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UNCLASSIFIED

UNITED STATES INTERNATIONAL DEVELOPMENT COOPERATION AGENCY
AGENCY FOR INTERNATIONAL DEVELOPMENT
Washington, D. C. 20523

BOLIVIA

PROJECT PAPER

AIDS/SIDS PREVENTION AND CONTROL .
AMENDMENT NUMBER 1

AID/LAC/P-652
CR-439

PROJECT NUMBER: 511-0608

UNCLASSIFIED

AGENCY FOR INTERNATIONAL DEVELOPMENT
PROJECT DATA SHEET

1. TRANSACTION CODE
 A = Add
 C = Change
 D = Delete
 Amendment Number: 1
DOCUMENT CODE: 3

2. COUNTRY/ENTITY: BOLIVIA

3. PROJECT NUMBER: 511-0608

4. BUREAU/OFFICE: LATIN AMERICA & CARIBBEAN (LAC) 05

5. PROJECT TITLE (maximum 40 characters): AIDS/STDS PREVENTION AND CONTROL

6. PROJECT ASSISTANCE COMPLETION DATE (FACD): MM DD YY: 09 30 95

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
 A. Initial FY: 91 B. Quarter: 4 C. Final FY: 95

8. COSTS (\$000 OR EQUIVALENT \$1 =)

A. FUNDING SOURCE	FIRST FY			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	504	--	504	3,422	78	3,500
(Grant)	(504)	(--)	(504)	(3,422)	(78)	(3,500)
(Loan)	()	()	()	()	()	()
Other U.S.						
1.						
2.						
Host Country		--	--	--	1,676	1,676
Other Donor(s)						
TOTALS	504	--	504	3,422	1,754	5,176

9. SCHEDULE OF AID FUNDING (\$000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH CODE		D. OBLIGATIONS TO DATE		E. AMOUNT APPROVED THIS ACTION		F. LIFE OF PROJECT	
		1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan	1. Grant	2. Loan
(1) AIDS	510	590		--	--	3,096	--	3,096	--
(2) HE	520	563		500	--	404	--	904	--
(3)									
(4)									
TOTALS				500		3,500	--	4,000	--

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	BU	PVON	TNG	R/H	BW
B. Amount					

13. PROJECT PURPOSE (maximum 480 characters)

To expand access to, and the use of, effective STD/HIV control and prevention services and education in the departments of La Paz, Santa Cruz and Cochabamba.

14. SCHEDULED EVALUATIONS

Interim	MM	YY	MM	YY	Final	MM	YY	MM	YY
			11	93		05	95		

15. SOURCE/ORIGIN OF GOODS AND SERVICES
 000 941 Local Other (Specify)

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)
 This amendment expands the project focus to include other sexually transmitted diseases (STDs).

The USAID Controller has reviewed the methods of implementation and financing and the financial procedures described herein and hereby indicates concurrence.

John R. Davison
 John R. Davison
 Controller

17. APPROVED BY

Signature: *Garber A. Davidson*
 Title: Garber A. Davidson
 Acting Director

Date Signed: MM DD YY: 07 19 91

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
 MM DD YY

PROJECT AUTHORIZATION AMENDMENT No. 1

Name of Country/Entity: **Bolivia**
Name of Project: **AIDS/STDS Prevention and Control**
Number of Project: **511-0608**

Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, the AIDS Prevention and Control Project was authorized on July 26, 1988. The authorization is hereby amended as follows:

1. Paragraphs 1 and 2 of the authorization are revised to read:

- "1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the AIDS/STDS Prevention and Control Project for Bolivia, involving planned obligations not to exceed Four Million United States Dollars (\$4,000,000) in grant funds over a six-year period, subject to the availability of funds, in accordance with the AID OYB/allotment process. The planned life of project is extended to approximately seven years. A new Project Assistance Completion Date (PACD) is, therefore, established of September 30, 1995.**
- "2. This project will contribute to the goal of improving the health status of the Bolivian population, especially women of child bearing age and their children. The purpose of the project is to expand access to, and the use of, effective STD/HIV control and prevention services and education in the departments of La Paz, Santa Cruz, and Cochabamba. The revised project is designed to (a) collect reliable epidemiological data to define and track the extent of STD/HIV/AIDS problems, (b) detect, treat and/or counsel STD/HIV patients, (c) develop and disseminate general information and targeted education programs directed at promoting safe sexual behaviors and avoidance of drug abuse by injection, and (d) make condoms accessible on demand."**

~~4~~

2. Based on the financial plan and justification included in the Project Paper Amendment, Section III, and the description of Project activities and implementation arrangements in the Project Paper Amendment, local cost financing with appropriated funds is hereby authorized for the Project, as necessary to fulfill program objectives and to best promote the objectives of the Foreign Assistance Program.

Except as hereby amended, the authorization remains in full force and effect.

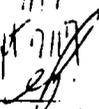

Garber A. Davidson
Acting Director
USAID/Bolivia

Date: 7/19/91

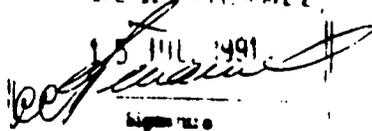
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72-1111021 LDGA-91-2551 -KG13 PA 060810089	\$ 400,000.00	(R091079)
72-1111021 LEHA-91-25511-KG13 PA 060810090	\$ 104,000.00	(R091080)

Clearances:

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ECON: C. Joel 7/17/91
in draft

FUNDS AVAILABLE
 15 JUL 1991

 Signature

0160B

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ABBREVIATIONS

AF	:	Dark Field
AIDS	:	Acquired Immuno Deficiency Syndrome
CENETROP	:	Centro Nacional de Enfermedades Tropicales, Santa Cruz, Bolivia
CIES	:	Centro de Investigación, Educación y Servicios
CUMETROP	:	Centro Universitario de Medicina Tropical, Cochabamba, Bolivia
ELISA	:	Enzyme-linked immunosorbent assay
EOPS	:	End of Project Status
ESF	:	Economic Support Funds
GOB	:	Government of Bolivia
HIV	:	Human immunodeficiency virus
HHR	:	Health and Human Resources Office (USAID)
IDU	:	Injecting drug user
IEC	:	Information, education and communication
IFA	:	Immuno-fluorescence assay
IHPO	:	International Health Program Office (CDC)
INLASA	:	Instituto Nacional de Laboratorios de Salud, MPSSP-La Paz, Bolivia
LOP	:	Life of Project
MOH	:	Ministry of Health (MPSSP)
MPSSP	:	Ministerio de Previsión Social y Salud Pública (MOH)
OR	:	Operations Research
PACD	:	Project Assistance Completion Date

PAHO/WHO : Pan American Health Organization/
 World Health Organization

PASA : Participating Agency Service Agreement

PD&I : Project Development and Implementation (USAID)

PTSJ : Prevention/Training Center in San Juan,
 Puerto Rico

RCO : Regional Contracting Officer (USAID)

RLA : Regional Legal Advisor (USAID)

SIDA : Síndrome de inmunodeficiencia adquirida

SM : Social marketing

STD : Sexually transmitted disease

S&T/H : Science and Technology Bureau, Office of Health (AID)

TA : Technical assistance

UNICEF : United Nations Children's Fund

USAID/B : United States Agency for International Development,
 Mission to Bolivia

U.S. CDC : United States Centers for Disease Control

USC : Unidad Sanitaria Cochabamba

USD : United States dollars

USSC : Unidad Sanitaria Santa Cruz

VDRL : Viral Disease Research Laboratory

WB : Western Blot test

CHAPTER I.

