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# A Matter of Rights: Human rights adherence and cross- country HAART access disparities in sub-Saharan Africa

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## ABSTRACT

Despite a sharp increase in efforts to ensure universal HAART access in regions hard-hit by the HIV/AIDS pandemic (such as sub-Saharan Africa), cross-country HAART access remains arbitrary at best. While recent studies have attempted to explain access disparities through a range of methods and explanatory factors, among them ethnic fractionalisation, variations in HIV prevalence, income levels per capita and levels of political engagement and support, this article explores the idea that adherence to international human rights standards also matters to a significant extent. Though current literature insists on the significance of integration of human rights in HIV/AIDS policy, it is unfortunate that the statistical links between the two have never been examined before. The article discusses the findings of a cross-country bivariate analysis, revealing that adherence to rights associated with physical integrity mattered more than rights associated with individual or collective empowerment, or with women's rights.

## INTRODUCTION

This article concerns disparities in the provision of highly active antiretroviral treatment (HAART)<sup>1</sup> across sub-Saharan Africa. The aim is to explore these disparities through countries adherence to human rights, and to establish if adherence matters to a significant extent. A cross-country bivariate analysis containing data from all 47 sub-Saharan African countries was carried out, where three human rights indexes were controlled for against levels of HAART access.<sup>2</sup> The study used an original set of data, derived from the 2008 UNAIDS Country Progress Report, and tested it in relation to the human rights indexes, which were collected from the CIRI Human Rights Data Project.<sup>3</sup> The final results of the analysis suggest that high human rights scores do not necessarily imply that levels of HAART coverage are similarly high. The method is in itself not entirely novel in this context (see for example Peiffer and Boussalis, 2009; Lieberman, 2007; Menon-Johansson, 2005); what is unique for this study is the implementation of human rights data in relation to HAART access. The study was guided by the hypothesis that states adhering to international human rights standards accomplish greater access levels of HAART. The article addresses other possible explanations behind cross-country disparities in HAART access. Though significant contributions to current research, no previous study has explored the connection between human rights adherence and HAART access. For the most part, the available literature arguing the case for a human rights approach to HIV/AIDS originates from non-governmental organisations (NGOs). In particular, it has been argued that adherence to women's rights is crucial in the design and implementation of successful HIV/AIDS policies; yet no study has previously analysed this in an HAART access context.

Epidemics of varying magnitudes have occurred irregularly throughout human history, but until the onset of AIDS, none have had a long-term demographic impact as population numbers have managed to bounce back fairly quickly. With AIDS came a pandemic with opposite effects, as HIV is normally transmitted to people in the prime of their lives, with hard-hitting consequences (Hays, 2005). At present there is no denying that HIV/AIDS poses an ongoing threat; especially, perhaps, in

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<sup>1</sup> Over the last twenty years treatment for AIDS and AIDS related symptoms have evolved from a single drug to dual drug therapy and now highly active antiretroviral treatment (HAART, or triple-therapy). HAART works simultaneously to prevent the HIV virus from developing resistance to the drugs while suppressing the blood's viral replication, thus keeping AIDS at bay.

<sup>2</sup> HAART access is measured in percentages of the population in current need.

<sup>3</sup> Please see <http://ciri.binghamton.edu/> for detailed information.

sub-Saharan Africa, the region of the world by far the worst affected by the pandemic. Here, thousands of people die of AIDS-related diseases every day, while similar numbers become infected with HIV. In an African context, the AIDS pandemic has been described as a development process in reverse (de Waal, 2003).

To begin with, the article will examine previous research concerning HIV/AIDS, HAART access, and HIV/AIDS from a human rights perspective. The article will then discuss the selection of data. A discussion of methodology, as well as of final results, will follow. The article concludes with suggestions for further research.

## **PREVIOUS RESEARCH**

The first reports of AIDS in Africa appeared in the mid-1980s, to which the reactions of African states varied greatly (Patterson, 2006). Some leaders ignored the growing peril of HIV/AIDS, some reacted immediately, and some refused to act upon it while laying the blame for the virus on 'deviants' such as gay men or sex workers. Within the realm of political science, the reaction to HIV/AIDS has been similarly varied. During the 1980s and 1990s, political research regarding HIV/AIDS was limited and displayed no apparent will to deal with related issues (Patterson, 2006; Peiffer and Boussalis, 2009). Political scientists undertook mainly quantitative research and focused their attention on macroeconomic and political influences on health outcomes (Peiffer and Boussalis, 2009). A well-cited argument claims that HIV/AIDS has been conceived as "too private, too biological, too microlevel and sociological, too behavioural and too cultural to attract the attention of many political scientists" (Boone and Batsell, 2001: 4). Thereby, our understanding of the macro determinants of HIV/AIDS is growing, though the lack of a coherent approach leaves much to be desired.

In an African context, failing to institutionalise the fight against HIV and AIDS into the political sphere means that state, civil society and bilateral and multilateral donors are able to continue their business without a long-term interest or a political stake in the pandemic. It has been argued that HIV/AIDS has received only sporadic attention from aid donors and African political leaders, especially in comparison to Africa's problems related to internal security and economic development (Patterson, 2006). Nonetheless, studies have shown that the presence of a strong political leadership, that is willing and able to implement informed interventions, can hinder the spread of HIV significantly (Bor, 2007). It was not until quite recently that it became clear that political solutions are required to stop the spread of the pandemic (Fredland, 2001). Cross-country political responses to the pandemic, even in regions with similar disease patterns, have been uneven and, in many cases, inadequate (Bor, 2007). For instance, Uganda has gained international fame due to its high-profiled leadership and swift response to HIV (Hjorth, 2005; de Waal, 2003, 2006; Persson and Sjöstedt, 2008). By contrast, South Africa has become infamous for its weak political response to the pandemic. On the whole, political commitment to the fight against HIV/AIDS has been found to be greater in countries with wide-spread epidemics (Bor, 2007). Moreover, a recent study investigated the relationship between bureaucratic quality and country responses to HIV/AIDS and found that high bureaucratic quality is vital for the success of implemented HIV/AIDS policies (Peiffer and Boussalis, 2009). Another study measured HIV prevalence in relation to bureaucratic quality and found that levels of HIV prevalence are directly related to levels of high or low governance and bureaucratic quality, and that health systems designed in response to HIV/AIDS should take such findings into account (Menon-Johansson, 2005).

