

# **HIV/AIDS and Human Rights in Nigeria**

Background Paper for HIV/AIDS  
Policy Review in Nigeria

Prepared by the Centre for the Right to Health for the POLICY  
Project with contribution from:

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**September 2003**

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## EXECUTIVE SUMMARY

As of December 2001, the Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that 40 million people worldwide are living with HIV/AIDS with 5 million new infections in 2001 alone. As of 2000, 21.8 million deaths were attributed to AIDS. Unfortunately, sub-Saharan Africa is home to the majority of new infections, deaths (including deaths of children), people infected and the subsequent social impacts of these phenomena.

The data for Nigeria show that the country has not escaped this regional trend. The results of the 2001 seroprevalence survey among antenatal clinic attendees indicated that HIV infection was present in all the states of the federation, with a national prevalence of 5.8 percent. An estimated 3.2 million Nigerians between the ages of 15 and 49 are currently living with HIV/AIDS.

While people living with HIV/AIDS (PLHAs) deal with the medical impact of HIV/AIDS, their status may result in or be a consequence of social and economic factors, including human rights. The links between health and human rights are complex and multidirectional. Human rights violations often increase people's vulnerability to HIV infection particularly for women, young people, and other marginalised groups. In Nigeria and elsewhere, PLHAs frequently experience gross violations of human rights, such as denial of treatment in health care institutions, breaches of privacy and confidentiality, termination of employment, ejection from housing, and other forms of discrimination and social exclusion. These violations affect not only PLHAs; family members and others perceived to be at high-risk of HIV/AIDS (such as sex workers) may experience discrimination and subsequent increased risk, thus perpetuating the cycle.

An effective policy response to the HIV/AIDS epidemic in Nigeria must therefore take into consideration the socioeconomic, ethical, legal, and human rights dimensions of HIV/AIDS. Nigeria's 1997 National Policy on HIV/AIDS and STIs lacks depth, and its use had been limited due to lack of dissemination to key stakeholders. Furthermore, as the 1997 policy itself notes, the policy must now be updated and reviewed in light of new information. This background paper on HIV/AIDS and human rights is aimed to inform and guide the review process.

The paper provides in-depth information on the inextricable relationship between HIV/AIDS and human rights, including issues relating to testing, confidentiality, access to treatment/drugs, gender, the workplace, health worker/patient interaction, and HIV/AIDS in the family and community and among vulnerable populations such as prisoners and sex workers. It draws extensively from material prepared by UNAIDS and the United Nations Centre for Human Rights (UNCHR), and International Guidelines on HIV/AIDS and Human Rights. It explores universal human rights set out in international and regional treaties of which Nigeria is a part, including the Universal Declaration of Human Rights (UDHR); International Covenant on Civil and Political Rights (ICCPR); International Covenant on Economic, Social and Cultural Rights (ICESCR); African Charter on Human and People's Rights (ACHPR); Convention on the Right of the Child (CRC); and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

These include the rights to

- life
- privacy
- marry and found a family
- equal access to education
- work
- the highest attainable standard of physical and mental health

- liberty and security of persons
- share in scientific advancement and its benefits
- freedom of association
- freedom of opinion and expression and the right to freely receive and impart information
- participate in public and cultural life
- freedom of movement
- an adequate standard of living
- social security, assistance, and welfare
- seek and enjoy asylum
- non-discrimination, equal protection, and equality before the law
- be free from torture and cruel, inhumane, or degrading treatment or punishment

Whenever possible, international consensus on many of the issues is presented along with anecdotal information about the experiences of PLHAs in Nigeria.

## ABBREVIATIONS

ACHPR	African Charter on Human and People's Rights
ADA	Americans with Disabilities Act
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral (therapy)
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
CRH	Centre for the Right to Health
HIV	Human immunodeficiency virus
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social, and Cultural Rights
ILO	International Labour Organisation
PLHA	People living with HIV/AIDS
SAA	South African Airways
STI	Sexually transmitted infection
TRIPS	Trade Related Aspect of Intellectual Property Rights
UAS	Unlinked anonymous screening
UDHR	Universal Declaration of Human Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCHR	United Nations Centre for Human Rights
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
VCT	Voluntary counselling and testing
WHO	World Health Organisation
WTO	World Trade Organisation

## **INTRODUCTION**

As of December 2001, UNAIDS estimates that 40 million people worldwide are living with HIV/AIDS with 5 million new infections in 2001 alone. As of 2000, 21.8 million deaths have been attributed to AIDS. Unfortunately, sub-Saharan Africa is home to the majority of new infections, deaths (including deaths of children), and people infected and the subsequent social impacts of these phenomena.

In Nigeria, the epidemic has grown from a relatively unknown infection with a seroprevalence rate of 1.8 percent in 1991 to a burgeoning epidemic with 5.8 percent prevalence in 2001 among antenatal clinic attendees. HIV infection is present in all 36 states of the federation. An estimated 3.2 million Nigerians between the ages of 15 and 49 are currently living with HIV/AIDS.

In Nigeria, as in other parts of Africa, persons living with HIV/AIDS (PLHAs) often experience discrimination and stigmatisation by family or in the workplace, at school, and in other settings including prisons, and health care and religious institutions. They may also face discriminatory practice in other sectors, for example, in access to insurance policies and international travel. Stigmatisation and discrimination may also place the most vulnerable members of society, such as children, women, youth, refugees, and prisoners, at increased risk for contracting HIV/AIDS. These violations are often driven by fear due to lack of knowledge, prejudice, and a dangerously misguided and misinformed desire to protect public health. In fact, public health often provides an added and compelling justification for safeguarding universal human rights, despite the respect, protection, and fulfilment that they merit in their own right. In the context of HIV/AIDS, an environment in which human rights are respected ensures that vulnerability to HIV/AIDS is reduced through information and empowerment, that those infected with and affected by HIV/AIDS live a life of dignity without discrimination, and the personal and societal impact of HIV infection is alleviated.

In an environment that is filled with stigma and discriminatory attitudes and practices against PLHAs, it is likely that PLHAs will have difficulty accessing information, counselling, and support services that would prolong their lives. They may also be reluctant to disclose their status or seek assistance for fear of repercussions. Indeed, stigma, discrimination, and lack of respect for human rights may also be powerful disincentives for people to find out their HIV status through available voluntary counselling and testing (VCT) services, thus increasing the likelihood that infected individuals will unwittingly spread HIV. Stigma and discrimination may also lead to a dangerous complacency in individuals and groups who are not targeted and therefore assume they are not at risk. It also exacerbates existing forms of marginalisation, which tends to deepen the already increased vulnerability to HIV infection of these marginalised groups and their ability to deal with the impact of the disease.

### **Human Rights**

Human rights are inherent in man; they arise from the very nature of man as a social animal. Human rights constitute a body of unique virtues, which are highly cherished and valued from inception of time. In a paper presented by Justice Izuako at a seminar titled "HIV/AIDS and Human Rights: The Role of the Judiciary," human rights were described in the words of former Indian Chief Judge, Justice B.N. Bhagwati, as not ephemeral, not alterable with time and space and circumstances. They are not the product of philosophical whim or political fashion. They have their origin in the fact of the human condition, and because of this origin, they are fundamental and inalienable. More specifically, constitutions, conventions, or governments do not confer them. These are the instruments, the testaments of their recognition; they are important, sometimes essential elements of the machinery for the protection



and enforcement of human rights, but they do not give rise to human rights. Human rights were born not of humans but with humans.<sup>1</sup>

The concept of human rights is grounded in concepts of human dignity and equality, which can be found in most cultures, religions, and traditions that are today reflected in many legal systems. PLHAs have the same fundamental social, cultural, civil, and political human rights as any other person by virtue of their humanity. These rights are universal, indivisible, interdependent, and interrelated.

The need to protect and promote the rights of PLHAs is predicated on the standards contained in the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights (ratified by Nigeria in 1993), and domesticated by means of the African Charter on Human and People's Rights (Ratification and Enforcement Act, Cap 10, LFN, 1990) and other international human rights instruments, such as International Labour Organisation (ILO) instruments concerning discrimination in employment and occupation, termination of employment, protection of workers' privacy, and safety and health at work. Many of these fundamental rights are enshrined in Chapter IV of the Federal Constitution of Nigeria 1999.

### ***HIV/AIDS and Human Rights: The Role of Policy***

Policy is a definite course or method of action selected in light of given conditions to guide and determine present and future decisions.<sup>2</sup>

Human rights, ethics, and law are critical frameworks to elucidate, define, and regulate human behaviour. More particularly, human rights, ethics, and law regulate the relationship between governments and their citizens and the relationships between individuals, among groups, and within communities. HIV/AIDS is a condition among human beings driven by human behaviour. It is affected by the nature of relationships between individuals, the nature of relationships among groups in society (particularly power relationships), and the nature of government response.

Legislators can advance HIV/AIDS and human rights issues at local, regional, and national levels in several of their roles:

- As political leaders, they can influence public opinion and increase public knowledge of relevant issues.
- As legislators, they vote on acts of parliament and can ensure that legislation protects human rights and advances effective prevention and care programmes.
- As advocates, they can mobilise the involvement of government, private sector, and civil society to discharge their societal responsibilities in responding appropriately to the epidemic.
- As resource mobilisers, they can allocate financial resources to support and enhance effective HIV/AIDS programmes that are consistent with human rights principles.

Legislators can specifically assist with implementation of international guidelines by

- Educating their peers about the guidelines at national, provincial, and local levels to encourage promulgation, acceptance, and endorsement;
- Devising a strategy for disseminating the guidelines to key actors and developing action plans for monitoring and implementation of priority issues; and
- Participating in consultative review and reform of the law by drafting either government-sponsored or private member's bills.

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<sup>1</sup> Centre for the Right to Health, 2001c. HIV/AIDS & Human Rights: The Role of the Judiciary.

<sup>2</sup> AIDS Law Project, South Africa (1997). AIDS and the Law – South African AIDS Legal Project.

Processes are needed to ensure that all branches of government follow a human rights-based response to the epidemic, including the legislature. Democratically elected parliamentarians are in a unique position to influence public opinion and lead their constituents towards attitudes supportive of an effective national response to the epidemic. Political commitment is an essential ingredient to a rights-based response to HIV/AIDS and to the allocation of adequate resources to implement it. The U.S. Department of State recently described AIDS as an important foreign policy issue: “critical to turning the tide is governmental acknowledgment and political commitment for national and international action...Political commitment at the highest level of national government makes the critical difference. Many governments remain slow to acknowledge and respond with appropriate measures...It takes strong leadership at the highest levels working with international institutions, other nations, and nongovernmental sectors to join the fight by sharing needed specialized skills in support of global interests to combat the AIDS pandemic” (UNAIDS, 1999: 41).

