CULTURAL PRACTICES AND HUMAN RIGHTS IMPLICATIONS ON HIV/AIDS DISCRIMINATION AND OTHER RELATED ISSUES IN NIGERIA

Abstract

In today's fact changing world law is generally acknowledged as a veritable instrument for the extension of liberties in all societies including Nigeria. In all these societies, the most overwhelming concern in the 21st century is the HIV/AIDS epidemic. Before now, the critical concern by governments and organization around the world have been the social, economic and psychological effects of HIV/AIDS as 'a global emergency and one of the most formidable challenges to human life and dignity, and the active enjoyment of human rights, which undermines social and economic developments throughout the world and effects all levels of society. In the world over considerable efforts are being made to tackle this endemic disease headlong, because of its economic, social and cultural adverse impact in the life of nations. One of such meaning of tackling the disease is through the enactment of legislations on the subject. For instance Nigerian government recently enacted HIV/AIDS Anti – Discrimination Act, 2014 among other laws and policies to address the challenges of HIV/AIDS in the country. The focus of this paper is to use the HIV/AIDS Anti-Discrimination Act, 2014, to justify the enactment of national legislation on AIDS in Nigeria with particular reference to gender discrimination law and human rights. Consequently, this paper will highlight the challenges facing the efforts of the government on HIV/AIDS issues and lastly some recommendations will be proffered

Keywords: *HIV/AIDS, Cultural Practices, Human Rights, Discrimination, Nigeria*

1. Introduction

HIV means Human Immunodeficiency Virus while AIDS stands for Acquired Immunodeficiency Syndrome[1]. With an estimated 3.4 million people living with HIV/AIDS, Nigeria ranks second, in terms of countries with the highest HIV/AIDS disease burden in Africa.[2] The country has continuously stepped – up its response to the pandemic. Recently, the National Agency for the Control of AIDS (NACA) in collaboration with the Joint United Nations Programme on HIV/AIDS (UNAIDS), Nigeria office and other partners conducted the gender assessment of the national HIV response in Nigeria. The assessment aimed at understanding gender dynamics critical for successful implementation of HIV and AIDS programmes in Nigeria. The findings were to be used to strengthen and consolidate existing HIV and AIDS control efforts at all levels and contribute to the implementation of National Strategic Plan (NSP)[3] etc. The National Gender Assessment on HIV/AIDS Report provides yet another opportunity to identify current gaps and helps to strengthen service delivery capabilities. It equally lends to credence to the goal of halting and reserving the HIV epidemic. The government remains committed to averting the potential negative effects of HIV/AIDS and bringing it under control. This is demonstrated in many ways including the efforts of National Assembly through law making, the timely completion of the gender assessment. Moreso, the process adopted that involved all stakeholders including development partners, civil society, public and private sectors and PLHIV showed government strategy of inclusive and collaborative partnership in its strategies to fight HIV/AIDS.

2. Basic facts about HIV/AIDS

AIDS was first officially reported by an America institution in the United States in 1981 and has since became a major epidemic especially in the African (Nigeria) region.[4] AIDS is caused by the HIV virus by killing or damaging cells of the body's immune system, the virus progressively destroys the body's

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[1] N. I. Aniekwu *Reproductive Health Law: A Jurisprudential Analysis of Gender Specific Human Rights for the African Region,* 1st Ed. (Benin; Ambik Press, 2011); 12

[2] Gender Assessment of the National Response to HIV/AIDS in Nigeria

[3] Ibid

[4] M. Wahlberg, *the Acquired Immunodeficiency Syndrome Journal of the National Institute of Allergy and Infectious Disease 29* (National Institute of Health, Bethesda, MD 20892, 1981).

ability to fight infections and certain cancers. People diagnosed with HIV become susceptible to life – threatening diseases called opportunistic infections which are caused by microbes, virus and bacteria that usually do not make healthy people sick.[5]

In many parts of the world, having unprotected sex with an infected partner spreads HIV most commonly. The virus can also be transmitted through contaminated drug needles and syringes, infected blood mother to child during labor and delivery through sexually transmitted diseases etc. Symptoms of opportunistic infections common in people living with AIDS include, coughing and shortness of breath, seizures and lack of coordination, difficult or painful swallowing, mental symptoms such as confusion and forgetfulness, persistent diarrhea, fever, vision loss, nausea, abdominal cramps, vomiting, weight loss and extreme fatigue, severe headaches and coma.[6]

