



LEGAL ENVIRONMENT ASSESSMENT FOR HIV/AIDS RESPONSE IN NIGERIA

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National Agency for the Control of AIDS (NACA)

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FOREWORD

The Constitution of the Federal Republic of Nigeria offers general protection against discrimination and protects the rights of Nigerians. The provisions also encompass the rights of People Living with HIV as contained in the Constitution of the Federal Republic of Nigeria Chapter IV, Sections 33 - 44. HIV/AIDS Anti-Discrimination Act 2014 has also been passed while some states have also done the same. A couple of other legislations are also in place which have supportive implications for HIV/AIDS response in Nigeria.

At the Regional level, the Economic Community of West African States, (ECOWAS) Ministers of Health including Heads of National AIDS Commissions, Public Prosecutors and Inspector Generals of Police, recently came up with the Dakar Declaration of 10th April, 2015 on factoring Key Populations in the response to HIV and AIDS in ECOWAS member states. This represents a positive step in fashioning a regional and integrated approach to addressing the issues of disproportionate prevalence among Key Populations. It will no doubt assist in reaching the new target of 90:90:90 and fast tracking to the end of the AIDS pandemic by 2030 as espoused by the UNAIDS Strategy 2016-2021.

Given this scenario, a LEA aimed at identifying and clarifying key legal and human rights issues acting as barriers to the national response to HIV and AIDS is timely to provide evidence informed advocacy for required policy and legal reforms. I would therefore like to thank the UNDP and other development partners for supporting us to conduct this assessment. It is my believe that the findings and recommendations of the LEA will in no small way help to guide the development, implementation and enforcement of laws, regulations and policies that protect rights to and promote access to HIV and AIDS-related services



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PREFACE

The 2011 Political Declaration on HIV and AIDS and the Global Commission Report on HIV and the Law titled 'Right, Risks and Health' recognize that the law can have a profound impact on the lives of vulnerable and marginalized people. In recent years the law has been a positive force in advancing effective HIV responses. Judicial and legislative actions have, for instance, improved access to life-saving treatments and have protected people living with HIV against discrimination. Where the law has guaranteed equal inheritance and property for women and girls, it has helped to mitigate the social and economic burden caused by HIV and AIDS.

An assessment of a country's national legal and regulatory frameworks is therefore an important step in strengthening response to HIV and AIDS. The primary aim of a legal and regulatory assessment is to identify and review HIV, health and any other related laws, regulations; and policies and practices, in order to establish their relevance to, and impact on the national response to HIV and AIDS.

The 1999 Constitution of the Federal Republic of Nigeria (as amended), offers general protection against discrimination and protects the rights of all Nigerians. However, there are concerns that the legal and regulatory environment for HIV response could be improved. Some of the ongoing efforts at mitigating the environment include the initiatives on integration of Key & Affected Populations (KAP) issues into the process of drafting the Concept Note, leading to the development of the New Funding Model of the Global Fund Grant (2014-2017). This is already providing the required space for Key Populations to engage on issues of enhanced access to services in a non-discriminatory environment. This is important, given the disproportionately higher HIV prevalence rates among Key Populations ranging from 27.4% among Brothel Based Female Sex Workers (BBFSW), 21.7% among Non-Brothel Based Female Sex Workers (NBBFSW), 17.2% among MSM to 4.2% among Injection Drug Users (IDUs) (Integrated Biological and Behavioural Survey, 2012)

It is my hope that the findings and recommendations of the Legal Environment Assessment (LEA) will inform the development of a national plan of action with clear accountability frameworks for all stakeholders for evidence informed policy and legal reforms.

Pa Lamin Beyai
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ACRONYMS/ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
APIN	AIDS Prevention Initiative in Nigeria
ARFH	Association for Reproductive and Family Health
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASWHAN	Association of Women Living with HIV/AIDS in Nigeria
ATM	AIDS, Malaria and Tuberculosis
CHEW	Community Health Extension Worker
CWIQ	Core Welfare Indicator Questionnaire Survey
CDC	Centre for Disease Control
CSOs	Civil Society Organization
EC	Emergency Contraceptives
FCT	Federal Capital Territory
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FGN	Federal Government of Nigeria
FIDA	International Federation of Women Lawyers
FMOH	Federal Ministry of Health
FMWASD	Federal Ministry of Women Affairs and Social Development
FCT SACA	Federal Capital Territory AIDS Control Agency
FSW	Female Sex Workers
GARPR	Global AIDS Response, Country Progress Report
GBV	Gender Based Violence
GHAIN	Global HIV/AIDS Initiative Nigeria
HCT	HIV/AIDS Counselling and Testing
HEAP	HIV/AIDS Emergency Action Plan
HIV	Human Immunodeficiency Virus
HRI	Harm Reduction International
IAP	Interim Action Plan
IBBSS	Integrated Biological and Behavioral Surveillance Survey
IDU	Injecting Drug Users
IEC	Information, Educations, Communication
ILO	International Labour Organisation
JSC	Justice of the Supreme Court
JUNTA	Joint United Nations Team on AIDS
KAP	Key and Affected Populations
LACA	Local Government Action Committee on AIDS
LSACA	Lagos State AIDS Control Agency
LEA	Legal Environment Assessment
LRRDC	Legal Research and Resource Development Centre
MDAs	Ministries, Departments and Agencies
MICS	Multiple Indicator Cluster Survey
MPPI	Minimum Prevention Package Intervention
MTCT	Mother To Child Transmission
MSM	Men having Sex with Men
NACA	National Agency for the Control of AIDS

NAPTIP	National Agency for Prohibition of Traffic in Persons
NARHS	National HIV/AIDS and Reproductive Health Survey
NBBFSW	Non Brothel Based Female Sex Worker
NETCUSA	Network to Curb Sexual Abuse
NC	North Central
NDHS	Nigeria Demographic and Health Survey
NDLEA	National Drug Law Enforcement Agency
NE	North East
NEPWHAN	Network of People Living With HIV/AIDS in Nigeria
NGOs	Non -Governmental Organizations
NHRC	National Human Rights Commission
NPC	National Planning Commission
NPF	Nigerian Police Force
NPoPC	National Population Council
NSP	National HIV/AIDS Strategic Plan 2010-15
NW	North West
OHCHR	Office of the High Commissioner for Human Rights
OPD	Office of the Public Defender
PABA	People Affected By AIDS
PCRP	President's Comprehensive Action Plan on HIV
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PRAWA	Prisoners Rehabilitation and Welfare Action
PReP	Pre-exposure prophylaxis
PWID	People Who Inject Drugs
RH	Reproductive Health
SACA	State Agency for the Control of AIDS
SE	South East
SFH	Society for Family Health
SGBV	Sexual and Gender Based Violence
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
SW	South West
SS	South South
TB	Tuberculosis
TBA	Traditional Birth Attendant
TPs	Trafficked Persons
TWG	Technical Working Group
UKAID	United Kingdom Aid for International Development
UN	United Nations
UN WOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nation Population Fund



UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
VAPP	Violence against Persons (Prohibition) Act
VAW	Violence against Women
VCT	Voluntary Counselling and Testing
VVF	Vesico-Vagina Fistula
WHO	World Health Organisation
WLWHA	Women living with HIV/AIDS
WWD	Women with Disabilities

EXECUTIVE SUMMARY

With a prevalence rate of 3.4% (NARHS Plus, 2012) and an estimated 3.1 – 3.8 million people living with HIV, Nigeria has the 2nd largest burden of HIV in the world after South Africa (NACA, 2014). Rates of infection among specific groups within the population are higher than the national prevalence rates. For instance, HIV prevalence rates among Key Populations range from 27.4% among Brothel Based Female Sex Workers (BBFSW), 21.7% among Non-Brothel Based Female Sex Workers (NBBFSW), 17.2% among MSM to 4.2% among IDUs (IBBSS, 2012). Being able to effectively stop the spread of HIV infection among the general population may be unachievable if current trends of infection among key populations are not reversed.

Partly responsible for higher rates of infection among key population is the programming approach which is often not driven by respect for the rights of key populations and other vulnerable groups. At the centre of any meaningful right based programme are laws and policies that can guarantee respect for human rights and access to services delivered in a dignifying manner. Achieving this can only be possible if the legal and policy environment of the country is clearly understood with gaps identified and addressed, hence this assessment.

The role of the law in any response on HIV/AIDS cannot be over emphasized. The law can play a proscriptive role, a protective role and an instrumental role (Kisoon *et al*, 2002). This legal environment assessment was designed to identify important legal and human rights issues affecting people living with HIV and those at higher risk of HIV infection e.g. Men who have Sex with Men (MSM), Female Sex Workers (FSWs) and Injecting Drug Users (IDUs). It also took a brief look at the issues of vulnerable groups like young people and women living with disabilities. It sought to identify and review laws and policies that have implications for responding to HIV either by individuals or organisations in Nigeria and determine the extent to which the current legal and policy framework protects rights and/or acts as a barrier to access to HIV-related services.

The assessment was conducted using different qualitative research methods including, identification and review of relevant laws and policies, gathering of primary data through Focus Group Discussion/Interviews, In-depth and Key Informant Interviews. Data was gathered from strategic stakeholders on their experiences with HIV related laws, policies and services. Those interviewed include representatives of National Agency for the Control of AIDS, State Agencies for the Control of AIDS, HIV Positive Women and Men, Young people, MSM, FSWs, IDUs, Civil Society Organisations, Academia, Health Care Providers as well as some key Ministries, Departments and Agencies etc.

The assessment reveals experiences of abuse of human rights of people living with and affected by HIV/AIDS as well as Key and Affected Populations across the country. The following were identified as some of the rights that are abused by members of the public and law enforcement agents in Nigeria: the right to privacy (e.g. being forced to submit to medical test), right to freedom from discrimination, right of access to treatment, reproductive rights including the right to marry and to remain married and the right to be able to secure and retain employment (NEPWHAN, 2011). FSWs, IDUs and MSM suffer from incessant police harassment, the reasons for which, often times cannot be substantiated by law. Respondents that participated in the assessment complained vehemently of extortion of money from them by members of the Nigeria Police Force. Despite widespread

experience of abuse of rights, only very few respondents will take up legal action to enforce their rights. Partly responsible for this is the lack of confidence in the country's justice system, the high cost of seeking redress and the lengthy time that it takes to pursue litigation. The national bill on anti-discrimination which was at the final stage at the time of data gathering has now been signed into law. Similarly, some states of the federation do have such laws. They have however not made much difference to the lives of Key populations and HIV positive persons as the laws have not been tested in the court of law.

Cultural and religious beliefs often shape decision making and practice at different levels with far reaching implications for the vulnerability of different groups of people to HIV infection. Policy and practice in relation to reproductive health issues of young people is often shaped by culture which makes access to HIV/AIDS services highly restrictive and limited.

The assessment reveals a weak legal environment for an effective human rights based response to HIV/AIDS. Gaps in the legal system can hinder the institutionalization of evidence-driven, rights based programmes for specific groups of people. For instance the law on drug control in Nigeria focuses on supply control and demand reduction via seizures and arrests. This means the only approach to addressing drug usage/addiction that is backed by law is criminalization. The assessment calls for the use of the law in its instrumental role to promote change. It highlights the need for a shift in paradigm which separates drug peddling/courier from drug usage, therefore viewing drug usage/addiction as a health issue rather than a crime. Response to issues of MSM and FSWs by the law enforcement agents is also driven by the perspective of criminalization, often times without direct legal backing.

The assessment calls for a human rights sensitive review of the Penal Code, Criminal Code and the Same Sex Marriage Laws. This will support the successful implementation of the new HIV/AIDS Anti-Discrimination Law and allow for improved access to health care services by key populations and other vulnerable groups in line with international guidelines. It will boost Nigeria's efforts at reversing the trend of infection among key populations. It will also support the fulfilment of Nigeria's responsibilities to its citizens, irrespective of their social status and its obligations under international law.

The assessment also highlights the need for sensitization, community mobilization for popularization of the provisions the Anti-Discrimination Act and the corresponding laws at the State level. It calls for legal literacy of the key populations on their own rights and how to pursue actualization of such rights as well as increased involvement of PLHIV and Key populations in the coordinating entities at Federal and State levels for effective response.

There is no doubt that reversing the trends of the epidemic will require gender sensitive and high-level political commitment in a variety of ways, including legal reforms, design and implementation of progressive policies, plans and implementation strategies.

CHAPTER I

LEGAL ENVIRONMENT ASSESSMENT FOR HIV RESPONSE IN NIGERIA

LEGAL ENVIRONMENT ASSESSMENT FOR HIV RESPONSE IN NIGERIA

INTRODUCTION

With a population of over 160 million, Nigeria presents one of the worst HIV & AIDS case scenarios in Africa. The adult HIV prevalence increased from 1.8% in 1991 to 5.8% in 2001 before dropping to 5.0% in 2003, 4.4% in 2005, 4.0% in 2007, 4.1% in 2010 and 3.1% in 2012. “Over the last two decades, the HIV epidemic in Nigeria has gone from affecting only a few populations with high risk behaviour ('concentrated' epidemic), to a 'generalized' epidemic in all states” (NACA, 2008). The current prevalence rate of 3.4% (NARHS, 2012) among the general population translates to an estimated 3.1 – 3.8 million people living with HIV in Nigeria (NACA, 2014). By sheer numbers, Nigeria has the 2nd largest burden of HIV in the world after South Africa with women and girls being the most vulnerable and affected. Young women between the ages of 15 and 24 are more than twice as likely to be living with HIV as young men in the same age range.

Most new infections (42%) are among persons engaged in “low-risk” sex, and include married persons or co-habiting sexual partners. According to IBBSS (2010), even amongst key target populations, women have a higher prevalence rate than men. The prevalence of HIV among female Injecting Drug Users (IDUs) (21.0%) is almost seven times more than that of male IDUs (3.1%). Among the police, the prevalence of HIV is higher among female police at 4.5% as compared to their male colleagues at 2.0%. This trend is however different with the group of men that have sex with men. According to UNDP, 'recent studies show that while HIV prevalence is dropping among sex workers and truck drivers, HIV prevalence among men who have sex with men (MSM) has increased from 13.5% in 2007 to 17.4% in 2013. In urban areas this trend is even more evident. For instance, in Lagos, the HIV prevalence rate among the general population is 5.1%, while the HIV prevalence among MSM is almost five times higher, at 25.4% (UNDP, 2011).

PURPOSE OF THE ASSESSMENT

The HIV legal environment assessment is aimed at promoting a deeper understanding of the laws and policies of the country especially as they affect the rights of HIV positive persons, vulnerability of women, men, boys and girls to HIV, as well as the implications of related laws for individuals and organisations that work on HIV/AIDS. The LEA is designed to help establish which laws and practices have the potential to mitigate or exacerbate HIV-related stigma, which laws protect against discrimination and, which laws can enable recourse to justice through legal redress of experiences of HIV-related discrimination. It is believed that a thorough assessment of the legal and policy environment will help strengthen the response system to HIV/AIDS in the country. The UN General Assembly also favours the conduct of LEA. At its Special Session on HIV/AIDS in 2001, and the Political Declarations of 2006 and 2011, the role of the law in any response to HIV was highlighted, including law reform, community education and enforcement mechanisms. Countries are encouraged to “Commit to intensify national efforts to create enabling legal, social and policy frameworks in each national context in order to eliminate stigma, discrimination and violence related to HIV and promote access to HIV prevention, treatment, care and support and non-

discriminatory access to education, health care, employment and social services, provide legal protections for people affected by HIV, including inheritance rights and respect for privacy and confidentiality, and promote and protect all human rights and fundamental freedoms with particular attention to all people vulnerable to and affected by HIV”.

The assessment is also designed to support the UNAIDS 2016–2021 Strategy on the Fast-Track to end AIDS which has been described as “a bold call to action to get on the Fast-Track and reach people being left behind.” The strategy seeks to drive the attainment of the 90–90–90 treatment targets towards closing testing gap and protecting the health of those on treatment. The strategy recognises that ending the AIDS epidemic will involve progress across the entire spectrum of rights: civil, cultural, economic, political, social, sexual and reproductive. It calls for the defence of the rights of all people—including children, women, young people, men who have sex with men, people who use drugs, sex workers and clients, transgender people and migrants.

Whereas previous AIDS targets sought to achieve incremental progress in the response to HIV, the aim in the post-2015 era is to end AIDS epidemic by 2030. It is believed that this assessment will serve as concrete evidence to drive a shift in paradigm as regards the programming approach to the issues of key populations especially, FSW, IDUs and MSM.

The strategic targets of the Strategy as far as law and justice is concerned are the:

- removal of Punitive laws, policies, practices, stigma and discrimination that block effective responses to HIV
- removal of punitive laws, policies and practices that block key populations' access to services
- creation of support systems for People living with, at risk of and affected by HIV to know their rights and be able to access legal services and challenge violations of human rights
- removal of HIV-related stigma and discrimination among service providers in health-care, workplace and educational settings
- issuance and implementation of laws, policies and programmes to prevent and address violence against key populations

The Specific Objectives of the assessment are as follows:

- To identify and examine all important legal and human rights issues affecting particularly people living with HIV and those at higher risk of HIV exposure such as the Key and Affected Populations – MSMs, FSWs and IDUs.
- To identify and review laws and policies that have implications for responding to HIV, either by individuals or organisations in Nigeria.
- To determine the extent to which the current legal and policy framework protects rights and/or acts as a barrier to access to HIV-related services.

Nature and Scope of the Assessment:

The assessment includes the following:

- Review of available documents on international, regional and national human rights obligations, particularly those relevant to HIV and AIDS
- Review of relevant national laws and policies, including laws that impact on vulnerable and key populations as well as recent and ongoing law reform initiatives and proposals
- Review of all relevant national public health – related policies and recent and ongoing law reform initiatives and proposals in relation to their impact on vulnerable and most at risk populations
- Review of issues relating to access to justice including institutional frameworks for access to justice and law enforcement in relation to health services with particular attention to HIV and AIDS prevention, treatment and care.
- Assessment of the current legal, regulatory and policy environment in terms of the extent to which it is conducive to HIV and AIDS national response
- Identification of protective laws, regulations, policies and programmes, which support human rights and access to health services within the context of HIV and AIDS
- Identification of punitive laws and prohibitive policies which pose barriers to human rights and access to health services within the context of HIV and AIDS
- Identifying gaps and weaknesses in the current legal, regulatory and policy frameworks for HIV prevention, AIDS treatment and care and impact mitigation.
- Compilation of recommendations for public health-related legal and policy environment, law review and reform, strengthening access to justice as well as ensuring enforcement of rights, and creation of an effective response to HIV and AIDS.

METHODOLOGY

The process for the assessment was highly participatory process. A technical Working Group was constituted before the commencement of the assessment. The committee comprised of key stakeholders such as network of people living with HIV, representatives of Development Partners and Government Agencies, CSOs etc. The group reviewed the initial plan and made input into the design of the assessment.

The LEA was conducted using qualitative methods of assessment which involved both review of secondary literature (such as research reports, laws, policies and guidelines etc.) and gathering of primary data through Focus Group Discussion sessions, In-depth and key informant Interviews.

Table 1: Breakdown of Interviews conducted

S/N	NATURE OF INTERVIEW	Groups Reached	FCT	LAGOS	OWERRI
1	FGDs	<ul style="list-style-type: none"> - Men having Sex with Men, - Association of Women Living with HIV/AIDS - Men Living with HIV/AIDS - Commercial Sex Workers - Youth network on HIV - Young people - CSOs working on HIV/AIDS issues 	6	5	5
2	KII	<ul style="list-style-type: none"> - Academia - Researcher - Health Care Providers - CSOs - MDAs - Development Partners 	17	12	12
3	IDI/Group interviews	<ul style="list-style-type: none"> - Injecting Drug Users - Commercial Sex Workers - SACAs 	14	14	14

Wide consultations were made from inception towards generating information on laws and policies to be reviewed. Consultations were also made to allow strategic stakeholders to speak out on their experiences with the law, policies and services in relation to HIV/AIDS. The people living with HIV and those affected by it, as well as Key populations i.e. FSW, MSM and IDUs, were reached through their associations and through National & State Agencies for the Control of AIDS. The key informants who were drawn from different professional fields were purposively selected based on their knowledge of the subject of focus. They include policy and decision makers, health care providers, CSOs, development partners, researchers, academia etc.

In reviewing laws and policies relating to HIV in Nigeria, suggested tools of analysis in the 'UNDP Practical Manual Legal Environment Assessment for HIV: An operational guide to conducting national legal, regulatory and policy assessments for HIV' was used extensively with adaption to local situations where necessary. The question guide for gathering data were also developed with the use of the manual as a guide and input from members of the Technical Working Group.

The consultation for data gathering was done in stages. The first stage entailed contacting 34 state AIDS Control Agencies/Committees out of the 36 states of the federation through electronic mail and telephone (34 because Lagos and Imo were visited physically). A set of questions bordering majorly on the laws and policies relating to HIV/AIDS in their states were forwarded to them. At this stage, some state laws and policies were identified and marked for review.

The two remaining States (Lagos and Imo) and the Federal Capital Territory were visited physically by

the research team to gather data. The criteria for selecting that States visited physically are as follows:

- (i). Two States with high prevalence
- (ii). One State with low prevalence
- (iii.) States where more of the categories of groups to be interviewed can be easily reached
- (iv.) Security situation of the country

Of the 34 states, only eight responded. These are Adamawa, Ekiti, Gombe, Kogi, Nasarawa, Ondo, Oyo and Rivers.

The second stage involved visits to the selected locations to conduct interviews.

Following the initial draft report, NACA organized a stakeholders' meeting which brought together representatives of institutions such as the Legal AIDS Council, FIDA, House Committee on AIDS, Malaria and Tuberculosis (ATM), National Human Rights Commission (NHRC), Key and Affected Populations Secretariat. The initial findings of the assessment was presented to the meeting and the discussions held thereafter generated further inputs for the report. Subsequently, USAID sponsored facilities for MSMs were visited to obtain the perspectives of more key populations on rights based approach to HIV response. Finally, a national validation meeting was held in Abuja on 6th October, 2015 with participants drawn from different sectors and states of the federation. Inputs made by stakeholders at all these meetings were then used to further update the report.

DEFINITION OF KEY TERMS

Discrimination

Gender discrimination includes distinctions, exclusions or restrictions based on the biological characteristics and functions that differentiate women from men (e.g., pregnancy). Gender discrimination typically disadvantages women more than men. Discrimination against women has the “effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on the basis of equality, of human rights and fundamental freedoms in the political, economic, social, cultural civil or any other field” (Division for the Advancement of Women, 1979).

Stigma

Stigma can be described as a dynamic process of devaluation that significantly discredits an individual in the eyes of others. Within particular cultures or settings, certain attributes are seized upon and defined by others as discreditable or unworthy (UNAIDS, 2011).

Key Population

Those most likely to be exposed to HIV or to transmit HIV – their engagement is critical to a successful HIV response i.e. they are key to the epidemic and key to the response. In all countries, key populations include people living with HIV. In most settings, men who have sex with men, transgender persons, people who inject drugs, sex workers and their clients, and seronegative partners in serodiscordant couples are at higher risk of HIV exposure to HIV than other people (UNAIDS, 2011).

Men who have Sex with Men

Men who have Sex with Men (MSM) are males who have sex with males, regardless of whether or not they have sex with women or have a personal or social gay or bisexual identity. This concept is useful because it also includes men who self-identify as heterosexual but have sex with other men. However, abbreviations should be avoided whenever possible (UNAIDS, 2011).

Female Sex Workers (FSW)

Females who engage in transactional sex. Adults and young people over the age of 18 who receive money or goods in exchange for sexual services, either regularly or occasionally (UNAIDS, 2011). For the sake of this assessment, 'prostitutes' as used by the criminal code refers to FSWs.

Injecting Drug Users (IDUs)

IDUs are persons who inject drugs (UNAIDS, 2011)

Youth/Young People

The terms youth and young people have been used interchangeably in this report. They refer to young boys and girls within the age bracket of 15 – 24.

ETHICAL ISSUES

In view of the sensitivity of the subject of focus, most of the respondents were contacted through their associations and other national and state platforms e.g. National & State Agencies for the Control of AIDS. Participation of all respondents in the survey was strictly voluntary. Measures were taken to ensure respect, dignity and freedom of each individual participating in the study. In order to guarantee the anonymity of each participant, provision of names, their addresses or other identifying information were not made compulsory.

LIMITATIONS

One of the key limitations of the exercise is the fact that the groups of positive women and men that participated in the assessment were drawn from association formed based on HIV status and sex in some cases. The issue of financial status did not form part of the parameters; as such they were of different economic status. Some were gainfully employed while some were not; as such the realities of their experience with the enjoyment of their rights sometimes differ. Secondly, some of the participants were among the first set of people to openly declare their status in Nigeria and are the pioneers of the associations while others are either new in the associations or are not open about their HIV status. Despite this, the information generated is reliable and capable of forming the basis for advocacy efforts towards strengthening the legal and policy environment for HIV response in Nigeria.

STRUCTURE OF THE REPORT

The report is divided into six chapters. The first chapter is the introduction which presents the

background to the project, the objectives and the methodology for its implementation. The second chapter is a background to HIV/AIDS and key human rights issues in Nigeria, while the third is a review of literature which is an examination of how existing literature address the issue of law, human rights and HIV/AIDS. The fourth chapter is the outcome of the consultation with stakeholders in the process of the assessment. It documents the views and experiences of HIV positive women and men, representatives of groups of MSM, FSWs and IDUs in relation to the enjoyment of their rights especially as it pertains to HIV epidemic. It also documents the contributions of strategic stakeholders/Informants on the subject of study. Chapter five entails findings of the review of laws and policies on HIV/AIDS in Nigeria. The sixth chapter is the conclusion and recommendations following the assessment.

CHAPTER II

BACKGROUND TO HIV/AIDS AND KEY HUMAN RIGHTS ISSUES IN NIGERIA

BACKGROUND TO HIV/AIDS AND KEY HUMAN RIGHTS ISSUES IN NIGERIA

1.0 Country Profile

1.0.1 Geography

Nigeria lies within latitudes 4 1' and 13 9' North and longitudes 2 2' and 14 30' East. It is bordered in the north by Niger Republic; in the north east by the Republic of Chad; in the east by the Republic of Cameroun; in the west by the Republic of Benin and in the south by the Atlantic Ocean. It has a total surface area of approximately 923,768 square kilometers making her the 15 largest country in Africa. Nigeria has a tropical climate with distinct wet and dry seasons associated with the movement of the two dominant winds—the rain-bearing south westerly winds and the cold, dry, and dusty north easterly winds commonly referred to as the Harmattan. The dry season occurs from October to March with a spell of cool, dry, and dusty Harmattan wind felt in December and January. The wet season occurs from April to September.

1.0.2 Population

Nigeria remains the most populous country in Africa with an estimated population of 177, 072,561 and a growth rate of 3.2% (Federal Republic of Nigeria Official Gazette, 2007). Approximately two-thirds of the population live in rural areas (NPopC 2006). Nigeria has a relatively young population with a median age of 17 years (NDHS 2003); however, the population figures vary widely across the states, just like the terrain and land mass.

