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THE IMPACT OF INTERNATIONAL ORGANIZATIONS ON THE AIDS EPIDEMIC IN SUB-SAHARAN AFRICA

Christopher Richins*

INTRODUCTION

Since the acquired immunodeficiency virus (AIDS) was first identified in 1981, over sixty-five million people have been infected worldwide and an estimated twenty-five million people have lost their lives to the virus.¹ The human immunodeficiency virus (HIV), the virus responsible for causing AIDS, has spread at an exponential rate throughout the developing world. Estimates project that if the current trend continues, another forty-five million people will be infected worldwide by the year 2010.²

In the twenty-seven years since the discovery of AIDS, numerous international organizations have been selected to combat the spread of the virus. In 1985, the World Health Organization was the first agency delegated with the responsibility of accomplishing this task.³ Roughly ten years later, the Joint United Nations Programme on HIV/AIDS was established for the same purpose.⁴ These intergovernmental organizations have been the developing world’s primary weapon in its war against HIV/AIDS.

Although these organizations have been efficient in slowing the spread of the virus throughout most of the world, there are certain geographic areas which seem impervious to the efforts of these agencies. In several developing African countries, for example, the infection rate among adults is greater than 30%, and in these countries, life expectancy has dropped to a level unknown to

advanced civilizations since medieval times.⁵ The geographic area hit hardest by the epidemic, sub-Saharan Africa, is home to only 10% of the world’s population, but accounts for greater than 60% of the world’s HIV and AIDS infections.⁶

The continued proliferation of HIV in areas such as sub-Saharan Africa, however, cannot necessarily be attributed to the purported failures of international organizations. The countries themselves are primarily responsible for enacting policies that effectively slow the progression of HIV/AIDS. Developing countries, however, are incapable of combating this epidemic unilaterally. Only through a concentrated effort by both domestic and international actors can the transmission of HIV be substantially reduced.

Part I of this paper will consist of an examination of the efforts put forth by international organizations to curb the spread of HIV. Part II will focus on two sub-Saharan African countries: one which has experienced a marked increase in HIV prevalence in recent years and one which has experienced a marked decrease. That section will focus on the actions taken by international organizations in these countries, the domestic law of these countries, and specific cultural and societal factors that may influence the proliferation of the virus in these countries.

Part III will examine the cultural, social, and legal differences between the countries examined in Part II. Ultimately, that section will explain why the virus has continued to spread in one country while concomitantly decreasing in prevalence in another. Part IV will elucidate the effect that international organizations have had on the proliferation of HIV in these two countries. This paper will conclude with a proposal on how international organizations can better curb the proliferation of HIV in sub-Saharan Africa.

I. EFFORTS OF INTERNATIONAL ORGANIZATIONS

Though not discovered until 1981, AIDS had already established a foothold on several continents many years before.⁷ By 1986, over 75,000 AIDS cases had been reported to the World Health Organization.⁸ This number rose

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Six-fold over the next several years, increasing the total number of worldwide infections to 460,000. By 2006, the number had increased exponentially, with over twenty-five million AIDS-related deaths occurring worldwide.

Developed countries, with advanced health care systems and established social welfare programs, have been successful in combating the spread of HIV/AIDS. Many of these countries have a prevalence rate far lower than 1%. Antiretroviral drugs are readily available, and AIDS has not affected the life expectancy rates of these countries. The developing world, however, faces a far different reality, and the statistics are startling.

Sub-Saharan Africa, with only 10% of the world's total population, is home to greater than 60% of all HIV and AIDS infections. AIDS is the leading cause of death in Africa and the fourth leading killer worldwide. In some African countries, experts predict that life expectancy will drop below thirty years of age by 2010. It is estimated that 25% of the sub-Saharan population will die from AIDS-related illnesses by 2014.

As quickly as the virus was discovered, however, the international community mobilized forces in an attempt to stop it. The United Nations quickly realized the effect AIDS could have on the human population, and over the last twenty-five years it has delegated the responsibility of reducing the spread of HIV to two of its intergovernmental agencies: the World Health Organization and the Joint United Nations Programme on HIV/AIDS.

A. The World Health Organization Global Programme on AIDS

In 1981 the World Health Organization (WHO) began publishing information available on AIDS in the Weekly Epidemiological Record. The WHO used information gathered from studies to educate some of its member...
states on the characteristics of the virus.\textsuperscript{19} In 1985, the United Nations (UN) asked the WHO to “recommend a global strategy [for] prevention and control” of AIDS,\textsuperscript{20} and a few short year later, the UN adopted a resolution confirming that the WHO “should continue to direct and co-ordinate the urgent global battle against AIDS.”\textsuperscript{21} Acting pursuant to this decree, the WHO Special Programme on AIDS (SPA) was established in 1987, and in 1988 the program’s name was changed to the Global Programme on AIDS (GPA).\textsuperscript{22}

In pursuance of its mission statement, “to mobilize an effective, equitable and ethical response to the (HIV/AIDS) epidemic,” the GPA established three primary objectives: to prevent the transmission of HIV; to reduce the social impact of HIV; and to “unify national and international effort[s] against AIDS.”\textsuperscript{23} Mindful of differences in social, religious and political perspectives, the GPA instituted a regionalized structure whereby factors specific to particular countries would be taken under consideration when determining which programs to implement.\textsuperscript{24}

Through this regionalized structure, the GPA assisted developing countries in a myriad of ways. Specifically, it helped UN member states establish better testing methods for transfused blood;\textsuperscript{25} it developed programs to reduce mother-to-child transmission of HIV;\textsuperscript{26} and it distributed and promoted the use of male condoms throughout the developing world.\textsuperscript{27} Through the efforts of the GPA, condom sales in Africa, which were totaling fewer than 1 million per annum in 1988, eclipsed 110 million in 1994 “by one social marketing firm alone.”\textsuperscript{28}

On the global level, the GPA collaborated with the pharmaceutical industry to develop drugs which would suppress the virus.\textsuperscript{29} The GPA developed quality assurance standards and extensively researched different strains of HIV for the purpose of assisting the pharmaceutical industry in developing antiretroviral drugs.\textsuperscript{30} The GPA also provided financial support to pharmaceutical companies who were engaged in the development of vaginal

\textsuperscript{19} Id.
\textsuperscript{20} 2006 Global Report, supra note 1, at 2.
\textsuperscript{22} Final Report, supra note 8.
\textsuperscript{23} Id. at 5, 72.
\textsuperscript{24} Id. at 4.
\textsuperscript{25} Id. at 23.
\textsuperscript{26} Id. at 29.
\textsuperscript{27} Id. at 19.
\textsuperscript{28} Id. at 20.
\textsuperscript{30} Id. at 3, 5.
microbicides and other prophylactic devices which could be used by women to ward off the virus.\textsuperscript{31}

Importantly, the GPA undertook to end social discrimination against people infected with HIV/AIDS. To achieve this goal, the GPA promulgated international standards requesting member states to enact legislation banning discrimination.\textsuperscript{32} The GPA also instituted an internal policy which barred the WHO from attending and contributing to conferences in countries that placed short-term travel restrictions on people infected with HIV.\textsuperscript{33} At the regional level, the GPA actively assisted member states in drafting legislation intended to end discrimination\textsuperscript{34} against HIV positive individuals.\textsuperscript{35}

