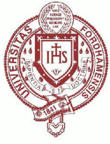

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Gender, Sexuality and Human Rights: A Comparative Analysis of the Role of Civil Society Organizations in HIV/AIDS Responses in Brazil and Nigeria

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ABSTRACT

A global epidemic that has affected lives around the world, AIDS has accentuated inequalities across class, race, gender and sexual orientation. In many developing countries, women are disproportionately affected by the epidemic and are more vulnerable than men to HIV infection. The objective of this paper is to address the cultural and social norms surrounding gender and sexuality that have allowed and perpetuated women's susceptibility to AIDS. I examine the gender constructs and inequities in Brazil and Nigeria to demonstrate how gender affects transmission in sexual relationships as well as the role it plays in creating differential experiences with HIV for men and women. Furthermore, I discuss how gay-related stigma and discrimination in both countries have precluded men who have sex with men from seeking HIV treatment. I analyze the centrality of human rights and social mobilization to health policy and demonstrate the ways in which Brazil has been able to make great strides towards reducing AIDS-related incidences and mortality rates by listening to the demands of civil society and following a rights-based approach to AIDS. The inclusion of civil society actors and a commitment to human rights are integral in effectively addressing AIDS.

INTRODUCTION

It is evident that the AIDS epidemic greatly affects millions living in developing countries due to a lack of access to appropriate and necessary treatment. Brazil is a country that has been comparatively more successful than other developing countries in combating AIDS through its inclusive health policies and treatment programs. Advocacy and social mobilization propelled by grassroots organizations have been essential to shaping and sustaining effective national health policies, particularly those concerning HIV/AIDS. To understand the relationship

between gender, sexuality and AIDS, it is important to look at the cultural perceptions of gender, sexuality and human rights and how they disproportionately tend to affect women and other marginalized groups like homosexual men. A country's acceptance of sexual diversity and exploration or lack thereof has influenced the ways in which homosexual males are affected by the AIDS epidemic, as the Brazilian and Nigerian cases demonstrate. Brazil's general acceptance of sexuality and its willingness to combat gay-related stigma and discrimination has significantly allowed the country to successfully address HIV. On the contrary, specific laws, policies and norms in Nigeria continue to discourage homosexual males from seeking treatment. In terms of human rights, Brazil has shown that a rights-based approach to health policy produces significant results in reducing cases and mortality rates of HIV/AIDS. The significance of human rights in policy-making entails that the needs of all individuals, irrespective of race, class, gender or sexual orientation, are met. When a country's citizens feel empowered to work collectively for the greater good of society, and the political establishment is committed to the realization of human rights, particularly in the health sector, policies are shaped to reflect the direct demands and needs of the people and as such, they can produce better outcomes for all groups of people.

METHODOLOGY

In my comparative examination of Brazil and Nigeria concerning the manifestation of and response to AIDS, I utilize a diverse array of sources including journal articles, books, UN reports, newspaper articles and official websites to lend data, analysis and facts to my argument. Firstly, I trace the history of AIDS, its global impact and the stigma attached to it as a sexually transmitted disease. Understanding the ways in which AIDS has been initially perceived is important to demonstrate the kinds of responses different countries have pursued to address it. Through my case studies, I observe the differences in approaches to HIV/AIDS as well as the

variations in social reactions to the epidemic in Brazil and Nigeria. What I aim to address is the significant and profound role that social ideas surrounding gender and sexuality have in the differential experiences of women and homosexual men with HIV, relative to heterosexual men. Furthermore, I discuss the importance of civil society in shaping and forming health policy that emphasize human rights, particularly with respect to a disease as stigmatized as AIDS.

I look at Brazil and the political and social factors that have contributed to the mobilization of society in the 1980s. The Brazilian case demonstrates the necessity of citizens to be actively engaged in their own political affairs if any meaningful change is to be effected. As Brazilians began to adopt a shared view of the importance of human rights, citizenship and solidarity, society increasingly mobilized around issues of civil rights. Much of the research on Brazil's response to AIDS highlights how critical of a period this was in setting the stage for a national approach to AIDS built upon human rights principles. I then analyze how cultural perceptions of men and women have rendered women comparatively more susceptible than men to contracting HIV. I discuss how their inferior political, economic and social statuses in society have traditionally left them with a lack of agency, subjected them to gender-based violence or compelled them to find economic security and support in high-risk jobs like sex work. A discussion of the social determinants of HIV illuminate the notion that AIDS is not a disease that affects everyone equally; instead, existing structures that reinforce women's subordination exacerbate the impact of HIV on the female population.

In the case of Nigeria, I look at the political, economic and social elements that have allowed AIDS cases and deaths to increase and have contributed to the epidemic's disproportionate effect on women and homosexual men since the 1990s, when AIDS started to become globally recognized, to present-day. While Nigeria has made noticeable progress in

addressing AIDS and creating more access to health care, it has been flawed in its initial approach to combating AIDS. The sources I use in my discussion of HIV and Nigeria outline the tangible stigmatization of AIDS and the deterring effects it has had on vulnerable groups like women and homosexual males in seeking treatment and care. Similar to Brazil, social and cultural constructions of gender have been the root cause of women's higher vulnerability to HIV infection. I explore how women's accepted inferiority to men in relationships tend to expose them to sexual violence, a key factor that has contributed to considerably high HIV infection rates among women. I also analyze how women' economic disempowerment has made them look for employment in sectors such as sex work, a job that inevitably has public health implications. Furthermore, I look to official documents containing existing laws and codes that criminalize homosexual behavior and activity in Nigeria. A discussion of the legally binding rules and implications surrounding homosexuality indicate how strong of an effect they have in perpetuating gay-related stigma, precluding marginalized and affected groups from seeking treatment and sustaining HIV prevalence. I utilize research studies to examine the importance and challenges of community-led responses in Nigeria. Funded by donors and the government that establish the guidelines on HIV/AIDS policies and programs, civil society organizations have a limited in role in analyzing and shaping policies. Findings from studies show that national and international agencies perceive civil society organizations as implementers of delivery service rather than as active participants in policy change. As such, civil society actors are disempowered in addressing repressive policies and creating new ones that reflect the needs of people living with HIV, especially of those most affected such as women, homosexual men, sex workers and drug users, and that address the fundamental socio-economic factors that have contributed to the spread of HIV among such groups.

I also observe and compare trends in HIV-related incidences and mortality rates in both countries to ascertain the strengths and flaws of each country's health policies and approaches to combating AIDS. I observe the more current challenges with HIV/AIDS and examine the changes that have occurred and the progress that has been made over the years in gender equality and human rights within the context of HIV/AIDS. Within a more contemporary framework, I examine the ways in which the novel coronavirus has influenced the healthcare behaviors of those living with HIV and compare the similarities and differences in approaches to health policy concerning AIDS and COVID-19, particularly in Brazil.

LITERATURE REVIEW

The Nature, Origin and Impact of HIV/AIDS

HIV, or the human immunodeficiency virus, is a virus that attacks the immune system, specifically targeting and destroying CD4 cells, or T cells, rendering the body unable to fight off disease or infection. This usually leads to the formation of AIDS, or acquired immunodeficiency syndrome, a severe form of HIV infection that makes patients vulnerable to other fatal infections such as pneumonia.[1] The time between infection with HIV and the onset of AIDS varies, and individuals may develop signs anywhere from several months to years after infection. Typically, people with HIV begin to develop signs within 10 years. Scientists have also observed connections between HIV and simian immunodeficiency virus (SIV), a virus similar to HIV that attacks the immune system of chimpanzees. The transmission of SIV to HIV likely occurred when the infected blood of chimps entered the wounds of hunters. HIV is believed by researchers

[1] 2020. *History.Com*

to have originated in Kinshasa, the capital of the Democratic Republic of Congo, around 1920.[2] The spread of the virus was made possible by infrastructure such as roads and railways as well as migration and human trafficking. International travel too has expedited the spread of the virus across all parts of the world. Throughout the 1960s, HIV spread from Africa to Haiti and then to the Caribbean. From the Caribbean, the virus moved to New York City in 1970 and subsequently to San Francisco.[3] While occasional cases of HIV did occur prior to 1970, it is widely accepted and confirmed by data that the epidemic started in the mid-to late 1970s, and by 1980, the virus was already spreading to other parts of the world, affecting an estimated 100,000 to 300,000 people.[4] Initially, scientists were uncertain of the exact nature and origin of the virus; however, new and unusual diagnostic patterns were observed across the globe. An aggressive form of pneumonia started to appear in young patients, chiefly homosexual men in cities such as New York and California, in 1981. Simultaneously, a cancer common among the elderly that causes lesions and bumps on the skin called Kaposi's Sarcoma (KS), became a part of a pattern of symptoms associated with HIV within the gay population.[5]

Despite the noticeably rapid spread and transmission of HIV throughout the 1960s and 1970s, the virus did not capture the attention and concern of the public until the 1980s. In fact, scientists and health experts themselves were not exactly certain what the virus was or that it was a sexually transmitted disease. In 1981, a report by the CDC revealed that *Pneumocystis carinii pneumonia* (PCP), a lung infection rarely found in individuals with uncompromised immune systems, were found in five healthy homosexual men in Los Angeles.[6] Both Kaposi's Sarcoma

[2] 2020. *History.Com*
[3] *Ibid*.
[4] "History of HIV and AIDS Overview." *Avert*
[5] *Ibid*.
[6] *Ibid*.

(KS) and *Pneumocystis carinii pneumonia* (PCP) would become recognized as two common opportunistic infections related to AIDS. When HIV weakens the immune system, opportunistic infections, as the name suggests, take the opportunity to cause illness within this weakened state. In 1982, the New York Times labeled the virus GRID (Gay-Related Immune Deficiency), and the CDC published a report that established the first connection between a potential sexually transmitted agent and the outbreak of KS and PCP among young gay men.[7] Later in the same year, the CDC used the term "AIDS" to describe the virus and defined it as: "A disease at least moderately predictive of a defect in cell-mediated immunity, occurring in a person with no known cause for diminished resistance to that disease."[8] By the end of 1982, cases of AIDS were equally being reported in a number of European countries. Even though AIDS was predominantly seen in the gay community, it also was reported among females in 1983, suggesting that transmission was also possible through heterosexual sex. It became clear that AIDS did not merely affect homosexual men. It reached heterosexual females, drug users and people with hemophilia. In 1983, the CDC published an article which "... suggests that AIDS may be caused by an infectious agent that is transmitted sexually or through exposure to blood or blood products and issues recommendations for preventing transmission."[9] The CDC article recognized AIDS as a sexually transmitted disease, and the nature of the virus was more understood by the scientific community, policy-makers and the public.

