The challenge of transnational prevention and treatment advocacy in an era of resource constraints and shifting global priorities

Reflections from South Africa

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Outline

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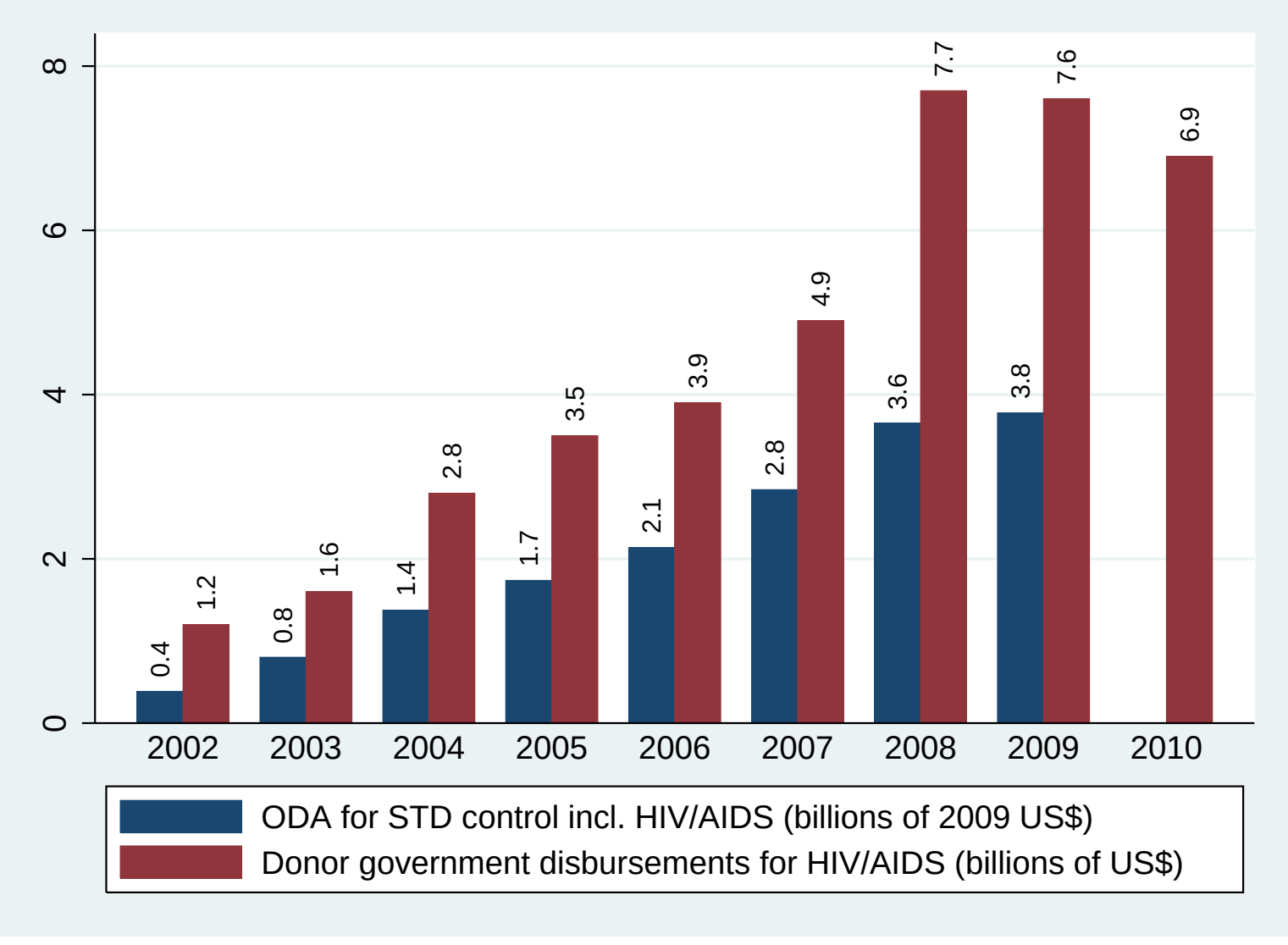
Introductory remarks

Activism born of necessity

The global AIDS activist may be the most impressive example of health activism the world has seen, and deserves substantial credit for the unprecedented international public health response since the 1990s.

