THE ADVOCATE

...DEFENDING HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS ...ENRICHING OUR DEMOCRACY

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CURE-NIGERIA SETS 53 CAPTIVES FREE, CONDEMNS DETENTION WITHOUT DUE PROCESS, AND SUES FOR THE AMENDMENT OF THE ACJ ACT, 2015.

Bar. Ndubuisi Kalu with one of the released inmates, Mr. James.

Barr. Ndubuisi Kalu, an attorney at CURE-Nigeria with two of the recently released inmates of Keffi Prison who stood trial at the Upper Area Court, Gudu, Abuja, Nigeria. The case was struck out for lack of diligent prosecution, bringing the total of inmates released by the organization to 42 in three years. 26 cases are on-going.

In an attempt to give indigent detainees access to justice and fair hearing, CURE-Nigeria has secured the releases of 53 detainees from Suleja, Keffi Old and New Prisons, and Kuje Prisons, while 26 other cases are on-going. The detainees were standing trial in different magistrates, FCT High Courts and Federal High Court in the Federal Capital Territory. The Executive Director of the organisation, Mr. Sylvester Uhaa made this hint in an interview with our correspondence in Abuja. He lamented the increasing number of detainees without lawyers, and called on the Federal Government to live up to its international obligation to provide all detainees with access to lawyers.

He describes as barbaric, unlawful and cruel, the detention of suspects in prison without records in any courts, meaning that the detainees will never have the privilege of being heard and will remain in prison for a long time. We have records of such inmates in Keffi New Prison and we have written to the CJ of the FCT for necessary actions. We have also gone to court to enforce their fundamental human rights and demand compensation for unlawful detention, he maintained.

Similarly, the organisation has gone to court to challenge Sections 293, 294 and the entire Part 30 of the ACJ Act, 2015 on the grounds that it contravenes Section 35 Subsection 4 and 5 of the 1999 Constitution of the Federal Republic of Nigeria as amended, stressing that the Constitution is the grand norm and any law that contravenes it has to be declared void, adding that the purpose and spirit of law is to serve justice and promote human dignity, so any law that directly or indirectly violates justice and human dignity is to be declared void by a court of competent jurisdiction. Some judicial and

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RIGHTS OF A JUVENILE

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15. Legal counsel, parents and guardians

Rule 15.1 uses terminology similar to that found in rule 93 of the Standard Minimum Rules for the Treatment of Prisoners. Whereas legal counsel and free legal aid are needed to assure the juvenile legal assistance, the right of the parents or guardian to participate as stated in rule15.2 should be viewed as general psychological and emotional assistance to the juvenile-a function extending throughout the procedure.

The competent authority's search for an adequate disposition of the case may profit, in particular, from the co-operation of the legal representatives of the juvenile (or, for that matter, some other personal assistant who the juvenile can and does really trust). Such concern can be thwarted if the presence of parents or guardians at the hearings plays a negative role, for instance, if they display a hostile attitude towards the juvenile, hence, the possibility of their exclusion must be provided for.

16. Social inquiry reports

16.1 In all cases except those involving minor offences, before the competent authority renders a final disposition prior to sentencing, the background and circumstances in which the juvenile is living or the conditions under which the offence has been committed shall be properly investigated so as to facilitate judicious adjudication of the case by the competent authority.

Commentary

Social inquiry reports (social reports or pre-sentence reports) are an indispensable aid in most legal proceedings involving juveniles. The competent authority should be informed of relevant facts about the juvenile, such as social and family background, school career, educational experiences, etc. For this purpose, some jurisdictions use special social services or personnel attached to the court or board. Other personnel, including probation officers, may serve the same function. The rule therefore requires that adequate social services should be available to deliver social inquiry reports of a qualified nature.

17. Guiding principles in adjudication and disposition

17.1 The disposition of the competent authority shall be guided by the following principles:

10(a) The reaction taken shall always be in proportion not only to the circumstances and the gravity of the offence but also to the circumstances and the needs of the juvenile as well as to the needs of the society;

(b) Restrictions on the personal liberty of the juvenile shall be imposed only after careful consideration and shall be limited to the possible minimum;

(c) Deprivation of personal liberty shall not be imposed unless the juvenile is adjudicated of a serious act involving violence against another person or of persistence in committing other serious offences and unless there is no other appropriate response;

(d) The well-being of the juvenile shall be the guiding factor in the consideration of her or his case.

17.2 Capital punishment shall not be imposed for any crime committed by juveniles.

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law enforcement officials have exploited the above provisions of the ACJ Act to detain suspects, particularly the poor without the due process of law. Section 35 of the 1999 Constitution as amended provides that once a person or a suspect is arrested by any of the law enforcement agencies, such a person should be brought before the court within a reasonable time. The reasonable time contemplated here was defined in subsection 5 of the same section to mean 24 or 48 hours as the case may be. The language "brought before the court" used in the Constitution envisages commencement of trial of the suspect and not remand pending investigation or advice from the AG as provided in the ACJ Act, 2015.

I am confident that the amendment of this section will impact positively on the administration of justice, the rule of law and on our collective efforts to decongest the prisons, he stated.

He called on president Buhari to place emphasis on prison reforms.

WOMEN'S HEALTH CARE IN CORRECTIONAL SETTINGS

Introduction

Women represented 9% of the correctional population in 2012; proportionally, this is a substantial increase over the last 30 years (Carson & Golinelli, 2013; Minton, 2013). Women have unique, gender-specific health needs. Incarcerated women report histories of alcohol and drug abuse, sexually transmitted infection, sexual and physical abuse, and mental illness, with rates of these conditions higher than those of incarcerated men, according to numerous studies. Moreover, the majority of incarcerated women are younger than 50 (Guerino, Harrison, & Sabol, 2011) and therefore have specific reproductive health issues, including pregnancy. This position statement is intended to guide the correctional administrator in the management of women's health care.

Gynecological

Research on the provision of gynecological services for women in correctional settings has consistently indicated that current services are inadequate (Weatherhead, 2003). Gynecological exams are not performed upon admission, nor are they routinely provided on an annual basis. Appropriate initial screening questions about a woman's gynecologic history often are not asked. Furthermore, many jails and prisons lack health providers who are trained in obstetrics and gynecology, which leads to inadequate and inappropriate gynecologic care. As a result, women in prison are at risk for having some diseases, such as breast and ovarian cancer, or abnormal Pap smears go undetected.

Pregnancy

Sexually active women remain at risk for pregnancy until they go through menopause (complete cessation of menses for greater than 12 months) either naturally (average age in the United States is 51) or surgically (hysterectomy or removal of both of their ovaries). At any given time, approximately 6% to 10% of incarcerated women are pregnant (American College of Obstetricians and Gynecologists [ACOG], 2011). Many women first learn they are pregnant when they enter a correctional facility. At the time of their arrest and incarceration, many pregnant inmates lack prenatal care and need considerable support to improve the clinical outcomes of their pregnancies. Research has demonstrated that these women are not consistently provided counseling on options or access to termination services (Roth, 2004; Sufrin, Creinin, & Chang, 2009). Owing to their past medical histories and high rates of substance use disorders, incarcerated women tend to have complicated and high-risk pregnancies. For example, fetal alcohol spectrum disorder creates psychological, neurological, and physical impairments in affected children (Pruett, Waterman, & Caughey, 2013). Pregnant women with opioid use disorders must not be detoxified and must be offered opiate substitution therapy, yet this is not uniformly available in jails and prisons. Despite these high-risk pregnancies, a 2008 Bureau of Justice Statistics report documented that only 54% of pregnant prisoners received prenatal care (Maruschak, 2008). Pregnant inmates have high levels of psychological distress, yet often do not receive counseling and support services. Restraints are still commonly applied in childbirth despite the medical risks (ACOG, 2011).

Postpartum

As many as 19% of women in the United States experience postpartum depression within 3 months of delivery, with 7% having a major depressive episode (Gavin et al., 2005). The general lack of attention to postpartum mental health issues has serious consequences. Postpartum incarcerated women are at higher risk for postpartum depression and psychosis owing to their high prevalence of underlying mental health disorders and the emotional trauma of being separated from their newborns. Nonetheless, screenings for postpartum physical and psychiatric complications often are not routinely performed for women who deliver while in custody and for women who enter custody and have recently given birth.

Mother–infant attachment is crucial for the infant's psychological development and the mother's mental health, especially in the immediate postpartum period. However, most women who give birth while in custody are forced to separate from their infants within 1 to 2 days of giving birth. Contact visits with the newborn can enhance mother–infant bonding and have a positive impact on the inmate's well-being. Several correctional facilities have instituted nursery programs that allow the infant to live with the mother in a specially supervised wing, with parenting support for the inmate. Such programs have been shown to improve women's feelings of attachment to their children, and to reduce recidivism; one study found that 86% of women in a prison nursery program remained in the community 3 years after release (Goshin, Byrne, & Henninger, 2013).