Through the years, the GPA accomplished several objectives: it raised awareness of the threat of HIV/AIDS; helped countries establish and strengthen their domestic AIDS programs; significantly contributed to assuring the safety of blood transfusions; advocated for the rights of individuals infected with HIV; and assisted in the development of antiretroviral drugs and prophylactic devices.\textsuperscript{36} While the GPA was accomplishing these goals, other agencies within the UN were contemporaneously involved in arresting the spread of HIV.\textsuperscript{37} Members of the UN were well aware of the difficulties inherent in attacking the HIV epidemic through multiple intergovernmental bodies. In fact, at the SPA’s Fourth Meeting of Participating Parties in 1987, it was suggested that the SPA enter “into arrangements with agencies such as the United Nations Development Programme (UNDP) and possibly the World Bank to ensure a sufficiently broad approach to the problem.”\textsuperscript{38} In an attempt to “avoid overlap and competition,” the GPA was dissolved in 1995 to make way for the next program responsible for combating the AIDS epidemic: the Joint United

\textsuperscript{31} Final Report, supra note 8, at 25, 27.
\textsuperscript{32} Id. at 40.
\textsuperscript{33} Id. at 41.
\textsuperscript{34} Id. at 41, 43.
\textsuperscript{35} I have designated the ending of discrimination against HIV positive individuals as highly important for the following reason: individuals who fear potential discrimination for HIV positive status are unlikely to undergo testing for the presence of the virus; individuals who are unaware of their seropositive status are unlikely to receive appropriate medical treatment for HIV infection; individuals who do not receive appropriate medical treatment have larger amounts of HIV in their system and are thus more apt to transmit the virus than individuals who are receiving proper treatment. Had the GPA not actively sought to end discrimination against HIV positive individuals, they would have been less efficient in accomplishing their overall goal of eradicating HIV.
\textsuperscript{36} Final Report, supra note 8, at 68-70.
B. Joint United Nations Programme on HIV/AIDS

Established in 1996, the Joint United Nations Programme on HIV/AIDS (UNAIDS) initially consisted of six intergovernmental departments within the UN. Over the last several years, the number has increased to ten. The purpose of combining these agencies, as noted supra, was to “avoid overlap and competition” between the several UN departments delegated with the responsibility of combating the AIDS epidemic. Along with performing the functions that had initially been delegated to the GPA, UNAIDS was charged with the responsibility of accomplishing several other goals, including, *inter alia*, educating individuals about the virus.

Although there are various UN declarations that address the AIDS epidemic, UNAIDS derives its mandate from the Declaration of Commitment on HIV/AIDS, adopted by the UN General Assembly in 2001. The Declaration assigns several responsibilities to the program: to establish national prevention targets; to implement “prevention and care programs”; to develop AIDS-
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related educational programs;\textsuperscript{48} to improve access to antiretroviral drugs;\textsuperscript{49} to end AIDS-based discrimination;\textsuperscript{50} to "increase investment in and accelerate research on the development of HIV vaccines";\textsuperscript{51} to develop special strategies for confronting the epidemic in war torn countries;\textsuperscript{52} and to provide financial counseling to member states.\textsuperscript{53}

Along with these responsibilities, UNAIDS periodically establishes international guidelines\textsuperscript{54} which advise member states on how to combat the epidemic.\textsuperscript{55} For example, Guideline 5 stresses that member states enact or strengthen existing antidiscrimination legislation,\textsuperscript{56} and Guideline 3 asserts that member states should promulgate health legislation that "addresses public health issues raised by HIV."\textsuperscript{57}

One of the Programme's the most important functions of is to gather data. Over the last several years, UNAIDS has compiled data from member states on, \textit{inter alia}, the percentage of the adult population (ages fifteen through forty-nine) infected with HIV, deaths caused by AIDS, the percentage of pregnant women infected with HIV, and the percentage of the total population that can identify HIV's primary modes of transmission (i.e. AIDS education).\textsuperscript{58}

Using this data, UNAIDS is able to track the progression of the virus within individual countries. Tracking prevalence rates, educational statistics and similar variables allows UNAIDS to concentrate their efforts on the areas in which particular member states need the most assistance.

Since its inception, UNAIDS has assisted developing countries by establishing national reduction targets.\textsuperscript{59} Through data gathering, UNAIDS has identified modes of transmission that are increasing in frequency in particular geographic regions and has assisted countries in establishing programs for the

\textsuperscript{47} \textit{Id.} \textsuperscript{49}.
\textsuperscript{48} \textit{Id.} \textsuperscript{52}.
\textsuperscript{49} \textit{Id.} \textsuperscript{55}.
\textsuperscript{50} \textit{Id.} \textsuperscript{58}.
\textsuperscript{51} \textit{Id.} \textsuperscript{70}.
\textsuperscript{52} \textit{Id.} \textsuperscript{75}.
\textsuperscript{53} \textit{Id.} \textsuperscript{88}.
\textsuperscript{54} The guidelines were first promulgated in 1996 and were subsequently revised in 2002. In 2006, UNAIDS consolidated these guidelines into one document.
\textsuperscript{56} \textit{Id.} \textsuperscript{21}.
\textsuperscript{57} \textit{Id.} \textsuperscript{19}.
\textsuperscript{59} Making the Money Work, \textit{supra} note 41, at 19.
purpose of addressing these concerns. Similar to its predecessor, UNAIDS provides some financial support to developing countries for the purpose of combating the spread of HIV.

In recent years, UNAIDS has identified certain social groups, primarily women and children, that are especially vulnerable to HIV infection. In response, UNAIDS has advocated for gender equality by instituting programs designed to increase the woman’s role in reproductive relations. For example, UNAIDS has promoted the use of the female condom in several countries and has financed pharmaceutical research for other prophylactic devices that can be used by women. For the protection of children, UNAIDS has provided supportive environments for children who have been infected and affected by HIV/AIDS.

UNAIDS has also assisted countries in managing funds distributed by other groups, such as the Global Fund. In the healthcare setting, UNAIDS has advocated for the development of an effective AIDS vaccine and helped secure financial assistance to companies pursuing the development of such a vaccine. Likewise, UNAIDS has been instrumental in educating healthcare providers in member states on how to reduce the transmission of the virus.

Although assistance from UNAIDS has been essential for the reduction of HIV prevalence in developing countries, many of these countries have nonetheless witnessed a substantial increase in the incidence of HIV over the

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60 Id. at 10 (noting that HIV rates are increasing in some sub-Saharan countries due to an increased use of injection drugs).
61 Id. at 21.
62 Id. at 24.
63 As with the WHO, UNAIDS has devoted funds to and promoted research for the development of vaginal microbicides. Similar to spermicide, the microbicide is intended to be injected into the vagina prior to sexual intercourse. The purpose of the microbicide is to kill HIV carrying agents (such as blood and semen) before these agents can be absorbed by the mucous membranes of the cervix. To date, however, no effective vaginal microbicide has been developed.
64 Making the Money Work, supra note 41, at 24.
65 The primary manner in which children have been ‘affected’ by the AIDS epidemic is through the loss of either one or both of their parents. Although this comment will only briefly explore the topic, a substantial number of children, primarily in sub-Saharan Africa, have been orphaned due to the AIDS-related death of their parents.
66 Declaration of Commitment, supra note 44, at ¶ 65.
68 2006 Global Report, supra note 1, at 71.
69 See Making the Money Work, supra note 41, at 25 (noting that male circumcision substantially reduces a man’s risk of infection).
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last several years. If one were to examine the success of UNAIDS through a cursory review of worldwide HIV/AIDS statistics, one may come to the conclusion that UNAIDS has not been effective in reducing the spread of the virus. A cursory review, however, would fail to consider factors specific to individual UN member states; factors which, in the end, may substantially outweigh the benefits bestowed on member states by international organizations.