In the late '80s and throughout the '90s, AIDS started to become internationally recognized. In 1987, the World Health Organization (WHO) created The Global Program on AIDS with the objective of raising awareness, generating policies, providing funds, conducting

[7] "A Timeline of HIV and AIDS." HIV.gov
[8] *Ibid.*
[9] *Ibid.*

research, encouraging NGO involvement and promoting the rights of people with HIV.[10] At the same time, the first antiretroviral medication for HIV, azidothymidine (AZT), became available.[11] Treatment for HIV has expanded to include other types of medications used in antiretroviral therapy (ART) or highly active antiretroviral treatment (HAART). These aid in preventing the virus from proliferating, giving the immune system a chance to recover and stave off infections related to HIV. In 1994, the FDA approved the first oral and non-blood HIV test and in 1996, it approved the first home testing kit and the first HIV urine test.[12] With the creation of new medications and treatment therapies, the number of AIDS-related deaths diminished. On the contrary, the WHO declared AIDS in 1999 the fourth largest cause of death worldwide and the leading cause of death in Africa. According to a 1999 World Health report, an estimated 33 million people were living with HIV and 14 million people had died from AIDS since the start of the epidemic.[13]

Gender, Sexuality and AIDS

Defining terms

In many parts of the developing world, women have been disproportionately affected by the AIDS epidemic. Prior to examining the relationship between gender, sexuality and AIDS, it is important to define certain terms. The Pan American Health Organization best defines the words "gender," "sex" and "sexuality," as employed in this paper. Sex can be described as "…"the sum of biological characteristics that define the

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[10] "History of HIV and AIDS Overview." *Avert*
[11] *Ibid*.
[12] *Ibid*.
[13] *Ibid*.

spectrum of humans as females and males."[14] Gender refers to "…the sum of cultural values, attitudes, roles, practices and characteristics based on sex."[15] Whereas sex indicates biological and physical difference, gender constitutes the "…expectations, norms and behaviors, which are differentially based on sex."[16] Social constructions of gender determine the femininity of women and the masculinity of men. Sexuality "…refers to a core dimension of being human which includes sex, gender, sexual and gender identity, sexual orientation, eroticism, emotional attachment/love, and reproduction. It is experienced or expressed in thoughts, fantasies, desires, beliefs, attitudes, values, activities, practices, roles, and relationships. Sexuality is a result of the interplay of biological, psychological, socio-economic, cultural, ethical and religious/spiritual factors."[17] These definitions clarify and best support discussions about how gender and sexuality are culturally and socially perceived and practiced and how influential such perceptions and practices are in women's and gay men's vulnerability to contracting AIDS as well as in their access to treatment for AIDS.

Gender and AIDS

During the mid- to late 1980s, social science research in response to AIDS has predominantly focused on risk-related sexual behavior, and based on empirical data, efforts to address AIDS have included prevention policies and intervention programs designed to mitigate behaviors associated with increased risk for HIV infection.[18] While behavioral research and

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[14] *Promotion of Sexual Health: Recommendations for Action*. Washington DC: PAHO, 2000
[15] *Ibid*.
[16] Anderson, Hilary, et al. Pan-American Health Organization, 2002. *The UNGASS, Gender and Women's Vulnerability to HIV/AIDS in Latin America and the Caribbean*
[17] *Promotion of Sexual Health: Recommendations for Action*. Washington DC: PAHO, 2000
[18] Parker, R. 2001. Sexuality, Culture, and Power in HIV/AIDS Research. *Annual Review of Anthropology, 30*, 163-179

behavioral interventions were employed in various social and cultural settings, sex research was neglected. By the late 1980s and early 1990s, it became evident that "…a far more complex set of social, structural, and cultural factors mediate the structure of risk in every population group, and that the dynamics of individual psychology cannot be expected to fully explain, let alone produce, changes in sexual conduct without taking these broader issues into account."[19] In order to develop a more comprehensive understanding of HIV sexual transmission in different social and cultural contexts, it became necessary to observe cultural meanings and structural factors that have shaped HIV vulnerability and have explained the social dimensions of the epidemic. In essence, the focus of research on sexuality with respect to HIV and AIDS has shifted from behavior to the cultural settings and contexts within which behavior occurs and to the "…cultural symbols, meanings, and rules that organize it."[20] As such, culturally specific and community-based programs could be designed to transform social norms and cultural values in ways that promote safe sex practices.[21] With AIDS being initially characterized as a man's disease, the experiences of women suffering with HIV and AIDs has remained largely invisible and absent from scientific research. The silence surrounding the increasing prevalence of AIDS within the female population is attributed to pre-existing structural forces, both socially and culturally crafted, which have historically placed women in a disadvantaged position in society.[22] Furthermore, the intersection between class, race and gender plays an important role in explaining the invisibility of women in conversations about AIDS.[23]

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[19] Parker, R. 2001
[20] *Ibid*.
[21] *Ibid*.
[22] Farmer, P. 2001. Invisible Women: Class, Gender, and HIV. In *Infections and inequalities: The modern plagues*, pp. 59-92. Berkeley, CA: University of California
[23] *Ibid*.

In order to understand the increasing rate of HIV infection among females, it is necessary to examine the social and cultural context of sexual relationships and risk behaviors. Social and cultural definitions and understandings of gender in particular shape the behaviors, especially those pertaining to sexuality, of males and females. Due to their inferior status in many parts of the world, women experience the consequences of AIDS in ways different from their male counterparts. Social and cultural norms dictating the role, behaviors and status of women, relative to men, place women in a disadvantageous position in terms of accessing information about HIV/AIDS prevention, negotiating safe sex practices and accessing treatment for HIV/AIDS. Gender roles, gender inequities and unequal power dynamics between men and women certainly influence the sexual activity and risk behaviors of each gender. Social constructions of gender characterize women as modest, pure, abstinent until marriage and subservient to their husbands, whereas men are depicted as independent, strong and dominant providers.[24] Furthermore, sexual activity is often seen as an indicator of masculinity and as such, the normalization and encouragement of prolific sexual activity among boys and men increases their risk of getting infected with HIV.[25] There is a critical distinction to be made between risk and vulnerability. Men increase their risk by proactively engaging in unsafe sexual behaviors and practices, whereas women are more vulnerable than men to contracting HIV from their sexual encounters with seropositive partners. In other words, it is more common for women to be exposed to HIV from men without necessarily engaging in risky behaviors themselves. Stemming from this, gender has a crucial impact on the transmission of HIV/AIDS in both heterosexual and homosexual relationships and in the differential experiences of infected and

[24] Anderson, Hilary, et al., 2002
[25] *Ibid*.

affected women and men.[26] A female's vulnerability to HIV can be explained by biological factors; however, it is evident that their subordinate status in society has rendered them socially vulnerable to contracting the disease as well. Women are more likely to have unwanted sexual encounters than men and are more susceptible to sexual violence. Furthermore, they seldom have the ability to discuss safe sex practices with men, specifically condom use, for fear of repercussions. In both Brazil and Nigeria, gender constructs and political, economic and social inequities between men and women have explained women's vulnerability to HIV.

CASE STUDY: BRAZIL

Gender and AIDS in Brazil

In Brazil, the increase in HIV positive and AIDS infected women can be explained by cultural understandings of sexuality. Sexuality, which is generally accepted and celebrated in Brazil, is understood in terms of sexual activity and passivity as opposed to homosexual identity.[27] Stemming from this, men who publicly identify themselves as heterosexuals can and do privately engage in same-sex sexual practices. On the contrary, the same flexibility men are afforded regarding sexual exploration and freedom is not extended to women in Brazil. Women are expected to remain abstinent until marriage, compelling them to participate in higher-risk sex practices that render them more vulnerable to HIV.[28] In 2002, 600,000 adults between the ages 15 and 49 were infected with HIV in Brazil, and women constituted 36.7 percent of that statistic.[29] The transmission of HIV is still fairly common among men; however, this affects

[26] Anderson, et al. 2002
[27] Deomampo, Daisy. 2008. *Gender, Sexuality, and AIDS in Brazil: Transformative Approaches to AIDS Prevention*. *New Directions in Medical Anthropology*
[28] Anderson, et al. 2002
[29] *Ibid*.

prevalence rates among women, many of who are vulnerable to getting infected as a result of their partners' prolific sexual activity with other men.

Given the feminization of poverty that is present across developing countries, with Brazil being no exception, most women do not communicate their sexual needs or concerns or make any effort to negotiate condom use for fear of possibly creating perceptions of infidelity, distrust, and HIV infection, which would render them more vulnerable to violence or loss of economic support from their husbands.[30] Research conducted by the World Bank found that women were increasing likely to be HIV-positive with greater frequency of experiencing both physical and sexual violence in their lives by an intimate partner (Fig.1 and Fig. 2).[31] The highest rates of violence against women are seen in Sao Paulo in the Southeastern region and Porte Alegro in the Southern region, the same areas that have the highest HIV prevalence.[32] While Brazil has adopted progressive laws and policies like the Maria da Penha law to address violence against women and meet the commitments of international treaties like the Convention on the Elimination of all Forms of Discrimination Against Women, violence and social discrimination against girls and women remain key obstacles to the full realization of a rights-based approach to AIDS in Brazil.[33]

It is also important to note how the intersection between race, class and gender produces different health outcomes for different groups of people, especially among the female population. Risks of HIV infection have been found by researchers to be greater among Afro-Brazilian women as a result of poverty and structural violence within Afro-Brazilian communities.[34] Race

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[30] Anderson, et al. 2002
[31] Gundersen, Kristin Kay, et al. "Gender-Based Violence and HIV Infection: Overlapping Epidemics in Brazil." *World Bank Blogs*, 25 Nov. 2016
[32] *Ibid*.
[33] "HIV and AIDS in Brazil." 2020. *Avert*
[34] Caldwell, Kia Lilly. 2016. Centering African-Descendant Women in HIV/AIDS Research, Policy, and Praxis in Brazil. *Meridians*

has played a critical role in health and access to health care and has explained the differential experiences between black Brazilian women and non-black Brazilian women. Furthermore, structural racism has further accentuated and exacerbated inequities not only in health care and access to health care but also employment, income and education for Afro-Brazilians.[35] The Brazilian government has undertaken efforts to ensure racial equality in health as a result of growing pressures from black female activists and black movements. For example, in 2009, the Brazilian government formulated a federal policy called the Integral Policy for the Health of the Black Population (*Política Integral de Saúde da População Negra*) to address racial health inequities and health issues affecting black communities in Brazil.[36]

