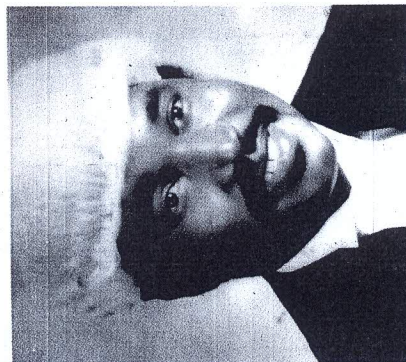


LEGAL PRISMS

Directions in

NIGERIAN LAW AND PRACTICE



A refereed book published by the Faculty of Law,
Usmanu Danfodiyo University, Sokoto

In honour of his Excellency,

(Dr) Ibrahim Shehu Shema CON, FNIM, FNATE,
The Executive Governor of Katsina State

Edited By
Professor Mohammed L. Ahmadu

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CHAPTER 39

FUNDAMENTAL RIGHTS OF PERSONS LIVING WITH HIV/AIDS (PLWA) IN NIGERIA: A GENDER-BASED APPROACH

Dr Mahmud K. Adebayo

Introduction

The chapter focuses on the need to entrench the rights of people living with HIV in the Constitution. A lack of respect for human rights fuels the spread of HIV and exacerbates the impact of the HIV/AIDS pandemic. Strategies for HIV prevention, treatment, support, and care are hindered when they are carried out in an environment where human rights are not respected.¹ Government must ensure that women's rights are respected when women have access to treatment, care, and testing services. Medical, health, and informational services must promote the dignity and equality of people living with the HIV/AIDS. This means that informed consent to testing and treatment be ensured and respected, equally the right to privacy, confidentiality and dignity and a reduction in the stigmatization and discrimination related to HIV/AIDS.²

It is increasingly recognized that HIV/AIDS thrives on an intensified inequalities. Put differently, the inadequate realization of human rights facilitates the spread of HIV/AIDS and worsens the impact of HIV/AIDS. Gender inequality and poor respect for the human rights of women and girls is a critical factor in the HIV/AIDS epidemic.

In 1997, four out of ten people living with HIV/AIDS world wide were women.³ By 2004, women made up almost 50% of people living with HIV/AIDS. In countries like Nigeria, where heterosexual transmission is the main mode of HIV transmission, women are more likely than men to be infected with HIV/AIDS. In sub-Saharan Africa close to six out of ten adults (15-49 years) infected with the HIV/AIDS are women. The highest gap in HIV/AIDS infection rates is recorded between

1 CRC 'Pregnant Women Living with HIV/AIDS: Protecting Human Rights in Programs to Prevent Mother-to-Child Transmission of HIV' Briefing Paper, August, 2005 p. 13.

2 Ibid.

3 UNAIDS, *Operational Guide on Gender & HIV/AIDS: A Rights Based Approach* (New Delhi-India, Thompson Press, 2005) p. 4.

young women and men between 15-24 years old. The understanding is how women and girls are more likely to become infected with HIV/AIDS brings us to the domain of gender relations and gender inequality in the spread and transmission of the dreaded disease.⁴

The fact remains that since growing large numbers of women and girls are being infected with HIV, this brings them within the ambit of persons requiring special attention and care. More sordid are women and girls who are pregnant or who are breastfeeding their babies, it is not only their own health and lives that are stake, but also that of their babies.

Among the many obstacles militating against the full realization of women's rights to health and to life are, household chores, attitudes, inadequate reproductive and sexual health services; negative attitudes of health workers towards women and girls, which results in poor treatment and neglect of women's rights among others.⁵ The trend is for boys and men to now assume responsibility for those who are sick and in need of care like orphans, a role exclusively meant for women and girls, thus change the traditional role of women in the household. The burden of care is particularly heavy and onerous particularly when public and private support services are lacking.⁶

Furthermore, HIV/AIDS related stigma and discrimination tends to intertwine with and reinforces existing prejudices and inequalities. Women and girls are often blamed for bringing the disease and death into the family, regardless of whether and how they may have contacted the HIV. Both from the point of view of effectiveness and from the perspective of social justice, HIV/AIDS programming/campaign must therefore take account of gender dimension of the HIV/AIDS epidemic as gender equality may possibly provide a more effective strategy in reducing the vulnerability to the infection and in enhancing the capabilities of individuals, household and communities to cope with the consequences of HIV/AIDS.⁷

4 Ibid.

5 Keeber, N Gender Mainstreaming in Poverty Eradication and the Development Goals: A Handbook for Policy- Makers and Stakeholders (Commonwealth Secretariat, 2003) p. 162.

6 Ibid.

7 UNAIDS op. cit p. 4.

When human rights of women and girls are truly respected and when women and girls are able to engage their males' counterpart as equal partners in the household, the community, the workplace, at school, at politics, it is hoped that the epidemic will to some extent cease to spread so rapidly and with least devastating effect. In order to enhance the effectiveness of HIV/AIDS programming, the inequalities based on gender relation have to be acknowledged and addressed. The reduction of these inequalities should be integrated to the strategic response to HIV/AIDS. The strategic response must also be informed by the experiences and perspectives of women and girls and should contribute to their empowerment.

