FOIA Number: 2007-1550-F

FOIA MARKER

This is not a textual record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

Collection/Record Group: Clinton Presidential Records

Subgroup/Office of Origin: National AIDS Policy Office

Series/Staff Member:

Subseries:

OA/ID Number: 21065

FolderID:

Folder Title:
King Mswati III Meeting (Swaziland), 06/23/00

Stack:	Row:	Section:	Shelf:	Position:
S	67	1	3	1

The Call to Action Project

A Global Program to Prevent Mother-to-Child Transmission of HIV

Kate Carr, CEO

Elizabeth Glaser Pediatric AIDS Foundation

Overview

- What is the Elizabeth Glaser Pediatric AIDS Foundation?
- Mother-to-child transmission of HIV (MTCT)
- What is the Call to Action Project?
- HIV/AIDS in Swaziland
- The challenges before us
- How you can participate

ELIZABETH GLASER
PEDIATRIC AIDS FOUNDATION

- Co-founded in 1988
- Dedicated to fighting HIV/AIDS in children through education, policy and research
- Raised $100 million to date
- Administrative overhead of 6%
- Now hoping to extend our success in the U.S. to developing countries

MTCT of HIV

- Worldwide, 14 million women of childbearing age are HIV positive.
- In sub-Saharan Africa women outnumber men among those becoming infected.
- Babies born to HIV-infected mothers have a 30-35% chance of acquiring the virus
- The virus is transmitted to babies during pregnancy, childbirth, or breastfeeding
- 1,800 children infected with HIV each day worldwide (95% in developing countries)
- **Short-course antiretroviral interventions (AZT, 3TC, NVP) can cut the rate of MTCT by 50%**

HIVNET 012 – July 1999

- Study performed in Kampala, Uganda
- Single oral dose of nevirapine (NVP) at onset of labor to mother
- Single oral dose of NVP to baby within 72 hours of birth
- 47% reduction in transmission measured 3 months post delivery in breastfeeding population
- Cost of two-dose NVP regimen: US $4
- NVP is inexpensive, potent and stable at room temperature.

A Call to Action

- In September of 1999 we issued a Call to Action together with Global Strategies for HIV Prevention to bring this advance to developing countries.

- Asks governments, organizations, foundations, and companies to help implement MTCT programs in the developing world.

- Hundreds of individuals and organizations signed on at the Global Strategies Conference in Montreal.

- The first donations were from EGPAF ($1 million), Global Strategies for HIV Prevention and International AIDS Society.

The Call to Action Project

With the first funds raised, we launched the Call to Action Project to provide funds for **implementation** of programs to reduce MTCT of HIV:

- Community mobilization/education
- Training of health care workers
- HIV counseling and testing
- Antiretrovirals to prevent MTCT
- Diagnosis of HIV in children
- Breastfeeding education

Timeline (first $1 million):

September:	Call to Action issued
November:	RFA issued
January:	Applications received
March:	8 awards made
June:	Sites start programs

Call to Action Sites

Kijabe, Kenya (20% seroprevalence)
Kijabe Hospital/Africa Inland Church Medical Missionaries

Kampala, Uganda (15% seroprevalence)
Mulago Hospital

Kisumu, Kenya (13% seroprevalence)
Nyanza Provincial Hospital

Durban, SA (38% seroprevalence)
City Health Clinic/Cato Manor

Thailand (2% seroprevalence)
Ministry of Public Health

Soweto, SA (25% seroprevalence)
Chris Hani Baragwanath Hospital

Call to Action Sites cont.

NW Province, Cameroon (20% seroprvlnc)

Cameroon Baptist Convention Health Board, Banso Baptist Hospital and Mbingo Baptist Hospital

Kigali, Rwanda (30% seroprevalence)

Ministry of Health (Central Hospital of Kigali, Gitega, Biryogo and Gikondo health centers)

Summary of first eight sites

Over 2 years:

- Train 1,200 people
- Counsel and test ~ 50,000 women
- Treat ~ 10,000 mothers and 20,000 infants (10,000 in Thailand)
- Prevent ~2,500 infections

CTA Sites

- Link with NGOs for community education/mobilization
- Have support of Ministry of Health and AIDS Control Programs
- Provide voluntary counseling and testing
- Will be monitored and evaluated by an independent group
- Have the oversight of an expert Advisory Board

HIV/AIDS in Swaziland

(UNAIDS data – 1997-8)

- Total population: 904,000
- HIV prevalence: 32% (1999)
- Birth rate: 37 births per 1000 population (33,448 per year)
- HIV prevalence in pregnant women: 26% (8700 positive women deliver each year)
- 30-35% of these babies will be infected with HIV without preventative treatment (2871 babies)
- With preventative treatment, half of these babies could be born free of HIV (1435 babies)

Collaboration

We recently convened a meeting among groups working in MTCT of HIV.

We hope to work together to avoid duplication and facilitate implementation.

- CDC
- USAID
- UNICEF
- UNAIDS
- NIH/Fogarty International Center
- WHO
- International Therapeutic Solidarity Fund (France)
- UN Foundation
- Secure the Future

Evaluation of Sites

Status reports every six months on:

- Training
- Women starting antenatal care
- Uptake of counseling and testing
- Positive/negative tests
- Mothers receiving intervention
- Babies receiving intervention
- Mother-infant pairs in follow-up
- Baby HIV status (6 wk & 15 mo)
- Uptake of replacement feeding
- Infant mortality
- Integration of MTCT programs into MCH programs

There are many challenges. . .

- Why not focus instead on primary prevention?
- Why focus on MTCT of HIV when there are so many other health issues facing children in the developing world?
- Breast milk transmission
- Lack of treatment for the mother
- Orphans
- Drug safety/resistance
- Sustainability and cost
- Many women decline testing
- Stigma and violence toward women
- Lack of political support

But we have to start somewhere.

Next Steps

- **Additional funding has been received**

$15 million Bill & Melinda Gates Foundation

$1 million from BI/Roxane

- **Solicit additional applications**

20 pending from various countries

- **Add new sites in phases**

I: Sites with established infrastructure

II: Sites with moderate infrastructure

III: Sites with minimal infrastructure

- **Cultivate sites in emerging regions**

e.g., India and China

- **Develop strategic partnerships**

- **Attempt maximum implementation**

Target two or three key countries

How you can participate

- Suggest a potential site
- Apply for CTA funds
- Inform us of other programs/NGOs that we could link with for our current sites to develop more comprehensive programs (i.e. programs addressing orphans)
- Tell us of your successes and failures in developing similar programs

SWAZILAND AND HIV/AIDS

Country Profile

The Kingdom of Swaziland is a small, landlocked country with a population of approximately one million, one-third of whom live in urban areas. Swaziland's economy is based largely on subsistence agriculture and the country is heavily dependent on South Africa, which almost entirely surrounds its borders, and from which it receives 90 percent of its imports. Remittances from Swazi workers in South African mines supplement domestically-earned income by as much as 20 percent. This migration of mine workers is a factor in the high HIV prevalence rate in Swaziland.

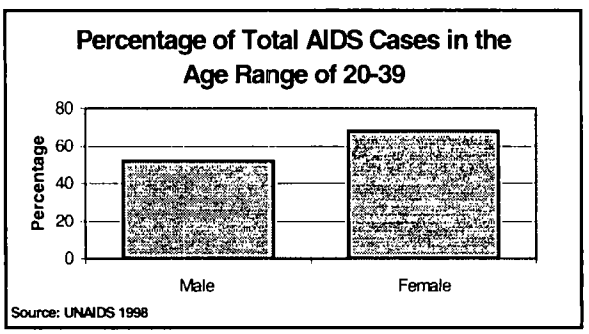
As of 1997, 16 percent of Swaziland's gross domestic product (GDP) was earned from agriculture, with the remainder split between industry and services. The GDP growth rate dropped from 3.9 percent in 1996 to 2.5 percent in 1997. Three percent of the GDP was budgeted for the health sector in 1996. The country's gross national product (GNP) per capita is US$1,440, close to the level of "lower-middle" income for sub-Saharan Africa.

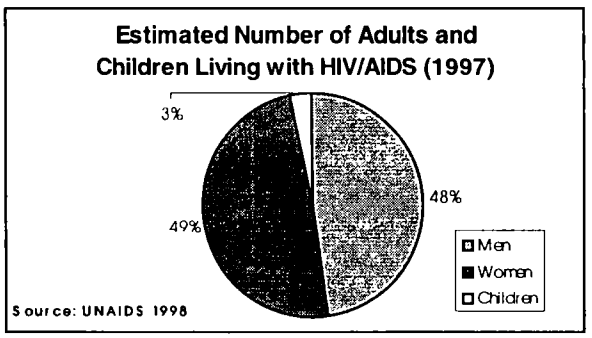
Swaziland faces serious health sector problems that threaten to exacerbate the country's HIV/AIDS epidemic, most notably the marked rise in tuberculosis cases, which doubled from 1994 to 1998.

HIV/AIDS in Swaziland

The first AIDS case was reported in Swaziland in 1987. Since then, the HIV/AIDS epidemic has continued to rise to alarming levels, with Swaziland now ranking as one of the four most-affected countries in the world, along with Zimbabwe, Botswana, and Namibia.

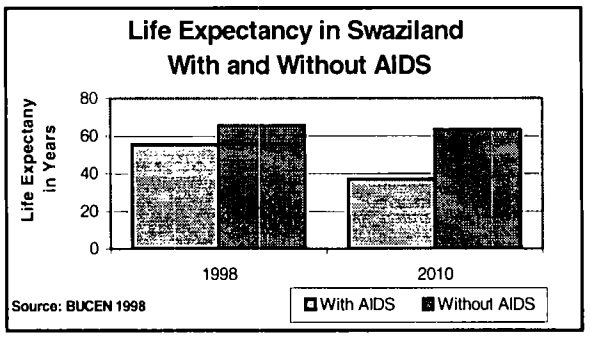
- According to the 1998 sentinel surveillance conducted by the National AIDS Program (NAP), 20 to 23 percent of adults (age 15 and over) are HIV-positive.
- In 1998 the National AIDS Task Force performed a blind study of inpatients at hospitals and found that 45 to 50 percent were HIV-positive.
- The majority of AIDS cases are among 20- to 39- year-olds—the reproductive and economically-productive age range; 52 percent of males and 68 percent of females fall within this age group.
- According to the World Health Organization (WHO), as many as one-third of young and middle-aged adults in Swaziland are infected with HIV.