Leaders of some of the most-affected nations in Africa have increasingly shown awareness and openness regarding HIV/AIDS issues:

- In Botswana, President Festus G. Mogae announced in 1998 a government monthly allowance (means-tested) for people living with HIV.
- Nelson Mandela, former president of South Africa and Honorary President of the Global Business Council on HIV/AIDS, which was launched in Edinburgh in October 1997, said, “Many people live with HIV and AIDS, and many are at risk of becoming infected. Yet the reality is that the rights which should protect them from the vulnerabilities which AIDS sufferers endure are not adequately respected. We need to confront that reality and speak out against it.”
- The then Deputy President of South Africa, Thabo Mbeki, launched a national public awareness campaign in October 1998. Many workers were given the day off work to listen to his televised speech, and flags flew at half-mast on government buildings.

### ***HIV/AIDS and Human Rights: Historical Perspective***

The 41st World Assembly in 1988 recognised the importance of the human rights dimensions of effective HIV/AIDS response in resolution 4124, which urged member states to foster a spirit of understanding and compassion for PLHAs.

During its first international consultation on HIV/AIDS and human rights in 1989, the United Nations Centre for Human Rights (UNCHR) acknowledged the public health rationale for the prevention of HIV/AIDS-related discrimination and the promotion and protection of human rights in the context of HIV/AIDS.<sup>3</sup> This was reiterated during the second international consultation on HIV/AIDS and human rights, which was jointly convened by UNAIDS and the Office of the United Nations High Commissioner for Human Rights in 1996.

The 1996 consultation resulted in the issuance of guidelines that detail the relationship between human rights and HIV/AIDS. Among other things, these guidelines underscore the fact that people cannot avoid infection if their rights to education, health, information, privacy, security of person, and nondiscrimination are not protected and respected. They also confirmed that people living with HIV/AIDS or otherwise affected by it cannot maintain their dignity and support themselves and their

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<sup>3</sup> UNCHR and WHO, 1989. Report of the First International Consultation on AIDS and Human Rights (HR/PUB/90/2).

families unless their rights to employment, housing, movement, social security, an adequate standard of living, and non-discrimination are protected.

The guidelines contain concrete measures that states can take to protect human rights in the context of HIV/AIDS and achieve public health goals in an ethical and effective manner. These measures involve appropriate multi-sectoral institutional processes that advance legal and ethical issues, law reform, and legal support services in such areas as public health law and antidiscrimination law; the legal rights of women, children, and marginalized groups; and promotion of a supportive and enabling environment through education, information and public campaigns on human rights, ethics, and law.

Resolution 49/1999 of the United Nations Centre for Human Rights reaffirmed that “discrimination on the basis of HIV/AIDS status, actual or presumed, is prohibited by existing international human rights standards, and that the term, ‘or other status’ in non-discrimination provisions in international human rights texts should be interpreted to cover health status, including HIV/AIDS.”

Currently in Africa and worldwide, there is an unprecedented level of consensus on and commitment to the importance of integrating human rights into approaches to stem the epidemic as demonstrated in the documents and discussions of the African Development Forum in 2000; the Abuja Summit on HIV/AIDS, Tuberculosis, and Other Related Infections in 2001; and the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) in June 2001.

In virtually all the areas identified for actions in the UNGASS Declaration,<sup>4</sup> the promotion and protection of human rights feature prominently either explicitly or implicitly. This reflects the statement in a document prepared by the Office of the United Nations High Commissioner for Human Rights for UNGASS that, “the protection and promotion of human rights are essential to preventing the spread of HIV and to mitigating the social and economic impact of the pandemic. The promotion and protection of human rights reduces vulnerability to HIV infection by addressing its root causes; lessens the adverse impact on those infected and affected by HIV; and empowers individuals and communities to respond to the pandemic.”<sup>5</sup>

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<sup>4</sup> Declaration of Commitment on HIV/AIDS, UNGASS 26<sup>th</sup> special session, UN Doc A/Res/S-26/2 (2001) New York, USA.

<sup>5</sup> UNDP. From Values to Action: Integrating Human Rights to HIV/AIDS Strategy.

# HIV/AIDS AND HUMAN RIGHTS IN CONTEXT

## The Right to Privacy

This right is provided for under Art. 12 of the UDHR. It implies that no one shall be subjected to arbitrary interference with his privacy, family, home, or correspondence, nor to attacks upon his honour and reputation. Everyone has the right to the protection of the law against such interference.

The Nigerian Constitution of 1999 in S.37 guarantees the right to privacy of every citizen. This right is also guaranteed under Art. 17 of the ICCPR. Similarly, Art. 6 of the ACHPR provides for the protection of this right.

In other jurisdictions, such as South Africa, Britain, and Canada, the right to privacy has been held to encompass obligations to respect physical privacy, including the obligation to seek informed consent to HIV testing and privacy of information, including the need to respect confidentiality of all information relating to a person's HIV status.<sup>6</sup>

### *Testing Without Consent*

In Nigeria, the right to privacy of PLHAs is often violated when an HIV test is conducted without informing the patient or seeking his or her consent. This appears to be common practice in both private and public health care settings; pregnant women who attend antenatal clinics are often tested for HIV without being informed. Testing without consent also occurs in pre-employment screenings.

There are reports of physicians and hospitals in Nigeria having performed HIV antibody tests without obtaining specific informed consent, relying instead on the implied consent to treatment and blood tests that hospital patients typically provide. This is often called "routine" HIV antibody testing—that is, testing without the specific informed consent of the patient, followed often by rejection and other negative consequences. Below are excerpts taken from the experiences of PLHAs as documented by the Centre for the Right to Health.

Martha's story is not atypical:

I have registered for antenatal in a private hospital near my house. I was told to do an HIV test as part of the routine test. I refused, and they bluntly told me they cannot take my delivery if I do not take the test. I went to a government health center. They filled out a form for blood test; I read it but there was nothing indicating HIV test so I went for the test. During my next visit, I was worried when the midwife told me that I have to go to the teaching hospital for special management. She would not explain why, rather she gave me a letter. Out of curiosity I read it on my way home and learnt that I had tested HIV positive. My world crashed on my face. I locked myself up and cried for weeks.

At the teaching hospital, the nurses kept on passing the letter from one person to another and eventually asked me to return in four weeks time because the doctor who will attend to me is on leave. By this time I was already seven and half months pregnant. I fell into labour before the appointment date and had to go to a traditional birth attendant, who

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<sup>6</sup> Canadian Legal Network on HIV/AIDS. Legal/Ethical Issues Raised by HIV/AIDS.

took my delivery. I did not tell her my HIV status because I was scared she would refuse to attend to me, too.

Respect for the privacy of PLHAs and confidentiality of test results are crucial to the prevention of the HIV epidemic. Failure to respect the privacy of a patient who is HIV positive may result in a number of consequences. Testing without informed consent damages the credibility of health services and may discourage those needing services from obtaining them. Mandatory testing can create a false sense of security, especially among people who are outside its scope and who use it as an excuse for not following more effective measures for protecting themselves and others from infection.

According to a statement from the consultation on Testing and Counseling for the HIV Infection published by the World Health Organisation (WHO) (1992), “mandatory testing and other testing without informed consent has no place in an AIDS prevention and control programme.” The statement explains that because of stigmatisation and discrimination directed at HIV-infected people, individuals who believe they might be infected tend to go “underground” to escape mandatory testing.

Experience has shown that some doctors conduct HIV tests on patients without their consent because they feel that in order to be able to protect themselves, they need to know the patient’s HIV status, contrary to the principle that precautions need to be applied universally. It has also been discovered that doctors engage in these acts because they do not seem to understand why HIV testing should be treated differently from other medical tests. With few exceptions (see below), testing for HIV without specific proper informed consent is unconstitutional, being contrary to S.37 of the 1999 Constitution of Nigeria.

### ***Testing of Donors***

The mandatory HIV testing of donors of blood, organs, tissue, ova, semen, or other human body parts and fluids has been universally endorsed as an essential and effective means of preventing the spread of HIV. Although the current test will not detect all HIV-positive donors, the introduction of HIV testing has nonetheless greatly improved the safety of the blood supply.

The general rule that HIV testing in Nigeria should only be undertaken with the specific informed consent of the person being tested does not apply to the testing of donors of blood organs, semen, or similar bodily products. In all cases of donations, prospective donors should be informed before the performance of the test that an HIV-related test will be conducted and given adequate information about the nature and purpose of the test.<sup>7</sup>

### ***Testing for Research Purposes***

A more controversial issue than the testing of donors is whether epidemiological screening should be allowed without informed consent. With the introduction of a test for HIV in 1985, it became possible to investigate how widespread the epidemic had become and to monitor how patterns of infection were evolving. Information of this kind is of great value in designing, implementing, and monitoring programmes for the prevention and control of HIV. Voluntary or compulsory testing cannot provide this information because it provides a flawed view of the prevalence of HIV in the population. In a voluntary testing regime, those who are at highest risk of HIV infection and people who are otherwise marginalised in society may be over- or under-represented in the group of individuals tested. Similarly, mandatory testing or screening will not provide information of sufficient accuracy or completeness for public health surveillance purposes, as persons at risk of HIV infection may selectively avoid contact with health services or testing activities, creating unpredictable participation bias.

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<sup>7</sup> Nigerian National Policy on HIV/AIDS and STIs, 1997.

Therefore, as an alternative to voluntary or mandatory testing of individuals for epidemiological research, unlinked anonymous screening (UAS) programs have been undertaken in some parts of the world, for example, in Canada and the United States. UAS, also known as “blinded” testing, is performed by systematically testing samples of blood left over after having been collected and tested for medical reasons other than HIV testing.

### ***Privacy & The Media***

The right to privacy is also violated in the media when information about the HIV/AIDS status of a PLHA is circulated without first getting consent of the individual. An example is the case of a policewoman in Nigeria whose HIV status was revealed to the public by the media and resulted in her demotion. In Canada, it has been held in Jean Pierre Valiquette v The Gazette that a personal action started based on violation of an individual’s human right would even survive the plaintiff. In the case, a journalist published an article about an HIV-positive male teacher on the front page of a newspaper without seeking the consent of the teacher. Although the teacher’s name was not mentioned in the article, he could be identified because of the indirect information contained in the article. This publication was held to encroach on the privacy of the teacher, and he was therefore awarded damages. Although this decision is not binding in our courts, it is of persuasive authority in the absence of a direct judicial authority in Nigeria.

