseases and development problems) caught some civil society organisations by surprise.

In many cases, whether at national, regional or global level, civil society groups were not adequately prepared or supported to react quickly and interrogate this new approach, critiquing it directly and rapidly. For example, civil society did not – as it should have – reject 'country ownership' as a concept that was being used disingenuously as a justification for stopping a funding relationship with a country, whether or not the government had agreed to take on those programmes, or was administratively or fiscally ready to fully take them on in the timeframes proposed by donor nations.

We also did not push back hard enough on the idea of 'efficiency' when this was used as an excuse to focus on relatively minor administrative challenges in order to scale back pre-existing budget commitments to global institutions such as the Global Fund.

Addressing this language was often further complicated when actual cases of corruption and inefficiency arose in programmes funded by the Global Fund,





PEPFAR or other bilateral donors. Underpinned by a political agenda that was driven by reducing funding for AIDS rather than ending AIDS, the idea of 'shifting from emergency to sustainability' did not result in a set of benign actions aimed at responsibly taking on new programme areas and increasing the capacity of health systems to roll out to broader populations. Instead, 'shifting from emergency to sustainability' resulted in a cascade of actions aimed at de-prioritising the HIV response and undermining innovative, high-impact financing approaches such as those created by the Global Fund.

The work and findings of the Global Fund's High Level Independent Review Panel provide an important example. The High Level Panel was established when high-profile corruption cases triggered a wave of distorting media coverage targeting the Global Fund in 2011. It was specifically set up after harsh donor criticism resulted in the withholding of several Global Fund contributions, and so it was ostensibly meant to review the Global Fund's fiduciary controls and oversight. It should have looked at a narrow set of governance and audit questions, but its members leveraged the environment of crisis and extended its work far beyond that mandate. Ultimately, they developed a strong set of arguments promoting the idea that the three diseases were no longer 'emergencies', and that it was time to abandon core tenets of the Global Fund's approach, such as allowing countries themselves to request funding based on what they actually needed rather than on what donors agreed to provide.

These conclusions should have been roundly criticised or rejected by civil society when they were published. As a sector, civil society did not have the capacity – the time, funding or human resources – to anticipate and curtail the way the conclusions of the High Level Panel would be framed and manipulated.

| In short, civil society was outflanked.

The audacity of hope: confronting the new Obama administration

Early in the Obama administration there were troubling signals that a bold commitment to HIV treatment scale up would not be a priority for the US president. The constraints brought on by the financial depression that was beginning to grip the US were only part of the story. Initially, President Obama's chief advisors in global health cast aspersions on the cost-effectiveness of HIV treatment – their concerns were technical and political rather than solely financial. It is also true that the president's budget officials balked at the out-year budget obligations created by the US investment in HIV treatment. So on two fronts – funding and technical analysis – the new administration seemed less than keen to keep the commitments that the president's predecessor had made.

There began to be clear signs that the questions being raised by administration officials about PEPFAR in Washington were playing themselves out at the implementing country level. PEPFAR seemed to be retreating from treatment expansion. For example, in Mozambique civil society partners began to report increases in technical support provision and other 'soft' investments at the expense of service delivery rollouts. In Uganda, a US government directive was issued in September 2009 that implementing partners were not to expand treatment coverage to more people unless a patient died or was lost to follow up.

In Washington, these developments were interpreted by some as the inevitable outcome of an administration that lacked the evangelical zeal for HIV treatment scale up that had been touted by President Bush. In response, some organisations





began proactively and tactically reframing their efforts in order to adapt to the new environment. If resources to fight HIV might be diverted to other health issues, they would need to learn the new language and take on new agendas.

Maternal and child health were a priority topic for Obama's team, as well as a legitimate cross-cutting issue. HIV infection is the leading killer of women of reproductive age around the world and thus is a crucial plank in the AIDS response. Likewise, chronic underinvestment in the leading causes of preventable maternal death undermine the impact of the AIDS response, particular in high-burden sub-Saharan African countries. Some organisations that were supported by US government funding sought to fit their AIDS activities into this new frame for cynical and pragmatic rather than programmatic reasons. It was clear to many in AIDS activist circles that maternal and child health were being raised by the new administration largely as an either/or proposition rather than as part of a vision of expanded ambition and service delivery. There were no increases in funding anticipated to accompany the new interest in maternal and child health, nor were there any clear, measurable targets that pushed over and above existing (and largely inherited) PEPFAR targets.

A core group of advocates in Washington and in implementing countries, including South Africa, Uganda and Kenya, decided to fight the shrinking political and financial space that was on display within the new administration. We were aware that it would require a multi-pronged strategy to transform this potential backlash into a commitment by the administration to champion the scale up of high-impact treatment and prevention interventions.

