WELCOME TO THE ARASA NEWSLETTER!

In this issue, we look back at 10 years of ARASA Country Programmes and give you a preview of a soon to be published report highlighting some of the successes of the programmes and the impact they have had on health and human rights in Southern and East Africa.

In light of our upcoming Universal Health Care (UHC) convening in November, we highlight an interview done by our Deputy Director, Felicita Hikuam with Aidsfonds.

It is also our great pleasure to introduce you to our new Programmes Lead, Nyasha Chingore-Munazvo, who joined us in September 2019.

We share with you the highlights of the 4th meeting of national human rights institutions from around the region that we co-hosted with NANHRI and the Centre for Reproductive Rights in Johannesburg, South Africa in September.

On the advocacy front, ARASA and its partners circulated a Call to Action advocating for an end to structural barriers to HIV prevention. We look at the content of this Call to Action in this issue.

We are also happy to present some of the highlights of our work in quarter 3 of 2019!

IN THIS ISSUE:

- A decade of strengthening national advocacy: The ARASA Country Programme
- Welcome to Our New Programmes Lead, Nyasha Chingore-Munazvo
- Rights-Based Responses Needed Now! 4th Regional Capacity Strengthening Convening for African National Human Rights Institutions
- Why lessons from HIV must be heeded as UHC rolls out in East and Southern Africa
- Addressing structural barriers to HIV prevention: We need to gain momentum!
- Highlights

Should you have any questions, comments or contributions for future editions of the newsletter, please email ARASA Communications at communications@arasa.info.

For updates and more information on ARASA's work, visit our website www.arasa.info and connect with us on Facebook @ARASA, Twitter @_ARASAcommsand Instagram @arasa_network.

Until next time!

A decade of strengthening national advocacy: The ARASA Country programme

By Paleni Amulungu and Bruce Tushabe

2018 marked the tenth anniversary of the ARASA Country Programme, which strove to strengthen HIV, TB and human rights programming in the region through the provision of both technical and financial support to national HIV, TB and human rights programmes over a two year period.

The objectives of this programme were:

1. To support and strengthen the capacity of civil society organisations, service providers and policy makers in Southern and East Africa to effectively advocate for, and provide, a human rights response to HIV and TB at national, regional and global levels, using the ARASA partnership, with a particular focus on people living with HIV and TB and key populations at higher risk of HIV and TB.
2. To support and strengthen advocacy by civil society, especially people living with HIV and TB and key populations at higher risk of HIV and TB, for their health and human rights.
3. To strengthen the partnership and the sustainability of partner organisations working at national and community levels.

We have compiled a report on the impact of the Country Programme, which will be published in the last quarter of 2019.

In the meantime we share with you some of the Country Programme highlights:

- **Increased prevention and treatment literacy** on HIV, TB and Hepatitis C among the communities where the programme was implemented. The high treatment literacy levels resulted in increased health seeking behaviour among the communities. For instance in **Tanzania**, as a result of the programme, children who had defaulted on ART were looped back into care and linked to specific points of care.
  In **Mauritius** there was increased access to methadone for people who use drugs (PWUD).
- **Policy and legal change:** In **Botswana** the programme host, the Botswana Network on Ethics, Law and HIV/AIDS (BONELA), made international headlines by challenging the government's decision to deport a Zimbabwean multiple drug resistant (MDR) TB patient and its refusal to give him access to TB treatment while in detention. Due to BONELA's intervention, access to treatment was provided. In 2008, BONELA also won a major case in the Botswana Industrial Court involving the dismissal of an employee living with HIV after he disclosed his status to his employer. In addition to impact litigation, BONELA made progress in its treatment literacy training work and started working with vulnerable groups by leading treatment preparedness efforts in a refugee camp. In recognition of BONELA's stellar work they were awarded the 2008 ARASA HIV and AIDS and Human Rights Award. In **Malawi**, the programme contributed to PLHIV and CSO movement building, which in turn contributed to strengthened advocacy for and the adoption of the HIV bill into law.
  In **Lesotho** and **Swaziland**, there was a successful mines and TB campaign, which galvanised considerable progress on mines and TB advocacy
  work. (https://www.arasa.info/media/arasa/Resources/research%20reports/mines-tb-and-southern-africa.pdf)
- **Movement building and cross-sectoral collaboration:** In **Mauritius**, partners such as PILS and Association Kinouete forged a relationship which enabled the programme in Mauritius to extend interventions in prisons. The programme also contributed to a strengthened relationship and collaboration between the Office of the Prime Minister (OPM) and PILS. Both the Prime Minister and the

President participated at the 2017 *Support don't Punish* conference and other high level meetings were held to set up the national Drugs and HIV Council, chaired by the Prime Minister. In **Zimbabwe**, the programme contributed to improved networking between SAfAIDS, the programme host, and other organisations and institutions such as GALZ, INERELA+ Zimbabwe, traditional leaders, and health institutions among others. The increased collaboration resulted into joint resource mobilisation.