- 1980s: LGBT-led activism in North America focused on political inaction and investment in research
- After 1996: transnational movement focused on access to HAART in developing countries
- Global movement drew on generation of gay activists but built new transnational 'networks of influence'
- By most measures, spectacularly successful

International AIDS assistance (2002-2010), US$ bil.



Sources: World Bank, Africa Development Indicators; Kaiser Family Foundation (2011)

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Do we know that activism and advocacy works?

Where would we be without transnational AIDS activism?

Without the pressure and moral force of transnational AIDS activism it is unlikely the broader coalition for a human rights-based approach and treatment access would have coalesced in the late 1990s and 2000s.

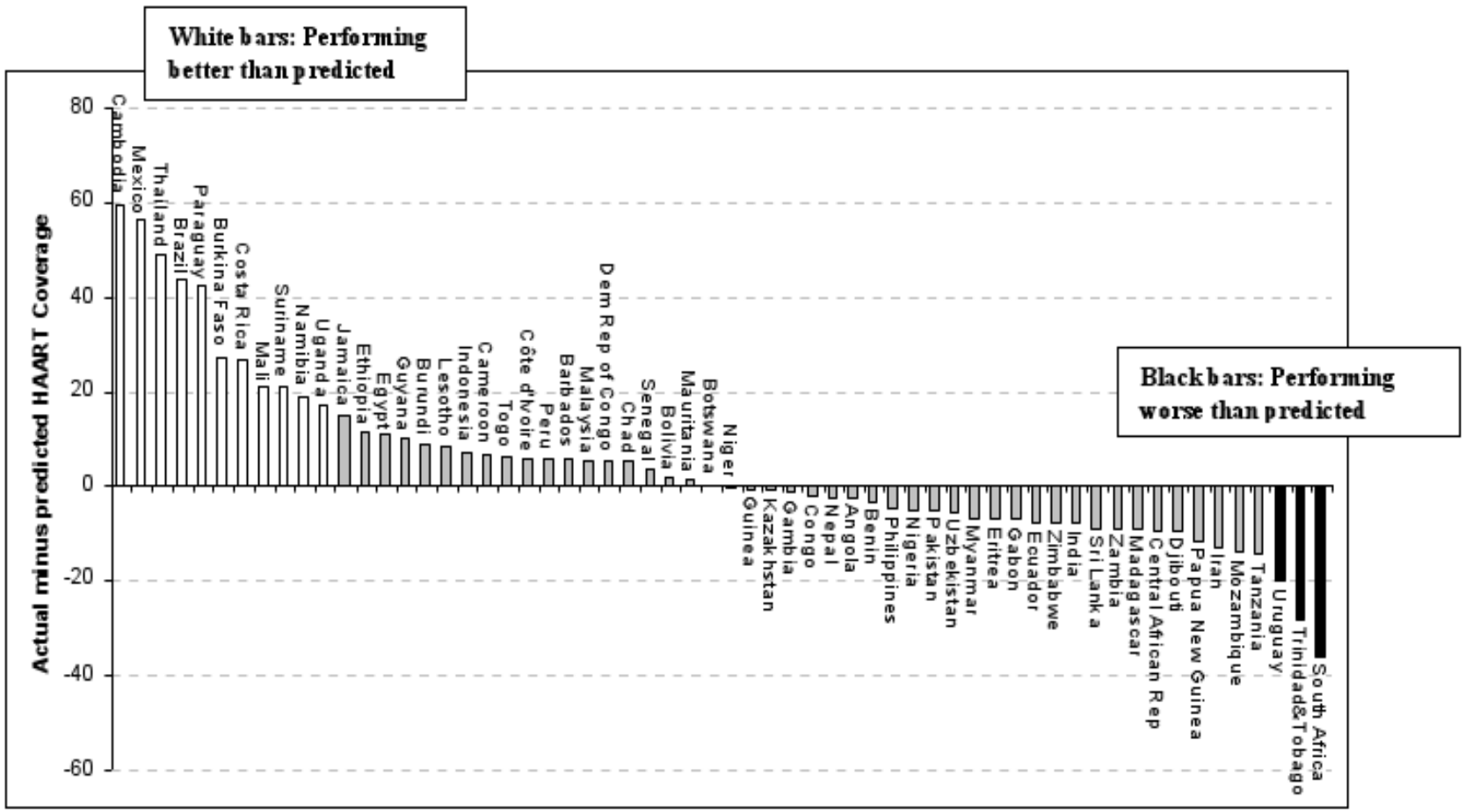
But, the relationship between civil society activism and state/government (and intergovernmental) responses is