### ***Testing in the Workplace***

In the workplace, breach of privacy may arise when an employee is made to undergo mandatory HIV testing by his employer. It may also arise where a health worker reveals the result of an employee’s HIV test to his employer without the consent (and often without the knowledge) of the employee. Failure to protect the privacy of a PLHA in the workplace may hinder other workers from finding out their HIV status, which will consequently fuel the spread of the epidemic. Experience of many PLHAs in Nigeria indicates gross breach of privacy in the workplace, as exemplified in the story told below.

I had worked as an auxiliary nurse for over five years in this hospital. I became pregnant and started having boils; the doctor who is also my employer sent me to the lab for a test. By the time I resumed from off duty, I could not locate my folder. On enquiring about my folder, the doctor gave me unsolicited two weeks leave to go and sort out my health problem and a referral letter to the teaching hospital. On getting to the teaching hospital, I was asked to bring my husband; they tested our blood and told us that I was positive and my husband was negative. In shock I went back to my boss to ask him why he did not even warn me on the reason for referral, he ordered me to go and see the hospital secretary who handed me a letter stating that the hospital is terminating my appointment because they cannot afford to put the staff and patient at risk. I could not believe it. With the entire trauma, I lost the pregnancy and the same hospital I was registered with refused to clean my womb telling me they cannot afford to contaminate their theatre.

### ***Confidentiality***

Confidentiality refers to the ethical, professional, and/or legal duty of the health care professional and other professionals, such as lawyers and social service providers, not to disclose to anyone else without authorisation, information that was given to or obtained by the professional in the context of his/her professional relationship with a client. It embraces intimate matters, which include sexual relationships, health status, and illicit drug use. Due to the special relationship that exists between the health care provider and the patient, a divulgence of information by the health care provider without the express

consent of the patient amounts to a breach of confidentiality, except in cases where the health care provider shares information about a patient with his/her colleagues in the course of treating the patient.

Confidentiality is an ethical principle particularly relevant in the provision of health care. The principle of confidentiality encompasses the view that a person should be entitled to privacy with regard to his or her most personal physical and psychological information. It is also part of the basis for an effective relationship between patient/client and health care provider, and hence the basis for the effectiveness of many public health interventions that rest on these relationships. Only if a person feels sure that the health care provider will keep confidential any information provided would he/she come forward and share information that may be critical to making decisions about effective clinical care and treatment.

Thus, health care professionals have long recognised and respected their duty and the need to protect the confidentiality of their patients. Because of the need to protect confidentiality in order to provide effective health care, health care professionals also recognise that they should normally only disclose highly personal information, such as HIV status, with the informed consent of the patient. For example, Rule 18 of the professional conduct for medical and dental practitioners in Nigeria provides that any information about a patient that comes to the knowledge of a practitioner shall be treated with utmost secrecy and that the medical records of a patient are strictly for the consumption of the patient alone.

In the context of HIV/AIDS, confidentiality applies to a person's HIV/AIDS status and requires that health authorities seek the consent of the person infected for the disclosure of his/her HIV/AIDS status to others. Confidentiality also includes the expectation by a person with HIV/AIDS that his/her status will not be disclosed by other persons without his/her consent.

The ethical principles of confidentiality and informed consent, which have private and public health benefits, should be distinguished from "secrecy," which is a state of affairs often resulting from fear, shame, and/or a sense of vulnerability. Whether secrecy is maintained depends solely on the personal motives of those who hold the secret. As discussed above, motives to maintain secrecy in the context of HIV/AIDS involve not only fear and shame, but also denial, fear of rejection, stigma, and discrimination. To the degree that secrecy harms the infected and the uninfected and undermines an individual's, family's, or community's ability to cope positively with HIV/AIDS, it should be strongly combated. UNAIDS and WHO are of the view that the secrecy surrounding HIV/AIDS and the related stigma, denial, and discrimination, can best be countered by a greatly increased commitment to beneficial disclosure and ethical partner counselling as described below.

"Disclosure" is a neutral term. In the context of HIV/AIDS, it refers to the act of informing any individual or organisation (e.g., health authority, employer, school) of the HIV status of an infected person, or it refers to the fact that such information has been transmitted, by any means, by the person him or herself or by a third party, with or without consent.

Where people fear forced testing or disclosure involving lack of confidentiality, they will avoid HIV counselling, testing, treatment, and support because these are likely to mean that their HIV status will become known against their will and they will face stigma, discrimination, lack of privacy, and other negative effects. Thus, fear of lack of confidentiality and forced disclosure may drive people away from HIV services, thereby reducing opportunities to encourage and empower people to change their behaviour in order to either avoid getting infected or avoid passing on their infection. It may also drive people away from other health care services, such as antenatal care, or from participating in blood donation.

UNAIDS and WHO encourage "beneficial disclosure." This is disclosure that is voluntary, respects the autonomy and dignity of the affected individuals, maintains confidentiality as appropriate, leads to beneficial results for those individuals and for their families and sexual and drug-injecting partners, leads

to greater openness in the community about HIV/AIDS, and meets the ethical imperatives of the situation where there is need to prevent onward transmission of HIV.<sup>8</sup>

Such beneficial disclosure, with its elements of voluntarism and confidentiality, not only maintains ethical principles but also serves a direct public health function because it encourages people to access HIV prevention and care services. It does this by establishing a climate of trust between health care providers and those who need HIV services, allaying their fears and respecting them as people who can and will make the right decisions regarding their behaviour. Beneficial disclosure also serves the goal of opening up the HIV/AIDS epidemic. As more people feel able and willing to disclose their status, there grows a critical mass of individuals and families within a community, and indeed within a nation, who are openly involved in dealing with the epidemic in positive and supportive ways. As a consequence, discrimination, stigma, and secrecy are reduced.

Partner counselling or partner notification involves the process of contacting sexual and/or injecting partners of an HIV-positive person (in this context often called the “source” or “index” client or patient) in order to advise these partners that they may have been exposed to HIV and to encourage them to obtain HIV counselling, testing, and, where applicable, treatment. This must be done with the consent of the patient. The objectives of this kind of disclosure are to

- prevent HIV transmission to people who may be exposed either sexually or through needle-sharing, and
- improve care and support for PLHAs.

Partner counselling can be undertaken by the source client or patient him/herself, by the health care provider, or through the combined efforts of both.

**Source referral:** HIV-positive people are encouraged to counsel partners concerning their possible exposure to HIV. This takes place without the direct involvement of health care providers. In this approach, the health care provider works with the HIV-positive person regarding the nature of the information to be passed on to their partner(s) and ways of doing it.

**Provider referral:** An HIV-positive person gives the name(s) of his/her partner(s) to a health care provider who then confidentially counsels the partner(s) directly. In this approach, the health care provider does not disclose the name of the HIV-positive person to the partner but only provides the information that the partner is likely to have been exposed to HIV infection. This is done with the consent of the source client or patient.

**Conditional referral:** The health care provider of the source client or patient obtains the names of his/her sexual/drug-injecting partner(s) but allows the source client a period of time to counsel the partner(s) him/herself. If partners are not counselled within this time period, the health care provider counsels the partners, without naming the source patient or client concerned.

One of the main reasons why protecting the confidentiality of HIV/AIDS-related information is so important is that the revelation of a person’s HIV status (and, often, a person’s sexual orientation or drug use) exposes people to stigmatisation, discrimination, and rejection. People with HIV or AIDS would have less reason to fear disclosure of their HIV status if that disclosure did not expose them to such negative reactions and if they were better protected against discrimination.

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<sup>8</sup> UNAIDS and WHO. Opening Up the HIV/AIDS Epidemic: Guidance on Encouraging Beneficial Disclosure, Ethical Partner Counseling and Appropriate Use of HIV Case-Reporting.



### ***Recommendations***

- Confidentiality laws in Nigeria should be reformed/drafted to conform to the recommendations in the International Guidelines on HIV/AIDS and Human Rights, which read as follows: “General confidentiality and privacy laws should be enacted. HIV-related information on individuals should be included within definitions of personal/medical data subject to protection and should prohibit the unauthorized use and/or publication of HIV-related information on individuals. Privacy legislation should enable an individual to see his or her own records and to request amendments to ensure that such information is accurate, relevant, complete and up-to-date. An independent agency should be established to redress breaches of confidentiality. Provision should be made for professional bodies to discipline cases of breaches of confidentiality as professional misconduct under codes of conduct ...”
- There should be training of health providers on the respect for human rights of PLHA patients.
- An ombudsman should be established to facilitate lodging of complaints by patients who are aggrieved by the way he/she has been treated by a health worker.
- Nigerian courts should encourage trials in chambers or trial with pseudo-names in order to guarantee the privacy of a PLHA.

### **The Right to Health**

The right to life is adequately guaranteed under S. 33 of the 1999 Constitution and Art. 4 of the African ACHPR. PLHAs should not be intentionally deprived of their lives through the refusal of care. According to Art. 25 of the UDHR, everyone has the right to a standard of living adequate for the health and well being of himself and his family, including food, clothing, housing, medical care, and necessary social services. The right to health implies the right to the best form of physical and mental well being. It also means that access to medical treatment be made available to all regardless of one’s health status. Even though the right to health care is not expressly provided for under Chapter IV of the 1999 Constitution (i.e., under Fundamental Rights), it is provided for under Chapter II of the Constitution (i.e., Fundamental Objectives and Directive Principles of State Policy). S.17(3)(d) provides that there shall be “adequate medical and health facilities for all persons.” This is further buttressed by Art. 16 of the ACHPR, which provides that state parties to the charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

Though it may be argued that items under Chapter II of the 1999 Constitution are non-justifiable, the same cannot be said of the provisions of the ACHPR, which has been incorporated as part of law by the legislature by virtue of the ACHPR Enforcement and Ratification Act Cap. 10 Laws of the Federation 1990. While it may be pointed out that the right to health under the ACHPR is not absolute, the provisions under Chapter IV of the Nigerian Constitution relating to fundamental human rights can be invoked to guarantee this right.

In regard to PLHAs, it is a common practice in Nigeria for hospitals to refuse or reject treatment of PLHAs because of their status. Many health care workers often refuse to treat PLHAs on the grounds of not wanting to expose themselves to the occupational risk of contracting the disease. Where PLHAs are attended to, they are treated poorly. The risk of patient-doctor contact is inexcusable, as the diligent use of universal precautions will greatly obviate these risks. Poor treatment violates their right to health care

treatment guaranteed under the ACHPR and the constitution. The story of Eby, as told in research conducted by the Centre for the Right to Health (CRH), reflects how badly PLHAs are treated and refused access to care in Nigerian health care institutions.

Everybody in that hospital, from the doctor to the cleaner, knew I had HIV. Some of them come to my room masked, gloved, and gowned, as if HIV flies in the air. No matter their fear, I cannot forgive them for keeping me on the delivery couch unattended to for over two hours after my delivery because no one was willing to suture my episiotomy and clean my baby and me up. My mother did the cleaning, and my episiotomy was never sutured. I paid dearly with recurrent infection and heavy antibiotics. I feel very bitter about the way I was treated.