II. COUNTRY ANALYSIS

To determine whether international organizations have been effective in combating the proliferation of HIV/AIDS, it is important to look beyond raw statistics. For instance, a statistical reduction in the number of infected persons may be the result of genocide or war, and not the result of effective legislation or international assistance. Moreover, a statistical increase in HIV prevalence may stem from a population influx rather than feeble regulations. As such, one must account for state-specific factors before the impact of international organizations can be adequately assessed.

This section will examine state laws along with cultural and social factors that may impact the spread of the virus. Since these factors vary from state-to-state, two sub-Saharan countries have been chosen for an in-depth analysis: Swaziland and Ethiopia. The remainder of this paper will be primarily devoted to analyzing the progression of the virus in these two countries and the responses employed by the respective states.

Swaziland and Ethiopia were chosen for analysis because they, at present, lie at opposite ends of the spectrum. From 1999 to 2005, the years for which the most reliable data is available, Swaziland's prevalence rate increased by nearly 8%, the most of any sub-Saharan country. Ethiopia, on the other hand, experienced a near 4% decrease in HIV prevalence, one of the largest decreases in sub-Saharan Africa. By examining these two countries, one with an increase in HIV prevalence and one with a decrease, it is possible to control for any state specific factors which may influence the spread of HIV. In doing so, the actual impact of international organizations on the HIV epidemic in sub-Saharan Africa can be observed.

A. Swaziland

Although the effects of AIDS have been felt throughout the world, no region has fared worse than sub-Saharan Africa. Of the roughly 33.2 million

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70 Novogrodsky, supra note 6.
people currently infected with HIV/AIDS, 22.5 million live in this region.\textsuperscript{71} Some of the countries in sub-Saharan Africa, however, are faring far worse than others.

Swaziland is a landlocked country which is bordered to the north, south, and west by South Africa and to the east by Mozambique.\textsuperscript{72} This mountainous country has a total area of 17,360 square kilometers\textsuperscript{73} and a current population of slightly over 1,133,000.\textsuperscript{74} The Central Intelligence Agency estimates the per capita Gross Domestic Product (GDP) of Swaziland to be only \$4,800\textsuperscript{75} dollars, roughly one-tenth of the United States’ per capita GDP.\textsuperscript{76} In recent years, Swaziland’s unemployment rate has reached 40%, and nearly 66% of the population is living on less than eleven dollars per month.\textsuperscript{77}

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This high level of poverty, however, is not the greatest threat to the Swazi people. In 1999, UNAIDS estimated that 13.5% of the country’s population was infected with HIV or AIDS.\textsuperscript{78} By 2005 the population had increased by 7%.\textsuperscript{79} The virus, however, had spread more rapidly. Though the population had risen by 72,000 people over the six-year span, UNAIDS estimated that an additional 90,000 people had been infected with the virus.\textsuperscript{80} Swaziland’s population had increased by 7% while the prevalence rate increased by nearly 8%. At the end of 2005, it was estimated that 21.3% of the

\begin{footnotesize}
\begin{enumerate}
\item See Michael Wines et al., \textit{Hut by Hut, AIDS Steals Life in a Southern African Town}, \textit{N.Y. Times}, Nov. 28, 2004, Sec. 1, at 1 (noting that Swaziland is roughly the size of New Jersey).
\item CIA, \textit{supra} note 72 (estimated population as of July 2007).
\item Id.
\item Id.
\end{enumerate}
\end{footnotesize}
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total population was infected with HIV or AIDS, designating Swaziland as the country with the world's highest infection rate. Among with the world's highest infection rate, 56% of pregnant women ages twenty-five through twenty-nine were HIV positive in 2004. In 2005, estimates projected that 56.3% of all people ages twenty-five through twenty-nine were infected with HIV or AIDS. Roughly fifty thousand Swazi citizens died from AIDS by the year 2001. It is currently estimated that another seventeen thousand continue to die each year. In recognition of the devastation caused by HIV/AIDS, Swaziland's King, Mswati III, declared AIDS a natural disaster in 1999.

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The increase in the prevalence of HIV/AIDS in Swaziland cannot necessarily be attributed to a lack of effort on the part of international organizations. As noted supra, the UNDP, the WHO, the United Nations Children's Fund (UNICEF) and the United Nations Educational, Scientific and Cultural Organization (UNESCO) are all cosponsors of UNAIDS. Over the last several years, these organizations have actively assisted the Kingdom of Swaziland in its battle against the epidemic.

For example, the UNDP has been working with the government of Swaziland to make antiretroviral therapy more accessible. This is of special importance for two reasons: first, experts predict that Swaziland's life expectancy will drop to thirty years of age by 2010. With a high percentage of Swazi citizens perishing before their fortieth birthdays, Swaziland is quickly losing its workforce. Antiretroviral therapy prolongs the lives of individuals

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81 Id.
82 Subjects, supra note 77.
86 Brody, supra note 83.
88 Haber, supra note 4.
90 Hut by Hut, supra note 73.
infected with HIV/AIDS. Widespread use of antiretroviral therapy will increase life expectancy, which, in turn, will help promote the economic vitality of Swaziland.

Second, only 23% of the country’s population resides in urban areas, thus rendering delivery of antiretroviral drugs quite difficult. The UNDP is helping to combat this problem by advising the Swazi government on ways to make antiretroviral therapy more readily available to the country’s rural residents.

The UNDP has also worked with nongovernmental organizations, including Swaziland’s largest church group, on developing community level HIV programs. As mentioned supra, over 70% of Swaziland’s population resides in rural areas. With a vast majority of Swazi citizens residing in rural areas, the establishment of community level programs is necessary to reduce the transmission of HIV in Swaziland. The UNDP has also collaborated with Swaziland’s national and regional governments on ways to reduce stigma and discrimination against people infected with HIV.

UNESCO has assisted Swaziland by developing a program designed for strengthening HIV and AIDS education. Additionally, UNICEF has assisted by “establishing a framework” for preventing mother-to-child transmission of the virus and has “supported training for more than 1,500 child protection workers” in Swaziland.

The WHO has also been active in Swaziland. It has provided “technical assistance in finalizing the national framework for scaling up antiretroviral therapy,” has helped the government establish guidelines on antiretroviral therapy, and has supported the government’s effort to improve “access to and [the] quality of voluntary testing and counseling services” within the country.