- undertheorised and under-studied beyond easy assumptions;
- highly context-dependent;
- subject to both structural conditions and individual agency.

Do we know that activism and advocacy works?

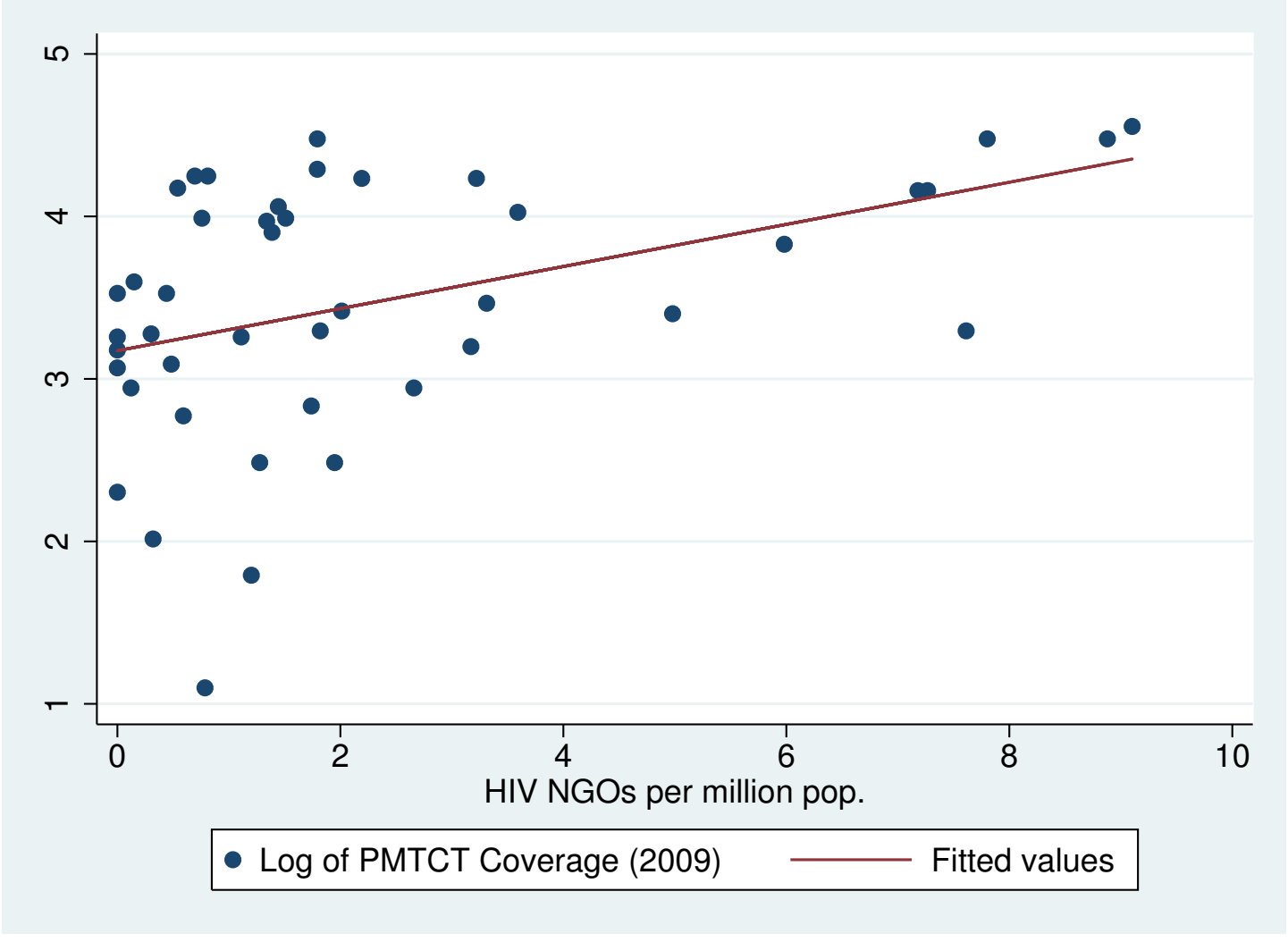
- The quantitative cross-country evidence is ambiguous, indicating that not all civil society activity is necessarily helpful in encouraging more effective state responses, as measured by PMTCT and HAART coverage.