3. Prevalence and Trends of HIV/AIDS in Nigeria

The first case of AIDS was officially documented in Nigeria in 1986 and HIV prevalence rose from 1.8% in 1988 to 5.8% in 2001.[7] As infection rates increased, the Federal Government developed the Nigerian AIDS policy in 1997. It provided that the fundamental human rights of people living with AIDS (PLWH) and other sexually transmitted diseases STDS and their families shall be respected at all times. In addition they should not be discriminated against in any public or private health care facility.[8] Despite these provisions, stigma and discrimination prevailed and infection rates continued to rise because the government did not address underlying factors such as sexual behaviour, treatment and prevention strategies nor did it specify legal obligations to the observance of the above privileges. In the country the emerging picture in the pattern, trend and level of HIV infection over the year show a great diversity and can be described as complex. The pattern shifted from being only a concentrated epidemic restricted to some populations in some states to a more generalized one. The adult HIV prevalence as monitored through antenatal HIV sentinel surveillance among pregnant women increased from 1.8% in 1999 and peaked at 5.8% in 2001 and then dropped to 5% in 2003. It however stabilized within the range of 4.6% - 4.1% between 2005 and 2010[9] . There are also geographic dissimilarities in the dynamics of the epidemic as the prevalence of HIV/AIDS vary from one state to another including rural and urban populations.[10] States like Benue, Akwa Ibom, Bayelsa, Anambra and the FCT have prevalence of between 8.6% and 12.7% while Kebbi, Ekiti and Jigawa States have prevalence of between 1.0% and 1.5%[11]. Benue State has been described as the epicenter of the infection. While some states have more of an urban epidemic, others a rural epidemic, some others seem to have pockets of high prevalence found among high risk groups that could easily infiltrate into the general population through bridge populations.[12] Of interest however, is the social dynamic of the infection. Of the 3.1 million PLWH, 1.72 million are females indicating that females are worst hit by the epidemic. It was observed that in 2007, prevalence was higher amongst females in all the geo-political zones except in the North West where prevalence is 3.6% for males and 2.3% for females. In the same year, the HIV prevalence was consistently higher for females than males in both urban and rural (F: (U: 4.7%; R:3.6%) and (M:(U:3.0%;R:3.3%). Females in the reproductive age bracket have the highest prevalence. Among young people aged 20-24, the infection rate of females (4.5%) is more than double that of their male counterparts (1.9%).[13]

4. Gender Dimensions of HIV/AIDS in Nigeria

HIV/AIDS is a disease which could be suffered by both sexes. However, certain fundamental societal paradigms, among other things, superimpose on women the status of vulnerability in relation to

[5]Anikwu, Supra Footnote 1
[6] *Ibid*
[7]Nigeria Country Profile on HIV/AIDS, USAID (July 2003) Available at www.usaid.gov/locations/sub-shaharanafrica/countries/nigeria.
[8] Section 7, National Policy on HIV/AIDS and STI (Nigerian Aids Policy), 1997
[9] National Agency for the Control of AIDS (2011) brief on the HIV Response in Nigeria, Factsheet
[10] *Ibid*
[11] *Ibid,*
[12] *Ibid*
[13] *Ibid,* Footnote 2

HIV/AIDS in Nigeria. Whatever can be said about HIV/AIDS it is important to note that several factual circumstances spanning from cultural, political, biological socio-economic inhibitions explain this vulnerability.[14] They include the following:

Cultural and Traditional Beliefs

Cultural/traditional beliefs in most Nigerian societies shape human behavioral patterns and ultimately contribute to the vulnerability of women to contracting HIV.[15]

Practice of Polygamy

This is a type of marriage between one man and many women. It is very popular in global south in which Nigerian is part of. Such practice exposes the men (the husbands) to contracting HIV which astronomically increases the risk of all the women who are his partners of being infected.[16]

Value Attached to Virginity

In some cultures, there exist beliefs that if a man has sex with a virgin, he will be cleansed of diseases particularly the chronic ones such as HIV. Also, all serious problems confronting him, his family etc will be solved. This clear misconception has put a sizeable number of young girls and women at high risk of being raped or unduly coerced to involuntary sexual intercourse by men influenced by such misconceptions.

Traditional Practice of Wife Inheritance

This cultural practice allows the wife of a deceased man to be inherited by his brother or relations. In some extreme cases, the women who refuse the practice are thrown out of the family house or economic or life support benefits accruable from the husband's family or personal estate are denied the women. Most women unable to fight for their rights are coerced involuntarily and most cases subdued to this cultural practice that has a high propensity of spreading HIV/AIDS among the women.

Female Genital Mutilation (FGM)

This harmful traditional practice of FGM is still ongoing particularly in the rural areas where current efforts to stop same appear not to be generating the much desired enthusiasm and result. It must be noted that the bulk of the women population resides in the interior or rural areas of the country, where basic infrastructures are mostly inaccessible. It is in these areas that the high priority traditional ceremonies take place. Studies have shown people, who conduct the FGM on women usually use unsterilized facilities on several women, a method which has the potential of contaminating and spreading HIV among the women.[17] However, the National Assembly recently enacted Violence Against Persons Prohibition Act 2015 (VAPPA) to address among other things the practice of FGM in the country. The Act criminalizes the practice of FGM in the country.