RECOMMENDATION AND PROJECT SUMMARY

A. SUMMARY RECOMMENDATION

USAID/Bolivia recommend that the AIDS/STDs Prevention and Control Project Amendment be approved.

The current AIDS Prevention and Control Project began in FY 1988 and provided \$500,000 through February 1992 for counseling training, condom marketing, redesigning the MOH blood screening strategy, HIV testing, HIV surveillance, and initial information, education, and communication (IEC) activities. The amended project will increase the AID contribution to a total of \$4.0 million, establish a new Project Assistance Completion Date (PACD) of September 1995, and expand the focus to include other sexually transmitted diseases (STDs). This amendment was included in the USAID/BOLIVIA Action Plan for FY 1992-1993, which was approved in State 15009 of 8 May 1991.

A U.S. direct hire officer and a Bolivian PSC secretary will manage the Project for USAID/B, within the office of Health and Human Resources. Funds are budgeted for evaluations, secretarial support, and project-related studies and logistical support.

B. PROJECT SUMMARY

The current project has provided \$396,000 to the Government of Bolivia (GOB) in support of its Medium Term Plan for AIDS Surveillance and Prevention, which was developed with assistance from the Panamerican Health Organization (PAHO). The amended AIDS/STD project will emphasize technical and material assistance through an add-on with the AIDS Technical Support Project, No. 936-5972 (\$2.8 million) and a PASA with the Centers for Disease Control (\$0.4 million). The proposed activities reflect the lessons learned over the past four years of AIDS/STD prevention and control experience, including condom accessibility, condom coverage, partner reduction, and improved STD/HIV diagnostics and treatment.

The devastating consequences of unchecked HIV infection are well documented and are threatening the South American continent. While less than twenty cases of AIDS have been reported to date in Bolivia, little is known about the prevalence of human immuno-deficiency virus (HIV) and related sexually transmitted disease (STD) infections or about the knowledge, attitudes, and behaviors of high risk populations. This is very significant given the five to seven year average incubation period between HIV infection and the onset of AIDS symptoms. During this extended period, the virus can be passed on through sexual intercourse, blood, and perinatal contact.

Extramarital male-female sexual relations are known to be common, male-male sexual contact is less understood, but thought to be significant, and injecting drug use has grown considerably in the past decade. Bolivia's proximity to and commercial (and social) contacts with Brazil (with a high HIV rate per capita), together with the lack of adequate diagnostic and screening capabilities, make it particularly susceptible to this insidious epidemic.

Bolivia offers an exceptional opportunity to develop a model program for AIDS/STD prevention and control before the problem gets out of hand. The goal of the proposed project amendment is to improve the health status of Bolivians, especially women of child bearing age and their offspring. The purpose of the proposed project amendment is to expand access to, and the use of, effective STD/HIV control and prevention services and education in the departments of La Paz, Santa Cruz, and Cochabamba. The amended project is designed to (a) collect reliable epidemiological data to define and track the extent of STD/HIV/AIDS problem, (b) detect, treat and/or counsel STD/HIV patients, (c) develop and disseminate general information and targeted education programs directed at promoting safe sexual behaviors and avoidance of injecting drug abuse, and (d) make condoms accessible on demand.

The project has the following major components: (1) the formation of one national and three regional advisory committees, (2) the strengthening of three STD/HIV reference laboratories in the cities of La Paz, Santa Cruz, and Cochabamba, (3) the development and operation of three model STD/HIV clinics in the same cities, (4) the development of a sentinel surveillance system, (5) training health workers in detection, treatment and counseling, (6) providing STD/HIV counseling and outreach services, (7) developing and implementing information, education and communication programs, and (8) the social marketing of 2.0 million condoms.

The final decision as to how this project will be implemented is still open because the buy-in/add-on contractor has not yet been selected and the final instrument has not yet been negotiated. The CDC PASA option seems viable only for those portions of the project that relate to its specialties (e.g., STD laboratory testing, etc.). The rest of the project components should be implemented via the S&T/H/AIDS contractor that can manage all other aspects (e.g., education, equipment purchases, etc.).

The development and operation of a comprehensive blood bank system was considered to be too costly and of relatively limited benefit to be included in the present project. The feasibility of such a system in the future will be explored with PAHO, the Ministry of Health, and other donors. Close collaboration will be maintained with both the Technical Advisors in AIDS and Child Survival Project (TAACS) and the Drug Awareness and Prevention Project (No. 511-0631). Regarding the latter in particular, there is considerable potential for cooperation with respect to survey research needs and target population interventions. Both projects are planning extensive education and communication programs.

CHAPTER II.

PROJECT RATIONALE AND DESCRIPTION

A. PROJECT RATIONALE

The control of major Sexually Transmitted Diseases (STDs) offers two benefits: the reduction of mortality and morbidity associated with STDs; and the slowing of the progression of HIV infection because of the increasing evidence that STDs facilitate the spread of HIV.

STDs are major contributors to mortality and morbidity among adults and infants in many developing countries. There are more than thirty recognized STDs and STD syndromes. Among these the most common are gonorrhea, genital herpes, chlamydia, syphilis, trichomoniasis, and chancroid. In developing countries, these diseases often remain untreated causing prolonged symptoms which frequently result in serious complications. For example, pelvic inflammatory disease (PID) is usually caused by treatable but ignored infection with Neisseria gonorrhoeae (NG) complicated by Chlamydia trichomatis (CT). Such serious infection of the uterus and the fallopian tubes leads to infertility in about 12% of first infections. Also, pregnant women infected with syphilis transmit it to their infant resulting in stillbirth in 40% of the cases. Gonococcal infection during pregnancy results not only in frequent adverse birth outcome but also contributes to the development of blinding gonococcal eye infection in infants. Finally, prolonged infection with untreated STDs increases the opportunity for infection of sexual partners, thus contributing to the propagation of the diseases.

Selected STDs, particularly the most common infections found in developing countries, have been shown to facilitate the acquisition or transmission of HIV. STDs causing abrasion of the skin, mucosa of the vagina or the cervix in women or of the urethra in men, destroy the natural protective barrier thus allowing the entry or exit of HIV. The mechanical disruption is augmented by bleeding (HIV is found in blood) and concentration of inflammatory cells (containing HIV) at the site of the infection. The degree of facilitation can be striking. In one study of uncircumcised males in Kenya, 43% of men who had one encounter with prostitutes (85% of whom were HIV positive) seroconverted (Schmid, May 1991).