Breast milk is known to have numerous benefits for newborns and for mothers, but incarceration makes it difficult for infants and postpartum women to receive those health benefits (ACOG, 2011).

Parenting Services

Many women in correctional facilities have young children, ranging from 56% in federal prisons to 70% in local jails (Glaze & Maruschak, 2010). Female inmates generally do not receive appropriate parenting and child custody services. Entering a correctional facility is very stressful, but for women with children it is even more intense because of the separation from their children.

Sexual and Physical Abuse

It has been estimated that 43% to 57% of state and federal women prisoners and 67% to 79% of women in jail have been physically or sexually abused (Fickensher, Lapidus, Silk-Walker, & Becker, 2001; Greenfeld & Snell, 1999). Such abuse can lead to lifelong psychological problems such as depressive disorders, stress disorders, anxiety disorders, learning problems, substance abuse (with its attendant physical health problems), and behavioral disorders of violence and impulsivity. Furthermore, being victimized can have serious consequences. One third of all female inmates serving time for a violent crime had victimized a relative or intimate, and of these inmates, two thirds had victimized either their spouse or a family member such as a sibling or even their own child (Snell & Morton, 1994). Prior sexual abuse or assault may also make women reluctant to undergo gynecologic exams.

Alcohol and Drug Abuse

A U.S. Department of Justice (1999) study revealed that more than 40% of female prisoners were under the influence of drugs at the time of their offense. Sixty-nine percent of women entering jails met criteria for substance dependence or abuse (Karberg & James, 2005). Because of this abuse, many women prisoners are at much greater risk of becoming HIV positive from having had unprotected sex or having used dirty needles. Drug counseling, by itself, is not enough: The track record shows that people with addiction almost always relapse.

Sexually Transmitted Disease (STD)

Women entering correctional facilities have high rates of STDs resulting from limited access to preventive health services; from risky behaviors with substances, unprotected sex, and commercial sex work; and from being victims of sexual assault. A Rhode Island study found that 33% of women tested positive for an STD at admission (Willers et al., 2008) and 26% of all women had trichomoniasis. The Centers for Disease Control and Prevention (CDC; 1999) reported that 27% of incarcerated women had chlamydia and 8% had gonorrhea, compared with 0.46% and 0.13% in the community. In 2008, 2% of women in prison were known to have HIV (Maruschak, 2010).

Family Planning

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Incarcerated women generally have had poor access to contraceptive services in the community (ACOG, 2012a; Clarke et al., 2006a) and have experienced high rates of prior unintended pregnancy (Clarke et al., 2006a). A study in Rhode Island showed that only 28% of sexually active women had consistently used birth control in the 3 months prior to incarceration; 85% of these women planned to be sexually active upon release, yet only 9% had a positive attitude about being pregnant (Clarke et al., 2006a). In this same setting, nearly half of the pregnant inmates had become pregnant in between incarcerations (Clarke, Phipps, Tong, Rose, & Gold, 2010). Moreover, more than 75% of women wanted to initiate or continue their method of birth control while in custody (Clarke et al., 2006b). Indeed, offering birth control in a correctional facility resulted in a 12-fold increase of a woman initiating contraception than when she was instructed to follow up in the community (Clarke et al., 2006b). In another study, nearly one third of women entering jail had had unprotected sex within the last 5 days and could therefore be candidates for emergency contraception (Sufrin, Tulsky, Goldenson, Winter, & Cohan, 2010). Incarceration is also a time to help women plan for healthy pregnancies upon release, offering preconception counseling that focuses on the risks of substance use, improving nutritional status such as folate supplementation, and optimizing physical and mental health (ACOG, 2012a).

Mental Health

It is well known that people who are incarcerated have higher rates of mental health diagnoses than the general population. However, rates of mental health disorders are even higher among incarcerated women than men. As reported in a 2006 Department of Justice study, the comparative prevalence of mental health problems in jail was 75% for women and 63% for men, in state prison 73% vs. 55%, and in federal prison 61% vs. 44% (James & Glaze, 2006). A study of Texas inmates found that 10% of women had major depressive disorder and 5.7% had bipolar disorder, compared to 3.5% and 2.3%, respectively, among men (Baillargeon et al., 2009).

Aging

Many prisons may be failing to recognize and prepare for the specialized physical, preventive health, social, and psychological needs of the older female inmate (Reviere & Young, 2004). For example, older female inmates may experience menopausal hot flashes, which can be challenging for women to manage in the correctional environment.

Nutrition and Diet

Correctional institutions should ensure that women receive a healthy diet consistent with federal dietary guidelines (U.S. Department of Agriculture [USDA], 2010). Recommendations for females aged 19 to 50 are 1,800 to 2,400 calories per day, depending on activity levels, with no more than 300 mg cholesterol, less than 10% saturated fat, and limited trans fats. Sodium intake should not exceed 2,300 mg for healthy females aged 19 to 50 and 1,500 mg for those 51 and older or with certain health conditions such as hypertension, diabetes, and chronic kidney disease. Fiber recommendations are 14 g per 1,000 calories or 25 g per day. To maintain bone health, women aged 19 to 50 should consume 1,000 mg of calcium (1,200 mg for those over age 50) and 600 IU of vitamin D daily (ACOG, 2012b). Women capable of becoming pregnant should consume adequate iron and 400 mcg of folic acid. Pregnant women have additional caloric and nutritional needs, including iron supplements and 600 mcg of foliate per day. Women 50 years and older should consume foods high in, or fortified with, vitamin B12 (USDA, 2010).

Standards

NCCHC recognizes the need to view women as a special population and to provide appropriate treatment. The Standards for Health Services (the basis of NCCHC's accreditation program for jails, prisons, and juvenile detention and confinement facilities) contain several standards that impact women's health care, including the following:

* Receiving Screening (E-02) suggests inquiry into current gynecological problems and pregnancy for women and female adolescents.

* Initial Health Assessment (E-04) recommends that clinical practice guidelines be followed for pelvic examinations and Pap smears.

* Intoxication and Withdrawal (G-07) acknowledges the special management of pregnant inmates with opioid use disorders.

* Contraception (G-08) recommends that women be provided with nondirective contraception counseling, access to emergency contraception, and continuation of current contraceptive method while incarcerated.

* Counseling and Care of the Pregnant Inmate (G-09) specifies that comprehensive counseling and assistance are given to pregnant inmates in keeping with their express desires in planning for their unborn children, whether they desire abortion, adoptive service, or to keep the child. It also addresses prenatal care and the nonuse of restraints during childbirth.

Position Statement

NCCHC recognizes that the number of female inmates is large and growing annually, presenting unique and increasing issues for health services in correctional facilities.

Therefore, NCCHC recommends the following:

1. Correctional institutions need to be required to meet recognized community standards for women's services as promoted by standards set by NCCHC.

2. Correctional health services and women's advocacy groups need to collaborate to provide leadership for the development of policies and procedures that address women's special health care needs in corrections.

3. Correctional institutions need to implement intake procedures that include histories on menstrual cycle, pregnancies, gynecologic problems, contraception, current breastfeeding, sexual and physical abuse, and a nutritional assessment (ACOG, 2012a).

4. Correctional institutions provide comprehensive services for women's unique health issues:

A. Considering women's special reproductive health needs, the frequency of repeating certain tests, exams, and procedures (e.g., Pap smears, mammograms) needs to be based on guidelines established by professional groups such as the American Cancer Society, the U.S. Preventive Services Task Force, and ACOG, and should take into account age and risk factors of the female correctional population.

B. Correctional institutions need to provide intake examinations that include a breast exam and, depending on the female's age, sexual history, as well as past medical history, pelvic exam, Pap smear, and baseline mammogram (ACOG 2012a; Anno, 2001).

C. All women at risk for pregnancy should be offered a pregnancy test within 48 hours of admission. Sexually active women remain at risk for pregnancy until they go through menopause.

D. Considering the high levels of victimization (sexual and physical) among the female inmate population, and considering the circumstances of incarceration of violent female offenders (i.e., many have committed interpersonal altercation violence against a family member or intimate), counseling to resolve issues of victimization and perpetration of violence against intimates (such as conflict resolution skills or parenting skills) needs to be available.

E. Considering the large number of incarcerated women who have dependent children, counseling on parenting and child custody issues needs to be available.

F Considering the unique needs of pregnant women, women need to have access to options counseling and pregnancy termination when desired, to routine prenatal care from a qualified health professional, and to specialty and emergency obstetrical care when indicated (ACOG, 2011).

G. Because of their high risk of postpartum depression and psychosis, women who deliver while in custody and who enter a facility within 1 year of childbirth should be screened for and educated about these conditions.

H. Considering the known benefits of early mother–infant attachment, correctional facilities need to facilitate contact visits for mothers with their infants.

I. Given the benefits of breastfeeding and breast milk, correctional facilities should make arrangements for postpartum women to either breastfeed their infants or to pump, freeze, and transport breast milk for their infants (ACOG, 2011).

