

# A rights-based approach to access to HIV treatment in Nigeria

*Ebenezer Durojaye\**

Attorney, Centre for the Right to Health, Lagos, Nigeria

*Olabisi Ayankogbe\*\**

Lecturer, Nigerian Law School, Lagos, Nigeria

## Summary

*This article focuses on the right to health under international and regional human rights instruments and issues affecting access to HIV/AIDS treatment in Nigeria. Although the Constitution of Nigeria does not recognise the right to health, Nigeria has ratified international and regional human rights instruments which guarantee the right to health as a fundamental human right. Arguing that access to treatment is a fundamental right, the authors focus on factors militating against access to treatment in Nigeria, such as the high cost of drugs, poor facilities in the health care sector, lack of respect for patients' rights, and stigma and discrimination associated with HIV/AIDS. A comparative analysis with other countries, such as South Africa, and possible suggestions for the way forward are then made.*

## 1 Introduction

For millions of people living with HIV/AIDS (PLWHA) worldwide, access to treatment is of utmost importance. Of the over 39 million PLWHA in the world, only a handful have access to treatment. Most PLWHA are found in sub-Saharan Africa — a continent that is already weakened by severe poverty, a wide-spread lack of education and the presence of other diseases. Millions of people are faced with death from opportunistic infections, such as tuberculosis, pneumonia, meningitis or other

---

\* LLM candidate (Free State); ebenezer1170@yahoo.com

\*\* LLM (Lagos); bisayanks@yahoo.com. The authors are grateful to Prof Charles Ngwena of the University of the Free State for his inspiration and suggestions during the preparation of this article.

severe diseases which their immune systems are unable to fight against.<sup>1</sup> Already millions have died as a result of these diseases. Most of the deaths could have been avoided had the appropriate drugs and needed expertise to monitor the diseases been available. Undoubtedly, providing treatment to PLWHA is an essential aspect of mitigating the impact of the epidemic on our society.

Access to treatment in the context of HIV/AIDS relates to the presence of care, the provision of painkillers, treatment of opportunistic infections and the availability of anti-retroviral drugs (ARVs), which help in suppressing the effect of the virus on the immune system. Although these drugs do not cure HIV/AIDS, they dramatically improve the rates of mortality and morbidity, prolong lives, improve quality of life, revitalise communities and transform perceptions of HIV/AIDS from a plague to a manageable chronic disease.<sup>2</sup>

However, as important as these drugs are, it is sad to note that in resource-limited countries, the majority of people who need them hardly ever have access to them. According to the World Health Organisation (WHO), most of the over 30 million PLWHA in developing countries do not have access to these drugs. The WHO states further that, of the six million people in dire need of anti-retroviral drugs in the developing world, only about 230 000 people have access, half of whom are from Brazil.<sup>3</sup> But this situation is not limited to anti-retroviral drugs alone. It is also true that in developing countries, access to mere palliative care and vitamins, which help in the treatment of opportunistic infections, is denied to the majority of people. Thus, millions of lives continue to be wasted to HIV/AIDS in developing countries, especially in sub-Saharan Africa.

In developing countries, access to HIV/AIDS treatment is difficult due to various reasons, such as the lack of political will or commitment, poor economic conditions and a lack of appropriate distribution mechanisms. Aside from these problems, two other important factors stand out: a lack of infrastructure in health care institutions such as inadequate health facilities, a lack of beds and laboratories, a lack of qualified personnel, poor funding and the high cost of anti-retroviral drugs and other medications occasioned by patent rights enjoyed by manufacturers of drugs in developed countries.<sup>4</sup> Also, discriminatory attitudes of health care workers to PLWHA often contribute to a lack of access to treatment. This situation therefore has raised critical issues as to the right to health of PLWHA, as guaranteed under international and regio-

---

<sup>1</sup> PANOS *Beyond our means? The cost of treating HIV/AIDS in the developing world* (2000).

<sup>2</sup> World Health Organisation *Scaling up anti-retroviral therapy in resource-limited settings. Guidelines for a public health approach* (2002).

<sup>3</sup> As above.

<sup>4</sup> See PANOS (n 1 above).

nal human rights instruments, including the domestic laws of countries. In a human rights context, access to treatment places legal obligations on states to ensure easy access to health facilities and goods, including essential drugs, particularly life-saving drugs, to treat pandemics such as HIV/AIDS. It is the aim of this paper to reaffirm that health is a human right and that the denial of access to treatment is a violation of human rights recognised by human rights instruments.

This article focuses on the right to health under international and regional human rights instruments and on issues affecting access to HIV/AIDS treatment in Nigeria. We will argue that access to treatment is a fundamental right and investigate factors militating against access to treatment in Nigeria, such as the high cost of drugs, poor facilities in the health care sector, lack of respect for patients' rights, and stigma and discrimination associated with HIV/AIDS. A comparative analysis with other countries, such as South Africa, will be undertaken.

## 2 The right to health

This right has been recognised ever since the birth of the United Nations (UN) in 1945. The Charter of the UN urges state parties to respect rights to a higher standard of living and solutions to international health problems.<sup>5</sup> Article 25(1) of the Universal Declaration of Human Rights (Universal Declaration) provides that 'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services'.<sup>6</sup> Although the Universal Declaration is not a treaty, it has been widely accepted as an authoritative document on human rights worldwide. In short, some of the norms set out in the Universal Declaration constitute part of customary international law.<sup>7</sup> However, it has been held that the right to health is 'insufficiently definite to constitute rules of customary international law'.<sup>8</sup>

The International Covenant on Economic Social and Cultural Rights (CESCR), in which appears the most comprehensive provision on this issue, provides as follows:<sup>9</sup>

---

<sup>5</sup> Art 55 Charter of the United Nations.

<sup>6</sup> Universal Declaration of Human Rights, GA Res 217 A (III) (10 December 1948).