In Bolivia, traditional STD and HIV control programs have been centered on the public sector with some involvement of the private sector. Prior to 1980, the public sector focus was very narrow and limited to sanitary

control. This included screening of food handlers and of prostitutes. In the mid-1980s, the Ministry of Health nominally incorporated HIV into the program. This change became consequential only in the late 1980s when USAID/Bolivia provided seed funding to enhance HIV screening and public education on AIDS. In the private sector, USAID funds allowed NGOs to expand in two new directions: social marketing of condoms and better understanding of reproductive health through social research. In 1990, the Ministry of health, with assistance from the Panamerican Health Organization, developed a Medium Term Plan (MTP) for AIDS Surveillance and Prevention in Bolivia. The MTP, however, has not yet been officially approved.

Currently there are only two categorical STD clinics in Bolivia, both located in La Paz. The clinics mostly serve food handlers and prostitutes for whom periodic screening is mandatory. Unfortunately, the prevalence and incidence of STDs and HIV in Bolivia is difficult to determine because of the paucity of reliable epidemiological information.

The premise of the proposed project amendment is that the strengthening of the STD/HIV control program in Bolivia will contribute to improving the health of the Bolivian population. However, before significant program expansion and impact can occur, the basic STD/HIV disease control infrastructure must be properly established and maintained. Also, major high risk groups and practices must be identified and the extent of STD/HIV infection must be quantified. Bolivia offers an exceptional opportunity to develop a model program AIDS/STD prevention and control before the problem gets out of hand.

B. PROJECT GOAL, PURPOSE AND END OF PROJECT STATUS

This project will contribute to the mission sector goal of improving the health status of the Bolivian population, especially women of child bearing age and their children. The purpose of the project is to expand access to, and the use of, effective STD/HIV control and prevention services and education in the departments of La Paz, Santa Cruz, and Cochabamba. The amended project is designed to (a) collect reliable epidemiological data to define and track the extent of STD/HIV/AIDS problems, (b) detect, treat and/or counsel STD/HIV patients, (c) develop and disseminate general information and targeted education programs directed at promoting safe sexual behaviors and avoidance of injecting drug abuse, and (d) make condoms accessible on demand.

The focus of project activities will be a reinforced reference laboratory and the development of a model STD/HIV clinic in each of the three targeted cities, where STD/HIV diagnosis, treatment, counseling, and prevention services will be provided. The three locations have been

selected because of the probable concentration of STD/HIV infections in the major urban centers and because there is already a basic infrastructure in place. Indeed INLASA is the national center for STD/HIV testing and management. CENETROP and CUMETROP both have substantial laboratory and clinical facilities in place with existing community outreach programs.

A most important factor in the selection of the three target locations is the knowledge that the population of these localities is vulnerable to the penetration of HIV and already has a substantial need for STD services. All three locations are located in growing urban areas. These urban areas have extensive commercial traffic and many contacts with neighboring countries where the AIDS epidemic is more advanced than in Bolivia. La Paz, Santa Cruz, and Cochabamba are perceived as potential points of entry and spreading of AIDS.

The end of project status indicators expected by the PACD (1995) are as follows:

1. Three reference STD/HIV laboratories strengthened in La Paz, Santa Cruz and Cochabamba
2. Three reference STD/HIV clinics strengthened in La Paz, Santa Cruz and Cochabamba
3. 1,500,000 condoms sold through social marketing program
4. 500,000 condoms distributed free
5. 32,700 HIV tests conducted
6. 78,900 Gonorrhoea tests conducted
7. 5,200 Herpes tests conducted
8. 5,200 Trichomoniasis tests conducted
9. 87,700 Syphilis tests conducted
10. 14,900 Chlamydia tests conducted
11. 22,800 Hepatitis tests conducted
12. 3,600 Chancroid tests conducted
13. 80,000 clinic patients counseled

C. ELEMENTS AND OUTPUTS

The proposed project is based on institutional development, the reinforcement of existing structures and personnel, and improving the effectiveness of services through systematic information, education, and operations research (OR) activities. Bolivian health workers will be empowered through technical and management training and through access to well supplied and organized laboratories and clinics and locally developed IEC materials. Their work will be facilitated by the development of coherent strategies to address the management, prevention, and control of STD/HIV in the three project target areas.

1. National and Regional STD/HIV Committees

In order to ensure that primary interested parties, from the public and private sectors are tangibly involved in the project and to promote coordination with national programs, four STD/HIV committees will be formed and/or strengthened:

- A national STD/HIV program committee, to provide policy direction and coordination; and,
- Three regional committees, providing guidance and oversight of project activities in La Paz, Santa Cruz, and Cochabamba.

These committees will be established at the onset of the project by MOH and will be staffed by technically appropriate persons from the government, health care institutions, the medical community, and non-governmental assistance organizations. Committee membership will be composed of six to eight professionals and community leaders committed to controlling the spread of STD/HIV infections in Bolivia and willing to serve on the committees on a voluntary basis.

The charge of the committees will be to review the broad STD/HIV intervention strategies developed under the project and to ensure coordination and consistency with the national program. The committees will coincide with the existing national and planned regional STD/HIV committees of the Ministry Health.

As the need arises subcommittees will be created and charged with managing issues dealing with specific components of the programs proposed under this project. Examples of issues to be considered by the subcommittees are described in detail in the STD/HIV Management and Control Strategies Section. They include policy decisions concerning the development of a fee-for-service system, partner notification, community outreach efforts, and conditions for free condom distribution.

2. Reference Laboratories

Three reference laboratories have been selected, and will be strengthened to offer a whole range of STD microbiologic and serologic tests. They will work closely with the model clinics, will provide training for personnel at other laboratories, and will also provide support for special studies. (See Table 2.1.)

The INLASA laboratory in La Paz will serve as STD/HIV reference laboratory for the entire country and offer research laboratory techniques not available elsewhere.

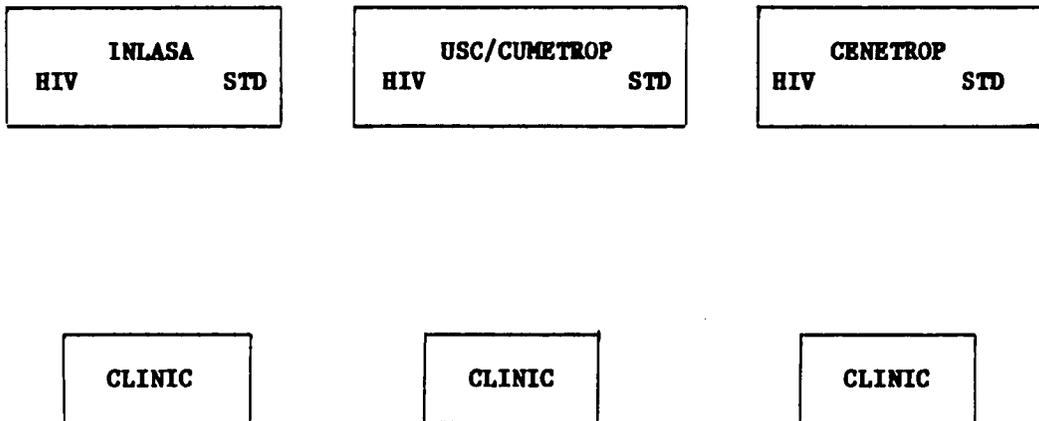
The GENETROP laboratory in Santa Cruz will participate as a regional STD/HIV reference laboratory for Eastern Bolivia. Likewise, the CUMETROP laboratory in Cochabamba will function as a regional STD/HIV reference laboratory for Central Bolivia. These institutions will be linked through the establishment of a National Network and Reference Center.

