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African Journal of Reproductive Health, ISSN: 1118-4841

Women's Health and Action Research Centre

African Journal of Reproductive Health, Vol. 6, No. 3, December, 2002 pp. 30-37

Gender and Human Rights Dimensions of HIV/AIDS in Nigeria

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ABSTRACT

Until very recently, researchers paid little attention to sex or gender issues in HIV/AIDS. When differences between females and males on health matters were considered at all the focus was clearly on womens' reproductive lives and not on factors affecting the spread of the disease. There was hardly any consideration of the influence of inequalities on the spread of HIV/AIDS and on outcomes of infection between the sexes. Hitherto, health policies and programmes focused on biological aspects of diagnosis, treatment and prevention. In this paper, the author seeks to provide an understanding of the social factors as well as identification of the capacity of human rights to develop an effective response to the disease. It is a gender perspective on human rights with specific implications for women in the context of HIV/AIDS. (*Afr J Reprod Health* 2002; 6[3]: 30–37)

RÉSUMÉ

Dimensions sexistes et des droits de l'homme par rapport au VIH/SIDA au Nigéria. Jusqu'à très récemment, les chercheurs ont prêté peu d'attention aux problèmes des sexes par rapport au VIH/SIDA. Quand on considérait les différences entre les hommes et les femmes sur le plan de la santé, l'accent était clairement mis sur la santé reproductive des femmes et non pas sur les facteurs qui concernent la propagation de la maladie. On considérait à peine l'influence des inégalités sur la propagation du VIH/SIDA et sur les résultats de l'infection entre les sexes. Jusqu'ici, les politiques et les programmes de la santé ont concentré sur les aspects biologiques du diagnostic, du traitement et de la prévention. Dans cet article, l'auteur cherche à fournir une compréhension des facteurs sociaux aussi bien qu'à identifier la capacité des droits de l'homme d'élaborer une réponse efficace à la maladie. Il s'agit là d'une perspective sexiste sur les droits de l'homme avec des implications spécifiques pour les femmes dans le contexte du VIH/SIDA. (*Rev Afr Santé Reprod* 2002; 6[3]: 30–37)

KEY WORDS: *Gender, human rights, HIV, AIDS, Nigeria*

INTRODUCTION

It is now established that women are biologically more vulnerable to HIV/AIDS, and more likely to contact infection from their male partners.¹ The combination of their sexuality and gender disadvantage in terms of cultural, economic and social factors place them more at risk of infection than men. At the Fourth World Conference on Women held in Beijing in 1995, emphasis on gender equity and reproductive health rights were accepted as cornerstone for the planning of effective health and prevention programmes by governments on HIV/AIDS.

The risk of HIV infection during unprotected vaginal intercourse is two to four times higher for women than men. This is because semen contains a higher concentration of HIV than vaginal secretions and can remain in the vagina for many hours after intercourse. Women are also more likely than men to contact other sexually transmitted diseases (STDs), which would increase their risk of infection with HIV. This vulnerability is too often reinforced by social constraints on women's ability to protect themselves and insist on safe sex. Social science and legal research, particularly research that takes a gender approach to human rights, is helpful in understanding how socio-cultural, legal and economic factors contribute to women's vulnerability to HIV/AIDS infection in Nigeria. A gender approach to the disease considers the critical roles that social and cultural factors play in the spread and management of HIV/AIDS and the higher vulnerability and susceptibility of women to infection.

The HIV/AIDS Pandemic: A Global Concern

Around the world, STDs, particularly HIV/AIDS, continues to spread, killing millions of women, men and children. At the end of 1998, UNAIDS and WHO estimated that 33.4 million people were living with HIV infection including 13.8 million women (43%) and 1.2 million children.² The vast majority of people living with HIV/AIDS are in developing countries — 22.5 million in sub-Saharan Africa (50% of whom are women), 6.7million in South and South East Asia, and 1.4 million in Latin America. These numbers are increasing every year. It is estimated that more than 60 million people would be infected by 2005.