<sup>7</sup> JP Humphrey 'The Universal Declaration of Human Rights: Its history, impact and juridical character' in BG Ramcharam (ed) *Human rights: Thirty years after the Universal Declaration* (1979) 21-28.

<sup>8</sup> *Flores v Southern Peru Copper Corporation* US Court of Appeal Second Circuit 343 F 3d 140 (2003).

<sup>9</sup> Art 12 CESCR, adopted 16 December 1966; GA Res 2200 (XXI), UN Doc A/6316 (1966) 993 UNTS 3 (entered into force 3 January 1976).

- 1 The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
- 2 The steps to be taken by States Parties to the present Covenant to achieve the full realisation of this right shall include those necessary for:
  - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
  - (b) The improvement of all aspects of environmental and industrial hygiene;
  - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
  - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

This provision is wide and all-embracing, placing an obligation on state parties to ensure that they take active steps towards realising the contents of the provision. It is similar to that contained in the Preamble to the Constitution of the WHO.<sup>10</sup> The Constitution of the WHO gives a comprehensive and detailed explanation of the nature of the right to health:<sup>11</sup>

Health is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of all human beings without distinction as to race, colour, and religion.

In addition to these instruments, article 24 of the Convention on the Rights of the Child (CRC)<sup>12</sup> and article 12 of the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW)<sup>13</sup> contain important provisions on the right to health.

Recently, the UN Committee on Economic Social and Cultural Rights (Committee on ESCR) explained that:<sup>14</sup>

The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.

It is to be noted that the right to health is linked to other rights such as the right to life, human dignity and freedom from discrimination. Leary

<sup>10</sup> The Constitution of the WHO was adopted by the International Health Conference, New York, 19-22 June 1945; opened for signature on 22 July 1946 by the representatives of 61 states; 14 UNTS 185.

<sup>11</sup> As above.

<sup>12</sup> Convention on the Rights of the Child, GA Res 25 (XLIV), UN GAOR Supp No 49 UN Doc A/RES/44/25 1989.

<sup>13</sup> Convention on the Elimination of All Forms of Discrimination Against Women, GA Res 54/180 UN GAOR 34th Session Supp No 46 UN Doc A/34/46 1980.

<sup>14</sup> The Right to the Highest Attainable Standard of Health, UN Committee on ESCR General Comment No 14, UN Doc E/C/12/2000/4 para 38.

argues that the right to health presupposes that fundamental principles of human rights, such as dignity, non-discrimination, participation and justice are relevant to issues of health care and health status.<sup>15</sup> Thus, a denial of treatment to a person because of his or her HIV status will have an impact on his or her right to human dignity, right to non-discrimination and right to life.<sup>16</sup> In the Vienna Declaration and Programme of Action of 1993,<sup>17</sup> it is reaffirmed that all human rights are universal, interdependent, interrelated and indivisible. The UN Human Rights Committee suggested that the right to life in article 6 of the International Covenant on Civil and Political Rights (CCPR) should not be given a narrow interpretation, but should be seen to affect other rights, such as the right to housing, food and medical care.<sup>18</sup> Mann notes that nearly every article contained in human rights documents has the propensity to impact upon the enjoyment of the right to health.<sup>19</sup>

The content of the right to health is summarised by the General Comment No 14 of the UN Committee on ESCR in this way:<sup>20</sup>

[T]he right to health must be understood as the right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health.

It identifies four key elements of the right, namely, availability, accessibility (including affordability), acceptability and quality.<sup>21</sup> Availability relates to making health facilities and goods available in sufficient quantities. Accessibility has four important aspects, namely, non-discrimination, physical accessibility, economic accessibility and information accessibility. Acceptability relates to the provision of health services that are culturally and ethically acceptable to all, while quality implies that health services of good quality must be provided for all.

In addition to the various international treaties mentioned above, the right to health is contained in regional human rights instruments. For example, the African Charter on Human and Peoples' Rights (African Charter),<sup>22</sup> in its article 16, provides that everyone has the right to enjoy the best attainable state of physical and mental health. Similar provisions exist in the European Social Charter and the Additional Protocol to

<sup>15</sup> V Leary 'The right to health in international human rights law' (1994) 1 *Health and Human Rights* 27.

<sup>16</sup> General Comment No 14 (n 14 above).

<sup>17</sup> Vienna Programme of Action UN Doc A/CONF 157/24 Part 1 ch III.

<sup>18</sup> 'The right to life' UN GAOR Human Rights Committee 37th session Supp No 40.

<sup>19</sup> JM Mann *et al* 'Health and human rights' (1994) 1 *Health and Human Rights* 6-23.

<sup>20</sup> General Comment No 14 (n 14 above) para 9.

<sup>21</sup> n 14 above, para 12.

<sup>22</sup> African Charter on Human and Peoples' Rights OAU Doc CAB/LEG/67/3/Rev 5, adopted by the Organisation of African Unity, 27 June 1981, entered into force 21 October 1986.

the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights.<sup>23</sup>

At the domestic level, provisions on the right to health exist in about 60 national constitutions, though many of them as directive principles,<sup>24</sup> thereby rendering the right to health non-justiciable.

### 3 Human rights and access to treatment

It is generally agreed that access to treatment is an integral part of the right to health. A lack of access to medication, especially life-saving medication, will adversely affect a person's physical and mental well-being. Besides, it has been held that a deportation of a person at an advanced stage of AIDS to his or her country of origin, where access to treatment will not be assured, amounts to cruel, inhuman and degrading treatment.<sup>25</sup> The UN Committee on ESCR observes that:<sup>26</sup>

The right to health is closely related to and dependent upon the realisation of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.