Leadership matters



Source: Nattrass (2008)

PMTCT coverage v no. NGOs/pop (SSA)



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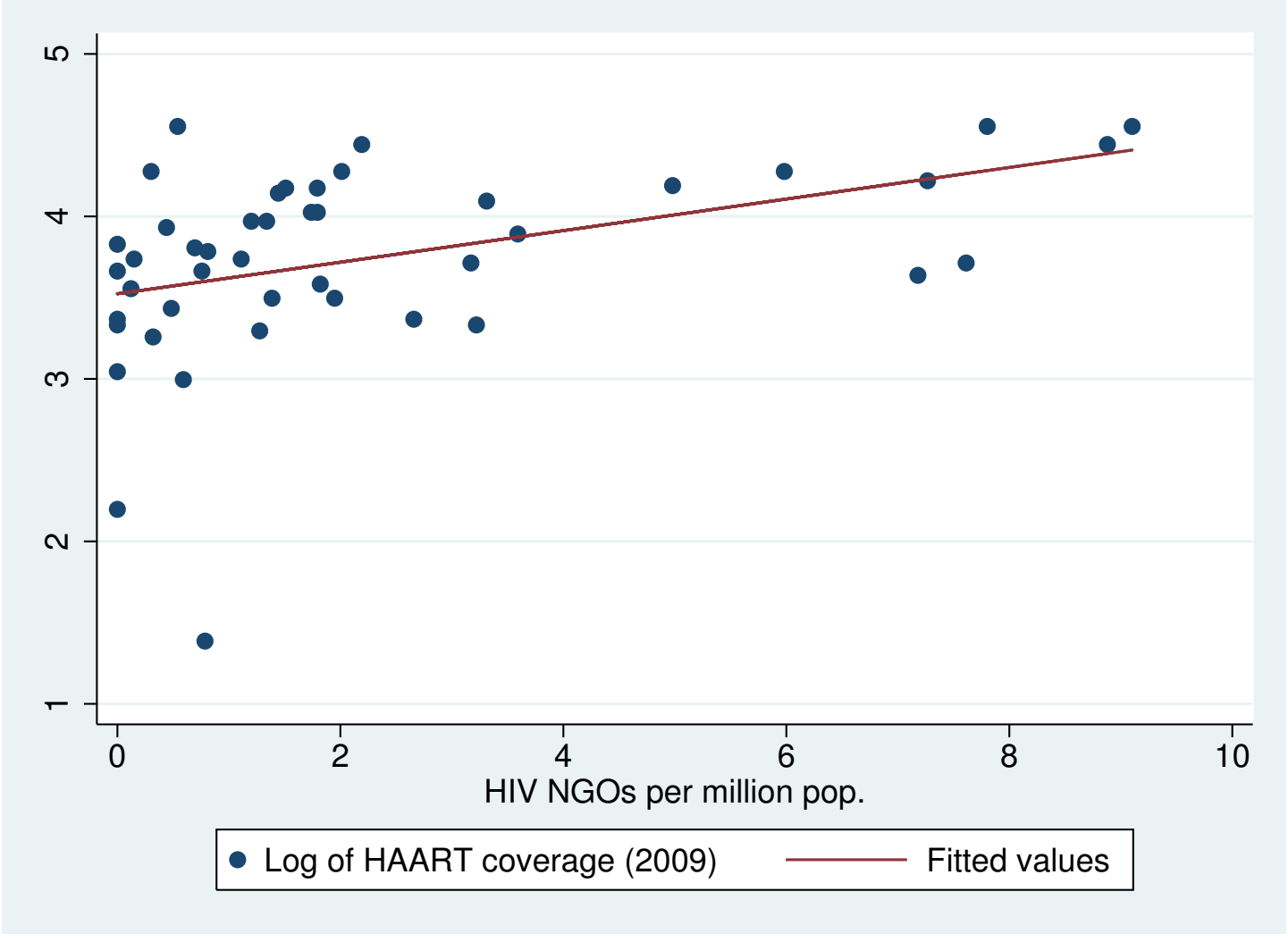
HAART coverage v no. NGOs/pop (SSA)