Governments, particularly those in developing countries where the epidemic is mainly focused, cannot ignore the statistics. The pandemic is concentrated in the poorest parts of the world with 90% of HIV positive cases living in the developing world.¹ Many developing countries are continually experiencing exponential growth of HIV/AIDS cases especially amongst women and children. Global spending on HIV/AIDS care, research and prevention reflects this disparity. Developing countries, including Nigeria, only receive about 12% of such resources despite having 95% of cases.³ Socioeconomic factors contributing to the spread of HIV/AIDS disproportionately impact on these countries and include poverty, illiteracy, gender inequality, increased mobility of populations within and between countries , rapid industrialisation involving movement of workers from villages to cities, and consequent breakdown of traditional values.⁴ Because HIV/AIDS is becoming increasingly concentrated in young women who are usually mothers, it has an immense impact on life expectancy, exacerbates inequality (e.g., surviving orphans) and increases the burden on health systems. Governance, development and human rights are recognised as interdependent⁵, as HIV/AIDS undermines recent developmental achievements.

In a few years of accelerated spread, AIDS has become the leading cause of death in most developing African countries, and may be the most important macroeconomic and social determinant of human welfare and poverty.⁶ More than exclusively a health crisis, today, AIDS is an emergency that affects many areas at once — human rights, development, economy and education.

In Africa, there have been examples of regional and national initiatives and attempts by states and non-governmental organisations to stem the tide of HIV transmission and develop effective national responses to HIV/AIDS that respect human rights. In the past decade, there has been increasing participation of governments, usually with community representations, to give an accurate picture of the human rights dimension of the epidemic. At the 10th international conference on STDs/ AIDS in Africa, an alliance of mayors and municipal leaders was formed which issued the Abidjan Declaration on 9 December 1997.³ The declaration states that the alliance commits itself to search for solutions relevant to local needs and realities in accordance with UN principles and national laws and

regulations, in order to respond more effectively to the epidemic. The creation of the alliance is to maximise commitment, participation, leadership capacity and experience at the community level in response to the challenge of HIV/AIDS epidemic in Africa.³

The International Partnership against AIDS in Africa was born of the understanding that, in isolation, none of its constituencies – neither governments, nor civil society, nor the various national and international organisations working against AIDS in Africa – will succeed in stopping the epidemic. Instead, a coalition or partnership approach promises to magnify the contribution of all partners, while giving a clear leadership role to African governments.⁷ According to Parker,⁸ the global distribution of HIV is anything but democratic and equal. The geographic distribution of HIV around the globe and in specific places is not random, arbitrary, or a chance. It is shaped by issues of structural violence.

According to Parker, these multiple forms of structural violence⁸ have resulted in two overriding global trends in the HIV/AIDS pandemic, namely:

- **Feminisation:** All over the world more and more women are contracting HIV/AIDS. In South Africa, for example, the male/female ratio for HIV infection has increased dramatically from 29:1 in 1985 to 2:1 in 2000.
- **Pauperisation:** Although there is little available data on the classwise distribution of HIV/ AIDS, data on education serves as a proxy. Today, the vast majority of cases of HIV infected persons are those who have some primary education, or are not literate.⁸

Thus, behavioral interventions are not the answer. Short-term interventions can be undertaken but can only be effectively accomplished if we understand the structural forces underlying the HIV/AIDS epidemic.⁸

Gender Inequality and Feminisation of HIV/AIDS in Nigeria

Although the majority of current HIV infections are still among men, AIDS is becoming an increasingly female affair. In Nigeria response to the HIV/AIDS epidemic started with a focus on high risk groups including commercial sex workers. Men were advised to stay away from sex workers or use the condom. Gradually, the focus shifted to high risk behaviour, which further emphasises males using condom. It avoids addressing the gender issues in sexual relations — women do not use condoms, they negotiate use. The gender dimension was not addressed until large numbers of women who were not commercial sex workers were getting infected.⁹ Presently,

it has been recognised that women's vulnerability to HIV/AIDS is as a result of lack of knowledge and access to information, economic dependence, and, in many cases, forced sex with their regular partners.