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J. Considering the high rates of mental health issues women report upon incarceration, counseling needs to be available.

K. Considering the high rates of alcohol and/or drug problems women report upon incarceration, counseling and treatment need to be available to address this issue.

L. Considering the high risk of unintended pregnancy upon release, correctional facilities need to offer contraception services in a non-coercive manner while women are in custody, and allow women to continue methods they are already on, especially if their incarceration is short term or if the method is for medical reasons. Emergency contraception also needs to be made available to women, especially at intake (ACOG, 2012a).

M. Correctional institutions should conduct laboratory testing for chlamydia and gonorrhea on all women up to age 25, and when possible age 35, and among pregnant women regardless of age, unless the inmate is transferred from a facility where testing was done. Because many STDs are asymptomatic, all females should be screened for risk factors for chlamydia and gonorrhea according to CDC guidelines (e.g., new sexual partner, multiple partners, previous STD) and tested if risk factors are present regardless of age. Syphilis screening protocols should be determined based on local prevalence and in consultation with local public health departments, in addition to screening all pregnant women. The CDC recommends routine opt-out testing for HIV in correctional settings, and such testing should be performed on all pregnant women.

N. Considering the aging of the prison population, correctional institutions need to address the unique health care needs of older women including symptom management and treatment of menopausal hot flashes.

5. Correctional institutions need to provide pre- and post-release services for women re-entering the community. Strong partnerships are encouraged between public health, community, public assistance, and correctional agencies.

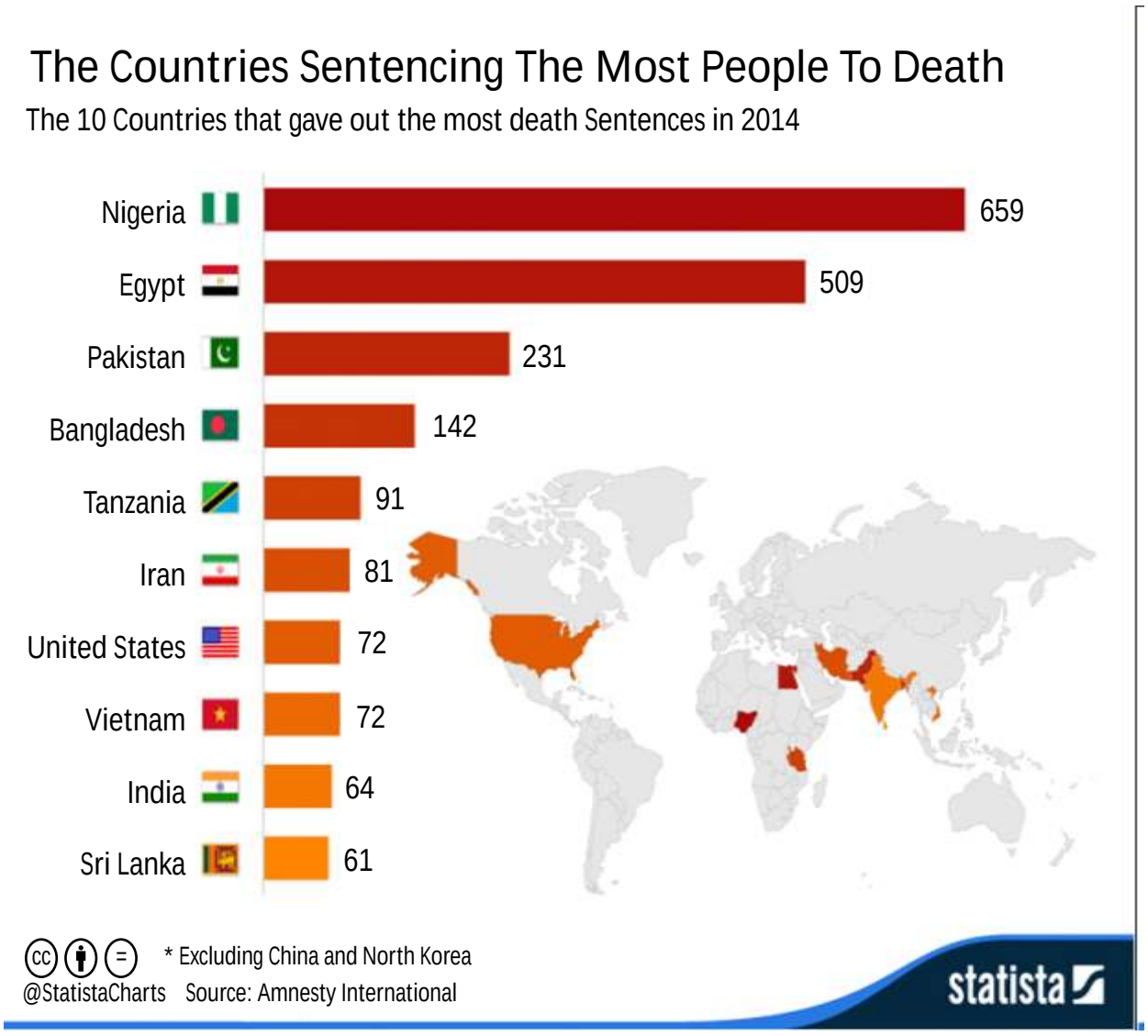
Programming such as employment and vocational training, health education, and parenting education also should be available.

Adopted by the National Commission on Correctional Health Care Board of Directors, September 25, 1994

Source: www.ncchc.org/women's-health-care

NIGERIA LEADS THE LIST OF COUNTRIES SENTENCING THE MOST PEOPLE TO DEATH.

By Abiola Afolabi



In spite of human rights Activists efforts to abolish the death penalty globally, it is gaining more popularity among countries. Report from Amnesty International shows that 1,925 sentences were issued in 2013 and the figures rose up to 2,466 in 2014. The dramatic rise is due to the number of the death sentence issued by countries seeking to tackle crime, terrorism, and internal stability.

In Nigeria, 659 death sentences were recorded in 2014, a jump of more than 500 compared with the 2013 figures- 141. Nigeria executed four individuals in 2013 after almost 8 years since its last execution, this happened shortly after President Goodluck Jonathan urged state governors to sign death warrants for death row prisoners on June 16, 2013.

The surge in 2014 is attributed to the mass death sentences to soldiers, who were convicted of mutiny in the context of the armed conflict with Boko Haram terrorists in the North, by Military courts. The methods of execution are not limited to hanging, shooting and stoning, although, execution by hanging is unconstitutional in Lagos State and shooting are stoning are commonly used under Sharia law in some northern Nigerian states.

Nigeria leads the chart with 659 death sentences, Egypt followed closely with 509 death sentences and Pakistan rounded off the top three lists with 231 inmates to be executed in 2014. Crimes like aggravated murder, murder, terrorism-related offenses resulting in death, adultery, rape, treason, kidnapping, and cannibalism etc. are punishable by death in Nigeria but not in all states, as kidnapping was only made a capital offence in 2006 in six states: Abia, Akwa-Ibom, Anambra, Ebonyi, Enugu and Imo and in 2013, it became a capital offense in Edo state.

Across the world, there were 19,094 people on death row at the end of 2014. After China, Iran executed the most people last year with 249 confirmed. Saudi Arabia came second with at least 90 while Iraq came third with 61.

Capital punishment has failed as a preventive measure against crime in Nigeria, as it is still unsafe due to the high rate of crime recorded on a daily basis. It has not proved to be an effective way to deter crime and in many cases people are wrongfully convicted. A statistical appraisal of crime rate in Nigeria by the Department of statistics, Abia State Polytechnic shows there is a significant growth over the years and if not checked it will keep rising.

In the 2014 report on the death penalty published on 1 April 2015, Amnesty International documented a drop of 22 per cent in the number of executions worldwide, from 778 to 607, and a 28 per cent rise in the number of death sentences imposed (from 1925 to 2466). These figures do not include the presumed thousands of executions in China and a high number of unreported cases in countries such as Iran, North Korea, and Viet Nam. By the end of 2014, 98 countries have abolished the death penalty for all crimes, 90% of countries have now banned executions.

Nigeria does not need more death sentences to curb crimes it needs sufficient structures to keep the system running. It needs to find a remedy to unemployment issues, NBS report claims there are over 22.6 million unemployed people, Government has to review its anti-crime strategies and strengthen existing security agencies.

Source:www.fitila.ng/nigeria-leads-the-list-of-countries-sentencing-the-most-people-to-death/

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17.3 Juveniles shall not be subject to corporal punishment.
17.4 The competent authority shall have the power to discontinue the proceedings at anytime.