Political Change, Social Mobilization and the Role of Civil Society in Brazil

In 1982, the first case of HIV/AIDS was reported in Brazil at the same time Brazil was undergoing a political transition from a military regime to a democracy.[37] This political transformation planted the seeds for a rights-based approach to health. The success of Brazil's prevention policy can be attributed to social mobilization, which responded to not only the emerging epidemic but also the various social and political issues associated with Brazil's former military authoritarian political structure. The WHO defines social mobilization as "the process of bringing together all societal and personal influences to raise awareness of and demand for health care, assist in the delivery of resources and services, and cultivate sustainable individual and community involvement." [38] Civil society can be defined as the "political space where voluntary

[35] Caldwell, Kia Lilly. 2016
[36] *Ibid*.
[37] Parker, Richard G. 2009. "Civil Society, Political Mobilization, And The Impact Of HIV Scale-Up On Health Systems In Brazil". *JAIDS Journal Of Acquired Immune Deficiency Syndromes*
[38] "Social Mobilization." 2019. *World Health Organization*

associations explicitly seeking to shape the rules that govern…social life."[39] Civil society organizations communicate with governments, deliver services and hold officials accountable.[40] Fundamentally, civil society helped shape the Brazilian response to HIV/AIDS through social mobilization, in which Brazil's citizens emphasized the importance of democracy, citizenship and solidarity in their demands for reform. The relationship between the Brazilian citizens and the state was defined by its democratic institutions and by citizenship, whereas the relationship among the people was defined by solidarity and respect for human rights.[41] Social movements, activist groups and various voluntary organizations emerged during this time to protest the regime and to promote "... the creation of mechanisms aimed at guaranteeing the protection of civil rights and at ensuring citizens' active participation in governmental decision-making…" which "... became one of the highest priorities in public life, culminating in 1988 in the promulgation of a new "democratic" Constitution."[42]

Increased demands about proper health policies and equal access to health services for all Brazilians by movements such as the Sanitary Reform Movement, a group of healthcare workers and health academics, helped articulate healthcare in Brazil as a universal, human right. The Sanitary Reform Movement in particular "...demanded a public system that was responsive to and controlled by the public and who defended the right to health as a fundamental human right

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[39] Scholte JA. Civil society and democracy in global governance. Glob Gov. 2002;8(3):281–304, quoted in Williamson, R.T., Rodd, J. Civil society advocacy in Nigeria: promoting democratic norms or donor demands?. *BMC Int Health Hum Rights*
[40] Gaventa J. Towards participatory governance: assessing the transformative possibilities. In: Hickey S, Mohan G, editors. Participation: From Tyranny to Transformation: Exploring New Approaches to Participation in Development. London: Zed Books; 2004. p. 25–41, quoted in Williamson, R.T., Rodd, J. Civil society advocacy in Nigeria: promoting democratic norms or donor demands?
[41] Berkman, Alan, et al. 2005. "A Critical Analysis Of The Brazilian Response To HIV/AIDS: Lessons Learned For Controlling And Mitigating The Epidemic In Developing Countries". *American Journal Of Public Health*
[42] Parker, Richard G. 2009

to be guaranteed by the constitution."[43] They were prominent in São Paulo, the center of the AIDS epidemic in Brazil. The political victory of opposition parties in state elections provided members of the movement to occupy senior positions in the health department.[44] This allowed the governmental response to HIV/AIDS to operate as a part of this historical moment in Brazil and within a civil rights context. The São Paulo State Health Department was the leader in the response to AIDS, and it served as the model for the National Unitary Health System (*Sistema Único de Saúde*), or the SUS, Brazil's publicly funded health care system.[45] The Brazilian Constitution of 1988 responded to the demands of citizens' rights as well as the demand for increased dialogue between the local, state and national government and civil society. Stemming from this, the case of Brazil demonstrates that leadership emerged from civil society actors. Citizens were active and vocal in the shaping of health policies that they would be subject to. Democratization allowed for the creation of political parties, trade unions and NGOs throughout the 1980s, all of which were integral in the establishment of such policies.[46] Subsequently, healthcare was added to the Brazilian Constitution of 1988 as a citizen's right, and health reform was institutionalized in the 1990s with the formation of a national health system called the Unified Health System.[47] As the influence of civil society became greater in Brazilian politics, NGOs were formed to work in collaboration with municipal and state health departments to pressure the national government to create a national AIDS program.

[43] Berkman, Alan, et al. 2005
[44] *Ibid*.
[45] *Ibid*.
[46] *Ibid*.
[47] *Ibid*.

Brazil's Rights-Based Approach to AIDS Policy

With HIV infecting mostly homosexual men, stigma surrounding the virus and homosexuality ensued not only in Brazil but also in other affected countries; however, gay and human rights activists successfully mitigated, to some degree, the stigma by operating within this popular human rights framework. They called for the government and the Brazilian people to recognize that the rights of gay men living with AIDS are also human rights; therefore, they should be equally met with respect. The demands of gay activists led to the formation of the first governmental AIDS program in Brazil in 1983. Two years later, GAPA (the AIDS Prevention and Support Group), the first nongovernmental AIDS service organization, was founded by an alliance of gay men, human rights activists and health professionals. In 1986, The ABIA (the Brazilian Interdisciplinary AIDS Association) emerged in Rio de Janeiro through the union of researchers, activists and health professionals. In 1989, the Group for Life (Grupo Pela Vidda), the first HIV-positive advocacy group in Brazil, was created (Fig. 3).[48] The National AIDS Program was established in 1986, and universal access to health care became a cornerstone of the program. Civil society led the government to adopt and implement a rights-based approach to disease prevention and treatment. While geographic and socioeconomic factors as well as age all determine HIV prevalence, which is expected to vary across the country, there was a specific emphasis on the rights of individuals living with HIV and marginalized groups such as homosexuals, women and sex workers.

Incidences of AIDS have been common in the South and southeast, particularly among key populations such as homosexual males, sex workers and injection drug users. Generally, AIDS has been concentrated among the male population in Brazil with the prevalence rate of

[48] Berkman, Alan, et al. 2005

men who have sex with men being 10.5 percent in 2013.[49] In cities, where most of the population is concentrated due to domestic migration from rural to urban areas, prevalence tends to be higher (Fig. 4). A 2016 survey indicates that the rate in cities was 18.4 percent.[50] Sex workers, which are usually concentrated in cities, constitute another group that is highly susceptible to contracting HIV/AIDS in Brazil. In 2017, the prevalence rate among female sex workers was 5.3 percent.[51] It is important to note that sex work is legal in Brazil and is seen as a profession, entitling sex workers social security and other benefits.[52] On the contrary, sex workers are often subject to human rights violations, mistreatment and abuse. Sex work is stigmatized and workers have faced discrimination, making them vulnerable to health implications such as increased risk of HIV. In response to the growing transmission of HIV within the sex work industry, Brazil's Ministry of Health has implemented a rights-based intervention in which the self-esteem, dignity and rights of sex workers are reinforced and condom use is emphasized. Other prevention measures include large-scale mass media prevention campaigns.[53] Brazil is also one of the very few Latin American countries that comes closest to offering comprehensive sex education that covers topics such as contraception and pregnancy, STIs and STDS as well as sexuality, gender identities and sexual and reproductive rights.[54]

Currently, Brazil has one of the highest numbers of HIV/AIDS cases in Latin America, a fact that could be attributed to its comparatively large and diverse population. As of 2019, 920,000 people were living with AIDS in Brazil, and HIV prevalence among adults was 0.5

[49] "HIV And AIDS in Brazil." 2020 *Avert*
[50] *Ibid*.
[51] *Ibid*.
[52] Kerrigan, D., et al. 2013. "The Global HIV Epidemics among Sex Workers." The World Bank
[53] "HIV And AIDS in Brazil." 2020. *Avert*
[54] Frayysinet, Fabiana. 2014. "Comprehensive Sex Education: A Pending Task in Latin America." *IPS*

percent (Fig. 5).[55] Even though more people live with HIV now than before, the number of people with ART coverage is also increasing (Fig. 6). As a result of the public health measures the Brazilian government has taken, the HIV epidemic in Brazil is generally regarded as stable at the national level.[56] From the 1980s onward, Brazil has been adamant about establishing HIV education to inform the public and implementing prevalence measures through the distribution of condoms and HIV testing. In fact, Brazil's National Health Service made HIV treatment and self-testing freely available to all, making it one of the first countries to do so. In 2015, The Brazilian Ministry Health created a strategy called *Viva Melhor Sabendo* ("Live Better Knowing") to increase HIV testing among key populations and to provide an alternative to traditional health services. In collaboration with NGO's, people from such populations were trained to administer rapid oral fluid HIV testing to others in social settings. This effort resulted in increased early diagnoses of HIV among key populations.[57] In the 1990s, drugs for AIDS treatment were costly, exceeding $10,000 per patient.[58] Civil society groups and policy-makers dismissed the WTO's Trade-Related Aspects of Intellectual Property Rights (TRIPS), a treaty that encouraged unified patent protection laws and precluded the domestic production of any generic pharmaceuticals patented outside of the country, despite the Brazilian government's initial support. Brazilians contended that the prices set by multinational pharmaceuticals for ARV were too high and that universal access to treatment required low-cost medicine. Brazil deviated from pharmaceutical companies and the World Bank's suggestion that developing countries do not favor cost effective treatment programs for costly ones. This aberration from the standard approach encouraged by organizations such as the WTO and World Bank allowed

[55] "HIV And AIDS in Brazil." 2020. *Avert*
[56] *Ibid*.
[57] *Ibid*.
[58] Nunn, Amy., et al. 2009. "AIDS Treatment In Brazil: Impacts And Challenges". *Health Affairs*

Brazil to produce generic versions of costly antiretroviral drugs, provide free access to highly active antiretroviral therapy and effectively curb AIDS prevalence and incidence as well as reduce AIDS-related mortality.[59] Brazil's adoption of a domestic health policy that operated according to the concept of universal access would later become a well-defined goal and point of discussion in the international community.