Despite these efforts, it is the member states, rather than international organizations, that are primarily responsible for enacting regulations intent on

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92 Id. at 1.
93 UNDP Swaziland, supra note 89.
94 Id.
95 See Swaziland Multisectoral Policy, supra note 91, at 1.
96 Id.
97 2006 Global Report, supra note 1, at 263.
99 The issue of child protection will be discussed in greater detail infra.
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combating the proliferation of HIV/AIDS. From the language employed by UNAIDS and its cosponsors, it is clear that UNAIDS operates primarily in an advisory capacity. The WHO has provided assistance to and supported Swaziland, an educational program was established within the country “under the leadership of UNESCO", UNICEF has “supported training” for child protection workers, and the UNDP has “worked with” nongovernmental organizations on establishing community level HIV programs. UNAIDS itself offers advice through developing guidelines and goals for the member states, such as the International Guidelines on HIV/AIDS and Human Rights and the Millennium Development Goals. Since UNAIDS and its cosponsors operate primarily in an advisory capacity, the member state itself is responsible for promulgating and enforcing regulations addressing the AIDS epidemic.

Domestic Regulations of Swaziland

Since the first case of AIDS was reported in Swaziland in 1986, the government of the Kingdom of Swaziland has been slow to respond to the crisis. Prior to 2001, Swaziland did not have an organized local government response to the HIV/AIDS epidemic. In fact, Swaziland failed to formally update its national health policy, adopted in 1983, until 2007. However, although the government did not formally adopt a new health policy immediately, steps were taken to curb the proliferation of the virus.

In December of 2001, Swaziland established the National Emergency Response Council on HIV/AIDS (NERCHA). Since its establishment, NERCHA has been the government body primarily responsible for combating the proliferation of the virus in Swaziland. From 2001 onward, the Swazi government has enacted several programs focused on combating the spread of HIV and AIDS. The government established the Behavior Change

101 Id.
102 See 2006 Global Report supra note 1, at 263 (emphasis added).
103 See UNICEF Swaziland, supra note 98 (emphasis added).
104 See UNDP Swaziland, supra note 89 (emphasis added).
105 International Guidelines, supra note 55.
107 UNGASS, supra note 84, at 4.
108 2006 Global Report, supra note 1, at 263.
111 Id.
Communication to promote abstinence among the youth. Programmes have been developed to target high-risk populations, such as prostitutes, factory workers, and long distance truck drivers. Educational programmes have been established for children attending school, and in 2003 the government established a national antiretroviral therapy program.

Some of these programmes have positively impacted the country: by September 2005, over eleven thousand Swazi citizens were receiving antiretroviral therapy from seventeen different facilities. Programs designed to prevent mother-to-child transmission of HIV, which were instituted in 2003, were responsible for the counseling of over 10,500 pregnant women in 2005. Lastly, in 2005, over ninety thousand children were exposed to media sources advocating for safer sex practices.

Along with national programmes, the Swazi government has established programmes at the community level for the purpose of curbing the proliferation of HIV and AIDS. For example, many communities have established Neighbourhood Care Points, which “provide day-to-day support to orphaned and vulnerable children.” Providing support to these children is of extreme importance. Due to the high number of AIDS-related deaths, the orphan population of Swaziland has skyrocketed in recent years. Many of these children turn to relatives for care, but the number of orphans has increased so drastically that relatives are often unable to provide support. Children are thus forced to care for themselves at a young age, and many turn to prostitution to acquire the necessities of life. Some of these children, in fact, choose to have unprotected sex for money, due to the larger sum they can charge. Heterosexual intercourse is the primary mode of HIV transmission in sub-Saharan Africa, and thus prostitution only precipitates the spread of HIV.

The Neighbourhood Care Points program assists in ending this cycle. For instance, orphaned children are given plots of land to grow food. With nourishment readily available, children are less likely to turn to prostitution for

112 UNGASS, supra note 84, at 14.
113 Id.
114 Id. at 20.
115 Id. at 7.
116 Id. at 7.
117 Id. at 8.
118 Id. at 16.
119 Helping Ourselves, supra note 110, at 17.
120 Hut by Hut, supra note 73.
121 Id.
122 Id.
123 Id.
124 Multisectoral Policy, supra note 91, at 1.
125 Helping Ourselves, supra note 110, at 18.
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sustenance. Neighbourhood Care Points also identifies orphaned children who are not attending school and helps place those children in formal school, where AIDS education is readily available. Another community initiative established by Swaziland is the KaGogo center. KaGogo centers have become places where the community gathers to discuss potential responses to the spread of the virus. These centers also assist in the distribution of food and are generally responsible for collecting data on orphaned children residing within the community. In essence, KaGogo centers operate as a town hall, acting as a distribution point for certain goods and providing the public with a place to voice their concerns.

Within some communities, volunteers have been selected to act as Rural Health Motivators. These individuals are equipped with first aid kits and are responsible for providing care to sick and dying individuals in their community. Rural Health Motivators bring sick individuals to hospitals when necessary and generally visit twenty households each. There were 4,500 Rural Health Motivators in 2006, roughly one per every fifty HIV positive Swazi.

On the national level, the Kingdom of Swaziland updated its 1983 health policy in 2007 to reflect the changing times. The new health policy announces that a patient’s inability to pay will not bar the receipt of health services. This policy even dictates that “eligible children, elderly persons, orphans and persons with disability” be provided health services free of charge. Responding to the great likelihood of death from mother-to-child transmission of HIV, the National Health Policy requires that all births “be attended by skilled physicians.”

Recognizing the need for a policy designed to combat HIV and AIDS specifically, the Kingdom of Swaziland promulgated the National Multisectoral HIV and AIDS Policy in 2006. The policy advocates for consistent condom use among the youth, directs that formal schools educate children on HIV and AIDS, and...

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126 Id. at 19.
127 UNGASS, supra note 84, at 20.
128 Id.
129 Id. at 31.
130 Id.
131 Id.
132 Id.
133 Id.
134 See Annex 1, supra note 79, at 460 (noting that an estimated 220,000 people were living with HIV/AIDS in Swaziland in 2005).
135 National Health Policy, supra note 109, at 11.
136 Id. at 17.
137 Id. at 20.
138 Multisectoral Policy, supra note 91, at 5.
AIDS, stipulates that certain forms of contraception be made available and affordable to all citizens, and encourages couples to undergo HIV testing and disclose HIV test results to one another.

Swaziland’s HIV/AIDS policy also asserts that basic human rights, including the right to privacy and confidentiality, will be afforded to all persons infected with HIV/AIDS. The Policy directs that laws be adopted to prevent HIV discrimination in employment, education, and the receipt of health care. Lastly, the policy promotes the equality of the sexes, declaring that young women and other “vulnerable groups” be protected from gender-based violence.

Culture, Society, and AIDS in Swaziland

Formal legislation, however, is not the only factor that may affect HIV prevalence in Swaziland. Cultural and social influences also dictate the ebb and flow of a country’s prevalence rate. For instance, the controlling law of Swaziland is an amalgamation of common law, statutory law, and customary law. Under customary law, Swaziland’s monarch is granted power to issue orders without receiving prior approval from Parliament. One such order revived a chastity rite under which “girls wear woolen tassels of different colors depending on their ages. ‘A man who dares touch a lady wearing a woolen tassel will find himself having the tassels thrown at him...’ and girls will subsequently congregate at the man’s home and ‘demand an animal which they will feast on.’” Many Swazis find the rite antiquated and refuse to adhere to it.