Lack of Sex Education and Ignorance

Of concern is the growing cultural belief in most Nigerian societies, that good women are sexually passive and ignorant about sex. Within this cultural paradigm men are expected to dominate sexual relationships and make reproductive decisions for both partners. While men are encouraged to experiment with their sexuality with partners outside the confines of their marital relationship women are expected to remain faithful. But in their faithfulness, they are still confronted and in most cases

[14] Bibobra Bellow Orubebe 'Comparative Reproductive Health Law: Gender Inequality and The Spread of HIV/AIDS in Africa, Recent Trends in the Right to Health: A Case for Coordinated Judicial Approach' in J. N. Ezeilo (ed), *Law, Reproductive Health and Human Rights*, (women aid Collective (WACOL) & Legal Resource Research & Development Centre (LRRDC): 2006

[15] *Ibid*

[16] *Ibid*

[17] R. J. Cook, B. M. Dickens and M F. Fathalla, *Integrity Medicine, Ethics and Law; Reproductive Health and Human Rights* p. 28, 8:4.2 (2003).

overwhelmed by the dangerous sexual exploits of men. This cultural belief indulged passive silence about sex and reproductive health issues make women more vulnerable to contracting HIV/AIDS.[18]

Poverty and Economic Dependence of Women

Women are particularly vulnerable to contracting HIV/AIDS because in most Nigerian societies, economic and power imbalance or gender inequality between women and men often compel women into submissive roles that usually require them to become economically dependent on men. Most economically dependent women for fear of abandonment by their spouses tend to stick to risky relationship in which they do not have control over their sexual activity including the ability to protect themselves and in some extreme cases their children from the transmission of HIV.[19]

Women Biological and Physiological Structure or make up

Statistics currently indicate that over 59% of HIV positive women in Nigeria have been infected with HIV through heterosexual sex. The risk of becoming infected during heterosexual vaginal intercourse (which is the most prevalent source of infection in sub Saharan Africa) is as much as 2-4 times higher for women than for men. This is because the physiological and biological nature of the vaginal mucosa makes it easier for the virus to infiltrate the epitheliel walls and pass into the blood system.[20]

Child Marriage

Female children of young age are married off to older men who usually have other wives and sexual partners. The girl's vulnerability is high because the HIV status of the prospective husband is not usually verified before marriage. Child marriage is not by choice and normally the girls do not have decision making power over their sexuality and health, which implies their inability to negotiate safe sex. The practice of child marriage is sometimes based on the religious/cultural belief that it curbs promiscuity because it reduces the exposure of young girls to multiple sexual partners before marriage. It is also economically motivated in other cases where baby girls even before they are born are betrothed to older man as a means of debt settlement. All this increases girl child vulnerability to the virus.

Gender Based Violence

There exists the belief that women are typically weaker, powerless and more dependent. This makes female more susceptible to violence, including intimate partner violence (IPU). Rape and sexual assault initiated by one or more persons against female makes them vulnerable to HIV.[21] Types of sexual assault generally identified by participatory evaluation process included wife battering with rape; curative rape' of lesbians (using rape as a corrective measure for their sexual orientation) and employers rape of female domestic workers who are often trafficked persons. This act often receive no redress due to the unequal power relations involved, also because victims are dissuaded by relatives not to speak up due to the societal shame that may surround the family of a rape victim, perceived loss of value and/or marriage prospects of the women/girl. It is sad to note that Section 55 of Panel Code encourages domestic violence by making a husband who beat his wife not criminally liable.

Abortion

Noteworthy is the fact that under Nigeria laws abortion is criminal offence except when done to save the life of the mother. Section 232 – 235 of the Penal Code and Sections 227 – 203 of Criminal Code. In order to avoid punishment women usually embark on unsafe abortion which has a high degree of contaminating HIV/AIDS on the process. Also in Nigeria same sex marriage has been criminalized by

[18] J. L. Andreeff, 'the Power Imbalance between Men and Women and its effects on the Rampant Spread of HIV/AIDS Among Women' P 24 Para 4 *American University Washington College of Law human Rights Brief* Vol. 9 (2001)

[19] Testimony on HIV/AIDS and Women's Property Rights Violations in Sub-Sahara Africa, Presented before the United States Congressional Human Rights Caucus (Thursday 10 April, 2003) Testimony Presented by Jennet Walsh, Deputy Director, Women's Rights Division of Human Right Watch.

[20] Ibid, Footnote 1

[21] In *Okoh v. Nigeria Army* (2012) NWLR (pt 167) where a female youth copper was raped by a soldier when the matter proceeded to court during the pendency of the trial a medical test conducted on the victim revealed she was infected with HIV by the accused person since she was a virgin prior to the rape incidence.

the Same Sex Marriage (Prohibition) Act 2014 which makes the offence punishable with 14 years imprisonment. The implication of such prohibition is that lesbians is well as other groups may secretly contract marriages with their partners without going for HIV/AIDS test before the marriage in order to avoid punishment. And such act increases the spread of HIV/AIDS in the country.

5. HIV/AIDS and Human Rights Issues

HIV/AIDS which has resulted in nearly 3 million death worldwide have raised issue about both the human rights of persons living with HIV/AIDS (PLWH and PLWAs) and issues of persons affected by the HIV/AIDS (PABA) M.S Marry Robinson, executive Director of the United Nations Committee on Human Right, has pointed out that HIV/AIDS is a human right issue. This is because human right is an all encompassing issue as one cannot talk of a right to health without right of PLWHA.[22] Prominent amongst the human rights issues being called to question is the right to freedom from discrimination and equally of treatment of all persons. The case of separating 'the healthy from the infected' and the discriminatory treatment meted out on PLWHA is based on the notion of common good of protecting the greater society.