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Determinants of HAART coverage in SSA

Log of HAART coverage (2009)		
Log of Adult HIV Prevalence (2008)	0.136	0.202**
Log of GNI per capita at PPP (2008)	0.019	0.047
PEPFAR Focus country (2009)	0.323*	0.172
Free or partly free (FH 2008)	-0.259*	-0.255
Stable state (Norris 2006)	-0.292	-0.070
Press Freedom > 50 (FH 2006)	-0.204	-0.240
Ethnic fractionlization (Alesina 2002)	-0.037	-0.125
HIV NGOs per million pop.	0.065**	
CSS responses per million pop.		-0.017*
Constant	3.621***	3.615***
Observations	42	42
Adjusted R^2	0.396	0.355
p	0.000	0.000

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Activism works better sometimes and in some contexts

Activism is most effective when it can result in cooperative collective action (even if that requires adverserial relations with the state and private sector). I.e. when it can pursue an inclusive coalition for policy change and implementation through the mechanism of 'networks of influence' that reach across boundaries.

Successful advocacy: the Treatment Action Campaign

Context & origins:

- Young constitutional democracy
- Politics dominated by party of liberation
- Memory of struggle against apartheid
- AIDS highly politicised
- Later: state denialism

From networks to coalitions

Movement & coalition-building:

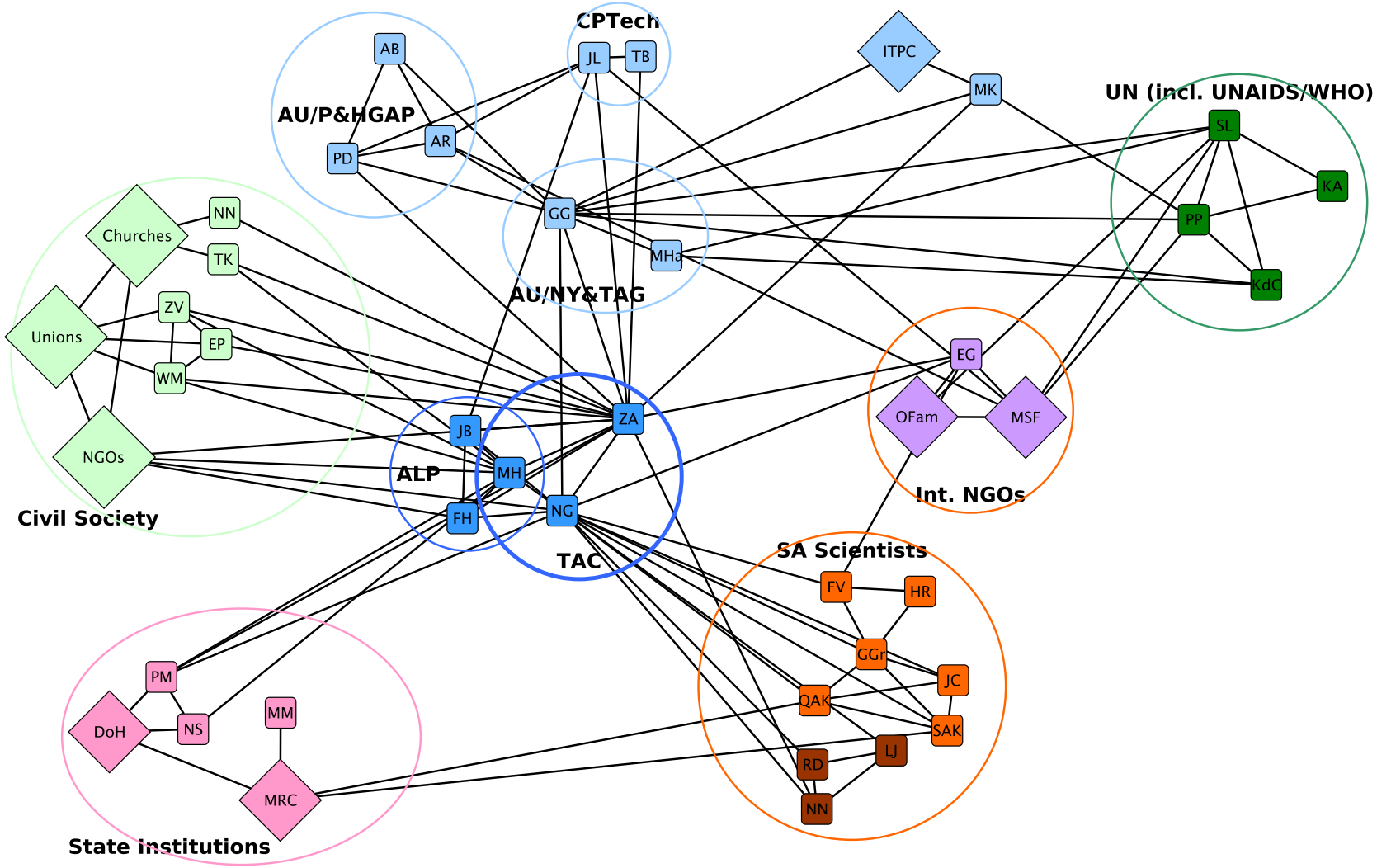
- dense informal networks
- relationships of trust
- pre-existing networks