1.0.3 Administration

Nigeria became a political entity through the amalgamation of the Northern and Southern Protectorates and the Lagos Colony by the British Empire colonial administration in 1914. The entity gained political independence in 1960 with three functioning regions (North, East and West) and became a Republic in 1963. In 1967, 12 States were carved out from the three Regions. Currently, Nigeria is a democratic Federal Republic consisting of 36 States and the Federal Capital Territory (FCT). The States and the FCT are organized for political administration and are further divided into 774 Local Government Areas. They have also been grouped mainly on the basis of geographical proximity into six geo-political zones, namely North Central (NC), North East (NE), North West (NW), South East (SE), South South (SS) and South West (SW). The zones differ from each other in size, population, ecological characteristics, language, culture, settlement patterns, economic opportunities and historical background.

1.0.4 Nigeria Legal System

The Nigeria legal system is characterised by multiple regime of laws i.e. Statutory laws, Received English statutes of general application in force before 1900 and are not yet repealed by local laws, received principles of common law and doctrines of equity, judicial decisions (case law), customary

laws and Sharia law as well as international law. The Constitution is the ground norm as all other laws derive their validity from it. Any law that is inconsistent with the Constitution is void to the extent of its inconsistency - Section 1(3). While statutory law is made up of those rules of conduct or standards enacted as law by a competent legislative body, Judicial decisions which constitute 'pronouncements that elaborate on the meaning, scope, applicability etc. of a specific law become a source of, and part of the law' (Atsenuwa, 2008). Customary law on the other hand, is made up of the laws derived from the customs (meaning customary beliefs, norms and practices) of the various people-groups of Nigeria (Atsenuwa, 2008). Sharia law is classified as a form of customary law.

The multiplicity of laws within the legal system means that women, men, boys and girls have different levels of enjoyment of their rights depending on their culture or religion. It also means different levels of vulnerability to HIV infection. The Constitution of the country, however, does not condone discrimination (Section 42 of the 1999 Constitution as amended) including acts of discrimination associated with HIV status. Nigeria also has a national HIV/AIDS Anti-Discrimination Law. Ten out of the 36 States of the federation also has similar laws. Apart from regular courts, one of the structures in place to protect citizens (including HIV Positive Persons) against discrimination is the National Human Rights Commission (NHRC). The NHRC is an extra-judicial mechanism for the enhancement of the enjoyment of human rights.

1.0.5 Health Status

Life expectancy at birth for male is 53 years and female 56 years (NBS, 2013). Annual deaths due to HIV/AIDS ranges between 190,000 and 240,000. Malaria and HIV/AIDS remain high cause of death. Malaria alone accounted for 32% of the global estimate of 655,000 malaria deaths in 2010 (NDHS, 2013). One of the serious health challenges of Nigeria is high maternal mortality ratio which is currently estimated to be 576/100,000 live births (NDHS, 2013). One of the major causes of maternal mortality in Nigeria is inadequate access to emergency obstetric care services coupled with the fact that women often do not deliver their babies under the supervision of skilled attendants. The 2013 NDHS revealed that overall, only 38% and 22% of deliveries are assisted by skilled birth attendants and traditional birth attendants respectively. Similarly, only 36% of deliveries take place in health facilities. Births in the South West (83%) and South East (82%) zones are more likely than those in the North West (12%) or North East (20%) to be assisted by a skilled provider and to be delivered in health facilities. This has serious implications for HIV transmission especially from mother to child. The survey further revealed that more women in the urban areas (86%) than rural areas (47%) receive antenatal care from a skilled birth attendant. The North West (41%) and North East (49%) geo-political zones had lower proportion of mothers reporting haven received antenatal care from a skilled health care provider. Antenatal care utilization is highest among women with more than secondary education (97%) and lowest among women with no education (36%). The proportion of mothers receiving antenatal care from a skilled health provider increased from 58% in 2008 to 61% in 2013.

Table 1 Nigeria Basic Indicators

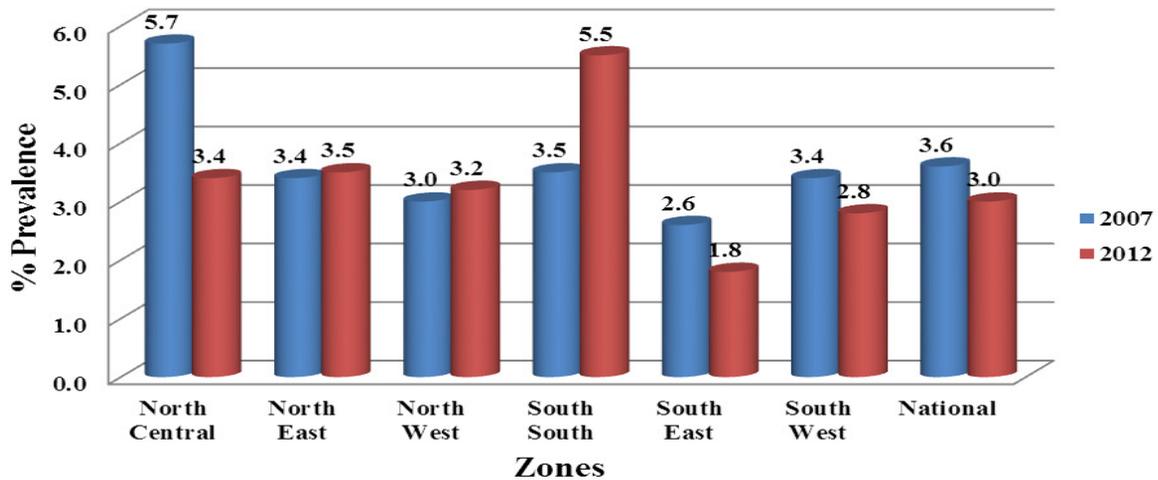
INDICATOR	VALUE	YEAR	SOURCE
Under-5 mortality rate	128	2013	NDHS
Infant mortality rate (under 1)	69	2013	NDHS
Neonatal mortality rate	37	2013	NDHS
Total population, 2013 estimates	177,072,561	2013	NPoPC
Annual number of births (thousands),	31828	2013	NDHS
Annual number of under- 5 deaths (thousands),	861	2013	NDHS
GNI per capita (US\$),	1280	2011	NDHS
Life expectancy at birth (years)	52	2011	NDHS
Contraceptive usage among married women (%)	15	2013	NDHS
Pregnant women who consult skilled health provider for the most recent birth (%)	61	2013	NDHS
Health Facility Based Deliveries (%)	33	2013	NDHS
Births delivered by Skilled Health Provider (%)	38	2014	NDHS
Total adult literacy rate (%)	61	2005-2010	
Primary school net enrollment ratio (%)	58	2013	
% share of household income, lowest 40%	15	2000-2010	
% share of household income, highest 20%	54	2000-2010	

1.0.6 HIV Prevalence and Trends in Nigeria

With a current prevalence rate of 3.4% among general population (NARHS, 2012), Nigeria has the second highest burden of HIV in Africa. Nigeria is estimated to have between 2.98 – 3.3 million people living with HIV and AIDS (NACA, 2013). Reports have shown that of the 1.5 million people living with HIV and requiring ARVs (using the new WHO guidelines) only 30% of them have access to it. Also about 30% of pregnant women have access to PMTCT services. About 220,394 new infections occur in 2013 with people aged 35 – 39 having the highest prevalent rate (4.4%) (NARHS, 2012).

Nigeria's epidemic is generalized, with wide variation in prevalence within the country. An analysis of the 2012 NARHS prevalence data in the country's six geopolitical zones shows that the prevalence is highest in the South South Zone (5.5%) while the lowest prevalence is in the South East Zone at 1.8%. There are also differences between urban and rural areas with prevalence figures in urban 3% and 4% in rural area.

HIV prevalence by Zones and National

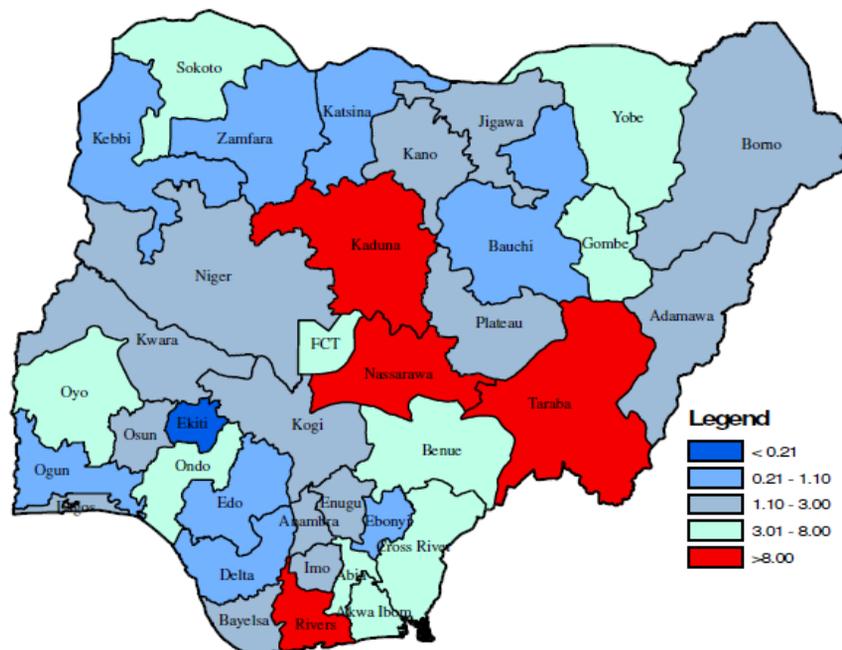


The main route of HIV transmission in Nigeria is heterosexual sex (FMOH, 2009; NACA, 2014), however, there is an increase in the infection rate through homosexual activities (UNAIDS, 2013). Beyrer (2013) argues that “HIV can be transmitted through large MSM networks at great speed and that molecular epidemiologic data showed marked clustering of HIV in MSM networks”. It is estimated that AIDS has claimed 2 million lives in the country since 1986. Also, annually an estimated 215 000 HIV-related deaths and 281 000 new infections occur in the country (NACA 2011).

1.0.7 Awareness of HIV/AIDS

Awareness of HIV is generally high among women and men with rates at 93% and 96% respectively. Awareness is however higher in urban areas (97.3%) than in rural areas (89.2%). Fifty four percent of women and seventy percent of men are aware that condom usage can help reduce the risk of HIV infection. Rate of awareness of the importance of condom usage in preventing infection does not necessarily correspond with rate of usage.

Figure 4- Geographic Distribution of HIV Prevalence by States



The 2013 National Demographic and Health Survey (NDHS) revealed that only 20 percent of men age 15-49 who reported having multiple sexual partners reported using condoms. The use of condom was higher in urban areas (36%) than in rural areas (11%) and higher among educated men with more than secondary school education (45%) than men with no education (2%)

1.0.8 Socio-cultural issues and HIV

Although current data presents a seemingly gradual decrease in national prevalence rate (3.4%) compared to the 2007 figure (3.6%), result of the National HIV/AIDS Reproductive Health Survey (2012) revealed that gender inequality is an important driver for the epidemic. Prevalence rates were found to be higher among females (3.5%) than males (3.3%). Gender inequality between women and men often fueled by socio-cultural practices that place women in a subordinate position compared to their male counterparts. For instance, because of the cultural division of domestic work, women and girls bear the burden of care for members of their families that are positive when they become ill. The implication of this is that women and girls have higher risk of exposure to infection than their male counterparts.

Major factors responsible for the spread of HIV among women, men, boys and girls in Nigeria include harmful socio-cultural practices that violate their rights as well as the dire economic conditions in which they find themselves. The point however must be made that women experience greater level of abuse of their rights than their male counterparts. Studies have shown that exposure to violence is a strong predictor of HIV infection. Gender-based violence which affects women and girls irrespective of their race, ethnicity, class, age, economic or educational status, religious or cultural divide etc. therefore exacerbate women's exposure to HIV infection.

The traditional subordinate status of women in many cultures in Nigeria as well as the unequal power relations between them and their male counterparts often make it very difficult for women to negotiate safer sex in marital and other forms of relationships, thereby increasing their level of vulnerability to HIV infection. The cultural practices that impact on women's human rights and leave them vulnerable to HIV&AIDS include female genital mutilation, widowhood rites, wife inheritance, domestic violence, denial of women's inheritance and property rights, poor access to reproductive health (RH) information with a resultant effect of poor health seeking behaviour among others.

The disadvantaged position of women is also evident in their level of enjoyment of reproductive health rights. In 2013, only 58% of pregnant women received antenatal care and 39% were assisted by skilled birth attendants at delivery with the situation of poor and rural based women being particularly worse than that of women in the urban areas. The NDHS 2013 report shows only 18% of women went to their first Ante Natal Care (ANC) visit during the first trimester of pregnancy – an increase from 16% recorded in 2008. Also, 51% of women who had a live birth five years preceding the survey had 4 or more ANC visits – a decrease from 45% in 2008. More women (95%) who are in the highest wealth quintile received ANC from skilled provider as compared to 36% of women in the lowest wealth quintile. In addition to the low use of facilities for ANC, coverage of services for Prevention of Mother to Child Transmission (PMTCT) has continued to lag behind antenatal care

access (UNAIDS, 2010). For instance, access to PMTCT services is still adjudged low. For instance, the national PMTCT ARV coverage is 30.1% (FMOH, 2013).

Cultural practices differ from society to society and therefore influence the spread of HIV in different ways. Although no direct association with HIV has been documented, according to WHO, 'the use of the same surgical instrument without sterilization could increase the risk for transmission of HIV between girls who undergo female genital mutilation together'. The national prevalence rate of FGM in Nigeria is 25% (NDHS, 2013). The highest prevalence rate is found among Yoruba women (55%), followed by Igbo women (45%). Osun has the highest prevalence of circumcised women (77 percent), followed by Ebonyi (74 percent) and Ekiti (72 percent); Katsina has the lowest prevalence (0.1 percent). The practice of sewing the genital area closed after cutting is most prevalent in Nasarawa (22 percent), Kaduna (21 percent), and Bayelsa (20 percent).

1.0.9 GBV and HIV

Another critical factor that increases the vulnerability of women and girls to HIV is gender based violence (GBV). The 2013 NDHS reveals that 28% of women have experienced physical violence since age 15. Studies have continued to show that intimate partner violence is an important contributor to women's vulnerability to HIV and STIs. In Nigeria, marital rape is not an offence; however, 4.2% of women reported being physically forced by their spouses to have sexual intercourse when they did not want to. Experience of sexual violence ranges from 6% among women age 15-19 to 9% among women age 20-24. It is interesting to note that more Christians (21.6%) than Muslims (4.6%) had experienced sexual violence and experience of physical violence is higher among Catholics and Protestants (44%) and lowest among Muslims (13%). A mapping exercise of laws, policies and services on HIV and GBV intersections conducted in 2012 revealed huge gaps in response to GBV/HIV intersection which led to the development of a National Plan of Action on GBV/HIV intersections 2014 - 2016.

1.10 Conflict and HIV

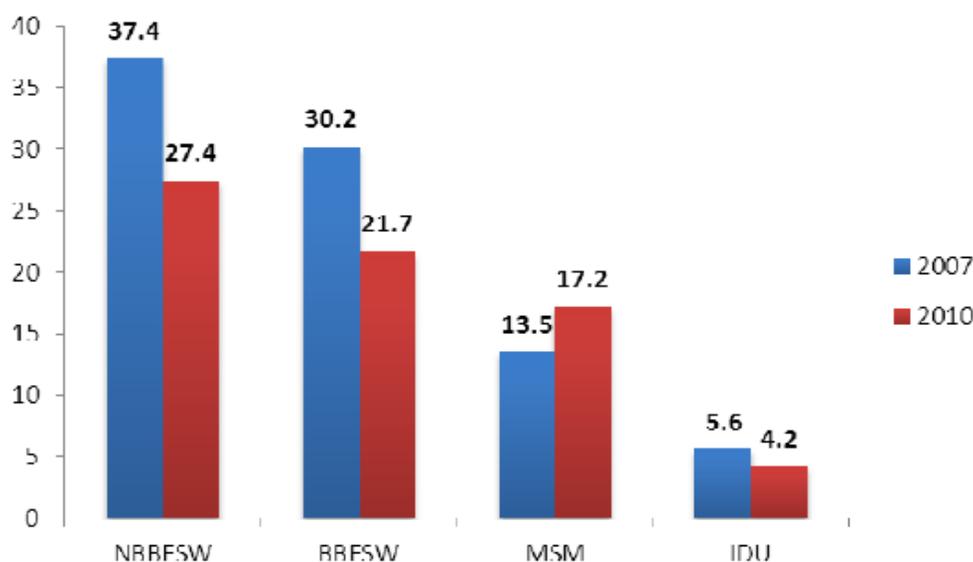
The vulnerability of women and girls to HIV infection has been greatly heightened with the spate of kidnappings and the issue of insurgency that is wreaking havoc especially in the North Eastern part of the country. Kidnappings and abductions of women and girls by insurgents are of great concern and have caused major setbacks to the education of the girl child, health and well-being of women, not to mention the exacerbation of sexual based violence which regularly accompanied violent/conflict situations.

Risky Sexual Behaviour and HIV

Apart from disproportionate level of infection due to gender inequality, high risk behavioural practices have been found to heighten the risk of infection among certain key population groups e.g. Female Sex Workers (FSWs), Men having Sex with Men (MSM) and Injecting Drug Users (IDUs). Although these key population groups constitute only 1% of the adult population, findings of the National Reproductive Health Survey (NARHS) (2012) revealed that they actually contribute as

much as 23% of new HIV infections. MSMs and IDUs and their partners contribute about 10% and 9% respectively of the annual new infections.

The survey further revealed that HIV prevalence among FSWs and MSM has remained high. In 2007, prevalence rate among brothel based Female Sex Workers (BBFSW) was 30.2% and 21.7% in 2010. A similar pattern was found among NBBFSW with 37.4% in 2007 and 27.4% in 2010. Among the MSM community prevalence rate is actually on the increase with 13.5% in 2007 and 17.2% in 2010. Compared to these groups prevalence rate among IDUs is low with 5.6% in 2007 and 4.2% in 2010 (IBBSS, 2007 and 2010). Of particular interest is the situation of male prisoners and detainees who have sex among themselves but do not buy the idea of using condoms. In a study of *Sexual Risk Behaviour and Knowledge of HIV/AIDS among Male Prison Inmates in Kaduna State, North Western Nigeria*, Audu et al (2013) found that “homosexual practices associated with HIV/AIDS transmission is practiced among the male inmates; however, the use of condom which is one of the evidence based strategies for the prevention of sexual transmission of HIV/AIDS is met with a high degree of resistance by inmates”.



Unfortunately, response of the law to the risky behaviour practiced by these key population groups is majorly criminalization which puts such population at higher risk of infection since they often have limited access to needed health services. Under Sharia law, which is operational in about 12 States of the federation, homosexuality, sex work and drug use are crimes.

Women Living with Disabilities and HIV

The condition of some women make them more vulnerable than others e.g. Women Living with Disabilities, Sex Workers, Women of Racial/Ethnic minorities, Refugees and Internally Displaced Women etc. Often easily forgotten are women with disabilities; they face stigma, discrimination, violence and poverty; in addition to the fact that their sexual and reproductive health issues have not received the desired attention over the years. They have limited access to health and social services; their sexuality has been ignored and their reproductive rights denied. They are seldom included in HIV-prevention, care and support programs, policies and programmes.

Dependency on others for survival and morbidity as well as widespread discrimination in access to services often place persons with disabilities at a higher risk of HIV infection (Interagency Coalition on AIDS and Development, 2008). Girls and women of all ages with any form of disability are among the more vulnerable and marginalized of society. Data on issues of persons with disabilities and HIV/AIDS in Nigeria is scarce and level of knowledge of information on HIV and how to prevent infection is adjudged very low among persons with disabilities especially adolescents with hearing impairment (Adeniyi and Olufemi-Adeniyi, 2014).

Poverty and HIV

In Nigeria poverty is a risk factor for disability and HIV infection. Poverty can make one engage in risky sexual/social behaviours as well as limit access to health care, HIV testing, and medications that can lower levels of HIV in the blood and help prevent transmission. In addition, those who cannot afford the basic necessities of life may end up in circumstances that increase their HIV risk. One of the ways women remain poor is by being denied inheritance either of their husband's or parents' property/asset. The 2013 NDHS reveals that 4% of women age 15-49 have ever been widowed. Forty two percent of widows were dispossessed of their property. Of these 62% were from the South West, 59% from the North Central and 51% from the South-South. The least dispossessed (14%) were from the North West. There is no urban/rural difference in the proportion of widowed women who have been dispossessed of their property.

In Nigeria, the way land is owned and accessed varies from place to place with women's right to access often secondary to that of men especially in rural areas (British Council, 2012). Land ownership is adjudged low among women (7.2%) compared to men (38.1%) (CWIQ, 2006). The legal landscape, especially as it concerns customary law recently experienced a progressive milestone with the decision of the Supreme Court in 2014 in the case of *Onyibor Anekwe & Anor v. Mrs. Maria Nweke* (2014) LPELR – 22697 (SC), which held that Nigerian customs that disinherit women are repugnant to natural justice, equity and good conscience and should therefore not be allowed to stand. The court declared as repulsive, the custom of the Awka people in Anambra State, which allows married women to be disinherited upon the death of their husband because they did not have a male child with the late husband.

Coordination of HIV response in Nigeria

HIV/AIDS response in Nigeria is coordinated by the National Agency for the Control of AIDS (NACA) which was established in 2001 by Act of the National Assembly in 2007. The Agency is led by a Director General and has a Governing Board. At the state and local government levels, coordination is led by State Agencies or Committee on AIDS (SACA) and the Local Government Action Committee on AIDS (LACA) respectively. Prior to 2007, the national and State coordinating bodies were committees and when it became clear that they would not be able to fulfil their mandate without autonomy and clear legal status, massive advocacy were mounted which led to the transformation of such bodies. About 15 States of the federation and the Federal Capital Territory are now agencies (NACA, 2010). However, some States still have their coordinating bodies as Committees and not

Agencies. Coordinating structures were put in place and an Interim Action Plan (IAP) was developed to combat the epidemic in 2000. This strategy was named the HIV/AIDS Emergency Action Plan (HEAP 2001-2003). In 2004, a review of the national HIV and AIDS response was carried out, which pointed to the need for a new plan, hence the development of the National Strategic Framework (NSF 2005-2009). The country is now implementing a third strategic plan – the National HIV/AIDS Strategic Plan 2010-15.

In recognition of the gaps in treatment and domestic financing of HIV response, the Federal Government developed the President's Comprehensive Response Plan (PCRP) in 2013. It is designed to 'accelerate the implementation of key interventions over a two year period and bridge existing service access gaps' (FGN and NACA, 2013).

CHAPTER III

LITERATURE REVIEW

LITERATURE REVIEW

Introduction

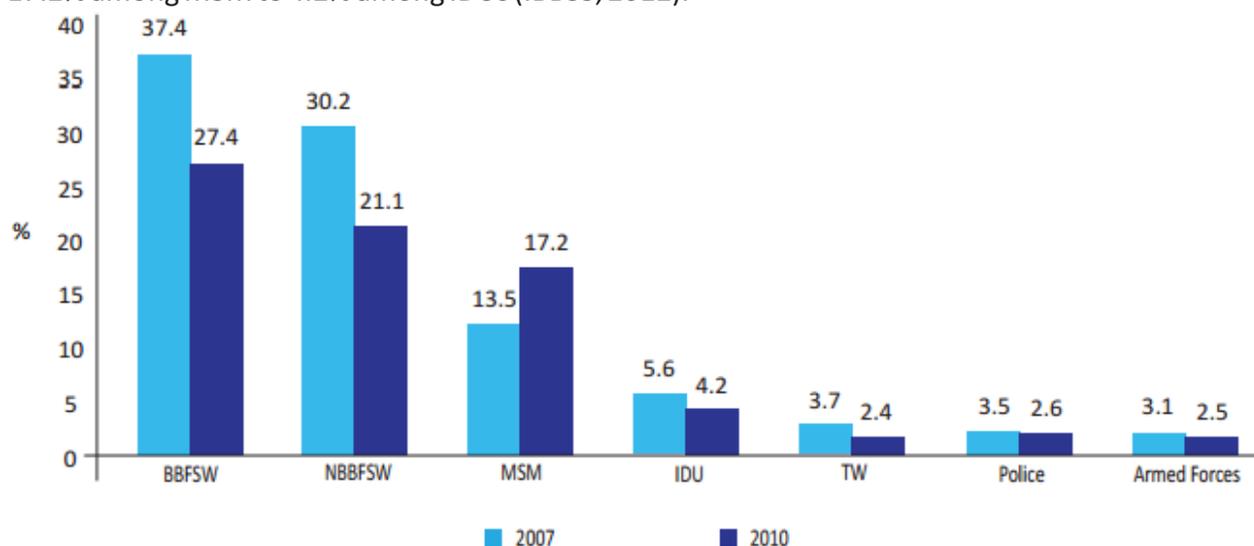
The population of HIV positive women and men has grown over the years and with specific groups of people, otherwise known as Key Populations having higher prevalence rates compared to the general population. 'Key populations are groups of people who are more likely to be exposed to or transmit HIV and whose engagement is crucial to a successful HIV response' (UNAIDS, 2010). In addition to people living with HIV, key populations often include men who have sex with men, transgender people, people who inject drugs and their sexual partners, and sex workers and their clients. In Nigeria, boys and girls age 15 – 24 are disproportionately infected, however, trend analysis of HIV prevalence among youths continue to show a consistent decline from 2001 to 2010 (i.e. from 6.0% (2001), through 5.3% (2003), 4.3% (2005), 4.2% (2008) to 4.1% (FMOH, 2010). This group also requires special attention partly because they constitute a significant proportion (31%) of the population (NPoC, National census, 2006).

Research has shown that female sex workers (FSWs) are disproportionately vulnerable to HIV infection in many parts of the world. An analysis of 102 articles written between 2007 and 2011 representing 99,878 female sex workers in 50 countries revealed a HIV prevalence rate of 11.8%, with female sex workers 13.5 times more likely to be living with HIV compared with all women of reproductive age in low and middle income countries (Baral et al., 2012). Another review of data on 1,027 sex workers from Uganda, covering the period 2008 to 2009 revealed HIV sero-prevalence rate of 37% (Vandepitte et al., 2011).

According to UNAIDS (2014), “gay men and other men who have sex with men have been profoundly affected by HIV, and have a 13 times higher HIV prevalence than the rest of the population. New HIV infections among men who have sex with men are driving or substantially contributing to national epidemics in all regions, accounting for 10% or more of new infections in Côte d'Ivoire, Ghana and Nigeria; 33% in the Dominican Republic; and 56% in Peru. HIV prevalence among men who have sex with men has been found to be as high as 38% in Jamaica, 25% in Ghana, 43% in coastal Kenya, 25% in Thailand and 19% in both Côte d'Ivoire and Guyana”. Beyrer et al (2013) argues that 'Ignoring this epidemic among all MSM and particularly Black race MSM, amounts to direct or reckless negligent genocide, homophobia and specifically, Black-race phobia and ethnic targeting. For reasons yet unexplained fully by epidemiologists and social scientists, Blacks are disproportionately at greatest risk of infections with HIV and AIDS death. The numbers are simply depressing'.