Commentary
The main difficulty in formulating guidelines for the adjudication of young persons stems from the fact that there are unresolved conflicts of a philosophical nature, such as the following:
(a) Rehabilitation versus just desert; (b) Assistance versus repression and punishment;
(c) Reaction according to the singular merits of an individual case versus reaction according to the protection of society in general;
(d) General deterrence versus individual incapacitation.
The conflict between these approaches is more pronounced in juvenile cases than in adult cases. With the variety of causes and reactions characterizing juvenile cases, these alternatives become intricately interwoven.
It is not the function of the Standard Minimum Rules for the Administration of Juvenile Justice to prescribe which approach is to be followed but rather to identify one that is most closely inconsonance with internationally accepted principles. Therefore the essential elements as laid down in rule 17.1, in particular in subparagraphs (a) and (c), are mainly to be understood as practical guidelines that should ensure a common starting point; if heeded by the concerned authorities (see also rule 5), they could contribute considerably to ensuring that the fundamental rights of juvenile offenders are protected, especially the fundamental rights of personal development and education.

Rule 17.1 (b) implies that strictly punitive approaches are not appropriate. Whereas in adult cases, and possibly also in cases of severe offences by juveniles, just desert and retributive sanctions might be considered to have some merit, in juvenile cases such considerations should always be outweighed by the interest of safeguarding the well-being and the future of the young person.

In line with resolution 8 of the Sixth United Nations Congress, rule 17.1 (b) encourages the use of alternatives to institutionalization to the maximum extent possible, bearing in mind the need to respond to the specific requirements of the young. Thus, full use should be made of the range of existing alternative sanctions and new alternative sanctions should be developed,11bearing the public safety in mind. Probation should be granted to the greatest possible extent via suspended sentences, conditional sentences, board orders and other dispositions.

Rule 17.1 (c) corresponds to one of the guiding principles in resolution 4 of the Sixth Congress which aims at avoiding incarceration in the case of juveniles unless there is no other appropriate response that will protect the public safety.

The provision prohibiting capital punishment in rule 17.2 is in accordance with article 6,paragraph 5, of the International Covenant on Civil and Political Rights.

The provision against corporal punishment is in line with article 7 of the International Covenant on Civil and Political Rights and the Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, as well as the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the draft convention on the rights of the child.

The power to discontinue the proceedings at any time (rule 17.4) is a characteristic inherent in the handling of juvenile offenders as opposed to adults. At any time, circumstances may become known to the competent authority which would make a complete cessation of the intervention appear to be the best disposition of the case.

18. Various disposition measures
18.1 A large variety of disposition measures shall be made available to the competent authority, allowing for flexibility so as to avoid institutionalization to the greatest extent possible. Such measures, some of which may be combined, include:

(a) Care, guidance and supervision orders;
(b) Probation;
(c) Community service orders;
(d) Financial penalties, compensation and restitution;
(e) Intermediate treatment and other treatment orders;
(f) Orders to participate in group counseling and similar activities;
(g) Orders concerning foster care, living communities or other educational settings;
(h) Other relevant orders.

18.2 No juvenile shall be removed from parental supervision, whether partly or entirely, unless the circumstances of her or his case make this necessary.

Commentary
Rule 18.1 attempts to enumerate some of the important reactions and sanctions that have been practiced and proved successful thus far, in different legal systems. On the whole they represent promising opinions that deserve replication and further development. The rule does not enumerate staffing requirements because of possible shortages of adequate staff in some regions; in those regions measures requiring less staff may be tried or developed.

The examples given in rule 18.1 have in common, above all, a reliance on and an appeal to the community for the effective implementation of alternative dispositions. Community-based correction is a traditional measure that has taken on many aspects. On that basis, relevant authorities should be encouraged to offer community-based services.

Rule 18.2 points to the importance of the family which, according to article 10, paragraph l, of the International Covenant on Economic, Social and Cultural Rights, is "the natural and fundamental group unit of society". Within the family, the parents have not only the right but also the responsibility to care for and supervise their children. Rule 18.2, therefore, requires that the separation of children from their parents is a measure of last resort. It may be resorted to only when the facts of the case clearly warrant this grave step (for example child abuse).

19. Least possible use of institutionalization
19.1 The placement of a juvenile in an institution shall always be a disposition of last resort and for the minimum necessary period.

Commentary
Progressive criminology advocates the use of non-institutional over institutional treatment.

Little or no difference has been found in terms of the success of institutionalization as compared to non-institutionalization. The many adverse influences on an individual that seem unavoidable within any institutional setting evidently cannot be outbalanced by treatment efforts. This is especially the case for juveniles, who are vulnerable to negative influences.

Moreover, the negative effects, not only of loss of liberty but also of separation from the usual social environment, are certainly more acute for juveniles than for adults because of their early stage of development.

Rule 19 aims at restricting institutionalization in two regards: in quantity ("last resort") and in time ("minimum necessary period"). Rule 19 reflects one of the basic guiding principles of resolution 4 of the Sixth United Nations Congress: a juvenile offender should not be incarcerated unless there is no other appropriate response. The rule, therefore, makes the appeal that if a juvenile must be institutionalized, the loss of liberty should be restricted to the least

possible degree, with special institutional arrangements for confinement and bearing in mind the differences in kinds of offenders, offences and institutions. In fact, priority should be given to "open" over "closed" institutions. Furthermore, any facility should be of a correctional or educational rather than of a prison type.

20. Avoidance of unnecessary delay
20.1 Each case shall from the outset be handled expeditiously, without any unnecessary delay.

Commentary
The speedy conduct of formal procedures in juvenile cases is a paramount concern.

Other wise whatever good may be achieved by the procedure and the disposition is at risk. As time passes, the juvenile will find it increasingly difficult, if not impossible, to relate the procedure and disposition to the offence, both intellectually and psychologically.

21. Records
21.1 Records of juvenile offenders shall be kept strictly confidential and closed to third parties.

Access to such records shall be limited to persons directly concerned with the disposition of the case at hand or other duly authorized persons.

21.2 Records of juvenile offenders shall not be used in adult proceedings in subsequent cases involving the same offender.

Commentary
The rule attempts to achieve a balance between conflicting interests connected with records or files: those of the police, prosecution and other authorities in improving control versus the13interests of the juvenile offender. (See also rule 8.) "Other duly authorized persons" would generally include, among others, researchers.

22. Need for professionalism and training
22.1 Professional education, in-service training, refresher courses and other appropriate modes of instruction shall be utilized to establish and maintain the necessary professional competence of all personnel dealing with juvenile cases.

22.2 Juvenile justice personnel shall reflect the diversity of juveniles who come into contact with the juvenile justice system. Efforts shall be made to ensure the fair representation of women and minorities in juvenile justice agencies.

Commentary
The authorities competent for disposition may be persons with very different backgrounds(magistrates in the United Kingdom of Great Britain and Northern Ireland and in regions influenced by the common law system; legally trained judges in countries using Roman law and in regions influenced by them; and elsewhere elected or appointed laymen or jurists, members of community-based boards, etc.). For all these authorities, a minimum training in law, sociology, psychology, criminology and behavioural sciences would be required. This is considered as important as the organizational specialization and independence of the competent authority.

For social workers and probation officers, it might not be feasible to require professional specialization as a prerequisite for taking over any function dealing with juvenile offenders.

Thus, professional on-the job instruction would be minimum qualifications.

Professional qualifications are an essential element in ensuring the impartial and effective administration of juvenile justice. Accordingly, it is necessary to improve the recruitment, advancement and professional training of personnel and to provide them with the necessary means to enable them to properly fulfill their functions.

All political, social, sexual, racial, religious, cultural or any other kind of discrimination in the selection, appointment and advancement of juvenile justice personnel should be avoided in order to achieve impartiality in the administration of juvenile justice. This was recommended by the Sixth Congress. Furthermore, the Sixth Congress called on Member States to ensure the fair and equal treatment of women as criminal justice personnel and recommended that special measures should be taken to recruit, train and facilitate the advancement of female personnel in juvenile justice administration.

Part four

NON-INSTITUTIONAL TREATMENT

23. Effective implementation of disposition
23.1 Appropriate provisions shall be made for the implementation of orders of the competent authority, as referred to in rule 14.1 above, by that authority itself or by some other authority as circumstances may require.

23.2 Such provisions shall include the power to modify the orders as the competent authority may deem necessary from time to time, provided that such modification.

Source: Year Book of the UN. 39.1985

Durumi II Primary School Roofs Blown Off

By Promise Izugbara

Photo by Promise Izugbara

On the 31st, October, 2016, 7PM, the sky went completely dark signifying a heavy downpour. Little by little the wind gained momentum. The least expected was that the roof of the one storey building in Durumi II school premises will be blown off. Citizens United for the Rehabilitation of Errants –Nigeria calls on Universal Basic Education Commission, Ministry of Education, the FCT Minister, the FCT Education Secretary and every well doing Nigerian to come to the aid of Durumi II Primary school to restore hope to the pupils and their teachers who will soon face the brunt of the mishap next year when rain returns to torment them.