The project will build on the experience of AIDSTECH/FHI, PAHO/WHO and other organizations providing assistance to Bolivia. In 1990 AIDSTECH/FHI and PAHO/WHO jointly sponsored and conducted two workshops in La Paz and Santa Cruz, where a total of 56 biochemists, physicians, and technicians were trained. The results obtained at both workshops led to the following conclusions, which will be supported by this project:

- a. 1) Support the establishment of a national Network and Reference Center through the national institutions (Ministry of Health - INLASA) and through non-governmental organizations (NGOs).
- 2) Establish quality control and proficiency guidelines throughout the network.
- 3) Provide continuous supervision to the different levels of the laboratory network.
- 4) Periodically evaluate the implementation and results of corrective measures.
- 5) Organize an external evaluation to strengthen weak areas in both theoretical and practical issues.
- 6) Implement mechanisms favoring continuing education of the personnel in the network on technological advances related to HIV and STD diagnostics.

TABLE 2.1

**PROPOSED LABORATORIES TO BE STRENGTHENED FOR STD/HIV
PREVENTION AND CONTROL IN BOLIVIA, USAID/LA PAZ**



Legend:

- INLASA** = Instituto Nacional de Laboratorios de Salud, La Paz
- USC/CUMETROP** = Unidad Sanitaria Cochabamba/Centro Universitario de Medicina Tropical
- GENETROP** = Centro Nacional de Enfermedades Tropicales, Santa Cruz

Building on this experience and through technical assistance provided by the CDC, with MOH participation, a system of laboratory quality assurance will be developed. The three STD/HIV Reference Laboratories will be upgraded with equipment, supplies, and reagents (see Annex 6: Procurement List). A total of 32,700 HIV tests and 618,300 STD tests will be conducted by the project (Table 1, Annex 6).

The above laboratory equipment, supplies, and reagents will enable three reference laboratories to perform culture for gonorrhea, including PPNG and/or antimicrobial resistance determination, and trichomonas, and chlamydia testing with nonculture ELISA test. The major reference laboratory (INLASA) will have chlamydia and herpes simplex virus culture capability. These target laboratories will be able to perform serology for HIV-1 and HIV-2, nontreponemal and treponemal tests, chlamydia complement fixation for LGV, hepatitis B; and hepatitis C.

Additionally, three model clinic laboratories associated with the reference laboratories will be supplied with selected equipment and reagents to enable them to culture all patients for gonorrhea, perform wet mounts and Gram stains, and perform syphilis serology on them, assuming most are women.

Existing personnel of the three reference laboratories and model clinic labs will be reinforced to include a minimum of two full time microbiologists or biochemists at each lab (consistent with Bolivian professional/technical standards). New and existing personnel will be trained as described in Section 5 below and Table 3.4, Annex 8.

3. STD/HIV Model Clinic

The project will support the development/reinforcement of three model STD/HIV clinics in La Paz, Santa Cruz, and Cochabamba.

By the end of the project the three clinics should have the infrastructure, the personnel and the demand for services to process approximately 60 patients per day (est. 25,000 per annum and per clinic). Over the life of the project it is anticipated that an estimated 80,000 patients will be served by the project as the three model clinics progress from their current case load to their proposed end of project case load.

The three clinics will provide the following services that will be phased in as the personnel is identified and trained, and as equipment, supplies and reagents are put in place:

- STD diagnosis and treatment;
- HIV diagnosis and management;
- STD/HIV Counseling; and
- Community outreach.

The following tests will be performed at the clinics laboratories focusing on screening of patients: GC Media tests, GC PPNG tests, syphilis RPR tests and bright and dark field microscopy. For all other tests and confirmatory diagnosis, samples will be collected at the clinics and forwarded to the reference laboratories according to Standard Operating Procedures.

The existing personnel of the model clinics will be reinforced to include a physician/epidemiologist, three clinicians, two social workers (education/counseling coordinators), a data manager and a secretary, in addition to regular nursing, laboratory and support personnel. New and existing personnel will be trained as described in Section 5 below.

Patients who are served at the model clinics will receive systematic counseling and follow up. The counseling programs will be developed, coordinated and reviewed periodically by the education/counseling coordinators. Counseling programs will be designed to encompass the results of the sentinel surveillance studies and of the focus group research and KAP surveys. Section 6, below, describes the elements of the counseling program.

Plans for targeted community outreach will be made to ensure larger community participation in the program and to provide education and prevention services. Community outreach activities will be developed on an as needed basis (see Section 7 for details). The model clinic will also be the focus of sentinel surveillance data collection efforts as well as other programmatic research (see Section 4 for details)

4. STD/HIV Sentinel Surveillance

The existing Bolivian STD/HIV surveillance system has many problems. The system lacks sensitivity, timeliness, and overall accuracy. The surveillance system is not unlike many other systems currently in place all over the world, and is described in detail in the consultation report of William Boyd (March 1991 Annex 5). To improve the system will require work on four fronts:

- a. Reinforcement of **medical management** will be accomplished through the development of STD/HIV Management and Control Strategies.
- b. Reinforcement of **laboratory facilities** will be accomplished through the development of improved laboratory procedures and institution of a Quality Assurance System.
- c. Reinforcement of **epidemiological surveillance strategies** will be accomplished through the selection of appropriate samples sizes, suitable high risk target groups to be tested and appropriate time frame and periodicity to conduct sentinel surveillance studies. Clinical and laboratory data will be obtained from the three model laboratories and clinics. Some data will be collected in other locations after the design of suitable Sentinel Surveillance program for Bolivia.

An epidemiology sub-committee will be formed to review existing epidemiological data available, then the sub-committee will develop a plan to determine:

- The priority STD/HIV parameters to be monitored by the sentinel surveillance program (key sub-populations, CC and PPNG, antibiotic resistances, syphilis, chlamydia, herpes, hepatitis, GUD, Chancroid, Trichomoniasis, cervical dysplasia, various genital cancers...);
 - The type of sub-populations to be sampled (this could include high risk groups such as prostitutes, known homosexual groups, owners of strip joints/bars, and other target sentinel populations such as pregnant women consulting for prenatal care at key locations, newborn infants at key locations, selected hospital populations, selected military personnel...);
 - The most appropriate periodicity of sentinel surveillance studies taking into account financial and other resource limitations versus the need to monitor the progression of various STDs and AIDS;
 - The most suitable sample sizes to enable good epidemiological analysis;
 - A plan to collect samples and conduct laboratory tests without disrupting normal clinic and laboratory schedules;
 - A study analysis and follow-up action plan.
- d. Reinforcement of the **data management system** will be accomplished by the development of guidelines for STD/HIV reporting systems, the design and production of data collection instruments at all levels (clinics, labs, epidemiological surveillance unit of the MOH, and other parts of the system as needed), the development or adaptation of hardware/software systems to process and analyze the data. Particular attention will be placed on developing systems to deal with patient follow-up and referral and partner notification in collaboration with the STD/HIV committees as discussed in Sections 1 (above).