A similar analysis of data on Injecting Drug Users (IDUs) in 61 countries, containing 77% of the world's total population aged 15–64 years suggests that about 3.0 million people who inject drugs might be HIV positive. HIV prevalence among injectors was between 20–40% in five countries and over 40% in nine. With China, USA and Russia having prevalence rates of 12%, 16% and 37% respectively (Mathers, B.M. *et al.*, 2008).

In Nigeria, HIV prevalence rates among Key Populations range from 27.4% among Brothel Based Female Sex Workers (BBFSW), 21.1% among Non-Brothel Based Female Sex Workers (NBBFSW), 17.2% among MSM to 4.2% among IDUs (IBBSS, 2012).



Source: FMOH, IBBSS, 2010

Contrary to what obtains with other groups, HIV prevalence rate among MSM continues to rise (13.5% in 2007 to 17.2% in 2010). Partly responsible for the higher HIV prevalence rates among key populations include the abuse of or lack of respect for their rights which makes them highly vulnerable to HIV infection. According to Louise Arbour and Peter Piot (2006) in the foreword to the International Guidelines on HIV/AIDS and Human Rights “vulnerability to HIV infection and to its impact feeds on violations of human rights, including discrimination against women and violations which create and sustain poverty”. The high prevalence of HIV among the key population highlighted above has called for urgent attention. The key requirements approved for Nigeria in the 2014-2017 Concept Note by the Global Fund for AIDS, Tuberculosis and Malaria (ATM) are among other things: Integration of gender, women and girls issues; Integration of Key and Affected Populations (KAP) and series of national, zonal and state consultations and dialogue by the Key populations.

PROMOTING HUMAN RIGHTS, HEALTH & DEV.

The actions needed will support all UNAIDS's strategy goals and advance objectives involving human rights, health and development beyond HIV—as illustrated by the following examples:

To reduce sexual transmission of HIV, key populations must be able to access evidence-informed and rights-based services for prevention, treatment, care and support without fear of stigma, discrimination, coercion or violence.

To end violence against women and girls, laws and policies that criminalize and stigmatize female sex workers that do not protect women and girls from various forms of violence and that prevent the equal participation of women and girls in all aspects of society must be removed.

To protect people who inject drugs from becoming infected with HIV, laws, policies and practices that prevent them from accessing HIV services must be reformed.

To ensure access to treatment, HIV-related stigma and discrimination must be removed from health-care settings, workplaces, prisons, refugee camps, displacement settings and communities.

Source: Joint Action for Results UNAIDS Outcome Framework: Business Case 2009-2011

HIV/AIDS and Human Rights

Several human rights are related to HIV/AIDS. HIV/AIDS can either hinder the enjoyment of such rights or the lack of enjoyment of such rights can make one vulnerable to HIV infection. Such rights have been articulated to include “the right to life; the right to liberty and security of the person; the right to the highest attainable standard of mental and physical health; the right to non-discrimination, equal protection and equality before the law; the right to freedom of movement; the right to seek and enjoy asylum; the right to privacy; the right to freedom of expression and opinion and the right to freely receive and impart information; the right to freedom of association; the right to marry and start a family; the right to work; the right to equal access to education; the right to an adequate standard of living; the right to social security, assistance and welfare; the right to share in scientific advancement and its benefits; the right to participate in public and cultural life; and the right to be free from torture and other cruel, inhuman or degrading treatment or punishment” (OHCHR).

For human rights to be seen to be enjoyed by the right owners, they must be enforceable by law hence they become mere letters. The Nigerian Constitution makes a clear distinction between Fundamental rights (Chapter Four) that are justiciable and Fundamental Objectives and Directive Principles of State Policy (Chapter Two) which comprise mainly socio-economic rights that are sometimes considered non-justiciable. In other words, some of the rights that are listed as being rights that HIV positive persons should enjoy may not be enforceable unless the court is creative and able to interpret such rights within the context of enforceable rights and other provisions of the Constitution (Sections 13, 60 (a), 224) that can be relied upon as basis for their enforceability. Unlike the Court in India, the position of the Nigerian Courts on the enforceability of socio-economic rights is not clearly defined (Aborishade, 2013).

Some of the commonly abused rights of HIV positive people in Nigeria include the right to privacy (e.g. being forced to submit to medical test), right to freedom from discrimination, right of access to treatment, reproductive rights including the right to marry and to remain married and the right to be able to secure and retain employment (NEPWHAN, 2011). The NEPWHAN, 2011 Stigma Index report reveals that about 12% of respondents had been forced to take HIV test with about 20% of them not receiving any form of pre or post counselling services. HIV positive women (28.1%) and men (29.6%) reported having been forced to move from where they lived or were denied accommodation on ground of their HIV status. Also in the area of employment, 29.2% of the respondents had lost their employment within the preceding year of the study. Of this figure, 50% of the men and 42.7% of the women believe that the loss of their job was due to their HIV status. HIV Positive women and men also experienced violation of their health rights as 1 in 5 (approx. 20%) of the respondents of the NEPWHAN study reported that they experienced denial of health services once or more times within the preceding year of the study. Some of the reasons why HIV positive women and men will not seek redress upon experience of violation of rights include lack of financial resource (26.3%) to take action and lack of confidence (13.3%) in the judicial process.

Apart from the general experience of abuse of human rights by people living with HIV, specific groups of people such as Men who have sex with men (MSM), Injecting Drug Users (IDUs) and Female Sex Workers also face different levels and forms of abuse of their rights. Studies have shown that in all regions of the world, men who have sex with men, bisexuals and transgenders are severely affected by HIV, but their needs are often ignored and/or under-funded. Specific laws are also targeted at them that often further compound their exposure to stigma and discrimination. Many societies fail to plan for them because of stigma and the denial of the fact that they exist and have human rights. Bisexuals and many men who have sex with men, also have sex with women. Unprotected sexual practices among MSM and other key populations do increase the vulnerability of women and girls to HIV infection which therefore makes the recognition of their existence and their health needs priority issues. Abuse of right of access to services through whatever form of barrier, increases their level of vulnerability to HIV infection. For example Female sex work/prostitution is unlawful under Nigerian law and members of the Police Force in different parts of the country often take undue advantage of this to harass, molest and extort money from Female Sex Workers. Punitive laws against men who have sex with men often drive the practice underground and compound their challenges.

A weak legal and policy environment can mar HIV response activities. A recent study on the mapping of laws and policies on HIV and its intersection with gender based violence (GBV) supported by UNDP revealed the need for the Nigerian Government to strengthen the legal environment for addressing HIV and GBV. The Nigerian government just signed into law the HIV/AIDS an Anti-Discrimination law which has been pending with the National Assembly for almost a decade. Apart from the law at the national level, some states of the federation have their own law. Out of 36 States only about ten states have Anti- Stigma and Discrimination Law. These States are Lagos, Nasarawa, Kaduna, Enugu, Ebonyi, Benue, Ogun, Ondo, Rivers, and Cross River.

Some of the challenges with the legal environment on HIV in Nigeria include poor implementation of laws and policies even where they exist and low level of knowledge of existing laws and policies

among members of the public. Often times not many people are aware of existing laws and policies. The demand side for services (including justice when human rights are violated) is very weak. Because of the cumbersome and long period for adjudicating cases in court coupled with the associated cost which is often too high for the average person to afford, many Nigerians sleep over their rights. There is the need for a thorough assessment of the legal environment for HIV response in Nigeria in order for the national response system to be better strengthened, with the ultimate aim of ensuring that HIV positive women and men do not only have their lives prolonged through access to drugs, but that they enjoy their human rights every day of their life. It will also help to reduce vulnerability to infection among different groups of people including female sex workers, MSM, IDUs and young people. Such an assessment will help to expose gaps as well as strengths in the response system towards better evidence based planning and advocacy for policy and legal reforms.

The Law and HIV/AIDS in Nigeria

The strong linkage between law, human rights and HIV/AIDS has been established by many including the Global Commission on HIV and the Law, which following its two year research found that “good laws, fully resourced and rigorously enforced, can widen access to prevention and health care services, improve the quality of treatment, enhance social support for people affected by the epidemic, protect human rights that are vital to survival and save the public money” (UNDP, 2012). The key terms here are 'good laws' and 'rigorously enforced'. When laws are bad they serve the wrong purpose and when laws made are not enforced, they are mere aspirations.

In her paper titled, 'The Role of Law in HIV and AIDS', Hamblin (1991) argued that 'law can play three distinct roles in the approach to any issue – a proscriptive role, a protective role and an instrumental role'. In its proscriptive role, law can be used to proscribe certain forms of conduct as well as impose sanctions for failure to adhere. Over the years, many countries have passed laws criminalizing acts perceived as contributing to the spread of HIV. Unfortunately proscriptive laws may create unenvisioned challenges if they are not 'good laws' as suggested by the Global Commission on HIV and the Law referred to above. For instance, in 2013, Nigeria passed the Same Sex Marriage (Prohibition) Law which criminalizes same sex relationships and related activities. The law has been used to proscribe same sex marriage and certain activities of persons in same sex relationships as well as those who implement programmes targeting people of same sex relationships. The implications of this law, however, are far reaching. According to WHO and UNAIDS, criminalization 'has a dire effect on public health, especially on efforts to prevent the spread of HIV. It can, for example, deter some of those most at risk of infection from coming forward for testing and treatment out of fear of being deemed a criminal'.

In its protective role, law seeks to protect individuals and groups from becoming less human as a result of their HIV status. Laws that seek to offer protection against discrimination, invasion of privacy and dehumanizing treatment are examples that demonstrate the protective role of the law, however, once again such law must be 'good' in order for the protection being offered to be worthwhile. The first HIV specific laws were passed in the United States in 1987, following which many other nations passed similar laws (UNAIDS, 2013). For instance, in Canada, it is a crime for an HIV positive person not to disclose his/her status to a sexual partner before having sex, even if they use a condom and even if no one gets infected. In 2012, the Supreme Court affirmed laws against

non-disclosure. Also in the United States, 34 out of 50 states have different laws on different behaviours against HIV positive people ranging from non-disclosure to spitting (Schulman, 2014). Similarly in some states of the federation e.g. Benue and Ondo States, it is a crime to deliberately infect another person with HIV. The idea behind these laws is that 'placing restrictions on people with HIV and AIDS, or people thought to be especially at risk of HIV infection' prevent the spread of the virus' (Hamblin, 1991).

The instrumental role of law in the AIDS pandemic is perhaps the most proactive. It does more than regulate the relationship between individuals. It actually helps to “change the underlying values and patterns of social interaction that create vulnerability to HIV/AIDS” (Commonwealth Secretariat, 2001). This can come by way of legislation and creative decisions of courts (case law).

Available reports show that the law has not been used to play its role fairly in the protection of the rights of people infected or affected by HIV, especially in Nigeria. Apart from the fact that not many cases have gone to court, the National Anti-Discrimination Law was only signed into law in December 2014 after being in the process of law making for about a decade. Until end of 2014, there was a major lacuna coupled with the low level of knowledge of issues around HIV among Judicial officers as well as law enforcement agents (GARPR, 2014). There is however a dire need for massive sensitization of those that the law is supposed to protect directly; those who are to implement the law (law enforcement agencies, the judiciary) and members of the public generally, who may offend the law.

Many researchers have published reports that highlight 'ways in which using criminal law to address potential or actual HIV exposure or transmission might undermine HIV-prevention efforts'. Criminalizing certain groups of people may encourage others not to appreciate the fact that everyone has a responsibility in the fight against the HIV epidemic. It may also mean passing on the wrong message around how HIV is transmitted, thereby diverting attention from more important issues. Criminalization may also discourage HIV-positive people from accessing HIV-prevention services. They may avoid seeking support for fear of being charged for a crime, should the information they share about their status be used against them in the criminal justice system (NAM aidsmap, 2015).

The idea of criminalization precedes the release of studies that show that 'antiretroviral therapy (ART) reduces HIV transmission risk by 96% and most do not account for HIV prevention measures that reduce transmission risk, such as condom use, ART, or Pre-exposure prophylaxis (PrEP). The analysis encouraged states with HIV-specific criminal laws to use its findings to re-examine state laws, assess the laws' alignment with current evidence regarding HIV transmission risk, and consider whether the laws are the best vehicle by which to achieve their intended purposes.' (CDC, 2014)

In examining the role of law and policy in HIV response, UNDP and ILO (2013) posit that 'the law can set normative standards which make HIV-related discrimination unacceptable. Legal education and interventions can help people living with HIV and key populations to assert their rights, while social mobilization and publicity can deter discrimination against others'.

Even in countries where mechanisms for legal action are weak, a government commitment

expressed in law about the importance of addressing discrimination is an important component of the national response. The UN General Assembly Special Session on HIV/AIDS in 2001, and the Political Declarations of 2006 and 2011, emphasized the role of the law in the response to HIV, including law reform, community education and enforcement mechanisms.

“Commit to intensify national efforts to create enabling legal, social and policy frameworks in each national context in order to eliminate stigma, discrimination and violence related to HIV and promote access to HIV prevention, treatment, care and support and non-discriminatory access to education, health care, employment and social services, provide legal protections for people affected by HIV, including inheritance rights and respect for privacy and confidentiality, and promote and protect all human rights and fundamental freedoms with particular attention to all people vulnerable to and affected by HIV.” (Political Declaration on HIV/AIDS, 2011)

Human Rights Based Approach to HIV/AIDS Response

According to Kisoona et al (2002) a rights-based approach to HIV/AIDS programming “means locating the needs of those infected and affected by HIV/AIDS in human rights that can be claimed and asserted, whatever an individual's, a community's or a government's view on AIDS might be. It means using the language of rights to name and to understand certain practices”. Reports have shown that a rights-based approach to HIV/AIDS offers the best way to respond to the challenges posed to the society by the disease (Kisoona et al. 2002). A rights based approach to HIV/AIDS addresses not just the infection but all issues and circumstances surrounding it. According to Kisoona et al., a check-list of rights ensures 'a greater chance of preventing a skewed response to the pandemic'. In addition to this, a rights-based approach will put at the centre of any response programme, the human beings involved and thereafter the infection. Any comprehensive HIV prevention strategy therefore must include combinations of interventions for populations most at risk for HIV infections (Fatusi, 2007).

The centrality of human rights to any HIV/AIDS response cannot be over emphasized (UNAIDS, 2013). Failure to address the violation of human rights of people living with HIV/AIDS can cause a lot of harm which was why many infected and affected persons died at the initial stages of identification of the disease. The UNAIDS Reference Group on HIV and Human Rights (2013) has emphasized the 'critical need for human rights leadership in a number of areas, such as consistent support for harm reduction, as well as addressing HIV-related stigma and discrimination, and criminalization (i.e., the criminalization of HIV exposure, drug use, sex work and homosexuality)'.

A human rights-based response on HIV/AIDS prevention among IDUs requires the implementation of a comprehensive package of nine interventions as defined by WHO, UNODC and UNAIDS and are referred to as harm reduction services for HIV. The components of such programmes are: needle and syringe programmes (NSPs); opioid substitution therapy (OST) and other evidence-based drug dependence treatment programmes; HIV testing and counselling (HTC); antiretroviral therapy (ART); prevention and treatment of sexually transmitted infections (STIs); condom programmes for people who inject drugs and their sexual partners; targeted information, education and

communication (IEC) for people who inject drugs and their sexual partners; prevention, vaccination, diagnosis and treatment of viral hepatitis; prevention, diagnosis and treatment of tuberculosis (TB). According to UNAIDS (2014), evidence has shown that the most successful HIV prevention intervention among IDUs is one that combined the first four components. Although the National Policy on HIV/AIDS (2009) and the Nigerian Minimum Prevention Package Intervention Implementation Guide (MPPI) commits Nigeria to the provision of harm reduction services to IDUs, this is not backed by law. 'The National Drug Law Enforcement Agency (NDLEA) continues to focus on supply control and demand reduction via seizures and arrests. IDUs are routinely harassed, raided and detained in already overcrowded prisons in the attempt by the NDLEA to control drug availability' (Rhodes et al (2010) in Harm Reduction Int. 2012). Reports including drug surveillance system over the last several decades continue to show that prices of drugs have dropped significantly making access to drugs to be less difficult for users.

In relation to MSM, UNAIDS (2014) posits that to be able to provide evidence-informed and rights-based response there must be an understanding that 'structural factors such as societal norms, policies, laws and economic factors influence HIV risk'. Hence, it is absolutely necessary to adopt a multi-sectoral strategy that will ensure supportive legislation, policies and financial commitments; community empowerment; address stigma and discrimination; as well as prevent violence. Highly beneficial gains will be derived from the following health interventions: comprehensive condom and lubricant programming; behavioural interventions; HIV testing and counselling; sexual and reproductive health services; HIV treatment and care; substance use related harm reduction interventions; prevention and treatment of tuberculosis (TB); prevention and treatment of viral hepatitis (UNAIDS, 2014).

Finally in relation to FSWs who are HIV positive, theirs is a case of double jeopardy as the stigma associated with sex work is compounded by the stigma associated with HIV and makes access to essential HIV services difficult. UNAIDS (2009 - 2012) suggests three pillars which were improved upon in 2014. These are pillars upon which efforts aimed at addressing HIV and sex work can be based. They are:

Pillar 1: Assure universal access to comprehensive HIV prevention, treatment, care and support. Countries are enjoined to ensure availability and accessibility of quality goods, services and information on HIV/AIDS prevention, treatment, care and support to all persons, especially vulnerable groups on a sustained and on an equal basis. For services to be effective, structural barriers to access must be removed. For instance discriminatory laws, policies and practices that hinder access to services needs to be changed or removed. Measures should be put in place to address gender-based violence perpetrated by clients, controllers, managers of sex work establishments, law enforcement officers (Rhodes et al 2008).

Pillar 2: This is designed to promote building of supportive environments, strengthening partnerships and economic empowerment of sex workers. This pillar highlights the need for environments that support health promotion with the active participation of communities in the determination of priorities, decision making as well as in the

planning and implementing strategies to achieve better health. It also involves promoting economic empowerment of sex workers and ensuring that all barriers that hinder their effective participation are removed. Central to this pillar is the need to respect, protect and fulfil human rights; combat stigma and discrimination; and strengthen partnerships between government, civil society, and community actors to achieve the most effective HIV responses (UNAIDS, 2012). It also recommends that sex workers should have access to a meaningful and comprehensive set of alternatives to sex work that respond to workers' individual circumstances. Comprehensive and effective programmes would address issues around drug dependency, family rejection, mental health and legal problems. A comprehensive package of services to facilitate expanding choices should include: meaningful alternative employment and livelihood opportunities.

Pillar 3: This promotes the reduction of vulnerability and the need to address structural issues. States are enjoined to take measures to reduce the vulnerability, stigmatization and discrimination that surround HIV and promote a supportive and enabling environment by addressing underlying prejudices and inequalities within societies. Addressing structural issues will require that programmes are designed to address gender inequality, discrimination and social exclusion, poverty, mobility and displacement as they often drive the resolve to engage in sex work as well as increase their vulnerability to HIV.

CHAPTER IV

FINDINGS OF THE ASSESSMENT: INTERVIEW OF STAKEHOLDERS

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In recognition of the need to protect the rights of people within the context of HIV epidemic, Nigeria reviewed its 1996 National Policy on HIV/AIDS in 2003 and acknowledged the centrality of respect for human rights to any effort at effectively reducing vulnerability, preventing new infections and mitigating the impact of HIV. A further review was carried out in 2009. The revised policy highlighted the poor performance of government in stigma reduction, human rights protection and involvement of People Living with HIV/AIDS (PLWHA) in decision making processes regarding HIV response. The thematic goal for human rights and legal issues is “to protect the rights of PLWHA and People Affected by HIV/AIDS (PABA) and empower them as well as other HIV vulnerable or marginalized groups so as to reduce their social, cultural, legal and economic vulnerability and ensure their full participation in the national HIV/AIDS response and development initiatives”. The objectives of this goal clearly express government's commitment to the protection, participation and empowerment of vulnerable populations such as:

(1) Women and girls (2) Children and Young people (3) physically challenged persons (4) Poor people (5) People engaged in transactional sex (6) Men who have sex with men (7) Injecting Drug Users.

In the course of conducting this study, people with positive and negative HIV status that fall within the listed categories were interviewed in order to have an appreciation of their experience with the enjoyment of their rights. Also interviewed were policy and decision makers, health care providers, CSOs, Development partners etc.

Identification of rights by respondents

Respondents such as HIV positive women and men, female and male youth, IDUs, MSM and FSWs etc. were asked to state what they consider to be their rights. Some of the rights identified by most of the groups consulted are the right to life, association, religion, education, health, employment, privacy and personal dignity, the right to get married, the right to know the status of the person one is getting married to, right to inheritance etc. In addition to these rights, each of the three key population groups mentioned rights that had to do with their peculiar situation. For instance, some of the FSW expressed the view that they have the right to work and be free from harassment and embarrassment, especially by the police. Interestingly, some of the FSWs in one of the study centres in Lagos remarked that they have no rights since they were engaged in illegal business. The MSM on the other hand added to the list of rights that they identified, the right to sexuality and the right to be free from discrimination on the

Stakeholders Assessment of Legal Environment for HIV Response

- The legal environment for HIV response in Nigeria is weak as experiences of discrimination abound with little or no access to justice for many
- Weakness of the legal system is not due to lack of laws, but the fact that the laws are not well implemented. People are either not aware of the laws or are not aware of how to go about seeking redress.
- The level of engagement between relevant agencies and people infected and affected by HIV was adjudged low.
- Poverty is a major factor that hinders access to justice coupled with the absence of safety nets.
- There is weak compliance and monitoring system for proper implementation of existing laws.
- There are new developments in the legal environment (e.g. the passage of the Violence Against Persons Prohibition Act 2015 and the Administration of Criminal Justice Act 2015

ground of their sexual orientation. The IDUs also mentioned the right to be respected as human beings, to be treated with dignity and be free from Police harassment. The HIV positive women and men highlighted the need for special protection of their right to health especially because of the incessant strikes by health workers which disrupts access to services from time to time.

Assessment of Enjoyment of Rights by the Respondents

Having articulated the rights that respondents considered to be theirs, they were asked if they are enjoying the said rights. While most of the respondents said that they do not enjoy their rights, some said they enjoy their rights to a certain extent. The following paragraphs contain contributions by respondents on their experiences of abuse of their rights:

Experience of Abuse of Health Rights

Most respondents complained that their health rights are often abused. The group of MSM that were interviewed in Abuja made the point that MSM do face high level of discrimination at the health facilities; as such many prefer self-medication and only visit hospitals when self-medication fails them. One of the respondents narrated an experience he had with a medical doctor in Abuja. After making his complaints, the doctor asked him how he came about the infection he has in his anus, to which he responded that he practices anal sex. According to the respondent, the doctor's countenance changed. He stopped having eye contact with him and quickly wrote an antibiotic on the prescription paper and pushed it to him. He reported further that because of the doctor's reaction he was unable to tell him that he had used the prescribed drug without success and had to leave the facility without getting help. According to him this is the experience of many MSM in the city.

This was corroborated by another respondent who recounted his experience with a Medical Doctor in Lagos as follows:

“I had an unpleasant experience with a female medical doctor when I visited a government hospital on the account of my being gay. The doctor insisted on knowing how I was infected with HIV. She said she will not treat me unless I tell her how I came about the problem that I have. I confessed to being gay and she made me promise that I will no longer engage in such practice. I complied so she can attend to my problem but I am still a gay.”

On a similar note, a FSW remarked as follows:

“In my business, I do not access the services that I need adequately because once some of the doctors know that you are a FSW, they treat you badly. They ill-treat you. Some of my peers have had this kind of challenge in the hospital. Once they look at your card and see you have been referred from a particular place, they will put your card aside and keep calling others. There are instances where you are forced to tell people including the doctors the kind of business that you do.”

The IDUs that participated in the assessment also complained about the attitude of nurses noting that they are not trustworthy as they often share information about their clients with people in the community, thereby discouraging IDUs from accessing services.

The group of positive men at an FGD session in Owerri expressed the view that they enjoy their rights to the extent that they have access to their drugs. Although incessant strike actions by health workers affect access to services. According to one of the participants:

“Some of us have access to other services such as the CD4 count and some of us do not. Sometimes the machine breaks down and we are unable to get access such services. We are also made to pay seven thousand Naira (N7,000) for routine test. This is done twice a year and if you don't do the test, you will be transferred to another facility. This is not good because many of us are not working. Sometimes, some of us demand for transfer to another facility because of the way we are treated. This problem affects men a lot”.

“When there is a prolonged strike by health workers, some positive people die because they cannot access health services”.

Some of the female respondents in Owerri at an FGD session also gave answers in support of the position that they do enjoy their rights:

“We also have access to drugs and we are no longer ashamed to go for our check-up”.
“Our doctors are very supportive and the treatment centres have capable hands”.

The point was made also, that the rights of women, men, boys and girls that have one form of disability or the other are constantly being abused. Plans and programmes for creating awareness on HIV never take into consideration people with impaired vision or people that are deaf.

Experience of Abuse of Employment Rights

Paramount on the list of reasons why respondents reported that they do not enjoy their rights is the poor attitude of employers to employment rights especially of PLWHA. Respondents reported that many employers secretly subject unsuspecting employees and job applicants to HIV tests without their consent and therefore lay off those that are found to be HIV positive without informing them of the real reason for them being laid off. “Despite the fact that it is a fundamental human right to seek a means of livelihood, employers witch hunt and sack HIV positive people” (A male respondent in an in-depth interview in Abuja)

A male respondents in Owerri expressed the view that the practice in many government institutions (especially security agencies) is that upon securing employment, people are often made to undergo fitness exercise where they demand to know ones HIV status. In his words “They are unwritten laws but are strictly adhered to. This hinders the right to voluntary positive health seeking behaviour. It should come from me but if it is a precondition to getting a job then it is no longer voluntary, it hinders my right to get a job, they also give less honourable assignments e.g. I am a soldier and I want to work on the field, but I have limited rights to enjoy my work”.

Another male respondent in Owerri said:

“We are not enjoying our right to employment because no employer wants to employ us because of our status. One of us was denied admission because of her status. There is no legal assistance to demand our rights. The support groups are almost dead. Imo SACA is no longer meeting our needs. Positive persons are not involved in SACA activities such as World AIDS Day. Our members are also not among their employees”.

An adult male (PLWHA) in Owerri said, “I was laid off from an organization that I used to work in the Presidential Officers Mess. My appointment was to be confirmed but I had a surgery and I tested positive. They called my brother to take me home and be treated, by the time I got back I had lost my job”.

A respondent reported that PLWHA hardly get good jobs: “PLWHA usually do not work with good organizations and are mostly not given employment letters”.