PRISONERS AND HIV/AIDS

Every year, 30 million people spend time in prisons or other closed settings and more than 10.2 million are incarcerated at any given time.

Prisons are a high-risk environment for HIV transmission with drug use and needle sharing, tattooing with homemade and unsterile equipment, high-risk sex and rape commonplace. Overcrowding as well as stress, malnutrition, drugs, and violence weaken the immune system, making people living with HIV more susceptible to getting ill. Yet, prisoner wellbeing is often neglected and overlooked.

HIV prevention programmes are rarely made available to inmates, and many prisoners with HIV are unable to access life-saving antiretroviral treatment. In many parts of the world, prison conditions are poor and inmates living with HIV barely receive the most basic healthcare. Moreover, mandatory HIV testing is enforced by some prison authorities, which is often seen as a breach of human rights.

HIV prevalence within prisons varies between 2 and 50 times those of general adult populations. HIV infection rates are particularly high among incarcerated women. A report from Indonesia found that HIV prevalence was several times higher among female prisoners (6%) than male prisoners (1%).

Why are prisoners particularly at risk of HIV?

"Prison conditions are often ideal breeding grounds for onward transmission of HIV infection. They are frequently overcrowded. They commonly operate in an atmosphere of violence and fear. Tensions abound, including sexual tensions. Release from these tensions, and from the boredom of prison life, is often found in the consumption of drugs or in sex."

Injecting drug use

The use of contaminated injecting equipment when using drugs is one of the primary routes of HIV transmission in prisons. Many prisoners begin injecting drugs for the first time in prison. Where there are high numbers of imprisoned people who inject drugs (PWID), there is a higher risk of HIV transmission.

Worldwide, between 56% and 90% of people who inject drugs will be incarcerated at some point. In 2012, in Mauritania, HIV prevalence was an estimated 24.8% among prisoners and 40% of this group were thought to inject drugs.

Within prisons it is difficult to obtain clean injecting equipment. Possessing a needle is often a punishable offence and therefore many people share equipment that has not been sterilized between uses.

"When I scored smack [heroin] I rented or bought works that had been used God knows how many times." ***- 27 year old male, imprisoned for six months*** Even if PWID are aware of the risks of HIV infection through sharing needles, if a clean needle is not available, many may still take the risk. In Ireland, 70% of PWID surveyed reported sharing needles while imprisoned, compared to 45.7% in the month before incarceration.

"As long as you can get the gear you inject as soon as you have a chance."- 27 year old male, imprisoned for four months

"There are a lot of people who come in, and haven't done drugs before who become addicted inside and come out with a HIV or hepatitis C infection. I saw a young guy who came in on a 16-month sentence, became addicted to drugs and contracted HIV. He ended up hanging himself in his cell. If they had needle exchanges in institutions a long time ago, it would have saved a lot of people's lives. So many people have become infected from one dirty needle." ***- Corey, Halifax, Nova Scotia***

Sexual violence, unsafe sex and other high-risk behaviours

Prison populations consist mainly of men aged 19 to 35 years old - a segment of the population that is at higher risk of HIV infection prior to entering prison. The prevalence of sexual activity in prisons is largely unknown and thought to be significantly under reported due to denial, fear of stigma and homophobia as well as the criminalization of same sex conduct.

- Unavailability of condoms

Prison systems in Western Europe, North America, Australia, Indonesia, Iran, South Africa and parts of Eastern Europe and Central Asia do provide condoms in prisons, however, many do not.

Sexual activities are often forbidden in prisons, with some believing the provision of condoms condones such behaviour and potentially leads to an increase in such activities. For example, most prisons in the United Kingdom only provide condoms when prescribed by a doctor and will refer to section 74 of the Sexual Offences Act 2003, which prohibits sexual activity in a 'public place'.

"Now condoms are hard to come by in prison. As I went down to the medical quarters twice a day (to get my medication), I used to ask there. But I was rationed to one a day (...) I was told that if I took the dirty condom back - to prove it had been used – they would give me more (...) But even taking dirty condoms back didn't always guarantee fresh supplies." ***- An HIV positive inmate in the UK who was forced to have sex with a fellow inmate in exchange for protection from other violent inmates***

A study of HIV transmission among male prisoners in Georgia, United States of America (USA), found that only 30% of those who reported having consensual sex used condoms or improvised condoms (like rubber gloves or plastic wrap).

- Rape and sexual abuse

While most sex in prisons is consensual, rape and sexual abuse is used to exercise dominance over other inmates. Roughly 25% of prisoners suffer violence each year, while 4% to 5% experience sexual violence and 1% to 2% are raped.

A survey by the U.S. Department of Justice in 2011-2012 showed how 4% of state and federal prison inmates and 3.2% of jail inmates experienced one or more incidents of sexual victimization by another inmate or prison staff. By contrast, another study from the USA estimated that 16% of male prisoners were being pressurized or forced into sexual contact.

Women prisoners are also vulnerable to sexual assault, including rape by both male prisoners and male prison staff. They are also at risk of sexual exploitation and may engage in sex for the exchange of goods.

- Tattooing

Tattooing is still commonplace among incarcerated people. It usually involves multiple skin punctures with recycled, sharpened, and altered implements including staples, paper clips and plastic ink tubes found inside ballpoint pens.

Those who perform the tattooing tend not to have new or sterilized tattooing equipment. Some people use metal points connected to a battery or other electrical source which increases the number of skin punctures, elevating the risk of HIV transmission.

There have only been a few reported cases of HIV transmission due to tattooing. However, one study of Iranian prisoners reported a significant association between HIV prevalence and tattooing.

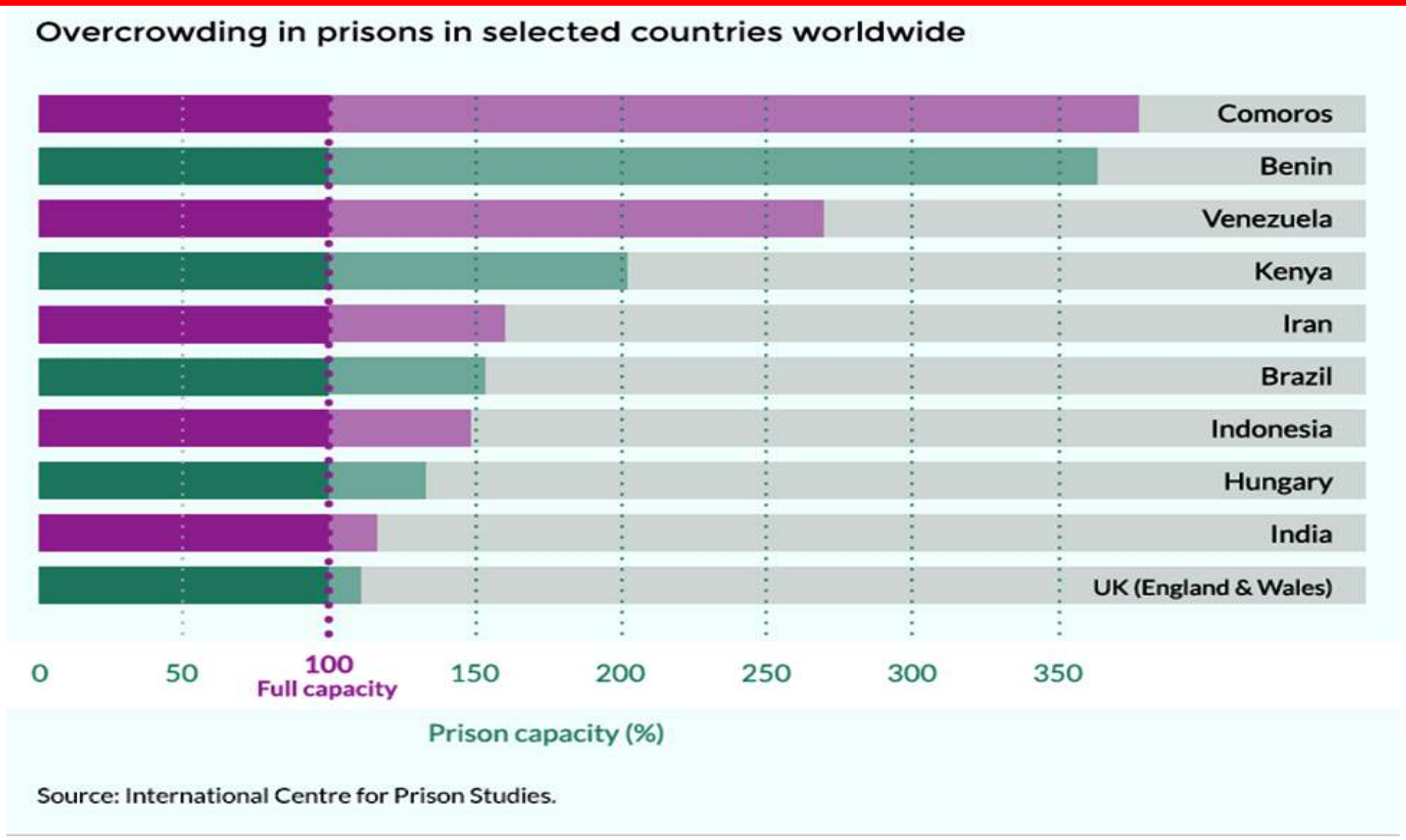
Punitive laws and overcrowding

Punitive laws lead to the incarceration of people living with HIV and other key affected populations who are disproportionately represented in prisons worldwide as a result.