In many societies, however, girls/women access to and use of appropriate health care services is restricted. This is apart from the fact that HIV/AIDS treatment is not readily available in most areas affected by the HIV/AIDS. Sexual and reproductive health services are often lacking and inadequate. It is also evident that the quality of health care is compromised where women/girls are concerned, and that women/girls experience inferior and at times degrading treatment by health care workers. Given the inferior social value attached to women's health and their bodies, it is probably not surprising that women themselves tend to neglect their personal health needs, nutrition and medical care in favour of others.⁸

Linked to this is the fact that the distribution of resources and income within the household is not equal. The stigma associated with HIV/AIDS merely serves to enhance these factors and tend to further restrict women's/girls access to health services, because of the inferior social status and the political and cultural sensitivities associated with the HIV/AIDS. As a result of these, women run the risk of being labelled promiscuous or loose when their moral and social status is brought into dispute, and of being rejected by their partners and families. The fear of rejection and consequent loss of support is preventing many women/girls from finding out their HIV status and from seeking out treatment.⁹

HIV/AIDS and Gender

The issue then is what is the relationship between gender and HIV/AIDS? It is evident that gender roles and gender relations

⁸ Keeber, N op. cit p. 162.

⁹ Ibid.

influence the extent to which women and men, girls and boys are vulnerable to HIV infections; can access quality treatment and care; or affected by the negative social economic consequences of HIV/AIDS.¹⁰

Gender refers to the rules, norms, customs, and practices through which the biological differences between males and females are transformed into social differences between men and women, boys and girls. As a result, women/girls and men/boys are valued differently and have unequal opportunity and life chances.¹¹ Gender equality of treatment under the law and equality of opportunity for women and men is far from being realistic. Gender inequality is generated within both genders by society written and unwritten norms, rules and shared understanding. This phenomenon is pervasive across societies and is the most prevalent form of social irregularity; it cuts across other forms of inequality such as class, caste, race, and ethnicity.

Vulnerability on the other hand is the likelihood of being exposed to HIV infection because of a number of factors or determinants in the external environment, which are beyond the control of a person or a particular social group. Women and children particularly from poor communities are among those with enhanced vulnerability to HIV infection as a result of unequal gender relation and inequality.

Femininity refers to the qualities or characteristics considered appropriate for women/girls, for instance the dominant ideologies of femininity expects women/girls to be subordinate, obedient and dependent, passive in sexual relations, virgin, chaste, and monogamous, and privilege motherhood as the primary reason for having sex. Masculinity refers too, on the other hand to the qualities or characteristics considered appropriate for men/boys, for instance, the dominant ideologies of masculinity expects men/boys to be independent, dominant, invulnerable, aggressive, strong and virile.¹²

There is a growing recognition that the HIV/AIDS epidemic thrives on and exacerbates socio-economic inequalities. HIV infection is spreading most rapidly in both rich and poor countries among populations who are economically and socially marginalized. It has been pointed out that this is so because of a complex range of factors,

¹⁰ Ibid at p. 8.

¹¹ Ibid.

¹² Ibid.

including among others lack of access to employment and income generating activities; lack of access to health and social services; lack of appropriate information and support; inability to avoid prevention, treatment and care, the need to adopt livelihood strategies that satisfy immediate survival needs; social exclusion and inability to draw on social support systems; and so on.¹³

At the same time, lack of appropriate services and resources and lack of power, skills and knowledge also impact on the ability of those infected with and affected by HIV/AIDS to cope with the debilitating consequences of HIV/AIDS on their lives, their work, their households and communities, and on social support systems and institutions.

Gender inequality and poor respect for the human rights of women and girls is particularly a critical factor in the HIV/AIDS epidemic. Gender inequality is intimately linked to the spread of HIV/AIDS and the consequences of the epidemic.¹⁴

Globally, heterosexual transmission is the most common form of transmission of HIV and in worst affected areas, a higher percentage of women and girls are infected compared to men /boys. This trend may be attributed partly to the physiological factors that accounts for more efficient transmission of infection from a man to a woman than vice-versa. It is widely accepted that the risk of HIV infection can be minimized if men/boys and women/girls take steps to have safe and consensual sex. This insight has informed the mainstream of national and global responses to HIV/AIDS which have put abstinence, condom use, and faithfulness at the center.¹⁵

However, the discretion to choose when, with whom and how to have sex, including the decision to protect oneself or ones partner from infection, is not merely a matter of individual's choice. The ability to make such decision is profoundly influenced by socio-cultural norms about the appropriate male and female behaviours, the unequal power relation stemming from these norms and the unequal economic condition of men and women. These norms and power imbalances constrain the ability of women/girls to choose the terms of sexual

13 ILO, HIV/AIDS and Human Rights: Promoting Human Rights Through the ILO Code of Practice on HIV/AIDS and the World of Work: Working Paper 3 Geneva: 2003 available at ILO(<http://mirror/public/English/protection/trav/pub/d3rights.pdf>). Accessed 10th April, 2010.