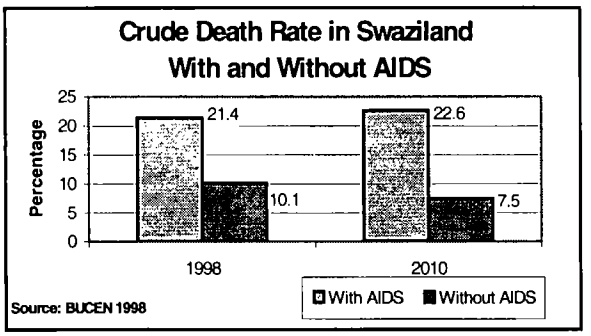




According to U.S. Census Bureau (BUCEN) data, by 2010 AIDS will increase the crude death rate in Swaziland by more than 200 percent.

- More than 5,000 Swazis died of AIDS-related diseases in 1997.
- By 2010, life expectancy will drop by more than 40 percent as a result of AIDS.





Women and HIV/AIDS

The number of women living with HIV/AIDS in Swaziland is growing. Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at increased risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound their vulnerability.

- According to NAP's 1998 sentinel surveillance data, 31 percent of pregnant women at antenatal clinics tested positive for HIV.
- According to 1996 U.S. Census Bureau statistics, the HIV prevalence rate in STI clinics ranged from 35 to 43 percent in different regions.
- The high incidence of illegal abortion is a growing concern in Swaziland, and a particularly significant problem among teenage girls (UN Secretariat 1995).

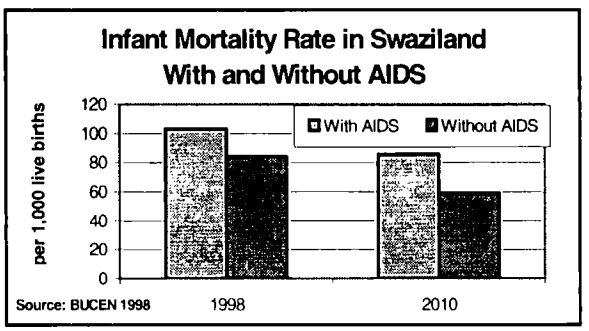
In Swaziland, marriage law, under Roman-Dutch Law, confers upon the husband undisputed control over the acquisition and disposal of marital property. The combined effect of the Roman-Dutch Law and Swazi Customary Law is to relegate women to the position of minors.

Children, Youth and HIV/AIDS

The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others. Approximately 30 to 40 percent of infants born to HIV-positive mothers will also become infected with HIV.

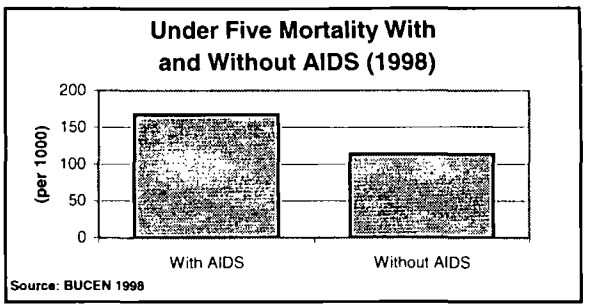
- Forty-nine percent of the Swazi population are under age 15.
- According to a 1998 UNICEF/Government of Swaziland report, an estimated 23,960 children will be orphaned by AIDS by the year 2000.
- As one of the African countries hardest hit by the HIV/AIDS epidemic, 20 to 33 percent of Swaziland's children will be orphaned over the next decade as the adult death toll climbs.

According to BUCEN, infant mortality in Swaziland in 1998 was 103 per 1,000. BUCEN



estimates the infant mortality rate would have been 84 per 1,000 in 1998 in the absence of AIDS.

- By 2010 the infant mortality rate will be nearly double what it would be in the absence of AIDS.
- Child mortality (under age 5) in 1998 was 168 per 1,000, compared with the estimated 114 per 1,000 it would have been in the absence of AIDS.



Socioeconomic Effects of AIDS

About 90 percent of reported AIDS cases are adults 20 to 49 years old. Since this age group constitutes the most economically productive segment of the population, an important economic burden is created. Productivity falls and business costs rise—even in low-wage, labor-intensive industries—as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. The diminished labor pool affects economic prosperity, foreign investment, and sustainable development. The agricultural sector likewise feels the effects of HIV/AIDS; a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this implies switching from export crops to food crops—thus affecting the production of cash and food crops.

There are also many private costs associated with AIDS, including expenditures for medical care, drugs, funeral expenses, etc. The death of a family member leads to a reduction in savings and investment, and increased depression among remaining family members. Women are most affected by these costs and experience reduced ability to provide for the family when forced to care for sick family members. And AIDS adversely affects children, who lose proper care and supervision when parents die. Some children will lose their father or mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children and 10- to 12-year-olds become heads of households.

(For country-specific information on the socioeconomic impact of HIV/AIDS refer to the *socioeconomic analysis* presented by the Policy Project.)

Interventions

National Response

The NAP Secretariat was established in the Ministry of Health in 1989, with support from the World Health Organization (WHO). A National AIDS Task Force has also been established.

The first sentinel surveillance was conducted in 1991 and has been conducted annually, except in 1997 because of resource constraints.

UNAIDS, through the Ministry of Education, has supported the NGO School AIDS Prevention Education (SHAPE) in working with secondary schools. Through their IEC activities, NGOs were largely effective in bringing information about HIV/AIDS information to the country. However, sexual behavior change and condom use have not accompanied the knowledge.

The Baphalali Swaziland Red Cross, in collaboration with the Ministry of Health, is working to improve the screening of the blood supply.

Following study tours to observe AIDS programs in Zambia and Uganda in 1996-1997, the Government of Swaziland (GOS) prepared a

comprehensive home-based care framework but was unable to implement a program because of resource constraints. Currently, the GOS, UNAIDS, and the Italian Cooperation are funding two pilot sites for home-based care in rural areas, involving traditional healers and community volunteers. The Salvation Army, Hospice at Home, the Catholic Church through Caritas, and the Swedish missionary Mkhuzweni Health Center are also involved in home-based care. These efforts are just now being initiated and are limited geographically and in their scope of services.

Recently, Swazi authorities have publicly acknowledged that HIV/AIDS has become a "national disaster." In February 1999, at the opening of Parliament, King Mswati III declared that AIDS was a national crisis and called for all sectors of the nation—public, private, NGOs, and communities—to take action.

In May 1999, the Prime Minister launched the Cabinet Committee on HIV/AIDS, chaired by the Deputy Prime Minister, and the multisectoral Crisis Management and Technical Committees on HIV/AIDS. The government recognized that the crisis could not be addressed by the Ministry of Health alone but requires a multisectoral strategy. The new committees will set policy directions and manage the mobilization of resources for all sectors, ensuring a more unified and coherent national response.

Donors

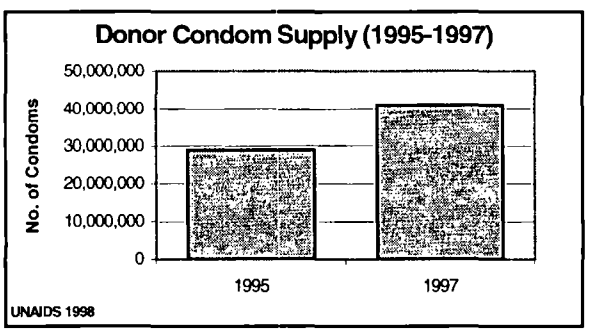
While few bilateral or multilateral donors are active in Swaziland, representatives from the United States, Britain, Italy, Germany, and the European Union (EU) are involved in HIV/AIDS prevention activities. USAID currently has no mission in Swaziland.

According to a UNAIDS/Harvard study:

The German Technical Cooperation (GTZ) has supported HIV/AIDS care activities and provided condoms, contributing DM 434,807 in 1996-97.

The European Union (EU) supports the NGO SHAPE's HIV/AIDS prevention project in secondary schools.

The Italian Cooperation is supporting home-based care pilot projects.



Donors supplied 29 million condoms in 1995 and more than 41 million condoms in 1997.

UNAIDS has a coordinating Theme Group in Swaziland, with representatives from UNICEF, UNDP, UNFPA, WHO, and UNESCO, chaired by WHO.

UNAIDS financed HIV/AIDS activities with US$106,000 in 1996-1997 and US$140,000 in 1998-1999. Activities include:

- Improving community home-based care and counseling.
- Strengthening a multisectoral response.
- Supporting the HIV and TB Prevention and Counseling Pilot Project.
- Building the capacity and coordinating the work of AIDS service organizations.
- Mobilizing young people against HIV/AIDS.
- Providing support for people living with HIV/AIDS (PLWHA).
- Supporting the work of the NGO SHAPE in secondary schools.

WHO has provided technical assistance in HIV/AIDS evaluation and programming; surveillance; a TB and HIV/AIDS program; and development of a national HIV/AIDS policy. WHO has also supported the publication of health education materials.

UNDP has been instrumental in policy-level advocacy; provides technical assistance to the Ministry of Health and NGOs; supports sentinel surveillance; and has assisted in the development

of the framework for home-based care programming and support for PLWHA.

UNICEF has supported a situation analysis of orphans; provided training for primary school teachers in HIV/AIDS education; and assisted NGOs in capacity building.

UNFPA has financed study tours for NGOs and sponsored workshops on HIV, gender, and poverty alleviation. UNFPA is the major donor of condoms.

Private Voluntary Organizations (PVOs) and Nongovernmental Organizations (NGOs)

A number of PVOs implement activities funded by multilateral and bilateral donors. *See attached preliminary chart for PVO and NGO HIV/AIDS activities target areas. This list is evolving and changes periodically.*

The bulk of AIDS activities to date in Swaziland have been carried out by NGOs and AIDS service organizations. Some NGOs working in Swaziland include:

- The Family Life Association of Swaziland (FLAS) conducts lectures on family planning, STIs, and AIDS in army barracks in eight sites, reaching about 2,000 men per year. FLAS also works in HIV/AIDS education in industry, and provides youth counseling.
- The Swaziland AIDS Support Organization (SASO) supports programs benefiting PLWHA.
- The AIDS Support Organization (TASO) provides counseling and testing services.
- The Traditional Healers Organization (THO) provides HIV/AIDS prevention education.