All stages of development of the Sentinel Surveillance Program will be closely coordinated with the MOH Division of Epidemiology.

5. STD/HIV Health Worker Training

The project staff will plan and conduct a series of conferences, workshops, and short courses for MOH and NGO personnel involved in project activities. On-the-job training will also be a necessary part of project activities. All training will draw heavily on feedback during Quality Assurance reviews in the laboratories and at the clinics. The technical assistance provided the technical support contractor and CDC, in both laboratory/clinic and IEC areas, as well as the interventions undertaken outside of the STD/HIV clinic settings will also provide a source of formal and informal education and training.

Priorities for training will be set in a dynamic way, taking into account changes in personnel, epidemiological and communication research findings, quality assurance system assessments, diagnostic and treatment algorithms developed and modified, and changing technology during the life of the project.

The major training priorities that were considered during the development of the project include, but are not limited to:

- STD/HIV laboratory diagnostic techniques;
- STD/HI clinical diagnosis and treatment;
- STD/HIV counseling and follow up;
- focus group, KAP and intercept survey methods;
- relevant microcomputer software systems;

Key individuals will receive training in STD/HIV clinical and laboratory management of STDs/HIV at the CDC Puerto Rico STD Training Center. Counseling training may best be handled by a repeat visit of an outside consultant, who will be faculty for a series of counseling workshops. Some of the focus group research can be used to modify the curriculum from the previous counseling workshops organized by AIDSCOM. The focus group and survey methodologies and software training may best be conducted either in-country experts or by outside consultants.

It will be important to ensure that both MOH and NGO individuals involved in the project have access to necessary training opportunities.

6. STD/HIV Counseling

Approaches to counseling persons with STDs, HIV infection, and AIDS will be developed locally using Bolivian as well as consultant experts. These approaches may vary by sub-population and patient pathology and other factors. Counseling approaches will be developed and modified using results of sentinel surveillance studies, KAP surveys, focus group research and other reproductive health background studies available in Bolivia. Decisions regarding partner notification will be made by the STD/HIV committees. Counseling approaches will take these decisions into consideration.

Clinical and medical support staff will be trained in STD/HIV patient counseling. A counseling course will be developed and conducted in each of the three project target areas. The course will be offered once or twice yearly as needed. The first course will be offered as soon as possible when the project is initiated. The training program in counseling will focus on:

- strengthening participants knowledge of STDs and HIV;
- knowledge of high risk group attitudes and behavior;
- instructing counselors in interpersonal communications skills, including verbal and non-verbal communication;
- problem identification and resolution; and,
- development of special skills to emphasize risk reduction, appropriateness of response to symptoms, compliance with treatment regimen and self referral of contacts.

The counseling courses will be developed with short term technical assistance and will be conducted by project personnel supported by the advisors. Funds for travel expenses, per diem, and materials have been included in the project account local operations under MOH Training. Efforts will be made to institutionalize the course and to also periodically update and review the course curriculum. A set of materials will be developed to support the training processes. The material will be modular to ensure easy updating and additions.

7. Communication Strategies and Prevention Programs

The primary emphasis of this project is to increase the formal diagnosis and treatment of STDs in general and specifically those STDs that are known to be important co-factors in HIV transmission. In addition, the project strives to establish reliable prevalence rates for STDs and HIV infection by attracting/convincing high risk individuals to be tested.

Minimally, the following knowledge, attitude and behavior changes need to take place in order to achieve these ends:

- a. sexually active individuals need to be able to recognize symptoms and signs of potential STDs, both in themselves and in their sexual partners;
- b. these individuals need to know that these symptoms and signs may increase their risk of transmitting or becoming infected by the HIV virus, and
- c. that eventually most STDs become asymptomatic even without treatment, but that the risks of HIV transmission may remain elevated;

- d. that only sophisticated diagnosis and treatment can be expected to adequately treat STDs;
- e. appropriate and effective diagnosis and treatment is available at the three project supported locations.;
- f. that services will be provided confidentially and patients will be treated with dignity;
- g. condom use with all (not just selected) partners will also reduce STD/HIV transmission;
- h. sexually active persons will need to learn the manual skills for appropriate condom use, the skills to negotiate with their partner for condom use, and practical information to safeguard condom integrity;
- i. the standard facts about HIV transmission and AIDS also need to be known.

This project will utilize various communication strategies to encourage at-risk individuals to seek diagnosis, treatment and counseling at the three project supported clinics. It is expected that the clinics will not be able to easily access members of some high risk groups without the assistance of NGOs with a track record of working with those groups. Consequently some of the communication strategies will involve NGO assistance in education and behavior modification with referral to the clinics for diagnosis and treatment. It is possible that some "marginalized" groups (e.g. some categories of gay males and unregistered prostitutes) will not be willing to seek diagnosis and treatment at a public clinic, or at least not early in the project, until the project clinics have demonstrated their ability to maintain confidentiality and provide care in a manner that does not patronize or show prejudice or violate confidentiality.

The following communication strategies will be considered during this project, and should be designed and coordinated by advisors or agencies with experience in the various technologies:

Mass Media

Radio and television: According to CIDEM, a market research firm, approximately 90% of homes in the three cities have a TV or a radio. Consequently it can be assumed that appropriately aired materials should be able to reach a large proportion of the target area populations. A publicity firm, with a track record in health communications, will be contracted to write a creative brief based on small surveys (such as intercept surveys) and focus group research in sexually active adults. Once the creative brief is agreed upon, TV and radio spots can be developed using state-of-the-art techniques. CIDEM already has rating

surveys showing listening preferences by age, sex, location and income status. For a fee this data can be utilized by the publicity agency to make decisions about appropriate broadcast times. Technical assistance will be necessary through the process.

Messages will be aimed at sexually active individuals and injecting drug users within the general population in the three cities. Messages will emphasize the associations between STDs, dirty needles, infected blood, and HIV/AIDS. They will also describe common STD symptoms and signs, encourage immediate confidential testing at the designated sites, and encourage STD/HIV diagnosis and treatment in persons who may have an untreated, but still active STD (this last idea would have to be stringently tested for cost-efficiency, as it could unnecessarily overburden services with "the worried well").

Print Materials

It will be necessary to review existing print materials for their utility in the current project. If existing materials are inappropriate it will be necessary to develop materials that can be seen by the general public and as well as specific high risk groups and encourage the appropriate utilization of the designated STD clinic. Examples might be posters and leaflets that can be given to youth groups and at schools.

Depending on focus group and pre-test results, different materials might have to be developed for specific high risk groups. It can be reasonably assumed that specialized print materials will have to be developed for female sex workers and some categories of men who practice sex with other men. Other groups such as military recruits might also need special materials.