Derogation from guaranteed fundamental rights and freedoms are also permitted in the interest of public health amongst others.[23] The issue of whether a medical officer who discriminates against a patient with HIV/AIDS on this notion of public health is acting in order and as such protected by the law.[24] What amounts to protection of public health? Under the constitution restrictions and derogations from human rights including right to freedom from discrimination are often justified on ground of public health, public safety, public morality and public policy. It is important to point out that HIV/AIDS is not as contagious as other diseases and any discriminatory approach will increase stigmatization and jeopardize relevant participation in prevention, care and support for PLWHA.

In Nigeria, PLWHA suffer from all sorts of discrimination, stigmatization, isolation, detention, quarantine and their right to privacy and confidentiality are breached with impunity. They are tested for HIV without their consent and worst still without pre and post counseling. Considering the serious nature of the HIV testing, it is inhuman and may amount to torture to test one for HIV/AIDS without proper counseling before and after the test.[25] In terms of employment PLWHA are either denied employment or have their employments terminated by their employers on the basis of their HIV statutes, such action is a sheer act of discrimination against PLWHA which may hasten or facilitate their deaths. More so, pregnant women and vulnerable groups are tested without their consent and without being counseled thereby exposing them to other negative consequences, ranging from being subjected to violence or being battered by their spouses and stigmatized by their communities. The cruelest aspect is that they are not offered or given any treatment after testing HIV – positive.

The discrimination, stigmatization, rejection, both mental and physical trauma undergo by PLWHA in Nigeria and world over is exemplified in the case of *Mrs. Georgiona Ahamefule v. Imperial Medical Center and Dr. Alex K. Molokwu*[26] the facts of this case will be discussed in due course. It is important to point out here that the fundamental human rights of PLWHA usually violated whenever they are discriminated, stigmatized etc either in public or private sector include the following:

- Right to life – Section 33[27]
- Right to dignity of the human person – Section 34[28]

[22] M.S Mary Robinson, UN High Commission for Human Rights. Htt/www.unaids.or/whatsnew/pressing/pressar02/humanrights100902htmlaccessed11/12/02.
[23] Section 45 of 1999 Constitution of the Federal Republic of Nigeria (As Amended 2011)
[24] Ibid
[25] See *Uzoukwu v Ezeonu* (1991)6 NWLR (Pt 200). 708
[26] Suit N0: 1D/1627/200 (Unreported) Lagos High Court, Ikeja
[27] Constitution of Federal Republic of Nigeria 1999 (As Amended) See also Article 3 UDHR Article 4 African Charter on Human and People's Right
[28] *Ibid*, See also *Uzoukwu v Ezeonu* (Supra)

- Right to personal liberty[29] Section 35
- Right to private and family life Section 37[30]
- Right to freedom of expression and the press Section 39[31]
- Right of peaceful assembly and association Section 40[32]
- Right to freedom of movement – Section 42[33]
- Right to freedom from discrimination -Section 42[34]

6. Government Responses and Actions on Hiv/Aids in Nigeria

There is no doubt that Nigerian governments had made laudable efforts at different times to address the issue of HIV/AIDS as well as that of discrimination and stigmization that are associated with the virus. Governments efforts in addressing HIV/AIDS in the country shall be discussed under three headings, i.e. firstly, government policies, programmes, guidelines etc on HIV/AIDS, secondly legislative framework on HIV/AIDS and lastly, case law impact on HIV/AIDS. Also by way of extension, relevant NGOs and other private bodies will be considered.

7. Governments Policies, Programmes and Guidelines on HIV/AIDS in Nigeria

It is important to note that the initial response to HIV/AIDS in the country was mostly counseling and support offered by a few NGOs and religious bodies. These private and NGOs of people living with HIV/AIDS currently exist in many parts of the country. Some are groups that provided subsidized services for testing, treatment of aids related diseases and counseling.[35] However, in 1997, the Federal Government, through the federal ministry of health, adopted the National Policy on HIV/AIDS and STI. The policy was designed to limit the spread of HIV/AIDS in the country. But, that was at a time when the magnitude and wide spread nature and impact of the disease was not completely recognized. For this reason, some essential components that are now known to be necessary to control the spread and the impact of the epidemic were not adequately addressed. The resultant effect is that the HIV prevalence rate continued to rise, the number of AIDS related deaths increased and its impact on the country worsened.[36]

It was at the outset of democracy in 1999 that a serious national effort was made by government to tackle HIV/AIDS. In 2000 the Federal Government established two key institutions, the Presidential Committee on AIDS and the National Action Committee on AIDS (NACA). In 2007, NACA was transformed into the National Agency for the Control of AIDS to coordinate the various HIV/AIDS prevention, treatment and care activities in Nigeria.[37] NACA's main responsibility is the execution and implementation of activities under the HIV/AIDS Emergency Action Plan (HEAP) introduced in 1996 as a bridge to long – term strategic plan. HEAP had two main components: firstly to break down barriers to HIV prevention and support community based responses, and secondly to provide prevention, care and support interventions directly. HEAP has now been replaced with the National HIV/AIDS Strategic Framework which will run till 2009[38]. So far there has been some progress towards the goals of HEAP but there are still huge gaps in HIV prevention, treatment and care services, particularly at community level.[39] In 2002, the Nigerian government started an ambitious antiretroviral (ARV) treatment programme to get about 10,000 adults and 5,000 children onto ARVs within one year. An initial 3.5 million worth of ARVs were imported from India and delivered at a subsidized monthly cost of $7 per