The NGO coalition Swaziland AIDS Network Organization (SWANASO) coordinates the activities of NGOs working in HIV/AIDS.

Challenges

Major constraints to HIV/AIDS control in Swaziland include the following:

- Political leadership was lacking until 1999.
- HIV/AIDS/STI prevention and care programs are few.
- Until recently, only the MOH has been involved in HIV/AIDS policy and programming.
- Resources and donor assistance are inadequate.
- Women have a weak social and economic position and have little control over their sexual health.
- There is resistance to change in high-risk sexual behavior, even with knowledge of HIV transmission, particularly among youth.
- Unemployment and poverty are growing.

The following gaps in programming must be filled in order to mount an effective response to HIV/AIDS in Swaziland:

- A clear national policy on HIV/AIDS is needed.
- Action plans must be prepared.
- National commitment must be demonstrated to convince donors to become involved.
- Budget allocations and programs are needed from all ministries.
- Programs must be developed for mass media information and education; care and support for PLWHA and those affected by HIV/AIDS; voluntary counseling and testing; and orphans.
- The promotion of, supply of, and access to condoms must be improved.

The Future

The recent commitment by the King of Swaziland and the Prime Minister are signs that the country is ready to tackle the HIV/AIDS epidemic; however, the government must also commit its resources to proactive HIV/AIDS/STI prevention and control. In addition to government efforts, community participation at all levels is essential for effective HIV/AIDS care, prevention, and support activities.

If a clear HIV/AIDS policy is established, multisectoral involvement is achieved, and action plans are established, Swaziland will be able to garner the external donor assistance—technical and financial—it desperately needs to fight the HIV/AIDS epidemic.

Important Links

1. AIDS Cabinet Committee: Deputy Prime Minister Arthur Khoza, Tel: (268-40) 42723/4; Fax: (268-40) 40084
2. Crisis Management and Technical Committee on AIDS: Ms. Christabel Motsa, Tel/Fax: (268-50) 52294
3. National AIDS Program: Beatrice Dlamini, P.O. Box 903, Mbabane. Tel: (268-40) 48209/48440
4. UNAIDS Focal Point: Alfred Mndzebele, UNDP, P.O. Box 903, Mbabane. Tel: (268-40) 42301-4: Fax (268-40) 45341; E-mail: alfred.Mndzebele@undp.org
5. Swaziland AIDS Network Organization (SWANASO)

U.S. Agency for International Development

Population, Health and Nutrition Programs
HIV/AIDS Division

1300 Pennsylvania Ave., N.W.
Ronald Reagan Building, 3rd Floor
Washington DC 20523-3600
Tel: (202) 712-4120
Fax: (202) 216-3046
URL: www.info.usaid.gov/pop_health

Implementing AIDS Prevention and Care (IMPACT) Project

Family Health International
2101 Wilson Boulevard, Suite 700
Arlington VA 22201 USA
Telephone: (703) 516 9779
Fax: (703) 516 9781
URL: www.fhi.org

June 1999

CALL TO ACTION

A Global Program to Prevent Mother-to-Child Transmission of HIV

Request for Applications

BRIEF DESCRIPTION

It is estimated that 1,800 infants become infected with HIV each day worldwide. The majority of those infections occur in developing countries, where resources to prevent mother-to-child transmission (MTCT) of HIV are scarce. We now have successful treatment strategies to prevent MTCT of HIV, but those interventions have not been implemented in resource-limited countries. Provision of antiretroviral therapies, coupled with resources to deliver them, can significantly decrease the rate of MTCT of HIV, and save the lives of thousands of infants each year.

A Call to Action was issued at the Second International Conference on Global Strategies for the Prevention of HIV Transmission from Mothers to Infants in Montreal, Canada, calling for programs to support and enable mothers to prevent MTCT of HIV. It is in the context of this Call to Action that the present program is proposed.

This program will focus on the reduction of MTCT of HIV. In coordination with Ministries of Health, local health care agencies, non-government organizations (NGOs) and other partners in countries most hit by the HIV epidemic, this program will support the implementation of coordinated activities to improve access and use of anti-retroviral interventions which will contribute to improvement of mother/child care.

SCOPE OF AWARDS

The program will provide resources to initiate and/or strengthen one or more of the following:

- Access to antiretroviral prevention therapy by donation, price reduction or purchase;
- HIV counseling and testing including rapid testing;
- Training on HIV education, counseling and implementation aimed at preventing MTCT of HIV; and
- Planning for expansion and integration of programs to reduce MTCT of HIV in the national policy of resource-limited regions.

The Call to Action will be implemented in three phases, according to the availability of additional resources. **This RFA will select sites appropriate for Phase I.** Sites needing more infrastructure and resources than we can provide with the funds we currently have available may be deferred and considered instead for Phase II support.

Phase I - Immediate (January, 2000)
Sites with Established Infrastructure

- Preference given to sites with established programs in place (counseling, testing, strong antenatal care, etc.) that can implement quickly, show immediate success, and have likelihood of sustainability
- Funds primarily for antiretroviral therapy to prevent MTCT of HIV, and a limited amount for counseling, testing, and training

Phase II: Intermediate
Sites with Moderate Infrastructure

- Support provided for sites needing to create or enhance infrastructure to counsel, test and treat large numbers of HIV-infected pregnant women in existing antenatal care systems, including training for care providers
- HIV/AIDS education and outreach on the availability of strategies to prevent MTCT of HIV
- Incorporation of improved treatment strategies for the prevention of MTCT of HIV as they become available
- Implementation of additional approaches for reducing MTCT of HIV, including universal treatment of pregnant women and their infants

Phase III - Long Term
Sites with Minimal Infrastructure and Expansion of Successful Models

- Development of antenatal care infrastructure to identify and treat HIV-infected pregnant women
- Resources for national expansion of successful local programs developed in Phases I and II
- Identification of HIV seroprevalence in pregnant women for countries with emerging HIV epidemics (India, China, Southeast Asia)
- Development of national policies for HIV counseling, testing, and treatment of HIV-infected pregnant women
- Identification of additional partners to implement comprehensive programs

SOURCE OF FUNDS

The Call to Action generated donations from organizations and individuals totaling $1.2 million to date. These funds are intended to support programs to reduce MTCT of HIV. This program will be administered by the Elizabeth Glaser Pediatric AIDS Foundation, in collaboration with an expert Executive Committee.

WHO MAY APPLY

Applications will only be accepted from groups with a proven track record of serving populations of women and children. Applications are solicited from not-for-profit Health System units, including health centers, communes, districts, provinces and ultimately entire countries located in resource-limited regions. For the purposes of this program, a resource-limited region is defined as one in which interventions to prevent MTCT of HIV have not been widely implemented. Grant applications are not accepted from for-profit institutions or organizations. Grants are not made to individuals.

AMOUNT OF AWARDS

The maximum amount of funding is U.S. $100,000 for a period of performance not to exceed two years. Indirect cost (overhead) is not allowed. The review committee will make final determination as to the amount and duration of support to be awarded. The number of grants awarded will be determined based on available funds. If your site requires funds in excess of $100,000 to implement programs to reduce MTCT of HIV, you may consider waiting and applying for Phase II support instead.

CONFIDENTIALITY

Every effort is made to respect the privacy of applicants. However, due to the fact that a number of groups and individuals are involved in the review process, strict confidentiality regarding any of the information provided in the application, supporting material, or budget cannot be guaranteed. Submission of a grant application is deemed acceptance of this provision.

REVIEW PROCESS

Initially, each application is subject to an overall administrative review by EGPAF staff. Those applications found to be incomplete or inconsistent with the goals of the program will be asked to submit a revised application, if appropriate. All applications accepted for consideration will be reviewed by the voluntary Executive Committee. Sites will be selected based on the likelihood that they will be able to rapidly implement HIV MTCT prevention programs. Grants will be reviewed for feasibility, resources required, future sustainability, in-country commitment, and likelihood of reducing MTCT of HIV.

CONDUCT OF THE IMPLEMENTING INSTITUTION/ORGANIZATION

In awarding grants, the Elizabeth Glaser Pediatric AIDS Foundation does not assume any responsibility for the conduct or acts of the applicant, since both are under the direction and control of their respective institutions and subject to those institutions' medical and legal policies. Award recipients are not considered to be employed by the Foundation, but to be employed by the applicant institution. Submission of an application is deemed acceptance of these provisions.

HOW TO APPLY

Applications are due in the Grants Department no later than 5:00 p.m., U.S. Pacific Coast Time on January 18, 2000. To accommodate delays in the mail system, you may submit your application via FAX or e-mail, with an original hard copy sent via mail. Applications must be submitted by this date to allow time for staff preparation and consideration by the Executive Committee. Applications received late or exceeding the budget or page limitations will not be accepted.

Applications should be directed to:

Research Department/ CTA
ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION
2950 31st Street, #125
Santa Monica, CA 90405
USA
Phone: 310-314-1459
FAX: 310- 314-1469
E-mail: research@pedaids.org

We realize that many of these applications will be submitted by e-mail . We are not requiring forms, as they often do not translate well into other word-processing programs. Please follow the instructions below carefully, and make sure that the application is easy to read. The reviewers will appreciate this. All text must be submitted in 12 point font, double-spaced, with one-inch margins. **The application must be assembled in the following order:**

1. FACE PAGE

- This page must appear first on the completed proposal.
- Provide the complete name, title, mailing address, phone number, FAX number, and e-mail for the contact person responsible for overseeing the implementation program.
- Provide the full legal name of the applicant organization.
- Indicate the total amount of funds you are requesting, not to exceed US $100,000. Indirect costs are not allowed.
- Provide the name, title, mailing address, phone number, FAX number, and e-mail to which payments and/or in-kind donations (e.g. drug) should be sent in the event that an award is made. Applicants requesting funds via wire transfer should contact the Foundation for instructions.
- Please indicate the period of time for which you are requesting support, not to exceed two years.

2. TABLE OF CONTENTS

The Table of Contents should appear after the Face Page and before the rest of the application. The Table of Contents lists order of the contents as requested.