Interpersonal Strategies

There are a large variety of different interpersonal communication strategies that will be effective in the Bolivian context:

- a. Clinic-based counseling. The support for at least two counselors per clinic is included within the budget for MOH personnel.
- b. NGO-based counseling will be necessary because of the special population groups that certain NGOs can reach. Peer counselors will often be trained and used by these groups;
- c. Lectures and seminars will be given at schools and universities, at places of work and to other community groups, including decision-makers, such as the press, medical societies, religious groups, and so forth;

- d. Various types of competitions can be developed, e.g. songs, poetry, plays, and art where the theme is consistent with the focus of this project;
- e. This project will train individuals who have many different sex partners in condom use and partner negotiation skills. Focus group research will be necessary to plan the intervention in the various sub-groups that will receive training. Once there are cohorts of individuals negotiating condom use it will be valuable to repeat some of the focus group research as new strategies and techniques will emerge. Long-term (six months to a year) follow-up of these groups will be useful to determine the level of maintained behavior change.

8. Social Marketing of Condoms

A contract will be developed with the SOMARC/PROSALUD to reinforce and expand the existing social marketing of condoms. The social marketing (SM) of condoms for STD/HIV prevention started in 1990 with seed funding from the USAID-sponsored reproductive health program. PROSALUD distributed only STD/HIV prevention condoms because they did not wish to create competition between a Family Planning SM condom and the STD/HIV prevention condom. Presumably the packaging of two types of condoms would have complicated the accounting and management of the SOMARC/Bolivia project. This activity was viewed as an initial phase. Plans for future activities are to be designed after review of the first year experience.

The condoms for this initial phase were obtained from AID/S+T/POP and packaged by PROSALUD (the packaging was printed in Colombia). A total of 3.4 million condoms were donated, of which about 400,000 have been distributed to date. The retail price of the condoms is one boliviano (\$.28) per package of three. Two million additional condoms will be purchased by the project. SOMARC/PROSALUD will be invited to develop a detailed plan for the marketing of these condoms. PROSALUD will work in close collaboration with the project management to take full advantage of focus group research and other relevant programmatic research information developed in the project. A coordinated strategy will be developed for the pricing of condoms and for the distribution of free condoms to ensure that the social marketing effort is supported and promoted by the overall project.

CHAPTER III.

COST ESTIMATE AND FINANCIAL PLAN

A. LIFE OF PROJECT COST ESTIMATES

Life of project (LOP) costs are estimated at \$5.176 million total USD, to be expended between August 1991 and September 1995. (See Table 3.1.) Of the total, AID will provide \$3.5 million (67.6%), the host country cash contribution will be \$1.3 million (25.9%), and the in-kind contribution is estimated at \$0.3 million (6.5%). A detailed explanation of the budget is provided in Annex 8.

1. AID Cost Estimates

The largest portion of AID funds (35.4%, \$1.2M) will provide four P/Y of long term and 32 P/M of short term technical assistance, primarily to Ministry of Health STD/HIV laboratory and clinic personnel and to non-governmental organization (NGO) personnel involved in information, education, and communication (IEC) activities.

An estimated \$0.8M (22.2%) will be used to purchase equipment, supplies and reagents (see Annex 6) for three MOH reference laboratories and model clinics, and 2.0 million condoms. Local operations costs (3 project staff, travel, office space, supplies, etc.) will amount to \$0.6M (16.7%), and \$0.6M (16.1%) will be available for sub-project grants to NGOs for IEC, social marketing (SM), and operations research (OR) activities.

Additional funds will cover the costs of training MOH and NGO personnel (\$0.1M, 3.1%) and will provide secretarial, logistics, and evaluation support by USAID/HHR (\$0.2, 6.6%).

2. Host Country Cost Estimates

The Government of Bolivia (GOB) is expected to contribute \$1.6M towards the implementation of this project, and local NGOs an additional \$80,000. (See Annex 8, Table 3.4). Most of the GOB contribution (\$1.0M) will support the operational costs of the STD/HIV reference labs and model clinics (personnel, supplies, equipment, etc.). USAID/HHR expects that \$590,485 of the cash portion of this contribution (11.4% of the total project cost) may be financed from Economic Support Funds (ESF).

3. Financial Plan

The financial plan for this Project is shown below in tables:
(1) Original Project Budget, (2) Estimated Budget by Object and Program Year; (3) Life of Project Cost Estimates and Financial Plan; (4) Disbursement Schedule and Projection by USG Fiscal Year; (5) Methods for Implementation and Financing; and (6) Estimates of Host Country Contributions. Additional discussion found in Annex 8.

TABLE NO.

ORIGINAL PROJECT BUDGET

<u>Element</u>	<u>Programmed</u>
1. Personnel Support	60,000
2. Technical Support	164,500
3. Lab supplies/equipment	124,580
4. Education Material	150,920
	<hr/>
	500,000

TABLE NO. 3.3

DETAILED BUDGET FOR PROJECT AMENDMENT
USAID MISSION TO BOLIVIA
AIDS/STDS PREVENTION AND CONTROL PROJECT

Estimated Budget by Object and Program Year, AID Funds (in US dollars)

Management Unit/Object	Notes	Year 1	Year 2	Year 3	Year 4	TOTAL
A. ADD-ON TO AIDS TECHNICAL SUPPORT PROJECT (No. 936-5972)						
1. Technical Assistance:						
Long term PH advisor	a	83,500	86,800	90,300	93,900	354,500
PHA allowances	b	60,500	40,500	44,200	68,600	213,800
Short term TA	c	36,000	37,000	38,900	40,500	152,800
Sub-total		180,000	164,000	173,400	203,000	721,100
2. Commodities:						
Lab equip. & supplies	d	105,300	32,100	43,400	49,400	230,200
Lab reagents	e	155,000	155,000	0	0	310,000
Sub-total		260,300	187,100	43,400	49,400	540,200
3. Local costs:						
Bolivian staff (3)	f	48,000	49,900	51,900	54,000	203,800
Operations	g	93,590	61,700	60,100	66,750	282,140
MOH training	h	25,000	20,800	21,600	22,400	89,800
NGO sub-projects	i	75,000	78,000	81,100	84,400	318,500
Condom marketing	j	75,000	75,000	0	0	150,000
Sub-total		316,590	285,400	214,700	227,550	1,044,240
4. Multiplier 20%		151,378	127,440	86,300	95,990	461,108
TOTAL BUY-IN		908,268	764,640	517,800	575,940	2,766,648
B. CDC PASA						
Short term TA	l	78,000	81,100	56,200	58,500	273,800
Program support	m	10,764	11,192	7,756	8,073	37,784
Overhead 20%	n	17,753	18,458	12,791	13,315	62,317
TOTAL CDC		106,517	110,750	76,747	79,888	373,901
C. USAID/BOLIVIA						
Secretary & logistics	o	18,000	19,000	20,000	21,000	78,000
Condoms	p	30,000	31,200	32,400	33,700	127,300
Evaluations & special studies, etc.	q	12,000	62,500	13,000	66,651	154,151
TOTAL USAID		60,000	112,700	65,400	121,351	359,451
GRAND TOTAL		1,074,785	988,090	659,947	777,179	3,500,000

NOTE: No funds have been provided for audits since this Project will be implemented thru Add-ons to a Central AID/W Project or PASA to CDC.