For example, sex workers are at a high risk of incarceration as more than 100 countries criminalize sex work or aspects of sex work. Likewise, 76 countries criminalize same sex activity, increasing this risk for men who have sex with men. In addition, there are 72 countries that have adopted HIV-specific laws that prosecute people living with HIV for a range of offences.

In places with weak criminal justice systems, people who are detained may have to wait for long periods during the investigation of a crime, while awaiting trial and before sentencing. These delays increase their likelihood of HIV infection while in prison.

Moreover, inappropriate, ineffective and excessive national laws and criminal justice



policies lead to high incarceration levels and overcrowding. In 20 countries, many of which are in Africa, the occupancy rate in prisons is over 200%. In both the Comoros and Benin, it is over 350%.

Overcrowding also allows diseases like tuberculosis (TB) to thrive and people living with HIV are more likely to develop TB because their immune systems are severely weakened. It also makes HIV services harder to access and increases the risk of violence and abuse as well as poor nutrition.

DENIAL OF ACCESS TO PREVENTION AND TREATMENT SERVICES

In many places, HIV and other relevant health services in prisons are severely limited or are simply not available either due to government policy or a lack of resources. In 2012, antiretroviral treatment (ART) for HIV was available to prisoners in just 43 countries. In the USA, a survey showed that while 90% of prisons provided ART, only half offered substance abuse counseling and support specific to inmates living with HIV.

Although some countries make condoms available to prisoners, other do not on the basis that sex is banned or for security reasons. Prison guards have been reported to refuse condoms to inmates to exercise power over them. Despite the tuberculosis (TB) being the leading cause of death among prisoners in many countries, only 63 countries provide TB treatment in prisons, while screening for hepatitis is equally uncommon.Even where treatment is available, its effectiveness can be undermined by substandard prison conditions, poor nutrition and violence. Moreover, prison health services often have too few or poorly trained staff, inadequate health assessments on entry, poor record keeping, and breaches of confidentiality. Even in adequately staffed facilities, prison staffs have negative attitudes toward key populations, contributing to poor monitoring and treatment of HIV as well as TB, hepatitis and drug dependency.

Preventing HIV among prisoners

Despite the high risk of HIV transmission among prisoners, HIV prevention and treatment programmes are often limited in prisons and other closed settings. Those that do exist also rarely link to national HIV prevention programmes.

In 2012, a comprehensive package of 15 key HIV interventions for prisoners was put forward by the United Nations Office on Drugs and Crime (UNODC) and includes:

- HIV testing and counselling (HTC)
- treatment, care and support
- information, education and communication
- harm reduction
- Condom programmes.

Some of the main interventions to prevent HIV among prisoners, and their effectiveness, are detailed below.

HIV testing and counseling (HTC)

Evidence shows that if HIV testing and counseling is made readily available on entry to prison and throughout incarceration, uptake increases. This is especially true if HTC is part of a comprehensive treatment and care programme.

Compulsory or mandatory testing (that requires all inmates have an HIV test) is used in some prisons as a means of identifying those who are living with HIV so that they can provide treatment and support, and protect staff and other inmates. In 2008, 24 states in the USA were testing all inmates for HIV upon admission or at some point during incarceration.

However, research suggests that mandatory testing and segregation of prisoners living with HIV breaches human rights by taking away the right of the individual to make their own decisions, is costly, inefficient and has negative consequences for these prisoners.

"The test was forced upon me also no counseling was given or offered. I was held in isolation until the results were known."

By contrast, voluntary HIV testing has been found to increase the likelihood that prisoners are tested and receive their results before they are discharged or transferred to another prison. Rapid testing in particular allows prisoners to know their HIV status in minutes.Opt-out testing (where people have the option to refuse an HIV test) has also been found to be popular among prisoners and staff. A study of incarcerated men in Jamaica who were offered opt-out HIV testing recorded an acceptance rate of 63%.

Other studies have shown how HTC programmes can be more cost-effective if done in conjunction with other prevention initiatives such as providing condoms and testing for sexually transmitted infections (STIs). For example, a study of incarcerated men who have sex with men (MSM) at Los Angeles County Men's Jail estimated that a 10-year intervention offering HIV and STI

testing, as well as condoms, could save $180,000 in treatment costs.

Treatment, care and support

Antiretroviral treatment (ART) can decrease mortality among prisoners living with HIV as well as the general population; however, there is not always access to these services in prisons. For example, treatment access in Malawi has improved dramatically among the general population but key affected populations such as prisoners still rarely have access to ART.Studies have shown that when provided with access to ART, prisoners can respond well to treatment, and adherence can be as high as in the general population. In South Africa, 97% of inmates living with HIV are currently on treatment and there is an 84% TB cure rate in these settings. From September 2016, all HIV-positive prisoners will receive treatment regardless of CD4 count.To increase treatment adherence in prisons, confidentiality must be guaranteed and positive relationships with prison health staff is essential. A study from Namibia also identified insufficient access to food, and a lack of knowledge about how HIV is transmitted and managed as barriers to good adherence.***"Most inmates are going for days and months without proper food...this has led to a deterioration of health for most inmates, especially those living with HIV. Some are not provided with regular counseling and treatment which further compromises their health." - A prison guard at Chikurubi Maximum Prisons, Zimbabwe***

Moreover, any progress made during incarceration can be lost when someone is discharged. To ensure continuation of treatment when discharged, linkage to community-based care with an adequate supply of antiretroviral drugs (ARVs) is vital.

HIV information, education and communication

"Prisoners and prison staff should be informed about HIV/AIDS and about ways to prevent HIV transmission, with special reference to the likely risks of transmission within prison environments and to the needs of prisoners after release."

Up to 50% of the USA prison population are illiterate, and many are not native English speakers. As a result, inmates often cannot understand the HIV prevention information they are given or it fails to address their particular needs.However, there is evidence that well-designed HIV and AIDS education and information programmes can improve prisoners knowledge and that there is a need particularly in low- and middle-income countries.

Research has reported successful behaviour change (particularly upon release) partly as a result of prison-based educational initiatives. However, the effectiveness of these efforts is difficult to measure, particularly any changes in HIV transmission among prisoners as a result of these programmes.

Peer education - prisoners educating other prisoners about HIV - has been found to be the most effective way of delivering these programmes.

One programme in Ghana recruits inmates who are literate, have good communication skills and can maintain confidentiality as peer educators. The peer educators receive five days of training on HIV prevention, stigma and discrimination, STIs, sexual and gender-based violence and facilitation skills. They run film sessions and drama performances on HIV-related issues and distribute educational materials. Confidential HTC is also provided with referrals to treatment and support services.

In 2014, the programme reached nearly 220,000 prisoners and 248 prison officers with advocacy sessions. Roughly 30,000 prisoners received HTC for HIV, 228 of whom tested positive and were referred for treatment.

Harm reduction

Making needles and syringes and opioid substitution therapy (OST) available in prisons has been shown to reduce injecting drug use and needle sharing by up to 75%, thereby reducing the risk of HIV.Needle and syringe programmes (NSPs)

Needle and syringe programmes provide drug users with access to clean needles and syringes, in order to reduce the frequency of injecting with contaminated equipment. Globally, only eight countries in 2014 implemented NSPs in prisons - all of these were in Europe and Central Asia. Typically, a dispensing machine is placed in a discreet location.

NSPs have been shown to lead to reductions in needle sharing in prisons, decreases in drug abuse and ultimately, lower levels of HIV transmission.

In Kyrgyzstan, a NSP intervention study in one prison saw a marked decrease in the injection and use of drugs. Research conducted in seven prisons in Iran found that 57% of prisoners on admittance had a drug addiction. Two months after the implementation of harm reduction interventions including NSPs, only 10% were still using drugs.

Prisoners and staff interviewed in Pereiro de Aguiar prison in Ourense, Spain, believed that the implementation of a needle and syringe programme reduced drug use and improved hygiene and living conditions. Between 1999 and 2009, HIV prevalence fell from 21% to 8.5%.

- Opioid substitution therapy (OST)

Opioid substitution therapy is another harm reducing approach that aims to reduce heroin use by providing a substitute in the form of either methadone or buprenorphine. However, in 2014, OST was available in prisons in only 43 countries.

Prison-based OST programmes can be effective in reducing injecting drug use and needle sharing and have additional benefits for the health of prisoners and the community.