Sub-Saharan Africa is the region by far the worst affected by HIV and AIDS – with a mere ten percent of the world’s total population living here, more than 64 % of those infected by HIV globally are Africans (UN, 2006; Persson and Sjöstedt, 2008). There are significant cross-regional and cross-country disparities both in levels of HIV prevalence and in HAART access. In particular, differences in HIV rates have been widely investigated, resulting in a range of explanations. Variations in state capacity are one such explanation, as is the connection with the prevalence of other (tropical) diseases, such as malaria (Persson and Sjöstedt, 2008). The primary method of monitoring trends in HIV prevalence is data collection in women attending ante-natal clinics; whereby the better proxy for national HIV trends is prevalence among young pregnant women, i.e. those aged 15-24 years. Susceptible HIV trends among this group show that the AIDS pandemic in sub-Saharan Africa has levelled off since the late 1990s (Asamoah-Odei et al, 2004); and since the turn of the century there has been an annual decline in regional HIV prevalence (Peiffer and Boussalis, 2009). However, disparities in HIV prevalence across countries suggest that there are several, overlapping, epidemics to be considered. Even within sub-Saharan Africa, the epidemics take different courses in different settings. Southern Africa is more hard-hit than western Africa, for instance, where HIV prevalence remain comparably quite low. This is in part due to the presence of a different strand of HIV, HIV-2, which is found only in some countries in Western Africa. HIV-2 has a longer incubation period than HIV-1 (the most widespread strand of HIV) and appears to be less transmittable. The oldest epidemics are found in urban centres in eastern Africa where prevalence has remained stable since the mid-1990s; being surpassed by southern Africa in 1993 (Asamoah-Odei et al, 2004).

There is no doubt that HIV and AIDS will affect governance in Africa, and can in the long-term destabilise peace and security in the region (de Waal, 2003). The demographic effects alone of HIV/AIDS are mind-blowing, as HIV/AIDS has lowered life expectancy at birth with twenty years in some countries; especially since the majority of sufferers are snatched away in the prime of their lives. The spread of the virus manifests gender differences as women more often become infected in their youth, whereby there will be a shortage of adult men in relation to adult women. Moreover, women are more vulnerable to contracting HIV, particularly in settings where they are subject to discrimination and subordination.<sup>4</sup>

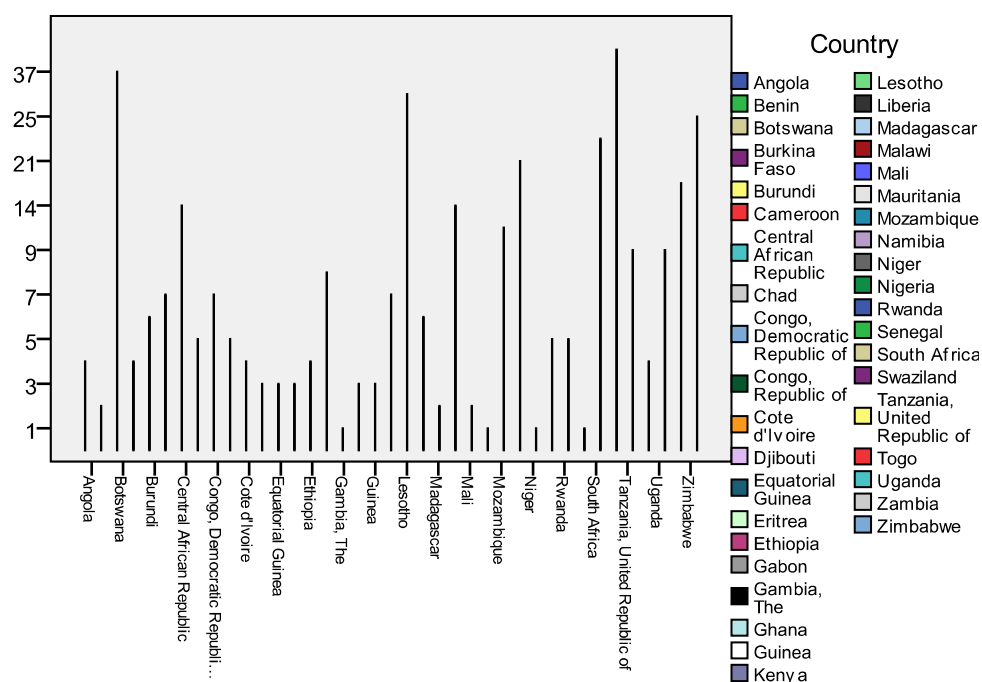
Possible impacts of HIV/AIDS on governance can be said to contain two strands: it reduces the capacity to implement democratic governance, and alters the rationale for political and social action by individuals and the collective (Strand and Chirambo, 2005). A reduction in the capability for democratic governance is realised in part due to AIDS induced labour shortages, as well as the larger economic strain placed upon a country’s budget following increases in health system finances. Civil society may suffer similar consequences of HIV/AIDS, when the loss of lives reduces its strength and sustainability, and hence its possibility to mobilise against the state and proposed policies. On an institutional level, HIV/AIDS threatens to undermine democratic processes through changes in the political attitudes of voters and increasing prejudices and intolerance among civil society (Mattes, 2003). The available research on governance and HIV/AIDS concerns for the most part HIV prevalence in relation to state capacity to hinder further spread of HIV (Persson and Sjöstedt, 2008). One quite popular justification for prevalence disparities is the presence of a strong

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<sup>4</sup> A more detailed discussion of women’s status and heightened vulnerability to HIV/AIDS is found in the following sections.

national leadership. Uganda and Botswana are usually mentioned as examples of where national leadership has been adamant; however, a closer examination reveals that only Uganda has HIV prevalence levels below the ten percent mark. Botswana is also often referred to as prominent examples of nations with a solid institutional framework, within which, the spread of HIV can be if not stopped, so at least slowed down. However, as Persson and Sjöstedt (2008) note, the solidity of institutions does not by implication mean a more successful response to the AIDS crisis. Likely economic implications of the HIV/AIDS pandemic have also been researched quite extensively. Most such studies have focused on variances in the spread of HIV and linked these with various financial explanations such as varying cost-efficiency in health service delivery and productivity loss resulting from widespread illness (Persson and Sjöstedt, 2008). Therefore the potential connection between HIV prevalence and HAART access levels will be analysed in this study.