AIDS/STD PREVENTION AND CONTROL PROJECT

Explanatory Notes for Budget Amendment Table

- a. Base salary of \$55,660 ; 25% fringe benefits ; 25% post differential, with 4% annual increase.
- b. See attached detail of LT/PHA allowances. Allowances are normal and customary for the USAID/Bolivia Mission, including \$37,800 to be disbursed by contractor HQ and \$176,000 to be disbursed by the project field office in Bolivia.
- c. Short term TA calculated at \$12,000 per month (30 days at \$250 per day, including 24 days in the field and 6 days preparation and travel, and \$4,500 travel and per diem) for the first year with 4% annual increase for inflation.

Based on the above, each year represents 3.0 months of ST/TA, including 2.0 months for IEC planning, sub-project design and Ta, and evaluative research, and 1.0 months for operations research, cost recovery studies, and other as needed.

- d. See Annex 6 for detailed lists and summary budget of requested laboratory equipment, supplies, and reagents. The CDC draft report recommended the purchase of \$277,450 in lab equipment and computers based on what is ideally needed by standard HIV/STD reference and clinic laboratories. The proposed AIDSTECH laboratory equipment and supply survey will establish that some or many of the items recommended by CDC are already available. For budgeting purposes, the requested amount has been reduced by nearly one-third in anticipation that an equivalent amount of recommended equipment is already in place.
- e. The CDC report estimated \$240,678 for reagents in Year 1 and \$253,678 in Year 2. These figures were also reduced by nearly one-third to \$155,000 for each of the first two years for the reasons discussed above. The purchase of reagents for Years 3 & 4 will be provided by the Ministry of Health.
- g. See attached detail of local operations cost estimates. First year requirements include \$30,240 for local travel, \$3,750 for international travel, \$21,600 for office space and operations, and \$38,000 for office equipment and furniture.
- h. Includes in-service training, workshops, short courses and conferences for MOH laboratory and NGO IEC personnel.

- i. NGO sub-projects estimated at \$75,000 per year with a % annual increase for inflation. Projects will concentrate on IEC activities but may include OR and special studies, e.g. cost recovery, as needed.
- j. These funds will be used primarily to continue the packaging and promotional efforts begun earlier with the Contraceptive Social Marketing II Project (No. 936-3051) through SOMARC's representative in Bolivia, PROSALUD.
- k. A multiplier rate is estimated at 20%. This should be considered an average as rates for overhead or G&A may vary for personnel, commodities, and in-country operations. In fact, the rates may be reduced or waived altogether considering that much or all of the central costs may be covered directly by the Cooperative Agreement (No. 936-5972). In this case, this line item can be reallocated to other activities and/or held for contingencies.
- l. All CDC ST/TA calculated at \$13,000 per month (\$9,000 salary and benefits, including 2 weeks preparation time for each month in the field, and \$4,000 travel and per diem for each month in the field) for the first year with 4% annual increase for inflation.

Based on the above, Years 1 and 2 each represent 6.0 months of ST/TA actual field time, including 4.0 months Levine, 1.0 month lab trainer, and 1.0 month other ST/TA as needed. In Years 3 and 4, Levine's time will be reduced to 2.0 months per year and the other will remain the same for a total of 4.0 months ST/TA per year.

- m. Calculated at 13.8% of CDC direct expenditures for JHPO administrative and management backstopping.
- n. Current CDC PASA overhead rate is 20% on all direct and program support expenditures.
- o. Secretarial and logistics support in the USAID/HHR office in La Paz.
- p. USAID will purchase direct from S&T/POP 500,000 condoms per year at a cost of \$6 per 100. These will be packaged and marketed/distributed to the STD/HIV clinics and other high risk groups through the SOMARC/PROSALUD program currently operating in Bolivia.
- q. Includes one midterm and one final evaluation of the project and an additional \$50,051 for special studies and unforeseen needs. No local audits are required because all funds will be disbursed either by the AIDS T/S contractor, the CDC/PASA, or USAID/Bolivia

Methods of Implementation and Financing

The methods of implementing and financing for each component of the project are summarized as follows:

Component	Implementation Method	Method of Payment	Estimated Amount
Technical assistance	Add-on to S&T/H/AIDS Cooperating Agreement	AID/W Direct Payment	2,800
"	PASA to CDC	Direct Payment	370
Management and Logistics Support	PIO/T Contracts	Direct Payment	360
TOTAL:			3,530

TABLE 3.1

USAID MISSION TO BOLIVIA
AIDS/STD PREVENTION AND CONTROL PROJECT (511-0608), AMENDMENT No. 1

Life of Project Costs Estimate and Financial Plan (\$000s).

INPUTS	A.I.D.			HOST COUNTRY			GRAND TOTAL	PERCENT
	FX	LC	TOTAL	CASH	IN-KIND	TOTAL		
Technical Assistance	1239	0	1239	0	0	0	1239	23.9
Training	108	0	108	0	0	0	108	2.1
Commodities	776	0	776	612	0	612	1388	26.8
Local Operations	583	0	583	730	254	984	1567	30.3
HHR Management support	154	78	232	0	0	0	232	4.5
TEC/SUM/OR sub-projects	562	0	562	0	80	80	642	12.4
TOTAL INPUTS	3422	78	3500	1342	334	1676	5176	100.0
Percent	66.1	1.5	67.6	25.9	6.5	32.4	100.0	

10. Host Country Counterpart Contribution

AIDS/STDS PROJECT BUDGET ANALYSIS UNDER ABAP

<u>Component and Activity</u>	<u>Type of Transaction</u>	<u>AID Dollar Contribution</u> (000)	<u>Total LCF</u>	<u>Exempt</u>	<u>To Be Waived</u>
I. I. Technical Assistance					
A. TA	Co-op. Agr. (CA)	850	0	0	0
B. Lab. Commodities	Sub-contrat	600	0	0	0
C. Local costs		1316	1316	1316	0
-Staff office	" "			(Sub-contracts less than \$250,000, items available only locally)	
-MOH training	" "				
-Condom marketing	" "				
-NGO sub-grants	" "				
II. CDC	PASA	374	174	174	0
III. USAID/B					
Project Support					
-Secy & office	Direct	160	160	160	0
-Eval & audit	Contract	100	160	160	0
-Condoms		100	0	0	0

By signing the Facesheet and Project Authorization or this Project, the authorizing official approves this authorization and waiver to permit local cost financing for the categories of transactions described above and determines that the prices of indigenous and locally available imported goods and services are reasonable (HB 1B, Section 18A.1.6.(1)).

TABLE 3.2

USAID MISSION TO BOLIVIA
AIDS/STD PREVENTION AND CONTROL PROJECT (511-0608), AMENDMENT No. 1

Disbursement Schedule and Projection of Expenses by USG Fiscal Year,
AID Funds (\$000s).