3. BUDGET

Funds available through the Call to Action are limited, and are therefore only available to cover the specific categories listed below. The maximum amount of funding is U.S. $100,000, for all categories combined, for a period of performance not to exceed two years. Indirect costs (overhead) are not allowed. The recipient institution is expected to provide the required physical facilities, administrative services, and other supporting services normally available in an institution or organization. Applicants may request in-kind support (direct shipment of drug or test kits) in lieu of funds, as long as the total value of the request does not exceed U.S. $100,000. Applicants requesting funds via wire transfer should contact the Foundation for instructions. Please keep in mind that **this RFA will select sites appropriate for Phase I** (see page 1).

Funds are available to support **only** the following:

- **Purchase of therapies** to reduce mother-to-infant transmission of HIV
- **Purchase of HIV test kits** to identify pregnant women with HIV
- Collection of blood samples from infants, including storage and shipping for **diagnosis of infant HIV status**
- **Training** of care providers in the provision of voluntary counseling and testing, and treatment to reduce mother-to-infant transmission of HIV
- Under special circumstances, **salary support for counselors/coordinators** to implement the above, not to exceed a total salary request of U.S. $10,000 per year.

The amount being requested within each budget heading should be entered and justified. The bolded sections above should be your budget headings (e.g. Purchase of therapies). Present all budget figures in whole U.S. dollars. Two additional pages may be added if necessary to provide detail and justifications. Justification pages should contain headings that are the same as those on the budget. In justifying salary costs, indicate the position of the person to be supported (e.g., nurse), rate of pay, and percentage of time of the individual to be assigned to the project. This figure should reflect the percentage of a full year which the employee is expected to work on the project. For example, an employee working full-time for six months would be 50%. Requests for salary costs of persons already employed full-time by the applicant organization will be scrutinized for appropriateness and need.

4. TWO-PAGE CURRICULUM VITAE

Please provide an abbreviated, two-page CV for the contact person responsible for overseeing the project.

5. OTHER SUPPORT PAGE

Applicant organizations that have existing infrastructure in place to amplify the Call to Action funds should indicate so. Preference in selection of recipients will be given to those applicants who provide evidence that resources are available that may amplify funds provided through the Call to Action, and that plans will be made to sustain the programs made possible through the Call to Action. Please tell us of the other funds available to you to support programs aimed at reducing MTCT of HIV. Please include any plans for soliciting additional sources of support of the entire program or of specific activities (e.g., donations, educational grants, government support, discounts for drug or HIV testing, and matching funds). We are interested in seeing if the funds that are awarded to you can attract other funds and thus be amplified. List on this page, in three separate groups: (1) all present active support; (2) applications and proposals pending review or funding; (3) applications and proposals planned or being prepared for submission. Include all government, industry, and institutional support. If none, state "none."

6. RESOURCES AND ENVIRONMENT

In three (3) pages or less, briefly describe the facilities of the applicant site (Health System units including health centers, communes, districts, provinces and ultimately entire countries located in resource-limited regions) and personnel currently available. Using a continuation page if necessary, include an explanation of any consortium arrangements with other organizations, including ongoing voluntary counseling and testing (VCT) programs. Should there be a consortium agreement, a copy of it should be appended after the implementation plan. Please provide a description of the antenatal, prenatal, and postnatal care provided at the site, including the number and proportion of women in care, the process for referral in the context of women and children's care, availability of testing for STDs, and availability of other treatments such as penicillin, multivitamins, and chlorhexidine. Also, please provide a description of the counseling and testing services available, including information on the availability of rapid HIV testing. Please discuss your ability to diagnose HIV in infants (ELISA antibody, PCR testing or other antigen detection). Please also provide evidence of discussions with Family Planning (FP) and Mother-child Health (MCH) programs on how to integrate the proposed program with FP and MCH activities and the outcome of those discussions.

7. ASSURANCES

- Please provide a letter of documentation indicating if the drugs to be used in your implementation plan are appropriately registered and authorized in your country. This information should be obtained from the National Drug Authority. If the drugs are not registered and your project is selected, the Call to Action Executive Committee will attempt to contact the relevant manufacturers and request that they submit a registration file in your country.
- Please attach a letter of collaboration with a pharmacist or responsible party who must describe how they will ensure accurate dispensing of the drugs to be used.
- A letter of endorsement or support from the National AIDS Program or other appropriate authorities at the national or provincial level is required. It is advisable that the letter of support includes an indication of the authority's position, policy, and future plans to make available interventions to prevent mother-to-child transmission.

8. DESCRIPTION OF POPULATION

In no more than two (2) pages, please provide:

- Information on the number of deliveries annually at the applicant site(s) and estimates of proportion of pregnant women receiving antenatal care
- Information on availability of VCT
- Information on the seroprevalence of HIV in pregnant women
- Information on status of feeding practices for children born to infected mothers, including availability and cost of replacement feeding
- Description of current community education and awareness programs and how these will be utilized to maximize the effectiveness of the program proposed

9. IMPLEMENTATION PLAN TO REDUCE MTCT

In no more than (seven) 7 pages, please provide:

- Attainable, specific, time-phased objectives for the program (e.g., number of staff you hope to train, number of women you hope to test, number of women you hope to treat, number of babies you hope to test, etc.);
- Plans to evaluate the effects of the program to be implemented. (e.g., number given VCT, number returning for test results, number of women receiving intervention, plans for follow-up of infants born to HIV-infected pregnant women (number of infected babies, number of uninfected babies) including estimates of proportions likely to be seen during first 3 months, 6 months, and 1 year; and
- Plans for developing sustainability of program implementation and expanding the implementation effort. This should include plans for extending the program through education and training, plans to link with other sites, and the potential for securing additional funds to continue the program once funds provided by this program are depleted.

10. SUGGESTIONS FOR NEXT RFA

This is the first RFA for the Call to Action. We anticipate issuing additional RFAs. We would like your feedback on how we can improve this process, and enhance the program. Please send us your ideas, even if you do not plan to submit an application for this cycle.

Elizabeth Glaser Pediatric AIDS Foundation
The Call to Action Project

More than 1,800 children are newly infected with HIV each day, and the majority live in the developing world. Reducing mother-to-child HIV transmission is vital, particularly in areas most affected such as sub-Saharan Africa.

In September of 1999, Global Strategies for HIV Prevention and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) issued a Call to Action to mobilize a worldwide response to prevent perinatal transmission of HIV. This "Call to Action" followed the results of a joint Uganda/US study that demonstrated the drug nevirapine could reduce perinatal transmission of HIV by nearly 50 percent. Nevirapine is administered in a single dose to the mother at the onset of labor and in a single dose to the baby in its first three days of life. The entire course costs less than four dollars at Western list prices. The current therapies that are practical for resource-poor countries to prevent mother-to-child transmission are nevirapine (Viramune) and AZT (ZDV, Retrovir). The "Call to Action" will support these and future therapies as they become available.

EGPAF designated the first $1 million to establish what is currently titled The Call to Action Project to implement programs to prevent perinatal HIV transmission. We have been joined by additional donors and collaborators including Boehringer Ingelheim/Roxane Laboratories which donated $1 million, and we have recently received a $15 million pledge from the Bill and Melinda Gates Foundation. With the first $1 million, EGPAF has already made awards to the following sites.

- University of Natal, Congella, South Africa
- Kijabe Hospital, Kijabe, Kenya
- Makerere University, Kampala, Uganda
- Nyanza Provincial Hospital, Kisumu, Western Kenya
- Cameroon Baptist Convention Health Board, NW Province, Cameroon
- Ministry of Public Health of the Royal Thai Government, Nonthaburi, Thailand
- Ministry of Health, Kigali, Rwanda
- University of Wirwatersrand, Johannesburg, South Africa.

The awards will help launch immediate implementation of programs to reduce mother-to-child transmission of HIV. Sites were identified through a worldwide competition and selected by an international panel of doctors dedicated to the prevention of HIV transmission from mother to child. Grants will be given to support HIV counseling and testing of pregnant women, training for medical professionals to deliver effective HIV counseling and care, and for the purchase and delivery of HIV/AIDS treatments that have been found to prevent the transmission of HIV from mother to child.

FAMILY HEALTH INTERNATIONAL

PETER R. LAMPTEY, MD., DrPH
SENIOR VICE PRESIDENT AIDS PROGRAM
PROJECT DIRECTOR, IMPACT

2101 Wilson Boulevard • Ste. 700 • Arlington, VA 22201 USA
Telephone: 703/516-9779 Fax: 703/516-9781
Voice Mail: 703/516-0460
E-mail: plamptey@fhi.org • www.fhi.org

FAMILY HEALTH INTERNATIONAL

PETER R. LAMPTEY, MD., DrPH
SENIOR VICE PRESIDENT AIDS PROGRAM
PROJECT DIRECTOR, IMPACT

2101 Wilson Boulevard • Ste. 700 • Arlington, VA 22201 USA
Telephone: 703/516-9779 Fax: 703/516-9781
Voice Mail: 703/516-0460
E-mail: plamptey@fhi.org • www.fhi.org

SWAZILAND AND HIV/AIDS

Country Profile

The Kingdom of Swaziland is a small, landlocked country with a population of approximately one million, one-third of whom live in urban areas. Swaziland's economy is based largely on subsistence agriculture and the country is heavily dependent on South Africa, which almost entirely surrounds its borders, and from which it receives 90 percent of its imports. Remittances from Swazi workers in South African mines supplement domestically-earned income by as much as 20 percent. This migration of mine workers is a factor in the high HIV prevalence rate in Swaziland.

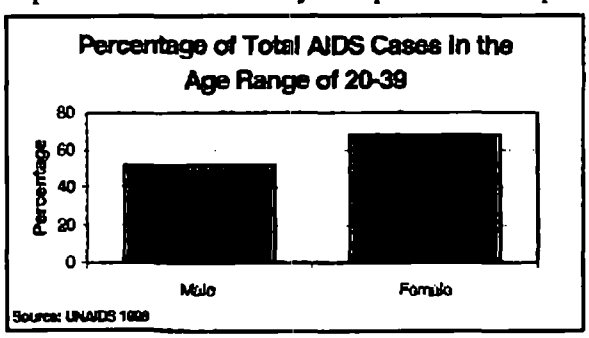
As of 1997, 16 percent of Swaziland's gross domestic product (GDP) was earned from agriculture, with the remainder split between industry and services. The GDP growth rate dropped from 3.9 percent in 1996 to 2.5 percent in 1997. Three percent of the GDP was budgeted for the health sector in 1996. The country's gross national product (GNP) per capita is US$1,440, close to the level of "lower-middle" income for sub-Saharan Africa.