14 Ibid.

15 UNAIDS 'Report on the Global AIDS Epidemic, Geneva 2004.

engagement, negotiate safer and consensual sex, and leave oppressive relations for fear of losing male support.¹⁶

As an example, in many societies in Nigeria the idea of feminine behaviour and sexuality rests on the notion that women/girls should be subordinate, dependent, and obedient and that virginity, chastity and motherhood are critical virtues of women/girls. In some other cultures, the morality of women/girls depends on large part of their passivity and ignorance in sexual matters. The dominant ideal of masculine behaviour and sexuality promotes men/boys as assertive, dominant, independent and strong. High sexual drive and the ability to father many children are considered among the many virtues of men.¹⁷

These notions of masculinity and femininity make it very difficult for both men and women, boys/girls to openly discuss sexual matters talk less of practicing safer sex and to promote more gender equitable relationship. It follows therefore that norms and values are not the only factor influencing the ability of women/girls, men/boys to make conscious choices to protect themselves or their partners from HIV infection. The subordinate status of women/girls often means that the enjoyment of human rights like the right to food, security, shelter, education, health, and work is mediated by, dependent on/or secondary to men/boys. For example, in many countries and cultures like in Nigeria women cannot own land, housing, access to credit, and so on. Women in some of these communities are considered minors; an inferior being.¹⁸

These factors in the long run help in explaining why the HIV infection rate is particularly high among young women/girls. In a study conducted in the sub-Saharan Africa,¹⁹ three out of four young people infected with HIV are young women/girls; between 15-24 years, meaning that the chances of young women/girls contracting HIV is at least 3 times higher than that of their males/boys counterparts in the same group. This has been attributed to the fact that young women are married off to or have sexual relations with older men who are more experienced sexually and may have AIDS infection. The greater

16 Commonwealth Secretariat 'Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach' (London, Commonwealth Secretariat, 2002).

17 Ibid.

18 UNAIDS op. cit p.41.

19 Rao-Guptial G, Whelan D, and Altendorf K, 'Integrating Gender into HIV/AIDS Programming' *Review paper prepared on behalf of WHO* (Geneva, 2000).

economic and social power of older men makes sexual relations with them often the only option for young women living in poverty to make it. In turn, the lesser social and economic power of young women, both because of their gender and age, constraints their ability to bargain for safe and consensual sex, thereby increasing their vulnerability to HIV infection.²⁰

Furthermore, gender based violence is another critical and disturbing factor that enhances the vulnerability of women and girls to HIV infection. Violence against women and girls arises from the notions of masculinity based on sexual and physical domination of women and girls. For instance, in a context of rape and sexual abuse whether by husband or boyfriend, women/girls are obviously least able to refuse sex or insist on protective measures like condoms. Violent sexual acts are likely to result in lacerations which significantly enhance the risk of contracting HIV or other sexually transmitted infections. Equally, fear of violence or abandonment often prevents women/girls from discussing faithfulness or safe sex practices with their partner.

As far as gender factor is concerned, a poster campaign on HIV prevention targeting young people in Africa used different slogans for young men and young women. The poster for young women read '*smart girls say not to sex before marriage*' whereas the poster for young men reads '*smart guys say no to casual sex*'. These messages reinforces notion that virginity is a female virtue, but not something that is valued in young men; thus thereby making the women more vulnerable to HIV infection.

These ideologies may in practice differ depending on age, ethnicity and other social differences. This means that there are many multiple femininities and masculinities in any given context, however, dominant ideologies could be changed, and this has some implications for the spread, infection and prevention of HIV/AIDS

There are commonalities in the factors that enhance vulnerability to HIV infection, the factors that limits access to care and services, and the human rights implication of HIV/AIDS, for instance, lack of food security, work, education, and health are not only contributing factors to HIV vulnerability, but also likely impact of the HIV epidemic.²¹

20 Ibid.

21 UNAIDS op.cit p. 10.

It is worthy of mention that not all women, girls, boys, or men, are the same. Societies and communities tend to hold different expectations of men and women depending on their age, ethnic background, class, marital status, and so on.²²

These factors also influence the extent to which women, girls, men and boys are able to challenge social expectations, overcome institutional constraints and are empowered to assert their human rights; in other words, it is important not to lose sight of the diversities and specific experiences of women, girls, men and boys in addressing the issue of commonality²³ because this will further reinforces the need for context of specific understanding of gender relations and inequality and for culturally sensitivity in terms of their level of vulnerability to HIV/AIDS.

The environments in which men and women, boys and girls live also determine the level of vulnerability to HIV/AIDS infection. Here for instance, the issue of power, skill and resources are important to consider. For example often women are not in a position to discuss sexual matters with their husbands, even if they suspect these men have other sexual liaisons and are not practicing safe sex. The men may deny it, blame the women for being immodest or unfaithful, get angry, become abusive or violent, or even threatened to leave her without economic support; thus leaving the women more disempowered.²⁴

The marital relationship is yet another factor where gender relation affects the vulnerability to HIV/AIDS infection. The husband in most relationship, feels he is physically strong and can impose himself; he believes he is entitled to his wife who has become his property; he is the breadwinner and decides on all expenses, thereby the use of condom as preventive does not arise as condoms are wasteful or diminish sexual pleasure; he can use or threaten physical or emotional violence; he owns the house and thus he is expected to produce many children; and he believes he is not at risk because he has regular girlfriends.

The wife on the other hand is not free to discuss sexual matters with the husband; traditionally believes that husband is entitled to sex

22 Ibid.

23 Ibid p. 11.

24 UNAIDS op. cit p. 18.

whenever he wants to, therefore she knows little or nothing about HIV and how to protect against infection; fears always that the husband will become violent or abandon her as she does not own the house or the land; she is equally expected to have children, even though she earns a living she is expected to hand over her money to the husband; she is not expected to demand for use of condom else the husband will ridicule and call her names as the husband will equate her with a sex hawker if she ever ask for a condom.²⁵

Conclusively, the following factors may be said to be responsible for gender vulnerability to HIV/AIDS in Nigeria; i. e why women are more prone to the risk of infection than men; girl education is not valued; poor parenthood; illiteracy; lack of awareness; inadequate health infrastructures; lack of political will or participation in decision making; lack of adequate women empowerment.