In the words of a respondent (a male PLHA, youth) in Abuja “most employers are afraid of the National Human Rights Commission (NHRC) about sacking employees, they never tell you the reason you are being laid off but hide under other reasons. In government institutions e.g. military/paramilitary during medical check-up they look for reasons not to employ you. Even government agencies do this”.

Closely linked with unemployment is the issue of poverty. Respondents in all study locations complained of high levels of poverty among HIV positive people, noting that many of their support group members find it difficult to adhere to their treatment requirement because of poverty. Some find it difficult to raise money for transportation as such they often miss their clinic appointments. “We are made to pay for our routine test in the hospital. This is not good as some of us are not

working” (A female respondent in Owerri).

Experience of Abuse of Inheritance Rights

The HIV positive women at an FGD session in Abuja reported that their members are often denied inheritance rights when their husbands die intestate. They shared the experiences of their members who are going through economic hardship because they were dispossessed of their family properties upon the demise of their husbands. They also mentioned the situation of Hausa women who, under Islamic law, are only entitled to a fraction of their husband's property upon death. The implication of which is to further deepen their poverty level.

Experience of Stigma and Discrimination

In contributing to the discussion on whether or not respondents enjoy their rights, one of the male respondents at an FGD session with a group of young people in Abuja remarked that the problem of stigma and discrimination pose major barriers to the right to desire to know one's status and the right to live freely and openly irrespective of one's status. According to him, stigma and discrimination discourage people from wanting to access HCT services. Discrimination is said to be a serious abuse of right that fuels the spread of HIV infection.

A positive woman at an FGD session in Owerri narrated experiences of abuse of her rights as follows:

“I used to run a restaurant. One day, a customer came to eat at the restaurant and misplaced his handset. He came back in search of the handset and when he could not find it, he brought a police man to arrest everyone working in the restaurant including me. I didn't go with my drugs because I did not know that I will be detained. When I was told that all of us will be detained, I sent a message to my state coordinator who later came to the police station and demanded for my release. He informed them of my status and the need to release so that I can take my drugs as prescribed. As a result of this revelation, I was released from detention. The following day, the policeman came to my restaurant and informed people in the community that I am HIV positive. My customers started avoiding my shop and before long, people stopped coming to the restaurant. That was how I lost my means of livelihood. Now I do not have a job again”.

The Men who have sex with men narrated horrible experience of violence and discrimination. Some of the respondents at an FGD session in Abuja said that they were among those that were beaten up immediately after the passage of the Same Sex Marriage Prohibition Act at Gishiri, a community near Abuja. According to one of the respondents “we were beaten up by a group of community boys. They made us homeless for months”. Another respondent reported that he is constantly been harassed by members of his family and neighbours. He was forced to marry a lady, an action he said he would ordinarily not take. According to him women are unnecessarily exposed to HIV infection because of pressure on gay men to get married.

One of the respondents also reported that he was very active as a peer educator in his community but immediately after the passage of the Same Sex Marriage Prohibition Act, he was arrested by the

Police “for distributing condoms and encouraging immorality”.

In the words of one of the men “people belittle you and make you feel unimportant. At times we hide or refrain from doing certain things for fear of negative reactions from the people. We are not free to go to the health centre, we are not free in places of worship, we are not free in the community or even in our homes. We cannot talk freely with fellow men. The girlish ones among us have the worst experience. But people should not be judged because of their outward behaviour. Some people are not girlish but they have sex with men. This happens everywhere, but things are worse in Hausa communities, young people are suffering they have no access to information, education, health care etc. For God's sake we are citizens of this country. We should be able to talk, work vote like others do business etc. We are not asking that men should be allowed to marry men. We just want to be allowed to live a normal life like every other person.”

Another respondent remarked that “many gay men have special talents, we should be able to express ourselves, we should be able to socialize. In some of our gatherings, Police come and harass us. Such harassment is having serious negative impact on the spread of HIV. Many have stopped coming for treatment and they have been coming before. Because of unemployment, some have sex without using condom because of tempting offers that they get. If not for ICAP we would have died. So many of our friends are dying. Young people need help. As it is, NACA is not visible in providing support to MSM”.

On the other hand some respondents reported that the issue of stigma and discrimination is not as bad as before.

“To some extent, we are enjoying the rights because some of us living openly are not being discriminated against, the people are used to us now, so no discrimination. We are no longer hiding.” (HIV Positive man, Owerri)

“We used to be discriminated against in our communities but since we came out openly with our status, it has stopped. We challenged those discriminating against us to go and know their status to see if they are positive or not.” (HIV Positive woman, Abuja)

“There is self-stigma by those who do not live openly with the virus. Many are not in any support group and this is not good for them.”

“Those who do not come out openly, we cannot help them because we do not know their problems.”

Experience of Harassment by the Police and Members of the Public

The FSW that participated in the study in all locations made the point that officials of the Nigeria Police Force often come to their brothels to harass them. In order to free themselves from Police

detention, they sometimes pay a fine or negotiate to have sex without pay with the police. Some of the respondents however reported that the Police sometimes rape their colleagues and sometimes without condoms.

The police actually come from time to time - when they come if you are with a man they just drag the man out when they are raiding, whatever you are doing, whether you are half dressed they just pick on you. Even if you are begging them to allow you to dress up they will not answer. When you get to their station, they then ask you to 'sex the gutter' just as you do with men. To be free they will ask you to pay charges. When you pay the charges they allow you to go. Sometimes they keep you in the guard room for a number of days before they let you go.

They sometimes just come in the name of raiding and they just rape you without condom. We have no choice, we sometimes think that probably if you allow them they will let you go. Some, if you run away they will enter your room and pack whatever is there, phones, money, laptop etc. and go away with it.

This narration was corroborated by a Key Informant and Programme Manager when he said “We have cases where the owner of the brothel locks the FSW up and force them to have sex against their will and without condoms. This is more or less like slavery – forced labour. These practices are not documented and where they should report such incidences is not clearly marked”.

In identifying the forms of abuse that Key populations are exposed to, one of the Key Informants stated that “FSW often experience physical abuse – people beat them up. They also are not able to rent accommodation easily, although difference in economic status and living area also determine the forms of abuse and gravity of exposure to abuse. FSW are vulnerable to forceful arrest. It is not that it is really rampant, but it happens. There are gaps in this area. In relation to the issue of police sexual abuse, we have had advocacy meetings with police authorities and informed them of what we are doing. Awareness raising is key as most of the abuses are carried out due to ignorance”

On the issue of MSM, the respondent said “We have quite a number in the FCT mostly in secondary schools and among different age groups such as between ages 16-18. The challenge they (MSM) have is harassment by police – they (Police) go to where they congregate. They (MSM) have a very strong network as such when they are arrested, they mobilize resources to get their members off the hook. They are well organized. The police are mainly their problem in terms of abuse of their rights.”

The IDUs are said to be a difficult group to reach in terms of programming. According to a Key Informant, “their trade is illegal and there are various laws. There is a high level of distrust amongst them and they suspect each other. However the system abuses their rights by criminalizing all of them.”

Access to Justice

Despite the high level of abuse of human rights of people living with HIV that was reported by

respondents, only a few took up legal actions and such actions were at the lower courts otherwise referred to as 'inferior courts'.

The respondents at an FGD session with positive women in Abuja shared the experiences of three different members of their group that were supported to take up legal action in order to enforce their rights. These cases were at different magistrate/customary courts in Karu, Mararaba and *Ataba Alafia*. According to them, one of the cases was a custody case and another was a landlord/ tenant case. They reported that the Judges often have little or no knowledge about HIV and their group had assisted many to acquire knowledge on the subject in order for them to be fair in their judgment.

Although the list of forms of abuse that respondents experience was unending, not much was reported on efforts being made to seek redress. Those who reported that they made attempts to assert their rights did so using social contacts that they have rather than using existing legal channels:

"I lost my husband and we went home for the burial. His people started harassing me and stigmatizing me because I didn't have a child for him. I was lucky because I went with police men; my late husband was a police man. The police helped me to stop my in-laws from further harassment. Through my support group, I met another man and we are now married and blessed with a daughter" (Female respondents at an FGD session with Positive women in Owerri).

"A woman's husband died and the in-laws threatened to throw her out of the house. She brought the matter to the support group and the leadership took up the case. The support group coordinator intervened in the case. This helped to put her in-laws in check" (Female respondent at an FGD session with Positive women in Owerri).

In response to the question why respondents do not take up legal actions in relation to the different acts of abuse that they experience, some of the respondents said that they do not know who to report to, others felt taking up legal actions involves a lot of financial expenses which they do not have. "The cost of hiring lawyers is high and PLWHA are often unable to afford such cost. There is also scarcity of lawyers offering pro bono legal services. Although the Federation of Women Lawyers (FIDA) does not charge for legal representation, their lawyers usually demand stipend for transportation which PLWHA are sometimes unable to pay. This discourages many aggrieved persons from pursuing their cases to a logical conclusion" (A positive woman during an FGD session in Abuja).

Some of the respondents said it is not possible to get justice when a Policeman is reported to another Policeman.

One of the FSW had this to say:

I have not made any report because I do not know where to go. If I go to the police station, they will say, no be ashawo (Is she not a prostitute)? Instead of me to go there and they eat up

all my money (extort money) and still maltreat me, I prefer dying in silence.

Another respondent, a Positive woman in Abuja said:

If we go to court, who will listen to us, Lawyer? Police? They will want something or do I go to Owerri to report to my uncle who is a Police man?

Two of the women interviewed in Owerri responded as follows:

“Most people don't report to police because they will not help if you don't have money to give. There is a popular saying “Oga, I no follow” meaning I will not follow you if you don't give me money”.

“Most people don't know where to go to, some don't have money to go to court”.

An IDU in Owerri said:

“The laws are not effective because police use us to make money for themselves. Once a person is arrested and is able to bail himself out by bribing the police, they allow the person to go so what is the use of the law?”

The assertions of the above respondents were corroborated by a key informant in Lagos who stated that – “there is no confidence in the judicial system at all; people do not know there is a law. When you tell them there is a law, they do not believe it will work. People just live with their injustice because the justice system is corrupt, hostile, can be manipulated. At times the people do not have enough resources and so they feel they will be let down a second time”.

In reacting to the issue of access to Justice, a key informant in Lagos remarked that although Lagos State has a law against stigma and discrimination, the law has not been tested because aggrieved persons often do not like to go to court. Court cases are said to be expensive and time consuming. Only one or two cases were reported to have been taken to court in the State and it took a long time to complete the process. For instance, the case of Georgina Ahamfulu V Imperial Medical Centre & Dr. Alex Moloku took twelve (12) years to complete. According to him, LSACA has a Human Rights Work Group that addresses reports brought to their office and tries to settle such cases through mediation.

In contributing to the discussion on access to justice, another key informant, a human rights lawyer in Lagos said “In terms of statutory provisions on the legal rights of people living with HIV/AIDS in Nigeria, there are opportunities and spaces in law but latching onto those spaces have been difficult because of the absence of legal dynamism in Nigeria. Not just at court level, a lawyer must be willing to test a case. Many lawyers do not go into advocacy. Criminal law cases are empty because there is little or no money in it. Lawyers who can afford to handle these cases are basically not in the sector of legal practice. Consequently the capacity to work in the area is weak. To change the law you must have resources to keep at it until it changes. Opportunities within legal status are available, but people are not testing it. We do not know whether the person who wants to bring a case against his

employer will have privacy in court, let us test, who is going to support it? The lawyers who handle these cases are not usually the best hands in the field. In terms of opportunities, I believe that there are enough that we can leverage on. We really do not have to wait for another law”.

The point was also made that one of the reasons some people do not go to Court is because they are not living openly with HIV infection. One of the male respondents in Owerri said “they cannot cope with the publicity which will not only affect them but members of their families. Even when they agree to go to court, they back out when the publicity is high.” Furthermore, a key informant in Abuja noted that IDUs do not have access to specialised services. According to him about 30% of persons in jail (Nigeria) are there on drug related issues and have been awaiting trial for a prolonged period and there are no programmes for reaching out to IDUs in prisons.

The cost of pursuing litigation was also raised as one of the factors that discourage people from seeking redress when their rights are infringed upon. Respondents made the point that hiring a lawyer can be quite expensive. No one however mentioned exploring the option of seeking the assistance of the Legal Aid Council – which is the government institution charged with the responsibility of providing free legal service to citizens who cannot afford engaging the services of a lawyer. Discussions held at a Stakeholders forum in Abuja in the course of conducting this assessment also revealed that the National and State Agencies for HIV response have not engaged effectively with the Council towards strengthening access to justice for people that are either positive or affected by HIV. According to a staff of the Council at the forum “The Legal AID Council is available at all times to provide legal assistance to people who cannot afford legal service. People's whose rights are infringed are free to visit the legal Aid Council for support. The council supports anybody who require its services whether or not they are in prison”. It is however not clear how many HIV positive persons have been able to benefit from the free legal services been offered by the council.

Laws, Policies and Practices that hinder the enjoyment of rights by the respondents

In the course of the study, the State coordinating bodies for HIV were asked to list laws and policies with negative or positive impact on HIV response in their State. They were also asked to identify gaps in law and policies in their state. The laws identified by the few states that responded are as presented in Appendix 1. Some of the SACAs reported that they do not have separate laws and policies in their states as they always key into available laws and policies at the federal level. A critical issue that also came out from the responses of the States was the need to have access to resources backed by law in order to guarantee consistency in response interventions. Respondents suggested that between 1 - 3% of the state budget should be allocated for state level programming on HIV/AIDS. The study revealed for example that the inability of the Imo State SACA to access funding from the World Bank has brought activities of the Agency to a near halt.

Laws

Respondents were asked about their knowledge of laws that hinder the enjoyment of the rights of Key populations in Nigeria. As at the time the respondents were interviewed, government had not

passed the Anti-stigma bill into law. They mentioned the non-passage of the Anti-stigma and anti-discrimination law as a major gap in effort at promoting or protecting their rights. They expressed disappointment at the insensitivity of the government to the plight of HIV positive persons, such that the Bill on HIV Anti Stigma and Discrimination was before the national Assembly for almost a decade and only passed by the Assembly in 2014, was yet to be passed into law six month thereafter.

Law on Same Sex Marriage in Nigeria (Same Sex Marriage Prohibition Law, 2011).

Respondents noted that rather than pass the Anti-Stigma Bill into law, government rushed into passing a law on Same Sex Marriage. There is however misunderstanding about the content of the law as many of the respondents remarked that they have not read it. Apart from the fact that they have not read the law, the Police have also given the impression that the law is aimed at arresting homosexuals. A respondent remarked that “the law criminalizing homosexual activities in Nigeria seems to back the negative attitude of health care workers towards this marginalized group and this will increase the spread of the virus. The law reduces support for positive people who are members of the MSM community.”

Law on Female Sex Work

The respondents in Abuja mentioned the Abuja Environmental Protection Law, the law that sets up the Abuja Environmental Protection Board, an agency charged with the responsibility of ensuring a safe and clean Abuja city. They noted that this law has been abused severally by agents of government to back the maltreatment of FSWs.

In the words of a key informant: “the Police have used the law on Prostitution severally to frustrate response activities regarding HIV and FSWs. The police use the law as a cover up to arrest sex workers. The implication of which is that they go underground and they cannot be reached with the services that they need or require. There is however a policy in Abuja that supports arrest of FSWs because of the beatification of the city. Lately there is the law relating to same sex marriage, the people are saying that the law is offensive to them. The law drives them underground”.

Law on drug abuse

Respondents mentioned the NDLEA noting that it gives power to the police to arrest drug users. It was also noted that because of this law, drug users prefer to remain underground and refuse to access health services. Due to the influence of drugs, the sexual practices of this group of people is very risky and puts them in a vulnerable state as regards contracting HIV.

Policies

Age restriction on young people's access to healthcare services

Government policy, (as stated in the National guideline on HIV/AIDS testing) - restricts access to reproductive health services for young people below the age of 18 years except with the consent of an adult was mentioned as one with serious implications for young people's vulnerability to HIV

infection. It also has serious implications for access to services for those who are already infected and are below the age of 18.

According to a Key informant (an expert on issues relating to young people and sexuality), 'one critical concern in relation to legal and policy environment of young people is the issue of consent which has highly limiting effect on young people's access to services. You cannot test nor treat a young person below the age of 18 years. AIDS prevention for young people is also restrictive. Can the law be designed to recognise the context of each service user? We need laws/policy that enables the service provider to take responsibility for the appropriate services that are necessary for the young people that he/she serves

The reality is that young people are sexually active and they do not take permission from their parents before becoming sexuality active. The question therefore is why they should take permission for accessing services that can enable them pursue a healthy life style

The fact is that as a professional service provider there are rules guiding the practice of different professions. If a professional offers services within the ambit of the laws regulating his/her professional practice, then there should be no problem with young people accessing services through such professionals. The sociocultural context within which we live does not recognise that young people have rights like adults. Societies often do not enable them to enjoy their rights

We need policy/legal framework for investment in the lives of young people. They are the largest group of people in the society, but the least catered for. They often access services as if they are being done a favour. They hardly participate in processes leading to the development of programmes and services being designed for them. We often do not prepare people for the different stages of life. There is a need for a new way of socialization that can prepare them for the next stages of their lives. We need to invest in people's lives. The National Health Act for instance has not in any way addressed issues of young people. What has prevented young people from having access to information has not been addressed by the law'.

Practices

Culture of silence on reproductive health (RH) issues in the home

Respondents reported that most parents do not discuss RH issues with their children and wards. This makes some young people to rely and act on wrong counsel from their peers, thereby increasing their vulnerability to HIV infection.

On the issue of acts of violence often perpetuated against MSM by members of the public, a senior officer in one of the state agencies visited in the course of the assessment said 'MSM is against our culture and it is not something that we should go and propagate'. The question here is whether this makes right the act of violence.

Recruitment of non-qualified people in SACAs

SACAs were accused of non-inclusion of positive people in decision making processes. One of the respondents shared an experience he had at the office of one of the SACAs when he had the opportunity of listening to a discussion between two members of staff of the Agency. According to him, one of them said she had never seen an HIV positive person before and the other person replied "Oh I learnt that the drugs they take come in very big sizes!" He allowed them to display their

ignorance and thereafter told them he is a positive person and that it is very disappointing for them to talk so ignorantly about positive people, being staff of an HIV/AIDS focused agency.

Preference for same-sex healthcare provider

Some Muslim women will not allow male healthcare staff to hold them in order to conduct HIV screening.

Illegal HIV screening by employers

Contrary to national guidelines on HIV screening, some employers carry out compulsory pre-employment HIV screening. Some employers also carry out routine medical screening of employees which generally include HIV test.

Practices within the health sector

The assessment revealed that subtle discriminatory practices persist in hospitals. A respondent in Owerri reported that despite the remarkable changes that have taken place within the health sector in relation to HIV response, subtle forms of discrimination still exist. He shared the experience of a positive woman who reported to his organisation that when she took her baby for circumcision she was the last patient to be attended to despite the fact that she was the first patient that was received by the Nurses. It was also reported that positive pregnant women are often kept in a separate ward in the hospital.

In identifying practices that impact response activities negatively, a key informant noted that prejudice often affects the provision of services by health workers. Health workers are said to be more judgmental of the client than the service they are providing.

The FGD session held with male IDUs in Abuja also revealed serious anomalies with the way services are delivered to HIV positive persons in all facilities. The following are direct statements from the respondents describing what the situation is:

“There are isolated unit for HIV test and they are branded by the isolation. People look at everyone that goes there and have them labelled, this makes them obvious and stigmatised. In the PHCs there is little interaction.

“In the tertiary institutions, they often separate space for treatment of HIV; most have separate labs, pharmacies. Consulting rooms are separate, even at the National Hospital, University of Abuja etc.”

“Discrimination- they insist positive women must buy gloves, they don't give them bed sheet when they are admitted in the hospital. As a matter of fact, they keep them along the corridor of the ward.”

“The lab scientists are not readily aware of the effect of anal sex and usually change the doctor's prescription.”

“The reaction to the client looks discriminatory as it seems judgmental, however the people do not know their sexual bent (self-stigma/misunderstanding).”

Contributions from medical practitioners in the course of the assessment highlight the need to revisit the rules around confidentiality. Instances where a partner is on treatment without the knowledge of an infected partner who also does not know his/her status seems an issue of concern. The protection of the right of one may lead to the violation of the right of another person and can even mean the perpetuation of the violation of the right of the ignorant partner. Although research has shown that is very unlikely to expose someone to HIV when using condoms or when an individual is on successful ART with an undetectable viral load and no other STIs (NAM Publications, 2015), with high rate of poverty among HIV positive persons in Nigeria coupled with incessant strikes of health workers as well as drug stock-out situations from time to time, drug adherence is sometimes unachievable for many. The 2011 HIV Stigma Index report revealed that 9.5% of the respondents in the study reported that their husband, wife or partner did not know their status. Strict adherence to the rule of confidentiality in order to promote the right to privacy of a patient who is already on medication may mean an abuse of the right to health of the unknowing partner.

Other negative practices identified by the groups of respondents at different study locations are highlighted in the following statements:

Women Living with HIV

“Some Christian stop taking their drugs because of messages preached by their Pastors. *Because people go to church they stop taking their drugs – they say Pastor said I should stop and exercise my faith*”. (HIV Positive woman at an FGD session in Abuja)

FSWs

“Some of our clients deliberately burst condoms after penetration”. (FSW in Owerri)

“Some clients refuse to use condoms. Some of them also give us wounds when we are having sex with them. They are very wicked”. (FSW in Owerri)

IDUs

“We are very vulnerable because we share needles and most of us do not know our status. Sharing needles can expose us to HIV infection. Most IDUs do not know their HIV status. They can infect both themselves and others. IDUs don't care about sex, they are only interested in taking drugs and they can get HIV through the needles”.

MSM

“If I am allowed to be myself. I will not be able to pass on the infection to a woman. The society forces me to marry a woman when I am not like that. A lot of people have gone underground after the passage of the Same Sex marriage law”

“Hausa clients do not like using condom”

Young People

“Young people engage in unprotected sexual activities. They just want to have fun so they don't protect themselves. Some are also shy to approach chemists for purchase of condoms”.

“There are very few youth friendly clinics across the country. If a girl has reproductive or sexual health issues, there are no youth friendly clinics to go to. This encourages young girls to seek help in the wrong places. (The young people at the FGD sessions)

“We cannot go to the regular school clinics because the adults will talk to us anyhow. We are not free to share our problems with them”.

“Many young people give up on education and take to business. Once they start making money, they are no longer interested in education. The female take to prostitution to make ends meet and this is capable of exposing them to HIV infection”.

Religious and Cultural Practices with Implication for HIV Infection

The impact of religion and culture on the enjoyment of individual rights especially as it relates to HIV was assessed in the course of the study. Some religious leaders, especially Christians, are said to be creating problems for positive persons. They bring their ignorance to bear on the vulnerability and ignorance of their Church members. Respondents reported that some Pastors tell members of their congregation that if they are HIV positive, they should stop taking their drugs and come for 'miracle healing'; unfortunately some of such people end up with full blown AIDS and die.

Their position on the issue of HIV and marriage also sometimes deny women and men the enjoyment of their health rights including reproductive rights. For instance a female respondent in Abuja reported that she lost two relationships at different Churches when they reported for marriage counselling. According to her she lives openly with her status therefore, the men in question knew her status before they proposed marriage to her. Even when the men were comfortable with her status, the Pastors who counselled them at different times insisted it was wrong for them to get married since one of them was HIV positive. According to her, one of the Pastors said “we will be very wicked to join you with this woman because you are young. I am doing you good by not anointing your wedding”. She reported that years later when one of the Pastors saw her, he was shocked that she was still alive.

Taboo associated with the use of condom

Respondents mentioned the issue of taboo associated with the use of condom especially among Muslims and Catholics. This they said increases the vulnerability of women and men to HIV infection. “Northern communities have cultures resisting the issue of distribution of condoms as the use of condom is not acceptable. You can merge the culture with religion but it is more of culture. The belief is that once you access HCT service they will distribute condom to you and believe that you are wayward, so a lot of people (IDUs) shy away from the service. Fear of being seen and stigmatised.

Ignorance plays a big role especially in the IDU community” (An IDU in Abuja).

Child marriage

Child marriage was highlighted as one of the cultural practices with severe implications for the vulnerability of women and girls to HIV infection. Respondents reported that it is still widely practiced in different parts of the country especially in the North.

Female Genital Mutilation

Interestingly female genital mutilation was said to be well practiced in some parts of the country despite the fact that many States now have laws against the practice. One of the respondents at the FGD session with female youth in Lagos remarked that in her community in Auchi, women are circumcised just before their wedding ceremony. She expressed the fear of getting married as she does not want to undergo the procedure but also cannot say 'No' because she cannot imagine going against her mother's wish.

The cultural expectation that a woman must be married at a certain age

Some respondents in Owerri reported that in the Eastern part of the country, marriage is a status symbol. Women who are seen to have passed a certain age bracket considered to be 'marriageable age' and are not yet married are often not respected. In the words of a female respondent, “your relations will throw you out and insult you as if you are not a part of that family”. This makes such women agree to marriage proposals of men whose HIV status they do not know. Some men are aware of their positive status but refuse to disclose such, thereby infecting unsuspecting women.

Festival in Mbaitolu

During a festival in a village called Mbaitolu, women are called out to dance. After dancing, they ask them to go and if they don't go on time, the men are free to rape them.

Respondents also reported that there are also festivals that allow women to expose their breasts. This makes them vulnerable to sexual harassment.

Myths and Misconceptions

Respondents also mentioned some wrong perceptions and myths that fuel the spread of HIV.

They include the following:

- It is wrong for a person that is HIV negative to marry a person who is HIV positive
- The use of condom is a sin
- You cannot contract HIV by sleeping with a male homosexual; you only contract it from women

Gaps in Research

The informants identified the importance of research, noting that funding and planning should be evidence based. On the area of needs, one of the respondents said “It is necessary to conduct a needs assessment of the economic status of PLWHA so we can see exactly what the issues are. We noticed over the years, despite numerous trainings and capacity building, that we do not seem to

see any change, it becomes worrisome. Research is required to know what is missing and what needs to be done to really empower them to build their capacity. This will also help in attracting grants and being able to commit such to where it is needed most”.

In relation to IDUs, the point was made that data is very scarce and that the magnitude of issues and implications in Nigeria prison is unknown. There is no accurate data on their location and there is no strategic information for planning and programming. There are also no studies on conditions of IDUs in the prisons. The group of positive women that contributed to the discussions in Abuja also mentioned the issue of HIV positive women in the prisons, noting that there is no data on what their situation is. They are not supposed to be in the general prisons with other people but there is no data on how many are in prisons as well as what their experiences are in terms of care, support, access to drugs etc.

According to a University Professor, one of the key informants in Lagos, “HIV research is still majorly about access to drugs, no focus on social contexts of PLWHA. Besides from early studies on relations of rights, there is no study with regular periodicity that enables you to chart improvements or regression. If you do not systematize research especially when it is about social context you will not have current knowledge. The gap is huge. A study on situation of PLWHA must be done periodically and be wide, focusing on all social concerns and other issues – are employers covering medical costs? Are PLWHA finding things easier? What kind of response do you have to positive people that want to get married? We just have anecdotal accounts but cannot tell the levels because there is no research”.