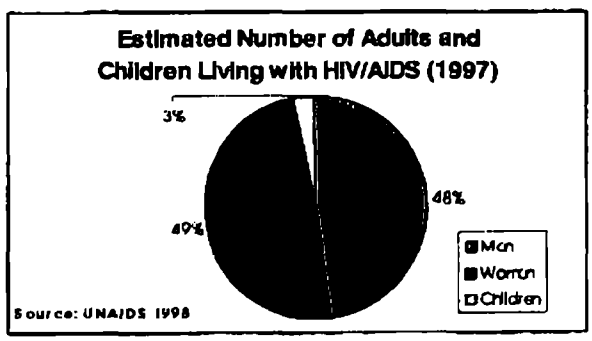
Swaziland faces serious health sector problems that threaten to exacerbate the country's HIV/AIDS epidemic, most notably the marked rise in tuberculosis cases, which doubled from 1994 to 1998.

HIV/AIDS in Swaziland

The first AIDS case was reported in Swaziland in 1987. Since then, the HIV/AIDS epidemic has continued to rise to alarming levels, with Swaziland now ranking as one of the four most-affected countries in the world, along with Zimbabwe, Botswana, and Namibia.

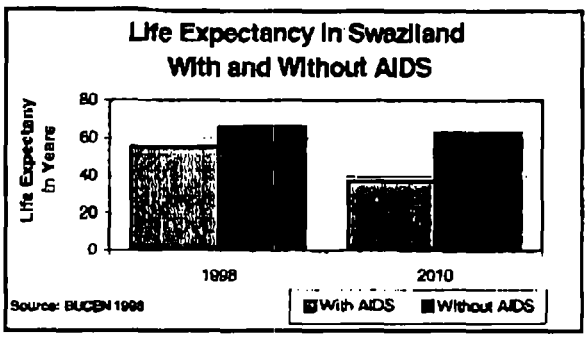
- According to the 1998 sentinel surveillance conducted by the National AIDS Program (NAP), 20 to 23 percent of adults (age 15 and over) are HIV-positive.
- In 1998 the National AIDS Task Force performed a blind study of inpatients at hospitals and found that 45 to 50 percent were HIV-positive.
- The majority of AIDS cases are among 20- to 39- year-olds—the reproductive and economically-productive age range; 52 percent of males and 68 percent of females fall within this age group.
- According to the World Health Organization (WHO), as many as one-third of young and middle-aged adults in Swaziland are infected with HIV.

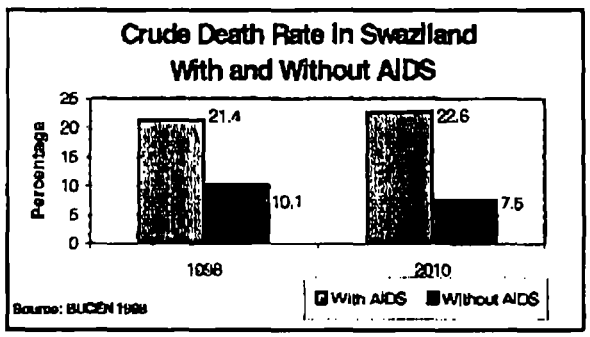




According to U.S. Census Bureau (BUCEN) data, by 2010 AIDS will increase the crude death rate in Swaziland by more than 200 percent.

- More than 5,000 Swazis died of AIDS-related diseases in 1997.
- By 2010, life expectancy will drop by more than 40 percent as a result of AIDS.





Women and HIV/AIDS

The number of women living with HIV/AIDS in Swaziland is growing. Women's low social and economic status, combined with greater biological susceptibility to HIV, put them at increased risk of infection. Deteriorating economic conditions, which make it difficult for women to access health and social services, compound their vulnerability.

- According to NAP's 1998 sentinel surveillance data, 31 percent of pregnant women at antenatal clinics tested positive for HIV.
- According to 1996 U.S. Census Bureau statistics, the HIV prevalence rate in STI clinics ranged from 35 to 43 percent in different regions.
- The high incidence of illegal abortion is a growing concern in Swaziland, and a particularly significant problem among teenage girls (UN Secretariat 1995).

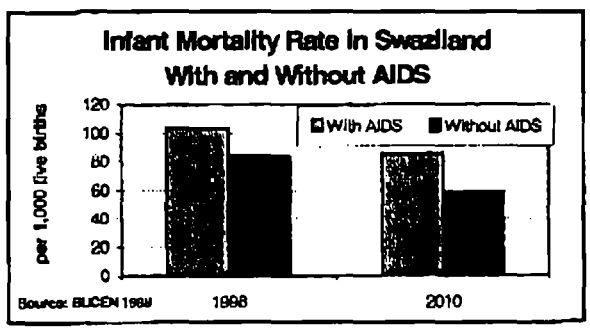
In Swaziland, marriage law, under Roman-Dutch Law, confers upon the husband undisputed control over the acquisition and disposal of marital property. The combined effect of the Roman-Dutch Law and Swazi Customary Law is to relegate women to the position of minors.

Children, Youth and HIV/AIDS

The HIV epidemic has a disproportionate impact on children, causing high morbidity and mortality rates among infected children and orphaning many others. Approximately 30 to 40 percent of infants born to HIV-positive mothers will also become infected with HIV.

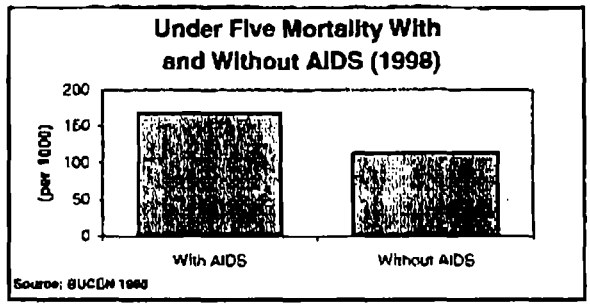
- Forty-nine percent of the Swazi population are under age 15.
- According to a 1998 UNICEF/Government of Swaziland report, an estimated 23,960 children will be orphaned by AIDS by the year 2000.
- As one of the African countries hardest hit by the HIV/AIDS epidemic, 20 to 33 percent of Swaziland's children will be orphaned over the next decade as the adult death toll climbs.

According to BUCEN, infant mortality in Swaziland in 1998 was 103 per 1,000. BUCEN



estimates the infant mortality rate would have been 84 per 1,000 in 1998 in the absence of AIDS.

- By 2010 the infant mortality rate will be nearly double what it would be in the absence of AIDS.
- Child mortality (under age 5) in 1998 was 168 per 1,000, compared with the estimated 114 per 1,000 it would have been in the absence of AIDS.



Socioeconomic Effects of AIDS

About 90 percent of reported AIDS cases are adults 20 to 49 years old. Since this age group constitutes the most economically productive segment of the population, an important economic burden is created. Productivity falls and business costs rise—even in low-wage, labor-intensive industries—as a result of absenteeism, the loss of employees to illness and death, and the need to train new employees. The diminished labor pool affects economic prosperity, foreign investment, and sustainable development. The agricultural sector likewise feels the effects of HIV/AIDS; a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this implies switching from export crops to food crops—thus affecting the production of cash and food crops.

There are also many private costs associated with AIDS, including expenditures for medical care, drugs, funeral expenses, etc. The death of a family member leads to a reduction in savings and investment, and increased depression among remaining family members. Women are most affected by these costs and experience reduced ability to provide for the family when forced to care for sick family members. And AIDS adversely affects children, who lose proper care and supervision when parents die. Some children will lose their father or mother to AIDS, but many more will lose both parents, causing a tremendous strain on social systems. At the family level there will be increased pressure and stress on the extended family to care for these orphans; grandparents will be left to care for young children and 10- to 12-year-olds become heads of households.

(For country-specific information on the socioeconomic impact of HIV/AIDS refer to the *socioeconomic analysis* presented by the Policy Project.)

Interventions

National Response

The NAP Secretariat was established in the Ministry of Health in 1989, with support from the World Health Organization (WHO). A National AIDS Task Force has also been established.

The first sentinel surveillance was conducted in 1991 and has been conducted annually, except in 1997 because of resource constraints.

UNAIDS, through the Ministry of Education, has supported the NGO School AIDS Prevention Education (SHAPE) in working with secondary schools. Through their IEC activities, NGOs were largely effective in bringing information about HIV/AIDS information to the country. However, sexual behavior change and condom use have not accompanied the knowledge.

The Baphalali Swaziland Red Cross, in collaboration with the Ministry of Health, is working to improve the screening of the blood supply.

Following study tours to observe AIDS programs in Zambia and Uganda in 1996-1997, the Government of Swaziland (GOS) prepared a

comprehensive home-based care framework but was unable to implement a program because of resource constraints. Currently, the GOS, UNAIDS, and the Italian Cooperation are funding two pilot sites for home-based care in rural areas, involving traditional healers and community volunteers. The Salvation Army, Hospice at Home, the Catholic Church through Caritas, and the Swedish missionary Mkhuzweni Health Center are also involved in home-based care. These efforts are just now being initiated and are limited geographically and in their scope of services.

Recently, Swazi authorities have publicly acknowledged that HIV/AIDS has become a "national disaster." In February 1999, at the opening of Parliament, King Mswati III declared that AIDS was a national crisis and called for all sectors of the nation—public, private, NGOs, and communities—to take action.

In May 1999, the Prime Minister launched the Cabinet Committee on HIV/AIDS, chaired by the Deputy Prime Minister, and the multisectoral Crisis Management and Technical Committees on HIV/AIDS. The government recognized that the crisis could not be addressed by the Ministry of Health alone but requires a multisectoral strategy. The new committees will set policy directions and manage the mobilization of resources for all sectors, ensuring a more unified and coherent national response.

Donors

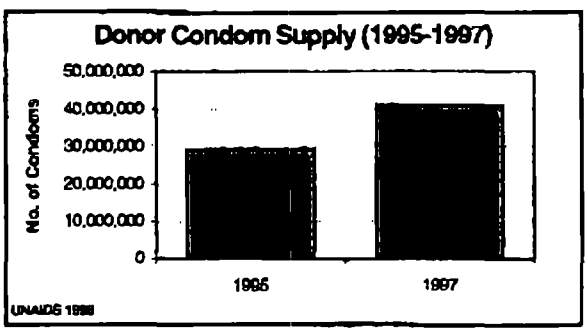
While few bilateral or multilateral donors are active in Swaziland, representatives from the United States, Britain, Italy, Germany, and the European Union (EU) are involved in HIV/AIDS prevention activities. USAID currently has no mission in Swaziland.