CASE STUDY: NIGERIA

HIV/AIDS in Nigeria and The Role of Civil Society Organizations

The AIDS epidemic has especially affected Sub-Saharan Africa where 69 percent of the 34 million cases of HIV worldwide were concentrated in 2012.[60] In 25 countries of western and central Africa, women account for 54 percent of adults living with HIV in 2015.[61] In the same year, HIV prevalence was 2.5 percent among females between the ages of 15 and 49 and 1.8 percent among males within the same age group.[62] In 2018, 1.9 million people were living with AIDS in Nigeria (Fig. 7).[63] There are many elements in Nigeria that have led to the exacerbation of the AIDS epidemic within the country. At the outset of the AIDS outbreak in many countries in Sub-Saharan Africa, there was a general denial among leaders and citizens alike about its potential prevalence in the country. Politicians were dismissive of the serious public health implications of HIV/AIDS and were unwilling to take action to address it. Consequently, there was a lack of information and awareness surrounding the illness, and this in turn, contributed to

[59] Nunn, A., Fonseca, E. D., & Gruskin, S. 2009. Changing global essential medicines norms to improve access to AIDS treatment: lessons from Brazil. *Global public health*
[60] *HIV and AIDS in East and Southern Africa Regional Overview*. 2020. *Avert*
[61] UNAIDS. 2017. "West and Central Africa Catch up Plan"
[62] *Ibid*.
[63] "HIV and AIDS in Nigeria." 2020. *Avert*

the rapid spread of HIV/AIDS throughout Nigeria.[64] The stigmatization of AIDS has been a key factor that has led to the disease's presence in the country.[65] The source of AIDS has always been contested, particularly between the Western and African world due to its stigmatized nature as a sexually transmitted disease. Whereas several African countries like Nigeria and South Africa have frequently perceived HIV as a Western illness and a "white man's disease," Western media has historically portrayed Africa as the birthplace of AIDS and Africans as the carriers of AIDS.[66] Due to the stigma attached to contracting HIV/AIDS, many people who are infected refuse to accept and disclose their seropositivity. If revealed to be HIV positive, infected individuals are often subject to condemnation, and assumptions are made about the nature of their sexual behaviors. In some cases, seropositive individuals may be dismissed from work and excluded by their family and friends. For them, the social costs are greater than those associated with their health. In this way, one can observe how the lack of factual information coupled with the fears produced by stigmatization have significantly driven the spread of HIV in Nigeria. On the contrary, one of the most fundamental elements that has been conducive to the spread of the AIDS epidemic in Nigeria has invariably been poverty within the country.[67] Global investments in HIV research, care and prevention highlight the disparity in HIV incidences between the developed and developing world. Developing countries, like Nigeria, have 95 percent of cases; however, they only receive 12 percent of resources.[68] Globalization has created a gap between the rich and the poor, and women disproportionately constitute a group of poor, less educated

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[64] Ajayi, J. O. 2003. *The HIV-AIDS epidemic in Nigeria: Some ethical considerations*. Roma: Pontificia Università Gregoriana
[65] *Ibid*.
[66] *Ibid*.
[67] Aniekwu, N. 2002 *Gender and Human Rights Dimensions of HIV / AIDS in Nigeria*. *African Journal of Reproductive Health / La Revue Africaine De La Santé Reproductive*
[68] *Ibid*.

and unemployed Nigerians. With such economic disparities, resources are unequally distributed; good quality water, housing and education are largely inaccessible to the most of the population.

HIV prevalence is high among the general population, but key groups such as sex workers, men who have sex with men and people who inject drugs, who make up 3.4 percent of the population, account for roughly 32 percent of HIV infections.[69] While prevention measures such as condom use and HIV education have been implemented to meet the standards in NACA's National Strategic Framework' there have been clear challenges. For example, condom uptake, an effective STI and STD prevention measure, is often contested and resisted from religious and cultural groups.[70] In terms of antiretroviral treatment, Nigeria has not seen much progress in enrolling diagnosed HIV patients on antiretroviral treatment (ART). In 2017, only 33 percent of all people living with HIV were on treatment and in the same year, the number of AIDS-related deaths remained high at 150,000 (Fig. 8).[71] Nigeria is insistent upon meeting the global target of ensuring that 90 percent of the population living with HIV are on treatment by 2021; however, in order to do so, they will need to address and eradicate the social determinants of HIV vulnerability such as the stigma and discrimination surrounding the disease so that individuals across all groups feel comfortable in seeking treatment for AIDS.

Any national strategy that developed subsequently was often created with the aid of external agencies.[72] The lack of a comprehensive national AIDS policy and the absence of programmatic responses compelled communities and NGOs to take responsibility. Civil society organizations are more aware of what local communities need than international organizations or

[69] "HIV and AIDS in Nigeria." 2020. *Avert*
[70] *Ibid*.
[71] *Ibid*.
[72] Rau, B. 2006. The Politics of Civil Society in Confronting HIV / AIDS. *International Affairs (Royal Institute of International Affairs 1944-)*

governments; however, their job becomes increasingly difficult when the government cannot collaborate with them and fail to provide supportive national AIDS policy or explicit protections for affected people and households. Furthermore, fears within communities and conflicts among them can preclude community responses and instead, reinforce name and blame as well as discriminatory practices.[73] Within a framework of poverty and gender inequality, it becomes even more imperative for governments and civil society actors to work collaboratively in shaping comprehensive policies that also directly address the underlying social factors that exacerbate the transmission of AIDS. The creative approaches suggested and promoted by civil society organizations to HIV/AIDS prevention and care are merely given lip service by government officials and international organizations.[74] Governments and large donors do not want to relinquish their control of funding and expertise. International organizations do not find community-led initiatives and efforts to be sustainable and have little trust in their expertise. As such, they use their funding power to formulate approaches and regulations.[75]

There are several reasons why community-based responses and approaches have not been entirely incorporated by national and international programs.[76] Firstly, many national and international agencies highlight the inability of civil society organizations to program, monitor and evaluate their initiatives. They believe that community-led responses won't implement the proper expert-approved approaches to HIV/AIDS such as individual behavior change, prevention messaging, condom promotion, STI treatment, and drug therapies.[77] Furthermore, there is concern among donors that funding and resources won't be appropriately allocated towards

[73] Rau, B. 2006
[74] *Ibid*.
[75] *Ibid*.
[76] *Ibid*.
[77] *Ibid*.

HIV/AIDS efforts. More often that not, "…the power of money and assumed expertise that defines "correct" approaches to HIV/AIDS prevention constricts what is proposed, what is allowed and what is documented."[78] Politically, civil society organizations do not only raise awareness of HIV/AIDS prevention and mitigation, but they also politicize the issue and invite more structural change to occur that addresses socio-economic factors such as gender inequality and gay stigma and discrimination that fuel the increased spread and disproportionate impact of HIV. Stemming from this, national elites fear that increased civil society participation in political processes and policy-making and assigning them credibility may challenge their own power and credibility, limit their control of budgeting and planning and question their priorities.[79]

A study in Nigeria in 2012 was conducted to ascertain the advocacy and service delivery roles of civil society organizations (CSOs) working in HIV mitigation and prevention.[80] Interviews with civil society organizations, State AIDS Control Agencies (SACAs), donors, international organizations, and people living with HIV served as the method by which advocacy efforts by CSOs were examined.[81] The 553 surveys that were conducted indicated that CSOs advocacy efforts focused on community mobilization related to behavior change and peer education, which constituted 54.9 percent of CSOs, and rallies, which accounted for 58.2 percent of CSOs (Fig. 9).[82] Efforts by civil society organizations did not include shaping government policies, and this can be attributed to role donors, international organization and the government play in formulating a merely apolitical function for most CSOs. HIV/AIDS networks such as the Civil Society HIV/AIDS Network, the Network of People Living with HIV/AIDS in Nigeria, and

[78] Rau, B. 2006
[79] *Ibid*.
[80] Williamson, R. T., & Rodd, J. 2016. Civil society advocacy in Nigeria: promoting democratic norms or donor demands?. *BMC international health and human rights*
[81] *Ibid*.
[82] *Ibid*.

the Youth Network on HIV/AIDS in Nigeria are funded by national and international agencies, which define HIV/AIDS policies and approaches. Such networks and other organizations funded by these agencies are obligated to disseminate established policies and seldom engage in policy analysis and advocacy.[83] In fact, most of the international funding for HIV went towards project implementation and coordination rather than policy analysis and advocacy.[84] Instead of directing advocacy efforts towards the federal government, civil society organizations in Nigeria look to village leaders within their communities, which governments have little reach of, to influence behavior change and convey prevention messages.[85] In this way, civil society actors rarely advocate for community interests at the federal level and instead adhere to the preferences of donors and the government.

Gender Dimensions of Nigeria's AIDS Epidemic

Within the context of impoverishment, women are the ones who suffer the most. The roots of suffering of seropositive women in Nigeria include the feminization of poverty, structural violence, rigid gender roles and patriarchal dominance ingrained in Nigerian culture, all which heavily influence the ways in which HIV positive women are affected and treated.[86] In most sub-Saharan African countries, "…gender inequalities, differential access to health services, and many forms of structural and gender-based violence predispose women to the risk of HIV/AIDS. Yet interventions have remained gender blind as gender considerations are involved in policy discourses but delighted in practice; thus, women continue to be constrained

[83] Williamson, R.T. Funding sources for non-state actors working on HIV prevention and mitigation in Nigeria. Global Science and Technology Forum: Second Annual Global Health care Conference Proceedings. 2013, quoted in Williamson, R. T., & Rodd, J. 2016
[84] *Ibid*.
[85] *Ibid*.
[86] Basikoro, E. E. 2020. *Pathologies of patriarchy: Death, suffering, care, and coping in the gendered gaps of HIV/AIDS interventions in Nigeria*

in their uptake of treatment."[87] There is this continued tension between discourse and practice in Nigerian policymaking, in which gender might be included in discussions regarding health policies but are seldom implemented effectively on the ground. It is the perpetuation of patriarchal social relations that has affected health outcomes."[88] It is not merely patriarchal values embedded in Nigerian culture that are at fault for the limits and restrictions placed on seropositive women in accessing the benefits provided by proper HIV/AIDS treatment. Rather, structural violence against women produced by historical, economic and social processes has also contributed to the vulnerability of Nigerian women to the risk of HIV/AIDS.[89] This, in turn, has aggravated the effects of social behaviors based on patriarchal attitudes and values, sustaining gender inequality and discrimination in the health sector and circumventing a gender-inclusive approach to policy discourse and practice.