Consequences of Gender Factor in HIV/AIDS

The consequences of HIV/AIDS at household, community, workplace and societal levels also tend to affect men/women, boys/girls differently. **Women/girls are likely than men/boys, to become primary care givers of those who are infected with and affected by HIV/AIDS.** Often they fulfill those roles in the absence of adequate public services and without proper support mechanisms. This responsibility can become so labour intensive that those women who work in the formal sector may be compelled to leave their jobs and enter the informal labour market or may neglect farm activities essentials for food security.²⁶

Due to absence from work, women working in small enterprises in the informal and formal sector lose trading or production and income opportunities, which may lead to growing debt burdens for the households. The enhanced poverty and developmental decline associated with HIV/AIDS may eventually compel women/girls to engage in risky sexual activities in exchange for money, food or other goods and services.

Furthermore, when household income is directed towards the health of male members infected with HIV, this has implications for the nutritional intake, education and overall wellbeing of other members of

the household, and more especially of women and girls. When mothers become ill or die of HIV/AIDS-related illness, the burden of care tends to fall on elderly women and young girls with significant implications for their quality of life and human development. As a result, young women and girls may be forced to forfeit opportunities for education or employment; for instance school drop out among girls may be on the increase.²⁷

Equally, in absence of an adult male breadwinner, the women/girls are likely to be compelled to contribute to household income or ensure food security for the siblings. Often the only viable income earning opportunities for these women/girls are highly exploitative, including sex work/hawking for money, food or protection. As a result, gender inequalities become further entrenched and HIV/AIDS continues to spread.

Women more than men are also at the risk of losing form of social and economic protection due to HIV/AIDS. More so, in many societies as well, widows and unmarried women have lost their access to land, housing and income benefits when their husbands or fathers pass away as a result of HIV/AIDS related illness; as these are not recognized as women's rights.²⁸ In the same vein social form of protection for example against the threat of coercion, violence and rape by other men falls away.

On the whole, there will be a general challenge in the traditional support system with attendant increase in orphans and vulnerable children, disruption in economic performance and reduction in productivity of both the formal and informal sectors.

More so, once a woman becomes HIV- positive, some national policies would restrict her right to become pregnant, carry her pregnancy to term, or even marry.²⁹ For instance in Ethiopia, abortion is severely limited; the country's HIV/AIDS and Human Rights Policy states that prevention of pregnancy shall be encouraged among HIV-positive individuals without specifying how this policy will be implemented in appropriate and non-coercive manner. Also in Chendgu, the capital of China's Sichuan province; the lawmakers made it a crime to marry anyone living with HIV/AIDS. The provincial regulations also suggest

27 Keeber, N op. cit p.42

28 www.genderaids.org.amongst/other. Accessed 10th April, 2010.

29 HIV/AIDS; Reproductive Rights On Line December 2002 (Item: 8025)

25 Ibid at p. 42.

26 ibid

that pregnant HIV-positive women should be persuaded to have an abortion.³⁰

Fundamental Rights of Persons Living with HIV/AIDS

The international community has adopted a number of key instruments/documents which provides a number of clear framework and mandate for addressing gender inequality in general and for addressing gender dimension of HIV/AIDS through the protection of human rights.³¹

These instruments also provide a tool for monitoring progress towards the realization of these rights. The key instruments for gender equality and HIV/AIDS among others are:- a) Convention on the Elimination of All Forms of Discrimination Against Women;³² b) Convention on the Rights of the Child;³³ c) International Conference on population and Development;³⁴ d) International Covenant on Economic, Social, and Cultural Rights;³⁵ e) International Covenant on Civil and Political Rights;³⁶ f) International Covenant on the Protection of the Rights of All Migrants Workers and the Members of their Families; g) United Nations General Assembly Declaration of Commitments on HIV/AIDS; h) United Nations General Assembly Declaration on Violence Against Women; i) International Guidelines on HIV/AIDS and Human Rights; k) and lastly the Millennium Declaration.³⁷

These Documents/Instruments helps in understanding the nature and extent of vulnerability to HIV infection of women, girl, men, and boys; and the gender related barriers to HIV prevention which includes lack of power, resources, skills and information; and putting the rights of women and girls central to programmatic response aimed at curbing HIV spread. Equally, it helps in understanding the social, cultural, economic, political and institutional barriers experienced by women and men, boys and girls living with HIV/AIDS, in accessing and

30 Ibid.

31 Kison, C, and Jithoo, M, "Whose Rights" *AIDS Review* (2002).

32 CEDAW, 1979.

33 CRC, 1989.

34 ICPD, 1994.

35 ICSECR, 1976.

36 ICCPR, 1976.

37 MDG's 2000.

benefitting from treatment and care and putting this understanding central to programmatic responses aimed at providing universal treatment and care. And lastly too, it helps in the understanding of the differential implications of HIV/AIDS on women and men to the coping capabilities of women and men in a manner that challenges and changes gender stereotypes.³⁸

Section 42 of the 1999 Constitution of the Federal Republic of Nigeria provides that a citizen of Nigeria of a particular community, ethnic group, place of origin, sex religion or political opinion shall not by reason only that he is such a person; be subjected either expressly by, or in the practical application of any law in force in Nigeria or any executive or administrative action of the government, to disabilities or restrictions to which citizens of Nigeria of other communities, ethnic group, place of origin, sex, religion, or political opinion are not made subject to.³⁹