According to a UNAIDS/Harvard study:

The German Technical Cooperation (GTZ) has supported HIV/AIDS care activities and provided condoms, contributing DM 434,807 in 1996-97.

The European Union (EU) supports the NGO SHAPE's HIV/AIDS prevention project in secondary schools.

The Italian Cooperation is supporting home-based care pilot projects.



Donors supplied 29 million condoms in 1995 and more than 41 million condoms in 1997.

UNAIDS has a coordinating Theme Group in Swaziland, with representatives from UNICEF, UNDP, UNFPA, WHO, and UNESCO, chaired by WHO.

UNAIDS financed HIV/AIDS activities with US$106,000 in 1996-1997 and US$140,000 in 1998-1999. Activities include:

- Improving community home-based care and counseling.
- Strengthening a multisectoral response.
- Supporting the HIV and TB Prevention and Counseling Pilot Project.
- Building the capacity and coordinating the work of AIDS service organizations.
- Mobilizing young people against HIV/AIDS.
- Providing support for people living with HIV/AIDS (PLWHA).
- Supporting the work of the NGO SHAPE in secondary schools.

WHO has provided technical assistance in HIV/AIDS evaluation and programming; surveillance; a TB and HIV/AIDS program; and development of a national HIV/AIDS policy. WHO has also supported the publication of health education materials.

UNDP has been instrumental in policy-level advocacy; provides technical assistance to the Ministry of Health and NGOs; supports sentinel surveillance; and has assisted in the development

of the framework for home-based care programming and support for PLWHA.

UNICEF has supported a situation analysis of orphans; provided training for primary school teachers in HIV/AIDS education; and assisted NGOs in capacity building.

UNFPA has financed study tours for NGOs and sponsored workshops on HIV, gender, and poverty alleviation. UNFPA is the major donor of condoms.

Private Voluntary Organizations (PVOs) and Nongovernmental Organizations (NGOs)

A number of PVOs implement activities funded by multilateral and bilateral donors. *See attached preliminary chart for PVO and NGO HIV/AIDS activities target areas. This list is evolving and changes periodically.*

The bulk of AIDS activities to date in Swaziland have been carried out by NGOs and AIDS service organizations. Some NGOs working in Swaziland include:

- The Family Life Association of Swaziland (FLAS) conducts lectures on family planning, STIs, and AIDS in army barracks in eight sites, reaching about 2,000 men per year. FLAS also works in HIV/AIDS education in industry, and provides youth counseling.
- The Swaziland AIDS Support Organization (SASO) supports programs benefiting PLWHA.
- The AIDS Support Organization (TASO) provides counseling and testing services.
- The Traditional Healers Organization (THO) provides HIV/AIDS prevention education.

The NGO coalition Swaziland AIDS Network Organization (SWANASO) coordinates the activities of NGOs working in HIV/AIDS.

Challenges

Major constraints to HIV/AIDS control in Swaziland include the following:

- Political leadership was lacking until 1999.
- HIV/AIDS/STI prevention and care programs are few.
- Until recently, only the MOH has been involved in HIV/AIDS policy and programming.
- Resources and donor assistance are inadequate.
- Women have a weak social and economic position and have little control over their sexual health.
- There is resistance to change in high-risk sexual behavior, even with knowledge of HIV transmission, particularly among youth.
- Unemployment and poverty are growing.

The following gaps in programming must be filled in order to mount an effective response to HIV/AIDS in Swaziland:

- A clear national policy on HIV/AIDS is needed.
- Action plans must be prepared.
- National commitment must be demonstrated to convince donors to become involved.
- Budget allocations and programs are needed from all ministries.
- Programs must be developed for mass media information and education; care and support for PLWHA and those affected by HIV/AIDS; voluntary counseling and testing; and orphans.
- The promotion of, supply of, and access to condoms must be improved.

The Future

The recent commitment by the King of Swaziland and the Prime Minister are signs that the country is ready to tackle the HIV/AIDS epidemic; however, the government must also commit its resources to proactive HIV/AIDS/STI prevention and control. In addition to government efforts, community participation at all levels is essential for effective HIV/AIDS care, prevention, and support activities. If a clear HIV/AIDS policy is established, multisectoral involvement is achieved, and action plans are established, Swaziland will be able to garner the external donor assistance—technical and financial—it desperately needs to fight the HIV/AIDS epidemic.

Important Links

1. AIDS Cabinet Committee: Deputy Prime Minister Arthur Khoza. Tel: (268-40) 42723/4; Fax: (268-40) 40084
2. Crisis Management and Technical Committee on AIDS: Ms. Christabel Motsa, Tel/Fax: (268-50) 52294
3. National AIDS Program: Beatrice Dlamini, P.O. Box 903, Mbabane. Tel: (268-40) 48209/48440
4. UNAIDS Focal Point: Alfred Mndzebele, UNDP, P.O. Box 903, Mbabane. Tel: (268-40) 42301-4; Fax (268-40) 45341; E-mail: alfred.Mndzebele@undp.org
5. Swaziland AIDS Network Organization (SWANASO)

U.S. Agency for International Development
Population, Health and Nutrition Programs
HIV/AIDS Division
1300 Pennsylvania Ave., N.W.
Ronald Reagan Building, 3rd Floor
Washington DC 20523-3600
Tel: (202) 712-4120
Fax: (202) 216-3046
URL: www.info.usaid.gov/pop_health

Impact
Implementing AIDS Prevention and Care (IMPACT) Project
Family Health International
2101 Wilson Boulevard, Suite 700
Arlington VA 22201 USA
Telephone: (703) 516 9779
Fax: (703) 516 9781
URL: www.fhi.org

June 1999

SWAZILAND AND HIV/AIDS

Key Talking Points

The HIV/AIDS epidemic has spread so rapidly that Swaziland now ranks among the four countries in the world most affected by HIV/AIDS:

- 20 to 23 percent of adults (ages 15 and over) are HIV-positive.
- In 1998 the National AIDS Task Force performed a blind study of inpatients at hospitals and found that 45 to 50 percent were HIV-positive.
- The majority of AIDS cases are in the reproductive and economically-productive age range of 20 to 39; 52 percent of males and 68 percent of females fall within this age group.
- According to the World Health Organization (WHO), as many as one-third of young and middle-aged adults in Swaziland are infected with HIV.

AIDS Deaths By 2010 AIDS will increase the crude death rate in Swaziland by more than 200 percent, and life expectancy will drop by more than 40 percent (to only 37 years) as a result of AIDS. More than 5,000 Swazis died of AIDS-related diseases in 1997.

Women and HIV/AIDS In 1998, 31 percent of pregnant women at antenatal clinics tested positive for HIV. The HIV prevalence rate for women in STI clinics ranged from 35 to 43 percent in different regions in 1996.

Children, Youth and HIV/AIDS In 1998, infant mortality in Swaziland was 103 per 1,000 and child mortality (under age 5) was 168 per 1,000. The U.S. Census Bureau estimates these mortality rates for 1998 would have been 84 per 1,000 and 114 per 1,000, respectively, in the absence of AIDS. By 2010 the infant mortality rate is expected to be twice as high as it would have been in the absence of AIDS.

Socioeconomic effects of HIV/AIDS According to a 1998 UNICEF/Government of Swaziland report, an estimated 23,960 children will be orphaned by AIDS by the year 2000. The migration of mine workers is a factor in the high HIV prevalence rate in Swaziland: Remittances from Swazi workers in South African mines supplement domestically-earned income by as much as 20 percent.

National Response Political leadership was lacking until 1999 when King Mswati III declared that AIDS was a national crisis and called for all sectors—public, private, NGOs, and communities—to take action. AIDS committees to establish policy and implement multisectoral programs have been launched by the Prime Minister, but until resources are committed, action plans are established, and programs are developed, Swaziland will not be able to garner the external donor assistance—technical and financial—it desperately needs to fight the HIV/AIDS epidemic.

USAID currently has no mission in Swaziland.

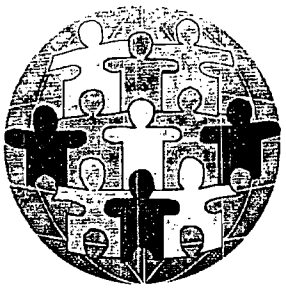
U.S. Agency for International Development

Population, Health and Nutrition Programs
HIV/AIDS Division

1300 Pennsylvania Ave., N.W.
Ronald Reagan Building, 3rd Floor
Washington DC 20523-3600
Tel: (202) 712-4120
Fax: (202) 216-3046
URL: www.info.usaid.gov/pop_health

Implementing AIDS Prevention and Care (IMPACT) Project

Family Health International
2101 Wilson Boulevard, Suite 700
Arlington VA 22201 USA
Telephone: (703) 516-9779
Fax: (703) 516-9781
URL: www.fhi.org



The POLICY Project

The Economic Impact of AIDS in Swaziland

by
John Stover
Lori Bollinger

September 1999

Activities (CEDPA)

The Futures Group International
in collaboration with:
Research Triangle Institute (RTI)
The Centre for Development and Population

POLICY is a five-year project funded by the U.S. Agency for International Development under Contract No. CCP-C-00-95-00023-04, beginning September 1, 1995. The project is implemented by The Futures Group International in collaboration with Research Triangle Institute (RTI) and The Centre for Development and Population Activities (CEDPA).