Another example of how a PLHA was denied access to treatment is exemplified in Maddy's story. Maddy's experience was at the general hospital where he went to have his teeth pulled. He told the dental surgeon that he is HIV positive and paid dearly for it.

On hearing I have HIV, the surgeon told me outright that they cannot attend to me because it is risky. I challenged him, threatening to report to the authorities concerned as I am entitled to treatment. He eventually asked me to come back in two weeks time to enable them to prepare well. Again I was messed up; even though I came before other patients, I was the last patient they attended to. Still they found a reason to ask me to come back two days later. Meanwhile, they were busy passing my case note from one person to the other, during which I found out that they wrote "HIV positive" on top of my case note. Again I objected strongly to such labeling, threatening to go to the media with the way they are treating me. (Already I had gone public about my HIV status.) They went on about wanting to warn other doctors to be careful. I asked them if they knew the sero status of all the patients they had been attending to, what about universal precaution, is this the price I pay for being open about my status? My tooth was finally extracted in circumstances that should have been filmed rather than discussed. People were wearing four gloves, masks and goggles, and moving about on tip toe, as if the virus would jump at them.

These refusals to care for PLHAs described above are not only violations of the ACHPR and Constitution of Nigeria but also represent breaches of professional codes of conduct such as Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria. In Costa Rica, the courts have held that it is unlawful for a doctor to refuse treatment to a person because he is HIV positive. Similarly, it is unethical for a health care provider to condition the provision of care upon completion of an HIV test.

Denial of access to antiretroviral (ARV) drugs amount to a violation of right to life of a PLHA. Many PLHAs do not have access to ARV drugs because they are too expensive due to the fact that companies in western countries manufacture them. The Trade-Related Aspects of Intellectual Property Rights (TRIPS) of the World Trade Organisation (WTO) restricts local manufacturing of these drugs. In some developing countries, such as Thailand and Brazil, governments have made ARV treatment available to their people at almost no cost through legislative reforms of the restrictive provisions of the TRIPS. The Nigerian government, which recently ordered importation of ARV drugs from India, is emulating this. However, the distribution mechanisms of these drugs through teaching hospitals in the country, which are often on strike in protest of poor funding, is questionable.

### ***Recommendations***

- A law or policy should be developed to make it unlawful to refuse treatment to PLHAs.
- Supplies such as condoms, testing kits, and other items should be made widely available by government by increasing the present annual budgetary allocation to health sector facilities.
- Health care providers need education on HIV/AIDS and universal precautions as well as materials to apply this concept consistently.
- Legislative barriers to availability of ARV drugs, such as TRIPS and WTO agreements, should be removed.
- Legislation protecting consumers, especially PLHAs, from fraudulent claims regarding cure for HIV/AIDS should be put in place by legislators.
- Emphasis should be placed on pre- and post-test counselling for patients. To achieve this, PLHAs should be trained as counsellors.

### **The Right to Human Dignity**

The right to human dignity includes a prohibition on inhumane treatment. This is provided for in Art. 5 of UDHR and Art. 7 of ICCPR. It is also contained in Art. 5 of ACPHR. S.34 of the 1999 Constitution contains a similar protection. The right of a PLHA to human dignity is violated where such a person is mistreated by a fellow human being simply because of his HIV/AIDS status. Thus, where a health worker refuses to treat a PLHA, an employer denies him employment, or his movement is restricted, his right to human dignity is violated. In short, any act of discrimination against a PLHA that relates to his status is an infringement to his right to human dignity. According to the court in the South Africa case of Hoffman v South African Airways (SAA),<sup>10</sup> “At the heart of the prohibition of unfair discrimination is the recognition that under our constitution all human beings, regardless of their position in society, must be accorded equal dignity. That dignity is impaired when a person is unfairly discriminated against.”

Generally, a denial of access to HIV/AIDS information and education to PLHAs infringes the right to human dignity. Also, mandatory HIV testing without proper counselling would amount to degrading treatment in breach of the right to human dignity. Ejecting a PLHA from his accommodation solely because of his status is a violation of the right to human dignity. Conducting clinical trials using PLHAs as subjects without their consent violates the right to human dignity. The right to dignity is also at risk when an institutionalised individual, such as a prisoner living with HIV/AIDS, is denied the right to information or is tested for HIV without benefit of counselling.

### ***Recommendations***

- Train health care providers on HIV/AIDS and human rights.
- Educate the public on the need to respect the human rights of PLHAs.

### **The Right to Work**

The right to work entails the right of every person to access to employment without any precondition except the necessary occupational qualifications. According to Art. 23 of the UDHR, “Everyone has the

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<sup>10</sup> Access to Justice Cases on Human Rights, Constitutional Court of South Africa 2000 (2) 628.

right to work...[and] to just and favourable conditions of work.” The right to work is provided for under Art. 7 of the ICESCR and Art. 15 of the ACHPR. This right guarantees safe and healthy working conditions. The right to work is not included under Chapter IV of the 1999 Nigerian Constitution, unlike the South African Constitution of 1996, which recognised this right as a justifiable right. However, Nigerian courts can invoke the provisions of the human rights provision in Chapter IV of the Constitution to safeguard this right.

The right is violated when an applicant or employee is required to undergo mandatory testing for HIV and is refused employment or dismissed or refused access to employee benefits or promotion on the grounds of a positive result. In Nigeria today, it is common for employers to deny employment to applicants who test positive for HIV/AIDS in pre-employment screenings. Similarly, employees have lost their jobs because they are found to be HIV positive. This is unlawful and unjustifiable.

In other jurisdictions such as South Africa, the courts have declared as unlawful a termination or refusal of employment solely based on the HIV/AIDS status of a person. In Hoffman v. SAA, the constitutional court in South Africa declared that refusing employment to an HIV-positive person amounted to an act of unfair discrimination forbidden by the law. In addition, some countries have adopted best practices guides to ensure that the interests of PLHAs are protected in the workplace. For example, in Australia, a body known as the National Occupational Health and Safety Commission has been established, which is responsible for a code of practice on HIV/AIDS for health care workers and others at risk. A similar code exists in the United States by virtue of the Occupational Safety and Health Administration. In South Africa, the Employment Equity Act has prohibited mandatory HIV testing before employment. Also, the Disability Discrimination Ordinance in Hong Kong forbids discrimination against PLHAs in the workplace. More importantly, most ILO Conventions and rules emphasise non-discrimination in the workplace for any reason whatsoever.

To conform with standards for the right to work, states should ensure that PLHAs are allowed to work as long as they can carry out the functions of the job. Thereafter, as with any other illness, PLHAs should be provided with reasonable accommodation to be able to continue working as long as possible and, when no longer able to work, be given equal access to existing sickness and disability schemes. The applicant or employee should not be required to disclose his or her HIV status to the employer or in connection with his or her access to workers’ compensation, pension benefits, and health insurance schemes. States’ obligations to prevent all forms of discrimination in the workplace, including on the grounds of HIV/AIDS, should extend to the private sector.

Whether as a result of the absence of training on HIV/AIDS for medical staff in enterprises or the subordination of employees to their employers, which binds enterprise doctors to their employers, there are many cases in Nigeria in which these doctors’ professional and ethical obligation to respect patient confidentiality is disregarded. Even beyond the issue of workers who are HIV infected or have AIDS, the confidentiality that should be observed for the medical files of individual staff members is frequently not respected.

As part of favourable conditions of work, all employees have the right to safe and healthy working conditions. “In the vast majority of occupations and occupational settings, work does not involve a risk of acquiring or transmitting HIV between workers, from worker to client, or from client to worker” (ILO, 1998). However, where a possibility of transmission does exist in the workplace, such as in health care settings, states should take measures to minimise the risk of transmission. In particular, workers in the health sector must be properly trained in universal precautions for the avoidance of transmission of infection and be supplied with the means to implement such procedures.

It is important to note that the creation of a hostile environment in the workplace may also have an impact on a PLHA's ability to perform his/her job. One individual with a large telecommunications firm had been on disability for two years. His condition had improved with combination therapies, and he wanted to return to work, but he feared the reaction of other employees who may have known that he had AIDS. He was afraid that the company would lay him off after he returned to work because of the expense involved in drug costs and workplace accommodations. The Centre for the Right to Health was able to educate people in this man's department about HIV/AIDS but was not invited to train staff in other departments. Word spread through the entire company that a man with AIDS was working in their building. The ensuing hysteria resulted in people refusing to come onto the floor where the man worked, requests for separate bathrooms, requests for a separate fridge and staff room, and so forth.

Anticipating such reactions, people with HIV/AIDS may prefer not to return to a previous place of employment and seek employment in an environment that would be more supportive or where their HIV status is not known. However, this may not always be possible. After a period out of the workforce, they may have lost skills and may require training. They may not be able to afford further training, and (if they are on long-term disability) their insurer may be unwilling to pay for it. Looking for work in a new area without security or benefits is also risky, particularly if one has to explain a gap in work experience. People who have benefits with their previous employment may simply not be able to risk moving to new employment.

#### ***Recommendations***

- Government should follow the examples of other countries by making a law that will adequately make the workplace safe for all. Such a law should discourage mandatory testing for HIV before employment but should encourage HIV/AIDS education in the workplace, emphasising universal precaution and prevention, and care and support for employees already infected.
- The proposed legislation should also clarify the employer's obligations in daily work practices to take reasonable care of the health and safety of employees.
- Government, labour unions, and employers of labour should work together in developing legislative codes for the industries, which will address specific risks of occupational infection. Perhaps HIV/AIDS educational programs should form the basis of collective agreements between employers and workers unions.
- Availability of first aid treatment should be encouraged in workplaces so that minor injuries can be easily treated to prevent spilling of blood.
- Legislation should be enacted to ensure that employment, promotion, and access to benefits in the workplace is not affected by the HIV status of a worker.

## **The Right to Marry and Found a Family**

Every individual has the right to decide whom he wants to marry and whether to raise a family. Art. 16 of the UDHR guarantees this right. S.37 of the Nigerian Constitution also recognises this right. It would amount to a breach of this right if a law is made limiting the ability of an individual to exercise the right to marry.

Marriage in Nigeria can be customary, religious, or civil. Although there is no federal or state law making premarital HIV testing mandatory, there is a lot of concern with the position of many religious organisations and leaders that are espousing and practising mandatory premarital HIV testing policies. For example, Rev. Akwashiki of the Assemblies of God mission in Abia State, Nigeria, in an interview with the CRH research team, stated

We require an HIV free certificate to wed couples. If it is found that one is positive, we discontinue the marriage; you don't continue the marriage with somebody who already has a death sentence. I will advise couple to discontinue the relationship.