**Figure 1: HIV prevalence variations in sub-Saharan Africa**



*Source: 2008 Report on the Global AIDS Epidemic, UNAIDS/WHO, July 2008*

The most recent study to link governance with country responses to HIV/AIDS offers valuable insights into the relationship between bureaucratic quality and HIV/AIDS policy (Peiffer and Boussalis, 2009). Bureaucratic quality is analysed through six features (levels of meritocracy, an optimal number of bureaucrats, independence from political pressure, budgetary practices, operational coordination and competitive compensation of bureaucrats) and measured through the Government Effectiveness indicator, an index constructed by the World Governance Indicators, WGI (ibid.). The authors hypothesize that high bureaucratic quality is vital for the successfulness of implemented HIV/AIDS policies, which their subsequent findings support. Similarly, the WGI has been used in an empirical analysis linking poor governance to high HIV prevalence (Menon-Johansson, 2005). In this study, all six WGI indicators were included and measured against HIV prevalence data derived from UNAIDS. Menon-Johansson drew similar conclusions as Peiffer and Boussalis: levels of HIV prevalence are directly related to levels of high or low levels of governance and bureaucratic quality, and that health systems designed in response to HIV/AIDS should take such findings into account. Though both

studies are unique in the sense that they correlate governance and bureaucratic quality with incidences of HIV/AIDS, their scope is limited as they fail to reflect on possible causalities. Thus they fail to address the possibility that HIV prevalence is higher in countries with reported poor governance, due to other reasons than their bureaucratic quality.

Most countries provide their citizens with basic education and primary health care services. Though many nations in sub-Saharan Africa can be found on the list over the world's poorest countries, the temptation to draw hasty conclusions between wealth and good quality service delivery should be resisted (Goldstein, 2007). Instead, focus should lie with the quality of service delivery and, in this context in particular, how many people of those in need the service actually reaches. Health infrastructures in resource-poor settings often suffer from years of under-investment, a shortage of human resources and the emergence of a pluralist system which see government institutions working concurrently with non-governmental organisations and private health providers (WHO, 2004). In this environment HIV/AIDS has been allowed to spread, adding to the heavy workload already experienced by health workers and their employers, thus exacerbating an already difficult situation. The fact that HIV/AIDS usually hit people in the prime of their lives means that health care personnel become infected while still employed; further adding to the burden and creating a situation in which the health service demands increase while human resources are dwindling.

Public service provision is a fundamental function of government (Besley and Ghatak, 2007). In terms of HIV/AIDS, a country's public service delivery needs to be thoroughly assessed in order to implement a successful response to the pandemic. However, the provision of public service goods is often rendered a particularly challenging task in poorer countries, where citizens often lack access to basic services such as clean water or health facilities (World Bank, 2003). In addition, it has become apparent that HIV/AIDS will decrease state capacity to provide basic social services (Patterson, 2006). That being said, it has been argued that the human rights framework can help to improve public services, as it aims to ensure the delivery of good quality services that meet the needs of individual service users (UK Audit Commission, 2003). As the provision of HAART falls within the scope of public service, the HIV/AIDS pandemic, and the needs of people affected by it, illuminate the significance of an effective public service sector. A common trait among those countries having made notable progress towards universal HAART access levels is that they have increased human resources in their public sectors, have improved access to appropriate equipment, and have strengthened health systems more generally (UNAIDS, 2008). Furthermore, an active and vocal civil society promotes the realisation of human rights, thus expanding the implementation capacity and improving service access for those most in need (ibid.). Human rights standards could, and should, be used as a normative framework in the design of HIV/AIDS policies. Equality in access to health services is of particular significance (MacNaughton, 2004) – especially since health services can relay both HIV prevention messages and provide AIDS treatment facilities.

Human rights approaches to HIV/AIDS include:

- ✚ Ensuring the inclusion of measures to combat HIV/AIDS related stigma and discrimination
- ✚ Securing the rights of marginalised populations and reducing their vulnerability

- ✚ Providing women with remedies against gender-based violence as well as redress against legally sanctioned violence and subordination regarding economic opportunity, property and inheritance
- ✚ Investing in legal empowerment for people living with HIV (PLHA) in order to make them aware of their rights and can mobilise around them
- ✚ Ensuring that young people have access to HIV information, sex education, condoms, family planning and health services for sexually transmitted infections (Gruskin and Tarantola, 2002; MacNaughton, 2004; Jürgens and Cohen, 2007; UNAIDS, 2008)

Thus, current literature assents that multi-faceted connections exist between HIV/AIDS and human rights. Indeed, the promotion and protection of human rights constitute a crucial component in preventing transmission of HIV and the impact of HIV/AIDS (UNAIDS, 2008). However, most of this literature originates from HIV/AIDS NGOs, such as advocacy organisations for improved prevention messages and/or enhanced treatment access.<sup>5</sup> Academic interest in the links between human rights seems to have experienced a peak during the mid-1990s (see Mann et.al, 1999; Parker, 1996; Tomasevski, 1992); which presumably explains the lack of relevant statistical research.

UNAIDS highlights a number of rights contextually relevant to HIV/AIDS; among them freedom of movement, the right to education and information, and the right to health. A recent surge in calls for a human rights-based approach to HIV/AIDS has drawn attention to the compatibility of the human rights framework and successful HIV/AIDS policies. A human rights-based approach to HIV/AIDS ensures a focus on the rights of population groups considered specifically vulnerable to HIV/AIDS (e.g. women, orphans, men who have sex with men, migrant populations, ethnic and indigenous groups, youths, drug users and refugees); thus reducing their vulnerability. Moreover, it would increase the likelihood that HIV policies are designed and implemented through an equality and non-discrimination approach. Programmes and strategies integrating human rights with HIV policy could empower both those affected by HIV and those vulnerable to infection; among other things, through education and information about the pandemic. If integrated into national law, the human rights framework can protect people by being able to turn to legislative bodies if faced with human rights violations in an HIV/AIDS context (ibid.). An increased respect for, and adherence to, human rights within the public sector is therefore likely lead to raised HAART access levels.