The Committee on ESCR further states that the right to health has imposed upon nations obligations to respect, protect and fulfil the right. It explains that the obligation to respect requires states to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect the right requires states to take measures that prevent third parties from interfering with the right, while the obligation to fulfil the right requires states to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right to health. This should include a comprehensive national health policy aimed at realising the right to health and efforts to enable the citizens to enjoy the right to health.<sup>27</sup>

<sup>23</sup> Art 11 European Social Charter and art 10 Protocol to the American Convention on Human Rights.

<sup>24</sup> See The Right of Everyone to the Highest Attainable Standard of Physical and Mental Health, Report of the Special Rapporteur, P Hunt, submitted in accordance with Commission Resolution 2002/31 UN ESCOR 59th session UN DOC ECN 6/2003/58 (2003).

<sup>25</sup> *D v United Kingdom* (1997) 24 EHRR 423 European Court of Human Rights.

<sup>26</sup> General Comment No 14 (n 14 above) para 3.

<sup>27</sup> n 14 above, para 36.

In addition, the International Guidelines on HIV/AIDS and Human Rights in its revised guidelines 6 provides as follows:<sup>28</sup>

States should enact legislation to provide for the regulation of HIV related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information and safe and effective medication at an affordable price.

States should also take measures necessary to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related technologies for preventive, curative and palliative care of HIV/AIDS and related opportunistic infections and conditions.

Recently, some decisions of domestic courts seem to support the assertion that a denial of the right to health may impact negatively on the right to life. For example, the Indian Supreme Court held that a denial of the right to emergency medical care constitutes a violation of the right to life guaranteed under the Indian Constitution.<sup>29</sup> Also, the Supreme Court in Costa Rica held that a denial of access to life-saving medication for people infected with HIV/AIDS infringes their right to life.<sup>30</sup>

It is clear from the above that a denial of access to treatment to a PLWHA will be tantamount to a violation of the right to life and other human rights recognised under international and regional human rights instruments.

Despite this array of laws on the right to health, PLWHA still encounter violations of their rights, particularly with regard to access to treatment in many developing countries. The right to health, being a part of social and economic rights, faces the challenges, under domestic laws, of non-justiciability and a lack of resources. A failure to respect the human rights of PLWHA causes them to run underground, thereby avoiding treatment or seeking help when they need it, thus conversely fuelling the spread of the epidemic within a society.

## 4 The situation in Nigeria

### 4.1 Background

The first clinical case of HIV was reported in Nigeria in 1986.<sup>31</sup> Ever since this, the epidemic has ravaged the country relentlessly. The pre-

<sup>28</sup> Adopted at the Third International Consultation on HIV/AIDS and Human Rights (Geneva 25 July 2002), organised by the Human Rights Office of the United Nations High Commissioner for Human Rights and Joint United Nations Programme on HIV/AIDS.

<sup>29</sup> *Pachim Banga Khet Majoor Samity v State of West Bengal* (1996) 4 SCC 37.

<sup>30</sup> *Alvarez v Caja Costarricense de Seguro Social Exp 5778-V-97 No 5934-97*, cited by AE Yamin in 'Not just a tragedy: Access to medication as a right under international law' (2003) 21 *Boston University International Law Journal* 370.

valence rate has risen from a mere 1,8% in 1991 to 5% in 2003, translating to about 3,7 million infected persons, mostly affecting people between the ages of 15 and 29.<sup>32</sup> In the early stages of the epidemic in the country, like in many other countries on the continent, there was an element of fear and denial exhibited by the government of the day. This made it impossible for proper action to be taken to address the epidemic. It must be admitted, though, that this inaction on the part of government was due mainly to political instability, a lack of political will and a lack of awareness. Coupled with this are the lack of reliable data, a lack of funding, the lack of participation by PLWHA and the inability of the legal system in the country to address the epidemic. All these factors contributed to insufficient advocacy and awareness-raising, and a public perception that HIV/AIDS was not significant.<sup>33</sup>

However, with the coming into power of a democratic government in 1999, things began to change for the better. The Obasanjo regime initiated bold steps to combat the spread of the epidemic. The steps taken include the setting up of the National Action Committee on AIDS (NACA), a body made up of representatives from government, NGOs, the private sector and PLWHA. This body is charged with the responsibility of managing government response to HIV/AIDS. The government also started one of the most ambitious ARV programmes in Africa by providing treatment for about 12 000 people at a highly subsidised price. Notwithstanding, some of the challenges faced by PLWHA as regards access to treatment include discrimination by health care providers, poor or no facilities in the health sector, the exorbitant cost of drugs due to patent rights and the lack of a proper legal framework.

#### **4.2 Legal and policy framework on access to treatment in Nigeria**

Nigeria has ratified most of the international and regional human rights instruments mentioned above. In addition, Nigeria incorporated into her domestic law the African Charter by virtue of the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Law.<sup>34</sup> The Nigerian Constitution of 1999 does not recognise the right to health as a justiciable right,<sup>35</sup> unlike the Constitution of South Africa, which ade-

---

<sup>31</sup> National Action Committee on AIDS: Situation Analysis Report on STIS/HIV/AIDS in Nigeria March 2000, <http://www.nigeria-aids.org> (accessed 5 March 2005).

<sup>32</sup> Federal Ministry of Health Report on National Surveillance on HIV/AIDS and STIS in Nigeria (2003).

<sup>33</sup> Situation Analysis Report on STIS/HIV/AIDS in Nigeria (n 31 above.)

<sup>34</sup> African Charter on Human and Peoples' Rights (Ratification and Enforcement) Law Cap 10 Laws of the Federation 1990.

<sup>35</sup> See sec 6(6) of the Nigerian Constitution 1999, which provides that all rights, including the right to health, listed in ch 2 of the Constitution, shall not be made justiciable.

quately guarantees social and economic rights, including the right to health.<sup>36</sup> Section 17 of the Nigerian Constitution is the only section that deals with or makes mention of health and medical facilities. Section 17(1) provides that the social order is founded on ideals of 'freedom, equality and justice', whereas section 17(3)(d) provides that the state shall direct its policy towards ensuring that 'there are adequate medical and health facilities for all persons'.