In the context of HIV/AIDS, discrimination is the greater problem faced by persons living with HIV/AIDS. Discrimination occurs when a distinction is made against a person that results in his or her being treated unfairly and is unjustified on the basis of their belonging, or being perceived to belong to a particular group. Hospital or prison staff may deny health services to a person living with HIV/AIDS. Employers may terminate a workers employment on the ground of his or her actual or presumed HIV status.⁴⁰

Families or communities may reject, and ostracized those living, or believed to be living with HIV/AIDS. Such acts constitute discrimination based on presumed or critical HIV positive status, a violation of human rights. Discrimination on any of the grounds mentioned under Section 42 is not wrong in itself, but also sustain conditions leading to societal vulnerability to infections caused by HIV/AIDS, in particular resulting in lack of access to an enabling environment that will promote behavioural change and enable people to cope with HIV/AIDS

The Constitution also provides for right to dignity of human person, that no person shall be subjected to torture, or inhuman, or degrading

38 Ibid.

39 Section 42 of the 1999 Constitution of the Federal Republic of Nigeria.

40 Ladan, M.T 'Review of Existing Reproductive Health Policies and Legislations in Nigeria' A Paper Presented At A One-Day Stakeholders' Forum on Reproductive Health in Nigeria Tahir Guest Palace Hotel, Kano 20th April, 2006 p. 6 of 44.

treatment, no person shall be held in slavery or servitude, and that no person shall be required to perform forced or compulsory labour.⁴¹ In the case of *UZOUKWU V. EZEONU*⁴² the Court of Appeal defined 'torture' to include mental harassment, as well as physical brutalization while inhuman treatment characterizes any act without feeling for the suffering of the other.

Degrading treatment was seen as the element of lowering the societal status, character, value or position of a person. From the perspective of HIV/AIDS, it means that segregation and stigmatization of person living with HIV/AIDS because of their zero-positive status, this violates the right to dignity.

The constitution also provides for a right to personal liberty, and that no person shall be deprived of his liberty except in circumstances permitted by law. One of such circumstances is in the case of persons suffering from infectious or contagious disease as HIV/AIDS.⁴³

This constitutional provision has eroded the protected right hereunder. Thus within the context of HIV/AIDS, persons infected or affected by AIDS can be deprived of their liberty, autonomy and privacy interests, thus in effect making the constitutional provision retrogressive. According to Ladan, M.T.⁴⁴ this is contrary to the trends in civil liberties and human rights law being espoused by most democratic nations of the world and under international law.

Arguably, it can be said that the provision is to protect healthy population from harm, and it is of substantial governmental interest to ensure that its population is healthy. Certainly, the early history of infectious diseases where quarantined, and isolation were routinely employed to demonstrate state's disregard for human rights, though this can be said to be any defense that persons suffering from infectious disease are part-ways of transmission and thereby be deprived of their liberty and autonomy.

It is submitted that the right to liberty should therefore, not be arbitrarily interfered with merely on HIV/AIDS status⁴⁵ by using measures such as quarantine, detention in special cases or isolation. Practically, there

41 Section 34 (1) of the 1999 Constitution.

42 (1991) 6 NWLR Pt. 200 p. 708.

43 Section 35(1)(c) of the 1999 Constitution.

44 Ladan, M.T op.cit p6

45 Ibid.

is no public health justification for such deprivation of liberty. On the contrary, it has been shown that public health interests are better served by integrating people living with HIV/AIDS within communities by encouraging their participation in economic and public life.

By interpretation, compulsory testing of HIV/AIDS too can constitute a deprivation of liberty, and a violation of the right to security of person. This coercive measure is often utilized in respect of persons who least are able to protect themselves, because they are within the ambit of governmental institution, for example soldiers, prisoners, sex workers, and homosexuals. There is limited public health justification for such compulsory HIV/AIDS testing and when it does occur, positive results should be followed by counseling and treatment. Hence, there is need for respect of individual's right to physical integrity which has been employed to mean that testing for HIV/AIDS should be voluntary, and that no testing be carried out without the informed consent of person's.⁴⁶

Furthermore, Section 33 of the constitution stipulates that every person has the right to life, and that no one shall be deprived intentionally of his life save in execution of the sentence of a court in respect of a criminal offence of which the person has been found guilty in Nigeria.

The constitution also mention certain exceptions to the above provision, under which an individual's life may be deprived; for instance for the defence of any person from unlawful violence, or for the defence of property, or in order to effect a lawful arrest, or to prevent the escape of a person lawfully detained, or for the purpose of suppressing a riot, insurrection or mutiny.

In relation to HIV/AIDS, government has a sacred duty to protect the life of its citizens. In this wise, government must ensure that treatment such as anti- retroviral drugs are available to persons living with HIV/AIDS. Government should be expected to provide treatments, particularly drugs and to make treatment as accessible to the ordinary people living with HIV/AIDS as possible. The prices of HIV/AIDS drugs and other medications and treatments are often beyond the reach of most citizens. It is important for government not only to subsidize

46 Ibid at p.7.

HIV/AIDS drugs and treatment, but also to facilitate a healthcare infrastructure that makes service accessible and viable nationwide.⁴⁷

The constitution also in its Section 37 provides that the privacy of citizens, their homes, correspondences, telephone conversations and telegraphic communications is hereby protected and guaranteed.