### **HUMAN RIGHTS IN THE HIV/AIDS ERA**

Article 12 of the Covenant on Economic, Social and Cultural Rights asserts ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ (UN International Covenant on Economic, Social and Cultural Rights, ICESCR, 1966/76); thus the promotion and protection of human rights constitute an essential part of the promotion and protection of health (Mann, 1996). As long as HIV/AIDS remains incurable yet treatable, access to treatment is crucial to ensure ‘the highest attainable standard’ of health. The HIV/AIDS pandemic is, however, no longer a strictly health related issue. As the pandemic continues to spread into areas with different economies, legal systems and social structures, human rights issues related to HIV/AIDS are expanding and diversifying (Gruskin and Tarantola, 2002). Interventions aimed to hinder the spread

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<sup>5</sup> For instance, Human Rights Watch, the International Treatment Preparedness Coalition, and the Treatment Action Campaign (South Africa).

of the pandemic thus need to address the variations of human rights issues, attempting to lessen societal factors that increase vulnerability to HIV/AIDS on both the individual and collective level. As previously mentioned, people can become increasingly vulnerable to HIV infection, and to lower HAART access levels if denied full realisation of their human rights. Without comprehensively integrating a realisation of human rights, universal HAART access levels will not be reached (Jürgens and Cohen, 2007). HIV has spread rapidly in developing countries, and among marginalised groups within many of these countries. Young women and girls comprise the largest, and most vulnerable, among these groups (Raimondo, 2005). Vulnerability to HIV/AIDS is deeply rooted in discrimination and a lack of respect for human rights and dignity (Gruskin and Tarantola, 2002). Marginalised groups suffering from stigmatisation and discrimination are often ignored in epidemiological surveys. Failure to monitor HIV prevalence among such groups lead to HIV prevention efforts that do not recognise real needs; thus HIV retains the upper hand (UNAIDS, 2004). Discrimination and stigma can also form a major obstacle to accessing HAART. This is particularly problematic since the rate at which the progression of the disease is entirely dependent upon the level of access to health care an HIV positive person has (Hjorth, 2005). Human rights approaches to HIV/AIDS emphasize social elements of the infection crucial for the understanding of what drives the pandemic. An effective response to HIV/AIDS therefore requires a grasp of the linkages between the pandemic and human rights, as the realisation of rights are crucial for the protection of the rights of those already infected and affected by HIV/AIDS, as well as those vulnerable to infection (Gruskin and Tarantola, 2002). This grasp needs to reach beyond the rights related to health, as the pandemic itself affects spheres beyond health issues. Indeed, it has been argued that failing to prevent HIV transmission in itself constitutes a human rights violation (de Cock et. al, 2002).

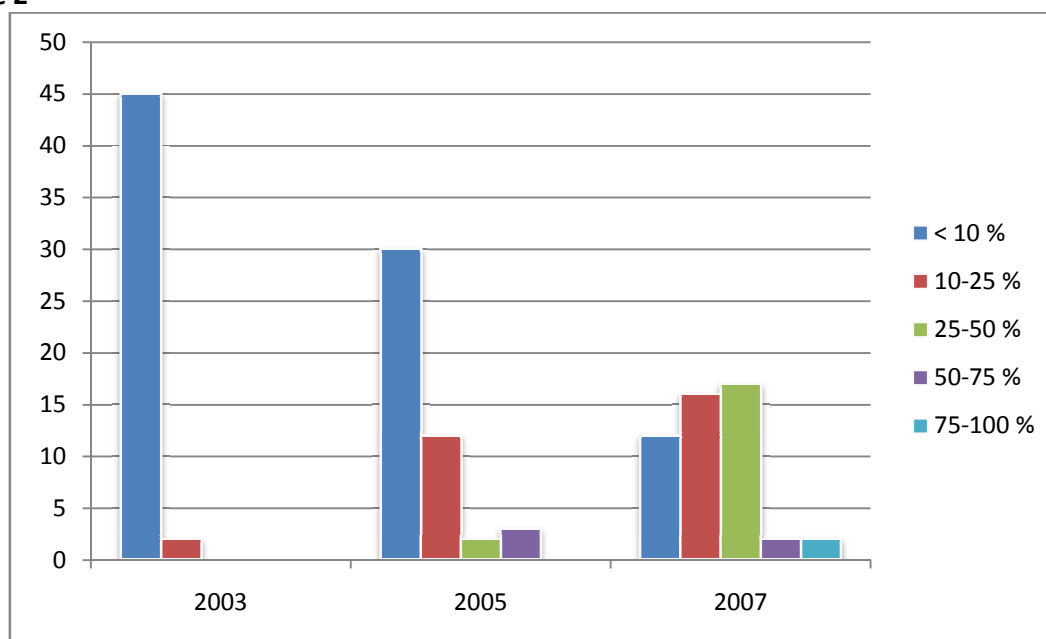
Despite the presence of weak health systems, plagued by economic deficiencies and a lack of human resources, research has shown that the provision of HAART is possible even in low resource settings (Schneider et al., 2006). High HIV prevalence countries Namibia, Botswana and South Africa have similar GDP per capita levels but experienced during 2004 great disparities in AIDS treatment access levels: Namibia and Botswana 28 % and 50 % respectively, while South Africa only managed 7 %. This is now widely accepted to be the result of a visible political commitment in Namibia and Botswana, whereas in South Africa the response to HIV/AIDS has been less well transpired and organised (Nattrass, 2006; Persson and Sjöstedt, 2008).