This trend is troubling, considering that religious leaders have powerful influence in shaping national policies. Premarital HIV testing has a benefit in helping couples make informed decisions; however, testing should be voluntary and their decision respected. As practiced, mandatory premarital testing in the face of intense stigma and discrimination would only serve to drive vulnerable people underground or force them to avoid religious weddings completely. This would be a sad loss considering that many Nigerians have a strong connection to their religious community. It is also important to consider that many couples have already had sex with each other before considering or committing to marriage. Therefore, HIV prevention messages should focus on encouraging couples to get voluntary HIV tests before unprotected sex with each other.

In South Africa, Australia, and Canada, the courts have recognised the right of every individual to marry and that no legislation or policy can impugn upon that right.

### ***Recommendations***

- Government and NGOs should embark on HIV/AIDS education among religious leaders/groups.
- Any law or policy that is contrary to the constitution should be declared null and void by the courts.

## **The Right to Freedom from Discrimination**

Art. 7 of the UDHR guarantees that no one must be discriminated against by virtue of his race, sex, religion, political belief, or other status. A similar provision is contained in Art. 2 of the ACHPR, which guarantees the right of equality of every person. S.42 of the Nigerian Constitution provides that every person is equal before the law and that no one should be discriminated against as a result of his birth/social status, sex, or religious background.

Discrimination is a serious psychological problem that affects the totality of a being. One of the greatest problems a PLHA encounters in Nigeria today is stigma and discrimination, which is experienced in virtually every facet of human endeavour, such as in the hospital, workplace, accommodation, and home.

Discrimination within the churches is often in the form of mandatory HIV testing before marriage and refusal to wed consenting adults because they are sero-discordant. Gregory shared his experience where the priest bluntly refused to wed them because his bride tested positive. Gregory explained to the priest that he and his wife had been married for sometime in the customary way and had been living as man and wife for a while, and if he was meant to get the virus he would already have it. Moreover, he did not think it made any sense to abandon her just because she tested HIV positive. The priest made them bring their parents before finally agreeing to wed them. Although a valid marriage may be contracted under the Marriage Act either in a religious place of worship or registry, where a man has indicated his interest to be wedded in a religious place of worship, a refusal to wed him based on his HIV status contradicts S.42 of the Constitution, which forbids discrimination against fellow human beings.

Rev. Akwashiki said, “In the church, we send couples for marriage for an HIV test. However, we have not had any positive results. We require HIV-free certificates from intending couples. It is for their benefit; many of them cannot cope with the crisis” (CRH, 2001b).

Another PLHA shares his experience:

I was sick in Lagos; after some time, the doctor told my relatives to take me home, that I will not survive. He told them that I had AIDS. I was taken to the village; it took very little time for all to know about my dreadful affliction. I was put in a room away from others, food shoved into the room irregularly.

One traditional ruler/community leader said he had not seen a PLHA but had heard of HIV as a disease predominant in Lagos and some other cities. His comments follow:

If we identify someone as HIV positive, the village will isolate him; he could not be allowed in people’s houses, will not eat or drink in their houses; he will remain with his family, that is if they care, and when he dies, it is his family’s business, not the village. However, I don’t think this is right. They are human beings and should not be discriminated against either in the workplace, the hospital, village, etc.; discrimination will do them more harm. It will push them into isolation and the wicked ones will start to spread it.

Stigma and the resulting stress, isolation, and lack of social support have significant negative impacts on the health of people with HIV/AIDS. Research has found that social support is associated with psychological well-being among people with HIV/AIDS. Those who feel stigmatised by HIV/AIDS—both those infected and those affected by the disease—and lack the support they consider helpful are more likely to experience symptoms of depression. There is also some evidence that stress has a negative effect on the human immune system and that social support (lacking among people who are isolated due to stigma) can moderate the effects of stress on the immune system. For people living in smaller communities where it is hard to remain anonymous, the need for secrecy is often greater than in cities. PLHAs must sometimes go to great lengths to protect the confidentiality of their status.

People with HIV/AIDS report that, when they disclose their HIV status, the response of the community is often more supportive than anticipated. But the impact of negative reactions in a small community is perhaps greater since other avenues of support may be less available. Therefore, there is silence and secrecy, at great cost not only to the PLHA but also to the person’s family. PLHAs who identify with a specific ethnic or cultural community experience stigma and discrimination from others within their community. For example, in one ethno-cultural community, a man who is HIV positive is unable to tell others in his community that he is living with HIV. The men in his ethnic community will automatically assume that he is gay or that he is an active drug user. Being identified as either a homosexual or an active

drug user in this community carries a considerable stigma. The result is a deep sense of isolation. The individual spends a great deal of time at home alone.

The experience of stigma and discrimination within a specific community is complicated by the fact that the community is already a minority in society as a whole and is often marginalised or discriminated against. This has implications for both the PLHA and for the community. For the PLHA, it means that there may be nowhere else to go once one has been isolated within one's own community. For the community, it means that it is difficult to address issues associated with vulnerability to HIV infection (such as sexual activity, homosexuality, and relations between men and women) and to support PLHAs.

It is generally known that PLHAs and their families are subjected to discrimination and stigmatisation because of misconceptions about the infection and the fatal nature of the disease. This attitude is pervasive despite the constitutional provision on the issue. PLHAs, like every other person, are entitled to the same protection under the law. Therefore, it is unlawful to discriminate against them. They deserve to be given the same opportunities as others and not to be denied access to justice merely as a result of their status.

In countries such as South Africa, Canada, Namibia, and the United States, the courts have held that it is unlawful to discriminate against PLHAs.<sup>11</sup> Aside from this, antidiscrimination laws have been passed. For example, the U.S. has the Americans with Disabilities Act (ADA), which protects a PLHA from discrimination. In Australia, there is the Disability Discrimination Act.

### ***Recommendations***

- Antidiscrimination legislation should be made that will protect vulnerable groups, such as women, children, and PLHAs, from unfair discrimination.
- Professional bodies, policymakers, legislators, interest groups, and the entire public should be sensitised to the human rights of PLHAs.
- NGOs should be involved in sensitising the legislators to the need to make an antidiscrimination law on HIV/AIDS. Also, the NGO community should pursue test cases dealing with the human rights of PLHAs.
- The courts have a great role to play in ensuring that PLHAs are not discriminated against. As a back up to the court system, an independent human rights body should be set up to hear cases on discrimination against PLHAs. This should ensure speedy trial of cases brought by PLHAs.
- Free legal assistance should be made available to PLHAs by the government or NGOs working on the human rights of PLHAs.

### **The Right to Education/Information**

Every individual is entitled to the right to be educated and to have access to information useful for his/her development in life. Art. 26 of the UDHR provides that "Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and

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<sup>11</sup> Hoffman v SAA 2000 (2) SA 628, N.V. Minister of Justice case no. ILC 24/98 Labour Court of Namibia, 2000.



fundamental freedom.” Art. 8 of the ACHPR as well as Art. 13 of the ICESCR both guarantee the right to education and information. This right should not be seen as a privilege; rather, it is a right exercisable by all regardless of social or health status. The Nigerian Constitution does not expressly provide for this right. However, the Constitution guarantees freedom of press and expression, which includes the right to be informed. Also, the ACHPR Ratification and Enforcement Act Cap. 10 Laws provide for this right.

It is sad to note that despite this constitutional provision for the right to information, patients in hospitals are denied the right to know about the form of treatment they receive from health workers. Drugs are prescribed without adequate and detailed information about them. It is even worse in the case of PLHAs as HIV tests are conducted without the benefit of pre- and post-test counselling. In most cases, HIV tests are conducted without consent of the patient. This is contrary to the Rules of Professional Conduct for Medical and Dental Practitioners in Nigeria. All these attitudes amount to a violation of rights of the patient.

Another critical area in which the right to information may be violated is in the conduct of clinical trials. In Nigeria, this relates both to trials of claimed cures of HIV as well as more traditional clinical trials for drugs to stop or slow the progression of HIV. Government and pharmaceutical-sponsored clinical trials involving PLHAs are often conducted without proper informed consent being carried out. Some participants in trials of claimed cures who attended a seminar organised by CRH revealed that their consent was not obtained before the trial and that they were not informed of the risks or likely benefits. All of these practices are evidence of how the rights of PLHAs to information and education are violated with impunity in Nigeria.

### *Recommendations*

- Prevention is the major objective of HIV/AIDS programs; therefore, people need information and education about the epidemic. Such information should emphasise modes of transmission and means of protection. The use of the mass media is imperative. Therefore, government should provide information through pamphlets, posters, newspapers, magazines, books, instructions on condom packaging, films, plays, and so forth. NGOs should be more involved in community education programs on HIV/AIDS, which should include messages in vernacular.
- The government should remove laws that serve as impediments to or censorship on HIV/AIDS advertisement.
- Legislation should make it mandatory for health providers to give full and adequate information to a patient about the nature of his treatment. Any health provider who is in breach of such a law should be adequately punished.
- The media should be educated on the human rights issues raised by HIV/AIDS. An independent body should be set up to attend to any violation of rights of a PLHA by a journalist.
- Full information and education of the procedures should precede any clinical trial, including vaccine trials. In addition, informed consent of any person involved in the trial must be obtained.

## **HIV/AIDS AND VULNERABLE GROUPS**

### **Prisoners**

In regard to attitudes towards prisoners at the societal level, the emphasis is often on protecting the public from prisoners to the exclusion of concern about the rights and well-being of prisoners. Such attitudes may be expressed most crudely in sentiments about “locking them up and throwing away the key.” They may be reflected in opinions that prisoners are receiving too many benefits and too few penalties. They can be implicit in discussion of problems with the correctional system that place most or all of the blame on the prisoner, without considering the relationship between prisoners and the correctional system or between the correctional system and society.

Attitudes of this sort have an impact on the lives of prisoners. Politicians are hesitant to initiate controversial programs such as needle exchange in prisons, despite their potential to protect prisoners from HIV infection, because the public could react negatively both to supplying prisoners with equipment to inject drugs and to the admission that drugs are available in prisons. Prison administrations and prison staff may view all aspects of inmates’ lives through the lens of safety and security without giving due consideration to such things as inmates’ right to confidentiality of medical information or right to health and health care.

The WHO Guidelines on HIV Infection and AIDS in Prisons, revised in 1993, state that

- All prisoners have the right to receive health care, including preventive measures, equivalent to that available in the community without discrimination, in particular with respect to their legal status or nationality;
- Preventive measures for HIV/AIDS in prisons should be complementary and compatible with those in the community and should be based on risk behaviours actually occurring in prisons, notably needle sharing among injecting drug users and unprotected sexual intercourse; and
- Prison administrators have a responsibility to define and put in place policies and practices that will create a safer environment and diminish the risk of transmission of HIV to prisoners and staff alike.

