Drew Dalton**:** *Cutting theRribbon? Austerity Measures and the Problems faced by the HIV Third Sector*

Introduction:

Recent figures show that there are over 101,200 people living with HIV in the United Kingdom (UK) and that HIV incidence (the number of new infections) remains high with an average of 6,000 people being diagnosed annually (Kirwan, et al, 2016, Brown, et al, 2017). It has been estimated that UK incidence figures are higher than most countries in Western Europe (Brown, et al., 2017). HIV transmission, though declining in some groups, such as MSM (men who have sex with men), is still an issue amongst those presenting with HIV as a late diagnosis and amongst older people aged 50 plus (Brown, et al, 2017). Though testing and treatment for HIV is free in the United Kingdom, there are still an estimated 13,000 people living with the virus who remain undiagnosed and who are at a higher risk of poorer health outcomes and premature death (Kirwan, et al, 2016; Brown, et al, 2017). Alongside these high levels of HIV incidence, the economic recession of 2008 has led to a series of governmental policy and ideological changes aimed at introducing fiscal austerity. Because of this, the nature of HIV funding has altered significantly over the last decade as the Health and Social Care Act (2012) shifted the responsibility for providing HIV prevention services from NHS Primary Care Services to local authorities. In this chapter there is an exploration of the implications of austerity for the HIV sector, drawing on symbolic violence to explore the impacts for, especially the HIV Third Sector, for both services and prevention.

The research which informs this chapter involved a quantitative survey and qualitative case studies of third sector HIV organisations (Dalton, 2016). The results revealed a struggling sector operating a ‘survival agenda’ (Crowley, 2012) wherein support services are

being withdrawn, organisations are using their reserves and redundancies are being made, notwithstanding evidence of an increased demand by both new and existing service users. Ironically, given one of the architects of austerity, ex-Prime Minister David Cameron's promotion of decentralisation and the importance of localism, local and often geographically knowledgeable services are closing and under threat of merger with or takeover by 'the big few' nationwide HIV organisations (Dalton, 2016). The fragmented nature of HIV funding is visible at local level where local authorities are withdrawing funding or putting services up to tender, which excludes many smaller organisations from applying (Clayton et al, 2015).

What is symbolic violence?

This chapter will offer Bourdieu and Wacquant's (1992) notion of 'symbolic violence' to explore the effects austerity is having on HIV organisations across the UK and how this has become accepted even by those who have become most negatively affected by it: members of the public who may be at risk of HIV transmission. This acceptance has been strengthened further by the dominance of biomedicine convincing the public that HIV and AIDS are no longer 'killer' viruses. Consequently, HIV has 'slipped off the radar' in terms of wider educational efforts and governmental funding. The chapter makes the case that austerity has led to this symbolic violence because of the denial of adequate funding and resources and the biomedical reconfiguring of HIV as a curable disease (Dalton, 2017).

Symbolic violence is not a physical act of violence, but invisible and pervasive forms of violence of the powerful exercised through cognition and misrecognition, often with the unwitting consent or complicity of the dominated. It is embedded within the very structures of power in society and exercised by legitimate organisations, such as government agencies and powerful social actors imposing their own "vision of the social world" (Bourdieu, 1992:

239). Manifestations of symbolic violence often appear via official offices such as government departments that create a veneer of legitimacy thereby obscuring power relations. In parallel to this, the dominated tend to accept the legitimacy of the office and facilitate the process so symbolic violence, "is exercised upon a social agent with his or her complicity' (Bourdieu and Wacquant, 1992: 167) using "taken-for-granted ways of thinking and behaving" (Scott, 2012: 16). This becomes as Bourdieu (1992) argues:

> "...a symbolic act of imposition which has on its side all the strength of the collective, of the consensus, of common sense, because it is performed by a delegated agent of the state, that is, the holder of the monopoly of legitimate symbolic violence" (Bourdieu, 1992: 239).

Bourdieu's work recognises organisations as important sites for the hidden production and reproduction of social inequalities, and so symbolic violence becomes a way through which to understand legitimate domination (Corsun and Costen, 2001).