However, this section is part of chapter 2 of the Constitution (Fundamental Objectives and Directive Principles of State Policy), which is non-justiciable. Moreover, the fact that under Nigerian law, an international treaty cannot be enforced unless it has been incorporated into the local law makes it difficult for the various provisions on the right to health contained in different international instruments to have force in the country.<sup>37</sup> However, under chapter 4 of the same Constitution, a number of fundamental human rights, such as the right to life, human dignity, privacy, association, liberty and freedom from discrimination, are guaranteed. As mentioned earlier, all these rights are important in safeguarding the right to health and access to treatment for PLWHA.

Apart from this general provision, no other legislation has a provision relating to HIV/AIDS in Nigeria.

Though there exists the National Policy on HIV/AIDS,<sup>38</sup> the HIV/AIDS Emergency Action Plan (HEAP),<sup>39</sup> the National Reproductive Health Policy,<sup>40</sup> the Draft Policy on HIV/AIDS and Workplace and others, these documents are not strictly adhered to or implemented.

The National Policy on HIV/AIDS contains provisions suggesting that access to treatment will be made available to PLWHA in the country. The policy provides as follows:

The government will work towards ensuring that all persons in the country shall have access to the quality of health care that can adequately treat or manage their conditions, including the provision of anti-retroviral medication.

It further states the following:

- (i) Cost-effective and affordable care shall be made accessible to all people with HIV related illnesses including access to anti-retroviral therapy.
- (ii) The use of ARV shall be under medical supervision and shall be governed by established effective guidelines. This will be updated regularly with the result of the research.
- (iii) A cost-effective drug list for the management of HIV/AIDS shall be developed and incorporated into Nigeria's essential drug list.

<sup>36</sup> See sec 27 of the Constitution of South Africa Act 108 of 1996.

<sup>37</sup> See sec 12 of the Nigerian Constitution 1999, which provides that a treaty only has force in the country if the National Assembly has enacted it into law. It is only the African Charter that has been so enacted.

<sup>38</sup> Launched in August 2003.

<sup>39</sup> Launched in 2000.

<sup>40</sup> Launched in 2000.

(iv) Sale of ARVs shall be provided solely under strict medical supervision.

Nigeria is not wanting in policy formulation. Rather, the proper implementation of these policies has been a major problem. Also, many of the policies lack enforceability under Nigerian law. For instance, the National Policy declares that mandatory HIV testing is illegal, but fails to state what will happen to culprits of such acts. The HEAP program is fraught with a lack of clarity of purpose and incoherent strategies.

This gap in policy formulation in the country is a reminder to us that the country needs the enactment of appropriate legislation to address the human rights issues raised by HIV/AIDS. The lack of legislation on HIV has made it almost impossible to redress human rights violations experienced by PLWHA.

Although Nigeria has an anti-retroviral therapy programme, this is not without obstacles. There are problems concerning a lack of treatment literacy on the part of health care workers and patients. Many doctors have placed patients on ARV therapy without knowing their viral load. Also, there have been cases where patients have had to stop taking the drugs simply because they were uncomfortable. This could have serious implications for the health of the patient. The fact that there are no clear-cut guidelines for the administration of ARV in the country is worsening this situation. There have been instances where ARV drugs are bought over the counter in public places. Also, there have been cases where PLWHA experienced shortages of the drugs. All these factors, coupled with the fact that there are only a few centres where one may obtain drugs, have marred the ARV programme.

### **4.3 Factors limiting access to treatment in Nigeria**

The following factors are often regarded as barriers to access to HIV/AIDS treatment in Nigeria:

#### **4.3.1 Discrimination in health care institutions**

It is well known that many PLWHA who seek medical attention in public and private hospitals have been subjected to various forms of human rights violations. Experience has shown that in hospitals, medical attention is often refused to PLWHA. PLWHA are stigmatised and made to suffer discrimination from health care providers. It has been observed that the principle of non-discrimination is important to human rights thinking and practice and that under international law, all people should be treated equally and given equal opportunities.<sup>41</sup> Research carried out by the Physicians for Human Rights, Boston, United States,

---

<sup>41</sup> S Gruskin & D Tarantola 'Health and human rights' in R Detels & R Beaglehole (eds) *Oxford textbook on public health* (2001).

Policy Project, the Futures Groups International and the Centre for the Right to Health, Lagos (PHR/TFG and CRH) in about four states in Nigeria,<sup>42</sup> revealed unethical and discriminatory practices against PLWHA by health care providers. About 48% of professionals expressed their belief that PLWHA could not be treated effectively in their facility. Another 10% was reported as refusing to care for PLWHA; while 65% had observed other health care workers who refused to care for PLWHA. The research further revealed that 10% indicated that they had refused PLWHA admission to a hospital. Also, some 40% agreed that a person's HIV status should be confirmed by his or her appearance. Eby, a PLWHA, tells us:<sup>43</sup>

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

Many of the human rights instruments mentioned above contain non-discrimination provisions on the ground of sex, race, religion, political belief or other status. It is recognised that, within the international human rights framework, discrimination is a breach of a government's human rights obligations.<sup>44</sup> The Committee on ESCR has noted that a state will fail in its obligation under the Covenant if it fails to guarantee access to health care services and goods to all on a non-discriminatory basis.<sup>45</sup> While it is admitted that not all discrimination amounts to a violation of human rights, it is widely agreed that adverse discrimination, such as denying treatment to an individual based on HIV status, will result in a human rights violation. Gruskin and Taratonla note that:<sup>46</sup>

Adverse discrimination occurs when a distinction is made against a person which results in their being treated unfairly or unjustly. In general, groups that are discriminated against tend to be those that do not share the characteristics of a dominant group within the society.