Another reason why HIV in Nigeria disproportionately affects women and young girls stems from the country's social norms and traditions surrounding gender. The unequal power dynamic between men and women as well as women's inferior political, economic, social and cultural position in Nigerian society renders them vulnerable to contracting a disease as prevalent as HIV. Laws and policies that maintain traditional roles have played a role in sustaining the vulnerability of women in contracting HIV as well as in limiting their access to important information and services regarding health, education and employment. Since gender norms are deeply rooted in culture and law, a Nigerian woman often lives with a lack of agency, as she cannot determine who she will marry, how many kids she will bear or if her partner should use

[87] Basikoro, E. E. 2020
[88] *Ibid*.
[89] *Ibid*.

contraception.[90] In addition, women do not have as many economic opportunities as their male counterparts, and this often makes them vulnerable to sexual exploitation and HIV. As a result, the susceptibility of Nigerian women to the risks of HIV/AIDS is a result of the relationship between economic circumstances and cultural perceptions of women's role and place in society. In countries where abject poverty is seen, women's bodies become sites of economic restoration and growth.[91] In desperate measures, women either voluntarily or involuntarily sell their bodies to make ends meet for their families. Due to their subordinate position in Nigerian society, women are often uninformed about their rights and uneducated on reproductive issues.[92] This lack of education renders women powerless and subject to the demands of their male counterparts. Nigerian gender politics is predominantly seen from a patriarchal, male-dominated lens in which men are assigned the responsibility of speaking for women in matters that exclusively affect females. There are many gaps in the discussions surrounding the health of Nigerian women since the gender dimensions of HIV/AIDS and the challenges women living with HIV face have been subject to little research.[93] While conversations about women's health have usually been expressed in terms of their reproductive rights, the social, cultural and economic factors that have affected the spread of diseases such as HIV have often been overlooked. Many women in Nigeria are dependent on men for economic and personal safety. Their low economic and social position in Nigerian society makes them submissive to the demands of their partners. In other words, they remain in unsatisfactory relationships and deal with the risks because they understand that they have very few choices to ensure their economic security.

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[90] Basikoro, E. E. 2020
[91] Ajayi, J. O. 2003
[92] *Ibid*.
[93] Aniekwu, N. 2002

While HIV infections have been more prevalent among men than women, women are becoming increasingly affected by the HIV/AIDS epidemic. In 2017, 45,000 females between the ages of 15 and 24 were infected by HIV compared to 38,000 males in the same age group in Nigeria (Fig. 10). It is evident that men and women experience the same health conditions in very different ways, but inequalities in health outcomes are also discounted, placing women at a much greater disadvantage. In Nigeria, health policies and programs have been approached through a biological lens.[94] More often than not, they reproduce gender inequalities and fail to take into account the socioeconomic challenges that women face in Nigeria. For example, policies do not address the feminization of impoverishment, women's economic inequality and the unequal distribution of resources between males and females. Traditional conceptions of femininity suggest that women are not seen as autonomous individuals, and this understanding of gender differences translates into policy-making, particularly health policy, as females do not have a say in their sexual relationships and health. This can be attributed to the social constraints on Nigerian women's knowledge and ability to engage in safe and protected sex.[95] Initially, the Nigerian response to HIV/AIDS centered on high risk groups like commercial sex workers, but the state's attention eventually shifted to high-risk behaviors, such as having unprotected sex, especially with sex workers. On the contrary, gender dynamics and issues in sexual relations were never addressed until a significant number of women who were not in the business of sex work were infected with HIV.[96] In relationships, Nigerian women often did not have a say in the ways in which sex was practiced, and don't express their own needs in a relationship. For example, whether or not a man is going to use a condom was solely the man's choice. In other instances, since sexual pleasure is seen to revolve around male pleasure, it is sometimes that case

[94] Aniekwu, N. 2002
[95] *Ibid*.
[96] *Ibid*.

that men choose when to have sex regardless if their female counterparts perhaps don't want to. All in all, women don't have a voice in their partner's sexual practices or infidelity, and this inevitably places them at a higher risk for HIV. The fact 60-80 percent of women infected with HIV have had only one sexual partner speaks to the normalization of certain behaviors within relationships that can mostly be practiced by men at the expense of women's health.[97]

Relative to men, women are biologically more susceptible to contracting HIV/AIDS among other sexually transmitted diseases; however, an exploration of sexuality and gender through a cultural, economic and social lens also accentuates women's vulnerability to such diseases. Women's biological vulnerability is merely one aspect; their susceptibility to sexual violence and discrimination and their exclusion in the decisions pertaining to gender-specific issues, all of which are sustained by cultural, social and religious constructions of gender and sexuality, better explains the increasing number of women living with HIV.

Gay-Related Stigma in Nigeria

Sexuality is another element that has determined the effectiveness of AIDS responses and has been indicative of the implications HIV has on another vulnerable and traditionally oppressed group: homosexual men. As stigma surrounding homosexual relations increases, so too does HIV and other STI prevalence. This causal relationship, studied by researchers in the International AIDS Society Journal, relates to the fear common to many gay men in Nigeria in seeking healthcare.[98] As a part of this study, conducted from March 2013 to February 2016, researchers asked homosexual males from Lagos and Abuja to complete a behavioral

[97] Aniekwu, N. 2002
[98] Harrington-Edmans, Francesca. 2018. "Strong Link Found between Gay-related Stigma and HIV Prevalence in Nigeria." *Avert*.

questionnaire, which aimed to measure stigma on the basis of nine major stigma indicators such as experiences of violence, rape, physical and verbal harassment, social rejection and exclusion, discrimination from family, a lack of police protection, blackmail, fear of seeking treatment and fear of walking in public. Participants were categorized into three groups to determine which individuals experienced high, medium or low levels of stigma.[99] This method of conducting research allowed researchers to observe which specific experiences were more strongly associated with HIV prevalence. Those who have encountered high levels of stigma were more likely to be diagnosed with HIV in addition to other STIs; those who revealed their seropositivity were also likely to experience great stigma, especially physical violence and blackmail. Across all three groups, fear of seeking healthcare was the common response to stigma.[100]

Gay-related stigma in Nigeria stems from various codes and laws that have been created and implemented to prohibit homosexuality and disavow the LGBT community. The Criminal Code Act, the Same Sex Marriage Prohibition Act and the Sharia Law, which is in effect in 12 northern Nigerian states, all explicitly state the criminalization of homosexual intimacy and same-sex marriage.[101] Sharia law and Section 5(1) of the Same Sex Marriage (Prohibition) Act are specifically extended to include sexual intimacy and marriage between two women. Section 5(2) of the Act expresses the criminalization of the operation of and participation in LGBT and the public display of same-sex relations, and Section 5(3) of the Act prohibits any aid to a same-sex marriage or support of an LGBT organization.[102] While punishments for failing to abide by one of the aforementioned laws vary, violators can expect to be imprisoned from three to

[99] Harrington-Edmans, Francesca. 2018
[100] *Ibid.*
[101] "Nigeria." *Human Dignity Trust*
[102] *Ibid*.

fourteen years, depending on the law that was broken.[103] These codes continue to be in effect and have served a significant role in the perpetuation of stigma surrounding homosexual men and AIDS (Fig. 11). In 2019, 11 percent of men who have sex with men in Nigeria had ART coverage (Fig. 12).[104] As indicated by the study, violence, harassment and rejection are deterrents in the seeking of professional care and treatment.

In 2013, Nigeria dismissed any recommendation to decriminalize homosexual activity in accordance with international human rights laws. Nigeria stated that its rejection of any revisions to the Anti Same-Sex marriage Bill stems from its belief that same-sex marriage is in contradiction to national values.[105] Furthermore, the Nigerian delegation advances its argument by claiming a poll conducted in 2011 demonstrated that 92 percent of Nigerians objected to same-sex marriage on the basis of their religious, cultural, national and moral beliefs.[106] The law and this strict commitment to tradition have justified human rights abuses against individuals based on their real or perceived sexual orientation. While two laws, the Violence Against Persons (Prohibition) Act and the HIV/AIDS (Anti-Discrimination) Act, signify some progress by the Nigeria government in protected historically marginalized groups; it is imperative to note that the effect of such laws can only be realized if they are implemented and practiced. If Nigerian society does not fully accept homosexuality, then such laws hold little real meaning and produce little positive change for the LGBT community and those living with AIDS.

[103] "Nigeria." *Human Dignity Trust*
[104] UNAIDS. 2019
[105] *Human Rights Watch*. 2017
[106] *Ibid*.

Challenges to Social Mobilization in Nigeria

Regarded as the most populous country in Africa, Nigeria is a country characterized by great ethnic diversity (Fig.13). The political history of Nigeria with respect to ethnic politics is important to take note of when assessing the challenges of social mobilization in the country. In order to understand the role ethnic politics plays in Nigeria, it is important to define three related yet different concepts: "ethnic group," "ethnicity" and "ethnicism." An ethnic group can be defined as "…an informal interest group whose members are distinct from the members of other ethnic groups within the larger society because they share kinship, religious and linguistics ties."[107] While members of a particular ethnic group are united by a shared ancestry, culture and language, ethnic groups are social formations that generally are bounded and most noticeably identified by language.[108] Ethnicity can be defined as "…the interactions among members of many diverse groups," while ethnicism entails ethnic loyalty and a sense of attachment to one's ethnic group."[109] As such, "ethnic loyalty or ethnicism usually involves a degree of obligation and is often accompanied by a rejective attitude towards those regarded as outsiders (that is, members of other ethnic groups)."[110]

A product of the imperialist project undertaken by Britain, Nigeria gained independence in 1960 and formed as a federation of three regions: northern, western and eastern. As differences became increasingly presented, three regionally-based and ethnically sustained