This right to privacy involves obligation to respect physical privacy including the obligation to seek informed consent to HIV/AIDS testing, and safeguard privacy of information, including the need to respect confidentiality of all information relating to a persons HIV/AIDS status. The individual's interest in his/her privacy is particularly compelling in the context of HIV/AIDS, especially by reason of the stigma and the discrimination attached to the loss of privacy and confidentiality if the HIV/AIDS status is disclosed.

The communities thus have an interest in maintaining privacy, so that the citizens will be safe and comfortable in using public health measures such as HIV/AIDS prevention and services. The right to privacy and family life, also includes the right to marry, and to have a family in a protected manner, therefore the right of people living with HIV/AIDS is infringed by mandatory pre-marital testing, or the requirement of HIV/AIDS free certificate as a condition precedent for the grant of travelling visa, or marriage license by the church. Also forced abortion or sterilization of HIV/AIDS infected women violates the human rights of a family as well as the right to liberty and integrity of the person. Women should be provided with accurate information about the risk of pre-natal transmission to support them in making voluntary informed choice about reproduction.⁴⁸

The right to freedom of expression and the press is also guaranteed by Section 39 of the 1999 Constitution. The Section provides that:

Everyone shall be entitled to freedom of expression including freedom to hold opinion and to receive and impart ideas and information without interference.⁴⁹

This right has been interpreted to include the right to seek, receive, and impart HIV related prevention and care information. Thus, the Nigerian Government is obliged to ensure that appropriate and

47 Ibid.

48 Ibid.

49 Section 39 of the 1999 Constitution of the Federal Republic of Nigeria.

effective information on methods to prevent HIV transmission is developed and disseminated for use by the entire population.

The media should be respectful of human rights and dignity, especially the right of privacy and use of appropriate language when reporting on HIV/AIDS. Media reporting should be accurate, factual, and sensitive and avoid stereotyping and stigmatization.

The Constitution also guarantee that everyone shall be entitled to assemble freely and association with other persons, and in particular he may form or belong to any political party, trade union, or any other association for the protection of his interest. The Universal Declaration of Human Rights also provides that everyone has the right to freedom of peaceful assembly and association.⁵⁰

In the context of HIV/AIDS, the freedom of assembly and association with others is essential to the formation of HIV/AIDS related advocacy, lobbying and the creation of self help group affected by HIV/AIDS. Furthermore, persons living with HIV/AIDS should be protected against direct or indirect discrimination based on their HIV status in their admission to organizations of employees or trade unions as well as continuation as members.

Conclusively, the Constitution also stipulates in Section 41 that every citizen of Nigeria is entitled to move freely throughout Nigeria, and to reside in any part of the country, and no citizen of Nigeria shall be expelled from Nigeria, or refused entry.

In the light of this provision, there is no public health rationale for restricting liberty of movement or choice of residence on the grounds of HIV status of a person; therefore any restriction on these rights based on suspected or reason of HIV/AIDS status alone, including HIV/AIDS screening of international travelers is discriminatory, and cannot be justified by public health concerns, and therefore equally contrary to the rights of persons living with the HIV/AIDS by restricting their movements throughout the Federal Republic of Nigeria.⁵¹

Other fundamental human rights guaranteed under the Constitution and having a bearing on persons living with the HIV/AIDS are: the right to freedom of thought, conscience and religion; the right to fair hearing; and the right to acquire and own immovable property anywhere in

50 Ibid at p. 9.

51 Ibid.

Nigeria.⁵² worthy of note is the fact that the Constitution equally makes exception to these fundamental rights when it provides that any law can be made to derogate and restrict these fundamental rights in the interest of defense, public health, or for the purpose of protecting the rights and freedom of others.

The provision of Section 45 (b) provides a general blanket for series of public health regulations enacted for the isolation, quarantine, or other forms of restriction of people living with HIV/AIDS, but the focus of the paper is to seek to diffuse all the form restrictions, and in favour of individual rights guaranteed under the Constitution. Presently these assumed rights of persons infected and affected by the HIV/AIDS exist in form of governmental policies like the Revised National Policy on HIV/AIDS 2003; HIV/AIDS Emergency Action Plan, 2001-2004; and National Action Committee on AIDS, 2004-2005.

However, these policies cannot be effectively promoted, protected, or enforced without a legislative backing or intervention that would upgrade these rights to the level of fundamental human rights provisions in Chapter IV of the 1999 Constitution of Nigeria, or at least to be part of Chapter II on Fundamental Objectives and Directives Principles of State Policy (non-justiciable rights).⁵³

Laws and Policies on HIV/AIDS

The revised National Policy on HIV/AIDS adopted in June 10, 2003 by the Federal Government of Nigeria, among others aims to improve upon the country's response to HIV/AIDS by adequately addressing the overlooked components and improving the previously used strategies of utilizing cost effective, practical, socially acceptable and scientifically sound solutions to ensure that the HIV/AIDS epidemic is brought under control and the country resumes its social and economic development unhindered by the disease.⁵⁴

The overall goal of the policy on HIV/AIDS is to control the spread of HIV/AIDS in Nigeria, and to mitigate its impact to the point where it is no longer of public health, social and economic concerns such that all Nigerians will be able to achieve socially and economically productive live free of the disease and its side effects.