Old customs and traditions, though firmly rooted in Swazi society and law, may not have the desired effect of reducing HIV transmission. Another social factor that may affect Swaziland’s prevalence rate is the practice of multiple concurrent sex partners. Polygamy is widely practiced in Swaziland, it being rumored that the King’s father himself had more than 100 wives. Evidence demonstrates that having multiple concurrent sex partners

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139 Id.
140 Id. at 6.
141 Id.
142 Id. at 9.
143 Id.
144 Id.
146 Id.
147 Tradition, supra note 85.
148 Henri E. Cauvin, To Fight AIDS, Swaziland’s King Orders Girls to Avoid Sex for 5 Years, N.Y. TIMES, Sep. 29, 2001, at A5.
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substantially increases the risk of HIV infection. Considering that heterosexual intercourse is the primary mode of HIV transmission in sub-Saharan Africa, the practice of polygamy likely has a drastic effect on the proliferation of the virus.

The preferred policy of Swaziland "is that orphaned and vulnerable children should be cared for in their communities." Currently, the Swazi government lacks the resources to finance institutional care. Even if the resources were available, however, institutional care would not be provided. Swazi custom dictates that communities, not the government, care for orphaned and vulnerable children. As mentioned supra, the orphan population has grown so rapidly that communities have been unable to adequately care for these children. In turn, some children are forced to live on the streets and to engage in prostitution to support themselves. The inability of the government to provide financial assistance, combined with the Swazi custom of relying on communities to care for orphaned children, may have a profound effect on Swaziland's prevalence rate.

Lastly, a rise in sexual abuse of children has been reported in Swaziland. Evidence indicates that "one of the driving forces for [that practice] is a persistent belief that if an infected person has sexual intercourse with a virgin he or she will be cured of HIV." This mistaken belief undoubtedly contributes to the proliferation of HIV. In fact, roughly "55% of the cases handled by Swaziland's Director of Public Prosecution involve sexual offenses."

B. Ethiopia

Swaziland is not the only sub-Saharan country struggling in a battle against HIV/AIDS. Roughly 4% of the 22.5 million people living with HIV/AIDS in sub-Saharan Africa reside in Ethiopia. The epidemic is so

150 Multisectoral Policy, supra note 91, at 1.
151 Helping Ourselves, supra note 110, at 17.
152 Id.
153 Id.
154 Id.
155 Hut by Hut, supra note 73.
156 Id.
157 Helping Ourselves, supra note 110, at 43.
158 Id.
159 Id. at 45.
160 See Annex 1, supra note 79, at 355.
161 In 2005, UNAIDS estimated that between 420,000 and 1.3 million people were infected with HIV/AIDS in Swaziland.
severe that the Central Intelligence Agency was recently advised that the Ethiopian AIDS epidemic posed a security threat to the United States.\textsuperscript{162}

Ethiopia is a landlocked country with a total area of 1.1 million square kilometers.\textsuperscript{163} Seventy-seven million people reside in Ethiopia,\textsuperscript{164} and in 1995 it was estimated that over 75% of the population survived on less than two dollars per day.\textsuperscript{165} For every 1,000 children born, 123 will die before reaching the age of five,\textsuperscript{166} and for every 100,000 births, an estimated 871 mothers will perish.\textsuperscript{167} Agriculture provides over 80% of the country’s employment,\textsuperscript{168} and Ethiopia’s per capita GDP is only seven hundred dollars,\textsuperscript{169} approximately 1.5% of the United States’ per capita GDP.\textsuperscript{170}

**HIV and AIDS in Ethiopia**

As with Swaziland, poverty is not necessarily Ethiopia’s greatest threat. In 1999, UNAIDS estimated that three million Ethiopians were infected with HIV/AIDS, representing nearly 5% of the total population.\textsuperscript{171} In 2001, the estimate had lowered to 2.1 million infections,\textsuperscript{172} due, in part, to the 160,000 deaths caused by AIDS that year.\textsuperscript{173} By the end of 2002, 1.7 million Ethiopians had perished from AIDS since the beginning of the epidemic.\textsuperscript{174}

Although these statistics are staggering, there is a silver lining: in 2003, the estimated number of people living with HIV/AIDS decreased to 1.5 million people.\textsuperscript{175} In 2005, UNAIDS estimated that only 1.1% of Ethiopia’s
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Population was infected with HIV/AIDS, decreasing the number to roughly 860,000.\(^\text{176}\) Though the estimate for the total number of people living with HIV/AIDS decreased substantially from 1999 to 2005, AIDS has left its indelible mark, potentially overshadowing the decrease in HIV prevalence.

By 2003, roughly 539,000 children had lost one or both parents to AIDS.\(^\text{177}\) This number increased to 656,058 by 2006.\(^\text{178}\) In 2004 it was estimated that there were roughly five million orphans living in Ethiopia.\(^\text{179}\) By 2007, the estimate had risen to 5.4 million.\(^\text{180}\) Of this 5.4 million, it is estimated that nearly one million were orphaned by AIDS-related deaths.\(^\text{181}\) Life expectancy at birth has decreased to fifty-four years of age,\(^\text{182}\) and "AIDS is now recognized as the leading cause of adult morbidity and mortality in the country."\(^\text{183}\)

International Organizations in Ethiopia

Though the people of Ethiopia have suffered greatly from the AIDS epidemic, international organizations have offered and continue to offer support to the country. Several international organizations, including the WHO, the UNDP, and UNICEF, have all actively assisted Ethiopia in combating the AIDS epidemic.\(^\text{184}\)

For instance, UNICEF launched a program in 1998 for the purpose of providing care to homeless children.\(^\text{185}\) The program was initiated in six towns, providing children with educational support and basic health care, such as vaccinations.\(^\text{186}\) As of 2003, the program was operational in fourteen towns, and by April 2002, nearly two thousand homeless children from the program

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\(^{177}\) Annex 1, supra note 79, at 355.


\(^{181}\) Garbus, supra note 163, at 15.

\(^{182}\) Garbus, supra note 163, at 9.

\(^{183}\) This is not an exclusive list of UNAIDS cosponsors that have been active in Ethiopia.

\(^{184}\) Garbus, supra note 163, at 85.

\(^{185}\) Id.
had been enrolled in school.\textsuperscript{187}

The program is of great importance for three primary reasons. First, “[a]wareness of HIV and how it is transmitted remains extremely low among the vast majority of Ethiopia’s largely rural population.”\textsuperscript{188} In fact, only 16\% of women and 29\% of men have comprehensive knowledge on how to avoid HIV infection.\textsuperscript{189} Second, in-school Ethiopian youth have greater knowledge of how to avoid HIV infection than their out-of-school counterparts.\textsuperscript{190} As such, enrollment in formal school increases the likelihood that a child will learn how to avoid HIV infection. Finally, Ethiopia currently has no program designed to support orphaned children.\textsuperscript{191}

The WHO has assisted Ethiopia by “[s]upporting the development of national and regional road maps for scaling up antiretroviral therapy.”\textsuperscript{192} As of 2007, only 37\% of Ethiopians in need of antiretroviral therapy were receiving it,\textsuperscript{193} and thus WHO assistance in this area is crucial. The WHO has also reviewed Ethiopia’s guidelines and policies for antiretroviral therapy and recently supported the establishment of two HIV counseling and testing sites.\textsuperscript{194}