We chose to use tactics that had been successful since the start of the global social movement to win treatment scale up, and had continued to be deployed throughout the period of the financial downturn.

Smart, strategic and high impact activism incorporating a range of tactics, from massive grassroots mobilisation to detailed, evidence-based policy analysis.

Between February and July 2010, the Obama administration was confronted by US criticism (led but by no means solely driven by Health GAP) as well as by pressure from around the world in response to its retreat from funding the fight against global AIDS. We were aware that the International AIDS Conference, which was to be held in Vienna, Austria, presented an important media opportunity to either shame the administration or demonstrate its success.

By the time of the Vienna conference, we had won several important near-term victories. For example, in June 2010 Ambassador Eric Goosby, the coordinator of PEPFAR, announced that Uganda would end its treatment waiting lists and create 36,000 new HIV treatment slots for clinically eligible Ugandans. This followed months of treatment caps, which we documented widely in international media and were also documented by civil society organisations in various countries.

In July protesters marched in the thousands through the International AIDS Conference venue, demanding that President Obama deliver on his pledge to fight global AIDS. They also challenged the rest of the world's leaders to keep their promises to existing AIDS programmes by not hiding behind fiscal austerity.





The attention generated by the Vienna protests served as a wake-up call for senior officials in the US administration. They began taking the consequences of waiting lists for treatment in PEPFAR-funded programmes more seriously. They also started to focus on expanding the pace of scale up even in the absence of budget increases. In other words, within a relatively short space of time, external political pressure had resulted in increased internal pressure to expand PEPFAR. This happened even before there was a financial commitment to back it up.

A year later, by the tenth anniversary of the United Nations General Assembly Special Session on HIV/AIDS, in July 2011, the collective grouping had managed to secure a new global commitment to reaching 15 million people on treatment by 2015. Less than six months later, by World AIDS Day on 1 December of that same year, President Obama announced that he was committing his administration to beginning to end the AIDS epidemic through intensifying scale up of priority interventions, including doubling the number of people being directly supported on treatment with US funding through PEPFAR.

This target was reached, with PEPFAR now investing in treatment for 6.7 million people. However, PEPFAR funding levels remain \$700 million below the funding levels invested at the programme's funding peak in 2010–2011. Many of us are now focused on fighting to reverse funding cuts from recent years in order to ensure that the positive trend in treatment scale up is continued.

This example raises a number of important questions about what might have happened if there had been enough funding for full-scale civil society advocacy campaigns led by strategic coalitions of activists in rich and poor countries. Had there been sufficient capacity in place so that the effort to challenge the Obama administration was taken on by more than a handful of groups and individuals, might the impact have been more far reaching? Had a broader range of civil society groups understood earlier on that the rhetorical shifts in 'ownership' and 'efficiency' were the beginning of a sustained assault on HIV programme ambition, scale and scope, would the cuts have been as deep?

A time for game-changing advocacy to match the game-changing evidence

When activists are at their most effective, they are fearlessly and intelligently confronting the realities of the present day while fighting to win tangible changes that transform those realities – disregarding the comfort and lure of received wisdom.

| At their best, activists are agitating for 'unreasonable' but winnable demands.

Since the start of the financial crisis in 2008, civil society organisations fighting for access to sufficient financing to end the AIDS epidemic have had to demonstrate skill in reacting quickly while defining a bold agenda for change. We haven't always risen to the challenge. In large part, this has been because underinvestment in civil society capacity for high-impact advocacy has left many organisations unprepared to fight back against arguments about fiscal austerity, let alone against ideological uses of otherwise welcome concepts such as 'country ownership', 'efficiency' and 'sustainability'.

In addition, few of us were fully prepared to leverage emerging findings from science. Although we had fought for the research, once it bore fruit we weren't ready to make the political arguments that would ensure that the HIV treatment we had so vociferously demanded in the 1990s would have wide and effective use in clinical and prevention settings.





The professionalisation of civil society advocacy also contributed to the ways in which we were caught flat-footed. Many organisations are unwilling to challenge policymakers with ambitious demands because they rely on them for budgets to implement programmes, as well as for the goodwill necessary to operate in sometimes complex national environments. This is the case for activists in both rich and poor countries.

Another factor was that with the rapid scale up of HIV programmes in the early 2000s, many activists who had previously used confrontational tactics began focusing more on service delivery; for example, through running treatment programmes. Others had been absorbed by global agencies, plucked out of the contexts in which they were most effective and deployed to pursue the institutional mandates of the very agencies that were now coopting the language of 'ownership and sustainability'. With the new battle seeming to be about getting the systems to work, or getting global institutions to work better, activist civil society was discovered to be extremely lean when the funding and political crisis of 2008 hit.