Bourdieu (2001) argued that the most effective domination of people takes place when culture is appropriated and exploited as a strategy by the powerful. Bourdieu (2001) defines this as an act of symbolic violence whereby one's symbolic value, worth, resources and skills are downgraded. The concept of symbolic violence enables us to explain how even the dominated may maintain and reproduce such structures by their actions in the field. It also demonstrates how the dominated act, the way domination affects them and how they comply, continue or maintain these values intentionally or unintentionally (Yamak, et al, 2015). This has been part of the central message of austerity cuts; which places value and importance on

volunteering, self-help, less financial state reliance and the scaling back of the state in favour of a third sector with fewer opportunities for central state funding (Clayton, et al, 2015).

Bourdieu (1977, 1992) contended that symbolic violence plays an equally important role as physical and material oppression in the formation and reproduction of social hierarchies in contemporary human society. People are subjected to forms of violence through the denial of resources or being treated as inferior which, in turn, limits aspirations and opportunities for social mobility. However, such is the delivery of the policy and rhetoric, people do not view it as violence and instead see it as the 'natural order' of things and become accustomed to it (McKenzie, 2015). In the current dominant framework of neo-liberalism, individualism, and self-responsibility, symbolic violence enacts itself within discourses that construct austere fiscal management as inevitable, needed and indeed a 'natural' response to the financial crisis the Coalition government inherited because of the perceived financial mismanagement of the previous New Labour Government. Through political rhetoric, used by the Coalition and subsequent Conservative governments the message of the naturalness of austerity has been reinforced further in the public consciousness. However, for Bourdieu, neo-liberalism is deeply complicit in numerous types of symbolic violence. The ideals of individualisation and self-help serve to hide the role of neo-liberalism in the creation of suffering and as such make "it possible to 'blame the victim' who is entirely responsible for his or her own misfortune" (Bourdieu, 2000: 7).

However, symbolic violence as a concept cannot be discussed in a silo and it is important to place it in the context of the other theoretical literature of Bourdieu. Bourdieu (1992) also uses the related notion of the 'habitus' to illustrate how individuals come to internalise these particular ways of seeing the world. The habitus is the set of predispositions

that individuals begin to develop in their own ways of thinking about and acting in their own social worlds and which they learn via experiences and because of their socialisation. The more they employ and use these thoughts and actions and find them to 'fit' within their own social environments, the more they become engrained and become part of habitualised and normalised daily life practices (Connolly and Healy, 2004; Scott, 2012). However, this habitus is located within a much larger social setting of the 'field' whereby in terms of symbolic violence, individuals are predisposed to misrecognising the structures that manipulate them (Bourdieu, 1992). Through internalisation and acceptance of these ideas and structures into their 'mental structures' (habitus), individuals accept them as they unconsciously learn limitations of choice, reproduce subordination and perpetuate inequality, without the need of actual physical force. Therefore, Bourdieu and Wacquant's (1992) theory of symbolic violence becomes a useful tool with which to explore austerity and how it operates as a tool of the dominant over the dominated.

What is meant by austerity and what has been its impact?

The UK Coalition Government's response to the global financial crisis of 2008 and recession has been fiscal *self-discipline* or 'austerity' after their election in 2010. This austerity was then developed further as a key party manifesto by the Conservative Party after the General Election in 2015. Underpinning austerity are four key ideological and policy commitments: firstly, cutting back the role of the state, secondly, promoting local control through localism and thirdly reducing funding to both central and local governments. Reducing the role of the state is a longstanding neoliberal aim in order to promote deregulated market capitalism (Atkinson, Roberts and Savage, 2012, Schrecker and Bambra, 2015). The final political rhetoric facilitating shrinking the state is the 'Big Society'

promoting what some have claimed are simply traditional conservative values of self-help and voluntarism (Donovan, Clayton and Merchant, 2012; Mendoza, 2015).