AIDS has the potential to create severe economic impacts in many African countries. It is different from most other diseases because it strikes people in the most productive age groups and is essentially 100 percent fatal. The effects will vary according to the severity of the AIDS epidemic and the structure of the national economies. The two major economic effects are a reduction in the labor supply and increased costs:

Labor Supply

- The loss of young adults in their most productive years will affect overall economic output
- If AIDS is more prevalent among the economic elite, then the impact may be much larger than the absolute number of AIDS deaths indicates

Costs

- The direct costs of AIDS include expenditures for medical care, drugs, and funeral expenses
- Indirect costs include lost time due to illness, recruitment and training costs to replace workers, and care of orphans
- If costs are financed out of savings, then the reduction in investment could lead to a significant reduction in economic growth

LABOR FORCE STATISTICS		
	Employment by Industry*: 1986	
Sector	**'000s**	**%**
AGRICULTURE		
Agriculture, hunting, forestry and fishing	23.1	30.2
INDUSTRY		
Mining and quarrying industries	2.4	3.1
Manufacturing industries	10.9	14.3
SERVICES		
Electricity, gas and water	1.4	1.8
Construction	5.3	6.9
Trade, restaurants and hotels	7.4	9.7
Transport, storage and communications	5.6	7.3
Finance, insurance, real estate and business services	3.4	4.5
Community, social and personal services	16.8	22.0
TOTAL EMPLOYED	**76.4**	**100.0**

Source: United Nations, Statistical Yearbook, 1992, table 30

The agricultural sector employs the greatest number of people in Swaziland; in 1996, about 33% of the labor force was in this sector, although it contributed only 11.6% of GDP. The main cash crops are sugar cane and cotton; livestock is also raised. Commercial forestry is also an important element in this sector. Manufacturing contributed 33.1% of GDP in 1996, consisting mainly of processing food, livestock, and forestry products. The services sector is the largest sector in Swaziland in terms of GDP contribution, accounting for 47% of GDP in 1996. Due to its close geographic proximity,

economic events in South Africa have a strong effect on the economy of Swaziland. It is also vulnerable to weather conditions and fluctuations in international commodity prices.

The economic effects of AIDS will be felt first by individuals and their families, then ripple outwards to firms and businesses and the macro-economy. This paper will consider each of these levels in turn and provide examples from Swaziland to illustrate these impacts.

Economic Impact of AIDS on Households

The household impacts begin as soon as a member of the household starts to suffer from HIV-related illnesses:

- Loss of income of the patient (who is frequently the main breadwinner)
- Household expenditures for medical expenses may increase substantially
- Other members of the household, usually daughters and wives, may miss school or work less in order to care for the sick person
- Death results in: a permanent loss of income, from less labor on the farm or from lower remittances; funeral and mourning costs; and the removal of children from school in order to save on educational expenses and increase household labor, resulting in a severe loss of future earning potential.

- Since approximately 90% of AIDS cases in Swaziland are projected to occur between the ages of 15 to 49, the earning capacity of households will be reduced significantly.

- The number of orphans due to AIDS is projected to increase from 10,060 in 1994 to 85,910 in 2006. Orphans tend to attend school less frequently, due to lack of financial resources for fees, uniforms, and books, as well as being more likely to work.

Economic Impact of AIDS on Agriculture

Agriculture is the largest sector in most African economies accounting for a large portion of production and a majority of employment. Studies done in Tanzania and other countries have shown that AIDS will have adverse effects on agriculture, including loss of labor supply and remittance income. The loss of a few workers at the crucial periods of planting and harvesting can significantly reduce the size of the harvest. In countries where food security has been a continuous issue because of drought, any declines in household production can have serious consequences. Additionally, a loss of agricultural labor is likely to cause farmers to switch to less-labor-intensive crops. In many cases this may mean switching from export crops to food crops. Thus, AIDS could affect the production

---

Europa World Year Book 1998, Volume 2 (1998) Europa Publications Limited (London).

Nkurlu, JI and Ilo Samat. (1994) "HIV/AIDS and Employment Policy and Practices." Prepared for Southern African Conference on AIDS and Employment, Harare, 28-30 November, 1994.

Whiteside, A and G Wood (1994) "The Socio-Economic Impact of AIDS in Swaziland," Government of Swaziland, Mbabane.

of cash crops as well as food crops.

- A case study of the Mhlume Sugar Company examined the effect of HIV/AIDS on all aspects of the operation of the estate. The sugar estate provides both housing and health care for all of its employees and their families. The study concluded that AIDS will have a major impact on the estate, including effects on the production process, employee benefits, the medical costs and facilities, and the overall well-being of the estate. The senior medical officer there attributed 30% of all employee deaths over a three-year period to AIDS.

Economic Impact of AIDS on Firms

AIDS may have a significant impact on some firms. AIDS-related illnesses and deaths to employees affect a firm by both increasing expenditures and reducing revenues. Expenditures are increased for health care costs, burial fees and training and recruitment of replacement employees. Revenues may be decreased because of absenteeism due to illness or attendance at funerals and time spent on training. Labor turnover can lead to a less experienced labor force that is less productive.

Factors Leading to Increased Expenditure	Factors Leading to Decreased Revenue
Health care costs	Absenteeism due to illness
Burial fees	Time off to attend funerals
Training and recruitment	Time spent on training
	Labor turnover

- Firms initially saw HIV/AIDS as a medical problem, to be handled by the government. After it became more widespread, firms began working with the government and NGOs on various campaigns, particularly to raise awareness. They have begun to recognize that cost-effective strategies include reducing labour requiring time away from families, such as migrant labour or driving long distances.

- In Swaziland, a government employee may have up to six months sick leave at full pay and then another six months at half pay before undergoing a medical retirement. Thus morbidity due to HIV/AIDS will have a significant effect on the government wage bill. A worker in the private sector will generally have about 21 days sick leave.

Gilbertson, I and AW Whiteside. (1993) "AIDS and commercial agriculture," Int Conf AIDS. 1993; 9(2):918 (abstract no. PO-D28-4202);

Ian Gilbertson, Senior Medical Officer, Mhulume Sugar Estate, Swaziland, quoted in Toupouzis, D (1998) "The Implications of HIV/AIDS for Rural Development Policy and Programming: Focus on Sub-Saharan Africa." HIV and Development Programme, UNDP, June 1998.

Toupouzis, D (1998) "The Implications of HIV/AIDS for Rural Development Policy and Programming: Focus on Sub-Saharan Africa." HIV and Development Programme, UNDP, June 1998.

Whiteside A and G Wood (1994) "The Socio-Economic Impact of AIDS in Swaziland," Government of Swaziland, Mbabane.

For some smaller firms the loss of one or more key employees could be catastrophic, leading to the collapse of the firm. In others, the impact may be small. Firms in some key sectors, such as transportation and mining, are likely to suffer larger impacts than firms in other sectors. In poorly managed situations the HIV-related costs to companies can be high. However, with proactive management these costs can be mitigated through effective prevention and management strategies.

Impacts on Other Economic Sectors

AIDS will also have significant effects in other key sectors. Among them are health, transport, mining, education and water.

- **Health.** AIDS will affect the health sector for two reasons: (1) it will increase the number of people seeking services and (2) health care for AIDS patients is more expensive than for most other conditions. Governments will face trade-offs along at least three dimensions: treating AIDS versus preventing HIV infection; treating AIDS versus treating other illnesses; and spending for health versus spending for other objectives. Maintaining a healthy population is an important goal in its own right and is crucial to the development of a productive workforce essential for economic development.

    - The cost per patient per year is estimated to be E4,000 in Swaziland. Therefore, it is estimated that by 2000, the AIDS epidemic will result in an annual health care cost of E62.9 million, and by 2006, that cost will be E73.4 million. The effect of HIV-related illnesses accounted for 13% of the Ministry of Health budget in 1994. The overall effect of HIV/AIDS is expected to double the number of outpatient visits by 1999.

    - Another earlier study estimates that, in 1994, about 250 hospital beds would be required for adults due to AIDS and another 149 beds would be required for the pediatric AIDS cases, requiring a significant percentage of the 1,540 total beds in the country. By 1998, this study projected that over half of the hospital beds in the country would be taken by AIDS patients.

- **Transport.** The transport sector is especially vulnerable to AIDS and important to AIDS prevention. Building and maintaining transport infrastructure often involves sending teams of men away from their families for extended periods of time, increasing the likelihood of multiple sexual partners. The people who operate transport services (truck drivers, train crews, sailors) spend many days and nights away from their

---

Whiteside, A and G Wood (1994) "The Socio-Economic Impact of AIDS in Swaziland," Government of Swaziland, Mbabane.

Loewensen, A and A Whiteside. (1997) "Social and Economic Issues of HIV/AIDS in Southern Africa," SAfAIDS Occasional Paper No. 2, SAfAIDS, Harare, Zimbabwe.

Whiteside, A and G Wood (1994) "The Socio-Economic Impact of AIDS in Swaziland," Government of Swaziland, Mbabane.

families. Most transport managers are highly trained professionals who are hard to replace if they die. Governments face the dilemma of improving transport as an essential element of national development while protecting the health of the workers and their families.

- In Swaziland, the country is small enough that few truck drivers are required to spend the night away from home while working. There are two groups who are at risk however; those who make cross-border deliveries, and those who in transit from other countries.

- **Mining.** The mining sector is a key source of foreign exchange for many countries. Most mining is conducted at sites far from population centers forcing workers to live apart from their families for extended periods of time. They often resort to commercial sex. Many become infected with HIV and spread that infection to their spouses and communities when they return home. Highly trained mining engineers can be very difficult to replace. As a result, a severe AIDS epidemic can seriously threaten mine production.

  - Miners working in South Africa send a considerable amount of money home to Swaziland to support their families there; in 1983, 15.1 percent of rural incomes were derived from this source. As migrants become ill and unable to work in the mines, they will return home, and that income will be lost. High HIV prevalence will also reduce the number of new miners recruited from Swaziland to work in South Africa. Since miners have a relatively high prevalence rate, this will have a significant impact on household income.

- **Education.** AIDS affects the education sector in at least three ways: the supply of experienced teachers will be reduced by AIDS-related illness and death; children may be kept out of school if they are needed at home to care for sick family members or to work in the fields; and children may drop out of school if their families can not afford school fees due to reduced household income as a result of an AIDS death. Another problem is that teenage children are especially susceptible to HIV infection. Therefore, the education system also faces a special challenge to educate students about AIDS and equip them to protect themselves.

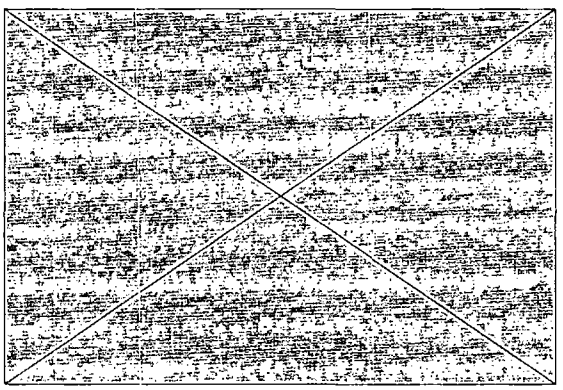
  - In 1994, there were 0.5% fewer six-year-olds entering school, as a result of the AIDS epidemic. That is expected to increase to 5.0% in 2000 and 16.6% by 2006.