The UNDP has supported Ethiopia by launching a media campaign spreading the message on the dangers of HIV.\textsuperscript{195} It has also assisted the Ethiopian government by assessing country laws relating to the protection of people living with HIV/AIDS.\textsuperscript{196} Importantly, the UNDP has sought to address sexual inequalities between men and women by “work[ing] to...address women’s inheritance and property rights in Ethiopia.”\textsuperscript{197}

In an effort to address the AIDS epidemic through other mediums, the UNDP is also working closely with faith-based organizations.\textsuperscript{198} Religious beliefs dissuade many Ethiopians from using condoms,\textsuperscript{199} and the UNDP is seeking to garner support from faith-based organizations to help amend these beliefs. Approximately 62\% of males and 77\% of females in Ethiopia have no

\begin{thebibliography}{99}
\bibitem{187} Id.
\bibitem{188} Multisectoral Issue Brief, \textit{supra} note 173.
\bibitem{189} 2008 Report, \textit{supra} note 163, at 12.
\bibitem{190} Id. at 25.
\bibitem{191} Id. at 33.
\bibitem{192} WHO, Ethiopia Country Profile, \textit{supra} note 181, at 3.
\bibitem{193} 2008 Report, \textit{supra} note 163, at 12.
\bibitem{194} WHO, Ethiopia Country Profile, \textit{supra} note 181, at 3.
\bibitem{196} Id.
\bibitem{197} Making the Money Work, \textit{supra} note 41, at 13.
\bibitem{198} UNDP Ethiopia, \textit{supra} note 195.
\bibitem{199} Yemane Berhane et al., \textit{HIV/AIDS}, http://www.etharc.org/publications/ch26_HIV-Epidemiology_eth.pdf
\end{thebibliography}
formal education, most people having learned of HIV/AIDS through community meetings. Support from faith-based organizations operating at the community level may result in increased condom use and higher HIV/AIDS awareness throughout Ethiopia.

Although UNAIDS cosponsors have been active in Ethiopia, they do not promulgate binding regulations, but rather operate primarily in an advisory capacity. As with Swaziland, Ethiopia has enacted numerous regulations for the purpose of curbing the proliferation of the virus. Unlike Swaziland, however, the prevalence rate in Ethiopia has decreased in recent years.

**Domestic Regulations of Ethiopia**

Though the first case of AIDS was not officially reported in Ethiopia until 1986, the Ethiopian government had already begun to address the forthcoming epidemic. In 1985, Ethiopia established a national HIV/AIDS task force. Two years later, the government officially established an AIDS department within the Ministry of Health. In 1989, the government adopted a four-point HIV/AIDS policy, "far earlier than most other countries." A national HIV/AIDS policy was drafted in 1991, but the policy was not adopted until 1998, taking much longer to complete than in other countries.

The 1998 Ethiopian HIV/AIDS policy sought to accomplish several objectives, with an overall goal to "provide an enabling environment for the prevention and control of HIV/AIDS in the country." The policy also declared that persons living with HIV/AIDS should be free from discrimination; that HIV/AIDS education be promoted at all educational levels; and that all donated blood be screened for the virus.

Prevention of mother-to-child transmission was also promoted, the policy declaring that "[e]fforts shall be made to promote safe home delivery by

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201 *Id.* at 51.
203 *Id.* at 3.
204 *Id.*
205 *Id.*
206 Garbus, *supra* note 165, at 78.
208 Garbus, *supra* note 165, at 78.
210 *Id.* at 5.
211 *Id.* at 7.
212 *Id.* at 9.
The policy endorsed the view that only married couples should engage in sexual relations, holding that one-to-one sexual relationships would be promoted by the government. However, for those individuals choosing to engage in non-marital sexual relations, the government declared that proper education on condom use would be promoted.

The most interesting provision of the 1998 policy addressed partner notification. Under the policy, persons living with HIV/AIDS were encouraged to inform sexual partners of their seropositive status. In some countries, the privacy of persons living with HIV/AIDS is strongly protected. In those countries, a persons' seropositive status will be kept completely confidential, and not even the persons' sex partner will be notified. The 1998 policy rejects that notion, holding that under certain circumstances “the endangered partner shall have the right of direct access to the information regarding the sero-status of the partner.” Lastly, the policy encouraged Ethiopians to undergo voluntary testing and screening for HIV.

In 2002, Ethiopia adopted a national policy providing a tax exemption for antiretroviral drugs. The program was launched in 2005 and has already generated positive results: the number of people “ever started on” antiretroviral therapy increased from 8,276 in June 2005, to 117,970 by December of 2007. The number of sites dedicated to preventing mother-to-child transmission also increased; from 71 in June 2004, to 428 in June of 2007. Considering that more than fourteen thousand Ethiopian children were born with HIV in 2007, the expansion of these sites is of great importance.

Ethiopia has also adopted a national strategy for the distribution of condoms, which has increased condom distribution from 41.8 million in 1999 to over 70 million between June 2004 and June 2005. This has correlated into an increase in condom use among males; from roughly 30% in 2000 to 51.9% in 2005. Heterosexual intercourse accounts for nearly 90% of all new infections

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213 Id. at 10.
214 Id. at 8.
215 Id.
216 Id. at 11.
217 See Brody, supra note 83 (referring to Swaziland’s privacy policy circa 2006).
218 Ethiopia 1998 Policy, supra note 209, at 11.
219 Id. at 9.
220 WHO, Ethiopia Country Profile, supra note 181, at 1.
221 Id. at 1.
222 2008 Report, supra note 163, at 11.
223 Id.
224 Id. at 17.
225 2006 Report, supra note 177, at 20.
228 Id.
229 2005 Report, supra note 163, at 11.
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in Ethiopia.\textsuperscript{227} Thus, as long as condoms are used correctly, the increase in condom use may assist in curbing the proliferation of the virus.

Along with national programs, Ethiopia has also established community-level programs to battle the epidemic. Mass media campaigns,\textsuperscript{228} the building of youth centers,\textsuperscript{229} and the institution of educational programs\textsuperscript{230} have all been established at the local level. Similar to Swaziland’s Rural Health Motivators, Ethiopia established the Health Extension Program, whereby individuals are trained to provide health care to persons living with HIV/AIDS.\textsuperscript{231}

Ethiopia has also established a program similar to Swaziland’s KaGogo Centers. The Community Conversation Program operates as a forum for individuals to both learn about HIV/AIDS and express their thoughts on how to combat the epidemic.\textsuperscript{232} Currently, 86% of women and 72% of men in Ethiopia have no exposure to mass media.\textsuperscript{233} For a majority of Ethiopians, community meetings are thus the only forum in which HIV/AIDS education is readily available.\textsuperscript{234}

In December 2007, Ethiopia updated its HIV/AIDS policy to address issues unresolved under the previous policy. The new policy addresses ways to combat the epidemic on both the community as well as the national level. It asserts that three Community Conversation sessions will be held every fifteen days for ten months at the ‘Kebele’\textsuperscript{235} level,\textsuperscript{236} that financial support must be provided to community media programs,\textsuperscript{237} that school attendance among orphans be increased,\textsuperscript{238} and that new health centers be constructed.\textsuperscript{239}