More recently there have been some measures enacted to protected the most vulnerable to austerity including raising the threshold for income tax (which started in April, 2017) and some investment in the building of affordable homes (Mitchell, et al, 2013). Nevertheless, according to the International Monetary Fund, austerity has led to the UK spending the least on public health of the world's major economies, being on par with the USA, a country which has traditionally had a small government (www.poverty.ac.uk., accessed 20/01/18). In addition, the Institute of Fiscal Studies, forecasts that around one million public sector jobs will be lost by 2018 (Crawford, et al, 2013) and in terms of public health resources and staffing, planned public health spending is more than 5 per cent less in 2017/18 than it was in 2013/14, with forecast cuts in public health funding of at least £600 million by 2020/21 (Evans, 2017). Overall spending on sexual health services has fallen by £64 million (10%), over the past four years from 2013/14 with a further 5% reduction in sexual health services pending (Evans, 2017). Thus, austerity has involved substantial cuts in social protection as a result of welfare reform and reduced local authority budgets (Schrecker and Bambra, 2015).

According to the largest ever study of poverty and deprivation in the UK, poverty rates have risen substantially during austerity, with rates at the highest level in 30 years (PSE, 2014). Changes planned and enacted from 2015 continue to intensify the losses and following the historical trend austerity will exacerbate health inequalities further, with implications for HIV and AIDS organisations and their service users (Schrecker and Bambra, 2015). There has been a widening gulf between the rich and poor within the UK as rising inequality has, on

a societal level, been linked to people's levels of unhappiness and mental ill-health. It has been suggested that as economic inequality has increased, so too have anxiety disorders and depression (Wilkinson and Pickett, 2010; Dorling, 2015; Mendoza, 2015). There is also growing evidence of social unrest in opinion polls, such as an Ipsos Mori Poll (Mitchell, et al, 2013) whereby 48% of the public agreed with the statement that *budget cuts have gone too far and threaten social unrest.* However, tellingly, 52% of this sample believed that the budget cuts were needed, reflecting the process of symbolic violence, whereby the very people impacted by the cuts, actively support them and normalise the process of austerity (Scott, 2012).

In relation to the Third Sector, austerity has had deep impacts and changed the social landscape. The 2010 election pledge by David Cameron was to create a 'big society': "communities taking more control, of more volunteerism, more charitable giving, of social enterprises taking on a bigger role, of people establishing public services themselves" (www.gov.uk, accessed 20/01/18). However, whether the increase in volunteering (Payne, 2017) is due to the big society in action has been questioned. As the state has been reduced and the public sector restructured and sold off to private businesses and organisations (Atkinson, Roberts and Savage, 2012), it has been left to the third sector to 'fill the gap' left behind. Volunteering has increased partly out of necessity that illustrates symbolic violence: individuals and communities have unwittingly rallied around the call for volunteers in revitalising their communities by running their own services in place of government financial support. Through internalising these discourses of the dominant even the most intolerable conditions of existence are perceived as acceptable and are increasingly viewed as the natural outcome of things (Bourdieu, 2001) as staff from once local authority funded and staffed services are made unemployed and are replaced by volunteers.

While Gross Domestic Product (GDP) fell by 6.3% in 2008/09, the overall voluntary sector's income fell in the same years by 3.6% in real terms (NCVO, 2013). The voluntary sector has been hit significantly by the recession and ongoing austerity and whilst there has been some acclimatising to the economic current conditions (NCVO, 2013), this has affected the sector to such an extent that what has been called "the survival agenda" (Crowley, 2012: 2) has emerged. This means that many community organisations are faced with the task of financially downsizing, letting staff go and increasing their use of volunteers. At the same time, they are facing increasing demands on their services as poverty levels deepen and public services are diminished. This survival agenda ensures that organisations increasingly plug the gap of local authority provision, live 'hand to mouth' financially and have fewer safety nets in terms of financial assistance due to the withdrawal of the state. This is within a climate whereby competition for charitable funding becomes increasingly narrow and charities are encouraged to become more entrepreneurial and 'business like' in their outputs for funders who themselves face increasing pressures to allocate funding only to those who can 'prove' their need via these business style outcomes. Within austerity and this uncertainty of survival, community organisations are faced with rationing or reducing much needed services to increasing numbers of people in need and redefining criteria that assess need and priorities (see chapter by Donovan and Durey in this collection for further discussion of prioritisation). Therefore, in an act of irony, community organisations and the staff and volunteers within them, become unwitting transmitters of acts of symbolic violence, such as delivering austerity at local and community level. HIV organisations also face these pressures, but they also face a second barrier, which is a unique cultural and social change as the construction of HIV and AIDS has been reframed as a curable biomedical problem