[29] *Ibid*
[30] *Ibid*, See also Article 17 ICCPR
[31] *Ibid*, see also Article 19 UDHF and Article 9 of African Charter.
[32] *Ibid*, see also Article 20 UDHR, Article 10 of African Charter
[33] *Ibid*, see also Art 13 UDHR, Article 12 African Charter, See also Shingaba v the Federal Minister of Internal Affairs and Ors (1981)2 N.L.C.R 459
[34] *Ibid*, See also Article 14 ECPHR, Article 7 UDHR, Article 2 of AFCHR
[35] *Ibid*, Footnote 1
[36] P. Buki, 'Nigeria Youths on Crossfire', 8 *Populi* 53 (December, 1999)
[37] Available at http://www.naca.gov.ng/
[38] Available at http://www.globalaidsalliance.og/docs/debtconversionnigeira.doc.
[39] *Ibid*

person.[40] In 2003, a National Policy on HIV/AIDS was adopted. However due to shortage of drugs the programme suffered a great set back in 2004 though it was later addressed and remedied.[41] In 2005, a National HIV/AIDS Policy for the Workplace was drafted. Both the 2003 and 2005 policies did not contain specific provisions for the legal implementation of human rights protection for PLWHA or PABA. In particular, there was no affirmative action to protect women's interests in both documents even though, by now, there was conclusive data to show the gender infection rates of the disease amongst the general population. By 2006, around 636,000 people were estimated to require antiretroviral therapy, of which only 7% were reported to be receiving the drugs[42]. A survey showed that discrimination was apparent in the availability and distribution of retroviral.[43] The fear of stigmatization was also responsible for PLWHA not availing themselves of the government subsidized supplies from NACA.[44] In April 2007, an HIV/AIDS summit was held in Abuja to review progress towards the achievement of national goods. Other policies, plans and guidelines on HIV/AIDS include

- National Policy on HIV/AIDS 2009
- National HIV/AIDS Strategic Framework 2010-2015
- National HIV/AIDS Strategic Plan 2010-2015
- National HIV/AIDS Prevention Plan 2010-2015 (under review)
- National Guideline for Implementation of HIV Prevention Programmes for FSWs (2012)
- Annual Strategic Plans of State Agencies for the Control of AIDS etc

It will be pointed out here that policies, programmes, plans and guidelines are at best statements of intention which are not justifiable. This status contributed to the poor realization and implementation of the objectives of those policies.

8. National Legislative Framework on HIV/AIDS in Nigeria

Not until 2014, there was no legally binding national legislation addressing HIV/AIDS and its related matters in the country. As such the practice of discrimination and stigmatization of PLWHA and PABA held swayed in both public and private sectors in the country.[45] As noted earlier, lack of legally binding law in the country accounted for the poor realization of various policies and programmes goals on HIV in the country. However in 2014 the National Assembly saw the need to enact the HIV and AIDS (Anti-Discrimination) Act, 2014 to address issues of HIV/AIDS in the country. Section 1 of the Act which is the objective section captures the whole essence of the Act and what it set out to achieve.

9. Key Sections of the HAD Act

Section 1 provides that 'the purpose of the Act is to protect the rights and dignity of people living with and affected by HIV and AIDS by'.

a. Eliminating all forms of discrimination based on HIV status
b. Creating supportive environment so that people living with HIV/AIDS are able to continue working under normal conditions for as long as they are medically fit to do so.
c. Promoting appropriate and effective ways of managing HIV in the workplace, community, institutions and other fields of human endeavour.
d. Creating a safe and enabling working and learning environment for all persons.
e. Creating a balance between the rights and responsibilities of all persons in the society and

[40] As Reported by NACA at World Aids Day held in December 2006 at Abuja.
[41] National HIV/AIDS and Reproductive Health Survey (NARHS), Federal Ministry of Health, Abuja (August, 2006).
[42] WHO, Progress in Scaling up Access to HIV Treatment in Low and Middle – Income Countries 29 (June – August 2016)
[43] Federal Ministry of Health survey in Reducing Stigma and Discrimination Surrounding HIV/AIDS in Nigeria, Engender Health, Available at www.engenderhealth.org/ift/nigeria-2html
[44] NACA Bulletin, November 2006
[45] Notably in 2007 Lagos State House of Assembly Passed into Law, Persons Living with HIV/AIDS Law 2007, which Guarantees Protection of Person Living with HIV and Affected by AIDS in the State by giving them Access to Medical Care/Treatment, Employment etc in the State. See also Enugu State HIV/AIDS anti- Discrimination and Protection Law, 2007

f. Giving effect to human rights guaranteed in chapter 4 of the 1999 Constitution of the Federal Republic of Nigeria, as amended and obligations under international and regional human rights and other instruments.