The road ahead, however, will be even more difficult for civil society than the road since the start of the financial crisis. Even more crucial scientific advances that have the potential to further revolutionise the standard of care are in the pipeline. These include improved antiretroviral regimens that are more effective in fighting HIV; important new medications to treat hepatitis C; improved and less expensive viral load monitoring at the point of care; and improved tools to diagnose drug-resistant tuberculosis.

Just as treatment activists insisted on learning the science of HIV in order to push for better treatment and to foster political agency among those living with the virus, so the next generation of civil society actors must enter the third decade of the response to HIV with a commitment to agitating for rapid uptake of this new science in the highest-burden communities.

Rather than accepting the argument that poor countries and marginalised groups must be the last in line to benefit from scientific innovation because of issues of 'sustainability and ownership', activists must raise issues of justice and equity. And, as we now know, they must do so quickly and authoritatively in order to influence the terms of these debates and the funding decisions that flow from them.

Civil society must also expand emerging models of grassroots and community-based 'demand creation' campaigns for new technologies and new programme approaches. Without insisting that the technological dividends of two decades of AIDS activism are unaffordable, civil society doesn't stand a fighting chance of changing the conversation from one of further, more acute rationing to one of truly winning the expanded programme coverage needed to save lives, halt new infections and end the AIDS crisis.

Where will the money come from?

Even if activists win the political arguments, many wonder where the new money will come from. While civil society activism will have some effect, there is also a need to ensure that the mechanisms are in place to sustain giving. In a sense, civil society groups need to push for funding mechanisms that are more resilient to political and 'economic crises', such as that experienced in 2008.

Three promising sources of large and sustained funding need intellectual and practical debate by activists globally. They represent the best hope for ensuring that





never again can resources be used as an excuse to scale back HIV programmes at precisely the moment when they need to be expanded.

First, a 'Robin Hood tax' to end AIDS seeks to levy a very minor tax on financial transactions such as trade in derivatives, stocks, bonds and foreign currency exchange. The proceeds from this tax would then be invested in critical community priorities, such as fighting HIV, tuberculosis and malaria. The tax would work well alongside increased political pressure on developed and developing countries to expand their AIDS funding.

Second, non-voluntary replenishment by countries is sorely needed in the response to infectious diseases such as HIV, or preventable conditions such as maternal mortality, where annual funding needs are relatively easy to predict. For example, the model of the World Bank's replenishment has been successful, despite the financial crisis, in large part because of its non-voluntary nature. The European Development Fund is also increasing its commitments, even to countries that have had concerns about governance issues, during this period of budget reductions in part because their funding must be spent. This demonstrates that the necessary funding can be mobilised to shore up for the lean years.

Third, and perhaps most importantly, no new approaches to mobilising sufficient levels of funding will take shape without substantially increased and predictable funding to civil society to engage in high-impact national, regional and global campaigning to drive up demand creation and government funding to control and ultimately end the pandemic.

Conclusion

Two years after a powerful rallying call to 'end AIDS' emerged at the International AIDS Conference in Washington in 2012, the concept risks being little more than self-serving rhetoric unless donors and governments fund the scale up of evidence-based, high-impact interventions required to defeat the epidemic, at the scale required, with the speed required, and over the long term.

In the last two years, the need for a more honest conversation about how to invest in what works has become acute, even as funding has flatlined or diminished. At the same time, activists have also faced the stark reality of virtually non-existent investment in the strategic, bold, authentic civil society advocacy that is required to push back at funding cuts and to chart new pathways to genuinely end AIDS.

As the funding cuts began in 2008, only a skeleton crew of activist organisations was equipped to respond with both elite 'insider' strategies and grassroots 'outsider' strategies. Only a few organisations and coalitions had the capacity to advocate and negotiate directly with decision-makers in the spaces in which common ground has been forged in recent years, while also ensuring that, if necessary, those same decision-makers could be confronted with the criticism, public pressure and even shame warranted by the high-stakes consequences of their policies.

A stark lesson of this period of flat-funding the AIDS response is that even a minor increase in investment in civil society campaigning, especially aimed at strategic coalitions of activists based in countries with epidemics and their allies in the global North, can force decision-makers to reverse course and even openly champion a political agenda for scaling up the AIDS response and acting on new evidence.





As activists prepare to face the post-Millennium Development Goal world, they are acutely aware that paper commitments to targets mean nothing if they are not backed by budgets. Scaling up, which is what the agreed AIDS targets require, in the face of flat funding will be next to impossible. Priority areas for programme expansion – for key populations, non-health facility-based community support services, strengthening grassroots civil society advocacy, and implementing ever-evolving and improving treatment guidelines – will not be possible with static budgets.

While the prize of reversing AIDS may be closer than ever, the stakes have never been so high.

The costs of inaction far outweigh the costs of genuinely investing in ending AIDS.



BIOGRAPHY

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