(Dalton, 2017). This change has facilitated the austerity cuts to HIV services, which will be discussed below.

Is HIV no longer a problem in the UK anyway? Bio-medical shifts and symbolic violence

Initially, when HIV and AIDS first appeared in public, there were no biomedical responses to the virus and the third sector led the way emphasising a social model approach based on prevention, community engagement and changing people's attitudes and behaviours (Weeks, 2016). However, the arrival and mainstreaming of antiretroviral therapy (ART) from 1996 onwards, increasingly offered to those at risk of HIV has meant that:

> "the voices powerfully associated with HIV have largely moved away from the campaign and advocacy groups, having switched to, and accruing dominance from, the biomedical establishment through the medicalisation of HIV" (Dalton, 2017: 63).

This has led to a parallel system in which, on the one hand, people today are living longer with HIV treatment and their standards of living are getting better yet, on the other hand, funding for prevention and addressing stigma has reduced. This has had an adverse impact on people's perception of the virus as they no longer worry about (or are aware) of HIV because it is assumed that adequate treatments exist to address it. What is less known and understood is that, living with HIV is still challenging because HIV/AIDS is still deeply stigmatised. The medicalisation of HIV has contributed to a silencing about HIV within public discourse because of the medical dominance of HIV discussion with treatment offered as prevention.

This dominant dialogue ignores the stigma accompanying the virus and favours the medical treatment of it, thereby side-lining prevention and the voices of people living with HIV and their allies and campaigners (Dalton, 2017).

The impact of silencing HIV discourses outside of the work of HIV organisations and bio-medical institutions means that it has yet to develop into a 'post-HIV' stage of public understanding, acceptance and education (Dalton, 2017). In short, HIV treatment and knowledge has become medicalised and dominated by the medical profession under the guise of the 'just take a pill and you will be okay' narrative (Dalton, 2017). The advancements in HIV medication have resulted in the lay public having little to no HIV knowledge and the resistance to the impacts of austerity comes from the HIV community and third sector. With HIV 'falling off the radar' coupled with the scaling back of HIV funding under austerity, this has made for a toxic mix of symbolic violence. This 'containment of information' has led many outside of the realm of HIV activism to have little or no education about HIV itself, in terms of prominence, transmission or prevention (Dalton, 2017). What is clear from the evidence is that there is still a manifest need for HIV organisations to exist to tackle the lived reality of living with stigma, to educate the wider public to reduce the engrained stigma around HIV (NAT, 2015); and to promote prevention of transmission. The success of the biomedical narrative that the harms of HIV are minimal is an example of symbolic violence because austerity cuts to public health and sexual health campaigns, as well as HIV advocacy and education agencies can be rationalised.

The HIV Third Sector and austerity

Austerity has led to many restructurings within institutions of the welfare state in order to facilitate cutting budgets. Such restructurings can also constitute symbolic violence.

For example, the Health and Social Care Act (2012) removed Public Health England from the governance of the NHS and made them independent executive agencies. It has been argued that this allowed government funding of public health to be reduced whilst not appearing to reduce NHS funding lest the voting public became aware (Dalton, 2017). Proposed cuts from 2015/16 are in the region of £200 million (NAT, 2015). Such tactics of hiding cuts to public health illustrate the ways in which symbolic violence can be enacted as cuts to prevention and other HIV services can be refigured as 'natural' because of the misleading idea, propagated by a biomedical narrative that HIV is no longer a problem There has been some resistance to these austerity cuts, led by the National AIDS Trust #StopHIVcuts campaign, and some successes such as their recent successful legal challenge to the NHS to provide PrEP, despite the claims by the NHS that it is too 'expensive' (NAT, 2015). However, PrEP is another biomedical medication which further medicalises HIV as this provides a preventative drug to be taken before having sex to lower the risk of HIV transmission. Such successes have not effected positive changes within the Third Sector where austerity continues unabated.