The duty to promote and fulfil international recognised human rights standards is ultimately a government matter (Evans, 2002), as is the obligation to ensure universal HAART access. If international human rights standards are respected, upheld and enforced, they form a sufficient framework upon which to build and organise a well-functioning public sector, and human rights adherence could have a positive impact on HAART access levels. The UNAIDS International Guidelines for HIV/AIDS and Human Rights state that '(u)niversal access to HIV prevention, treatment, care and support is necessary to respect, protect and fulfil human rights related to health' (UNAIDS International Guidelines for HIV/AIDS and Human Rights, 2006: 41). As of December 2007, around one third of those in need in sub-Saharan Africa had access to HAART. Though a seemingly low figure, this is a considerable improvement compared to previous figures; indeed, a thirty percent coverage rate is an all-time high. High treatment access levels also ensure greater incentives for HIV testing. In circumstances where a positive test causes stigma and discrimination, and where treatment access is low, individuals are less likely to undergo voluntary HIV testing. Access to HAART can also decrease the impact of discrimination likely to be present in communities hard-hit by HIV and subject to



anxiety and a sense of hopelessness (MacNaughton, 2004). Many foreign donors and AIDS activists have prioritised treatment over HIV prevention strategies (de Waal, 2006), and the number of deaths due to AIDS has declined in the past two years (UNAIDS, 2008). In part, this is due to the “3 by 5”-initiative jointly launched by the WHO and UNAIDS. The initiative aimed to provide three million people from low- and middle-income countries with HAART before the end of 2005. This goal was reached, albeit not until 2007.<sup>6</sup> Thus, it seems that the effort of substantially increasing resource provision of HAART pays off (Tsai et al., 2009), though at a considerable cost. The scale-up of HAART programs represents the most ambitious service delivery exercise ever undertaken in Africa. Several equally significant factors are required for its success, among them a credible system for HIV testing, improvements in health infrastructure (particularly in rural areas), training of health workers, meeting the nutritional, shelter and livelihoods needs of patients, improved health sector financing, and monitoring drug resistance (de Waal, 2006; Boulle and Ford, 2007). A rapid scale up of HAART access exposes inherent weaknesses in health systems already heavily burdened by the impact of HIV/AIDS. However, even a moderate increase in access reveal discernible improvements in the lives of patients treated with HAART (Boulle and Ford, 2007); and not providing universal HAART access is ‘literally rationing the right to life’ (de Waal, 2006: 112). There are still, however, considerable inequalities in cross-country access levels. Figure 2 shows the number of countries achieving greater HAART access levels between 2003 and 2007. Note that by 2007; only one country – Botswana – had reached universal access levels (above 80 % of those in need).

**Figure 2**



Source: WHO, 2008

## METHODOLOGY AND DATA

All data is derived from UNAIDS, the WHO, the Quality of Government Institute and the CIRI Human Rights data project.<sup>7</sup> Unless otherwise stated, all figures are from 2007. The aim of this article is to

<sup>6</sup> <http://www.avert.org/aidstarget.htm>, accessed May 14, 2009

<sup>7</sup> Please see [unaids.org](http://unaids.org), [who.int](http://who.int), [qog.pol.gu.se](http://qog.pol.gu.se), and <http://ciri.binghamton.edu/>, respectively.

explore possible disparities in HAART access levels; hence, the data was applied in a bivariate analysis with HAART access levels tested against three human rights indexes, and then against HIV prevalence, GDP per capita rates and health expenditures (as percentages of GDP). Given that this may be the first analysis to be conducted with these indexes, there are no thumb rules or guidance principles by which to compare the data interpretations; however, the Pearson correlation ( $r$ ) ranges from -1 (negative covariance) to +1 (positive covariance). The human rights indexes have been selected from the CIRI database as contextually the most applicable, out of those available.<sup>8</sup> The Physical Integrity and Empowerment Rights indexes were accumulated by CIRI; the Women's Rights index is an amalgamation of the CIRI Women's Economic Rights, Political Rights and Social Rights, combined for the sake of this study. This index has been included in the study as women now represent the majority of new HIV infections; contrary to the first decades of the HIV/AIDS pandemic, when men suffered most new infections. Moreover, gender inequality increases the spread and the severity of the pandemic (Raimondo, 2005). Realising the empowerment of women is recognised by the UN to be a fundamental element in reducing the vulnerability of women and girls to HIV/AIDS (UN General Assembly Declaration on HIV/AIDS, 2001). Several of the rights included in the Women's Rights Index can be directly related to HAART access, as the possibilities to enjoy one's full human rights cannot be realised for an HIV positive person without consistent access to HAART.

**Table 1: The Human Rights indexes**

<b>Human Rights Index</b>	<b>Range and description</b>
Physical Integrity Rights Index	Variable comprised of four indicators: Extrajudicial killing, Disappearances, Torture and Political imprisonment. It ranges from 0 to 8 where low scores indicate less government respect for these rights and high scores show high government respect.
Empowerment Rights Index	Additive index comprised of Foreign Movement, Domestic Movement, Freedom of Speech, Freedom of Assembly and Association, Workers' Rights, Electoral Self-Determination and Freedom of Religion. Ranges from 0 (no government respect for these rights) to 14 (complete government respect).
Women's Rights Index	Additive index which includes (among others) the right to gainful occupation without husband's or father's consent, the right to vote, the right to equal pay for equal work, the right to be free from harassment in the workplace, the right to join political parties, the right to run for political office, the right to petition government officials, the right to hold elected and appointed government positions, the right to participate in social and cultural activities, and the right to an education. Index ranges from 0 (women's rights not legislated) to 9 (women's rights guaranteed by law and enforced).

The study also included in the analysis figures of HIV prevalence, GDP per capita and health expenditure (in percentages of total GDP). A possible connection between HIV prevalence and levels of HAART access could be that higher levels of HIV prevalence lead to higher levels of HAART access. Countries with a wide-spread epidemic are more likely to receive greater financial aid and international expertise to help lessen the burden of the national health system. However, a rapid

<sup>8</sup> Though it would have been intriguing to establish the correlations between the Right to Health, or indeed other Economic, Social and Cultural Rights, and HAART access levels, there was no such data to be found.

scale-up of health infrastructure is no guarantee for increased levels of health system access, particularly not for poor and marginalised populations groups (Tsai et al, 2009). Achieving high levels of HAART access may also lead to an increase in HIV prevalence, as more people are able to live longer lives with the virus (Peiffer and Boussalis, 2009). Out of HIV prevalence, GDP per capita and health expenditures, covariance was the highest for HIV prevalence (see Table 2). Botswana, renowned for achieving the highest HAART access levels in sub-Saharan Africa, currently experiences correspondingly high HIV prevalence. Namibia, the second best HAART access achiever, reports lower prevalence levels. Notably, Swaziland has the highest HIV prevalence in sub-Saharan Africa, but manages to provide less than half of its population with HAART. The largest cluster of countries seems to have responded with similar effort levels to the pandemic, reaching neither high prevalence levels nor high access levels.