The policy also orders the expansion of antiretroviral therapy outlets\textsuperscript{240} and advocates for the provision of physical and emotional support to orphaned and vulnerable children.\textsuperscript{241} Lastly, the policy purports to “[u]ndertake [a] media

\begin{thebibliography}{99}
\bibitem{227} 2006 Report, \textit{supra} note 177, at 7.
\bibitem{228} \textit{Id.} at 19.
\bibitem{229} \textit{Id.} at 20.
\bibitem{230} \textit{Id.} at 28, 29.
\bibitem{231} \textit{Id.} at 9.
\bibitem{232} 2008 Report, \textit{supra} note 163, at 36.
\bibitem{233} Garbus, \textit{supra} note 165, at 80.
\bibitem{234} \textit{Id.} at 51.
\bibitem{235} http://www.reference.com/browse/wiki/Kebele (defining Kebele as “the smallest administrative unit of Ethiopia similar to a ward, a [neighborhood] or a localized and delimited group of people”).
\bibitem{236} Multisectoral Plant of Action, \textit{supra} note 178, at 13.
\bibitem{237} \textit{Id.} at 30.
\bibitem{238} \textit{Id.} at 44.
\bibitem{239} \textit{Id.} at 48.
\bibitem{240} \textit{Id.} at 15.
\bibitem{241} \textit{Id.} at 16.
\end{thebibliography}
campaign on [the] female condom," and commands that judges, social workers, educators and the like receive training on the rights of persons living with HIV/AIDS.

Culture, Society, and AIDS in Ethiopia

As noted above, cultural and social issues have the ability to greatly influence the proliferation of HIV. Of great concern in Ethiopia is the practice of Female Genital Mutilation, also known as female circumcision, whereby the clitoris and other portions of the exterior female genitalia are removed. The practice causes permanent damage to the female genitalia and carries with it a heightened risk of HIV infection. It is estimated that approximately 80% of all Ethiopian women have undergone the procedure. As heterosexual intercourse is the primary mode of HIV transmission in Ethiopia, the cultural practice of Female Genital Mutilation may substantially contribute to the proliferation of the virus.

Evidence demonstrates that “[i]n times of conflict, girls and women are even more vulnerable to sexual violence, HIV and AIDS.” Rape is frequently used as a “weapon of war,” and it is during these times that the virus tends to spread. For several years, Ethiopia and Eritrea were entangled in a bloody war. The existence of conflict between these countries may have influenced, and continue to influence, the prevalence of HIV in Ethiopia.

Moreover, conflicts in other nations may induce individuals to seek refuge in neighboring countries. An HIV survey conducted at Ethiopia’s Dima Refugee Camp in 2005 revealed a prevalence rate of 13%, well above the national average. According to the United Nations High Commissioner for

242 Id. at 35.
243 Id. at 47.
244 See Garbus, supra note 165, at 8.
246 Multisectoral Plan of Action, supra note 178, at 2.
247 Garbus, supra note 165, at 8.
248 2006 Report, supra note 177, at 7.
250 Id.
251 Garbus, supra note 165, at 7.
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Refugees, over one million refugees entered Ethiopia between 1999 and 2005. If the statistics gathered at the Dima Refugee Camp are indicative of refugees entering Ethiopia as a whole, the influx of refugees into Ethiopia may have a profound effect on the proliferation of HIV in the country.

Lastly, it is estimated that roughly 14% of all married Ethiopian women are members of polygamous marriages. As noted supra, evidence demonstrates that having multiple concurrent sex partners substantially increases the risk of HIV infection. With heterosexual intercourse accounting for nearly 90% of all HIV transmission in Ethiopia, the practice of polygamy may substantially affect the spread of the virus.

III. COUNTRY COMPARISON

As noted supra, UNAIDS operates primarily in an advisory capacity. Thus, decisions regarding the expenditure of funds and the implementation of policy are left primarily to the member states. A cursory statistical examination of HIV prevalence in Ethiopia and Swaziland may lead to the conclusion that the former has been efficient in curbing the proliferation of the virus while the latter has not. However, a more detailed examination of the countries reveals that the legal, cultural and societal differences seem too remote to account for the disparity in HIV prevalence. In fact, similarities between the countries render it difficult to determine why a difference in HIV prevalence exists at all.

One of the most striking similarities between Ethiopia and Swaziland is the lack of legislation criminalizing intentional transmission of HIV. Although Swaziland intends on criminalizing intentional transmission, to date no formal legislation has been enacted. In fact, much of Swaziland’s penal code is antiquated, with criminal statues enacted during colonial rule still governing today. Similarly, Ethiopia has no law officially criminalizing intentional transmission of HIV.
For several years, however, there was a noticeable difference in the HIV/AIDS policies of the respective countries. Though Swaziland "encourages" couples to disclose HIV test results, this provision was not formally adopted until 2006.262 Ethiopia, on the other hand, encouraged the disclosure of seropositive test results in its 1998 HIV/AIDS policy.263 At first glance, the fact that Ethiopia adopted this policy earlier than Swaziland seems to provide some explanation for the difference in HIV prevalence. Yet due to the low rates at which Ethiopians are being tested for HIV, this eight-year gap provides little, if any, explanation at all.

Another similarity shared by Ethiopia and Swaziland is the percentage of the national budget spent combating HIV/AIDS. Though Ethiopia spends substantially more on HIV/AIDS- $18.9 million during the 2004/2005 fiscal year264 compared to Swaziland’s $3.9265 million in 2005266- both countries spend roughly 7%267 of their national budgets on HIV and AIDS prevention.268

Both countries also suffer from poor doctor-to-patient ratios, with Ethiopia providing one doctor for every 45,651 people269 and Swaziland providing one doctor for every 5,953. Though Ethiopia’s doctor-to-patient ratio is far lower than Swaziland’s, both ratios are poor considering that industrialized countries tend to have one doctor for every 500 people.270

There are a plethora of other similarities shared by the countries: both have experienced difficulty in expanding HIV/AIDS education to rural populations; antiretroviral therapy programs were only recently adopted; programs aimed at prevention of mother-to-child transmission are still in their infancy; and the practice of polygamy is widespread. Thus, these factors cannot adequately explain why Swaziland’s prevalence rate has increased in recent years while Ethiopia’s has diminished.

There are, however, some differences between the countries that seem
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to explain the gap in the infection rate. For instance, although the Swazi government is comprised of democratic institutions, the country’s monarch, King Mswati III, essentially retains ultimate control over the country.271 In 2002, the government took forty-five million dollars earmarked for economic development and instead purchased the King a luxury jet.272 This amount represents approximately eleven times the total domestic expenditure on HIV/AIDS in 2005.273 This inefficient use of funds was demonstrated again in 2004, when $600,000 was spent on the King’s thirty-sixth birthday party, while $2.8 million earmarked for orphan’s education remained locked in the Treasury.274

Although these expenditures may indicate that the government values the King’s comfort more than the health of its citizens, there is no concrete evidence that the government of Swaziland has used funds earmarked for combating AIDS for any purpose other than to combat AIDS. Moreover, both Ethiopia and Swaziland allocate roughly 7% of their national budgets to combating HIV/AIDS. Absent some evidence that the Swazi government has misused funds earmarked for combating HIV/AIDS, the Swazi government’s otherwise poor use of funds does not adequately explain the gap in the infection rate.