Failure to provide accessible HIV testing; to protect the confidentiality of prisoners with HIV/AIDS; to provide a standard of HIV/AIDS care equal to that in the community; to provide a range of drug treatment programs comparable to those available in the community; to introduce measures that reduce the harms of injecting drugs (such as provision of bleach and sterile syringes); to make condoms and dental dams easily and discreetly available to prisoners; and to provide education and information about HIV/AIDS, safer sex, and ways to reduce the harms of drug use would constitute discrimination in terms of the WHO Guidelines.

Disclosure of HIV status has significant consequences for inmates within the confines of prison. Some prisoners with HIV/AIDS choose to enter into protective custody; others remain in the general population. Reasons for choosing protective custody include stigma, discrimination, and risks to safety due to HIV status or being identified as transgender or gay. Peer-based outreach, education, and support programs incorporating face-to-face encounters with PLHAs are essential to creating a more supportive and accepting environment for prisoners with HIV/AIDS.

Loss of liberty does not entail loss of human rights, including health. The often closed, overcrowded, violent, and unsafe environment in prisons creates a special responsibility for prison authorities to protect the health of prisoners. Mandatory testing of prisoners is not a solution, as this violates their rights and

merely creates stigma and lack of confidentiality for HIV-positive prisoners without providing any protection for prisoners who are not infected. Adequate measures that are respectful of human rights include providing sufficient staffing resources to enable effective surveillance and appropriate disciplinary measures to protect prisoners from rape, sexual violence, and coercion.

As stated by UNAIDS to the U.N. Commission on Human Rights, “Prisoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities” (UNAIDS, 1999). Services for prisoners as a captive population should be equivalent to the education, treatment, care, and support received by the general population. This means providing access to HIV-related prevention information and education, particularly ongoing peer programmes, voluntary (including anonymous) testing and counselling, and the actual means to implement them (condoms, dental dams, water-based lubricant, and bleach). Easy access to the means of prevention is critical, as merely making items like condoms available on request (particularly in a way that identifies prisoners, thereby revealing their engagement in illegal sexual behaviour) is not effective.

Denial of treatment, care, and voluntary participation in clinical research trials can be viewed as a form of inhumane or degrading treatment or punishment. Other examples of degrading treatment include denial of privileges or facilities and segregation solely on the basis of HIV status, as opposed to recalcitrant behaviour, or for the protection of HIV-positive prisoners.

Segregation *per se* reveals HIV status to other prisoners and warders, providing an excuse for abuse and threats, which can enhance stigma and isolation even after release to the community. Mandatory testing and unauthorised disclosure of HIV status in prisons should be prohibited. Both mandatory testing and segregation lead to a false sense of security. Segregation is stigmatising and implies that casual contact with PLHAs is unsafe and has no impact on violent or dangerous behaviour unrelated to HIV status. Segregation can result in the denial of work release and workshop activities, as well as requiring the mixing of maximum and minimum security prisoners in the same unit for reasons of economy.

### ***Recommendations***

HIV is transmitted in prisons through unsafe needle use (sharing needles for injection drug use, tattooing, or body piecing) and unsafe sex. Male-to-female transsexual and transgender prisoners are engaging in these activities and putting themselves at risk for HIV infection because they do not know that these activities are unsafe, do not know how to engage in them safely, or are denied access to the materials necessary to prevent HIV transmission.

- Comprehensive education and responsive, gender-positive programs are the first steps in preventing HIV infection in the male-to-female transsexual and transgender prison population.
- Comprehensive educational sessions for medical staff should be implemented that address the unique medical issues of male-to-female transsexual and transgender prisoners. They should address issues such as hormones and their effect on overall health; the regular monitoring of hormones; and drug interactions between hormones, street drugs, and HIV/AIDS medications.
- Educational services must also be provided to prison social workers and case management officers to assist them in developing skills to serve the unique needs of male-to-female transsexual and transgender prisoners, for example, helping to ensure that all requirements and documentation necessary for sex-reassignment surgery are being met in the prison system.

### ***Recommendations (cont'd.)***

- External, community-based AIDS and health organisations should lead educational sessions. Peer education should also be promoted. Federal and state correctional services should recognise and utilise the expertise of community-based, gender-positive agencies when planning any male-to-female transsexual and transgender HIV/AIDS programs.
- Condoms, dental dams, latex gloves, appropriate lubricants, and other safer-sex materials must be made available to male-to-female transsexual and transgender prisoners in a discreet, non-identifying manner. Condoms prevent the sexual transmission of HIV/AIDS. Lubrication is essential for male-to-female transsexual and transgender prisoners due to their risk of tissue damage during intercourse, which may cause bleeding and place male-to-female transsexual and transgender individuals at increased risk for HIV/AIDS transmission.
- While incarcerated, transsexual and transgender prisoners have access to a health care system that many of them described as indifferent, or sometimes hostile, to their unique needs. To provide this population with appropriate health care, it is necessary to consider and address the specific barriers transsexual and transgender prisoners face when trying to access optimal health care.
- Correctional health care providers must be given the resources and training to enable them to support the unique medical, hormonal, and psychosocial needs of transsexual and transgender prisoners.

### **Women**

According to UNAIDS, women account for about 50 percent of the total number of people said to be living with HIV/AIDS. Of the over 24 million people said to have died of AIDS, about 60 percent of them are women (UNAIDS, 2000). It has been observed that many reasons account for this, and the situation is not different in Nigeria.

Apart from increased biological susceptibility to infection, women's subordinate status in Nigeria limits opportunities to be informed about HIV/AIDS, making them more vulnerable to infection and impairing their ability to deal with possible consequences of infection that require care and support (e.g., violence and abandonment by family). Violence against women in all its forms during peacetime and in conflict situations increases their vulnerability to HIV infection. Such violence includes, *inter alia*, sexual violence, rape (marital and other) and other forms of coerced sex, as well as traditional practices affecting the health of women and children. States have an obligation to protect women from sexual violence in both public and private life.

Systematic discrimination in all facets of life, but particularly, education, health care, and employment, disproportionately increases the risk of women becoming infected. Education and prevention programmes are hindered where women lack the skills to understand or the capacity to act upon the information contained in them. Women sometimes cannot negotiate safer sex or leave their partners because of social and legal norms and economic dependency. Norms that promote motherhood as the ideal form of self-worth and identity for women increase vulnerability to HIV and constrain reproductive choices for HIV-positive women. Double standards about chastity and fidelity mean that many monogamous married women have been powerless to avoid infection by their husbands.

Sexual and other violence directed at women (including within marriage), as well as traditional practices such as female circumcision and infibulation, are not legally prohibited in some states. Such acts, or even fear of the threat of violence, cause increased risks of HIV infection, as well as physical and emotional harm to women. Guideline 6 of the International Guidelines on HIV/AIDS and Human Rights (1996) discussed the discriminatory impact of laws, such as those that prevent women from owning land or property or perpetuate inequity by failing to provide equal remuneration for work of equal value.

HIV/AIDS prevention and care for women are often undermined by pervasive misconceptions about HIV transmission and epidemiology. There is a tendency to stigmatise women as “vectors of disease,” irrespective of the source of infection. As a consequence, women who are or are perceived to be HIV-positive face violence and discrimination in both public and private life. Sex workers often face mandatory testing with no support for prevention activities to encourage or require their clients to wear condoms and with little or no access to health care services. Many HIV/AIDS programmes targeting women are focused on pregnant women, but these programmes often emphasize coercive measures directed towards the risk of transmitting HIV to the foetus, such as mandatory pre- and postnatal testing followed by coerced abortion or sterilisation. Such programmes seldom empower women to prevent perinatal transmission by prenatal prevention education and an available choice of health services, and they overlook the care needs of women.

There has been increasing recognition that in order to influence gender relations, men must also be targeted. The Panos AIDS Programme is of the view that men drive the global epidemic “...Because men have more sexual partners than women, because men tend to control the frequency and form of intercourse, and because women are physiologically more susceptible to the virus, it is men’s behaviour which determines how quickly, and to whom, the virus is spread. Such behaviour does not mean that men are ‘responsible’ for the AIDS epidemic. Men are also at risk, since they cannot transmit the virus to others unless they contract it first themselves” (Foreman, 1998).

### ***Recommendations***

- Laws, cultures, and attitudes that discriminate against women should be discontinued.
- Legislation imposing harsher punishments on violence against women should be enacted.
- More girls should be encouraged to go to school at an early age, encouraged to stay in school, and withdrawal of children from school for marriage should be penalised.
- There is need for women to be empowered economically by creating job opportunities for them. This will make them less dependent on men and help them to be assertive about their rights.
- Government programs should aim at sensitising women to negotiate safe sex and determine the number of children they want.
- Men should be sensitised to respect the human rights of women and desist from negative practices against women.

## Sex Workers

Sex workers live and work in an environment that stigmatises and marginalises them in many ways. Personal and public disapproval of sex work is expressed in the attitudes of communities, politicians, and service providers; in local bylaws and police surveillance; and in the criminal status of prostitution. Many sex workers are further marginalised by involvement with the street, poverty, race, alcohol, and drug use, and, as with bisexual or transgender sex workers, sexual identity.

Street prostitutes are often the most marginalised of sex workers. Street prostitution is illegal, whereas escort services are not—a discriminatory feature of the law that has an adverse effect on poorer sex workers. Street prostitutes are more vulnerable to harassment and are more likely than other types of sex workers to be arrested for soliciting and imprisoned.

The HIV epidemic has heightened and exposed the vulnerability of sex workers to discriminatory attitudes, attention, and regulation. Sex workers have been characterised as “vectors of transmission,” a phrase that ignores the fact that many sex workers use condoms more consistently than other populations, that they frequently exercise more responsibility than their clients, and that they are generally at a higher risk of infection from their clients than vice versa. Research on sex workers has focused more on their working lives than their private lives, even though many sex workers may be more at risk in the latter than the former. Certain countries, such as the United States, have introduced regulatory regimes composed of mandatory HIV testing and detention, disproportionately overemphasising the role that sex workers play in HIV transmission. Confidentiality of HIV status is often breached, particularly for street prostitutes. Word of HIV status is spread not only by other prostitutes but also by public officials.

The prospect of criminalising HIV transmission is ominous for sex workers. As a prostitute, one could be blamed as an easy scapegoat for someone else’s unsafe behaviour. Prostitutes are easily identifiable targets, and the potential for this is high.