The index GDP per capita is intended to measure if higher GDP rates correlate with higher levels of HAART access.<sup>9</sup> Similarly to findings by Natrass (2006), this study found a positive covariance between GDP rates and HAART access levels. In predicting the level of HAART coverage, Natrass found economic variables to be the most significant. A higher average income, in that study, in combination with lower levels of economic inequality, corresponded with greater access to HAART. An equally strong connection is found here. Both countries with the highest HAART access levels, Botswana and Namibia; belong to the group with the highest GDP. It should be noted that one country has a GDP rate way beyond those of the rest, Equatorial Guinea, but does not supply even half of its HIV positive population with HAART. The middle-ranging countries, with a higher than average GDP, similarly fail to reach universal access levels.

Health expenditure, as a percentage of GDP per capita, was also controlled for; this to rule out that those countries devoting more of their GDP to health services ensured higher HAART access levels. It is noteworthy that the countries having reached high access levels also belong to the middle-range group. Malawi, which spends the most of its GDP on health, still does not reach HAART access levels above 25 %. Disparities in HAART access can become apparent during large scale-up operations, stressing the variations in the capacity of health sectors dealing with the increasing work load that the provision of HAART entails (Kovsted, 2005). Health sector capacity, in turn, is affected by the scale of national and regional HIV epidemics (Natrass, 2006). Malawi is one of the poorest countries in the region, and suffers from one of the most rampant HIV/AIDS epidemics, which could serve to explain the difficulty in achieving higher HAART access levels.

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<sup>9</sup> The GDP per capita variable shows GDP in 1990 International Geary-Khamis dollars, a hypothetical unit of currency that has the same purchasing power that the U.S. dollar had in the United States at a given point in time (Teorell, Holmberg and Rothstein, 2008).

**Table 2**

	<b>Physical Integrity</b>	<b>Empowerment</b>	<b>Women's Rights</b>	<b>HIV prevalence</b>	<b>GDP per capita</b>	<b>Health expenditure</b>
<b>HAART Access</b>						
Pearson correlation	.266	.149	.118	.386*	.364*	.284
Significance (two-tailed)	.093	.353	.463	.015	.021	.071
N	41	41	41	39	40	41

\* Correlation is significant at the 0.05 level (two-tailed)

## **RESULTS AND DISCUSSION**

The Physical Integrity Index, which includes rights such as Freedom from Torture (or Cruel, Inhuman or Degrading Treatment or Punishment, Article 7 of the International Covenant on Civil and Political Rights, ICCPR) and Freedom from Extrajudicial killing, Disappearances and Political imprisonment (inherent in the Right to Liberty and Security of Person, ICCPR Article 9)<sup>10</sup>, shows the strongest correlation with HAART access levels, out of the three human rights indexes ( $r=.266$ ). A possible explanation for this is that countries that enforce these rights have gone through a democratisation process through which such abhorrent state behaviour has diminished. While not suggesting that democratisation has a positive or negative impact on HAART access levels, in fully democratised countries the institutional framework may be solid and well-functioning enough to be able to achieve high access levels. This is also the main reason for including this index in the analysis; yet this correlation is less positive than expected. Though there are some examples of countries scoring high on both the Physical Integrity Index and HAART access (Botswana and Namibia), there are also examples where a high Physical Integrity score corresponds to low levels of HAART access (for instance, Guinea-Bissau and Tanzania). The great variations in covariance thus had the implication that the discovery of a significant link between this rights index and HAART access levels failed to appear.

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<sup>10</sup> Of which all sub-Saharan African countries are signatories.

The Empowerment Rights Index is an additive index consisting of indicators of Foreign Movement and Domestic Movement (Article 12 of ICCPR), Freedom of Speech (Article 19 of the Universal Declaration of Human Rights), Freedom of Assembly and Association (Article 22 of the ICCPR), Workers' Rights, Electoral Self-Determination (inherent in Article 1 of the ICCPR), and Freedom of Religion (Article 18 of the ICCPR). The covariance was here found to be  $r=.149$ . That the right of foreign and of domestic movement is respected ensures that people are able to travel freely if that is required in order to gain access to HAART. Circumstances of poverty restrict citizens' ability to travel; however, if domestic movement, in particular, is restricted in ways beyond those that is limited by poverty, then HAART access levels are lowered. Freedom of Speech is important in this context concurrently with the Freedom to Assembly and Association, guarding the right to join AIDS activists organisations which can increase HAART access through grass-root lobbying and voicing discontent with prevailing AIDS policies. In South Africa in particular, AIDS activism has come to play a vital role in shaping national AIDS policies. Widely criticised both domestically and internationally, the South African government failed for years to acknowledge HAART as a treatment for AIDS, instead promoting nutrition as a valid alternative.<sup>11</sup> Intensive activism campaigns saw the initiation of a HAART program in late 2003. It is therefore interesting to note that South Africa scores a 10 (of 14) on the Empowerment Rights Index while HAART access levels hover slightly above the relatively low 20 % mark – thereby contradicting the study's initial hypothesis. Workers' Rights are contextually relevant as many countries has made it possible to receive HAART as an employment benefit. Respect for these rights ensure HAART access while employed, as well as the security of employment for people living with HIV (PLHA). Respect for and adherence to the Right to Electoral Self-determination ensures the right of citizens to show their commend or discontent with elected officials through their vote. Citizens' trust in government adherence to this right can also hinder that a sense of helplessness spreads in similar patterns as the HIV/AIDS pandemic. Enforcement of the Right to Freedom of Religion suggests a greater respect for citizens' freedom of life choices, which is assumed to affect HAART access levels positively. In this context, the Empowerment Index is relevant as it indicates if citizens are enabled (or hindered) to assume an active role in society. As the projected prime beneficiaries of public service delivery, citizens should be granted the possibility to participate in decision-making processes affecting public service delivery (Osterreider, 2006). Other key aspects of a functioning public sector are a non-discriminatory approach and the inclusion of all groups of society – including PLHAs. Similarly to the analysis with the Physical Integrity Index, however, the score reveals that high index scores do not necessarily imply high HAART access levels.