Although most human rights instruments do not specifically prohibit discrimination based on health status, the UN Human Rights Commission explained that the phrase 'other status' contained in human rights

<sup>42</sup> An unpublished research report conducted in 2002 in four states, namely Abia, Gombe, Kano and Oyo.

<sup>43</sup> Centre for the Right to Health *HIV/AIDS and human rights. Experiences of people living with HIV/AIDS in Nigeria* (2000).

<sup>44</sup> RB Bilder 'An overview of international human rights law' in H Hannum (ed) *Guide to international human rights practice* (1992) 3-18.

<sup>45</sup> General Comment No 14 (n 14 above).

<sup>46</sup> Gruskin & Tarantola (n 41 above).

instruments applies to health status, particularly HIV status.<sup>47</sup> It is noted that, though section 42 of the Nigerian Constitution does not include the phrase 'other status', article 2 of the African Charter, which has been incorporated into Nigerian law, forbids discrimination on 'other status'. The implication of this would seem to be that Nigeria is bound to prevent discrimination based on HIV status. The Commission has further noted that access to medication in the context of pandemics, such as HIV/AIDS, is one fundamental element for achieving progressively the full realisation of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.<sup>48</sup>

In its General Comment No 14, the Committee on ESCR states that states have an obligation to 'ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups'.<sup>49</sup> According to the UN General Assembly Special Session on HIV/AIDS in its Declaration of Commitment, states are enjoined to ensure respect for the human rights of all, including PLWHA, and that states should take steps to eliminate all forms of discrimination associated with HIV/AIDS in their countries.<sup>50</sup> While it is agreed that the Declaration is not legally binding on states, it is no doubt a highly respected and universally acceptable resolution, having been issued by the UN General Assembly. The South African Constitutional Court has held that a denial of employment to a person based solely on HIV/AIDS status, without proof of incompetence, amounted to unfair discrimination contrary to the South African Constitution.<sup>51</sup>

There is no doubt that the responsibility of government under international law includes ensuring equal protection under the law, as well as guaranteeing access to medical care for all, regardless of health status. The denial of treatment to PLWHA is a violation of their recognised human rights guaranteed under the Nigerian Constitution and other human rights instruments which the country has ratified. In addition, discrimination hinders PLWHA from seeking treatment when in dire need, and even prevents people from knowing their status, thereby fuelling the spread of the epidemic within a particular society.

#### 4.3.2 Poor facilities

The health care system in Nigeria is grossly underfunded and understaffed and suffers from acute problems, including a scarcity of materi-

---

<sup>47</sup> Commission on Human Rights Resolutions 1995/44 of 3 March 1995 & 1996/43 of 19 April 1996.

<sup>48</sup> Commission on Human Rights Resolutions 2001/33 of April 2001.

<sup>49</sup> General Comment No 14 (n 14 above) para 45.

<sup>50</sup> UN General Assembly Special Session on HIV/AIDS Resolution A/S-26/L2 June 2001.

<sup>51</sup> *Hoffman v South African Airways* 2000 11 BCLR 1235 (CC).

als and an inadequacy of infrastructure, contributing to the overall bad behaviour of health care workers.<sup>52</sup> Just like in other developing countries, Nigeria's health professionals are poorly paid and work long hours, experiencing equipment shortages and obsolete facilities.<sup>53</sup> Poor funding has led to a state of total decay in the health care sector. Nigeria's life expectancy has declined from 53 years in 1990 to 50 years in 2002. The increasing prevalence of HIV/AIDS has exacerbated this decline.<sup>54</sup>

Often medical attention is not available to everyone in the developing world due to the appalling condition of the health sector. Because government spending on the health sector is often very limited, goods such as gloves, syringes, drugs and the like are not available. Research conducted by PHR/TFG and CRH (mentioned earlier) revealed that in most of the health facilities visited, adequate provisions such as gloves, disposable injections, overalls and such were lacking. It was estimated that Nigeria allocated a mere 2,5% of her total budgetary spending in the year 1998 to the health sector.<sup>55</sup> In a country where there are about 3 000 patients to a doctor, this amount is ridiculously low.<sup>56</sup> Although it is admitted that spending on health has increased in recent times, the margin is still small compared to the need of the health care sector. During the African Leaders Forum on HIV/AIDS in Abuja, it was agreed that at least 15% of the total budget of countries in Africa be devoted to the health sector in order to combat the HIV epidemic.<sup>57</sup> Many African countries, including Nigeria, have not lived up to this commitment.

Part of the obligations of a state under international law is to fulfil the right to health by ensuring that adequate resources are spent on the health sector to guarantee access to health services and goods for all. According to the Committee on ESCR, a state in which a significant number of its citizens are denied access to medical care is failing in its obligation under the Covenant.<sup>58</sup> While it is recognised that the issue of resources is important in Nigeria, where the majority of its citizens live below the poverty level, this may not be a justification for an inability to meet her core obligations under the Covenant.<sup>59</sup> The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights state that the realisation of rights

---

<sup>52</sup> UN System in Nigeria: Nigeria Common Country Assessment (2001) xix.

<sup>53</sup> As above.

<sup>54</sup> See Federal Ministry of Health *HIV/AIDS: What it means for Nigeria* (2002).

<sup>55</sup> PANOS *Patent, pills and public health: Can TRIPS deliver?* (2002).

<sup>56</sup> As above.

<sup>57</sup> Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases by African leaders April 2001 OAU/SPS/ABUJA/3.

<sup>58</sup> The Nature of State Parties' Obligations Committee on ESCR General Comment No 3, 5th session UN Doc E/1991/23 Annex III.