Furthermore, Section 3 of the Act prohibits all forms of discrimination against persons living with HIV in every institution, whether public or private in Nigeria.[46]
It provides as follows:

(1) 'People living with or affected by HIV or AIDs have a right of freedom from discrimination on the basis of their real or perceived HIV or status concerning access to and continued employment conditions of employment, employment benefits, comprehensive health services, education use of public facilities and other social services, provided by the employer, individual, community, government or any other establishment.
(2) 'Individual, communities, institutions, employers and employees have a mutual responsibility to prevent HIV – related stigma and discrimination in the society'.
(3) No culture, practice or tradition shall encourage practices that expose people to the risk of HIV infection.

This section has been described as one of the sections of the Act with a far reaching effect as it tends to protect PLWA from discrimination in both public and private life.

Section 5 of the Act requires the taking of affirmative action by employers, communities, institutions etc to ensure the welfare and protection of PLWHA/PABA.[47]

There is a need to reproduce the provision of the section for a better comprehension. The section provides that;

4(1) 'Every individual, community, institution and employer shall take steps to protect the human rights of people living with or affect by HIV or AIDS by eliminating HIV related discriminations in all settings, including employment health and educational institutions, policies and practices'.
(2)Every individual, community and employer shall take steps to promote equality of opportunity and treatment and non-discrimination on the basis of real or perceived HIV status and HIV related illness.

This paper submits that this section is unnecessary duplication since it is all furs with Section 3 which gives protection to PLWA against any form of discrimination in both public and private sector.

Under Section 8 no public or private body shall require an individual to disclose his or her HIV status whether in relation to employment or not.[48] Section 13 of the Act makes provisions for confidentiality of a person's HIV status, especially by the health personnel. Moreso under section 13 (2) any person who breaches this obligation of confidentiality shall be liable on conviction to a fine not less than N500,000 for an individual and N1 million for corporate body or for a term not exceeding two years or both fine and imprisonments.[49] Section 22 makes discriminations, threats, intimidation, offer of inducement to intimidate etc offences, while contraventions of this provision is liable on conviction to a fine not less than N500,000 for individuals and N2 million for corporate bodies or a term not less than one year or both such fine and imprisonment under section 23.[50] Apart from criminal liability, the Act also makes provision for civil liability which makes it a comprehensive law in relation to HIV/AIDS matters. Section 26 gives an individual or group a right to commence a civil suit against any person(s) or body (ies) who violate his/their rights under the Act. Remedies available under the Act include

[46] S. 4 of the Act Provides for the Protection of the Rights of People Living with HIV/AIDS in the Country
[47] S. 8 provides a checklist of acts constituting or amounting to discrimination
[48] S. 11 prohibit disclosure of an individual hiv status to another person without his written consent.
[49] Ss. 15. and 17 provide for occupationally acquired hiv infection and the duty of the employer to prevent and report such occurrence
[50] S. 24 it is the duty of minister of justice to ensure compliances with the provisions of the act while under S. 25 the minister shall make recommendation based on inquiry he conducted

payment of compensations and damages, prevention of discrimination, deregistration of corporation and withdrawal of individual professional license.[51]

10. The Limitations in the HIV/AIDS Act

However, as commendable and laudable as the Act may look, there are some holes that could be picked in the Act. For instance section 5 of the Act which provides for affirmative action to be taken under subsection (2) (b) provides that 'it is not unlawful to distinguish, exclude or prefer any person on the basis of an inherent requirement of a job or any other service. It is submitted here that many organizations and institutions will hide under this provision to exclude PLWH/PABA on the ground that they are not suitable for their job. For the purposes of clarity there is need to reproduce the two sections.

Section 5 provides that (2) for the purpose of the Act, it is not unlawful to;

a. Take affirmative action consistent with the purpose of the Act; or
b. Distinguish, exclude or prefer any person on the basis of an inherent requirement of a job or any other service.

Secondly, the combined effects of Sections 9 (5) and 14 of the Act is that its provisions are subject to any existing law which empowers an institution to demand a person to undergo a compulsory HIV testing either for an employment or for other reasons. Section 9 (1) (5) provides as follows;

(1) 'No employer, institution, body or individual shall require an HIV test as a precondition to an offer of employment, access to public or private services or opportunities' except where it is shown, on the certification of two competent medical authorities (working independently) to the court, that failure to take such a test constitutes a clear and present danger of HIV transmission to others.

(5) 'Nothing in subsection (1) of this section shall prevent the medical testing of persons for fitness for work and any other responsibility as a precondition for an offer of employment and any other responsibility as provided in any existing law'.

While section 14 (1) (2) provides that;

(1) subject to any existing law, the HIV status of an employee shall not affect his or her eligibility for any occupational or other benefit scheme provided for employees.

(2) Where under any existing law, the eligibility of a person for any occupational or other benefits scheme is conditional upon an HIV test, the conditions attached to HIV and AIDs shall be the same as those applicable in respect of comparable chronic conditions.

It is worthy to note that these sections made jest of the objectives of the Act because any recognized laws including bye laws qualify as existing law.