In identifying research gaps at a stakeholders forum in the course of conducting the assessment, the point was made that Nigeria was yet to adopt option B+ in programming for Prevention of Mother To Child Transmission (PMTCT) of HIV recommended by WHO for especially resource-constrained settings.

CHALLENGES THAT RESPONDENTS FACE IN THE STUDY LOCATIONS

In the course of the study, respondents were asked to state some of the challenges with HIV response that they have observed. The following are some of the issues that they raised.

At the level of Service Delivery

- **Couple disclosure:** The medical doctors who participated in the study spoke strongly against the policy of confidentiality which they say actually means infringing on the rights of others. An example was given of a positive woman who just had a baby but did not disclose to her husband and his family her HIV status. Her mother-in law came to help out and washed the clothes she used during delivery that was stained with blood. She did not disclose her status to the mother in-law. The hospital staff stopped the mother in-law from washing the clothes although they could not tell her the reason. He suggested that there should be guidelines for pregnant women, married couples etc. to disclosure their status to their relatives/family members.

- In Imo State, hospitals use different colour cards for HIV positive and HIV negative people. It is therefore easy to identify positive people and treat them shabbily. For instance, a positive woman shared her experience when she took her baby for circumcision. Her baby was the last to be circumcised. Despite the fact that she got to the clinic before other patients.
- The practice of 'First come, first served' is not observed in some hospitals in Imo State when HIV positive persons are involved. There is subtle discrimination. Positive women are kept waiting until others have been attended to. They are also kept in different wards.

At the State level – Imo State

- Contrary to existing data, respondents in Imo state express the strong view that Imo State is not a low prevalence state.
- Some respondents are of the opinion that the prevalence rate in Imo State will continue to rise because some HIV positive individuals in the State are deliberately spreading the virus.
- Young people have a lot of misconceptions about HIV. They believe it is not real. Some of them are HIV positive but refuse to access treatment.
- Most of the Support groups in the State are no longer meeting due to lack of funds. The funding by GHAIN has stopped. There are no more fora for positive persons to share information and support one another. Newly infected people are facing a lot of discrimination and stigma.
- The Imo State SACA is not functioning – it has no funding and it cannot access World Bank fund because of issues that the last leadership of the Agency has with accounting for grants received.
- The need for a framework for reporting abuse was identified by the positive women who remarked that the Ministry of Women Affairs in the State is not easily accessible for complaints. According to them “We have attempted to register our group (ASWHAN) with the Ministry of Women Affairs, we were asked to pay N27,000 before we can be registered”.
- Absence of Anti-discrimination laws in the state.

Lagos State

- HIV people are not involved in the decision making process for coordination of HIV response in Lagos. LSACA does not have positive people on the list of employees.
- Some members of staff of LSACA and Lagos State General Hospital are ill informed about HIV and therefore discriminate against positive persons .

Abuja

- HIV positive volunteers are often overworked because health care providers abandon their duties to them.
- Some institutions do not pay the volunteers regularly – particular mention was made of the Institute of Virology.
- Nurses and Community Health Extension Workers (CHEW) are not well trained and are

highly misinformed.

Young People

- Young people - Those below age 18 cannot access services without the consent of an adult – the confidentiality rule does not apply to this group.
- There should be clinical protocols on the conditions for which young people can be given services.
- Health care delivery in private hospital not regulated.
- Lack of youth friendly services.
- Age to access services to be reviewed. 10-14 is missing, below 10 is with parents.
- Data gathering on HIV does not disaggregate for young people e.g. age 0 – 14.
- There are no programmes targeting children 10 -14.
- FLHE is watered down to the extent that it's no longer important.

Recommendations made by the Various Groups Consulted in the Course of the Assessment

The following recommendations were suggested by the different groups of people reached in the course of the assessment.

Policy Level

- The confidentiality policy should be reviewed in view of the current realities. Nobody should be shielded unnecessarily.
- Any positive person should be mandated to come with the spouse before being allowed to access drugs. There should be strict measures in drug access.
- The current situation in Imo state needs NACA intervention. The mission hospitals provides over 70% of the services. They should be brought under government support so that they can service the people more.
- The criteria for setting up the comprehensive sites should be liberalized
- The number of available comprehensive treatment sites is few making access to services very difficult especially with the high rate of poverty among HIV positive people. There is a need to increase the number of treatment sites.
- Respondents remarked that there is a need to train health workers because “they are very rude. The nurses still discriminate and gossip about positive persons”.
- Security should be provided in schools including Universities as cultists sometimes go to female hostels to rape girls.
- The exorbitant prices of treatment by the private hospital should be looked into.
- Increased advocacy for the development and adoption of HIV/AIDS Workplace policies by all employers of labour e.g. factories, construction companies, hospitality industry etc.

Law

- There is the need for a Legal framework to address the needs of IDUs – disabling legislations

should be repealed, leverage on enabling legislation, build capacity of judiciary to take on cases towards protecting the rights of IDUs.

- The operation of the private hospitals as regards HIV treatment should be regulated.
- HIV cure claimants, faith organizations and TBA activities should be regularized. A lot of positive people patronize herbalists and different cure claimants. Some of them even advertise their drugs. Since medical doctors cannot advertise, cure herbalists should not be allowed to advertise.
- Anyone who infects an unsuspecting person should be punished. The policy used in cases of STIs should be introduced to HIV.
- There are incessant strikes by health care providers. There should be a law to protect treatment access for positive persons so that people don't miss out on their drugs. Sometimes people lose their children, lives during strike.
- There is the need for a law/bill to protect PLWHA e.g. on medical fitness HIV status should be removed.
- There is the need for laws to protect women within marriages. Women need protection when they lose their husbands.

Programme level

- Young people need to be well informed to make the right choices; as such all schools should offer sexuality education as most parents cannot talk to their children about sexuality.
- Programmes should be put in place for out-of-school youths to have opportunity to access sexuality education/information.
- There is a need to have experienced youths on the board of relevant agencies so that they can facilitate the provision of youth friendly services and the wellbeing of youths adequately catered for.
- Enforcement and implementation of policies, laws that affect young people.
- There is a shortage of IDU facilities in the country. Heroin use is a chronic disorder which needs long term treatment. There is a different thinking with people not seeing long term treatment as essential.
- There is a need to adopt the human rights approach in addressing the problem of IDUs.
- There is need for emphasis on empowerment for positive women. In the words of one of them. "most of us are jobless".
- The issues with Imo SACA and World Bank need to be resolved
- There should be policies for IDUs: better rehabilitation centres, harm reduction programmes, IDU empowerment programmes, getting back into school programmes etc.

CHAPTER V

**REVIEW OF LAWS AND POLICIES
RELATING TO
HIV/AIDS IN NIGERIA**

REVIEW OF LAWS AND POLICIES RELATING TO HIV/AIDS IN NIGERIA

With over 58 million infected people in the past 2 1/2 decades, HIV/AIDS has become the sixth-largest cause of death worldwide (OHCHR & UNAIDS, 2006). HIV/AIDS has become a serious development issue with so many inter-connected strands that require monitoring and regulation through laws and policies in order to ensure respect for the rights of women, men, boys and girls that are infected and affected by it. The connection between human rights and HIV/AIDS is often influenced by the legal, economic and social conditions of an individual or group. This is why certain groups of people are more vulnerable to infection than others. Such groups include Women (especially poor women), Young people, Female Sex Workers, Injecting Drug Users, Men having Sex with Men, Women Living with Disabilities etc. According to the Office of the United Nations High Commissioner on Human Rights, the relationship between HIV/AIDS and human rights is highlighted through increased vulnerability, discrimination and stigma and the way it impedes effective response.

Although there are few laws specifically designed to address issues relating to HIV, existing legal and policy framework for health and health related issues do address some of the HIV related issues in the country. This section is a review of such laws and policies with implications for HIV response in Nigeria especially as they concern issues of Key Population groups such as FSWs, MSM and IDUs.

Nigeria Legal System and International law

The Nigeria legal system consist of multiple regimes of laws e.g. statutory laws, case law or decisions of the court, customary laws, which include Sharia law as well as international and regional conventions and treaties that Nigeria is a signatory to.

Until 1999, customary and sharia laws were restricted largely to family and personal status law—marriage, divorce, child custody, inheritance etc. In principle, Nigerians had the choice of abiding by Received English Law, Customary, or Sharia laws. The constitutionality of three parallel legal systems regulating issues of marital and personal issues have always generated some confusion about which law takes precedence over what and when (Atsenuwa, 2010).

Nigeria's obligation to promote and protect HIV/AIDS-related human rights are defined in existing international treaties. Nigeria operates a dualist legal

Some relevant international and regional human rights treaties that Nigeria is a party

- The Universal Declaration of Human Rights (1948)
- International Covenant on Economic, Social and Cultural Rights (1966)
- International Covenant on Civil and Political Rights (1966)
- Convention on the Elimination of All Forms of Discrimination Against Women (1979)
- The Optional Protocol To The Convention On The Elimination Of All Forms Of Discrimination Against Women
- African Charter on Human and People's Rights (1986)
- The Protocol to the African Charter on the Rights of Women
- Convention on the Rights of the Child (1989)
- The African Charter on the Rights and Welfare of the Child
- The Convention Against Torture and other Forms of Cruel, Inhuman or Degrading Treatment or Punishment (CAT)
- The Convention on the Rights of Persons with Disabilities (2006)
- International Labour Organisation (ILO) Discrimination (Employment and Occupation) Convention¹⁵³
- ILO Convention Concerning Termination of Employment

system in operationalizing international treaties and conventions. Section 12 (1) of the 1999 Constitution provides for the domestication of all treaties before they can become law within the country. The section provides thus: “No treaty between the Federation and any other Country shall have the force of law except to the extent to which any such treaty has been enacted into law by the National Assembly”

In other words, it must be passed by both Chambers of the National Assembly and assented to by the President to become law. In Nigeria, there are two known ways in which international treaties can be transformed into domestic law. These are by re-enactment or by reference. To re-enact a treaty is to either adopt the whole law as it is in form of a schedule or pass some part of it into law. The other way is to make reference to the treaty in another Statute. Reference to a treaty 'could be contained either in the long and short title of the statute or in the preamble or the schedule, although such a treaty does not appear to be an implementing law as such' (Oyebode, A. in Atilola, B. Not dated). Hence, subject to the Nigerian Constitution, upon domestication, treaties and international convention are at par with other Nigerian statutes. The implication of domestication of an international treaty or convention is that it can be pleaded directly in a court of law in pursuing a breach of human right. The point must be made however, that non-domestication of a Convention does not absolve the nation of its obligations under the Convention that it has ratified.

Some of the HIV/AIDS related human rights treaties (directly and indirectly related) that have either formed part of Nigeria law or influence plans and policies on HIV in Nigeria are the International Covenant on Economic, Social and Cultural Rights (1966), International Covenant on Civil and Political Rights (1966), Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), African Charter on Human and People's Rights, Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa etc.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

Although CEDAW does not address HIV directly, it addresses the issue of discrimination against women. It enjoins State parties to 'adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all forms of discrimination against women' (Article 2(b)) and accord women equality with men before the law (Article 15(1)). The act of harassment of female sex workers by the police and other law enforcement agents across the world, 'lack of access to life-saving information about their health, particularly reproductive and sexual health, and the general criminalization and stigmatization of sex workers which continues to keep women who engage in sexual services underground', has been adjudged a blatant violation of CEDAW provision (Urban Justice Centre, 2007). Nigeria has not been able to satisfy its obligation under CEDAW especially as it concerns the rights of female sex workers. The gap here is the failure to shift response approach from criminalization to a human rights based approach that institutionalize holistic programmes that respond to health, psychological, economic aspects of the challenges associated with sex work. This is bound to reduce the rate at which girls engage in this high risk profession with the ultimate result of reduced rate of infection.

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

Article 14 (1) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa specifically addresses HIV and provides as follows:

- d) the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS;*
- e) the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;*

This section of the Convention addresses the disproportionate vulnerability of women to HIV following from the fact that they are often powerless in marital or sexual relationships and therefore unable to negotiate safer sex. The Convention also tries to address a major challenge that women are often faced with when their husbands/partners are infected and refuse to disclose their status, thereby infecting them. By the provisions of this Convention, women have a right to know the status of their partners. Unfortunately the rules around confidentiality conflicts with this provision of the convention. The question it raises is whose responsibility is it to disclose the status of an infected person to his/her partner should the infected person refuse to disclose his/her status. The interviews conducted in the course of this study reveals that cases abound whereby infected persons who are already on treatment refuse to disclose to their partners and end up infecting them. Such partners only get to know their HIV status when their health has been highly compromised.

Convention on the Rights of the Child (CRC) 1989

Nigeria is a party to the CRC and it has gone ahead to domesticate the convention as far back as 2003 as the Child Rights Act. Article 33 of the Convention states that “Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties and to prevent the use of children in the illicit production and trafficking of such substances. By the phrase 'all appropriate measures... to protect children from illicit use of narcotic drugs', state parties are simply enjoined to look beyond possession alone which seems a narrow approach to addressing the myriad of issues associated with drugs. The word 'appropriate' has been described as “an important qualifier, defending against arbitrariness, disproportionate measures and abuses of human rights in pursuit of protecting children from drugs”. It is said to guide a child rights based approach in a more positive sense (HRI, 2011).

It includes 'specific obligations relating to the right to health, and reflective of the 3AQ framework (available, accessible, acceptable and sufficient quality health services). It therefore provides an entry point for a normative discussion of State parties' responses to drug use and dependence in the

context of child rights.

Regional and International Commitments

Declaration on Factoring Key Populations in the Response to HIV and AIDS in ECOWAS Member States

Although a Declaration does not have the force of law, it speaks a lot about integrity. Nigeria is committed to the Declaration that emerged from the meeting of Ministers of Health, Heads of National AIDS Commissions, Public Prosecutors and Inspector Generals of Police of ECOWAS countries held in Dakar in 2015. The Declaration acknowledges that “more than half of new HIV infections occur within key populations and that they are the most-at-risk people in comparison with the general population. Member nations therefore commit to invest in stigma reduction programs by:

- including non-stigmatization modules in basic and continuing training of judges and court officers and most especially of law enforcement officers;
- Training individual health care providers, regulators and administrators
- Organizing information and dialogue meetings between beneficiaries and providers

Members also commit to enhance community service provision for key populations through:

- support for the creation of community centers offering education, community mobilization, essential health services, social support and advocacy for political and legal changes;
- Legal protection for community actors involved in various services for key populations;

Members will streamline health systems strengthening to better meet the specific needs of key populations and build the capacity of health actors to facilitate access to prevention, treatment and care to key populations.

Furthermore, member nations undertake to relentlessly lay emphasis on key populations as a priority group in national HIV/AIDS response strategies.

The Declaration is very precise and apt. Taking appropriate steps to ensure that the commitments are met will go a long way in changing the landscape of HIV response and the outcome of national interventions.

Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS, 2011.

Nigeria is a party to the 2011 Political Declaration on HIV/AIDS – a Declaration of the General Assembly of the United Nations whereby Heads of States “commit to intensify national efforts to create enabling legal, social and policy frameworks ... in order to eliminate stigma, discrimination and violence related to HIV and promote access to HIV prevention, treatment, care and support and non-discriminatory access to education, health care, employment and social services, provide legal protections for people affected by HIV, including inheritance rights and respect for privacy and confidentiality, and promote and protect all human rights and fundamental freedoms, with particular attention to all people vulnerable to and affected by HIV”. Unfortunately as at the time of gathering data for this study, Nigeria did not have a national law on stigma and discrimination against HIV positive population despite the high level of abuse of their rights.

The leaders also committed to reviewing “as appropriate, laws and policies that adversely affect the successful, effective and equitable delivery of HIV prevention, treatment, care and support programmes to people living with and affected by HIV and to consider their review in accordance with relevant national review frameworks and time frames”. Laws requiring urgent reviews in Nigeria include those relating to the treatment of drug users. The public orientation about drug use needs to change from that of criminalization to that of a public health issue. Also requiring urgent reviews are laws relating to FSW and ownership of brothels as such laws have significant implications for the vulnerability of FSWs to HIV infection. The law on same sex marriage also needs to be revisited in view of available evidence which shows that a punitive approach to sexual behaviour do more harm than good.

Nigeria’s ratification of agreed international community goals

- Programme of Action of the International Conference on Population and Development ICPD (1994)
- Beijing Declaration and Platform for Action (2000)
- Political Declaration at the World Summit for Social Development (1995)
- The United Nations Millennium Declaration (2000) which target 2015 for the reversal of the epidemic trajectory
- Greater Involvement of People with AIDS (GIPA) and Meaningful Involvement of People with AIDS (MIPA) principles
- The Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and other related diseases in Africa (2001)
- United Nations General Assembly Special Session on HIV/AIDS (UNGASS) (2001).
- 2005 Gleneagles G8 Universal Access Targets
- 2006 United Nations Political Declaration on HIV/AIDS
- 2011 UNGASS *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*
- African Union’s Abuja Call for Accelerated Action towards Universal Access for HIV/AIDS (2006)
- Brazzaville Commitment on scaling up towards Universal Access to HIV and AIDS prevention, treatment, care and support services in Africa by 2010
- African Union *Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa (2012)*

Chapter II of the Constitution of the Federal Republic of Nigeria

- (1) The State social order is founded on ideals of Freedom, Equality and Justice.
- (2) In furtherance of the social order -
 - (a) every citizen shall have equality of rights, obligations and opportunities before the law;
 - (b) the sanctity of the human person shall be recognised and human dignity shall be maintained and enhanced;
 - (c) governmental actions shall be humane;
 - (d) exploitation of human or natural resources in any form whatsoever for reasons, other than the good of the community, shall be prevented; and
 - (e) the independence, impartiality and integrity of courts of law, and easy accessibility thereto shall be secured and maintained.
- (3) The State shall direct its policy towards ensuring that-
 - (a) all citizens, without discrimination on any group whatsoever, have the opportunity for securing adequate means of livelihood as well as adequate opportunity to secure suitable employment;
 - (b) conditions of work are just and humane, and that there are adequate facilities for leisure and for social, religious and cultural life;
 - (c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused;
 - (d) there are adequate medical and health facilities for all persons;
 - (e) there is equal pay for equal work without discrimination on account of sex, or on any other ground whatsoever;
 - (f) children, young persons and the age are protected against any exploitation whatsoever, and against moral and material neglect;
 - (g) provision is made for public assistance in deserving cases or other conditions of need;
 - (h) the evolution and promotion of family life is encouraged.

The ground norm in Nigeria is the 1999 Constitution of the Federal Republic of Nigeria. Section 1 (1) states that 'the Constitution is supreme and its provisions shall have binding force on the authorities and persons throughout the country'. It goes further in sub section (3) to state that 'If any other law is inconsistent with the provisions of this Constitution, this Constitution shall prevail, and that other law shall, to the extent of the inconsistency, be void'.

The critical challenge that people living with HIV do have is with stigma and discrimination. Although the Nigerian Constitution does not specifically mention HIV, Section 17 of the Constitution provides that "every citizen shall have equality of rights, obligations and opportunities before the law" and forbids discrimination of any sort against the citizens in Section 42. This section of the Constitution provides as follows:

Section 42.

(1) A citizen of Nigeria of a particular community, ethnic group, place of origin, sex, religion or political opinion shall not, by reason only that he is such a person:-

(a) be subjected either expressly by, or in the practical application of, any law in force in Nigeria or any executive or administrative action of the government, to disabilities or restrictions to which citizens of Nigeria of other communities, ethnic groups, places of origin, sex, religions or political opinions are not made subject; or

(b) be accorded either expressly by, or in the practical application of, any law in force in Nigeria or any such executive or administrative action, any privilege or advantage that is not accorded to citizens of Nigeria of other communities, ethnic groups, places of origin, sex, religions or political opinions.

(2) No citizen of Nigeria shall be subjected to any disability or deprivation merely by reason of the circumstances of his birth.

(3) Nothing in subsection (1) of this section shall

invalidate any law by reason only that the law imposes restrictions with respect to the appointment of any person to any office under the State or as a member of the armed forces of the Federation or member of the Nigeria Police Forces or to an office in the service of a body, corporate established directly by any law in force in Nigeria.

Apart from the right to equality of persons before the law and freedom from discrimination, the Constitution also provides that “the sanctity of the human person shall be recognised and human dignity shall be maintained and enhanced”. In addition, HIV positive citizens also have socio economic rights that are listed in Chapter II of the 1999 Constitution. Unfortunately it limits the enjoyment of the rights listed in Chapter II (for all citizens) where in Section 6(1) it provides that “The judicial powers of the Federation shall be vested in the courts to which this section relates, being courts established for the Federation”. The section lists the courts of the federation including the Supreme Court. It went further in sub section 6 and 6(c) to provide that “*The judicial powers vested in accordance with the foregoing provisions of this section (c) shall not except as otherwise provided by this Constitution, extend to any issue or question as to whether any act of omission by any* The section lists the courts of the federation including the Supreme Court. It went further in sub section 6 and 6(c) to provide that “*The judicial powers vested in accordance with the foregoing provisions of this section (c) shall not except as otherwise provided by this Constitution, extend to any issue or question as to whether any act of omission by any authority or person or as to whether any law or any judicial decision is in conformity with the Fundamental Objectives and Directive Principles of State Policy set out in Chapter II of this Constitution;*

In other words, even the Supreme Court cannot adjudicate over the rights listed in Chapter II. This makes a clear distinction between Fundamental Rights (Chapter Four) that are justiciable and Fundamental Objectives and Directive Principles of State Policy (Chapter Two) that may be argued to be non-justiciable. There are diverse opinions regarding the issue of justiciability of socio-economic rights.

i. Some are of the opinion that in as much as section 6 (6)(c) contains the statement 'except as otherwise provided by this constitution ...', there exist a window of opportunity to adjudicate on issues contained in Chapter II.

ii. Section 224 of the Constitution provides thus: *The programme as well as the aims and objectives of a political party shall conform with the provisions of Chapter II of this Constitution.* The programmes, aims and objectives are not issues that should be held in loose rhetoric. They are serious issues with implications for accountability and good governance. Bearing this in mind, it may be right to conclude that if political parties are to be held accountable for their programmes and their aims and objectives are to conform with the provisions of chapter II, then it only makes sense that the provisions of Chapter II should be actionable.

iii. Item 60 (2) of Part II – The Exclusive Legislative List which itemizes the issues that only the Federal Government can legislate on provides as follows:

The establishment and regulation of authorities for the Federation or any part thereof -

(a) To promote and enforce the observance of the Fundamental Objectives and Directive Principles contained in this Constitution;

The implication of this is that the Federal Government can establish institutions and regulation aimed at promoting and enforcing socio-economic rights as contained in Chapter II of the

constitution.

The Nigerian courts have somehow favoured the justiciability of Chapter II where statutes based on actualizing Chapter II provisions are challenged. In *Attorney General of Ondo State v. Attorney General of the Federation & others. (2002)*, Uwaifo JSC, justified the enactment of the Act on the Fundamental Objectives and Directive Principles of State Policy by drawing knowledge from the Indian jurisprudence, as follows:

“[Every] effort is made from the Indian perspective to ensure that the Directive Principles are not a dead letter. What is necessary is to see that they are observed as much as practicable so as to give cognizance to the general tendency of the Directives. It is necessary therefore to say that our own situation is of peculiar significance. We do not need to seek uncertain ways of giving effect to the Directive Principles in Chapter II of our Constitution. The Constitution itself has placed the entire Chapter II under the Exclusive Legislative List. By this, it simply means that all the Directive Principles need not remain mere or pious declarations. It is for the Executive and the National Assembly, working together, to give expression to any one of them through appropriate enactment as occasion may demand”.

This case and other similar ones do confirm the possibility of enforcing socio-economic rights.

Another aspect of the 1999 Constitution that is relevant to a discussion on vulnerability to HIV is section 21 which enjoins States to protect, preserve and promote Nigerian cultures that “enhance human dignity and are consistent with the fundamental objectives as provided...” The challenge here is the definition of *cultures that enhance human dignity*. For many people, a practice such as Female Genital Mutilation enhances human dignity, however, the fact that research has shown the possibility of the practice contributing to the spread of HIV if the same instrument is used for more than one person at a time calls for caution. Women's rights advocates have called for it to be expunged from the Constitution. The test for determining whether or not a culture/practice should be upheld by the Court or not is the Repugnancy Rule which tests to ensure that the culture/practice is ***not repugnant to natural justice, equity and good conscience or incompatible either directly or by implication with any law, for the time being in force***. This test gives a lot of discretionary power to the Judge.

HIV and AIDS Anti-Discrimination Act, 2014

One of the major issues that affects persons living with HIV/AIDS negatively, increases their vulnerability to HIV re-infection and also has intersections with GBV is stigma and discrimination. A national law on stigma and discrimination has just been signed into law after years of advocacy for its passage. Out of 36 States only ten states have Anti- Stigma and Discrimination Law. These States are Lagos, Nasarawa, Kaduna, Enugu, Ebonyi, Benue, Ogun, Ondo, Rivers, and Cross River. One of the challenges identified in the report of the Joint Annual Review of the National Response to HIV commissioned by NACA in July 2011 is that despite the fact that “some states have passed the anti-discrimination bill into law in their states, some state law enforcement agencies (Judiciary and Police) are still not aware of the existence of the law (GARPR, 2014)”.

HIV/AIDS Anti-Discrimination Act, 2014.

The purpose of the Act is to protect the rights and dignity of people living with HIV and affected by AIDS by-

(a.) eliminating all forms of discrimination based on HIV status;

(b.) creating a supportive environment so that people living with HIV and AIDS are able to continue working and living under normal conditions for as long as they are medically fit to do so;

(c.) promoting appropriate and effective ways of managing HIV in the workplace, community, institutions and other fields of human endeavour;

(d.) creating a safe and enabling working and learning environment for all persons;

(e.) creating a balance between the rights and responsibilities of all persons in the society and

(f.) giving effect to the human rights guaranteed as contained in Chapter 4 of the 1999 Constitution of the Federal Republic of Nigeria as amended and international and regional human rights and other instruments.

The HIV and AIDS Anti-Discrimination Act seeks to eliminate all forms of discrimination based on HIV status especially as it concerns employment, education, accommodation and access to health care services etc. The law supports the adoption of affirmative towards ensuring that persons living with HIV/AIDS action have equal opportunities and treatment in relation to employment (section 5). Section 6 of the law contains a list of offences that constitute discrimination – these include denial of access to and use of communal places, religious or worship areas, credit facilities, denial of admission, and refusal of treatment. Of particular interest is section 6(f) which makes it an offence to prohibit a person from marrying anyone of their choice provided the HIV status of the spouse is made known, his/her consent is obtained, and he/she is in the right frame of mind. Reports were made in the course of this assessment to the effect that religious leaders refused to conduct weddings on the ground one party being HIV positive. This provision of the will help to check the excesses of such leaders. However, the law has to be well disseminated as many are still ignorant of its provisions.