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[107] Cohen, A. 1974. The Politics of Cultural Pluralism, quoted in Salawu, B. and A.O. Hassan. 2011. *Journal of Public Administration and Policy Research*
[108] Noli, A. 1978. Ethnic Politics in Nigeria, quoted in Salawu, B. and A.O. Hassan. 2011. *Journal of Public Administration and Policy Research*
[109] Pepple, IA. 1985. Ethnic Loyalty and National Identification. Conference Paper Proceedings on Rural Resources and National Development, quoted in Salawu, B. and A.O. Hassan. 2011. *Journal of Public Administration and Policy Research*
[110] Salawu, B. and A.O. Hassan. 2011. Review of *Ethnic politics and its implications for the survival of democracy in Nigeria*. *Journal of Public Administration and Policy Research*

political parties materialized: the Northern People's Congress (NPC), the National Convention of Nigeria Citizens (NCNC) and the Action Group (AG).[111] Since independence, Nigeria has experienced three different republican governments, which were, at certain points in time, interrupted by military rule. Military leadership rendered the establishment of a political democracy a challenging task in Nigeria. In 1979, a parliamentary form of government was replaced by a presidential system. The multiethnic nature of Nigeria's demography undermined the parliamentary multi-party system, and the politicization of Nigeria's ethnically diverse groups hindered Nigeria's efforts for national unity, effective governance and development.[112] Furthermore, ethnic divisions and conflicts were exacerbated by the militarization of power and political corruption.[113] Socio-economic differences among ethnic groups produced a cultural dissimilarity, and within this context of diversity, issues between ethnically different groups largely pertained to the acquisition of wealth and power.[114] Constitutional developments have fostered ethnicism and precluded any possibilities of national integration. The Arthur Richard Constitution of 1946, for example, created the first regional government in Nigeria and introduced the concept of regionalism. Stemming from the 1946 constitution, fragmentation on the basis of ethnicity occurred. Ethnic nationalism has inevitably become a byproduct, in which individuals have greater allegiance to their particular ethnic groups than the country and identify themselves according to the ethnic groups of which they are a part as opposed to the nation in which they live. Given the salience of ethnicism and ethnic nationalism, there is great competition among ethnic groups, particularly larger ones who vie for wealth and power and seek to avoid domination from other ethnic groups. This fear of domination then results in the

[111] Salawu, B. and A.O. Hassan. 2011
[112] Yagboyaju, D.A. & Akinola, A.O. 2019. Nigerian State and the Crisis of Governance: A Critical Exposition. SAGE Open.
[113] *Ibid*.
[114] Salawu, B. and A.O. Hassan. 2011

formation of political parties imbued with ethnicism.[115] While Nigeria has developed as a multi-ethnic, multi-lingual, multi-religious and multi-cultural society with 374 ethnic groups and several hundred language, Nigeria's ethnic pluralism, cultural diversity and tribalism has been seen to prevent efforts of national integration and solidarity.[116] Without political leadership that recognizes and values the diversity of Nigeria and is willing to treat all ethnic communities equally as one people, the complete realization of national unity is not possible.

Stemming from this, it is apparent that Nigerians may not necessarily identify themselves nationally but ethnically, and this inevitably produces challenges in making progress on issues that require national unity, such as AIDS. While Brazil is also a multicultural society itself, unlike Nigeria, one of the key reasons it was able to achieve a sense of national unity was the presence of a single language. As a result, social mobilization and the active participation of civil society in formulating AIDS policy were feasible. Differences among ethnic groups in Nigeria in terms of culture, language and lifestyle can make it comparatively more difficult for different groups to unite for a national project that addresses the socioeconomic implications of a disease so heavily stigmatized as AIDS.

HIV AND COVID-19

Encountering A New Epidemic in Brazil and Nigeria

A notable feature of Brazil's response to HIV in the '80s and '90s mainly focused on human rights, citizenship and solidarity. In the midst of a political transition from a military dictatorship to a democracy, society was compelled to mobilize around issues of civil rights, one

[115] Salawu, B. and A.O. Hassan. 2011
[116] *Ibid*.

of which included the emerging and increasingly prevalent AIDS epidemic. The reality of discrimination and stigma associated with HIV precluded many to seek care and treatment; however, the power of social mobilization lies in its ability to compel the government to establish a national health policy that not only reduced stigma but also lowered the rates of incidence and mortality associated with AIDs on the basis of human rights and dignity. The government listened to the people's demands for a more inclusive approach in addressing AIDS that focused on testing, prevention, education and safety. This particular approach has been quite unique to Brazil and eventually became the model for many other countries later on in time. Stemming from Brazil's history with public health crises and its robust public health system, it would be logical to assume that within the current COVID-19 context, Brazil would have been able to appropriately address the risks and consequences of the modern epidemic. The reality is enough evidence to suggest that Brazil's current administration had learned little from the HIV situation. In fact, Brazil became the global epicenter of COVID-19 at one point, although recent statistics show that both cases of infection and death have decreased.[117] This can largely be attributed to President Bolsonaro's cavalier attitude towards the coronavirus pandemic from the outset. Conflicting messages from the government and tensions between the executive and the state and health officials produced low compliance among the population.[118] On another note, it is quite useful to analyze the risks and responses of the coronavirus in Brazil within the framework of HIV/AIDS. What we can observe from Brazil's response to COVID-19 is that it completely counters the response to HIV in the '80s and '90s. Effective and strong health policies to address AIDS were made possible through the solidarity of civil society; there was a shift from a self-centered health perspective in which each individual protects himself/herself to

[117] Parker, Richard. 2020. *Sexuality Policy Watch*
[118] *Ibid*.

a communal perspective in which people act for the protection of their community. Another factor worth discussing is testing, which proves to not only be a powerful biomedical but also political tool.[119] As such, testing, in practice, serves two opposing purposes: it evidently aids in the reduction of the spread and occurrence of the disease but it can be used to discriminate and exclude certain people.[120] People with pre-existing conditions and elderly people were seen as a threat and were subject to confinement much in the same way that gays and people who tested positive for HIV were seen as a danger to society and were consequently marginalized. Perhaps if the current Brazilian administration were to encourage a rights centered approach to COVID-19 and employ rhetoric that did not exclude but fostered a sense of solidarity, less people would have had to deal with the implications of the pandemic.

In Nigeria, the persistent fight against HIV has been marked by corrupt leadership and limited control of the epidemic. The introduction of the coronavirus has exacerbated the risks, consequences and already seemingly inadequate responses to HIV. There are real concerns among Nigerians living with HIV regarding the negative impact of COVID-19 on their quality of life and their access to critical medication and treatment. With a political structure tainted by embezzlement and corruption, funds meant to strengthen the health care system are often misallocated. Health policies established by the government lack consistency in practice and as a result, NGOs are met with the task of providing out-of-pocket or donor aid to HIV-positive individuals living in Nigeria.[121] With a significant portion of the responsibility placed on NGOs, it is quite evident that as coronavirus safety measures are implemented in societies, their business operations come to a halt at the expense of seropositive Nigerians. Organizations such as the AIDS Prevention Initiative in Nigeria, AIDS Healthcare Foundation Nigeria and PATA (Positive

[119] Parker, Richard. 2020. *Sexuality Policy Watch*
[120] *Ibid*.
[121] Owoh, Ugonna-Ora. 2020. *The HIV/AIDS Resource*, TheBody

Action for Treatment Access) have all had to bear the brunt of the coronavirus and the restrictions that have ensued.[122] The strict and sometimes abusive enforcement of stay-at-home orders by military officers in Nigerian states render the distribution of antiretroviral drugs difficult. Even when drugs arrive later than the intended time, very few people who need treatment the most actually defied stay-at-home orders to obtain refills. On the other hand, as the COVID-19 pandemic rendered resources limited, the responsibilities of some of these organizations have perhaps temporarily shifted. PATA is a NGO in Nigeria specifically established for the needs of women and girls. Their intended objective was to educate females on sexual and reproductive health; however, within the context of COVID-19, their newfound goal was to feed low-income and impoverished communities.[123]

In both Brazil and Nigeria, it is evident that the coronavirus has significantly impacted people living with HIV in accessing treatment. The new virus has made it difficult to distribute resources and medications to those who need it as a result of overly broad lockdown measures. As attention, resources and care is invested in addressing COVID-19, civil society has had step in to help those with health conditions and participate in the distribution of adequate nutrition and treatment to an already vulnerable population.

DISCUSSION AND ANALYSIS

In Brazil and Nigeria, cultural definitions of gender and sexuality have invariably contributed to women's increased vulnerability to contracting HIV. Social constructions of the roles, behaviors and sexual attitudes of males and females inevitably affect the ways in which each gender experiences AIDS. While Brazil does not have an unblemished human rights record,

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[122] Owoh, Ugonna-Ora. 2020

[123] *Ibid*.

it has been successful in reducing AIDS-related mortality rates and expanding access to necessary treatment to all groups. Their emphasis on human rights has allowed issues underlying the disproportionate impact of AIDS, particularly gender inequality as well gay stigma and discrimination, to be addressed. Civil society organizations have played and continue to play a role in the delivery of services and education and have had an impact on policy-making in Brazil. Marginalized groups especially affected by HIV, namely homosexual men and sex workers, were given a chance to voice their specific needs and concerns so that a proper and effective AIDS policy could be formulated. Brazil's experience with AIDS demonstrates that it is through educational and advocacy efforts by civil society that human rights is positioned at the center of national health policy.

In Nigeria, the stagnancy of health policy can be attributed to a number of related factors. Weak and complacent leadership, low domestic funding and dependency on foreign investments have been integral in the lack of progress for the HIV agenda.[124] In order to effectively address the AIDS epidemic in Nigeria, the domestic government needs to demonstrate willingness to work collaboratively with civil society actors and organizations as well as increase domestic funding for their own health care. Health systems are weak, and there is little attention on the importance of community involvement and community service delivery in care and treatment. In Nigeria, medication is financed out-of-pocket, and private contractors produce inflated prices for drugs at the expense of many impoverished HIV-positive Nigerians.[125] This practice makes it harder for the Nigerian government to reduce the price of antiretroviral drugs and eliminate inequities in the accessibility of health care. Furthermore, user fees for medication, testing and

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[124] UNAIDS. "West and Central Africa Catch up Plan." 2017
[125] *Ibid*.

hospitalization are another related factor that deters universal access to health care.[126] Stigma and discrimination, as evidenced by gender-based violence and the criminalization of homosexuality, are still salient features in the realities of HIV-positive Nigerians. While Nigeria has many strategies on gender equality and HIV, less than 1 percent of spending on HIV goes towards them.[127] When laws and policies reinforce violent and discriminatory practices, it is safe to say that certain groups are precluded from benefiting from health services for fear of being subject to unfair treatment.

Poverty, illiteracy, gender inequality, gay stigma, migration and rapid industrialization have all contributed to the exacerbation of HIV/AIDS in countries like Nigeria.[128] In order to effectively win the fight against AIDS, people must understand and aim to address the structural forces at play that fuel the HIV/AIDS epidemic. As a signatory of various human rights treaties designed to advance gender equality, Nigeria is obligated to make an active effort to directly address the underlying causes of women's increased vulnerability to the HIV infections. Guidelines like those outlined by the National Agency for the Control of AIDS that aim to reduce HIV risk among females by including gender in the HIV response, raising awareness on the relationship between gender inequality and HIV and reducing violence against women and girls through legal protection must be taken seriously and thoroughly realized. AIDS is not merely a health crisis; it is a health emergency whose implications leak into other sectors of the state including human rights, economic development and education. Human rights principles and a rights-based approach to an HIV/AIDS response that honors the liberties of all groups is of the utmost importance in addressing the gender disparities in incidences of HIV. An approach to health policy that places human rights at the very center recognizes that behavioral interventions

[126] UNAIDS. "West and Central Africa Catch up Plan." 2017
[127] "HIV and AIDS in Nigeria." 2020 *Avert*
[128] Aniekwu, N. 2002

are not the solution to a systemically fueled issue. Instead, there needs to be greater focus on the social factors that have exacerbated the epidemic in Nigeria.