Moreover, a number of studies have also reported high acceptance and retention rates. In one study from Geneva, Switzerland, OST was offered to all dependent users and all patients accepted treatment. Another study monitoring the roll out of OST in Tihar Prisons in India recorded a 98% retention rate after 12 months.

However, delays in OST implementation can have a negative impact on the health of prisoners. Education should be provided with or before OST and there should be better linkage to treatment between prison-based healthcare and community-based healthcare to avoid potential relapse after release from prison.

Condom programmes

There is evidence that condoms are provided in a wide range of prison settings, including in countries where same-sex activity is criminalized, and that prisoners use condoms during sexual activity when they are made available, leading to reductions in HIV transmission.

Indeed, prisons that have implemented condom programmes to date have not reversed their policies. These schemes are generally accepted by staff and inmates, and very few problems, such as drug smuggling, have been reported.

Moreover, the evidence has shown how they do not to lead to increases in sexual activity, are not a threat to security staff or operations and most importantly, decrease HIV transmission. For example, one study from Australia compared condom use during anal sex among prisoners in New South Wales (NSW) and Queensland prisons. While anal sex prevalence was equally low in NSW (3.3%) and Queensland (3.6%) prisons, in NSW prisons, where condoms are freely distributed, a much higher proportion of prisoners who engaged in anal sex used a condom (56.8%) than in Queensland (3.1%). Moreover, there was no evidence of increased consensual or non-consensual sexual activity.

However, where there are deeply held prejudices against homosexuality, education about condoms as well as their provision should be introduced to counter the stigma that people engaging in same-sex activity face.

The way forward

Prisoners are part of the community, people work in prisons, others visit prisons, and most prisoners will be discharged at some point. As a result, HIV in prisons is both a public health and a human rights issue that needs to be addressed urgently for an effective response to the epidemic. However, worldwide, governments are failing to address this.

A substantial body of evidence shows that targeted HIV prevention programmes can reduce HIV transmission within prison populations. Existing efforts need to be scaled-up, particularly comprehensive HIV prevention and treatment programmes in order to provide prisoners living with HIV with the services they need.

Protective laws, policies and programmes that are adequately resourced, monitored and enforced can also improve the health and safety of prisoners as well as the community as a whole.

"Failure to provide prisoners with the same health care options available to the general population violates human rights and international standards." - Harm Reduction Coalition

Source: Prisoner.jpg

CITIZENS UNITED FOR THE REHABILITATION OF ERRANTS

CURE-NIGERIA

...Defending Human Rights and Fundamental Freedoms ...Enriching our Democracy

1st November, 2016

Distinguished Senator (Dr) Abubakar Bukola Saraki,

The Senate President, Nigerian Senate,

Federal Republic of Nigeria,

Three Arms Zone,

Abuja.

OFFICE OF THE PRESIDENT OF THE SENATE
RECEIVED
02 NOV 2016
Sign.....
NATIONAL ASSEMBLY, ABUJA

The Senate President

RE: A LETTER OF REQUEST TO ASK INEC TO COMPLY WITH THE JUDGEMENT OF THE FEDERAL HIGH COURT THAT PRISON INMATES IN NIGERIA HAVE THE CONSTITUTIONAL RIGHT TO VOTE.

As the people of Ondo State prepare to go to the poll to elect their governor, we write to bring to your attention and that of the entire Senate our letter to the Chairman, Senate Committee on INEC dated 28 September, 2016 and attached here for your attention, in which we asked the Chairman and members of his committee to use their oversight powers and influence to prevail over INEC to comply with the judgement of the Federal High Court in Benin in December 2014 that prison inmates in Nigeria prisons have the constitutional right to vote. Also, we have attached the two copies of our letters to INEC and a copy of the judgement for your attention, please.

Our organisation is concerned that more than a month after our letter was sent to the Committee, we have neither received any acknowledgement of it nor are we aware of any action the committee has taken to engage INEC and the Nigerian Prisons Service over this matter.

More so, we are deeply concerned that close to two years after this judgement was delivered, none of the defendants have taken any steps to comply with the judgment, despite our letters and visits to them.

Consequently, we write to request Your Excellency, to use your good office as the President of the Senate to ask the Senate Committee on INEC to do the needful.

Please, accept our esteemed regards and assurances of working with the National Assembly to achieve this goal in particular and criminal justice reforms in general.

Yours faithfully,

Sylvester Terhemen Uhaa,

Executive Director,

CURE-Nigeria

Cc: Chairman, Senate Committee on INEC

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Tel: (234)-92911-314 , 08034365657

CURE Chapter

Hon. Edward Gyang Pwajok, SAN

Chairman House Committee on Human Rights
House of Representatives
JOS SOUTH/JOS EAST FEDERAL CONSTITUENCY PLATEAU STATE.

25th October, 2016

The Chairman,
National Independent
Electoral Commission,
INEC, Headquarters,
Maitama, Abuja.

RE: LETTER OF REMINDER OF OUR LETTER TO THE COMMISSION ON THE COURT RULING THAT PRISON INMATES IN NIGERIA HAVE THE CONSTITUTIONAL RIGHT TO VOTE.

Above refers and for your perusal.

I am under directive by Hon. Edward Gyang Pwajok, (SAN) House of Representatives Committee Chairman on Human Rights to write to your good office that we are in receipt of the above letter which was copied to us dated 11th July, 2016.

It is the desire of the Chairman and the entire House to know the disposition of INEC on the issues raised for further legislative action.

Thank you and do accept the esteem regards of the Honourable Chairman now and always.

Sincerely: 25/10/16

Hon Ayuba Pam Daingwong
Senior Legislative Aide –
SLA to the Hon Chairman.

Member Committee on:- Sports, House Services, Federal Judiciary, FCT Judiciary, Power, and FERMA

Suite 3.60 House of Representatives National Assembly Complex Three Arms Zone

CITIZENS UNITED FOR THE REHABILITATION OF ERRANTS

CURE-NIGERIA

....Defending Human Rights and Fundamental Freedoms ...Enriching our Democracy

1st November, 2016

Rt. Hon. Yakubu Dogara,

The Speaker, House of Representatives,

Federal Republic of Nigeria,

Three Arms Zone,

Abuja.

RECEIVED
- 2 NOV 2016
OFFICE OF THE SPEAKER
NATIONAL ASSEMBLY ABUJA

The Honourable Speaker,

RE: A LETTER OF REQUEST TO ASK INEC TO COMPLY WITH THE JUDGEMENT OF THE FEDERAL HIGH COURT THAT PRISON INMATES IN NIGERIA HAVE THE CONSITITUTIONAL RIGHT TO VOTE.

As the people of Ondo State prepare to go to the poll to elect their governor, we write to bring to your attention and that of the entire House of Representatives our letter to the Chairman, House Committee on Electoral and Political Party Matters dated 28 September, 2016 and attached here for your attention, in which we asked the Chairman and members of her committee to use their oversight powers and influence to prevail over INEC to comply with the judgement of the Federal High Court in Benin in December 2014 that prison inmates in Nigeria prisons have the constitutional right to vote. Also, we have attached the two copies of our letters to INEC and a copy of the judgement for your attention, please.

Our organisation is concerned that more than a month after our letter was sent to the Committee, we have neither received any acknowledgement of it nor are we aware of any action the committee has taken to engage INEC and the Nigerian Prisons Service over this matter.

More so, we are deeply concerned that close to two years after this judgement was delivered, none of the defendants have taken any steps to comply with the judgment, despite our letters and visits to them.

Consequently, we write to request you to use your good office as the Honourable Speaker of the House of Representatives to ask the House Committee on Electoral and Political Party Matters to do the needful.

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CURE Chapter

Please, accept our esteemed regards and assurances of working with the National Assembly to achieve this goal in particular and criminal justice reforms in general.

Yours faithfully,

Sylvester Terhemen Uhaa,

Executive Director,

CURE-Nigeria

Cc: Chairman, House Committee on Electoral and Political Party Matters,

CITIZENS UNITED FOR THE REHABILITATION OF ERRANTS

CURE-NIGERIA

....Defending Human Rights and Fundamental Freedoms ...Enriching our Democracy

25th October, 2016

Your Lordship, Hon. Justice Ishaq Bello,

The Chief Judge of the Federal Capital Territory,

Abuja.

RECEIVED
26 OCT 2016
25/10/16

Your Lordship,

A LETTER OF REQUEST TO PAY AN URGENT AND EMERGENCY VISIT TO KEFFI PRISON

We wish to bring to your notice that during our routine visit to Keffi New Prison three months ago to interview inmates for legal aid, we found out that there were inmates there who do not have record in any court in the FCT, even though the remand warrants bear the signatures and stamps of some high courts in the FCT.

Further investigations reveal that the affected inmates, whose names are listed in the attachment, were not arraigned in courts prior to their detention in prison and that they were taken to the prisons directly from the police stations.