- **Increased resource mobilisation for HIV and human rights programmes:** In **Malawi**, the programme resulted in increased advocacy for health financing with government, which contributed to increased domestic health budget. CEDEP and CHRR were also able to acquire a grant from Elton John Foundation, OSISA, HIVOS, Aidsfonds and the Global Fund as a result of the structures put in place through the programme. The grant increased access to health among LGBTI through establishment of STI screening sites and training of LGBTI friendly health workers. In Tanzania, CHESA was able to raise funds from Bill and Melinda Gates Foundation to support MSM interventions after the country programme life span.
  In **Mauritius**, PILS was able to secure funds from the European Union to support 8 of the original community health advocates employed under the programme to continue their HIV and human rights work after the programme in Mauritius came to an end.
- **Increased access to justice:** In **Kenya** linking the community health advocates with programme host KELIN's network of pro bono lawyers and paralegals ensured that matters that required legal advice and redress were tackled in record time. This provided communities with confidence to identify and report any form of human rights violations within their communities to community health advocates. The resulting information gathered by the community health advocates enabled KELIN to conduct an analysis of the common structural barriers to access to HIV, TB and SRH services. These included stigma, cultural beliefs, norms and harmful cultural practices such female genital mutilation, police harassment especially around the coastal region of Mombasa,
- **Increased documentation, research and monitoring of human rights violations:** In **DRC** the programme contributed to improved

documentation and monitoring of human rights violations across the country. In **Kenya**, the community health advocates were able to monitor and document cases and refer them to paralegals for redress.

- **Increased media coverage of HIV, TB and human rights:** In **Mauritius** the commemoration of international days such as Pride, IDAHOT and World AIDS Day increased ARASA partner's visibility through media coverage as well as increased sensitisation of the public about HIV, TB and human rights issues.
- **Increased community mobilisation:** Participation of the community health advocates in national Technical Working Groups, various stakeholders' fora and task forces also helped in promoting information sharing and dissemination on the programme activities. This interaction between the community health advocates and other national structures assisted with enabling the community health advocates to share information about the programme nationally and to collaborate with other NGOs in advancing the HIV, TB and human rights advocacy agenda.

Welcome to Our New Programmes Lead, Nyasha Chingore-Munazvo

On 1 September 2019 ARASA welcomed its new Programmes Lead, Nyasha Chingore-Munazvo. Nyasha, who initially interned at ARASA many years ago, joins us from the Centre for Reproductive Rights (CRR) Africa Programme, where she served as the Regional Manager in Nairobi, Kenya from 2017. During her time at CRR, Nyasha was responsible for the enhancement of the African programme's internal organisational processes, aiding it to fulfil its mission and engage with key constituents. She also was responsible for overseeing the litigation, research and policy analysis, advocacy and capacity-building work of the Africa Programme.

Prior to joining CRR, Nyasha worked for the Southern Africa Litigation Centre (SALC) where she initially served as the programme lawyer on the HIV programme and subsequently became responsible for leading SALC's legal and advocacy work on sexual and reproductive rights.

Nyasha holds an LLM from the University of Pretoria, South Africa and a Bachelor of Laws with Honours from the University of Zimbabwe.

We warmly welcome Nyasha to the ARASA team and look forward to her leading the charge in ARASA's new programmatic direction focused on SRHR and Bodily Autonomy and Integrity.

Rights-Based Responses Needed Now!
4th Regional Capacity Strengthening Convening for African National Human Rights Institutions

By Nthabiseng Mokoena

ARASA, the Network of African National Human Rights Institutions (NANHRI) and the Centre for Reproductive Rights (CRR) co-hosted the 4th Regional Capacity Strengthening Convening for African National Human Rights institutions, in Johannesburg, South Africa from 16 to 18 September with support from the Global Fund through the Africa Regional "Removing Legal Barriers" Grant.

The meeting brought together senior National Human Rights Institutions (NHRIs) representatives and key experts on sexual and reproductive health and rights (SRHR) from 15 African countries and provided a platform for NHRI representatives to engage in evidence informed discussions and identify their roles in advancing human rights-based responses to SRH and HIV.

NHRIs play a significant role in monitoring and addressing the inappropriate use of criminal law at national level. They are also in a unique position to hold governments accountable to their commitment to respect, protect and fulfil reproductive rights as defined in the International Conference on Population and Development (ICPD) Programme of Action and further articulated in international and regional human rights documents and national laws. As a result, NHRIs have a strategic role to play in ensuring everyone enjoys the right to health as well as the enjoyment of their sexual and reproductive rights, as well as the advancement of gender equality and equity.