52 Sections 36-45 of the 1999 constitution of the Federal Republic of Nigeria.

53 Ladan, M. T op.cit p. 32-33.

54 Ibid at p32.

The revised policy also signified a new approach to the epidemic in terms of planning, implementation, and evaluation of the country's response to HIV/AIDS. In the same vein all the stakeholders that are affected by the epidemic are to jointly develop plans and processes to mitigate its impact. The strategies include among others the prevention of transmission, provision of support and care for the people affected by the disease, and also to ameliorate the economic and social impact of the HIV/AIDS scourge; all in upholding and protecting the rights of Nigerians including women and children who are more vulnerable to the disease.⁵⁵

This policy though laudable, lacked the necessary legal and institutional framework for its full implementation which has led to poor coordination, multiplicity of efforts, and the general inability to achieve its aims and objectives. These lapses lead to the formulation of HIV/AIDS Emergency Action Plan 2004 (HEAP) with a three years plan to fully maximize investments in the actualization of the Policy. The Action Plan declared that the Federal Government of Nigeria shall constitute a permanent statutory body or agency that derives its power from legislation who shall assume responsibility for the definition of the HIV/AIDS epidemic, build up the country capacity plan, implement and monitor HIV/AIDS programmes, and evaluate the progress and impact of the country's response to the epidemic. An example of such agency is the National Action Committee on AIDS (NACA),⁵⁶ and similar agency established in some state of the Federation, like Borno State Action Committee on AIDS (BOSECA).

However, despite this declaration of the policy and the necessity for an enabling law to establish a permanent statutory body or agency, to date no such legal framework has been passed into law to enable the body/agency to take-off with clearly defined functions, powers and responsibilities to account to the public and other stakeholders in terms of effectiveness, development, execution, monitoring and revision of the (HEAP) objectives, and of all subsequent plans.⁵⁷

The Medium Term Plan of Action for Health Sector Reform for the year 2001-2003, employed a combination of practical approaches, increased funding and additional resources mobilization from donors to

55 Ibid.

56 Ibid.

57 Ibid.

achieve tangible improvements in areas of disease control, sexual and reproductive health diseases including STI's and HIV/AIDS with developmental, partners, organizations and management.⁵⁸

One practical demonstration of the political commitment on the part of Nigerian leadership is the 2004 revision of the National Health Policy which seeks to improve and provide a comprehensive framework for a more coordinated, integrated and sustainable reproductive health programming and clearly specified implementation process including monitoring and evaluation techniques.

Furthermore, the recent 2004-2007 Health Sector Reform Plan of Action seeks to among others support the implementation of the revised National Health Policy, guide investments and actions by all levels of government, the private sectors, donors and all development partners. The development of the HIV/AIDS Emergency Action Plan (HEAP) document as a back up to the National Policy on HIV/AIDS shows a kind of proactive national response to the spread of the epidemic under the current dispensation.⁵⁹

The HIV/AIDS Emergency Action Plan (2001-2004), is a programmatic framework which identified over 200 activities conceived as short term and high impact interventions. Among the achievements of the HEAP is the sustained improvement in establishing and documenting the magnitude, trend and future projections of HIV/AIDS/STDs epidemic, which serve as a formidable tool for advocacy and effective planning; high level advocacy to policy makers and opinions leaders which has resulted in the recent increase in political commitment and increased funding of the national response; acceptance of the reality and an increased level of awareness about HIV/AIDS epidemic by the general population; more openness in the discussion of the disease and its impact on society; the economy and the family; significant mobilization of financial and technical resources from within and external sources; broad based consultative and participatory planning process and the increasing mainstreaming of HIV/AIDS into all facets of national life.⁶⁰

Despite these efforts, however, the national responses to HIV/AIDS, there are lots of challenges and problems to contend with. For instance are, voluntary counseling and testing; provision of drugs and

58 Ibid p. 36.

59 Ibid.

60 Ibid p. 37.

treatment; build infrastructures and general awareness programmes; provision of safety nets for the poor through access to affordable drugs, nutrition; counseling and assistance to help orphans stay in school; rapid expansion of intervention programmes; and to reverse its impact on human development in Nigeria.

The Protocol on the Rights of Women in Africa, Adopted on July 11, 2003, entered into force on 25th November, 2005, is a milestone Instrument for advancing reproductive and sexual health rights of women in Nigeria having been ratified by Nigeria though yet to be domesticated or incorporated as part of Nigerian law,⁶¹ hence legally binding on Nigerians in terms of respect, observance, promotion and protection of the rights guaranteed therein.⁶²

The Protocol in its Articles 1-26, affirms reproductive choice and autonomy as a key human rights, it requires state parties like Nigeria to the protocol to ensure that the right to health of women, including sexual and reproductive health rights are respected and promoted. This includes; the right to self protection and to be protected against sexually transmitted infection including HIV/AIDS, the right to be informed of one's health status and or the health status of one's partner, particularly if affected by sexually transmitted infection including HIV/AIDS.