To ascertain the validity or otherwise of these claims, CURE-Nigeria went to all the courts that issued the remand warrants, including the registry at the FCT High Court to trace their records, but could not find any record of these defendants.

Consequently, the affected inmates have not been to court since their detention in Keffi Prison, as all efforts by Keffi Prison authority and our organisation to trace their records so that they can have access to fair hearing have failed.

Hence, we are writing to you on behalf of the affected inmates, the NPS to request Your Lordship to pay an urgent and emergency visit to Keffi Prisons to review these and other cases requiring urgent attention for necessary actions. Please, note that there are reports from the same prison that the number of inmates affected by this phenomenon has increased since we visited, as this has become a common practice.

We do hope that in your usual manner, you would take immediate actions to bring justice to this issue and to ensure that the affected inmates do not stay in

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CURE Chapter

prison beyond December, 2016, as well as hold anyone found wanting accountable and put in place mechanisms that would prevent this from continuing to happen.

As usual, we wish you all the best in your work, while placing ourselves at your service towards ensuring justice reforms in the FCT.

Please, accept our highest regards,

Yours faithfully,

Sylvester Terhemen Uhaa,

Executive Director,

CURE-Nigeria.

CC: In-Charge, Keffi New Prison, Keffi, Nasarawa State

IS CAPITAL PUNISHMENT A UNIQUE DETERRENT?

A DISPASSIONATE REVIEW OF OLD AND NEW EVIDENCE

1.The deterrence argument: why is it popular?
By EZZAT A. FATTAH, Ph. D

Retributive, religious and philosophical arguments in support of the death penalty have lost favor with many of its advocates. The radical change in penal philosophy that took place in the second half of the twentieth century was bound to bring about a change in retentionist rhetoric and strategy. At a time when correctional efforts were geared towards treatment and change, it was no longer fashionable to advocate the principles of talion law and the claim a life for a life, an eye for an eye and a tooth for a tooth. Advocates of the death penalty chose to focus instead on its presumed preventive effects and protective functions. Gradually, the deterrent effect of capital punishment became the focal point in arguments to support its retention or its reintroduction and continues to be presented by its supporters as the indisputable justification for the state's deliberate taking of human life. This change in focus that characterized death penalty debates of recent years is understandable. The deterrence argument is, in many respects, an attractive one.

Firstly, deterrence makes sense. It is common knowledge that people are afraid of death and will do everything they can to avoid it. The threat of execution is, therefore, likely to deter them from committing the criminal offences carrying the death penalty. In fact, the logic of the deterrence argument is impeccable. After all, what can be more obvious than the assumption that people cherish life above everything else and will not willingly and deliberately put it in peril? Common-sense views, however, are not always' correct. And if we are to justify the retention of the death penalty solely or mainly un grounds of its preventive effects, its supporters will have to come up with a more solid and convincing proof than more conventional wisdom.

Secondly, the deterrence argument is more civilized than arguments based on revenge and retribution. Retaliation and expiation are no longer acceptable ne the ultimate goals of criminal sanctions. Changes in philosophy are not always accompanied by changing in people's sentiments. Since vindictive, retributive feelings continue to exist it is only appropriate to cloak them in rational arguments such as deterrence and protection of society. The deterrence argument thus serves to disguise the primitive desire to see the murderer pay for his crime with his life. As Hans Zeisel (1976) puts it:
"It is the belief in retributive justice that makes the death penalty attractive, especially when clothed in a functional rationalization."
Thirdly, the deterrence argument provides a utilitarian rationale for the shedding of blood since this is supposedly indispensable for saving innocent lives.

The superiority of the deterrence argument to others advanced in support of the death penalty was reaffirmed by the Subcommittee on Moral Arguments For And Against The Death Penalty (Massachusetts, 1958). The Subcommittee stated:
"The only moral ground on which the State could conceivably possess the right to destroy human life would be if this were indispensable for the protection or preservation of' other lives. Thin places the burden of proof on those who believes that capital punishment exercises e deterrent effect on the potential criminal. Unless they can establish that the death penalty does, in fact, protect other lives, at the expense of one, there is no moral justification for the State to take life."[1]
Not only did the Subcommittee proclaim deterrence as the only legitimate justification for the death penalty, but it also squarely placed the burden of proof on the shoulders of the retentionists.

2 Is capital punishment a unique deterrent?
Discussions of the deterrent effect of capital punishment usually center on a wrong question. The question to be asked is not whether the death penalty deters would-be murderers, but whether it deters them more than the prospect of life imprisonment. The question is not whether the death penalty has a deterrent effect but whether it provides a unique and supreme deterrent whether it is the most powerful and most effective of all deterrents. It seems obvious that the death penalty cannot be justified on grounds of its deterring function alone unless and until it has been proven beyond a reasonable doubt that it supplies an additional increment of deterrence above and beyond the alternative which, in most jurisdictions, is life imprisonment. Has such an unique deterrent effect been unequivocally proven? The answer to this question is no.

Early deterrence research failed to show any relationship between the abolition or reinstatement of the death penalty and homicide rates. Despite the fact that several different studies reached the same conclusion, namely that the death penalty has no noticeable effect on the rates of homicide, these studies were dismissed by retentionists as "extremely primitive atavistically" and as having been done by "not very good statisticians". Retentionists, on the other hand, were quick to hail' the one study that reached an opposite conclusion, namely the now famous Ehrlich study. They either failed to detect the flaws in Ehrlich's data and methodology or simply decided to ignore whatever defects the study suffered from.
3 Empirical tests of the difference hypothesis
Scholars who tried to assess the preventive functions of the death penalty used various methods to test the deterrence hypothesis. And proponents and opponents of the death penalty used various types of evidence to support or to challenge its unique deterrent effect. This evidence may be divided into two main categories: anecdotal stories and statistical findings.

i) Anecdotal stories
Proponents of the death penalty usually argue that almost every prisoner under sentence of death seeks a reprieve and welcomes it when it comes. This is seen as evidence that men fear death more than anything else and fear more than life imprisonment. It seems fallacious to assume from the terror of death experienced and manifested by an individual on death row that the same fear was operative in his mind at the time of the crime. This argument overlooks one indisputable fact: the difference between a potential and remote danger and one that is imminent and seemingly inevitable. In Sellin's words (1980):
"Surely a murderer, for whom a possible death penalty had proved to be no deterrent, would be considered abnormal were he not to make every effort to escape death after being discovered and sentenced to die." (p. 79)
Another fact this argument overlooks is that the murderer on death row who is showing extreme fear and terror in fact of execution has not been deterred by the threat of death in the first place. It seems illogical to use the words or the psychological state of those who were not deterred by the death penalty to prove this penalty's unique deterrent effect.

Proponents of the death penalty also cite real life stories of criminals who have told the police that they refrained from killing the victim or from shooting at the pursuing police officer to avoid being put to death. For example, the Los Angeles Police Department reported to a California Senate Committee considering the abolition of the death penalty.(1960) that during the course of one year, 13 robbery suspects had told the police that they used loaded or simulated guns "rather than take a chance on killing someone and getting the gas chamber". The unreliability of such anecdotal evidence is obvious, and for every story alleging that the fear of the death penalty has acted as a deterrent, there are 10 others alleging that it has not. Clinton Duffy, former warden of San Quentin prison (California) asked thousands of prisoners convicted of homicide or armed robbery whether they had thought of the death penalty before their act. Not one had!
Among the most frequently quoted stories to deny the deterrent effect of capital punishment are those of the English pickpockets who actively applied their trade in the shadow of the gallows from which their fellow knaves were strung. Another often cited story is the one of an Ohio convict named Charlie Justice who devised the claps that held the condemned man in the electric chair. After his release, he was convicted of murder and electrocuted. A similar fate befell Alfred Wells who helped install San Quentin's gas chamber in 1938. It was his conversational cachet around the prison yard, usually with the moral: "That's the closest I ever want to come...". Four years later, back at San Quentin for a triple killing, he was sealed in the chamber to die.

Needless to say, arguments and claims based on this kind of anecdotal evidence tend to neutralize each other and are of little help in settling the basic factual question whether or not the death penalty is a unique deterrent.

ii) Statistical evidence
Earlier studies on the preventive functions of the death penalty tried to ascertain its deterrent effect in five different ways:
a) examining the effect of a declining rate of executions on criminal homicide rates;
b) comparing homicide rates within countries and/or states before and after they abolished or restored the death penalty;
c) comparing homicide rates between adjacent and apparently congruent states with and without the death penalty;
d) ascertaining whether law enforcement officers and prison guards were safer from murderous attacks in states with the death penalty than in those without it; and
e) examining homicide trends in cities where executions were carried out and were presumed to have been widely publicized.

Source: *http//www.ildialogo.org/cEv.?f=http://www.ildialogo.org/nopenamorte/Notizicommenti_1480628058.htm*

Contd. on next edition

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