In Nigeria, civil society organizations have not been afforded the opportunity to influence the policy-making process and shape governmental responses to AIDS health policy by focusing on the broader socioeconomic factors that have worsened the impact of AIDS. Efforts of political advocacy by civil society organizations were undermined by a lack of funding and as well as the limited scope of their influence.[129] The profound difference between Brazil and Nigeria is that civil society organizations in Brazil are respected as active developers of national programs and approaches to AIDS that participate in democratic norms, whereas in Nigeria, community-level civil society organizations are conceived of as mere service delivery organizations and implementers of policies, programs and approaches that are created by external actors and organizations. Unlike in Brazil, civil society organizations in Nigeria are not conceived as independent actors who are assigned some political power and a political voice to inform leaders of the specific needs and demands of the people, especially those most affected by HIV. Furthermore, there isn't a civil society forum in which the protection and fostering of the rights of marginalized groups is advanced. With respect to AIDS organizations, the Nigerian public perceives Nigerian AIDS NGOs to be "conduits of corruption."[130] Despite the rhetoric of international treaties and governments that identify adequate, accessible and affordable health care as a fundamental human right, the realization of such care varies across countries, and in, practice, rarely lives up to this objective. Regional and national efforts have been made by states and non-governmental organizations to establish initiatives that slow the rate of HIV transmission and pursue proper national responses to the epidemic that accord with human rights

[129] HIV and AIDS in Nigeria. 2020 *Avert*
[130] Smith, D. J. 2012. AIDS NGOS and corruption in Nigeria. *Health & place*

principles; however political dedication to recognizing the rights of all people has still yet to be seen in Nigeria. The Abidjan Declaration, issued in 1997, has been one such effort, which stated the commitment of municipal leaders to seek effective HIV/AIDS solutions that respond to local needs and align with UN principles and national laws and regulations.[131] The International Partnership against AIDS recognized that one group of individuals invested in combating HIV/AIDS was insufficient. Instead, a partnership among civil society, government and international organizations is needed.[132] African governments have been the dominant voice in making decisions about health policies, since the responsibility of the government is to protect its people, but a coalition between different sectors of society produces a much more effective right-based response to HIV/AIDS.

CONCLUSION

A nation's response to an epidemic like HIV/AIDS can be understood within that nation's particular social, political, economic, historical and cultural context. In the Brazilian case, political activism from below and cooperation between civil society and policy-makers allowed healthcare to be recognized and treated as a human right in the country. As a multiethnic country, Brazil has traditionally seen regional and social differences, but the political transition that materialized in the 1980s compelled citizens to mobilize and unite for a common cause: democracy. It was through democracy, they believed, that a sense of social solidarity could be attained. The unity of the Brazilian people helped them in their pursuit of democracy, and, in turn, it paved the way to an effective response to the AIDS epidemic that had by that time emerged and rapidly spread. The responsiveness of the Brazilian government to the demands of

[131] Aniekwu, N. 2002
[132] *Ibid*.

civil society groups led to the creation of a public health care system that functions according to the principle of universal health care and health access. Through various prevention measures and access to treatment, the AIDS epidemic was properly addressed and effectively reduced. Brazil's success in its response to HIV/AIDS demonstrates the need for governments to recognize that healthcare is a central responsibility and a human right and that international organizations should alter the macroeconomic policies that in reality prevent the governments of developing countries from strengthening their health systems.

Nigeria proceeded on a political and economic path different from Brazil, and these two factors have certainly contributed to the nation's response to the HIV epidemic. On the contrary, as Brazil demonstrates, a key solution in expanding access to health care and protections for vulnerable groups of people rests in the hands of the people themselves, especially those most affected by the disease. Structural gender differences and inequalities as well as disapproval of LGBT practices and the community in general, which stem from the cultural, religious and national ideas and values embedded in Nigerian society, have hindered efforts to sustain equitable AIDS health practices and responses. Existing national laws prohibiting same-sex marriage and behavior conflict with the human rights principles of international treaties that many countries including Nigeria have promised to uphold. This inconsistency is indicative of Nigeria's commitment to the preservation of cultural ideas and beliefs that stand in distinction to human rights law and subjects certain groups of people to discrimination, violence and unequal treatment over the willingness to cater to the specific needs and demands of such vulnerable groups in the fight against AIDS. An effective national health response can be created by the demands, challenges and concerns articulated by the people, especially those living with AIDS. If a political willingness to transform the social and cultural thinking that has long dominated

Nigerian society is absent, fair approaches to and equitable practices of AIDS health policy will not be effectively implemented.

It is critical for human rights to be at the very center of policy-making regarding AIDS, as the Brazilian case demonstrates; this can reduce stigma, expand opportunities for women and homosexual men to seek care and receive treatment and ensure that every person's humanity is recognized before his or her gender, sexual orientation or social status. The extent to which other countries such as Nigeria could adopt the Brazilian model is incumbent upon certain conditions that allowed social mobilization and civil solidarity to take place in the first place. This is not to say that Nigeria could not draw important lessons with Brazil's approach to health policy as it relates to HIV/AIDS. Actors can and should invoke human rights, because it is not only a moral obligation but also a legal one. Nigeria is a signatory of international human rights treaties and outlines in its national constitution the value of human rights. It is essential for people to oppose HIV-related stigma and discrimination in order to advance a right-based health policy that extends the right to health to all members of society.

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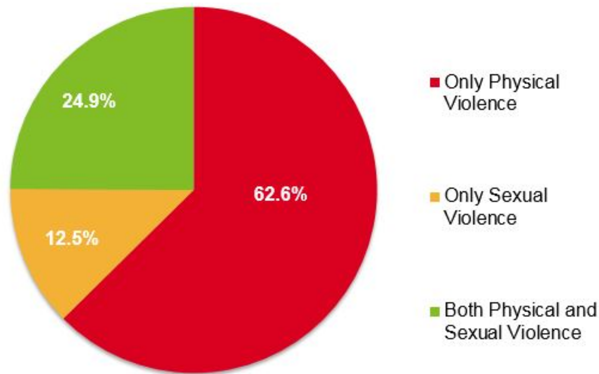
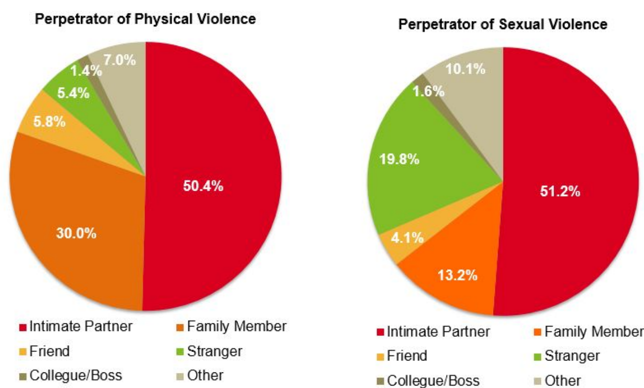
APPENDIX

Fig. 1



Types of Violence Experienced by Women in Brazil. Source: Data and graph from Gundersen, Kristin Kay, et al. "Gender-Based Violence and HIV Infection: Overlapping Epidemics in Brazil." *World Bank Blogs*, 25 Nov. 2016. https://blogs.worldbank.org/voices/are-victims-gender-based-violence-higher-risk-hiv-infection-brazil

Fig. 2

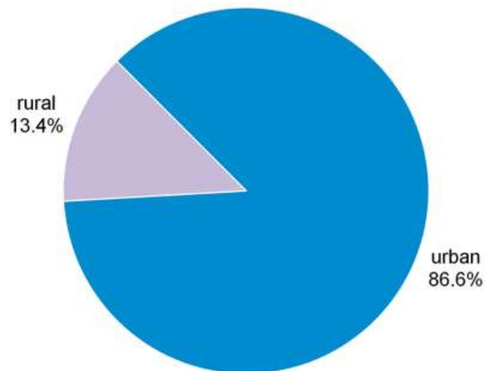


Perpetrators of physical and sexual violence against women. Source: Data and graph from Gundersen, Kristin Kay, et al. "Gender-Based Violence and HIV Infection: Overlapping Epidemics in Brazil." *World Bank Blogs*, 25 Nov. 2016. https://blogs.worldbank.org/voices/are-victims-gender-based-violence-higher-risk-hiv-infection-brazil

Fig. 3

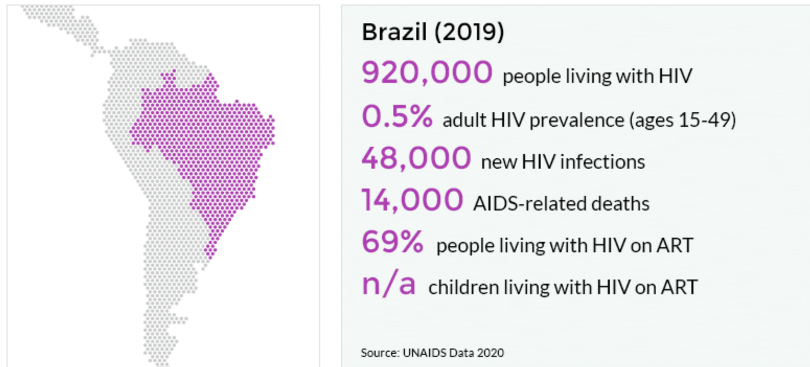
Symbol for Grupo Pela Vidda (Group For Life), the first HIV-positive advocacy group in Brazil. Source: Grupo Pela Vida, https://www.aids.org.br