In Africa, there are already six women with HIV for every five men.¹⁰ Of the estimated 5.8 million HIV infections that occurred in 1999, nearly half were in women and about 590,000 occurred in children.¹⁰ Women now account for 42% of people living with HIV. This increase in the number of HIV positive women reflects their greater biological vulnerability to the disease.¹¹ It is also a consequence of the social constructions of female and male sexuality as well as the profound inequalities that continue to characterise many heterosexual relationships in Nigeria. Many women find the heterosexual relationship a difficult one to negotiate as strategy for their own safety. Generally, and culturally, sex continues to be defined primarily in terms of male desire with women being the relatively passive recipients of male passions.¹¹ Under these circumstances, women often do not articulate their own needs and desires and their own pleasure may be of little concern. Even in marriage most women cannot assert their wish for safer sex, for their partner's fidelity, or for no sex at all. As a result their health and invariably that of others are put at grave risk. It is estimated that in parts of Africa 60–80% of women infected with HIV have only had one sexual partner.¹² Though partner change increases risk, most HIV positive women would have been infected through their male spouse or regular partner.¹² This also applies to young unmarried women who are often sought after out by older men because of their presumed passivity and freedom from infection.

Cultural pressures of this kind are reinforced by gender inequalities in income and wealth. For many women, economic and social security, and often their very survival, is dependent on the support of a male partner.¹³ In Nigeria, economic globalisation has benefited the rich (mostly men) but penalised the poor, less educated, low skilled or unemployed. Women who are disproportionately poor, uneducated and unemployed fall within this other group.¹⁴ More than 15 years after the introduction of the Structural Adjustment Programme in Nigeria, the consequences of the economic policy are glaringly tragic. Women are increasingly resorting to risky sexual behaviours as part of multiple livelihood strategies.¹⁵ The average Nigerian woman finds it increasingly hard to leave abusive or risk-bearing relationships because of increased economic dependence.¹⁶ Under these circumstances, many will prefer to risk unsafe sex in the face of more immediate threats to their well being. More often than not, the poorer women have the fewest choices, run the most risks, and are more likely to become infected.¹⁵ When a woman becomes infected with HIV/AIDS, gender inequalities in income and wealth invariably affects progression of the illness and possibly her survival chances. In the final analysis, the combination of physiological vulnerability and exposure contributes to a situation where women are decisively more at risk of HIV infection than men.¹³

HIV/AIDS, Human Rights and Inter- national Obligations

A rights-based prevention and protection approach recognises societal vulnerability to HIV/AIDS, not just individual risk behaviour. It also recognises vulnerabilities in different groups such as women and children. International human rights norms provide coherent normative framework for analysis of the HIV/AIDS problem.¹⁷ They also provide a legally binding foundation with procedural, institutional and other accountability mechanisms to address the societal basis of vulnerability, and implement change.¹⁸ Health and human rights are thus complementary rather than conflicting goals. The range of human rights, whether found in national or international human rights instruments, conventions and declarations, more often than not address (reproductive) health issues and protects vulnerable groups.

In the legal application of human rights, it is important to identify those bound by legal duty to observe human rights such as government agencies, those working under the authority of government and those carrying out governmental responsibilities. The legal challenge is to find not only the human rights protecting gender equality and health, but also the rights that would contribute most effectively to future remedies.¹⁹ For instance, a woman may have suffered because a family member was allowed to veto or frustrate her request for necessary care. A remedy may be approached by ensuring respect for a woman's confidentiality in requesting health care and in applying human rights to achieve women's economic and social equality in access to health care.

Sources of human rights to advance gender equality and protect women's health are found in nearly all national constitutions and in international and regional human rights treaties and declarations based on the universal declaration of human rights.²⁰ The universal declaration itself was not proposed as a legally enforceable instrument but it has gained legal acceptance and legal enforceability through a series of international human rights conventions and charters. The primary modern human rights treaty concerning women's rights is the Convention on the Elimination of All Forms of Discrimination Against Women (the Women's Convention).²¹ This convention reinforces the universal declarations' two initial legally binding implementing covenants, namely, (i) the International Covenant on Civil and Political Rights (the Political Covenant)²² and (ii) the International Covenant on Economic, Social and Cultural Rights (the Economic Covenant).²³ Additional documents reflect widespread international consensus on issues of women's health and human rights, notably, (i) the Cairo Programme of Action (the Cairo Programme)²⁴ and the Cairo Plus Five follow-up document²⁵ developed respectively at the 1994 UN Conference on Population and Development in Cairo, and its five year review and (ii) the Beijing and Platform for Action (the Beijing Platform),²⁶ developed at the 1995 Fourth World Conference on Women in Beijing, and its five-year review.²⁷