Another envisaged challenge in the Act is the issue of implementation. The Act vests in the Minister of Justice the power of implementation.[52] The problem arising from this is the fact that Minister of Justice had already too many duties to perform under different laws which may affect the discharge of his obligations under the Act. Moreso the Minister of Justice is too far from the people especially the grass root since the Act did not create a collaborative bodies in the States and/or local, government councils. Lastly, another food for thought is the compulsory requirement to communicate in writing to the Minister of Justice an individual's decision to commence a civil suit under section 26 (1). It provides that 'Nothing in this Act shall limit the personal right of an individual or group affected directly by a contravention of this Act to bring a civil action in court against any person or institution provided' that whoever elects to do so shall communicate his or her decision to the minister of justice in writing alongside the petition.

[51] See section 27 (a-d) of the Act
[52] s. 24 of the Act

It is submitted here that this provision has the potential to create procedural and practice problem in enforcing the Act as the defence counsel will usually and always raise a preliminary objections on the ground that the petitioner has not communicated his intention to the minister which is a condition precedent to institution of action under the Act.

11. International and Regional Instruments on HIV/AIDs in Nigeria

It is also relevant to mention both international and regional instruments ratified by Nigerian Government which address the issue of HIV/AIDS. They include

- Convention on the Elimination of all Form of Discrimination Against Women (CEDAW) 1979
- UN Declaration on HIV/AIDS
- The Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa (2005)
- International Conference on Population and Development (ICPD) 1994
- Beijing Platform of Action, 1995
- Sustainable Development Goals 2015[53]

12. Impact of the Judiciary on HIV/AIDS in Nigeria

There are a few reported cases on HIV/AIDS in Nigeria unlike the cases in South African and other countries. A well known case in Nigeria is that of *Mrs Georgina Ahamefune v Imperial Centre and Anor*.**[54]** Below is the summary of the facts. In the case the plaintiff was an auxiliary nurse employed by the 1st defendant and Dr. Alex. K. Molokwu, 2nd defendant. Sometime in 1995, when she became sick, she was treated by 2nd defendant who later carried out diagnostic tests on her but did not tell her the results of the test. Instead he asked the plaintiff to proceed on two weeks medial leave and also referred the plaintiff with a sealed envelope to Dr. Okanny of LUTH. Upon reading the note ask the plaintiff to come with her husband, where upon their blood was obtained without telling them the nature of the test to be conducted. Thereafter the doctor told the plaintiff that she is HIV positive while her husband tested negative. When the plaintiff returned to the Centre the 2nd defendant without counseling her terminated her employment on the ground of the plaintiff's HIV/AIDS status without termination benefits. Later on, the plaintiff had a miscarriage and lost the pregnancy. The 2nd defendant refused to carry out its own recommendation of 'clean up or evaluation' a medical procedure to remove the dead foetus on the grounds of the plaintiff's HIV status, because he did not want the plaintiff to contaminate the medical center's instruments. The plaintiff then sued the 1st and 2nd defendants in the High Court of Lagos State. In the court, the plaintiff counsel urged the court to grant him accelerated hearing of the case. While the defence counsel contended that a medical report from an expert is necessary to guarantee that the plaintiff will not contaminate others in the courtroom. But the plaintiff counsel argued that the plaintiff being a human being has the right to give evidence in court. However, the judge ruled in favour of the defence counsel that 'life has no duplicate and must be guarded jealously'. Therefore, a medical report is importance to show that she will not infect others. The plaintiff then appealed to the court of appeal contending that the trial court ruling violated her constitutional rights of dignity of human person, right to fair hearing and right of access to court[55]. The court of appeal upheld the appeal and held that it was unconstitutional to refuse the plaintiff access to court on the bases of her HIV positive status.

Furthermore, in the South African case of Hoffmann v South African Airways[56] when the plaintiff an HIV positive person applied for employment to work as a Cabin attendant/crew and successfully completed the required cumbersome four – stage employment selection process. As part of the requirement, he was subject to a detailed medical examination, which revealed his HIV – positive status and based on this fact, the South African Airways (SAA) rejected the plaintiff's application. The plaintiff then brought action against SAA arguing that its refusal of his application violated his constitutional guaranteed rights. SAA responded that their refused was justified for public health concerns as plaintiff, being HIV positive could not have yellow fever vaccinations, which world pose a

[53] This present world goal successor of millennium development goals, 2000 which it duration ended in 2015
[54] Suit N0: 1D/1627/2000 (unreported) Lagos High Court, Ikeja
[55] See sections 34, 36 and 6(6) (c) of the Constitution of Federal of Nigeria 1999 (as Amended 2011).
[56] Republic of south Africa, Constitutional Court (2001) BHRC 571; 3 CHRLD PP. 146-148 92003)

considerable public health risk to customers. Among other things, the court held that an employer that declined to hire an HIV – positive applicant violated S. 9 of the Constitution which prohibits unfair discrimination.[57]

13. Participation and Coordination of Various Sectors on HIV/AIDS in Nigeria

Networks and organizations focused on PLWHA, women's rights, gender equality, youth and other key populations have been constituted into constituency coordinator entities (CCEs) as an integral component of the national partnership. They are involved in decision–making at different stages, levels and sectors of the national HIV response, including design and implementation of the response where necessary. The CCEs include:[58]