<sup>59</sup> General Comment No 14 (n 14 above) para 47.

under the Covenant, based on maximum available resources, obliges state parties to ensure minimum subsistence rights for everyone, regardless of the level of economic development in a given country.<sup>60</sup> This position was further stressed in the Maastricht Guidelines, where it was said that 'resource scarcity does not relieve states of certain minimum obligations in respect of the implementation of economic, social and cultural rights'.<sup>61</sup>

HIV/AIDS has further stretched the already weak health system of the country. Inadequate bedding, drugs and personnel are common in private and public hospitals in Nigeria. This makes it difficult for PLWHA to seek medical attention or even get good medical attention when the need arises. The right to health requires that medical services of good quality be provided to all.<sup>62</sup> Thus, many lives that could have been saved are lost to a lack of medical attention. As stated above, there is an obligation upon a state to guarantee the human right to health of their citizens in accordance with international human rights treaties which they have ratified.<sup>63</sup> Thus, any state which fails to ensure the availability of adequate facilities in the health care sector, is failing in its duties and obligations under international law.

#### 4.3.3 The high cost of drugs

Access to HIV/AIDS treatment has been very difficult in Nigeria and many developing countries because of the high cost of medication. Anti-retroviral drugs can ensure PLWHA a normal life for a considerable number of years. The truth remains that many PLWHA in Nigeria and Africa do not have access to these drugs. Many deaths resulting from AIDS-related complications in Africa could have been avoided by access to anti-retroviral drugs. The Trade Related Aspect of Intellectual Property Rights (TRIPS agreement) of the member states of the World Trade Organisation (WTO) allows for strong protection of patent rights over manufactured drugs. This in turn has led to the high cost of drugs for PLWHA in Nigeria and other developing countries.

The TRIPS agreement, which members of the WTO are to incorporate into their domestic legislation, allows for exclusive rights over patented drugs for a period of 20 years.<sup>64</sup> Many of the manufacturers who enjoy patent rights over pharmaceutical products are from developed countries. They justify the existence of patents by the need for research and

---

<sup>60</sup> Limburg Principles E1991/23, annex III.

<sup>61</sup> Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, reprinted in (1998) 20 *Human Rights Quarterly* 691.

<sup>62</sup> See General Comment No 14 (n 14 above).

<sup>63</sup> As above.

<sup>64</sup> See arts 28 & 33 of the Agreement on Trade Related Aspect of Intellectual Property Rights (TRIPS Agreement).

development. But drug patents, especially patents over HIV/AIDS drugs, lead to a monopoly. high costs, thus hindering access to these drugs. In 2003 alone, about two and half million people died of AIDS-related illness in sub-Saharan Africa.<sup>65</sup> Perhaps many of these deaths could have been avoided had there been access to life-saving drugs. In some developing countries, people spend as much as US \$300 per month on drugs.<sup>66</sup> For a country like Nigeria, the minimum monthly spending on HIV drugs is about US \$200.<sup>67</sup> Only a handful of infected persons are able to afford this. Women and children are worst hit, as the numbers of infections and deaths among them continue to rise. Mother-to-child-transmission of HIV could have been reduced easily but for a lack of access to anti-retroviral drugs.

The TRIPS agreement is a serious obstacle to the fulfilment of obligations under international human rights law, particularly those obligations contained in CESC. Chapman argues that, for intellectual property rights to qualify as widely accepted universal human rights, its regime and implementation must be consistent with other internationally recognised human rights.<sup>68</sup> In one of its statements, the Committee on ESCR notes:<sup>69</sup>

[A]ny intellectual property regime that makes it more difficult for a State party to comply with its core obligations in relation to health, food, education, especially, or any other rights set out in the Covenant is inconsistent with the legally binding obligations of the State party.

Similarly, the UN High Commissioner for Human Rights expressed concerns about the negative implication of strict patent rights on access to medications and the enjoyment of the right to health.<sup>70</sup>

Although the TRIPS agreement allows some flexibility, compulsory licensing, parallel importation and exceptions while incorporating the agreement into domestic legislation, not many countries of the developing world have been able to take advantage of this. This is due to a lack of expertise or political will on the part of governments. Where some of these countries have indicated their willingness to invoke the exceptions (for instance South Africa and Brazil), they have often faced serious opposition from developed countries that benefit from the

<sup>65</sup> UNAIDS AIDS Epidemic Update Report December 2003.

<sup>66</sup> 'Zimbabwe: High costs hamper access to ARVs' *Plus News* 9 January 2005 <http://www.irinnews.org/AIDSreport> (accessed 9 September 2005).

<sup>67</sup> G Kombe *et al* *Scaling up anti-retroviral treatment in the public sector in Nigeria: A comprehensive analysis of resource requirements* (2004).

<sup>68</sup> AR Chapman 'The Human rights implications of intellectual property protection' (2002) 5(4) *Journal of International Economic Law* 861.

<sup>69</sup> Human rights and intellectual property issues: Statement by the Committee on Economic, Social and Cultural Rights EC.12/2001/15 26 November 2001 para 12.

<sup>70</sup> The impact of the Agreement on Trade Related Aspects of Intellectual Rights on Human Rights: Report of the High Commissioner ECN 4/Sub/2/2001/13 27 June 2001.

patents on drugs. A strict patent regime, as suggested by TRIPS, is an impediment to access to HIV/AIDS treatment and a threat to the right to life guaranteed under international and regional human rights instruments. Yamin notes:<sup>71</sup>

The duty to provide access to life-saving or life-sustaining medications would not only clearly seem to fall within these expanded notions of obligations deriving from the right to life, but has also explicitly challenged international human rights bodies to draw together conceptually the rights of life and health.