The law makes it mandatory for employers to adopt workplace policies on HIV/AIDS in consultation with their employees. By the law, all organisation in business at the commencement of the Act are to adopt a workplace policy within 12 months of the passage of the Act and for organisations established after the commencement of the Act within 12 months of commencement of business (section 21). Copies of such policies are also supposed to be lodged with the Minister.

Going by the definition of 'Employer' as provided for in the definition section of the law, this provision sounds a bit cumbersome. As laudable as the provision sounds, one wonders if the office of the Minister will be able to accommodate the quantity of policies that this provision will generate.

The law places enormous responsibility on the Minister of Justice in the area of implementation and enforcement of the law. By virtue of section 24 of the law, the Minister for Justice is supposed to receive reports of contravention of the law and make inquiries into such allegations. The Minister is also expected to make regulations within 12 months of the passage of the law to specify the procedure for inquiries.

Violence Against Persons Prohibition Act (VAPP), 2015

The VAPP Act is a national draft law on different forms of violence including gender based violence. Section 1 of the national law provides for the offence of rape. At a time when the country is said to be experiencing increased report of rape cases, the positioning of the offence of rape as the first offence in the law can be described as strategic. Sexual violence contributes to the spread of HIV infection especially among women and girls. The law expands the definition of rape to cover penetration of the vagina, anus or mouth of a person or any part of the body of either a male or female as opposed to the definition in the criminal and penal codes that cover only carnal knowledge.

Despite the expansion of the definition of rape, marital rape was deliberately left out of all that constitute rape. Research has continued to show that women who reported having experience of spousal violence reported experience of being forced to have sexual intercourse by their partner. The existence of this act of violation should not be ignored by law. Women should be protected by law so they can feel safe within relationships including marital relationships.

Other offences covered by the law are incest, female genital mutilation, spousal battery, forceful ejection from home, forced financial dependence or economic abuse, harmful widowhood practices, harmful traditional practices etc.

Child Rights Act 2003

The Child's rights Act was passed in 2003 and following that, 24 States of the federation have adopted the law. Despite this, the Nigerian child has not been able to benefit from the seeming viable legal environment. According to UNICEF 'this landmark legislative achievement has not yet translated into improved legal protection throughout the Federation. Nigeria has been unable to deal with several issues hindering the protection rights of children such as children living on the streets, children affected by communal conflict, drug abuse, human trafficking and the weaknesses of the juvenile justice system amongst others'.

The Child's Rights Act addresses different issues such that have links with the intersections between HIV/AIDS and Gender Based Violence. The Act addresses issues of rights and protection such as right to freedom from discrimination, right to dignity of the child, right to health and health services, prohibition of child marriage, hawking or begging for alms or prostitution, unlawful sexual intercourse with a child, prohibition of recruitment of children into the armed forces etc. The challenge is with the implementation of the law which has been adjudged weak. There is a need to the implementation mechanisms to be strengthened across the country.

National Health Insurance Scheme Act 35, 1999

Nigeria has a national health Insurance Scheme (NHIS) which was established by the federal government in 2005 under the National Health Insurance Scheme Act of 1995. It seeks to regulate

financing and delivery of healthcare services to the general populace. The objectives of the Scheme are to (a) ensure that every Nigerian has access to good health care services; (b) protect families from the financial hardship of huge medical bills; (c) limit the rise in the cost of health care services; (d) ensure equitable distribution of health care costs among different income groups; (e) maintain high standard of health care delivery services within the Scheme; (f) ensure efficiency in health care services; (g) improve and harness private sector participation in the provision of health care services; (h) ensure adequate distribution of health facilities within the Federation; (i) ensure equitable patronage of all levels of health care; (j) ensure the availability of funds to the health sector for improved services.

By virtue of section 16 (1) of the Act, every 'employer who has a minimum of ten employees may, together with every person in his employment, pay contributions under the Scheme, at such rate and in such manner as may be determined, from time to time, by the Council'. Coverage of the scheme is currently limited to the formal sector. In relation to HIV positive persons, it is only those that are in formal employment that can benefit from it. Unfortunately, apart from the fact that the scheme does not cover HIV drugs, so far the scheme is said to cover only about 3% of the Nigerian population, the implication of which is a health care system that is extremely weak and highly unfavourable to PLWHA. "Without adequate financing mechanisms such as insurance, people living with HIV are usually unable to afford treatment at private facilities. Even those who manage to pay out of pocket for services at private facilities run the risk of going into debt and not being able to continue treatment (USAID, 2013)." Annual death among HIV positive persons is between 190,000 and 214,000. According to UNAIDS, "19% of AIDS-related deaths in the Africa region occurred in Nigeria where only two in every ten people living with HIV have access to treatment. It is no coincidence that between 2005 and 2013 there was no decline in the number of AIDS-related deaths in Nigeria, although there has been a slight decline since the peak in 2008". HIV treatment has been largely donor driven over the years and with the recent change in policy of the US government whereby only anti-retroviral drugs (ARDs) and CD4 test will be free to all those that are currently enrolled for treatment in all states of the federation, the situation seems gloomy for HIV positive persons especially the poor, unemployed and newly infected persons. Under the new policy, opportunistic infections, management and care will no longer be funded, and massive community testing, provider-initiated testing and counseling and opt-out approach to HIV enrolment will only happen if the government of Nigeria funds such.

Nigerian Law and FSW

The issue of female sex work is addressed by the Criminal law regime which is majorly governed by the criminal code in the South and Penal Code in the North. Some States however, do have their own codes. The difference between the Penal and Criminal codes is that while the Penal code draws knowledge from Sharia law, criminal code is largely based on the received English law. The law relating to female sex work in Nigeria is contained in Chapters 21 and 24 of the Criminal Code Act, CAP 77, Laws of the Federation of Nigeria, 1990. Chapter 21 of the Act is titled *Offences Against Morality* while chapter 24 is titled *Idle and Disorderly Persons, Rogues and Vagabonds, Bringing Contempt on Uniform*. Section 222A of the Criminal Code makes it a crime to cause or encourage seduction, unlawful carnal knowledge or prostitution of a girl under sixteen years of age and *Section 222B* outlaws the housing of persons under sixteen in brothels. Similar offences are created under the Criminal Law of Lagos State but with a difference in age. The Lagos State law adopts the

definition of a Child under the Child Rights Law which is any one below the age of 18 years. The key issue in relation to this offence is the age of the girls in question and the offender is the owner of the premises. In other words, with respect to this section of the law, there is no offence if the girl who is engaged in sex work is above 16 years (in States where the Criminal Code is the operational law) and 18 years if it is in Lagos State and in private premises.

Section 225 on the other hand criminalizes the practice of pimps and madams 'who keeps or manages or assists in the management of a brothel' or allows a premises to be used for prostitution. In all these sections of the law, the focus is not the person involved in sex work but the person encouraging it or running a brothel. The law is emphatic on the owner of premises or person using the premises for sex work and not the sex worker.

Section 249 provides that 'Every common prostitute behaving in a disorderly or indecent manner in any public place; loitering and persistently importuning or soliciting persons for the purpose of prostitution; ... shall be deemed idle and disorderly persons, and may be arrested without warrant, and shall be guilty of a simple offence, and shall be liable to imprisonment for one month'.

It suffices therefore to say that under the Criminal Code applicable in the South, female sex work is not a crime if practiced by someone above the age of 16. What constitute a crime as envisaged by the sections and 249 is soliciting and promotion. A similar provision to this, is section 142(1)(b) of the Criminal Law of Lagos State, 2011 which makes it an offence to persistently solicit or importune for immoral purpose in any public place. The Criminal Code is problematic as it describes persons engaged in sex work as 'common prostitutes'. This term is derogatory and capable of giving law enforcement agents a biased mind set against such girls. The punishment for soliciting is one month imprisonment under federal law and two years under the law of Lagos State. The assessment reveals that policemen capitalize on this provision of the law to extort money from most of the girls arrested rather than enforce the law. This practice and negative attitude towards female sex workers has been found to fuel stigma and discrimination thereby driving the practice underground, denying FSW access to quality health care and increasing the spread of HIV.

Section 200 of the Penal Code creates an offence relating to doing any obscene or indecent act in a public place. It is not clear if this can be interpreted to cover sex work. Furthermore, section 201 of the same law makes it an offence to keep a brothel and this offence is punishable with imprisonment of up to one year or with fine or both.

Section 126 of the Sharia Penal code of Zamfara state creates the offence of *Zina* – *i.e.* Adultery or Fornication. FSWs can also be prosecuted under this law as it is against any form of sexual intercourse between unmarried couples. The punishment is stoning to death where an offender is married and where unmarried the punishment is one year imprisonment and 100 lashes of cane.

Nigerian Law and IDUs

The National Drug Law Enforcement Agency Act (NDLEA), 1989

Major legal and policy barriers, including criminalization of people who use drugs (PWUD), do hinder IDUs from accessing existing programmes where these do exist, and exacerbate unsafe injecting practices and HIV transmission among them. Although there has been an increasing awareness of the need to address IDU-related HIV in Africa since 2010, approaches in many countries continue to focus on supply reduction and law enforcement rather than public health.

The National Drug Law Enforcement Agency Act (NDLEA) opens with the statement – “An Act to establish the National Drug Law Enforcement Agency to enforce laws against the cultivation, processing, sale, trafficking and use of hard drugs and to empower the Agency to investigate persons suspected to have dealings in drugs and other related matter”. The implication of this is a blanket criminalization of anyone on drugs without consideration for the circumstances surrounding the user and how he/she got into such a risky practice.

Sections 19 and 20 (1)(c) of the NDLEA law state as follows:

19. Unlawful possession Cocaine, etc.

Any person who, without lawful authority, knowingly possesses the drugs popularly known as cocaine, LSD, heroine or any other similar drugs shall be guilty of an offence under this Act and liable on conviction to be sentenced to imprisonment for a term not less than fifteen years and not exceeding 25 years.

20. (1) Any person who, without lawful authority (the proof of which shall lie on him) commits any of the following offences, that is to say:

(c) Has in his possession or engages or purchases any narcotic drug or psychotropic substance for the purpose of any of the activities enumerated in paragraphs (a) of this subsection.

The language of these sections of the law envisages that possession of hard drugs can be lawful under certain circumstances. For any harm reduction programme to be implemented, service providers must be protected by law, bearing in mind that they must possess before they can administer. The challenge therefore, is being able to use the law in its instrumental role to deal with the problem of addiction which is more or less a health issue for many.

Some of the SACAs have enabling laws that allow them to implement revolutionary programmes in order to prevent and control the spread of HIV:

“Design and prosecute an intense multi-sectoral approach on prevention and control” (Nasarawa SACA Enabling Law).

“provide a proactive and aggressive response to issues that rests at the very heart of the development of a cohesive and cross-cutting strategy for the prevention and mitigation of HIV and AIDS impact on Nigeria society” (Ondo State SACA Enabling law)

Ordinarily, legal provisions like these should allow for innovative programmes that will look beyond criminalisation of Key Populations. Unfortunately, issues of drugs and poisons are under the exclusive legislative list of the 1999 Constitution, as such only the federal government can legislate on them. Reviewing laws therefore, that will allow for other approaches other than criminalization will require federal level legislation, especially for a programme that is centred on harm reduction. As a part of its Positive Health, Dignity and Prevention Interventions, National Policy on HIV/AIDS provides that “Harm Reduction Services shall be offered to HIV–Positive Drug Users”. Unfortunately this is contrary to the current approach of government on drugs which is backed by law – the National Drug Law Enforcement Agency Law. The National Minimum Package also prescribes harm reduction as one of the services to be offered to Most At Risk Population (MARPS) as part of its response on Biomedical transmission. The Package however, does not say what services constitute 'harm reduction interventions' as it explains what other services such as HCT entails.

Nigerian Law and MSM

Same Sex Marriage (Prohibition) Act, 2013

The Federal Government law on same sex marriage - *Same Sex Marriage (Prohibition) Act, 2013* prescribes a 14-year jail term for anyone who engages in same sex marriage or civil union. It also stipulates a 10-year jail term for any person who directly or indirectly makes a public show of same-sex amorous relationships. All persons, clubs, societies or organisations and those who register, aid and abet such unions, would be liable on conviction to 10 years imprisonment. The law further specifies that where same sex marriage or unions had been contracted abroad, such marriage will not be recognized in Nigeria.

The equivalent of the law in Lagos State is the Lagos State Same Sex (Prohibition) Law 2007 prohibits marriage between persons of the same sex. Unlike the federal law on Same Sex Marriage, the Lagos State Law does not criminalize institutions who are engaged in HIV/AIDS interventions focused on same sex relationships. It only criminalizes same sex marriage and defines “same sex marriage as “the coming together of two persons of the same gender or sex in a civil union, marriage, domestic partnership or other forms of same sex relationship for the purpose of cohabitation as husband and wife (Section 6)”. Although it does not make mention of homosexual relationships that do not end up in marriage, the criminalization of act connected to homosexuality often make the practice to be hidden and this is having severe implications for the spread of HIV infection among members of the public and especially among men having sex with men or young people generally.

Criminalization of homosexuality has been a part of the Nigerian Law for a long time. Section 214 of the Criminal Code CAP C38 provides for Unnatural Offences. It provides that: Any person who (1) has carnal knowledge of any person against the order of nature; or (2) has carnal knowledge of an animal or (3) permits a male person to have carnal knowledge of him or her against the order of nature; is guilty of a felony, and is liable to imprisonment for fourteen years. Attempts at committing the above stated offences attract a punishment of seven years. It is not clear how the law intends to arrest offenders especially if this is being done by consenting adults. The use of the term '*against the order of nature*' is highly controversial and debatable. For instance, having babies through artificial insemination is in a way against the order of nature and that is not considered an offence. Helping

people to have access to information that can enable them to lead healthy lifestyles is more beneficial than making laws that can be hardly implemented and therefore not beneficial to anyone.

Sharia law is operational in twelve of the 36 states of the federation. In the said states, Sharia runs parallel to the state and federal justice system. The punishment for homosexuality differs from state to state and ranges from caning to imprisonment and in extreme cases death by stoning.

Nigeria Law and Children

Child's Rights Act, 2003

The Child's Rights is Nigeria's version of the International Convention on the Rights of the Child. It seeks to protect the rights of the child. Of the 36 states of the federation, 24 have adopted the law. In the course of the assessment, participants identified child marriage as one of the cultural practices that predisposes women and girls to HIV infection (UNIFEM, 2006). The Child's Rights Act 2003 sets the age of marriage at 18 years. However, this is an Act that is only operational in the Federal Capital Territory. The States (24) that have adopted the law have similar provisions. Unfortunately the States that have not passed the law are states where child marriage is highly acceptable and practiced. Although there is no guaranty that if the remaining States adopt the law, the practice will stop, there is a need to intensify advocacy effort in order to get the law passed in those states.

Criminal law

Although not directly the reason behind the laws, the criminal code and the penal code, as well as relevant state laws have provisions that seek to protect children against offences with implications for the spread of HIV e.g. sexual abuse and exploitation. Section 278 of the Penal code creates an offence of buying or selling minor for immoral purpose. This offence is punishable with imprisonment up to ten years in addition to a fine. A similar law to this is in section 223 of the criminal code and section 140 (1) of the criminal law of Lagos state, although the punishment in both laws is lighter (2 years imprisonment).

Under the law of Lagos state (Section 139(1)), it is an offence for a person who has custody, charge or who cares for a child who has attained the age of four (4) years, to allow such a child to reside in or frequent a brothel. This offence is punishable with a fine of Ninety Thousand Naira (N90,000.00) or to imprisonment for six (6) months or to both.

National Human Rights Commission (NHRC) Act, 1995

In order to guarantee protection of fundamental human rights and in compliance with the United Nations General Assembly resolution, which enjoins states to establish National Human Rights Commission (NHRC), the government of Nigeria passed the National Human Rights Commission (NHRC) Act in 1995. The NHRC Act 1995 established the NHRC. The 1995 Act was amended in 2010 giving more independence and powers to promote and protect fundamental human rights.

The commission has express powers to enforce its decisions. The decisions of the Governing Council can be registered as decisions of the High Court. This is a good window of opportunity for MSM, IDUs and FSW to seek the protection of their rights. A thorough examination of the mandate reveals that the commission is in the right position to protect HIV Positive persons as well as people referred to as key populations if their rights are violated. Unfortunately the assessment reveals that reports are hardly received by the commission from this group of people.

MANDATE OF THE NATIONAL HUMAN RIGHTS COMMISSION:

- (a) deal with all matters relating to the promotion and protection of human rights guaranteed by the Constitution of the Federal Republic of Nigeria, the United Nations Charter and the Universal Declaration on Human Rights, the International Convention on Civil and Political Rights, the International Convention on the Elimination of all forms of Racial Discrimination, the International Convention on Economic, Social and Cultural Rights, the Convention on the Elimination of all forms of Discrimination Against Women, the Convention on the Rights of the Child, the African Charter on Human and Peoples' Rights and other international and regional instruments on human rights to which Nigeria is a party;
- (b) monitor and investigate all alleged cases of human rights violations in Nigeria and make appropriate recommendations to the Federal Government for the prosecution and such other actions as it may deem expedient in each circumstance;
- (c) assist victims of human rights violations and seek appropriate redress and remedies on their behalf;
- (d) undertake studies on all matters pertaining to human rights and assist the Federal, State and Local Governments, where it considers it appropriate to do so, in the formulation of appropriate policies on the guarantee of human rights;
- (e) publish and submit, from time to time, to the President, the National Assembly, the Judiciary, State and Local Governments, reports on the state of human rights promotion and protection in Nigeria;
- (f) organize local and international seminars, workshops and conferences on human rights issues for public enlightenment;
- (g) liaise and cooperate, in such a manner as it considers appropriate, with local and international organizations on human rights for the purpose of advancing the promotion and protection of human rights;
- (h) participate, in such manner as it considers appropriate, in all international activities relating to the promotion and protection of human rights;
- (i) maintain a library, collect data and disseminate information and materials on human rights generally;
- (j) receive and investigate complaints concerning violations of human rights and make appropriate determination as may be deemed necessary in each circumstance;
- (k) examine any existing legislation, administrative provisions and proposed bills or bye-laws for the purpose of ascertaining whether such enactments or proposed bills or bye-laws are consistent with human rights norms;
- (l) prepare and publish, in such a manner as the Commission considers appropriate, guidelines for the avoidance of acts or practices with respect to the functions and powers of the Commission under this Act;
- (m) promote an understanding of public discussion of human rights issues in Nigeria;
- (n) undertake research and education programmes and such other programmes for promoting and protecting human rights and co-ordinate any such programme on behalf of the Federal, State or Local Government on its own initiative or when so requested by the Federal, State or Local Government and report concerning the enactment of legislation on matters relating to human rights;
- (o) on its own initiative or when requested by the Federal, State or Local Government, report on action that should be taken by the Federal, State or Local Government to comply with the provisions of any relevant international human

rights instruments;

(p) refer any matter on human rights violation requiring prosecution to the Attorney-General of the Federation or of a State, as the case may be;

(q) where it considers it appropriate to do so, act as a conciliator between parties to a complaint;

(r) carry out all such other functions as are necessary or expedient for the performance of these functions under the Act.

In implementing the recommendations of the Vienna Declaration and Programme of Action, adopted at the World Conference on Human Rights in Vienna Austria in 1993, the government of Nigeria developed a National Action Plan for the Promotion and Protection of Human Rights (NAP) to cover the period 2009–2013.

The Police Act, 1943

Section 24 of Police Act gives the Nigerian Police the power to arrest without warrant. Sub section (1) of section 24 states that “In addition to the powers of arrest without warrant conferred upon a police officer by section 10 of the Criminal Procedure Act, it shall be lawful for any police officer and any person whom he may call to his assistance, to arrest without warrant in the following cases-

(a) any person whom he finds committing any felony, misdemeanour or simple offence, or whom he reasonably suspects of having committed or of being about to commit any felony, misdemeanour or breach of the peace;

(b) any person whom any other person charges with having committed a felony or misdemeanour;

(c) any person whom any other person-

(i) suspects of having committed a felony or misdemeanour; or

(ii) charges with having committed a simple offence, if such other person is willing to accompany the police officer to the police station and to enter into a recognisance to prosecute such charge.

This power, given to the police limits the enjoyment of several fundamental rights provided for in the 1999 Constitution (as amended). Such rights include right to privacy (s.37), freedom of thought and conscience (s. 38) freedom of expression (s.39), freedom of association (s.40), freedom of movement (s.41).

Section 24 of the Police Act is the basis of most arrests of members of key Populations. Section 45 of the Constitution gives further backing to the Police Act when it provides that “Nothing in sections 37, 38, 39, 40 and 41 of this Constitution shall invalidate any law that is reasonably justifiable in a democratic society (a) in the interest of defence, public safety, public order, public morality or public health; or (b) for the purpose of protecting the rights and freedom or other persons. The only qualification given by section 45 is 'reasonably justifiable'. The failure to determine and make explicit what is 'reasonably justifiable' especially in relation to issues of morality explains the sometimes arbitrary arrests made by the Police especially of members of Key populations. According to CLEEN (2009) “the provisions in the Police Act and the Criminal Procedure Act are insufficient to control exercise of discretion by police officers...”. There is an urgent need to review these laws and bring them up to date for better effectiveness of the Police and improved respect for the rights of citizens especially members of key Populations.

State Laws

People Living with HIV/AIDS (anti-stigmatization and discrimination) Law, 2013 of Benue State

The law provides that certain persons can be subjected to HIV/AIDS test – pregnant women, persons charged with a sexual offence for purposes of criminal investigation and prison inmates awaiting trial. The court can also order that a person be tested. The law seeks to protect the unborn child from being infected by their HIV positive mothers and it seeks to protect victims of sexual violence from HIV infection. The law provides that 'Any person, who, with fore knowledge of his status, intentionally transmits HIV to another person commits an offence and shall be liable on conviction to one year imprisonment without option of fine'. The implication of this law is that where a positive person sexually abuses another person, apart from the punishment for the sexual offence, he can also be charged with the offence of willfully transmitting HIV and upon conviction, be sentenced to one year imprisonment.

Section 11 of the law guarantees treatment, care and support for pregnant women and their children who test positive to HIV while Section 35(i) provides that 'Government shall provide the necessary support systems and structures for people living with HIV/AIDs to seek redress. The laws seems to be very radical compared to the national one and that of some other States of the federation. This may not be far from the fact that Benue State is one of the States with very high HIV prevalence rate in the country. The State is exploring the proscriptive role of the law to check the spread of HIV infection. This assessment, was however, not able to record the impact of the law so far.

Law for the Protection of Persons Living with HIV and Affected by AIDS in Lagos State and for Other Connected Matters, 2007.

In 2007, the Lagos State Government passed a Law for the Protection of Persons Living with HIV and Affected by AIDS in Lagos State and for Other Connected Matters. This law provides protection for persons living with HIV and affected by AIDS in the State. It addresses issues around access to drugs, voluntary counseling and testing, protection against discrimination and stigmatization in the area of employment, education, shelter, access to health care, social, religious or political gathering, transportation, insurance etc. Acts declared unlawful and discriminatory by section 10 of the law include denial of accommodation to a positive person by a Landlord, denial of access to a health facility, denial of access into an educational institution discrimination and stigmatization in any social, religious or political gathering, segregation and discrimination in the work place and compulsory and mandatory HIV test for employees and employers of labour. As opposed to the federal law, the Lagos state law requires all 'corporate organisations' to adopt a workplace policy (section 11(3)), although it does not define what it means by corporate. Also different from the National law is its section 18 which makes it an offence to willfully infect another with HIV (although the law says AIDS virus). This offence attracts a punishment of N200,000 or imprisonment not exceeding 10 years or both. It is, however, not clear what the law envisages as 'willfully or knowingly endangers other persons by infecting them'. Does this entail non-disclosure of status of an infected person to a sexual partner or infection through medical procedure?

A major gap in the law is the fact that it sees HIV positive persons as a homogenous group. The law makes provision for a Justice and 'Human Rights Watch Group' which is charged with the responsibility of monitoring implementation of the law. So far this mechanism has not worked to the benefit of the HIV community in Lagos State. The Law provides for the establishment of 'The Anti-Retroviral Drugs Fund Board'. Members of the board are drawn from different sectors e.g. Health, Justice, Social Welfare, Civil Society, People Living with HIV, Private sector etc. There is also a slot for a physician and a nurse with vast knowledge in the care of people living with HIV and affected by AIDS on the board.

Section 18 of the law makes it an offence to 'willfully or knowingly endanger other persons by injecting them with AIDS virus'. The punishment for this is a fine of N200,000 or imprisonment of not more than 10 years or both fine and imprisonment. Willful disclosure of the HIV status of any one by a health worker is also an offence under the law.

Although this law makes government responsible for provision of anti-retroviral drugs to all positive people, it did not do the same in the area of care and support. In Section 12 (1), the law states that 'Government shall make adequate provisions as appropriate to ensure the establishment and funding of:

- (i) homes for the protection of orphans and children of deceased HIV/AIDS patients within orphanages in the State in order to ensure their integration with other orphans
- (ii) homes or where required adequate provisions for the protection of vulnerable and abandoned children of HIV/AIDS patients in the State
- (iii) Sub section 2 of the same section of the law provides that 'government shall make adequate provision of social security, care and support for:
- (iv) children that are heads of households; and
- (v) vulnerable widows and widowers who, in the reasonable estimation of the State Government are not able to provide adequate care and support for themselves
- (vi) grandparents

Access to social security and other social services help to reduce vulnerability to HIV infection. From the foregoing other women (aside widows) and young people who are in difficult circumstances (but not HIV related) seem to be out of the picture of government social security, care and support. Provision of shelter can help protect women and girls from being vulnerable to HIV through sexual violence on the one hand or help protect positive people from being exposed to sexual violence thereby getting re-infected or infecting their abusers. There is room to advocate the expansion of the scope of this law to mainstream GBV. The slot of the Physician and Nurse on the Anti-Retroviral Drugs Fund Board can be reviewed to be for a physician or nurse vast in the knowledge of GBV issues and in the care of persons living with HIV/AIDS.

Legal Aid Act, 2011

The Legal Aid Act, 2011 repealed the Legal Aid Act Cap. L9, Laws of the Federation of Nigeria, 2004, It provides for the establishment of legal aid and access to justice fund into which financial assistance would be made available to the Council on behalf of the indigent citizens to prosecute their claims in accordance with the Constitution and further to empower the existing Legal Aid Council to be responsible for the operation of a scheme for the grant of legal aid and access to justice in certain matters or proceedings to persons with inadequate resources in accordance with the provision of the Act.

Section 10(1) of the Act makes legal aid only accessible to a person whose income does not exceed the national minimum wage (i.e. N18,000 or \$90). The Board may however (in exceptional circumstances), grant legal aid service on a contributory basis to a person whose earning exceeds the national minimum wage.

The Act seems to have pegged poverty line at N18,000. This may be unrealistic in view of the high cost of litigation in Nigeria, even those who earn twice the minimum wage may not necessarily be able to access justice without the support of institutions like the legal aid council. There is a need to review this law in order to expand the scope of those that can benefit from the services of the Council.