Women, of course, possess the same human rights as men; rights that have been addressed in the UN through a variety of documents and covenants. Among them are the Convention on the Elimination of All Forms of Discrimination of Women (CEDAW, adopted by the UN General Assembly in 1979)<sup>12</sup> and supplementary documents addressing issues such as trafficking, voluntary marriages and women's political rights (Howard, 1993). The actual establishment of women's rights is a normative exercise, as UN declarations are not necessarily enforceable in national legislation. Howard (1993) argues that conventions of rights rather provide a standard for comparison by which signatory governments can be assessed. Women, as a social category, are almost universally subordinate to men, though there are variations in the degree of subordination

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<sup>11</sup> <http://www.avert.org/aids-south-africa.htm>, accessed May 21, 2009.

<sup>12</sup> As of 2009, 36 sub-Saharan African countries are signatories to CEDAW.

(ibid). Women's rights cannot be expected to transpire without changes in the political and economic sphere, both within which women's subordination is apparent. However, women's subordination in an African context is deeply rooted in norms of appropriate gender-specific behaviour that emerged in early social formations (ibid). The additive index of women's (political, economic and social) rights was included in the analysis due to women's particular vulnerability to HIV/AIDS, and because current human rights frameworks can provide a useful strategy for illuminating the relationship between gender inequalities and the increasing number of women becoming infected with HIV (Raimondo, 2005). Settings of subordination can lead to unequal access to information for women and girls, whereby they may not gain appropriate knowledge about HIV and how it is spread (MacNaughton, 2004). In general, girls are expected to retain a sexual innocence and refrain from seeking information about sexual issues, and thus the likelihood that they contract HIV increases. But there exist other spheres where violations of women's rights render them vulnerable to HIV infection. It is not uncommon that women's ability to own or inherit property is restricted by law. This leaves women economically dependent on their husbands, fathers or other male relatives, restricting them from leaving marriages and living arrangements. Upon the death of a husband (or father/brother, etc.), women risk becoming impoverished, increasing the likelihood that they are forced to engage in sex work or other harmful practices to earn a living (Jürgens and Cohen, 2007). Women's vulnerability to contract HIV is therefore severely heightened. It is worthwhile noting that out of these three women's rights, political rights are more strongly enforced by national legislation in sub-Saharan Africa than economic and social rights. When each right was controlled for in turn, the results showed that two out of the total of 47 countries scored 1 (on a scale from 0 to 3) on the women's Political Rights' scale (the Comoros and Nigeria; both of which also scored low on women's Economic and Social Rights). Out of the three rights indexes, covariance for Women's Rights was weakest in relation to HAART access ( $r=.118$ ). Violations of every one of the rights included in the index increase the likelihood that women receive lesser HAART access, in particular if they belong to a marginalised group.

## **CONCLUDING REMARKS**

As it was felt that the dynamics determining disparities in HAART access needed to be more thoroughly addressed, this article has explored the relationship between adherence to human rights standards and HAART access levels. The final results of a bivariate analysis show that adherence to human rights does not have a significant effect on HAART access, contrary to what the study initially hypothesized. In the countries where human rights adherence seem to have mattered the most (namely Botswana and Namibia), the results mirror those of Peiffer and Boussalis (2009), and to a certain degree also Menon-Johansson (2005). Adherence to human rights should be regarded as an integral part of addressing the HIV/AIDS pandemic, as human rights-based approaches can determine both prevention efforts and treatment access policies. Efforts to sustain the spread of HIV/AIDS should embrace and integrate efforts to achieve full realisation of human rights; in particular when addressing the needs of marginalised populations. Heightened vulnerability to contract HIV and to be subject to lower HAART access levels are often a result of existing human rights violations.

As the statistical analysis carried out in this study is of the simpler kind, a deeper exploration into the causal mechanisms behind the factors analysed here in relation to HAART access levels, would further enhance our comprehension of the determinants behind access levels. For instance, an investigation into the reasons why the protection of women's political rights does not correspond to greater HAART access would be useful. Moreover, should data on Economic, Social

and Cultural Rights be made available, it would be intriguing to run these in an analysis with HAART access data. In particular, HAART access levels in relation to national ability to enforce the Right to Health would make interesting research.

Current estimates establish that around 80 percent of African HIV/AIDS programmes are sponsored by international donors, both bi- and multilateral (de Waal, 2006), a proportion which is expected to rise in coming years. Thus African governments can increasingly be devoting their time to serve as a mechanism for processing donor finances to provide HAART. The infusions from international actors provide both funding and expertise, and the influence of these open up a new area into which research could be directed.