The nature of HIV funding has altered significantly over the last decade. In another sleight of hand restructure, The Health and Social Care Act (2012) shifted the responsibility for providing HIV prevention services from NHS Primary Care Services to local authorities. This has been accompanied by a dramatic shortfall in the amount of funding evidenced by the fact that in 2001/02 £55 million was allocated to local authorities for HIV prevention services, yet in 2014 it was just over £10 million. This level of funding is available at a time where there are more people living with HIV in the United Kingdom than ever before (Godfrey, 2015) suggesting that prevention measures are still needed. Ironically, the cuts in funding come at a time when many organisations have professionalised and are reliant on governmental funding streams as HIV support services have altered. Historically, from the

1980s, third sector organisations grew independently because governmental support was lacking. Whilst the rate of new infections is decreasing (Brown, et al, 2017), one of the 'at risk' groups of HIV transmission within the United Kingdom are men who have sex with men (MSM) along with women, trans people, young people, older people and Black and Minority Ethnic (BAME) groups (NAT, 2015). It has been calculated that each new HIV diagnosis costs the public purse between £280,000 and £360,000 in lifetime treatment costs. This rises significantly with late diagnosis. Therefore, the move toward cutting sexual health and HIV services is worrying, not only in terms of the personal, social and emotional costs of each individual HIV transmission, but for the future fallout and the impact upon NHS services (NAT, 2015).

LGBT (Lesbian, Gay, Bisexual, Transgender) support services, who often have important links to MSM and who offer HIV testing, have voiced concerns that they must now reduce services and in some cases, remove services such as informal 'drop in' sessions, reduced hours of operation and the turning away of clients (Mitchell, et al, 2013). This impacts upon their clients at the same time as evidence points toward an increased demand for services around HIV services and sexual health (Mitchell, et al, 2013). Further concerns raised are around fewer testing opportunities for HIV and so the longer-term implications are thought by Public Health England (Kirwan, et al, 2016,) to be an increase in people going undiagnosed and the transmission of HIV to others. Whilst currently standing at one in ten people, the number of people unaware of their own HIV condition could increase further with fewer specialist services, as seen in Greece, where HIV infection has risen by 200% since 2011 as prevention budgets have been cut and intravenous drug use has increased amid a 50% youth unemployment rate (Stuckler and Basu, 2013).

The National AIDS Trust (2016) in their research into the importance of HIV support services found that for all service categories, nearly all their service respondents believe that HIV specialist provision is vital due to the nature of specialist knowledge, trust and being part of the 'community.' This is compounded with a general wariness of generic providers of services (see Donovan and Durey's chapter for more discussion of this), whereby perceived HIV-related stigma can be an issue which stops people living with HIV from using these generic services. Furthermore, the report found inconsistencies within funding arrangements, with localised decisions over whether services are funded or not, "which provides the worrying impression of a 'postcode lottery' developing in HIV support services" (NAT, 2016: 5). Because of austerity funding cuts many local authorities have removed their HIV provision completely and specific HIV charities been forced to close as a result of this (Dalton, 2016). As evidence of symbolic violence, very little media outrage presented itself after this. In fact, the councils in these areas often defended their decision to close their HIV provision due to having 'small numbers' of people living with HIV in their constituencies, which works to enforce the naturalness and inevitability of austerity cuts as well as the public perception that HIV is no longer a concern.