1) Civil Society for HIV/AIDS in Nigeria (CISHAN)
2) Network of People Living with HIV/AIDS in Nigeria (NEPWHAN)
3) Society for Women Against AIDS in Nigeria (SWAAN)
4) Nigeria Youth Network on HIV/AIDS
5) National Faith – Based Advisory Council on AIDS (NFACA)
6) Media, Arts and Entertainment
7) National AIDS Research Network
8) Nigeria Diversity Network – representing groups with high risk of infection
9) National Women Coalition on AIDS (NAWOCA)
10) Association of Women Living with AIDS in Nigeria (ASWHAN)

NACA facilitated the formation, funding and capacity building of CSOs into constituent coordinating entitles. These CSOs have had active involvement in the development of the multi- sectoral strategy: the review of the national HIV/AIDS policy, participation in the NSP development, work with the house committee on HIV/AIDS and participation in the review of the NSF 11[59] . They have also been actively involved in the planning and budgeting process for the NSP on HIV both at the state and national levels. Furthermore, NACA created a platform for CSO interaction and partnerships with donors.[60]

14. Challenges Encountered in Addressing HIV/AIDS and other Related Matters in Nigeria

Studied have shown a number of obstacles militating against the fight on HIV/AIDS discriminations and other related matters in the country. They include:

- stigma is a major factor driving this epidemic, creating disincentives to disclose status or seek for treatment, thereby increasing the spread of infection
- many PLWHA/PABA often do not recognize their rights and as such unable to respond when violation takes place
- the level of sensitization is low and political commitment is still low to address anomalies in our laws
- litigation and it processes are quite long and expensive justice is hard to access, sometimes PLWHA see court action as a source of stigma to them
- some states are lagging behind due to political, religious and cultural factors, which impede the fight against HIV/AIDS and other developmental issues
- Skills gap on the part of implementers and ignorance on the part of law enforcement officers.
- System failure: most institutions have week administrative structures, and sometimes policies are not backed by implementation framework
- Lack of budgetary allocation for HIV/AIDS and other related matters
- lack of implementation of the existing laws, policies, programmes and guidelines on HIV/AIDS in the country

[57] See also *Treatment Action Compaign and 2ors v Minister of Health & 9 ors* case N0. 21182/2001
[58] Supra, footnote 2
[59] *Ibid*
[60] *Ibid*

- Non justifiability of social and economic right, for example the right to health and access to health care facilities, constitute a major obstacle in bringing an action to claim the right to free anti-retroviral drugs.[61]

15. Conclusions and Recommendations

This paper views HIV and AIDs (Anti, Discrimination) Act as a right step in the right direction, as the Act if effectively implemented will go a long way in protecting PLWA in Nigeria. Nigeria government is encouraged to under study South African government programme on HIV / AIDs. For instance, in South Africa condom use and distribution has become a matter of public policy. More so, HIV education and awareness programme is implemented through life orientation lesson.[62] South Africa has zero tolerance for discrimination against PLWA in the country. In fact, HIV is now seen like every other sickness and people now declare their HIV positive status with proud and without fear of discrimination and stigmatization.[63]

As Nigeria Government is making effort to conform with best international practices on HIV / AIDs, the general public is encouraged to develop attitudinal change over PLWA, as the disease is not a choice rather could happen to anybody no matter how holy and religious one maybe. Therefore, we generally owe it a duty to treat those living with HIV/AID with care and humanity.

By a way of conclusion and in view of the above stated challenges to the fight against HIV/AIDS in the country, the following recommendations have been made.

- Criminalization of deliberate and international transmissions of HIV from experience of countries that have attempted that has shown that it impedes prevention and control.[64]
- Increase effort at community levels to create awareness by enjoying in human rights education that will boost understanding of HIV and the rights of PLWHA and reduce the stigma associated with the disease.
- Law reform and legal advocacy integrated to other community interventions to address stigma can bring effective change.
- Health care workers should undergo training on ethics and human rights in order to be licensed to practice and should be re-trained continuously. Also, there is need for insurance policies of the lives of medical personal in every hospital.
- Code of conduct based on human right and ethics including HIV related issues should be adopted and enforced in all public health facilities.
- The country must ensure access to treatment for people with HIV/AIDS that will enhance prevention, openness and non – discrimination in the epidemic. It must promote and respect individual autonomy and dignity even in provision/delivery of aids treatment.
- International regulations on HIV/AIDS should be made binding at international and domestic levels for actualization of these rights
- Policies, programmes guidelines etc HIV/AIDS should be translated into laws to create binding legal obligations at the national level.
- Free legal aid services should be made available to PLWHAS whose rights have been violated
- The law should enable all PLWHA to bring an action under a pseudo name and prohibits lifting of identity and to permit hearing in camera to protect the privacy of person involved.
- Intergovernmental agencies and donors should found programmes and projects focusing on human rights and HIV/AIDS particularly outreach legal education at grassroots level.
- There is need for public and private partnership in fighting against HIV/AIDS , stigma, discrimination among others in the country
- An adequate budgeting provision is a key to the fight against HIV/AIDS as well as its treatments.

[61] section 6(6) and chapter 2 of the 1999 Constitution (as amended)

[62]HIV and AIDs in South Africa UNAIDS Gap Report 2014, http://www.avert,org/professionals/hiv_around_world/sub_saharan_Africa/SouthAfrica.

[63] Ibid

[64] Supra, footnote 14