Whiteside, A and G Wood (1994) "The Socio-Economic Impact of AIDS in Swaziland," Government of Swaziland, Mbabane.

Whiteside, A and G Wood (1994) "The Socio-Economic Impact of AIDS in Swaziland," Government of Swaziland, Mbabane.

Whiteside A and G Wood (1994) "The Socio-Economic Impact of AIDS in Swaziland," Government of Swaziland, Mbabane.

•



In Swaziland, between 1994 & 1996, the mortality rate among teachers was expected to rise from .78% to 1.18%. The number of AIDS deaths in this group was expected to rise from 75 to 129 within those same years. This was expected to result in a cost of E1.3 million for replacing ill teachers in 1994, and E2.4 million in 1996. Further, the cost of training additional teachers was estimated to be E1.4 milllion in 1994 and E2.6 million in 1996.

- One survey found that, in the early 1990s, the HIV prevalence rate among university students was 18.4 percent; it was predicted that most of these students would die within 10 years of their graduation. Thus the investment society has made in their human capital will not be fully realized.

- **Water.** Developing water resources in arid areas and controlling excess water during rainy periods requires highly skilled water engineers and constant maintenance of

---

Nkurlu, J.I. and Ilo Samat. "HIV/AIDS and Employment Policy and Practices". Prepared for Southern African Conference on AIDS and Employment, Harare, 28-30 November, 1994.

Whiteside A and G Wood (1994) "The Socio-Economic Impact of AIDS in Swaziland," Government of Swaziland, Mbabane.

Southern African Economist , 1997. "AIDS toll on regional economies," April 15-May 15, 1997.

wells, dams, embankments, etc. The loss of even a small number of highly trained engineers can place entire water systems and significant investment at risk. These engineers may be especially susceptible to HIV because of the need to spend many nights away from their families.

Macroeconomic Impact of AIDS

The macroeconomic impact of AIDS is difficult to assess. Most studies have found that estimates of the macroeconomic impacts are sensitive to assumptions about how AIDS affects savings and investment rates and whether AIDS affects the best-educated employees more than others. Few studies have been able to incorporate the impacts at the household and firm level in macroeconomic projections. Some studies have found that the impacts may be small, especially if there is a plentiful supply of excess labor and worker benefits are small.

There are several mechanisms by which AIDS affects macroeconomic performance.

- AIDS deaths lead directly to a reduction in the number of workers available. These deaths occur to workers in their most productive years. As younger, less experienced workers replace these experienced workers, worker productivity is reduced.

- A shortage of workers leads to higher wages, which leads to higher domestic production costs. Higher production costs lead to a loss of international competitiveness which can cause foreign exchange shortages.

- Lower government revenues and reduced private savings (because of greater health care expenditures and a loss of worker income) can cause a significant drop in savings and capital accumulation. This leads to slower employment creation in the formal sector, which is particularly capital intensive.

- Reduced worker productivity and investment leads to fewer jobs in the formal sector. As a result some workers will be pushed from high paying jobs in the formal sector to lower paying jobs in the informal sector.

- The overall impact of AIDS on the macro-economy is small at first but increases significantly over time.

- Life expectancy in Swaziland is projected to decline to 49.2 years in 2006, versus a life expectancy of 63.2 years in 2006 without the impact of AIDS. In 1991, life expectancy in Swaziland was 55.1 years.

Whiteside, A and G Wood (1994) "The Socio-Economic Impact of AIDS in Swaziland," Government of Swaziland, Mbabane.

- Since the economy of Swaziland is dependent on scarce skilled manpower and investment, it is predicted that the impact of AIDS will be severe. Migrant remittances from South Africa will decline and government spending will either increase in various sectors or have to be reallocated.

What Can Be Done?

AIDS has the potential to cause severe deterioration in the economic conditions of many countries. However, this is not inevitable. There is much that can be done now to keep the epidemic from getting worse and to mitigate the negative effects. Among the responses that are necessary are:

- **Prevent new infections.** The most effective response will be to support programs to reduce the number of new infections in the future. After more than a decade of research and pilot programs, we now know how to prevent most new infections. An effective national response should include information, education and communications; voluntary counseling and testing; condom promotion and availability; expanded and improved services to prevent and treat sexually transmitted diseases; and efforts to protect human rights and reduce stigma and discrimination. Governments, NGOs and the commercial sector, working together in a multi-sectoral effort can make a difference. Workplace-based programs can prevent new infections among experienced workers.

- **Design major development projects appropriately.** Some major development activities may inadvertently facilitate the spread of HIV. Major construction projects often require large numbers of male workers to live apart from their families for extended periods of time, leading to increased opportunities for commercial sex. A World Bank-funded pipeline construction project in Cameroon was redesigned to avoid this problem by creating special villages where workers could live with their families. Special prevention programs can be put in place from the very beginning in projects such as mines or new ports where commercial sex might be expected to flourish.

- **Programs to address specific problems.** Special programs can mitigate the impact of AIDS by addressing some of the most severe problems. Reduced school fees can help children from poor families and AIDS orphans stay in school longer and avoid deterioration in the education level of the workforce. Tax benefits or other incentives for training can encourage firms to maintain worker productivity in spite of the loss of experienced workers.

- **Mitigate the effects of AIDS on poverty.** The impacts of AIDS on households can be reduced to some extent by publicly funded programs to address the most severe

---

Whiteside, A and G Wood (1994) "The Socio-Economic Impact of AIDS in Swaziland," Government of Swaziland, Mbabane.

problems. Such programs have included home care for people with HIV/AIDS, support for the basic needs of the households coping with AIDS, foster care for AIDS orphans, food programs for children and support for educational expenses. Such programs can help families and particularly children survive some of the consequences of an adult AIDS death that occur when families are poor or become poor as a result of the costs of AIDS.

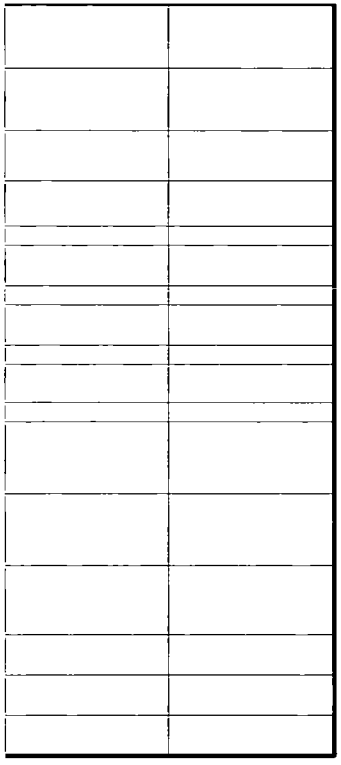
A strong political commitment to the fight against AIDS is crucial. Countries that have shown the most success, such as Uganda, Thailand and Senegal, all have strong support from the top political leaders. This support is critical for several reasons. First, it sets the stage for an open approach to AIDS that helps to reduce the stigma and discrimination that often hamper prevention efforts. Second, it facilitates a multi-sectoral approach by making it clear that the fight against AIDS is a national priority. Third, it signals to individuals and community organizations involved in the AIDS programs that their efforts are appreciated and valued. Finally, it ensures that the program will receive an appropriate share of national and international donor resources to fund important programs.

Perhaps the most important role for the government in the fight against AIDS is to ensure an open and supportive environment for effective programs. Governments need to make AIDS a national priority, not a problem to be avoided. By stimulating and supporting a broad multi-sectoral approach that includes all segments of society, governments can create the conditions in which prevention, care and mitigation programs can succeed and protect the country's future development prospects.

azil

Organization	Intervention								
	Advoc.	BCI	Care/S	Training	Cond.	SM	Eval.	HR	IEC
Cooperating Agencies									
Pathfinder International		X							X
PVOs/NGOs									
Media for Development International		X							X
IPPF/WHR				X					
Civil/Military Alliance to Combat HIV/AIDS	X							X	
Lutheran World Relief				X					X

MTCT	Research	Policy	STD	VCT	Orphan	TB	Other			
[redacted]										
[redacted]										
[redacted]										
[redacted]										
[redacted]										
[redacted]										
[redacted]										
[redacted]										



SWAZILAND

12 April 1999

Socio-Economic Data

Total population (thousand), 1997	906	UNPOP
% of population urbanized, 1996	32	UNPOP
Average annual growth rate urban population , 1980-1996	7	UNPOP
Infant mortality rate (per 1,000 live births), 1996	68	UNICEF/UNPOP
Maternal mortality rate (per 100,000 births),1990	560	WHO/UNICEF
Life expectancy at birth, 1996	59	UNPOP
Adult literacy rate, 1995	77	UNESCO
Per capita GNP (US§), 1995	1,170	World Bank
Human Poverty Index Value (HPI)		

Status of the Epidemic

HIV prevalence in selected populations in percent:

- Pregnant women (urban areas), 1996: 26
- Pregnant women (rural areas), 1996: 26.5
- STD patients (urban areas), 1994: 26
- STD patients (rural areas), 1994: 28.68

National Response

A National Aids Committee and a National AIDS Task Force is operational in the country. The National AIDS Programme is administered by the MOH.

UN Support

UN Theme Group:

Chair: Dr. A. Maruping, WHO Representative.

Support from UN in 1996-97:

Organization	Amount US$
WHO	
UNDP	
UNFPA	
WFP	
ILO	

UNESCO	
UNAIDS*	106,000
Total	106,000

PSR activities* **US$0**
Core support* **US$50,000**
SPDF*
Community home based care and counselling US$56,000

Support from UN in 1998-99:

Organization	Amount US$
WHO	
UNDP	
UNFPA	
WFP	
ILO	
UNESCO	
UNAIDS*	140,000
Total	140,000

PSR activities*

- **US$ .....**
- **US$ .....**

SPDF* Projects
- "Strengthening a multisectoral response", "Dual infection (HIV and TB) Prevention and Counselling Pilot Project", "AIDS Service Organization Capacity Building", "Young People's Mobilization against HIV/AIDS Epidemic","Support for people living with HIV and AIDS" - US$140,000

Other External Support

Bilateral organizations in 1996-97:

Organization	Amount US$

Total	

Bilateral organizations in 1998-99:

Organization	Amount US$
Total	