ARASA and NANHRI have, for the past four years, hosted the Regional Convening for NHRIs, in order to strengthen the capacity of NHRIs on human rights and health but to also strengthen the relationship between NHRIs and CSOs.

"*We cannot deny the fact that these meetings are very helpful for NHRIs, they provide a space for us to learn from each other and to exchange experiences as NHRIs working in different contexts. Thank you to ARASA for remaining so loyal to us through this process*"

- Commissioner George Morara, Kenya National Commission on Human Rights.

By the end of the convening all attendees were in agreement that maternal healthcare, access to safe abortion, adolescent SRHR, UHC and SOGIE issues are high priority areas, not only at country level but regional levels as well. Further recommendations were that NHRIs should and will continue to advise governments and provide policy options while working closely with CSOs to advance a human rights based approach that ensures the development of model laws, resolutions and declarations that progressively speak to SRHR.

Why lessons from HIV must be heeded as UHC rolls out in East and Southern Africa

Ahead of the Universal Health Care (UHC) PITCH Regional Workshop on 5 -7 November 2019 in Johannesburg, South Africa, ARASA, Deputy-Director, Felicita Hikuam had an in-depth interview with Aidsfonds on the importance of the role of civil society in advocating for advocating for universal health care.

In our series of articles assessing progress towards UHC implementation, we hear activists from Indonesia, Kenya, South Africa, Ukraine and Vietnam on the challenges facing marginalised groups affected by HIV and the actions they are taking in the battle to ensure UHC truly leaves no one behind.

Although all countries in East and Southern Africa have expressed commitment to universal health coverage (UHC) and are making moves towards it, implementation varies widely between countries.

Many governments have already begun engaging with the process and are setting in place the mechanisms and policy changes that need to happen to rollout UHC. Some countries have embarked on major reforms. Examples include South Africa where discussions around a national health insurance scheme and primary healthcare re-engineering are taking place. In Kenya, a national insurance scheme is also being considered and 'affordable healthcare for all' is one of the President's 'big four' priority goals. Other countries, such as Zimbabwe, Mozambique, Tanzania, Zambia and Botswana, are currently developing or redesigning UHC essential packages, redefining systems and conducting policy discussions.

Information gaps

One thing that unites all countries in the region in relation to UHC is a lack of clarity for civil society about what UHC is, how and where decisions about it are being made, what implementation could mean and how civil society can engage in UHC platforms and processes.

"There's a dearth of information on the implementation of UHC in the region," says Felicita Hikuam, Deputy Director of the AIDS and Rights Alliance for Southern Africa (ARASA). "This is partly because civil society, which has traditionally worked on influencing and supporting the HIV response, is currently not focused on UHC to the extent that we should be. Many [civil society actors] are preoccupied with adapting to other changes in the region, many of them funding-related.

"But it's also due to the way the UHC conversation has been framed and conducted. In the region UHC has been presented as really technical, and the

space in which these conversations are taking place has been closely guarded. This is partly because governments fear that involving communities will result in an unmanageable situation due to the competing and unlimited priorities that may be presented.

"People working on HIV and activists from at-risk communities don't really understand what UHC is, what it is not, and why it is relevant. There's a general lack of knowledge about who the key players are and the best way to ensure the priorities of marginalised groups are reflected."

Funding and access

A lot of services for populations most affected by HIV in the region have been externally funded, but as some countries transfer to middle income status the funding architecture is changing. "There's a lot of push for national ownership of the HIV response," says Felicita. "But we are really concerned that HIV services, particularly those for key populations that are not currently covered by governments, will not be covered [under UHC] because they are not considered a priority and because of the criminalised nature of some of the groups the services are for. "What are governments currently doing to address laws that criminalise certain populations? This is a key barrier to people from these groups accessing services, yet existing barriers are not being considered in UHC debates. This is something we will be looking to change through our advocacy work."

Health economics

Another priority for ARASA is to build capacity among civil society organisations so they can make compelling arguments about why it makes economic sense to invest in certain services and reach certain groups of people. But this requires robust evidence.

"My understanding is that a lot of the national conversation about UHC centre around health governance and economics. To engage in these discussions, we will need a better understanding of these issues as well as evidence to back our arguments, particularly relating to service and coverage needs for communities most affected by HIV.

"But although data on key populations has got better in recent years, in some countries we still don't know how many people we are talking about, what services

they require and what will it cost. And if decisions are being made around who gets covered and what gets covered what does it mean for equity? What about the right to health and human rights?"

“If we are dealing with people who are economists they may not be used to, or convinced by, the argument from communities most affected by HIV that they should be listened to simply because they are at risk. So it’s about how we shape our argument in a way that can be compelling but also show that community voices are important.”

The prioritisation of biomedical interventions

Another advocacy focus for ARASA will be to establish what kind of HIV services are being included in UHC packages.