Civil society networks:

- local civil society coalition
- international 'advocacy networks' (Keck 1998)

But: broader 'networks of influence' (Grebe 2008)

Network of influence around TAC (historical, c. 2002)



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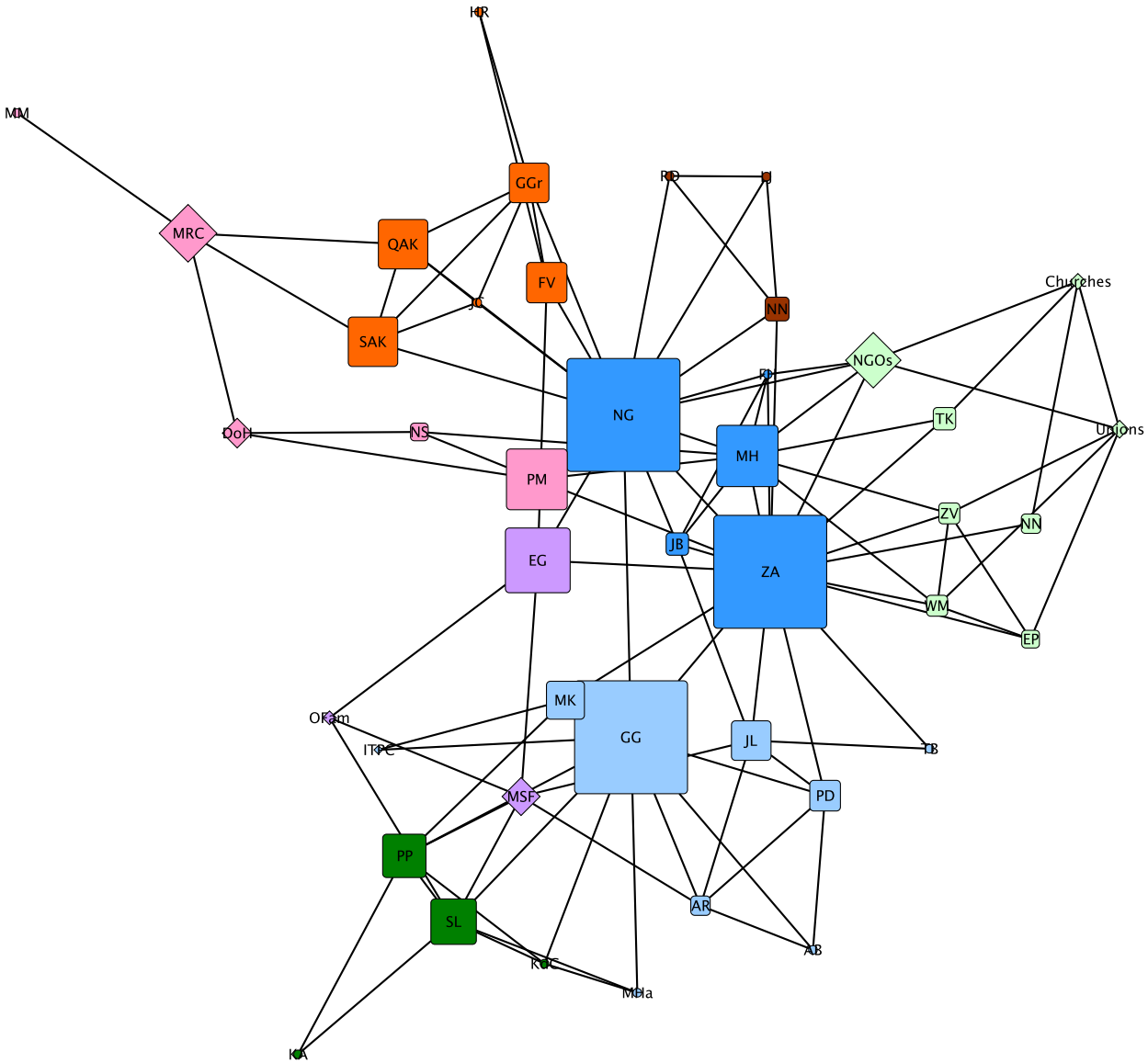
Network brokerage