Indeed, in the Thissen case, an HIV-positive prostitute was charged with aggravated assault for biting a police officer although the risk of infection from biting was extremely small (Canadian Legal Network on HIV/AIDS, 2000a). As Elliott of the Canadian Legal Network on HIV/AIDS, commenting on the Thissen case, observes, the charge was a misguided overreaction by police and prosecutors: “While there is no question that biting someone constitutes an assault, the HIV-positive status of the accused does not render a mere bite an ‘aggravated’ assault.” Media reports of the case did not question the charge or the sentence—in fact, a Toronto radio host suggested that the accused should have been executed rather than given a sentence of two years in prison.

Such attitudes, laws, and policies regarding sex work affect the health, well-being, and safety of sex workers, particularly street prostitutes, and increase their vulnerability to HIV infection. Sex workers are often disinclined to access health and social services on account of the stigma associated with their occupation. Bylaws regulating their activity, along with police surveillance, may push them into less safe neighbourhoods, away from drop-in centres, and beyond the range of outreach workers. The illegal status of their activity can prevent sex workers from prosecuting abusive clients and protecting themselves from HIV infection.

The criminalisation of sex for money means that sex workers who are subject to abuse from their customers are less able to report their abusers. It also makes it difficult for them to insist on condom use with their customers, and thus increases their chances of becoming infected. In conversations with a number of women who were raped by their customers, without condoms, they said that because their work is illegal, they are not willing to prosecute these men. Instead, they maintain a “bad date” list and disseminate it to other sex workers.

### *Recommendations*

- Criminal law in the area of prostitution impedes the provision of HIV/AIDS prevention and care by driving people engaged in the industry underground. Such laws should be reviewed with the aim to decriminalise sex work where no victimisation is involved and regulate occupational health and safety conditions to protect sex workers and their clients.
- Criminalisation is stigmatising and may be reinforced by other laws, such as automatic reductions in penalties for rape of prostitutes. In some countries, the human rights of sex workers are violated when they are detained in rehabilitation centres or medical programmes against their will; are forced to reside at their place of work or declare their residence in designated areas; are unable to be married while registered; are required to use special identity cards; or have their papers, such as passports, marked with their occupation.
- Victimisation, including the use of children as sex workers and adults who are trafficked or otherwise coerced into the industry, should continue to be subject to criminal penalties. Victims should not be prosecuted for their participation but removed from the industry and provided with medical and psychological support services, including those related to HIV. Most prostitution laws are founded on nineteenth century notions of morality that were as ineffective then as now in suppressing the industry. Nonetheless, there continues to be a demand-driven market.
- By treating sex work as a personal service industry that is neither condemned nor condoned, public health objectives are much more likely to be achieved than under the criminal law.
- To be effective in preventing transmission, laws regulating business need to focus on management responsibilities. By removing the fear of prosecution and harassment by police for a range of offences (either engaging in the profession, or associated offences of living off the earning), a freer flow of information and education is encouraged, with workers more likely to present regularly for advice, counselling, testing, and treatment. By recognising the industry through regulation, some of the stigma associated with sex work would be removed. This would make access by health educators with targeted programmes easier and alleviate the fear of public identification, which ironically makes it more difficult to leave the profession. In improving working conditions, a culture of safer sex can be promoted in the industry and responsible behaviour by workers, clients, and management can be encouraged. Features of legislation that have successfully regulated the sex industry in some jurisdictions include the following:
  - Controls on owners/operators should not be so onerous to comply with that a second illegal industry is created, which is inaccessible to health educators.
  - Controls on land use by premises used for prostitution and on public nuisance protection (e.g., parking by clients, noise, and hours of operation) should be analogous to other personal service businesses.

## **CRIMINALISATION OF HIV/AIDS**

Many countries have specific criminal offences for the intentional exposure or transmission of HIV. The existence of these offences has little impact on the spread of the virus, given that the vast majority of transmissions occurs at a time when the infected person is unaware of his or her own infection. Such laws divert attention and resources from measures that do make a difference in curbing the epidemic and can, in fact, be counterproductive because of the danger of further stigmatising alienated groups, already treated as outsiders by society. By placing blame on one party, the criminal law undermines public campaigns aimed at placing responsibility for adopting preventive measures on both parties engaging in risky behaviour.

Coercion is a crude tool in educating for behaviour change, particularly in areas of intimate private activity like sex. Inevitably, scapegoating occurs with a focus on unpopular minorities, and people living with HIV are seen in the public mind as potential criminals. The type of cases likely to come to the attention of prosecutors often involve members of vulnerable groups who are of interest to authorities for a variety of reasons (e.g., mental illness), and likely to be inarticulate and/or poor. Variable or targeted law enforcement can be arbitrary, and minorities are often subjected to intrusive policing practices. Potential abuses in enforcement exist for vulnerable populations, such as gay men and sex workers, because of discriminatory judgments and assumptions about their lifestyles.

Criminal penalties for making false blood-donor declarations do not have the same negative policy implications as private behaviour where transmission may occur. This is because the right to health is clearly violated by the use of contaminated blood, and there is no countervailing or legitimate public interest in donating infected blood.

There are not usually offences for perinatal transmission because of the overwhelming countervailing interest in childbirth. The risk of a mother transmitting HIV to a child at birth or through breastfeeding is thought to be somewhere between 13 and 48 percent and can be greatly reduced by the administration of ARV therapy (e.g., zidovudine or nevirapine). The scientific evidence about the actual risk of transmission should be seriously considered by states that routinely force HIV-positive women to have sterilisations and abortions in violation of the human right to found a family.

Punishment under criminal or public health law should be reserved for the most serious culpable behaviour. Relevant charges for HIV exposure/transmission include attempted murder, assault and battery, unlawfully causing bodily harm, or other offences relating to public nuisance, dangerous acts, and noxious things. Society and the individual concerned may not be well served by imprisonment of offenders under such laws for a number of reasons.

The risk of HIV transmission is increased in the prison environment as a result of higher risk behaviour without access to preventive information and measures. Imprisonment is less likely than counselling and social support to change behaviour in the community. In addition, adequate health care and other facilities or privileges may not be available for HIV-positive prisoners in some prisons.

It is preferable for such cases to be treated under general criminal, public, or mental health law provisions, provided that such application is appropriate. In Canada, increased sexual abuse of minors by perpetrators wanting to avoid HIV infection prompted legislators to make rape a capital offence in 1990. Not only was this contrary to international human rights obligations, but the law was counterproductive as the number of cases increased (Canadian Legal Network on HIV/AIDS, 2000a).



Civil law, which seeks to deter wrongdoing and compensate those who are injured by it, is sometimes used to provide remedies for aggrieved individuals. Although it has a lower standard of proof than criminal law, there are many practical obstacles to proving fault in civil litigation, such as legal expense and delay, which may not make it worthwhile to pursue an uninsured defendant.

Defences should be available for such offences. Many public health offences contain specific defences in the case of informed consent by a partner (this class should not be restricted to de jure or de facto couples, but any couple having sex). In some jurisdictions, marriage is a complete defence, with or without consent. Such a provision unfairly discriminates between married and unmarried persons who have sex and implies that there is no need for safer sex in the case of married couples. This puts married women at a disadvantage in negotiating safer sex and being able to insist on the use of protective measures.

It has been argued that consent should not be available as a defence as infection results in a health and welfare burden on the community. This, however, ignores the significant privacy and autonomy interests of individuals being able to choose to engage in sexual activities without state intervention. Draconian measures that prohibit HIV-positive people from having sex, even with informed consent, are impossible to enforce and undermine public health campaigns designed to encourage people to present themselves early for counselling, testing, treatment, and support. Use of preventive measures should be a full defence against charges relating to exposure without consent—either inherently, because there would be no intention to expose to infection where, for example, condoms are used, or explicitly. More problematic is the rare case where preventive measures are used but fail (e.g., a condom breaks), and infection occurs. Legal recognition should be given to the use of preventive measures, thus providing further incentive to use them. One possible solution is to create a partial defence to such offences, or to grade the offences in terms of their seriousness.

To ensure that state policy is sound, a number of principles should guide state policy regarding the use of criminal sanctions or coercive public health measures and any discussion of strategies.

- First, states should respect and promote human rights, as set out in the HIV/AIDS and Human Rights International Guidelines.
- Second, if states must resort to criminal law, then preventing HIV transmission must be the single most important objective of doing so. HIV prevention should not be sacrificed in pursuit of other criminal law goals (such as retribution). This is acknowledging that there may be instances when deliberate malicious transmission of HIV should be punished, but this should be on a case by case basis. A blanket criminalisation policy will only serve to prevent people from finding out their status so that they are not held liable.
- Third, decisions regarding the scope of the criminal law's application must be based on the best available evidence regarding modes of transmission and levels of risk. Irrational, overbroad uses of the law are unjust and endanger the public health by communicating misinformation about how HIV is transmitted.
- Fourth, coercive measures are of limited utility in responding to HIV transmission. They will be inapplicable or ineffective with respect to most instances of HIV transmission or exposure and may undermine more effective initiatives to prevent the spread of HIV and provide care to those living with the disease.

- Fifth, coercive measures should be used sparingly and as a last resort, on the principle that the least intrusive measures possible to achieve the demonstrably justified objective are always preferred so as to minimally impair valuable rights and interests.

Keeping these guiding principles in mind helps in assessing the strength of arguments for and against various coercive measures and in answering specific questions about how and to what extent the criminal law should be applied.

The law could only have any appreciable effect in cases where a person (a) knows they are HIV-positive, (b) considers the potential for criminal penalties, and (c) as a result, modifies their conduct by avoiding or reducing activities that risk transmission and/or by disclosing their status to the other person. It would be dangerous to the public health to overestimate the deterrent value of the crude tool of criminal prohibitions on such complex, intimate, deeply ingrained human behaviours, such as sex or drug use, often not motivated by fully rational assessments of risks and benefits. Any deterrent effect would also be undermined when a person's ability to disclose their HIV-positive status or avoid or reduce risk is impaired (e.g., by stigma and discrimination, possibility of violence, poverty, addiction, etc.). Similarly, social, economic, and legal realities often undermine any deterrent effect of criminal prohibitions (e.g., already widespread impunity for men who harm women or children or place them at risk of harm).

### **Policy Considerations Suggesting Restraint**

There are also a number of other reasons why criminal law is limited as an HIV prevention tool and why its application to HIV/AIDS should be restricted.

First, there are difficulties with proof on a number of fronts, including uncertainty as to what physical and mental elements should be necessary as proof for a conviction. It would be unjust to prosecute and imprison a person who did not even know they were HIV positive. But should a conviction also require that the person knew their conduct posed a risk of transmission? What level of mental culpability (*mens rea*) should be required for criminal liability: intention to harm or to risk harm? Recklessness about whether harm occurs? Mere negligence? Furthermore, in most cases, only the participants in the activity, which usually take place in private, will be able to give evidence as to what was disclosed or not, or what acts took place. The credibility of the HIV-positive person accused, or of a complainant, could determine their criminal liability in such a case.