"We are concerned that biomedical interventions, particularly treatment access, PrEP and voluntary medical male circumcision will be prioritised above the community-based groundwork that needs to happen to ensure people from marginalised communities are aware of their right to health and to create a demand for services, including prevention-related services and commodities."

“Even now treatment is the first priority and takes up the bulk of resources. That’s what governments focus on because it’s about giving a pill to someone, ticking the box and being able to say ‘we have X number of people on treatment’. It’s not really doing the hard work relating to HIV prevention, particularly for key populations, which is much more than just giving someone a condom. HIV isn’t a disease you can just manage in a healthcare setting; it’s about looking at the complexity of people’s lives and what determines the choices they are able to make.

“In order to deal with HIV, you need to deal with the social determinants of health such as gender equality, the legal environment, stigma and discrimination – all the ‘fuzzy’ things that often times scientists and governments don’t want to deal with. I think the HIV movement has done really well to continually push that message, which is something that needs to be brought to debates on UHC as well.”

Getting a place at the table

Early in November, the Partnership to Inspire, Transform and Connect the HIV response (PITCH) and ARASA will bring together civil society partners from across Africa to strengthen their understanding of UHC and to identify opportunities. The meeting will ensure that community-led groups can participate in crucial national UHC debates. Part of this work will be to devise a plan so that activists are equipped to hold governments to account to the commitments they make in the outcome document of the UHC High Level Meeting, in order to monitor UHC's rollout.
"PITCH is enabling civil society to start to question what is happening on UHC," says Felicita. "It is helping civil society engage in those conversations and find out where the opportunities are to influence and to push our interests.

"Since the beginning of the HIV response people living with HIV have said 'nothing about us without us'. With civil society actors working on HIV, we have become used to pushing our way into spaces and being included, being at the forefront of conversations. Now it's strange to be in a position where again we're having to ask where conversations are happening and why we haven't been invited."

"We feel that many governments in the region are trying to keep plans around UHC rollout among a small group of technical experts, which has really sidelined communities most affected by HIV. One of the main barriers to engagement is just getting access to the table where these conversations are happening – and PITCH is helping us to link up with partners that have influence in opening up that space."

Felicita's call to action

PITCH activists in East and Southern Africa are calling for:

- More information on UHC.
- Meaningful engagement of communities most affected by HIV in UHC debates and in the planning, implementing and evaluating of UHC rollout.

Source: Aidsfonds

Continue Reading About UHC

Addressing structural barriers to HIV prevention: We need to step up our game!

By He-Jin Kim

With one year left, it is clear that the 2020 Global Prevention Targets and Commitments on reducing new HIV infections will not be met. A lot of progress has been made in the SADC region, but it has not been enough. Now, clearly, we must shift our focus beyond 2020 towards 2030 and the commitment to end AIDS as a public health threat. However, in order to do this, we need to address the structural barriers to HIV prevention and to ensure that the same attention is given to addressing structural barriers and human rights issues as there is to biomedical and behavioural interventions. Without this our work will not be sustainable.

Since 2017, the AIDS and Rights Alliance for Southern Africa, with support from PITCH, has been running the “Missing Piece of the Puzzle” campaign to highlight the need to keep human rights at the centre of the HIV response. This campaign was launched at ICASA in 2017, and since then ARASA has organised activist meetings to identify and discuss the specific structural barriers that need to be addressed. The most recent activist meeting took place

in April this year. This meeting illustrated clearly that structural barriers are not being addressed when it comes to vulnerable populations. Activist participants at this meeting drafted a Call to Action that focussed on the structural barriers and the needed structural interventions for each of the 5 pillars to HIV prevention. This Call to Action was at the centre of discussions at the SADC HIV Prevention Stock-Taking CSO meeting in September, and a CSO statement was drafted that was presented to the NAC Directors at the SADC meeting itself.

We are currently supporting national level advocacy in Mozambique and in Zimbabwe to spur decision makers on to accelerate action on addressing structural barriers. At a regional level we are engaging with the Southern Africa Development Community in its HIV Prevention Stock Taking process to ensure that they include structural indicators in tracking progress towards meeting the 2020 targets and beyond. In collaboration with its national and regional partners, and through support from PITCH, ARASA aims to take this advocacy forward and to ensure that there will be increased focus on structural barriers interventions beyond 2020 and towards 2030.

Read the full Call to Action here
Read the full CSO Statement here
View the 5 Pillar Issue Briefs here

Highlights

- 23 August 2019 – ARASA hosts Intersex Workshop in Johannesburg – Watch the "*Let's Talk About Intersex"* Video produced by Rachel Oh here
- 31 August 2019 – International Overdose Day – Read our full statement here
- 31 August 2019 – ARASA Alumni leads Maternal Mortality march in Mozambique – Read full article here
- 28 September 2019 - International Safe Abortion Day – Read our full statement here