Fig. 4



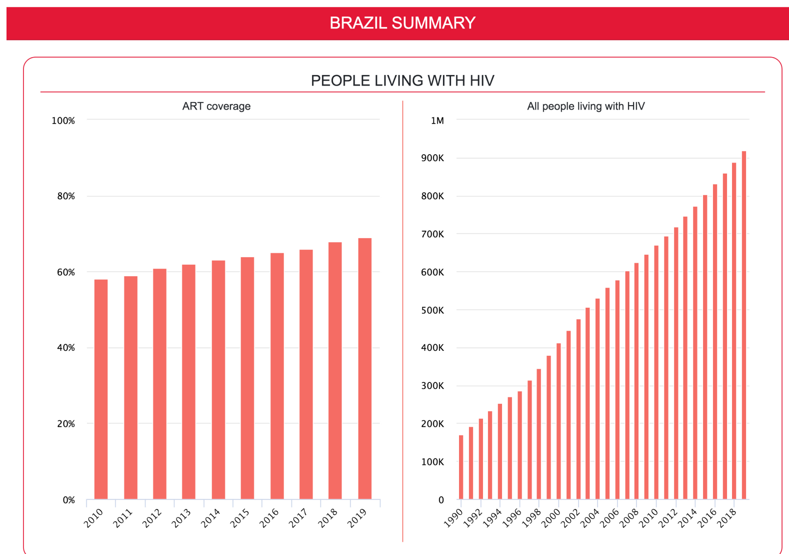
Percentages of Urban and Rural Populations in Brazil. Source: Britannica, https://www.britannica.com/place/Brazil/Ongoing-domestic-migration

Fig. 5



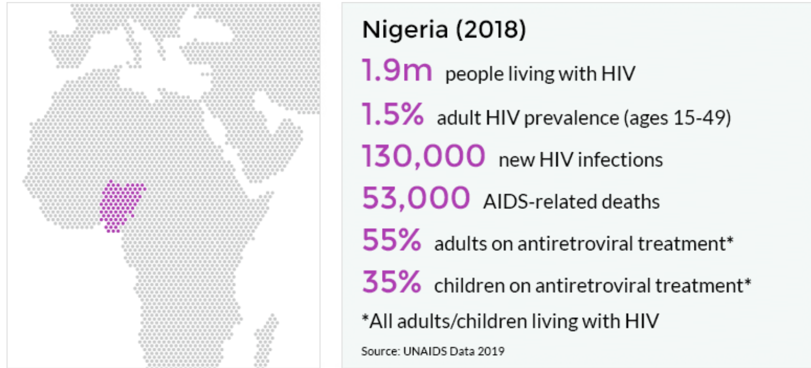
HIV Statistics in Brazil (2019). Source: Data taken from UNAIDS and Graph created by Avert, https://www.avert.org/professionals/hiv-around-world/latin-america/brazil#HIV%20prevention%20programmes%20in%20Brazil

Fig. 6



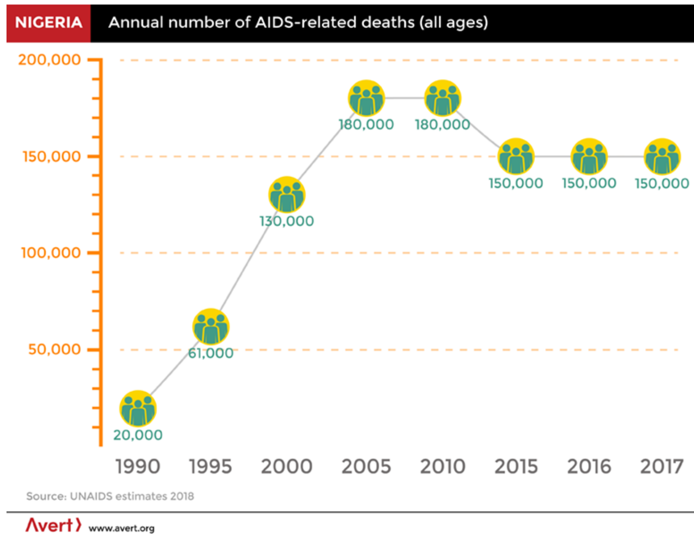
Number of People Living With HIV and Have ART Coverage in Brazil. Source: UNAIDS

Fig. 7



HIV Statistics in Nigeria (2018). Source: Data taken from UNAIDS and Graph created by Avert, https://www.avert.org/professionals/hiv-around world/sub-saharan-africa/nigeria

Fig. 8



Annual number of AIDS-related deaths in Nigeria (all ages). Source: Data taken from UNAIDS and Graph created by Avert, https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/nigeria

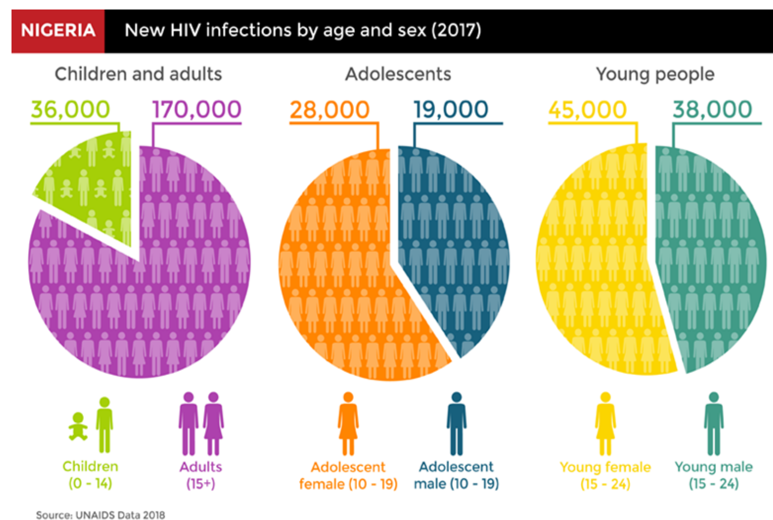
Fig 9.

Advocacy activities reported by CSOs

	Number	Percent
Peer education	286	54.9 %
Rallies	309	58.2 %
Discussions w/ elected officials	173	32.6 %
Mass media campaigns	155	29.2 %
Discussions w/ regulators	98	18.5 %
Policy briefs	58	10.9 %
Press releases	53	10.0 %
Press conferences	42	7.9 %
Petitions	23	4.3 %

Activities reported by Civil Society Organizations in Nigeria. Source: Data and Table taken from Williamson, R. T., & Rodd, J. (2016). Civil society advocacy in Nigeria: promoting democratic norms or donor demands?. *BMC international health and human rights*, *16*(1), 19. https://doi.org/10.1186/s12914-016-0093-z

Fig. 10



New HIV infections by age and sex in Nigeria (2017). Source: Data taken from UNAIDS and Graph created by Avert, https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/nigeria

Fig. 11

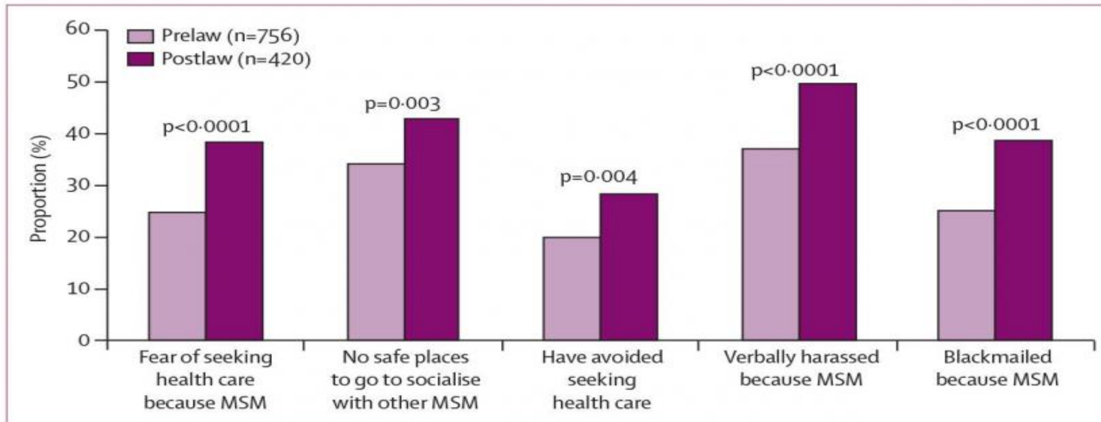
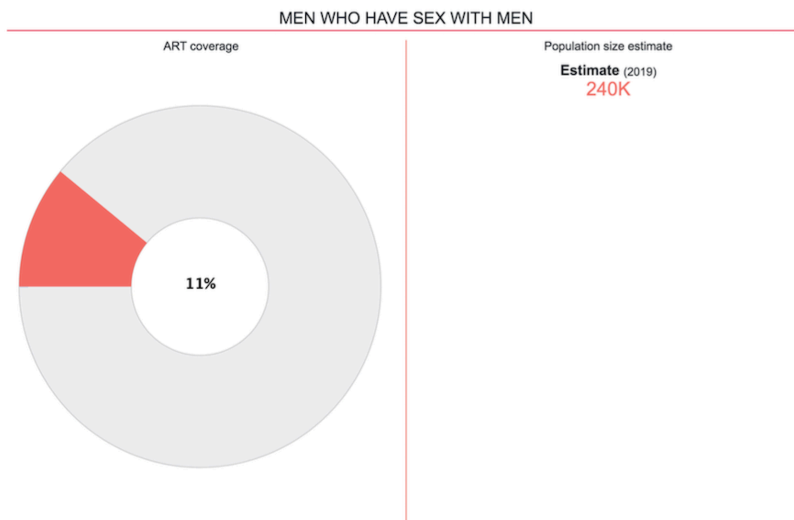


***Figure* 1: Reporting of discrimination and stigma during study visits in the prelaw and postlaw periods**
MSM=men who have sex with men.

Reports of Discrimination and Stigma Among Men Sex Who Have Sex With Men Before and After The Implementation of the Same-Sex Marriage Prohibition Act. Source: Data and Graph taken from Schwartz, S. R., Nowak, R. G., Orazulike, I., Keshinro, B., Ake, J., Kennedy, S., Njoku, O., Blattner, W. A., Charurat, M. E., Baral, S. D., & TRUST Study Group (2015). The immediate eff ect of the Same-Sex Marriage Prohibition Act on stigma, discrimination, and engagement on HIV prevention and treatment services in men who have sex with men in Nigeria: analysis of prospective data from the TRUST cohort. *The lancet. HIV*, *2*(7), e299–e306. https://doi.org/10.1016/S2352-3018(15)00078-8

Fig. 12



ART Coverage for Men Who Have Sex with Men (2019). Source: UNAIDS

Fig. 13

Map of Nigeria depicting different ethnic groups.
Source: OTEDO,
https://ihuanedo.ning.com/profiles/blogs/demographics-of-nigeria?overrideMobileRedirect=1