Second, criminalisation could damage important public health initiatives in a number of ways, particularly if overextended or misused. Media coverage of court cases or new legislation inevitably contributes to the stigma surrounding PLHAs as “potential criminals.” Any effect in deterring risk activity could ultimately be outweighed by deterring people from getting tested for HIV so as to avoid possible criminal liability for not disclosing (although the significance of this potential effect is hard to gauge). If search warrants or subpoenas in pursuit of evidence for a criminal prosecution breach the confidentiality of counselling sessions, access to support for PLHAs that may in fact assist in changing risk behaviours may be undermined. Creating a category of “other” people who are the sole focus of criminal sanctions may create a false sense of security among people who are (or think they are) HIV negative, encouraging risk behaviour on their part. Finally, the overextension of the criminal law, particularly when accompanied by sensational media reporting, undermines efforts to educate the public about how HIV is, and is not, transmitted.

Third, criminalisation may, in practice, amount to selective prosecution of those who are socially and/or economically marginal and are associated in the public mind as the “guilty” people with HIV/AIDS. The singling out of PLHAs for criminalisation is also a form of selective prosecution. As the AIDS Law Project in South Africa has pointed out, the intensity of the demand for criminalisation of HIV

transmission may itself be a reflection of the prejudices surrounding the HIV epidemic, because no comparable demand has arisen in response to transmission of other sexually transmitted infections (STIs) which, although less serious in their medical consequences, are in fact more easily transmitted than HIV and result in physical and emotional harm to the person infected.

Fourth, while we may understand the desire to protect women at risk of HIV infection from male partners by invoking the criminal law for risk activities, a concern about gender inequality means we must also consider the effect of criminalisation on women—particularly women with HIV/AIDS. Some women exposed to HIV or infected by their partners may not benefit from the prosecution and incarceration of their partner if this means a loss of economic support for them or their children.

Criminalisation may be tainted by gender bias if it fails to account for differing levels of risk: all else being equal, the risk of female-to-male transmission is lower than male-to-female transmission (although this difference may not be great enough that a court would consider it legally significant). Also, the same gender inequality factors that increase many women’s vulnerability to HIV infection will also hinder their ability to avoid or reduce the risk of transmission to their husbands or other male partners. Criminalisation does not address these issues. For example, research reveals physical violence against PLHAs following disclosure, including against HIV-positive women at the hands of male partners. In such circumstances, criminalising nondisclosure and/or unsafe sex does not protect those who are vulnerable; it compounds the dual burden of vulnerability and HIV.

Finally, one must consider the intrusion into privacy that criminal prosecutions would entail for both the accused HIV-positive person and the complainant, whose sexual histories and confidential records kept by health professionals or counsellors would become evidence in the courts. Court orders suppressing media reporting of a person’s identity are a partial solution at best.

Three strategic legal questions regarding the criminalisation of HIV transmission/exposure are briefly discussed here.

“One reason people tend to accept uncritically criminalisation of HIV is that they do not compare it to other possible methods of dealing with the problem” (Canadian Legal Network on HIV/AIDS, 2000a). Most jurisdictions grant powers to authorities to protect public health, which could be used to intervene in cases of conduct that risk transmitting HIV. In addition to education, counselling, and support, the law may also authorise more coercive measures, such as compelling a medical exam, orders to refrain from certain kinds of conduct, and detention for breach of a public health order or if otherwise necessary.

### ***Recommendations***

A number of factors suggest that the exercise of public health powers may be preferable to criminal prosecutions:

- First, they offer greater flexibility. Tailoring an intervention to an individual’s specific circumstances (including addressing underlying causes of risk behaviour) is likely to be more effective in changing behaviour.
- Second, they are proactive measures aimed at preventing risk activity, rather than solely reactive to events that have already occurred.
- Third, they are more private interactions, preserving confidentiality better and avoiding further stigmatisation associated with HIV.

### ***Recommendations (cont'd.)***

For these reasons, public health interventions achieve the most important goals as well as, or better than, criminalisation. While the criminal law is certainly better suited for retribution, this cannot be the prime determinant of public policy. Public health interventions are more likely to achieve rehabilitation (i.e., behaviour change). If ultimately necessary, they offer a more effective means of incapacitation (detention in a health setting rather than a prison). Absent additional research, we can only speculate whether

criminal sanctions or public health interventions will have a greater effect in deterring risky behaviour, the key consideration. But experience suggests the activities accounting for most HIV transmission (sex and injection drug use) are highly resistant to change, persisting in the face of criminal prohibitions. An individualised approach, addressing the causes of risk activity, may be more effective.

Two other factors must also be considered in deciding whether criminal prosecutions or public health interventions are the preferable route.

- First, public health laws may not always offer the same degree of (at least theoretical) protection against deprivations of liberty as the criminal law, and interventions may frequently be directed at marginalised individuals already subject to governmental surveillance as “clients” of the mental health, criminal justice, disability, or drug/alcohol systems. But the same rights and interests are engaged, so substantially equivalent protections should be incorporated. “Due process protection” in the application of public health or criminal laws to restrict the rights to liberty and security of the person is required as a matter of human rights. This suggests that there is a need for reform to public health laws, not that criminalisation is a preferable policy response.
- Second, public health interventions may not represent a viable or credible alternative to criminalisation if lack of resources undermines their feasibility. The resources needed to staff and sustain a public health system and accompanying services to address issues such as drug addiction, domestic violence, intellectual disability, mental illness, or poverty, may simply be unavailable in Nigeria. Rather than necessarily suggesting a greater role for the criminal law, this highlights the need for adequate resources for more effective measures to prevent HIV transmission.

If a new offence is created, the following issues should be considered:

- The offence should be generic rather than HIV specific and apply to other serious communicable diseases but with discretion in sentencing based on the curability of the disease.
- Difficulties with evidentiary issues need to be addressed, such as foreseeability (i.e., that the accused knew that the act he or she was contemplating was criminal), intent (*mens rea*), causality (i.e., that the accused’s conduct did in fact infect the victim, as opposed to another source or contact), and consent.
- Criminal responsibility is usually based on an individual’s capacity to make voluntary and intentional choices for acts of which he or she understands the significance. The coverage of the legislation should be limited to deliberate or intentional acts. Some countries have offences for reckless, negligent, or wilfully blind, as well as intentional, behaviour after unsafe activity to ensure that culpability is not avoided by refusing to be tested for HIV. The general legal test of recklessness is whether the accused foresaw the result of his or her conduct but nevertheless took the risk of bringing it about. There is a danger that any criminal provisions on testing (seen by

***Recommendations (cont'd.)***

some commentators as “backdoor” mandatory testing and punishing mere ignorance) could act as deterrents and undermine public health.

- The consequences of the criminal behaviour should be specified. In some countries, legislation punishes endangerment without actual infection because of the deterrent nature of such laws and the avoidance of evidentiary problems in proving harm. The main argument in support of such

legislation is that when public health measures aimed at changing behaviour fail, then the intervention of the criminal law as a last resort should not have to wait until infection occurs.

- It is important that objective criteria based on scientific evidence are used to measure the actual degree of risk involved in the behaviour concerned. For example, early cases brought against HIV-positive people for spitting are inappropriate as there is no real risk of transmission. A protocol should be developed between health and law enforcement authorities to ensure that only cases with a scientifically established risk of infection are brought before the courts.
- Care should be taken in classifying a syringe filled with HIV-infected blood as a “deadly weapon” to ensure that it does not discourage the return of used equipment to needle and syringe exchanges.
- The modes of transmission should be specified—usually sexual acts, as other modes of transmission, such as sharing needles and syringes, may not be included because of public policy issues regarding consent to the use of illegal drugs.

## CONCLUSION

HIV/AIDS presents a challenge to all the human rights affirmed in several international and regional treaties of which Nigeria is a part, including the Universal Declaration of Human Rights (UDHR); International Covenant on Civil and Political Rights (ICCPR); International Covenant on Economic, Social and Cultural Rights (ICESCR); African Charter on Human and People's Rights (ACHPR); Convention on the Rights of the Child (CRC); and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). These rights include the right to life, privacy, marriage and founding a family, equal access to education, work, the highest attainable standard of physical and mental health, liberty and security of persons, sharing in scientific advancement and its benefits, freedom of association, freedom of opinion and expression, freely receiving and imparting information, participation in public and cultural life, freedom of movement, an adequate standard of living, social security, assistance and welfare, seeking and enjoying asylum, non-discrimination, equal protection and equality before the law, and being free from torture and cruel, inhumane, or degrading treatment or punishment.

Policies and legislators are important starting points in preventing and redressing human right abuses related to HIV/AIDS. Unfortunately, in the face of a poorly understood threat like HIV/AIDS, there is a tendency to make policies based on the reactionary feelings and prejudices of a few founded on ignorance and fear. Sometimes even with the best of knowledge, ethical dilemmas exist that are not easily resolved. Therefore, the need for policies to be founded on sound scientific facts, ethical principles, international norms, and best practices from other jurisdictions cannot be overstated. This document attempted to present scientific, legal, and international norms associated with HIV/AIDS and human rights as they apply to the situation in Nigeria, with the hope those charged with the noble task of reforming the Nigerian HIV/AIDS policy will find it useful.

## **APPENDIX: HIV/AIDS AND HUMAN RIGHTS INTERNATIONAL GUIDELINES**

**(Second International Consultation on HIV/AIDS and Human Rights, 1996)**

1. States should establish an effective national framework for their response to HIV/AIDS, which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV/AIDS policy and programme responsibilities across all branches of government.
2. States should ensure, through political and financial support, that community consultation occurs in all phases of HIV/AIDS policy design, programme implementation and evaluation and that community organisations are enabled to carry out their activities, including in the field of ethics, law and human rights, effectively.
3. States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV/AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations.
4. States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.
5. States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasise education and conciliation, and provide for speedy and effective administrative and civil remedies.
6. States should enact legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of qualitative prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price.
7. States should implement and support legal support services that will educate people affected by HIV/AIDS about their rights, provide free legal services to enforce those rights, develop expertise on HIV-related legal issues and utilise means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units, and human rights commissions.
8. States, in collaboration with and through the community, should promote a supportive and enabling environment for women, children, and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services, and support to community groups.
9. States should promote the wide and ongoing distribution of creative education, training, and media programmes explicitly designed to change attitudes of discrimination and stigmatisation associated with HIV/AIDS to understanding and acceptance.
10. States should ensure that government and the private sector develop codes of conduct regarding HIV/AIDS issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

11. States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV/AIDS, their families, and communities.
12. States should cooperate through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV/AIDS at the international level.



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