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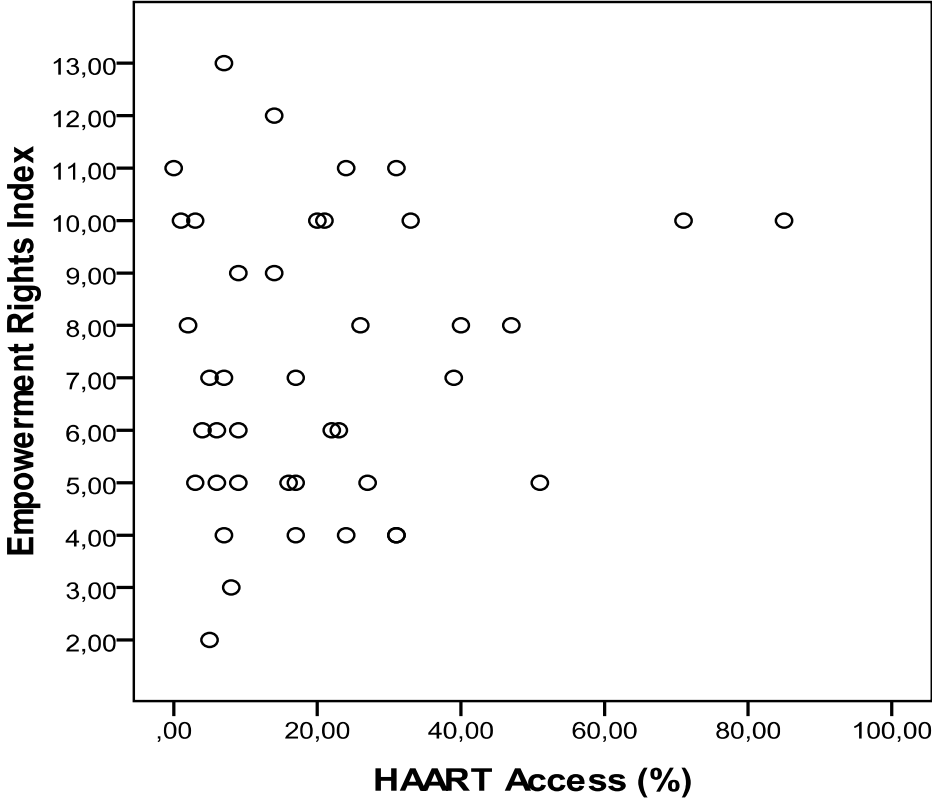
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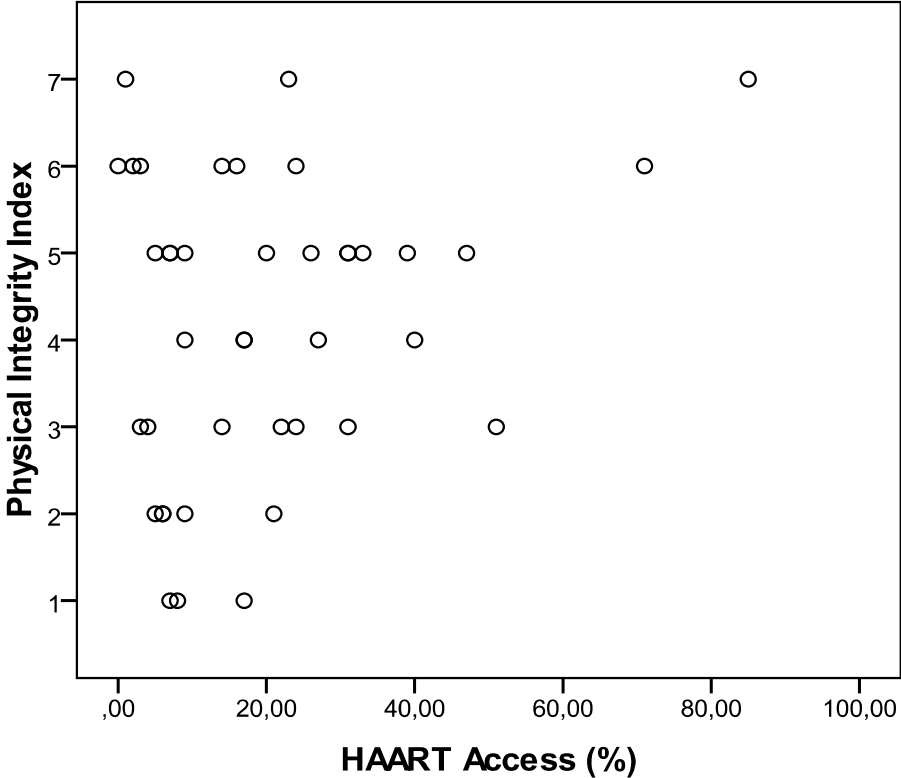
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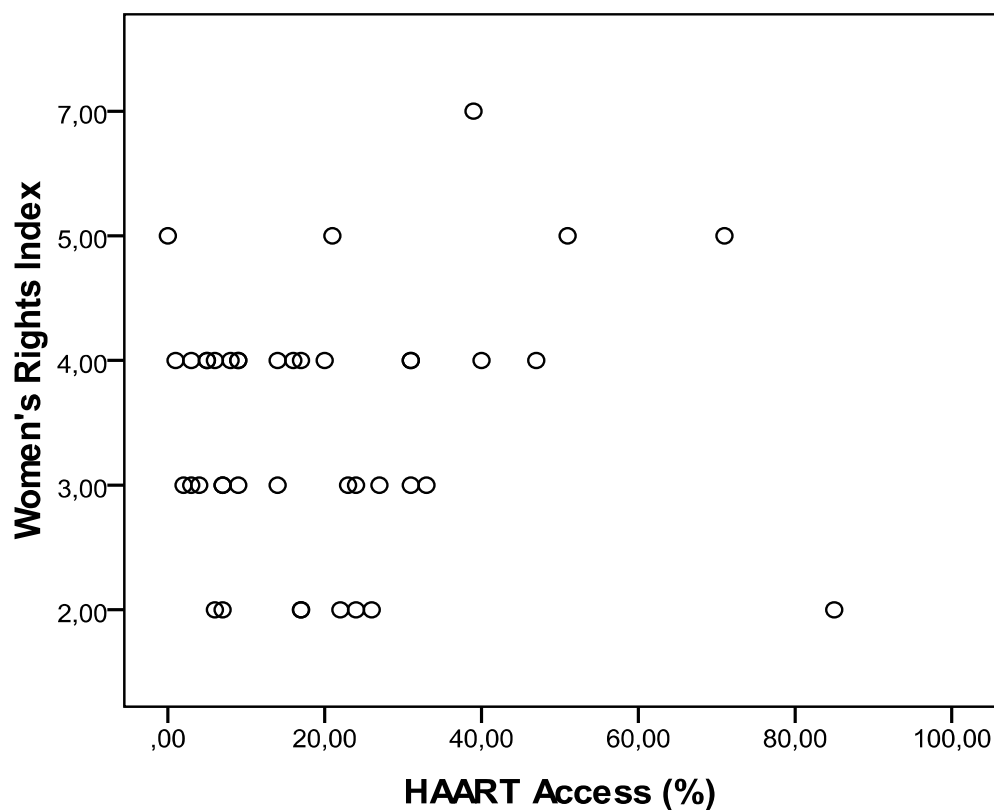
Appendix I: Scatter graph, the Empowerment Index and HAART Access



Appendix II: Scatter graph, the Physical Integrity Index and HAART Access



**Appendix III: Scatter graph, the Women's Rights Index and HAART Access**



**Appendix IV: Descriptive statistics**

	N	Minimum	Maximum	Mean	Std. deviation
Physical Integrity Index	46	1	8	4.46	1.822
Empowerment Rights Index	46	2.00	13.00	7.5652	2.97136
Women's Rights Index	46	2.00	7.00	3.6522	1.19661
HIV prevalence (%)	39	.60	38.80	9.0410	9.66945
GDP per capita	46	211.61	13561.56	1901.7558	2636.10745
Health expenditure, % of GDP	46	2	12	5.25	2.060
HAART access (%)	41	.00	85.00	20.2927	18.59199