Ethiopia’s decrease in HIV prevalence might be partially attributable to statistical error. In 1999, it was estimated that three million Ethiopians were living with HIV/AIDS.275 UNAIDS estimated that between 420,000 and 1.3 million were infected in 2005.276 There were no HIV/AIDS programs in Ethiopia between 1999 and 2005 that can account for such a drastic decrease in the number of infected persons. Moreover, the decrease cannot be fully attributed to deaths caused by AIDS related illnesses.

Prior to 2001, a testing site located in the town of Estie was classified as rural.277 In 2001, however, the site was reclassified as urban.278 The reclassification, “according to the [Ministry of Health], is the primary reason why national adult HIV prevalence reported in 2001 is less than that reported in 2000.”279 The reclassification of the site at Estie, however, does not sufficiently explain the decrease in Ethiopia’s prevalence rate. In fact, the Ethiopian

271 See Law and Legal Research, supra note 139.
273 See UNGASS Report, supra note 84, at 10.
274 Hut by Hut, supra note 73.
275 AIDS in Africa; Country by Country, supra note 78, at 85.
276 Annex 1, supra note 79, at 355.
277 Garbus, supra note 165, at 17-18.
278 Id.
279 Id.
Ministry of Health explicitly stated that the decrease observed at the Estie site did not indicate "that the HIV epidemic in Ethiopia is declining." 280 As such, the reclassification of the Estie site does not adequately account for the disparity in HIV prevalence between Ethiopia and Swaziland.

IV. THE IMPACT OF INTERNATIONAL ORGANIZATIONS

International organizations have engaged in substantially similar activity in both Ethiopia and Swaziland. Thus, the efforts of international organizations cannot adequately explain the disparity in HIV prevalence between Ethiopia and Swaziland. The UNDP has forged alliances with non-governmental organizations in both countries, the WHO has worked with both governments on scaling-up antiretroviral therapy programs, and UNICEF has been similarly active in both countries. There is, in fact, no readily ascertainable difference in the actions taken by international organizations that can adequately account for the vast disparity in HIV prevalence between Ethiopia and Swaziland.

Moreover, there appears to be no direct correlation between international funding and HIV prevalence in Ethiopia and Swaziland. For instance, in 2003, the Global Fund distributed over eight million dollars in funds to Swaziland and another forty-five million dollars to Ethiopia. 281 Although Ethiopia received far more than Swaziland in total dollars, due to the vast difference in population, Swaziland received roughly eight dollars per capita while Ethiopia received less than one dollar per capita. Assuming arguendo that these funds were spent on HIV/AIDS programs, there appears to be no direct correlation between international funding and HIV prevalence.

Although the impact of international organizations on HIV prevalence in Swaziland and Ethiopia is unclear, undoubtedly the number of infected persons residing in sub-Saharan Africa 282 would be higher without the involvement of international organizations. Developed countries generally have the finances and technology available to halt the spread of HIV without international assistance. Many developing countries, and most sub-Saharan countries, lack the technology, finances, and infrastructure required to address the AIDS epidemic unilaterally. As such, Swaziland, Ethiopia, and other sub-Saharan countries must rely on international assistance to effectively curb the

280 Id.
282 The sub-Saharan countries included are Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Comoros, Congo, Cote d’Ivoire, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mozambique, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Tanzania, Togo, Uganda, Zambia, and Zimbabwe.
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Finally, it must be noted that international organizations have been combating the AIDS epidemic since it first began, and thus it would be impossible to determine whether a country receiving international assistance would have been successful combating the virus on its own. Once again, though, given that most sub-Saharan countries lack the necessary resources, it can be safely assumed that HIV prevalence in sub-Saharan Africa would be higher absent involvement from international organizations.

PROPOSAL

Although assistance from international organizations has been essential to the reduction in HIV prevalence in sub-Saharan Africa, more can be done by international organizations to reduce the proliferation of the virus in the region. For instance, although international organizations have recognized the global pervasiveness of discrimination against people living with HIV/AIDS, more studies must be conducted to determine the impact of discrimination on the AIDS epidemic.

International organizations should conduct studies to determine the impact of discrimination on HIV testing, HIV counseling, and AIDS-related education. By conducting these studies, international organizations will have a greater chance of designing programs that effectively address the underlying causes of discrimination against people living with HIV/AIDS. The development of these programs may diminish the pejorative impact of AIDS-related discrimination and subsequently lead to greater HIV testing, HIV counseling, and expanded enrollment in AIDS-related educational programs.

On a related issue, international organizations must improve the efficiency of statistical gathering. In 2005, UNAIDS estimated that anywhere from 420,000 to 1.3 million people were infected with HIV/AIDS in Ethiopia. The vast disparity in this estimate is primarily a result of inefficient data gathering in rural areas. Absent correct statistics, it is difficult for international organizations to determine the number of persons requiring antiretroviral therapy, the number of mothers in need of childbirth assistance, and the amount of money necessary to combat the proliferation of the virus.

Increased investment in statistical gathering may lead to a decrease in HIV prevalence. For example, if statistics indicated a high prevalence rate in a particular region of a country and a contemporaneous low prevalence rate in another region, international organizations may advise member states to allocate

283 Across the region HIV prevalence decreased by nearly 1% from 1999 to 2005.
285 Annex 1, supra note 79, at 355.
more resources to the area with the higher rate. Allocating more resources may have the effect of reducing the infection rate in that area. Absent efficient data gathering, however, international organizations are incapable of accurately advising member states on how best to allocate their resources.

At present, UNAIDS cosponsors seem to be placing more emphasis on remedial care, primarily the distribution of antiretroviral therapy, than on preventative care. Although the implementation of remedial measures is necessary to curb the proliferation of the virus, international organizations should nonetheless increase investment in educational programs. The vast rural sub-Saharan population has strained local governments. International organizations have the resources and technology available to reach even the most isolated populations. Studies have demonstrated that substantial investment in AIDS-related educational programs leads to a decrease in HIV infections. Increased investment in educational programs will lead to a decrease in the infection rate, thereby diminishing the need for investment in remedial care.

CONCLUSION

For sub-Saharan Africa to prevail against the AIDS epidemic, continued assistance from international organizations is paramount. Sub-Saharan states simply do not have the technology or resources that are required to effectively curb the proliferation of the virus. Even though UNAIDS operates primarily in an advisory capacity, the Programme brings to sub-Saharan Africa all the benefits of the developed world. Without these benefits, the recent 1% decrease in sub-Saharan HIV prevalence would not have transpired.

Although a close examination of Ethiopia and Swaziland does not clearly illustrate the importance of international organizations, continued assistance from international organizations is essential to sub-Saharan Africa’s success against the virus. Despite their importance, however, international organizations can provide greater assistance to sub-Saharan countries. Although a concentrated effort by both domestic and international actors is necessary to reduce HIV prevalence, increased investment in statistical studies, statistical gathering, and AIDS-related education from international organizations can further reduce the transmission of HIV in sub-Saharan Africa.

See generally Legal Implications, supra note 150, at 66 (noting that large investment in HIV prevention and awareness programs in Senegal have led to a decrease in HIV prevalence).