At the Ministerial Meeting of the WTO in Doha, it was resolved that the TRIPS agreement 'can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all'.<sup>72</sup>

Today, in some developing countries efforts are made to ensure the provision of anti-retroviral drugs to PLWHA, but this is just for few people. With the exception of Brazil — where ARVs are available for free to virtually all PLWHA — other countries are only meeting the needs of a small percentage of infected persons. For example, in Nigeria, the government's ambitious ARV programme is catering merely for the needs of about 12 000 PLWHA out of about 3,7 million people infected. The lack of care and support, including treatment for PLWHA, hinders prevention programmes on HIV/AIDS and fuels the stigma associated with the epidemic. During the African Union meeting in Maputo, 2003, African leaders, realising the importance of access to HIV treatment as a way of combating the spread of the epidemic, resolved that they would<sup>73</sup>

ensure that all opportunities for scaling up treatment for HIV/AIDS are pursued energetically and creatively and 'seek' partnerships with international donors, civil society business sector and people living with HIV/AIDS, in order to extend effective care, support and treatment to the maximum number of people . . . made vulnerable by HIV/AIDS.

Not many countries in Africa have explored this avenue.

#### 4.3.4 HIV testing and confidentiality

In private and public hospitals in Nigeria, there exists a lack of respect for patients' rights. Patients are not expected to question the actions of health care providers. With the advent of HIV/AIDS, the situation deteriorated as testing is conducted without informed consent and patient confidentiality is breached. Women are often worse off. Many women attending antenatal programmes in Nigeria have reportedly been sub-

<sup>71</sup> Yamin (n 30 above) 337.

<sup>72</sup> The 4th Ministerial Meeting of the World Trade Organization, Doha, Qatar, 20 November 2001 WTO Doc No WT/MIN(01)/DEC/2 (2001).

<sup>73</sup> Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Assembly /AU/DECL 6(II) para 4.

jected to mandatory testing for HIV, contrary to their wishes. This is a violation of recognised human rights guaranteed under the Nigerian Constitution and the African Charter.

The PHR/TFG and CRH research revealed that over 50% of health professionals reported obtaining informed consent for HIV testing half of the times or fewer. Of these, 27% indicated that they never obtained informed consent for HIV tests. Similarly, 54% reported that, regardless of consent, routine HIV testing of all patients scheduled for surgery always took place at their facilities, and 50% reported such routine HIV testing of all women attending antenatal care clinics.<sup>74</sup> This point is buttressed by a personal experience:<sup>75</sup>

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

Mandatory testing for HIV without informed consent denies patients the opportunity of pre- and post-test counselling, a very crucial aspect of the HIV/AIDS prevention programme. As noted earlier, it is also a violation of the right to privacy, bodily integrity and freedom from degrading and inhuman treatment, all guaranteed under chapter IV of the Nigerian Constitution. When testing is targeted at pregnant women attending antenatal clinics, as shown from the situation in Nigeria, it becomes an act of discrimination forbidden under the Constitution and international human rights instruments. It is noted that article 12 of CEDAW enjoins state parties to the Convention to ensure access to health care services to women without discrimination.

In many health care institutions, the HIV status of a patient is made known to others without the consent of the infected person. Information regarding patients is not properly kept. In most cases, the HIV status of a patient, especially a woman, is revealed to her partner without her knowledge. Employees going for medical treatment at their employer-owned hospital complained of unethical practices on the part of the hospital. The hospital sends the results of their test to their employers without them knowing the outcome of the test.

Practices such as these contravene the right to privacy under section 37 of the Constitution and other international and regional human

---

<sup>74</sup> See unpublished Report (n 31 above).

<sup>75</sup> Centre for the Right to Health (n 43 above).

rights instruments that Nigeria has ratified.<sup>76</sup> Moreover, it is against the ethics of the medical profession.<sup>77</sup> The Committee on CEDAW, in its General Recommendation No 24, stated that states should take measures to ensure that health services to women are made acceptable.<sup>78</sup> The Committee explains further:<sup>79</sup>

Acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives. States parties should not permit forms of coercion, such as non-consensual sterilisation, mandatory testing for sexually transmitted diseases or mandatory pregnancy testing as a condition of employment that violate women's rights to informed consent and dignity.

The loss of privacy and confidentiality in the context of HIV/AIDS fuels stigma and discrimination. The International Guidelines on HIV/AIDS summarise it in this way:<sup>80</sup>

The individual's interest in his/her privacy is particularly compelling in the context of HIV/AIDS, firstly, because of the invasive character of a mandatory HIV test and, secondly, because of the stigma and discrimination attached to the loss of privacy and confidentiality if HIV status is disclosed. The community has an interest in maintaining privacy so that people will feel safe and comfortable in using public health measures, such as HIV/AIDS prevention and care services. The interest in public health does not justify mandatory HIV testing or registration, except in case of blood/organ/tissue donations where the human product, rather than the person, is tested before use on another person. All information on HIV sero-status obtained during the testing of donated blood or tissue must also be kept strictly confidential.

In the South African case of *Jansen van Vuuren v Kruger* (popularly called the *McGeary* case), the South African court held as unethical and a breach of duty of confidentiality a disclosure by a doctor to his colleague of the HIV status of his patient without the consent of the patient.<sup>81</sup>

Negative actions and unethical practices on the part of health care workers may cause PLWHA to avoid seeking medical information or attention, even when in dire need, thus denying them the opportunity to receive treatment and to prevent death. It is crucial that in combating the spread of HIV, the suggestion given by the International Guidelines on HIV be heeded.

<sup>76</sup> See art 4 African Charter; art 17 International Covenant on Civil and Political Rights (CCPR) adopted 16 December 1966 GA Res 2200 (XXI) UN Doc A/6316 (1966) 999 UNTS 171 (entered into force 23 March 1976).

<sup>77</sup> See the Code of Dental and Medical Practitioners in Nigeria (revised edition 1995), which forbids disclosure of information obtained from a patient to a third party without the consent of the patient.

<sup>78</sup> General Recommendation No 24 Women and Health (art 12) 2 February 1999.

<sup>79</sup> n 78 above, para 22.

<sup>80</sup> Second International Consultation on HIV/AIDS and Human Rights (Geneva, 23-25 September 1996), Report of the Secretary-General, E/CN 4/1997/37 Annex 1.