Fundamental Human Rights Enforcement Procedure Rules, 2009

In order to ensure the enforceability of fundamental human rights enshrined in the 1999 Constitution of the Federal Republic of Nigeria, the constitution confers on the Chief Justice of the federation, the power to make enforcement rules. Section 1 of Order III of the Rules, which deals with issues of Limitation of Action provides that “An Application for the enforcement of Fundamental Right shall not be affected by any limitation Statute whatsoever. This is highly favourable for HIV positive persons with experiences of abuse of their fundamental human rights. Such cases can be instituted at any time so far it can be well proven by the aggrieved person. The Rules also provides as follows:

“The Court shall proactively pursue enhanced access to justice for all classes of litigants, especially the poor, the illiterate, the uninformed, the vulnerable, the incarcerated, and the unrepresented. (e) The Court shall encourage and welcome public interest litigations in the human rights field and no human rights case may be dismissed or struck out for want of locus standi. In particular, human rights activists, advocates, or groups as well as any non-governmental organisations, may institute human rights application on behalf of any potential applicant. In human rights litigation, the applicant may include any of the following: (i) Anyone acting in his own interest; (ii) Anyone acting on behalf of another person; (iii) Anyone acting as a member of, or in the interest of a group or class of persons; (iv) Anyone acting in the public interest, and (v) Association acting in the interest of its members or other individuals or groups (f) The Court shall in a manner calculated to advance Nigerian democracy, good governance, human rights and culture, pursue the speedy and efficient enforcement and realization of human rights. (g) Human rights suits shall be given priority in deserving cases. Where there is any question as to the liberty of the applicant or any person, the case

shall be treated as an emergency”.

The foregoing implies apart from individual taking action to seek redress for infringement of their rights, groups and associations can also take up actions on behalf of members. This is a good window of opportunity that association of people living with HIV can latch on to promote the enforcement of their rights of their members. It however, calls for increased awareness among HIV positive person on their rights and where to go when their rights are infringed upon.

The National Health Act, 2014

The National Health Act, 2014 establishes the national health system, which is designed to provide a framework for standards and regulation of health services for the nation. By extension, the Act seeks to ensure the actualization of the right to health and the right to life as contained in section 17(3)(c), 17(3)(c) and section 33 of the 1999 Constitution as amended. The Act also strengthens the actualization of the right to health by making it an offence to refuse a person emergency medical treatment (section 20(1)). The offence attracts a fine of N10,000 or three months imprisonment or both (section 20(1)).

Section 18 of the Act provides that 'the Minister shall prescribe mechanisms to ensure a co-ordinated relationship between private and public health establishments in the delivery of health services'. Sub section 2 of section 18 further provides that 'the Federal Ministry, any State Ministry or any Local Government may enter into an agreement with any private practitioner, private health establishment or non-governmental organisation in order to achieve any object of this Act.' This section creates a wide window of opportunity for the expansion of access to quality health services to the citizens of Nigeria. This is critical, especially in relation to increasing access to HIV related services in underserved areas.

The Act also protects medical records of users of health care services where in section 26, it provides that “All information concerning a user, including information relating to his or her health status,

THE BASIC HEALTH CARE FUND

1. There is hereby created a Fund to be known as **Basic Health Care Provision Fund**.
2. The Basic Health Care Provision Fund shall be financed from-
 - (a) Federal Government Annual Grant of not less than one per cent of its Consolidated Revenue Fund.
 - (b) grants by international donor partners; and
 - (c) funds from any other source.
3. Money from the fund shall be used to finance the following:-
 - (a) 50 percent of the fund shall be used for the provision of basic minimum package of health services to citizens, in eligible primary/or secondary health care facilities through the National Health Insurance Scheme (NHIS);
 - (b) 20 percent of the fund shall be used to provide essential drugs, vaccines and consumables for eligible primary health care facilities
 - (c) 15 per cent of the fund shall be used for the provision and maintenance of facilities, equipment and transport for eligible primary healthcare facilities; and

treatment or stay in a health establishment is confidential.” Information of Users of health services can only be released where (a) the user consents to that disclosure in writing; (b) a court order or any law requires that disclosure; or (c) non-disclosure of the information represents a serious threat to public health. This provision is important especially in relation to the challenges that people living with HIV face in the world of work. With proper implementation the law is bound to improve the enjoyment of health related rights.

(d) 10 per cent of the fund shall be used for the development of Human Resources for Primary Health Care;

(e) 5 percent of the fund shall be used for Emergency Medical Treatment to be administered by a Committee appointed by the National Council on Health.

The Act creates the Basic Health Care Provision Fund which is to be financed from federal government annual grant of not less than partners. The Fund is to be managed by three national entities – 1% of its consolidated revenue fund and grants by international donor National Health Insurance Scheme, The Federal Ministry of Health and the National Primary Health Care Development Agency (NPHCDA)

The Act contains many positive provisions, which if fully implemented would impact the lives of the citizens positively. Therefore, all relevant stakeholders are expected to take advantage of the new Act and bring positive development into the health sector; and ensure full-fledged allocation of the proposed at least 1% oil revenue allocation to the sector. Half (50%) of the fund is earmarked for health insurance. It is hoped that health insurance would be made to cover health challenges that HIV positive persons face, in order to reduce over dependence on foreign aid which has started to dwindle. The National Health Care Development Agency is also to manage 45% of the fund to cover provision of essential drugs, vaccines, consumables, transport, equipment and maintenance of health facilities and human resources for primary health care.

The Federal Ministry of Health is to manage 5% of the fund for the provision of emergency medical treatment.

Administration of Criminal Justice Act (ACJ Act), 2015

The Nigeria criminal justice system experienced a boost in recent times with the passage of the Administration of Criminal Justice Act in 2015. The Act replaces the Criminal Procedure Act (CPA) and the Criminal Procedure Code (CPC). These laws have been operational since the colonial era and had become grossly inadequate in addressing various procedural issues, thereby encouraging massive abuse of human rights especially by the police. Many (including HIV positive persons) have been arrested and locked up unlawfully for civil litigation related issues. Many innocent persons have also been unlawfully arrested in lieu of offenders by the Police with the belief that the real offenders will show up if they realised that their loved ones have been apprehended.

The Act seeks to “promote efficient management of criminal justice institutions and speedy

dispensation of justice, protect the society from crime, and protect the rights and the interest of the defendant and the victim. The objectives of the ACJ Act are captured in section 1 of the Act. These indicate a deliberate shift from punishment as the main goal of criminal justice to restorative justice which pays attention to the needs of the society, the victims, vulnerable persons and human dignity.

The Act clearly reiterates the constitutional provision of the right to dignity of persons. Section 8(1) of the Act provides that: a suspect shall-

(a) be accorded humane treatment, having regard to his right to the dignity of his person.

(b) Not be subjected to any form of torture, cruel, inhuman or degrading treatment.

If properly implemented, the Act should change the landscape of criminal justice in Nigeria positively with a positive effect on the enjoyment of rights by HIV positive persons.

CASE LAW

Not many cases have been handled by the courts on issues relating to HIV/AIDS in Nigeria. The main case on employment related discrimination took 12 years to conclude during which period a lot transpired. This shows that between the time the case was instituted and the time judgment was reached, information on HIV have improved tremendously. However, it is difficult to describe a pattern of response by the court since the court has not been given the opportunity to try many cases. In the case of Georgina Ahamefule V. Imperial Medical Centre & Dr. Alex Molokwu (Suit No. ID/1627/2000), Georgina Ahamefule an auxiliary nurse at the Imperial Medical Center challenged the termination of her employment which was based on her HIV status. In 1995, while she was pregnant, she developed boils on her skin and sought medical attention from her employer Dr. Alex Molokwu, who conducted medical examinations and diagnostic tests without disclosing to her the nature and the outcome of the tests. Georgina tested positive for HIV and her employment contract was promptly terminated. The termination letter explained that the hospital's management could not compromise the facility or its patients by exposing them to risks associated with Georgina's HIV-positive status. Following the emotional and psychological trauma suffered by Georgina as a result of the news about her HIV-positive status and the loss of her employment, she had a miscarriage. Georgina was never provided any form of counseling either before or after the tests were carried out, even though both medical ethics and the law require such counseling to be conducted.

The Lagos State High Court ruled that the purported termination of the Plaintiff's employment is illegal, unlawful and actuated by malice and extreme bad faith. That the Defendants' action of subjecting the Plaintiff to HIV testing without her informed consent constitutes an unlawful battery on her. That the Defendants' action is not affording the Plaintiff pre-test and post-test counseling services constitute an unlawful negligence of a professional duty to the Plaintiff. That the Defendants' action in denying the Plaintiff medical care on grounds of her HIV-positive status constitutes a flagrant violation of the right to health guaranteed under article 16 of the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act CAP 10 Laws of the Federation of Nigeria and article 12 of the International Covenant on Economic, Social and Cultural Rights (ratified by Nigeria in 1993).

An order for five million Naira (N5,000,000) general damages was made for the wrongful termination of the Plaintiff's employment. An order for Two million Naira (N2,000,000) being compensation for unlawful conduct of HIV testing without the Plaintiff's informed consent and for the Defendants' negligence. This decision represents a major victory for Georgina and for all those living with the virus in Nigeria. It is also a major triumph of justice over illegality and unfairness. Being the first ever judicial pronouncement on the unlawfulness of HIV-based discrimination.

The case signifies a major victory over a legal battle that took 12 years to conclude. At the inception of the case, Justice Caroline O. Olufawo of Ikeja High Court 7 quashed the case on April 5, 2001. She had earlier disallowed Georgiana Ahamofe from appearing in her defense out of fear she would infect those in court with the virus!

NATIONAL HIV/AIDS RELATED POLICIES

National Policy on HIV/AIDS, 2009

The National Policy on HIV/AIDS is designed, among other things, to

'provide a framework for advancing the national multi-sectoral response to the HIV/AIDS epidemic in Nigeria so as to achieve control by reducing the rate of new infections, providing care and support for those infected and affected and mitigating the impact of the infection thereby enabling all people in Nigeria to be able to achieve socially and economically productive lives free of the disease and its effects'.

The goal is clear about reducing rate of new infections. Achieving this will require working closely and in an innovative manner with key populations. One of the core principles of the policy is the protection and promotion of the rights and access of PLHIV to comprehensive health care and other social services. It also commits the government to “protecting rights of PLHIV, reduction of stigma and discrimination and ensuring greater involvement of PLHIV in national HIV/AIDS program at all levels. Despite its progressive goals, there seems to be a disconnection between the provisions of the policy and the reality on ground. Despite the passage of the HIV and AIDS Anti- Discrimination Act, 2014 and the existence of similar law in nine states of the federation, this assessment reveals that such laws have not made any significant impact on the lives of People Living with HIV/AIDS in the States where such laws exists. It calls for concrete policy direction on efforts to build the capacity of Persons Living with and Affected by HIV/AIDS.

Workplace Policy on HIV/AIDS

The Federal Ministry of Labour developed a workplace policy on HIV/AIDS in 2005 and revised it in 2014 with a work plan developed alongside. The policy is aimed at guiding prevention of HIV/AIDS, response to its spread and management of its impact in the workplace.

It recognizes the fact that stigmatization of people living with HIV/AIDS is rife in the workplace. It however does not mention the issue of sexual harassment/exploitation as well as other forms of GBV that are rife in the workplace and can, in fact, contribute to the spread of HIV. Although gender

equality was stated as one of the key thematic areas of the policy, its reference to gender equality is limited to the involvement of male and female workers in policy formation, programme planning and implementation so as to capture the aspirations of vulnerable groups.

An important policy such as this should address the different written and unwritten practices that can fuel the spread of HIV in the workplace. GBV-related issues such as sexual harassment/exploitation are some of such. A workplace policy should be seen to encourage all employers of labour to have detailed strategies for HIV prevention in the workplace. Organizations should be encouraged to develop codes of conduct that discourage such practices and also have laid-down procedures that are known to all staff on how such cases would be handled should they arise.

National HIV/AIDS Research Policy 2010

This policy is designed to drive evidence-based interventions in the country. It recognizes the fact that earlier researches in the field of HIV/AIDS focused on 'epidemiology and prevention with little attention given to the social and human rights among other things'. The foreword to the policy was written by the Director General of NACA and it states among other things that the policy will be reviewed periodically. This provides a window of opportunity for advocating increased commitment to social researches focused on preventing HIV infection resulting from gender-based violence and other related issues.

The research priorities of the policy are classified into four groups i.e.

- basic clinical sciences, epidemiology and public health;
- social and behavioural sciences;
- economics, operations research, and health systems; and,
- policy, law, human rights and governance.

The section on Social and Behavioural Sciences looks at issues around behavioural interventions (which includes vulnerability reduction, behaviour change communication, knowledge and attitude), gender, sexual culture and HIV/AIDS (This includes issues around gender issues in sex work, same-sex sexual interactions, monogamy, abstinence, sexual values and sexual networks etc.), key populations (risk behaviour patterns and trends, uptake and service utilization etc.). The issue of GBV and strategies around male involvement in its prevention, although not expressly mentioned, fit into this section. Current trends in women and girls' vulnerability to HIV infection call for the need to pay serious attention to interventions that are based on evidence. It is important to understand the patterns of GBV in the country and what makes women and girls in one part of the country more vulnerable to HIV infection than others.

National Policy on HIV/AIDS for the Education Sector

The National Policy on HIV/AIDS for the education sector 2005 was designed to guide prevention activities, mitigate impact of HIV/AIDS on staff learners and their families within the education sector. The policy adopts a narrow perception of the gender dimensions of the epidemic, viewing it

as an issue for women and girls, whereas different gender issues now put men and boys at risk of the infection.

In articulating the sector's commitment to voluntary counseling and testing, the section 6.2.3 of the policy states that "HIV-related information in respect of student admission, staff employment, staff or their dependents and learners shall be kept strictly confidential". It is not clear here what the policy envisages by HIV information relating to admission, staff employment, etc. as this should not even be an issue for discussion. However, section 6.10.4 provides that no individual shall be denied employment or admission into schools based on their HIV status.

The policy highlights the government's commitment to the implementation of the Family Life and HIV/AIDS Education Curriculum and commits to producing, distributing and implementing same. The said curriculum had passed through a series of evolutionary stages and the time is ripe for a policy such as this to speak to directions for the future based on experiences of the past years of implementation.

The policy has a separate chapter dedicated to Gender Rights and Ethics. Without articulating the causes of gender discrimination it recommends 'strict disciplinary measures against perpetrators of physical and/or verbal abuse and harassment'. It also did not articulate the diverse approaches for addressing gender discrimination. The policy was developed 10 years ago when knowledge about the dynamics of issues relating to HIV were limited. The current situation of issues calls for a review of the policy in order for it to respond appropriately to the present day realities of the disease.

The National Policy on Rehabilitation of Persons with Disabilities

The National Policy on Rehabilitation of Persons with Disabilities is designed "to ensure that disability issues are on the agenda in all spheres of social, economic and political life". The policy seeks to enhance full participation of persons with disabilities in all domains of Nigerian society. It is not clear when the policy was developed as it is not dated.

Paragraph 1.3 of the policy identifies "Sexually Transmitted Diseases including AIDS" among others, as one of the causes of disabilities. Unfortunately, nowhere in the body of the policy was HIV further discussed as an issue for persons with disabilities. The policy expresses a narrow perspective of disability as it looks at it from the angle of physical disability alone. Clause 1.3 which lists causes of disability does not contain issues such as poverty as major causes of disability. In a place like Nigeria poverty is a risk factor for HIV infection and disability; therefore, it must not be overlooked.

The 'special targets' of the policy are older persons with disabilities, children with disabilities, women with disabilities and people with disabilities living in rural areas. Section 2.3.2 recognises the fact that children with disabilities are vulnerable to physical, sexual and emotional abuse. It however does not link this with vulnerability to HIV. The policy does not state what should be done to protect children with disabilities which here should include girls with disabilities.

Section 2.3.3 which articulates the issue of women with disabilities does not in any way highlight the challenges of women with disabilities in relation to GBV, HIV as well as their sexual and reproductive

health. These are areas of serious challenge for women with disabilities. For a policy to be seen to be responsive to the needs of women with disabilities these issues should be well-articulated and what needs to be done to address them clearly stated. There is no implementation plan attached to the policy other than the fact that each section in the policy has its objectives and the strategies for implementation. There is a need for a revised policy on persons with disabilities to address the challenge of vulnerability to GBV as well as HIV and the need to engage men and boys in charting the course for the protection of the rights of women and girls with disabilities.

National Gender Policy, 2015

The policy views HIV/AIDS as a serious cross-cutting issue among other issues such as participation, conflict and disaster, disability, violence against women, poverty and age. HIV is therefore integral to the enjoyment of the full rights of women and girls and must be resolved before women's empowerment can be achieved. Nigerian women and girls experience high levels of discrimination in both private and public spheres due to patriarchy. Addressing vulnerabilities is one of the priority objectives of the policy. It therefore seeks to promote efforts aimed at designing and tracking inclusive growth mechanisms that respond to the needs of vulnerable groups (in particular those living with disabilities, including those living with HIV/AIDS and terminal diseases. It also seeks to promote the development of programmes and projects that recognise the specific needs of vulnerable social categories (the physically challenged, the elderly, OVCs etc.) as well as track and manage gender issues associated with vulnerabilities.

Some of the targets of this objective are that all government agencies have HIV Workplace Policy and implementation strategies, ensure that at least 50% of MDA Programmes for women specifically target poor women in hard to reach communities, ensure that 60% of registered pensioners (male or female) receive their benefits without distress, implement social safety net for the aged (in at least 2/3 of the Nigerian 36 states), passage of the Act on the Rights of Persons with Disabilities not later than 2017, attention should be paid to the needs of children with learning disability, and federal and state governments should establish frameworks for targeting the needs of women, children and other vulnerable groups to cushion the effects of environmental impacts and climate change, natural disasters, and conflicts/insurgencies any time these occur.

If properly implemented, the barriers to the enjoyment of the rights of HIV positive women and men should be gradually removed with the resultant effect of improved conditions of living in the coming years.

Revised National Health Policy, 2004

The current National Health Policy is a revised version of the 1988 health policy. The revision was carried out following the need to address emerging issues and a better focus on trends and realities. It is designed to strengthen the national health system for the provision of effective, efficient quality, accessible and affordable health services that will improve the health status of Nigerians through the achievement of the health-related Millennium Development Goals (MDGs). Its main targets are the same as the health targets of the Millennium Development Goals, namely: reduce by two-thirds, between 1990 and 2015, the under-5 mortality rate, reduce by three-quarters, between 1990 and

2015, the maternal mortality rate, to have halted by 2015 and begun to reverse the spread of HIV/AIDS, to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases. The policy aligns well with the National Policy on HIV/AIDS. One of its key thrusts is review of existing legislation and enacting appropriate new laws for protection of rights of those living with HIV and those susceptible and vulnerable to the disease. It has as its objectives for national reproductive health the following: to reduce the incidence and prevalence of STIs including HIV infections, and to limit all forms of gender-based violence and other practices that are harmful to the health of women and children. It also seeks to reduce gender imbalance on available reproductive health services.

National Policy on Population for Sustainable Development (2004)

The policy is designed to “improve the standard of living and quality of life of the people, promote maternal child and reproductive health, achieve a lower population growth rate through the reduction of birth rates by voluntary fertility regulation methods compatible with the national policy to achieve even distribution of population between urban and rural areas, prevent the causes and spread of HIV/AIDS pandemic and address the problems of internal migration and spatial distribution of population”. The policy recognises that HIV/AIDS is a major threat to health status and the social economic conditions of the nation. It recognises that in order to proactively pursue sustainable development, the nation has to strategically address the challenges of HIV epidemic, gender inequality and women's reproductive rights among others. The policy identifies the following groups of people as those with special needs: nomads, elderly, persons with disabilities, refugees and displaced persons, youth and adolescents. Although it recognises that HIV is found in every part of the country with varying levels of prevalence, apart from young people, it does not pay particular attention to issues of key population.

The policy calls for legislation to eliminate all harmful practices including early marriage and female genital mutilation and violence against women. It calls for legislation aimed at protecting PLWHA and legislation to make unlawful the deliberate spread of HIV by infected individuals. The policy also seeks, among other things, to strengthen “efforts to control HIV/AIDS by addressing unsafe health care practices and drug abuse”. It is not clear how the connection between 'unsafe health care practices' and 'drug abuse' were pulled together in promoting efforts at stemming the spread of HIV.

In relation to issues of persons with disabilities, the policy recognises the fact that persons with disabilities have fundamental human rights that should be protected by the society.

National Policy on Protection and Assistance to Trafficked Persons in Nigeria and its Strategic Implementation Framework (2011)

The goal of the national policy on protection and assistance to trafficked persons in Nigeria (2008) is to ensure that victims of trafficking and exploitative/hazardous child labour are empowered to become functional members of the society. Its target groups are trafficked persons, victims of exploitative/hazardous child labour and other persons at risk (children, women and youth). Some of its objectives in this area are:-

- i. To ensure equitable access to comprehensive and qualitative health care services for all Trafficked Persons (TPs) irrespective of age, gender or other circumstances;
- ii. To provide adequate health information and communication services on reproductive health, HIV/AIDS, STIs, malaria, mental health, etc., all Tps;

The policy recognizes that victims of human trafficking are exposed to various health risks and abuse. This may result in health problems such as sexually transmitted infections (STIS), HIV/AIDS, and pelvic inflammatory disease etc.

It therefore seeks to promote the health rights of trafficked persons by providing non-discriminatory comprehensive and equal access to adequate health care services.

NATIONAL PLANS AND STRATEGIES

National Action Plan for the Promotion and Protection of Human Rights (NAP) 2009 – 2013

The National Action Plan is described as 'an integrated and systematic national strategy to help realise the advancement of human rights in Nigeria'. It consist of an audit of human rights situation in Nigeria, identifying areas in need of promotion and protection, as well as improvement. The nature of rights assessed in the document are civil and political rights, economic, social and cultural rights, right to sustainable development, peace and a protected environment, rights of women, children and young persons, and rights of persons with disabilities. Although the right to freedom from discrimination was mentioned under civil and political rights, no specific reference was made to the rights of people living with HIV/AIDS. There is a need for the process of review of the plan to take on the issue of people living with HIV/AIDS as a critical area of concern.

National HIV/AIDS Strategic Plan 2010 – 2015

The National HIV/AIDS Strategic Plan 2010-15 (NSF II) is a comprehensive plan developed with the contributions and participation of a wide spectrum of stakeholders. It has targets to halt and begin to reverse the spread of HIV infection, as well as mitigate the impact of HIV/AIDS, by 2015. With the condition that where appropriate, the targets of the NSP should be population-based, the Federal Government of Nigeria implicitly recognizes HIV care and treatment as a national public health good. To this effect, the NSF II was developed to provide direction and ensure consistency in the development of the strategic plans by all stakeholders including all the 36 states of the Federation and the Federal Capital Territory (FCT); Government Ministries, Departments and Agencies (MDAs); and the constituent coordinating entities of Civil Society Organization (CSOs) Networks. The NSF II, unlike the NSF 2005-2009 (NSF I), is linked to Universal and MDG targets and Vision 20:2020 and has an overriding emphasis on HIV prevention. The NSFII recently underwent a mid-term review, and the report is currently available. The findings of the MTR of the NSPII show that Nigeria is making some progress with respect to achieving a number of the UN general assembly targets. In particular, the country reports being on course to achieve targets 1, 5, 6, and 8.

National Strategic Health Development Plan (NSHDP) 2010–2015

The NSHDP (2010- 2015) is described as the first of its kind in the history of the Nigeria health care delivery system. It is designed to serve as the overarching all-encompassing reference document for action in health by all stakeholders to ensure transparency and mutual accountability for results in the health sector. The strategic goal of the health services delivery component of the Plan is to revitalize integrated service delivery towards a quality, equitable and sustainable health care. The plan is committed to improving the health status of Nigerians through the development of a strengthened and sustainable primary health care delivery system. It seeks to support the delivery of high impact interventions with one of its targets being to halt by 2015 and begin to reverse the spread of HIV/AIDS. It is worthy of note that the adult prevalence rate was 4.1 when the plan was developed and reduced to 3.1% in 2012 with the current rate being 3.4% (NARHS, 2012)

National Guidelines for HIV/AIDS Treatment and Care in Adolescents and Adults 2010

The document provides a framework for the delivery of safe and effective Anti-Retroviral Therapy (ART) backed by a comprehensive care and support package. The guidelines seek to ensure that the “management of ART in Nigeria remain modern and compatible with global best practice.” The 2010 National Guidelines is a revision of the 2007 guidelines. They provide comprehensive details of what constitutes the different aspects of treatment and care – ranging from pre-ART baseline assessment to criteria for initiating ART and Salvage Therapy which is the ART offered to PLWHA in response to failure of second line treatment and the non-response to available regimens. The Guidelines recommend the Highly Active Antiretroviral Therapy (HAART) for all persons who are eligible to ART.

National Guidelines for Prevention of Mother to Child Transmission, 2010

The guideline for PMTCT is a comprehensive document which addresses all components of a mother to child prevention programme. It provides implementation strategies for PMTCT Programme. The strategies to achieve the National PMTCT goal and objectives include:

- Offering of HIV testing and counselling for all pregnant women by ANC facilities as part of existing integrated reproductive health care services and shall include referrals for family planning counselling and other services when necessary.
- Provision of counselling on risks associated with the possible MTCT during pregnancy, delivery and breast feeding and adequate information to limit MTCT if the mother is HIV positive, including referrals for family planning services by all maternity facilities
- Prioritisation of nationwide access to ARVs for all HIV positive pregnant women and their babies
- Proper management of nutritional status of all HIV positive pregnant women and their children by all institutions offering antenatal care or child healthcare services
- Training of health care providers at all levels on PMTCT
- Integration of PMTCT into MCH services and Linkages with other Services HIV prevention particularly in young women and their partners

National Operational Plan for the Elimination of Mother to Child Transmission (eMTCT) of HIV in Nigeria 2015–2016

The Plan is designed to support the realisation of the global target of eliminating new HIV infections among children by 2015 and keeping their mothers alive. It is designed with the understanding that access to comprehensive PMTCT services could reduce the number of infected infants to 0–2% depending on the scope of service coverage. The eMTCT operational plan has been developed to address the implementation gaps of the 2010–2015 NSP and the PCRPP and to increase the momentum of PMTCT implementation towards the elimination goal. The priority areas of the plan are adolescent and young people, condom programming, integration of PMTCT and MNCH/FP interventions, Provider initiated counselling and Testing, Referral system strengthening, increased involvement of formal and non-formal private health services providers in PMTCT, Adherence and surveillance of ARV Drug Toxicity, Early infant diagnosis, Human Resources for Health M & E System for EMTCT, and procurement.