The research methodology

The aim of the study was to provide a 'snapshot' of the current financial health of HIV/AIDS organisations across the United Kingdom. Data was collected via an online survey using 'Survey Monkey' and specific respondents were followed up with further questions via email. Data was collected throughout the time period November to December 2015 for survey responses and third sector case studies were collected in February 2016. Within the survey, respondents were invited to answer a range of questions on their financial and

funding position, staffing and volunteers as well as any organisational and sector concerns which they had. There was room to leave comments on the future of their organisation and the HIV Third Sector.

Access to organisations was via email or social media (Twitter and Facebook) as some organisations had a social media presence but not a website or physical address. The sample of different types of organisations, from larger charities to smaller community groups, was intentional through purposeful sampling (Bryman, 2012) so that final results would show an overall perspective of the health of HIV Third Sector organisations who work solely, or pre-dominantly, with people living with HIV. In total, twenty-four organisations answered the survey (six did not respond) from those found online and as there is no definitive 'list' of HIV organisations in the United Kingdom, it was difficult to find them all. Organisations were approached across the United Kingdom and common emerging themes were identified across the sector, despite being in differing locations. Whilst this survey did not claim to be representative of all HIV organisations in the United Kingdom, it did attempt to cover different types of organisations in order to obtain a 'snapshot' of the current financial and physical health of organisations under a changing financial landscape of austerity. For the purposes of this chapter, the 'HIV Third Sector' includes voluntary and community organisations, groups, charities, social enterprises, mutuals and co-operatives.

What did the research reveal?

From the results of the research it is clear that the HIV Third Sector is largely running on a survival agenda (Crowley, 2012) which can be evidenced through the following themes: 1) Funding and government-led complacency and 2) Staffing, volunteers and demand.

Threaded throughout these seemingly obvious findings under conditions of austerity, lies the power of symbolic violence and the added structural barrier of the medicalisation of HIV.

Funding and government-led complacency

Most organisations surveyed evidenced a survival agenda with 50% of HIV organisations indicating they had to rely on and use their reserves to survive in their previous financial year. When asked how long an organisation could survive on their reserves, if no income or funding materialised, the outlook was bleak, with a total of 31% of the organisations having no reserves at all. Many of these were smaller community groups a might be expected not to have reserves and suggests the 'hand to mouth' nature of their existence. A total of 62.5% organisations either had no reserves or only enough to last between one and three months (of which many of these were the larger organisations). Only 37.5% of organisations had the capacity to survive on their reserves for up to six months and only one organisation answered that they could last 'over a year.' When asked about whether organisations are preparing to use their reserves in the upcoming financial year (2016-2017) the figures were alarming in that a total of 69% organisations answered either 'likely' (19%) or 'yes' (50%) to this question. In terms of sources of income, HIV organisations rely heavily on public sector and local authority funding, which under current changes to funding, will decrease substantially. Future funding therefore was a key concern amongst respondents, who identified their concerns about austerity reductions on their own organisations, a wider governmental complacency about HIV and the impact that this will have on people living with the virus:

> *"As local authorities continue to cut back on HIV funding now that it is no longer ring fenced more agencies will close. This will result in an increase in transmissions, a growth in stigma and increased levels of mental health and other issues for those already living with HIV. In essence we are heading in reverse and there seems little anyone is prepared to do about it" (Manager, HIV Organisation 1)*

On-going austerity funding cuts will exacerbate future financial difficulties for organisations which are currently struggling in the challenging financial climate and who may currently be using their reserves. This is exacerbated by the finding that almost two fifths (37%) of organisations have suffered a loss in overall income in the previous financial year. As public-sector finance given to HIV organisations has been slowly reduced over the years, it appears that organisations have had to increasingly use their reserves as a 'safety cushion.'