Nigeria is a state party and signatory to the above treaties and documents.²⁸ Some of these conventions, like the Women's Convention and the Economic Covenant, have monitoring bodies to monitor compliance with treaty provisions. Unlike the national courts that act only on occasions when parties bring cases before them, the treaty monitoring bodies receive reports that member states must submit periodically, usually at three to five-year intervals.²⁸ In the specific area of women's health, Nigeria as a member state is committed to report regularly to CEDAW on what she has done to take all appropriate measures to eliminate discrimination against women in the field of health care.²⁹

With regard to specific articles of the CEDAW relating to women's health, the General Recommendation on Women and Health³⁰ requires that in order to enable the Committee to evaluate whether measures to eliminate discrimination against women in the field of health care are appropriate, state parties must report on their health legislation, plans and policies for women with reliable data disaggregated by sex on the incidence and severity of diseases and conditions hazardous to women's health and nutrition and on the availability and cost-effectiveness of preventive and curative measures. This Recommendation emphasises that reports to the Committee must demonstrate that health legislation plans and policies are based on scientific and ethical research and assessment of the health status and needs of women in that country and must take into account ethical, regional or community variations or practices based on religion, tradition or culture³⁰

The General Recommendation also adds that the committee requires state parties to report on what they have done to address the magnitude of women's ill health, in particular when it arises from preventable conditions such as tuberculosis and HIV/AIDS.³¹ It further states that the issue of HIV/AIDS and other sexually transmitted diseases are central to the rights of women and adolescent girls to sexual health, and that state parties should ensure without prejudice and discrimination the right to sexual health information, education and services for all women and girls.³¹

The Cairo Programme noted that reproductive health eludes many of the world's people because of factors such as inadequate levels of knowledge about human sexuality and inappropriate or poor quality reproductive health information and service; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and reproductive lives.²⁴ It also recognises that health services must be particularly sensitive to the needs of individual women and adolescents and responsive to their often powerless situation, with particular attention to those who are victims of sexual violence.²⁴ The programme further reiterated that referral for family planning services and further diagnosis and treatment for complications of pregnancy,

delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases including HIV/ AIDS should always be available as required.²⁴

Similarly, the Beijing Platform²⁶ emphasised that women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality with men. Women are affected by many of the same health conditions as men but they experience them differently. The prevalence among women of poverty and economic dependence, their experience of violence, negative attitudes towards women and girls, racial and other forms of discrimination, the limited power many women have over their sexual and reproductive lives, and lack of influence in decision-making are social realities that have adverse impact on their health.²⁶ It went on to add that health policies and social programmes often perpetuate gender stereotypes and fail to consider socioeconomic disparities and other differences among women and may not fully take account of the lack of autonomy of women regarding their health.²⁶

The above-mentioned treaties and international instruments are binding on Nigeria as a member state that has signed and ratified these documents. The Vienna Declaration and Programme of Action affirmed that human rights, whether civil, political, economic, social or cultural, are universal and indivisible.³² In 1996 the UN Commission on Human Rights resolved that the term “or other status” used in several human rights instruments should be interpreted to include health status including HIV/AIDS and that discrimination on the basis of actual or presumed HIV/AIDS status be prohibited.³³ The duty to fully realise human rights obligations in the HIV/AIDS context can best be approached by adopting a national framework that can address issues of discrimination, vulnerability and equality.

Implementing HIV/AIDS-Related Human Rights Standards in Nigeria

National Guidelines

Under national constitutions and international human rights treaties, governments face a variety of obligations including general obligations that can be applied to particular circumstances, care obligations, and immediate and long-term obligations.¹⁹ Experience is growing on the protection and promotion of human rights through a variety of legal, quasilegal and customary law systems. The ways in which human rights are protected depend on national circumstances and priorities, and the development of a national strategy for the protection of rights will employ various means. Consideration should also be given to special and vulnerable groups of persons such as women and children. The guidelines advanced here is a gender perspective on HIV/AIDS-related human rights standards and

monitoring in Nigeria.

The Nigerian constitution protects human rights that are already recognised in international instruments and other consensus documents.³⁴ In addition, there is need to create explicit benchmarks and guidelines to implement and develop effective rights-based response to gender inequality and HIV/AIDS.³ Government is the responsible party under relevant international instruments to protect rights. However, it is important to recognise that partnerships with other essential sectors of the society are crucial for an effective response to the epidemic.