National Guidelines for HIV Counselling and Testing, 2011

This National Guidelines for HIV Counselling and Testing guides the practice of HIV counselling and testing and provide the minimum acceptable standards for the provision of HCT services in Nigeria. The Guidelines sets the minimum age for ability to give consent for the sake of having HIV test at 18 years. The Guidelines provide that “anyone aged 18 years or above and requesting HCT should be considered able to give full informed consent. A parent's or legal guardian's consent is required before testing of children below the age of 18 years. Young people below 18 years of age, that are married, pregnant, parents or sexually active, may be considered “mature minors” and should be able to grant consent for HIV testing. Counsellors should make an independent assessment of the minor's maturity to undergo an HIV test and ensure the availability of follow-up post-test support services”. The Guidelines' positive disposition to the ability of married minors to give consent for HIV test is in recognition of the widespread practice of child marriage in many parts of the country. However, this position contradicts many other laws and policies of government that condemns child marriage (e.g. the Child's Rights Act).

The Guidelines provide protection for children by given power to the counsellors to determine the reason for testing and reserve the right to refuse testing, if not in the best interest of the child. This is particularly useful in protecting the rights of young girls often used as house helps. A good example is where parents bring a child for testing in order to find out their own HIV status.

National HIV/AIDS Prevention Plan, 2014 – 2015

This National Prevention Plan (NPP) 2014-2015 is aimed at providing direction for the implementation of the Behaviour Change and Prevention of New HIV infections track of the 2010-2015 National HIV/AIDS Strategic Plan. It builds on the lessons learnt from previous national prevention plans, especially the NPP, 2010-2012. The plan is focused on evidence-based programming and standardization of approaches to HIV prevention in the country. It draws on the evolving evidence, the success of national and state level programmes, operational research

findings and the outcome of monitoring and evaluation of ongoing prevention programmes in the country'.

The plan focuses on addressing four thematic areas of HIV prevention: HIV Counseling and Testing (HCT), Prevention of Mother to Child Transmission of HIV (PMTCT), biomedical HIV prevention and prevention of sexual transmission of HIV. The NPP is designed to enhance access of PLHIV, key populations and other vulnerable groups to comprehensive programmes that address behavioural, biomedical and structural vulnerabilities. The NPP also address gender equality related factors that increase the vulnerability of women and girls to HIV, promote integration of services and evidence-based HIV programming. The priority interventions for target populations emphasize coverage, depth and quality of service provision as well as consider geographical variations in prevalence. It calls for increased attention to identified state priorities, including the engagement of the private health sector, private businesses and implementation of HIV workplace programmes.

Minimum Prevention Package Intervention Implementation Guide (MPPI), 2014

The MPPI is described as Nigeria's version of the combination prevention approach which is defined as 'the strategic, simultaneous use of different classes of prevention activities (biomedical, behavioural and structural) that operate on multiple levels (individual, community and structural) to respond to the specific needs of particular audiences and modes of HIV transmission, and to make efficient use of resources through prioritizing, partnership, and engagement of affected communities" (UNAIDS Prevention Reference Group Definition). The guide presents in tabular form the minimum services that should be accessible to the general population on one hand and MARPS on the other at different levels. The strategies prescribed under biomedical interventions to be targeted at MARPS are HCT, PMTCT, Condom and lubricant programming, STI Control and Treatment, as well as Harm Reduction intervention for IDUs. While the guide provides a further breakdown of what other strategies entail, it was however silent on harm reduction intervention for IDUs. It does not state what harm reduction constitute just as it did for other forms of interventions.

President's Comprehensive Response Plan for HIV/AIDS in Nigeria, 2013

This plan is aimed at accelerating 'the implementation of key interventions over a two year period to bridge existing service access gaps, address key financial, health systems and coordination challenges and promote greater responsibility for the HIV response at the federal and state levels'. The plan seeks to reach 80 million men and women aged 15 and above with HCT services; enroll an additional 600,000 eligible adults and children on ART, provide ART for 244,000 HIV pregnant women to prevent mother to child transmission of HIV; provide access to combination prevention services for 500,000 MARPs and 4 million young persons; and activate 2,000 new PMTCT and ART service centres.

The plan highlights the high rate of infection among young people and MARPS and seeks to apply the combination prevention approach and Minimum Prevention Package (MPP) as outlined in the National HIV Prevention Plan. Unfortunately, the MPP does not spell out what constitute harm reduction intervention for IDUs (a sub group of MARPS) which is one of the strategies for biomedical prevention activities under the combination prevention approach. Hence it is not clear what exactly this plan will do differently from what is in the National Strategic Plan especially as it concerns issues

of MARPS. Adopting a harm reduction strategy will require having a new orientation towards IDUs and legislation to back interventions in view of the sensitivity of the procedures involved.

The plan seeks to promote behaviour change by expanding school-based Family Life, HIV and AIDS Education (FLHE) and National Youth Service Corps (NYSC) program. Addressing the intersections between HIV and GBV requires involvement of all segments of the society and essentially paying particular attention to the role of men and boys and seeking to engage them in efforts at preventing violence and vulnerability to HIV. A seeming recognition of the importance of mainstreaming gender issues into the interventions addressed in the plan is the provision for the development of tools for gender mainstreaming within the section on Care and Support. This does not reflect commitment to the reduction of risks and vulnerability to HIV infection by women and girls.

The National Family Life and HIV/AIDS Education (FLHE) curriculum

The main goal of National Family Life and HIV/AIDS Education (FLHE) is the promotion of awareness and prevention of HIV/AIDS. It is designed: to assist individuals in having a clear and factual view of humanity; to provide individuals with information and skills necessary for rational decision making about their sexual health, and to change and affect behaviour on humanity (FMOE, 2003). The FLHE is designed to guide school based programme aimed at providing young people with knowledge, positive attitudes and skills to foster behaviour change and thus reduce their vulnerability to HIV/AIDS and other reproductive health complications. The FLHE programme is widely adopted (34 states), yet implementation (training, texts, teaching) remains very poorly-resourced despite national policy backing. Majority of the existing programmes are focused on young people in school and very few programmes target out-of-school adolescents, married adolescent girls, young people in especially difficult circumstances, or those in rural areas. One of the major criticisms of the programme as revealed during one of the Key Informant Interviews held in the course of this assessment, is in relation to government policy on integration of the FLHE curriculum into the core subjects offered in school. According to one of the key informants, “the idea of integration makes a mockery of the programme”. In essence there is no flow in the delivery of FLHE topics anymore.

CHAPTER VI

CONCLUSION AND RECOMMENDATIONS

CONCLUSION AND RECOMMENDATIONS

Law has been widely adjudged to be an instrument of social change as such the existence of good laws and policies is just a starting point or a pathway for a desire. An assessment of the legal environment for HIV response is necessary in order to ensure that laws and policies are actually in tandem with the change envisaged or desired for a population within periods in time. Such assessment helps to identify gaps in law and policy and points to actions necessary in order for progressive change to occur. The burden of HIV in Nigeria is huge calling for more innovative approach in order to curtail its spread. Good laws and policies can help to institutionalize human centered response on HIV that guarantees respect and protection for fundamental human rights of people infected and affected by the disease if they are implemented.

With a national response that is largely donor driven; a national health insurance scheme that is still at 'infant stage' after about 10 years of existence; a constitution that classifies socio-economic rights as rights that are ordinarily non justiciable, there is no guaranteed access to the enjoyment of health rights for HIV positive population and Nigerians generally.

The assessment reveals the availability of a wide range of laws and policies with implications for HIV/AIDS. It also reveals weak implementation of such laws and policies, often with negative implications for the enjoyments of the rights of people living with HIV/AIDS and especially key populations. There are in existence, old laws that predate the coming into being of the nation Nigeria e.g. law on prostitution. Such laws are no longer responsive to the current trends and emerging issues in the field that they are meant to regulate. Existing laws were found to be punitive, thereby driving underground different negative practices and denying key populations access to much needed services. To end AIDS, what is needed is nothing less than a social transformation, one that shifts from punitive approaches to evidence and rights-based response approaches. The negative attitudes towards men who have sex with men, FSWs and IDUs by community people, health practitioners and the law enforcement agents continues to have terrible impacts on efforts at controlling the spread of HIV. This calls for the need to work closely with the law enforcement agents towards changing their orientation especially as it pertains to how they handle the issues of FSWs, IDUs and MSM.

There is also the need to open up a national dialogue that will bring together professionals from different fields to develop an effective response to drug abuse and its implication for HIV/AIDS. The road map that emerges from such a process should be backed by law. The role of law as an instrument of change can be explored in the drive for adopting a right-based approach to meeting the needs of key populations in relation to HIV.

Some of the challenges impacting the enjoyment of rights by PLWHA and other key and vulnerable population are the presence of policy, regulatory barriers and practices that prevent engagement and recognition of these groups, increasing stigma and discrimination are threatening all efforts made at providing effective prevention, treatment, care and support for them. It will be expedient to partner closely with the NHRC in a bid to ensure a paradigm shift in the approach currently being

adopted to respond to issues of Key Populations. There is no better alternative to an approach based on respect for fundamental human rights and the NHRC is rightly positioned for promoting such idea which is ordinarily part of its mandate.

The high level of apathy exhibited in relation to the quest for justice by PLWHA calls for the creation of accessible legal support systems for HIV infected and affected persons. It also calls for the need to strengthen the judiciary especially at the level of the lower courts (e.g. customary and magistrate courts) where poor HIV positive women and men are likely to engage with the judicial system.

The culture of silence associated with sexual and reproductive health issues, age restriction on access to health services for young people as well as the paucity of youth friendly service centres across the country continue to exacerbate young people's vulnerability to HIV infection. Realizing the goal of the National Policy on HIV/AIDS will require that particular attention be paid to the needs of young people, a group, which incidentally constitute a considerable proportion of the nation's population.

The assessment reveals the need for research on the conditions of Key populations that are in the prisons. For any effective planning to take place, there is a need for evidence that will drive plans and decisions.

Often, Women with Disabilities (WWDs) are invisible both among those promoting the rights of persons with disabilities, and those promoting gender equality and the advancement of women. There is a need therefore, to take them into account through mainstreaming their issues in the national HIV/AIDS response/NSP. There is a need for the development of indicators that disaggregate data and captures peculiar issues of vulnerable populations in a distinctive manner. This will aid monitoring so that concrete and targeted steps can be taken towards creating an enabling legal and social environment that can steer transformation.

Furthermore, in order for concrete progress to be made in ensuring that people living with and affected by HIV/AIDS enjoy their fundamental human rights, the assessment also highlights the need for the following:

- Funding of the State Agencies for the Control of HIV/AIDS to be backed by law in respective states
- Training and retraining of health care providers both in public and private facilities to enhance quality and friendly service provision
- Sensitization, community mobilization for popularization of the provisions of the Anti-Discrimination Act and the State level corresponding laws including interpretation of laws in local languages
- Sensitization of the Police, National Assembly, Key Population and members of the public on the provisions and implications of the Same Sex Marriage (Prohibition) Act
- Legal literacy of the key populations on their own rights and how to pursue actualization of such rights
- Legal literacy for the judges, parliamentarians (on the supply side)

- Engagement of the bar for pro-bono legal services e.g. FIDA
- Capacity Development of law enforcement agencies – police on sexual diversity and human rights based approach
- NACA to constitute and institutionalize a Human Rights Response Team (a Watch Group) with representatives from different strategic stakeholders as members for effective response to human rights abuse
- HIV/AIDS Desk at the NHRC for documentation, monitoring and follow up of human rights abused, violations of PLHIV
- HIV/AIDS Desk at the Legal Aid Council at the national and state level for easy access to justice for People Living with and Affected by HIV/AIDS
- The review process of the National Action Plan for the Promotion and Protection of Human Rights (NAP) 2009 – 2013 should take on the promotion of the rights of people Living with HIV/AIDS and Key Populations as a critical area of concern
- Economic empowerment of PLHIV
- Accelerate implementation of the National Health Insurance Scheme especially for the informal sector
- Capacity Development for Health care providers (Public and Private) on human rights based approaches to public health as it affects PLHIV and Key populations
- Greater involvement of PLHIV and Key populations in the coordinating entities at federal and state levels for effective response
- Develop national action plan on LEA with clear accountability framework that spelt out the roles and responsibilities of all stakeholders
- Commitment to processes of empowerment of women and girls should be prioritised at all levels of programming and governance.
- Increased attention to the issue of access to healthcare services by Key Population (MSM, FSW, IDU)
- Guidelines on the protection of the rights of intending couples within Churches/ Mosques
- Integration of the recommendations in the Gender and Human Rights component of the National Strategic Plan on HIV/AIDS 2016-2020

There is no doubt that reversing the trends of the epidemic will require gender sensitive and high-level political commitment in a variety of ways, including legal reforms, design and implementation of progressive policies, plans and strategies.

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<http://www.ncbi.nlm.nih.gov/pubmed/23330152>

APPENDIX 1

S/NO	STATE	STATE LAW IMPACTING HIV/AIDS	STATE POLICIES IMPACTING HIV/AIDS
	Akwa Ibom State	<ul style="list-style-type: none"> Akwa Ibom State Law to prohibit certain obnoxious traditional widowhood practices and rites and for other matters connected thereto, 2012 	
	Anambra State	<ul style="list-style-type: none"> Anambra State Malpractices against Widows and Widowers (Prohibition) Law No. 2005 Anambra State Gender and Equal Opportunities Commission Law, 2007. 	
	Bayelsa State	<ul style="list-style-type: none"> The Female Genital (Prohibition) Law, Bayelsa State, 2000 	
	Benue State	<ul style="list-style-type: none"> People Living with HIV/AIDS (anti-stigmatization and discrimination) Law, 2013 of Benue State 	<ul style="list-style-type: none"> Benue State Workplace Policy on HIV/AIDS 2008
	Ebonyi State	<ul style="list-style-type: none"> <i>Ebonyi State Domestic Violence and Related Matters Law, Law No 003 of 2005</i> HIV/AIDS Anti-discrimination and protection Law, 2012 	
	Edo State	<ul style="list-style-type: none"> Edo State Female Circumcision and Genital Mutilation (Prohibition) Law No.4 of 1999 	
	Ekiti State	<ul style="list-style-type: none"> Ekiti State HIV and AIDS law (Anti – discrimination and other related matter, 2014.) Ekiti State gender- based violence (Prohibition Law 2011) Ekiti State child Rights Law Ekiti State female genital mutilation law Ekiti State harmful widowhood rites prohibition law 	<ul style="list-style-type: none"> Ekiti State gender development policy, 2011 Ekiti State HIV/AIDS workplace policy, 2007
	Enugu State	<ul style="list-style-type: none"> Enugu State HIV/AIDS Anti-Discrimination and Protection Law, 2007 	

	Jigawa State	<ul style="list-style-type: none"> • Jigawa State Gender Policy, A Holistic Approach Towards Women Development, May 2013 	
	Kaduna State	<ul style="list-style-type: none"> • A Law to Protect Persons Living with HIV/AIDS 	
	Lagos State	<ul style="list-style-type: none"> • Lagos State Protection Against Domestic Violence Law 2007 • Lagos State Administration of Criminal Justice Law, 2011 • Lagos State Protection of People Living with HIV and Affected by AIDS Law 2007 • A Law to Provide Rules on Criminal Conduct, Regulate Public Order and for Connected Purposes, 2011, Lagos State • Lagos State Same Sex (Prohibition) Law 2007; 	
	Ondo State	<ul style="list-style-type: none"> • Anti-Stigma and Discrimination Law 	
	RIVERS State	<ul style="list-style-type: none"> • Rivers State Abolition of Female Circumcision Law, No. 2 of 2001 • Rivers State Dehumanizing and Harmful Traditional Practices Law, No. 2 of 2003 • Rivers State Reproductive Health Services Law, No. 3 of 2003 • Rivers State Prevention of HIV (through blood transmission) Law, No 4 of 2004 • Rivers State Employee with HIV/AIDS Non-Discrimination Law, No 3 Of 2005 • Rivers State Agency for the control of AIDS law, No. 4, 2009. • Rivers Sate Child Right Law, No 10 of 2009. 	
	Nasarawa State	<p>Nasarawa State Law to Prevent all forms of Stigma and Discrimination and Give Protection, access to Justice, Support and Care for all Persons Living with and affected by HIV/AIDS</p>	Nasarawa State Workplace Policy on HIV/AIDS, 2010

	Ogun State	Law Prohibiting all forms of Stigmatisation and Discrimination against Persons Living with HIV/AIDS in Ogun State	
	Oyo State	Oyo State Agency for the Control of AIDS on 25th November, 2010	

APPENDIX 2

LIST OF IDENTIFIED NATIONAL LAWS, CONVENTIONS, POLICIES, PLANS AND GUIDELINES RELATED TO HIV/AIDS

S/NO	LEVEL OF LEGISLATION	NAME OF LEGISLATION
	CONSTITUTION	The Constitution of the Federal Republic of Nigeria, 1999
	NATIONAL LEVEL	<ul style="list-style-type: none"> • The Police Act, 1943 • Criminal Code CAP C38 • Penal Code Law, cap 89, Laws of the Federation of Nigeria (LFN), 1963. • National Human Rights Commission (NHRC) Act, 1995 • Child's Rights Act, 2003 • The Trafficking in Persons (Prohibition) Act, 2003 establishing the National Agency for the Prohibition of Trafficking in Persons (NAPTIP) • <i>African Charter on Human and People's Rights (Ratification and Enforcement) Act, Cap A9, 2004 Laws of the Federation</i> • The Trafficking in Persons (Prohibition) Law Enforcement and Administration (Amendment) Act, 2005 • Fundamental Human Rights Enforcement Procedure Rules, 2009 • <i>Legal Aid Act, 2011</i> • <i>Same Sex Marriage (Prohibition) Act, 2013</i> • The National Health Act 2014 • An Act to make Provision for the Prevention of HIV Discrimination and to Protect The Human Rights and Dignity of People Living with HIV and Affected by AIDS and Other Related Matters, 2015 • Administration of Criminal Justice Act, 2015 • Violence Against Persons Prohibition Act, 2015
	INTERNATIONAL CONVENTIONS/DECLARATIONS	<ul style="list-style-type: none"> • UN Declaration on HIV/AIDS • Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), 1979 • International Covenant on Economic and Socio Cultural Rights (ECOSOC) • International Covenant on Civil and Political Rights (ICCPR) • The UN Convention on the Rights of Persons with Disabilities, 2008
	REGIONAL CONVENTIONS	<ul style="list-style-type: none"> • The African Charter on Human and Peoples' Rights in Africa, 1986 • Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2005) • The African Charter on the Rights and Welfare of the Child, (1990)
	POLICIES (NATIONAL LEVEL)	<ul style="list-style-type: none"> • National Policy on Maternal and Child Health – Federal Ministry of Health, (1994) • National Reproductive Health Policy and Strategy – Federal Ministry of Health, (2001) • National Policy and Plan of Action on Elimination of Female Genital Mutilation in Nigeria (2002). • National Workplace Policy on HIV/AIDS, April 2005 • National Gender Policy, 2006 • National Policy on Protection and Assistance to Trafficked Persons in Nigeria,

		<p>2008</p> <ul style="list-style-type: none"> • National Policy on HIV/AIDS-Federal Ministry of Health, (2009) • Gender policy for the Nigeria Police Force - Nigeria Police Force, September 2012 • The National Policy on the Health and Development of Adolescents and Young People in Nigeria (which is a revised version of the National Adolescent Health Policy (1995)
	PLANS AND GUIDELINES	<ul style="list-style-type: none"> • National HIV/AIDS Strategic Framework 2010 – 2015 • National HIV/AIDS Strategic Plan • Annual State Strategic Plans of State Agencies for the Control of AIDS • National Strategic Framework on the Health and Development of Adolescent and Young People in Nigeria –Federal Ministry of Health (2007-2011) • National Strategic Health Development Plan (NSHDP) 2010 – 2015 • National Gender Policy Strategic Implementation Framework and Plan, 2008 • National Action Plan for the Promotion and Protection of Human Rights (NAP) 2009 – 2013 • National Guidelines for HIV/AIDS Treatment and Care in Adolescents and Adults 2010 • National Guidelines for Prevention of Mother to Child Transmission, 2010 • National Operational Plan for the Elimination of Mother to Child Transmission (eMTCT) of HIV in Nigeria 2015–2016 • National Guidelines for HIV Counselling and Testing, 2011 • National HIV/AIDS Prevention Plan, 2014 – 2015 • Minimum Prevention Package Intervention Implementation Guide (MPPI), 2014 • President’s Comprehensive Response Plan for HIV/AIDS in Nigeria, 2013 • The National Family Life and HIV/AIDS Education (FLHE) curriculum
	CONSENSUS DOCUMENT	<ul style="list-style-type: none"> • International Conference on Population and Development (ICPD), 1994 • Beijing Platform of Action, 1995 • Millennium Development Goals, 2000

APPENDIX 3

SOME OFFENCES WITH IMPLICATIONS FOR THE SPREAD OF HIV UNDER NIGERIAN LAW

S/NO	SEX RELATED OFFENCES UNDER NIGERIA LAW	LEGAL PROVISION	PUNISHMENT
1.	Procurement of a woman or girl for prostitution in or outside Nigeria	Criminal Code, 1916 Section 223(2)	2 Years
2.	Pimping by males only	Criminal Code, 1916 Section 225 (a)	2 years at first instance and upon subsequent convictions whipping will be added to “any term of imprisonment” imposed.
	Pimping by females	Section 225 (4)	2 years
3.	Administering drugs to a woman for her to submit to sex with a man	Criminal Code, 1916 Section 224	2 years
4	Encouraging prostitution of women	Penal Code, 1960 Section 276	10 years maximum or fine
5	Enticement of girls below 16 or boys below 14 into prostitution without consent of guardian	Penal Code, 1960 Sections 271, 272, 273	10 years and a fine
6	Procurement of minor girls for illicit intercourse	Penal Code 1960 Section 275	10 years and a fine
7	Kidnapping	Penal code, 1960 Section 274	10 years and a fine
8	Sexual intercourse with a child	CRA Sections 31, 32	14 years
9	Inducement of a child to leave home	Child Rights Act, 2003 Section 47	3 years or fine
10	Sexual Abuse	Child Rights Act, 2003 Section 31,32	14 years
11	Marrying a child; betrothal of a child, marriage, promoting child marriage, to whom a child is betrothed	Child Rights Act, 2003 Section 21 – 23	N500,000 fine or 5 years imprisonment or both
12	Rape	Criminal Code Section 357, 358	Life Imprisonment
13	Indecent Assault on females	Criminal Code Section 360	2 years
14	Rape	Penal Code Section 282	14 years with fine
15	Abduction	Penal Code Section 255, 259	2 years
	Wrongful restraint	Section 256	1 month Imprisonment or Fine

16	Abduction (under sixteen) For Immoral purpose	Criminal Code Section 362 Section 361	2 years 7 years
17	Human Trafficking	Penal Code Section 278	10 years with Fine
18	Trafficking in Women	Penal Code Section 281	7 years with Fine
19	Kidnapping	Penal Code Section 260	3 years with Fine
17 339 and 340	Kidnapping Compelling Action By Intimidation By Assault	Criminal Code Section 364 Section 366 Section 367	10 years 1 year 5 years
18	Child stealing	Criminal Code Section 371	14 years
19	Abandoning children	Criminal Code Section 341	5 years
20	Acts done with intention to endanger a child's health (under sixteen)	Criminal Code Section 339, 340	3 years

APPENDIX 4

LIST OF RESPONDENTS

S/N	Name	Organization	Email
1	David Owolabi	UNDP	david.owolabi@undp.org
2	Udo Amarachi Esther	Heartland Alliance	luvliamra@yahoo.com
3	Paul Umoh	Heartland Alliance	pumoh@heartlandalliance.org
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5	Adeolu Aiyewumi	NACA	aaiyewumi@naca.gov.ng
6	Moses Okpara	NYNETHA	mosesokpara@yahoo.com
7	Adamu S.W.	FMWA&SD	adamsam67@yahoo.com
8	Zubaida Abubakar	UNFPA	zabubakar@unfpa.org
9	Charles-Martin Jjuuko	UNAIDS	jjukoc@unaid.org
10	Bernardo Cocco	UNDP	bernardo.cocco@undp.org

S/N	Name	Organization	Sector Represented
1	Prof. Ayo Atsenuwa	University Of Lagos	Academia
2	Fatima Shamaki	National Human Rights Commission	MDA
3	Mr F. K. Bebu	Federal Ministry Of Justice	MDA
4	Dr. Uche Okoro	FCT SACA	MDA
5	Dr. Segun Ogboye	LSACA	MDA
6	Dr. Nwammadu	IMO SACA	MDA
7	Mr. Benjamin Mbakwem	Community and Youth Dev. Initiatives (CYDI), Owerri.	CSO
8	Dr. Akannumu	Imo Specialist Hospital	MDA
9		Women with Disability	
10	Mrs Toyin Towobola	Women Protection Organisation, WOPO	CSO
11	Mr. Gabriel Ndelikwo	UNAIDS	UN Agency
12	Mianko Ramaroson	UNAIDS	UN Agency
13	Mr. Gunashekar R.	UNODC	UN Agency
14	Dr. Olayinka Falola - Anoemuah	NACA	MDA
15	Margaret Onah	Safehaven Development Initiative	CSO

GROUPS AND ORGANISATIONS THAT PARTICIPATED IN THE FGDs AND IDIs CONDUCTED IN THE COURSE OF DATA GATHERING

A. FGDs

1. Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) (In Lagos and Owerri)
2. Group of men living with HIV in Abuja
3. Association of Women Living with HIV/AIDS in Nigeria (ASWHAN) – In Abuja and Owerri
4. Group of women living with HIV in Lagos
5. Youth Network on HIV/AIDS (NYNETHA) – National – Abuja, Lagos and Owerri
6. Group of Young People (Female) – Abuja, Lagos and Owerri
7. Group of Young People (Male) – Abuja, Lagos and Owerri
8. Civil Society for HIV/AIDS in Nigeria (CisHAN) - Abuja, Lagos and Owerri
9. Group of Brothel Based Female Sex Workers in Lagos and Owerri
10. Group of MSM at an Abuja Based Facility.

B. IDIs

1. Group interview with female sex workers and MSM – Abuja
2. Individual interviews with men who have sex with men (MSM) in Lagos and Owerri
3. Individual interviews with People who inject drugs Abuja, Lagos and Owerri

C. LIST OF ORGANISATIONS THAT PARTICIPATED IN THE VALIDATION WORKSHOP

1. National Human Rights Commission, Abuja
2. International Federation of Women Lawyers (FIDA, Abuja)
3. Network of People Living with HIV/AIDS in Nigeria (NEPWHAN)
4. Association of Women Living with HIV/AIDS in Nigeria (ASWHAN)
5. National Planning Commission, Abuja
6. Legal AID Council, Abuja
7. Federal Ministry of Women Affairs and Social Development
8. Youth Network on HIV/AIDS in Nigeria (NYNETHA)
9. National Agency for the Control of AIDS (NACA)
10. Federal Ministry of Health, Abuja
11. Federal Ministry of Justice, Abuja
12. United Nations Development Programme (UNDP)
13. Centre for Women's Health and Information
14. Federal University, Ikwo, Ebonyi State
15. National Association of Women Journalists (NAWOJ), Abuja
16. AIDs Healthcare foundation (AHF) Abuja
17. International Center for Advocacy on Rights to Health, ICARH, Abuja
18. HIV Advocacy Network, (HAN)