Concerns about complacency from the government and, consequently, wider society reflects respondents' views that there is 'little anybody is prepared to do about it', a common theme throughout the responses. Symbolic violence is illustrated here in the fact, that the dominated no longer question the order of things, even if it causes great risk to themselves. Austerity measures mixed with governmental complacency based on the medicalisation of HIV impacts upon the wider public who accept the both austerity and biomedicalisation rhetorics. This complacency points to the symbolic violence of structural barriers not just to funding but to any consensus that specialist services are necessary. So many respondents argue they just have to *"Keep going in the face of [government] indifference"* (Senior Manager, HIV Organisation 4) and *"inaction from NHS/LA [Local Authority]"* (Senior Manager, HIV

Organisation 2). The symbolic violence experienced by staff and service users, current and potential is summed up:

> *"Too many lives will be needlessly affected by penny pinching, which is a scandal. We seriously risk losing all the progress made in HIV prevention, and a huge amount of experience, as staff are then lost to other sectors. It is nothing short of a Public Health disaster really, orchestrated by those who know little, and seemingly care even less about those living with HIV or those most at risk." (Senior Manager, HIV Organisation 6)*

People do not question their own role in the production and reproduction of domination and subordination (Bourdieu, 1977; Bourdieu and Passeron, 1977). Symbolic violence and domination becomes exercised over individuals through their everyday social habits. Therefore, symbolic violence can occur through the mundane processes, practices of everyday life and even through inaction and complacency. This was highlighted by respondents as they have tried to fight the cuts and some resistance has mobilised, but this has had varying degrees of success due to what some respondents refer to as the protectionist stance by other HIV organisations in light of austerity cuts and tendering processes:

> *"We have received no support from other HIV organisations or charities, in fact quite the reverse. It seems that a fortress mentality exists within the sector and that we are perceived as a threat purely because we have survived and are continuing to provide services. Unfortunately, we do not think many other charities will be able to survive in the way we have and that there will be a great many lost in the next 5 years, possibly sooner" (Manager, HIV Organisation 1)*

Even in this excerpt there is evidence of symbolic violence as the fault for protectionism is seen to be in the other HIV organisations rather than seeing the wider context in which the tendering processes for reduced funding sets organisations into competition with each other.

New funding regimes have also made things very difficult for smaller third sector organisations to survive. As Clayton et al (2015) show, it is larger, national charities and organisations that can afford the time and have the resources to apply to fund raising and it is they that are most likely to succeed. Similar results were found in this survey with smaller groups indicating their concern about being unable to submit tenders due to their size or resources and reliance of some organisations on staff members who were working unpaid. There was a wider concern that larger HIV organisations would 'swallow up' smaller bespoke groups and be more successful in gaining access to available funding because of having a more professionalised and resourced infrastructure including fundraising departments. Thisimpacts not only on smaller regional HIV organisations, but also on the service users who use them. For example:

> *"[we have been] decimated. Only the big corporate one will survive" (Senior Manager, HIV Organisation 2)*

"Small volunteer run, and user led groups are so vital but are just can't compete with competitive tendering processes" (Senior Manager, HIV Organisation 8)

Several respondents also talked about merging as a way to survive for smaller organisations though some still aired their concerns that if merging was a response to funding problems this might have adverse impacts for service users. For example:

> *"Only big organisations [will remain] most smaller [organisations] having merged or closed" (Senior Manager, HIV Organisation 13)*

> *"We could merge with other organisations. The concern is that merger is due to cuts and not based on the needs of people with HIV" (Senior Manager, HIV Organisation 2)*

Concerns outlined related to a lack of partnership working within the sector, coupled with fears about HIV organisations working in 'silos' to preserve their organisations rather than share resources and skills. Some reported that larger HIV organisations who were not based in their area were not always best placed to offer the support that was needed for service users (for example, they provided online services instead of face to face groups) and that the closure of smaller organisations would see traditional face to face services decline. Most of the HIV organisations surveyed managed to use their available resources to campaign to stop HIV cuts to services, while simultaneously creating a space for dialogic understandings of their situation. In doing so this has potential to disrupt the habitus which reproduces their domination, however this has yet to result in changes to government funding of HIV support, the removal of tendering processes, or any reduction in the dominance of the medicalisation of HIV. The problem is identified in what one respondent stated:

"[we need to be] [r]eaching audiences beyond HIV communities" (Senior Manager, HIV Organisation 11)