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TAC's impact at community level

Using a representative survey in Cape Town, South Africa, Grebe & Nattrass (2011) show that *having had no contact with TAC* is associated (in multivariate models controlling for socio-economic status etc.) with

- greater likelihood of believing false AIDS conspiracy theories (OR=1.97, $p = 0.000$)
- reduced likelihood of using a condom (OR=0.55, $p = 0.000$)

Evolution over time

- Coalitions and their environments evolve, presenting both challenges and opportunities
- Influx of resources: pressure to formalise
- TAC: hybrid leadership model, but elsewhere less successful
- Tension between charismatic leadership necessary for movement building & formal structure for longer-term sustainability

Concluding thoughts

- Networks are the basic infrastructure for coalitions
- Inclusive AIDS treatment coalition was based on a **moral consensus** and built through 'networks of influence'
- Individuals matter
- Leadership is political and contextual
- International actors (like donors) can help broker successful AIDS response coalitions, but can also inhibit them

Major challenges

- Reduced funding for global AIDS response
- Loss of momentum in global treatment advocacy
- Resurgence of IPR protection and lack of access to new drugs
- Continued failures in prevention

Funding crisis

- Economic crisis of 2008
- Shifting global priorities: e.g. climate change seen as a greater threat than HIV/AIDS
- Failure to keep our house in order (GFATM)
- 'Backlash' against AIDS-specific funding (see Nattrass & Gonsalves 2009)

How do we respond?

We must renew global HIV/AIDS prevention and treatment activism and rebuild our fading coalition. But we are swimming against the tide.

Reduce the dependency of African countries on external resources for health and HIV/AIDS:

- Hold our governments to the Abuja declaration
- Renew pressure on high-income countries to maintain commitment to global HIV/AIDS response
- Ensure the GFATM restructuring results in a more efficient fund without diluted civil society representation
- Help our governments secure long-term predictable and sustainable investments in AIDS programmes from donors
- Embrace 'treatment 2.0' (UNAIDS)

How do we respond?

Furthermore:

- Renew the medicines access movement, especially by supporting our Indian colleagues in their struggles
- Launch campaigns on newer medicines and third-line/salvage drugs so that quality of treatment can improve in poor countries, not just quantity
- Push for investment in pharmaceutical production capacity and for more coordinated regulation in Africa
- Embrace more radical prevention interventions -- we have we not been vigourous enough on issues like on medical male circumcision, targeted interventions for MSM in Africa and other neglected populations?

Thank you.

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