<sup>81</sup> 1993 4 SA 842 (A).

## 5 The South African experience

South Africa has one of the highest HIV/AIDS prevalence rates in the world. In 2003 it was estimated that about five million people were living with HIV/AIDS in South Africa.<sup>82</sup> The South African Constitution of 1996<sup>83</sup> contains elaborate provisions on social and economic rights, such as rights to housing, social security, health and others. In particular, section 27 of the Constitution deals with the right to health care and access to treatment. An equality clause is also contained in section 9 of the Constitution. This section states that everyone is equal before the law and that no one should suffer discrimination as result of sex, race, gender, marital status, ethnic or social origin, colour, sexual orientation, age, disability and so on.

The South African Constitutional Court held in *The Government of RSA and Others v Grootboom and Others*<sup>84</sup> that the social and economic rights contained in the South African Constitution are as important as civil and political rights and therefore should be accorded similar respect and enforceability. In this case, the respondents had brought an action under section 26 of the Constitution, dealing with the right to access to housing, claiming that the government had been in breach of this provision. The Constitutional Court held that the South African government had an obligation under international law and the Constitution to ensure the protection of the right to housing by taking reasonable steps to guarantee this right. The Court further said that it was not enough for the government to claim that it had made laws or taken measures towards the realisation of this right. Such laws or measures must be reasonable and protect the rights of those in urgent need.

In South Africa legislation has been enacted to address HIV/AIDS-related issues. Among these are the Employment Equity Act, dealing with HIV discrimination in the workplace,<sup>85</sup> the Occupational Health Safety Act, which enjoins employers to ensure safety in the workplace and observe universal precaution in the workplace; the Compensation for Occupational Injuries and Disease Act,<sup>86</sup> which governs the right to compensation for workers that get infected in the workplace due to HIV/AIDS status; the Promotion of Equality and Unfair Discrimination Act,<sup>87</sup> which deals with all forms of discrimination in the country and particularly HIV/AIDS-related discrimination.

<sup>82</sup> UNAIDS (n 65 above).

<sup>83</sup> Constitution of South Africa Act 108 of 1996.

<sup>84</sup> 2000 11 BCLR 1169 (CC).

<sup>85</sup> Sec 5 Act 55 of 1998.

<sup>86</sup> See Act 130 of 1993.

<sup>87</sup> See Act 4 of 2000.

In addition to this, there are policies in existence such as the National Policy on Testing, which forbids mandatory testing without informed consent;<sup>88</sup> the National Patients' Rights Charter,<sup>89</sup> which requires all health workers to treat patients with respect, regardless of their disease or condition. There is also the Health Professional Council of South Africa's Guidelines, which require all HIV testing to be done with prior informed consent of patients.

Recently, the Constitutional Court was called upon to make a pronouncement on the right of PLWHA to access treatment. In the case of *Minister of Health v Treatment Action Campaign (TAC)*,<sup>90</sup> an action was filed by the TAC against the South African government for failing to provide Nevirapine (ARV) for the prevention of mother-to-child-transmission of HIV in public hospitals, contrary to section 27 of the South African Constitution. The government argued that it was not obliged to make this drug available due to the huge financial implications of doing so, and that the safety of the drug had not been ascertained. The Court held that evidence abounds of the safety and efficacy of the drug and that the refusal of the government to make it available in public health institutions was a violation of the right to access to health care. Furthermore, the Court held that the actions of the South African government were in violation of the right to life of mothers and children who may benefit from the drug. It ordered the South African government to make the drugs available at public hospitals at no cost.

This is a landmark decision by the Court, as it recognises access to treatment as a human rights issue. There are indeed great lessons to be learnt from the situation in South Africa. As we have seen, there appears to be an enabling environment where the rights of PLWHA are protected. Moreover, the willingness of the judiciary to promote the rights of PLWHA is commendable and can be emulated by Nigerian courts.

## 6 Conclusion

From the above, it is clear that access to HIV treatment is by no means easy in Nigeria. Many factors, including stigma and discrimination, poor funding of the health sector, a lack of respect for patients' rights, the high cost of medication, a lack of political will and a lack of an enabling environment, all exacerbate the problem of access to treatment in Nigeria. Though the Nigerian government is making efforts to ensure access to HIV treatment in the country, such efforts have not been adequate, neither have they recognised access to treatment as a

---

<sup>88</sup> Published by the Department of Health in 2000.

<sup>89</sup> Developed by the Department of Health in 1999.

<sup>90</sup> 2002 5 SA 721 (CC).

human rights issue. Since Nigeria has ratified numerous international human rights instruments that recognise the right to health as a fundamental right, the government must ensure that it respects, protects and fulfils this right. One of the ways of doing this is by guaranteeing access to treatment for all, particularly PLWHA.

Access to HIV treatment may not be realisable unless an enabling environment, where the human rights of every citizen, including people infected or affected by HIV, are respected. Therefore it is high time that the Nigerian government enacts appropriate legislation to address the issue of stigma and discrimination associated with HIV. Furthermore, training for health care providers, which emphasises a respect for human rights, is essential to ensure that patients seeking treatment or information on HIV are treated with respect and guaranteed of their rights. As Nigeria prepares to amend her patent law in line with her obligations under the TRIPS agreement, it is stressed here that such an amendment must be done in accordance with the country's obligations under international human rights treaties. Moreover, flexible options such as parallel importation, compulsory licensing and others available under TRIPS must be explored.

We would like to emphasise that, unless the international community is committed to the various declarations and resolutions made with regard to access to HIV medication, nothing will be achieved. Unless the richest countries of the world are sincere and committed to contributing to the global fund on HIV/AIDS, tuberculosis and other diseases, millions of people will be denied access to treatment. Unless governments all over the world, particularly in developing countries, introduce favourable policies on HIV/AIDS and exhibit a political will to execute them, millions of people will continue to die.