Staffing, volunteers and demand

There is evidence of a growing strain on the HIV Third Sector, in that some continued staff cuts are expected (17%) and as a likely effect of this, services will have to be closed (33%) or organisations merged (8%) with the loss of specialist knowledge and experience that this entails. Importantly, during the writing up of this research two HIV organisations closed and five had major funding reductions which led to redundancies of staff. Due to an increase in demand for HIV services and high HIV rates in the UK, a potential issue emerges as 33% organisations expect increases in their numbers/types of service user, and with 25% providing new services and 58% expecting to increase their volunteers, this shows tensions in what can be offered in terms of quality provision. There are some concerns here as paid staffing levels overall are decreasing (17% decreasing versus 8% increasing) and volunteering levels are expected to increase dramatically. HIV organisations reported an increase in volunteer levels (42%) and 58% of all organisations plan to increase their volunteer levels in the coming twelve months. Due to service demand, many volunteers may be expected to run these services, as per the 'Big Society' agenda. However, with fewer paid, specialist staff, questions remain about provision of adequate training and supervision to offer a quality service? There is no doubt that well-trained, experienced volunteers bring excellent rewards to organisations and add an estimated economic value of £50 billion a year to the economy (Elliot, 2014). However, with staff shortages and time-pressures of paid staff, high quality training and supervision of volunteers may not always be feasible which may affect volunteer turnover. Practices that would ordinarily be deemed as problematic or

'violent' such as the removal of services and staffing eventually gain social acceptance through discourses, practices and policies. In the current dominant framework of austerity and neo-liberalism, individualism, and self-responsibility, symbolic violence often leads people to (unjustly) blame themselves for their own suffering whilst the role of society remains hidden (Bourdieu, 2000). As an example of this, staffing pressures and financial suffering have forced HIV organisations to increase their volunteering levels to replace staff members, which whilst necessary for services to run, perpetuates the myth that austerity is needed and that volunteers can plug gaps in staffing levels.

Conclusion: cuts to the HIV Third Sector as an act of symbolic violence

The HIV Third Sector is in crisis and is running on a survival agenda. Government austerity policies and rhetoric can be seen as acts of symbolic violence stripping away access to funds whilst normalising the cuts as natural/needed to address the budget deficit. Normalisation of the cuts is greatly facilitated due to the medicalisation of HIV removing HIV as a problem from the public consciousness. Power operates through misrecognition of the meanings implicit in government action, practice and ritual, and, "any language [the language of the establishment] that can command attention is an 'authorised language'" (Bourdieu, 1977: 170) and thus legitimate. Both the language of austerity and the dominance of biomedical understandings of HIV result in a unique experience for HIV organisations under austerity. The uniqueness lies in the biomedical account of HIV rendering discussion of HIV as unnecessary (Dalton, 2017) and as the discourse of biomedicine as heroic medicine increases, prevention and education agendas are cut because people believe that they are no longer needed. The outcomes of this symbolic violence mean that people are becoming infected with HIV needlessly. In addition, effective biomedical treatment has not filtered

through to address stigmatisation. The data evidences that this still affects the lives of those living with HIV and therefore, symbolic violence becomes evidenced through cuts to prevention and to specialist HIV Third Sector services which provide the redress and resistance to this stigmatisation.

Symbolic violence is imperceptible, insidious and invisible. This invisibility constitutes an effective tool of silent domination and of silencing the dominated. Dominant discourses often work to silence marginalised voices, in this case the HIV organisations and people living with HIV who often find their voices through the campaigns of these organisations. This silence is not overcome simply by allowing the HIV organisations to speak or for them to voice their concerns because in an era of medicalisation and austerity, such acts seem futile in overcoming the silence. So how might this be contested? Bourdieu (2001) suggests that systemic and structural change needs to take place to ensure that these voices are heard and accorded much more agency. The current UK government's austerity position in terms of HIV needs to change. HIV Third Sector organisations need funding so that they not only continue their work with people living with HIV, but also to educate and promote prevention and develop campaigns to resist the wider stigma process, which continues to grow so long as HIV is seen as only a medical concern.

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