The Protocol also provides that state parties shall take all appropriate measures to provide adequate, affordable, accessible health services including information, education and communication programmes to women especially those in rural areas. Apart from this Protocol, women's reproductive and sexual health rights includes; equality, right to life, liberty, security of the person, health, family planning, consent to marriage, privacy, protection from all forms of discrimination, sexual violence, harmful practices, and from cruel, inhuman and degrading treatment or punishment. These rights are embedded in the following African and United Nations Human Rights Treaties ratified by Nigeria.⁶³

These treaties are:- The African charter on Human and People's Rights,⁶⁴ the OAU Charter on the Rights and Welfare of the African

61 Section 12 of the 1999 Constitution of Nigeria.

62 Ladan, *op. cit* p. 38.

63 Ibid p. 39.

64 Cap A10 Laws of Federation of Nigeria 2004 Articles 3-6, 16.

Child,⁶⁵ United Nations Convention on the Right of the Child,⁶⁶ United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),⁶⁷ International Covenant on Economic, Social and Cultural Rights (ICESCR),⁶⁸ International Covenant on Civil and Political Rights (ICCPR),⁶⁹ United Nations Convention Against Torture (CAT),⁷⁰

These treaties are legally binding instruments that require all ratifying countries like Nigeria to take specific actions at the national level to respect promote and protect reproductive and sexual health rights of women in particular.

Conclusion

Given the crisis associated with HIV/AIDS, it can be very tempting to assume the use of negative messages in the hope that it will shake people's false sense of security or propel organization into action may tend to result in a sense of disempowerment, fear and apathy. At the same time communication for prevention demands a critical examination of the implicit assumption and norms conveyed in messages to ensure that these messages do not perpetuate gender stereotype.

The information or message must adhere to the 'ACCEPT' principle which stand for Affirming; Correct; Challenging; Empowering; Positive and Transforming. In order words affirming what is ignored or undervalued; correct inaccuracies, ignorance, or lies; challenge dominant norms, perceptions and stereotypes that are degrading and perpetuate inequality; empower for action; present the negative into something positive; transform dominant perceptions and stereotypes.

An advocacy for a gender and right based approach to HIV/AIDS must address the following issues in the near future:- that human rights and gender equality are protected, respected and fulfilled; governmental policies, strategic framework, and delivery mechanisms should be put in place for the promotion of human rights and gender equality.

65 1989 Articles 3-16.

66 Articles 1, 6, 16, 24, 37, 19, 34.

67 1979, Articles 1, 2, 5, 10-12, 16.

68 1966, Articles 2, 10, 12-13.

69 1966, Articles 6, 7, 9, 17, 23.

70 1976 Article 1.

Without these inputs being put in place, the believe is that the HIV/AIDS scourge cannot be effectively curtailed unless human rights are realized, hence the respect for human rights and the promotion of gender equality are pivotal for the reduction of vulnerability to HIV/AIDS infection.

It is the belief that the provision of improved medical care and services for people living with HIV/AIDS, and the mitigation of the social economic impact of the disease more specifically through a gender based approach to reducing the HIV/AIDS scourge, which among others, aims at minimizing the specific nature of vulnerability to HIV infection of women/girls, men and boys. And also to ensure that women/girls, boys and men living with HIV/AIDS enjoy equal access to and use of quality care and support services; minimize the impact of HIV/AIDS on women, men, girls and boys and support their capability to cope with the epidemic.

It is obvious that the need for an appropriate treatment, care and support is particularly high among women. On the other hand, treatment is crucial in preventing HIV transmission from women/girls to their newly born and unborn babies. The right to health of women/girls needs be recognized. In other words, their health and well being has intrinsic value; it should not be promoted as an instrumental strategy to save the lives of their babies which in any case targets only pregnant women and new mothers, rather all women and girls.

Until recently, there has been a marked shift in the global response to the complex AIDS crisis, which continues to worsen. National responses are broader and stronger, and have improved access to financial resources and commodities. As well as increased commitment by affected countries themselves, the advent of the global fund to fight AIDS, Tuberculosis, and malaria, under the AIDS programme of the World Bank, by expanding commitments from donor countries and the work of private sector foundations.

Last, but not the least, we recommend the adoption and passing into law of the Barcelona Bill of Rights, which was a global effort initiated by women at Barcelona and Mujeres with lead involvement by the International Women's AIDS caucus of the International AIDS society and the International Community of Women Living with HIV/AIDS.⁷¹

71 XIV International AIDS Conference, Barcelona, Spain, 11th July, 2002.

The Conference identified women, especially young and the poor as the most affected, because gender inequality fuels the HIV/AIDS pandemic. It is imperative that women and girls speak out, set proprieties for action and lead the global response to the crisis; therefore, women and girls from around the world should unite and urge all governments, organizations, agencies, donors, communities and individuals to make their rights a reality.

Women and girls under the Bill have the right to live with dignity and equality; to bodily integrity; to health and healthcare including treatment; to safety security and freedom from fear of physical and sexual violence throughout their lives; to be free from stigma, discrimination, blame and denial; to their human rights regardless of sexual orientation; to sexual autonomy and pleasure; to equity in their homes; to education and information; and to economic independence.

Under the Bill, the fundamental rights shall include, but not limited to right to support and care which meets their particular needs; to access acceptable, affordable, and quality comprehensive healthcare including antiretroviral therapies; to sexual and reproductive health services, including access to safe abortion without coercion; to a broader array of preventive and therapeutic technologies that respond to the needs of all women and girls regardless of age, HIV status or sexual orientation; to choose to disclose their status in circumstances of safety and security without the threat of violence, discrimination or stigma; to food security, safe water and shelter; to freedom of movement and traveling irrespective of HIV status; to express their religion, cultural and social identities; to associate freely and be leaders within religious, social and cultural institutions; to lead and participate in all aspects of politics, governance, decision-making, policy development and programme implementation.

Appendices

CHAPTER 7

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