A proposal for national guidelines on HIV/ AIDS and human rights should clarify the obligations contained in the aforementioned international instruments.³ Key human rights with specific implications for women in the context of HIV/AIDS are:

- Non-discrimination and equality before the law, e.g., eliminating discrimination against people living with HIV/AIDS especially vulnerable groups such as women, in the areas of health care, employment, education, housing and social security. The disproportionate impact of the disease on vulnerable populations makes the improvement of their legal status and realisation of their human rights critical if an effective response to the epidemic is to be achieved. Without full respect for human rights, these groups (especially women) are not in a position to avoid infection because they either do not receive prevention, education and information, or cannot act on it, and when infected are disempowered to cope with the impact.³ The most effective remedy is the enactment of general anti-discrimination legislation, which prohibits unfair and irrelevant distinctions being made between infected and non-infected persons.
- Health, e.g., ensuring equal and adequate access to the means of prevention, treatment and care, especially for vulnerable populations with lower social and legal status (e.g., women and children). In this regard, the state must adequately address the public health issues raised by HIV/AIDS and specify that provisions applicable to casually transmitted diseases are not inappropriately applied to HIV/AIDS and that they are consistent with international human rights obligations.³ Service integration of HIV/AIDS prevention and STD diagnosis and treatment within reproductive and family planning services is an important issue as well as free or low-cost services addressing biological, legal, psychological and socio-cultural aspects of women's health.³⁵
- Education and information, e.g., ensuring equal and adequate access to prevention, education and information. As prevention is a main objective of HIV/AIDS programmes, people need information and need to be educated about the virus and disease, mode of transmission and means of protection. Information can be provided through pamphlets, posters, newspapers, magazines, books, instructions on condom

packaging, advertisements, radio, television, films, videos, plays, the Internet, group meetings and assemblies.³

- Employment, e.g., prohibiting dismissal of staff solely on the basis of their HIV status. Some areas of concern in employment law are (i) that workers with HIV/AIDS are not subjected to unfair discrimination and (ii) that appropriate prevention measures are available for workers who are occupationally infected. Employees with HIV/AIDS are able to lead reasonably long and productive lives particularly with recent advances in anti-retroviral treatments.³
- Reproductive health. Apart from increased biological susceptibility to infection, women's subordinate status impairs their ability to deal with possible consequences of infection, which require care and support (e.g. violence and abandonment by family). Systematic discrimination in all facets of life but particularly education, health care and employment disproportionately increases the risk of women becoming infected. Education and prevention programmes are hindered where women lack the skills to understand or the capacity to act upon the information contained in them.³
- Support services and legislative reform. These services take the form of increased enhancement of men's participation in HIV/AIDS prevention and treatment. This is because men have more sexual partners than women and tend to control the frequency and form of intercourse, and because women are physiologically more susceptible to the virus. It is men's behaviour that determines how quickly and to whom the virus is spread.³⁶ Legal reform is a key component of campaigns to improve the status of women. The impact of current laws on women is already being felt in Nigeria with a national policy and plan of action to end female genital mutilation.³⁷ In addition, laws should be reviewed and reformed to ensure equality of women regarding property and marital relations and access to employment and economic opportunity especially in the context of an HIV/AIDS diagnosis. The HIV status of a woman should not be treated differently from any other analogous medical condition in making decisions regarding custody, fostering or adoption.³

CONCLUSION

In the final analysis, a gender perspective on HIV/AIDS and human rights must take into consideration the impact of the epidemic on women. National guidelines in these areas should implement the development of adequate, accessible and effective HIV-related prevention and care education, information and services by and for vulnerable communities such as women. They should examine issues such as:

- The role of women at home and in public life.
- The sexual and reproductive rights of women and men, including women's ability to negotiate safer sex and

make reproductive choices.

- Strategies for increasing educational and economic opportunities for women.
- Sensitising service deliverers and improving health care and social support services for women.
- The impact of religious and cultural traditions on women.

In particular, primary health services, programmes and information campaigns should contain a gender perspective, and harmful traditional practices including violence against women, sexual abuse, exploitation, early marriage and female genital mutilation must be discouraged. This paper is a contribution to national initiatives to promote compliance with human rights principles and provide information on the critical role of human rights in the overall response to the epidemic.

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