INPUTS	FX 1991			FY 1992			FY 1993		
	FX	LC	TOTAL	FX	LC	TOTAL	FX	LC	TOTAL
Technical assistance	173	0	173	302	0	302	399	0	399
Training	0	0	0	43	0	43	38	0	38
Commodities	312	0	312	255	0	255	116	0	116
Local operations	110	0	110	127	0	127	134	0	134
HHR management support	0	9	9	74	19	93	13	19	32
TEC/SM/OR sub-projects	0	0	0	180	0	180	281	0	281
TOTAL INPUTS	595	9	604	981	19	1000	981	19	1000

INPUTS	FX 1994			TOTAL LOP		
	FX	LC	TOTAL	FX	LC	TOTAL
Technical assistance	365	0	365	1239	0	1239
Training	27	0	27	108	0	108
Commodities	93	0	93	776	0	776
Local operations	212	0	212	583	0	583
HHR management support	67	31	98	154	78	232
IEC/SM/OR sub-projects	101	0	101	562	0	562
TOTAL INPUTS	865	31	896	3422	78	3500

TABLE NO. 3.4

ESTIMATES OF HOST COUNTRY CONTRIBUTIONS

A. IN-KIND	
1. Facilities & Equipment (depreciation):	
3 ref labs at \$5,000/yr x 4 yrs	= 60,000
3 clinics at \$1,000/yr x 4 yrs	= 12,000
Subtotal	= \$ 72,000
2. Existing personnel:	
4 technical (P/T) x 3 labs x \$250/mos. x 50%	
x 15 months/yr x 4 yrs (adjusted for 4% COL)	= 95,545
3 support (P/T) x labs x \$150/mon x 50%	
x 15 mon/yr x 4 yrs (w 4% COL)	= 85,990
	= \$ 181,535
3. NGO contribution at 33% of 33% of 238,875	= 79,625
Total In-kind	= 333,160
B. CASH	
1. Sale of condoms:	
1.5 million at 3/pkg x \$.28/pkg	= 140,000
2. Purchase of reagents (Annex 6):	
Year 3 = 168,000 ; Year 4 = 174,000	= 342,000
3. Purchase of antibiotics, etc. (Rx):	
45,000 patients x \$6	= 270,000
4. Lab & clinic operations (utilities, supplies, maintenance, etc.)	
\$500/mon x 12 mons x 6 labs x 4 years	
(w/4% infl.)	= 152,870
5. Personnel, clinics:	
1. MD/epidemiologist at 300/mon.	= \$ 300
3. clinicians at 280/mon	= 840
1. secretary at 150/mon.	= 150
1. data manager at 200/mon	= 200
2. auxiliary nurses at 150/mon.	= 300
2. social workers at 200/mon.	= 400
Total	= \$2,190
x 15 mon/yr x 3 clinics x 4 yrs (w/4%COL)	= \$418,490
6. Furniture for clinic staff:	
2- lg. desk at 112	= \$ 225
6- med desk at 70	= 420
1- table at 100	= 100
20- chairs at 30	= 600
8- shelves at 85	= 680
2 file cabinets at 400	= 800
3 exam tables at 1000	= 3000
3 fans or heaters at 100	= 300
1 manual typewriter	= 250
Total Furniture	= \$ 6375 x 3 = \$ 19,125
TOTAL CASH	\$ 1,342,485
GRAND TOTAL (4 years)	\$ 1,675,645

The Ministry of Health will provide laboratory reagents for the third and fourth years of project implementation and medicines for the treatment of STDs, worth an estimated \$612,000. It is likely that these reagents and medicines will be obtained through the Panamerican Health Organization and financed by special country donations. Finally, the NGOs participating in the IEC activities will be expected to contribute 25% of the total sub-project costs.

B. DISBURSEMENT SCHEDULE AND PROCEDURES

AID funds will be disbursed as per the schedule presented in Table 3.2.: FY1991 - \$604,000; FY1992 - \$1.0M; FY1993 - \$1.0M; and FY1994 - \$896,000. In FY1991, \$204,000 will be allocated from the Health Account; all other funds for the remainder of the project will be allocated from the AIDS Account.

AID/W (S&T) may contribute additional central funds to Bolivia during the life of this Project. Because the availability of these funds is conjectural, no figures can be given for these possible contributions.

1. AIDS Technical Support Project (No. 936-5972)

The primary implementing agency for the amended AIDS/STD Prevention and Control Project is expected to be the eventual contractor for the new AIDS Technical Support Project. Up to \$2.8 million will be available for a buy-in to this S&T/Health Cooperative Agreement, which is expected to be awarded by September 1991. (See Annex 8, Table 3.3.) The contractor will provide long and short term technical assistance, purchase and ship the required lab commodities, design and manage the MOH training and NGO sub-projects, and staff and operate a local project implementation office in La Paz.

Funds will be transferred from the USAID/Bolivia health and AIDS accounts to the S&T/H contractor according to standard AID Mission buy-in procedures. The contractor will receive periodic advances based on expenditure/cash flow requirements and the appropriate reporting and documentation of expenditures. Financial audits of project-related activities will be conducted as stipulated in the Cooperative Agreement, under Standard Provisions in accordance with the requirements of OMB circular A-133.

2. CDC PASA

The International Health Program Office (IHPO) of the U.S. Centers for Disease Control (CDC), based in Atlanta, Georgia, will provide up to 20 P/M of short term technical assistance and training to the project in the

areas of STD/HIV epidemiology, laboratory and clinic organization and procedures, STD diagnosis and treatment, and other project-related topics. The mechanism for obtaining these services will be a Participating Agency Service Agreement (PASA), for up to \$400,000. Funds will be transferred from the USAID/Bolivia AIDS account to the Centers for Disease Control according to standard AID PASA procedures. CDC/IHPO will receive reimbursement for actual expenditures, plus approved program support and overhead rates, according to annual activity plans and the documentation of expenditures. Financial audits of project-related activities will be conducted as stipulated in the PASA standard provisions.

3. USAID/Bolivia/HHR

The USAID/B HHR office will assign one U.S. Direct Hire officer and one PSC secretary to manage the Project, in collaboration with the TACS Advisor. The USAID/HHR office will directly manage \$360,000 of project funds. The PSC secretary will provide clerical and logistic support to the project and HHR will directly arrange for project midterm and final evaluations and other special studies as needed. USAID/Bolivia will also purchase condoms through existing arrangements with the S&T Population Office.

Funds will be disbursed by the local Mission using standard PIO/Cs, PIO/Ts, central AID Indefinite Quantity Contracts (IQCs) and other mechanisms as appropriate.

C. OTHER DONOR CONTRIBUTIONS

1. MOH Medium Term Plan

International donor support for AIDS prevention and control activities is governed by the Medium Term Plan (MTP) for AIDS Surveillance and Prevention in Bolivia. The MTP was prepared with the assistance of the Panamerican Health Organization (PAHO) but has yet to be officially approved by the Ministry of Health. Nevertheless, under the original AIDS project, as of January 1991, USAID has directly supported the MTP by providing \$88,000 to the MOH for equipment, supplies, and educational materials and \$120,000 in technical assistance. A balance of \$188,000 remains in the account for additional lab equipment, supplies, and educational materials for the MOH. (Of the total \$500,000 obligation for AIDS Prevention and Control, USAID/HHR retained \$104,000 for personnel and technical support costs.)

In FY1991, PAHO had programmed a reported \$160,000, including technical assistance, in support of the MTP. In addition, the Government of Sweden and the European Economic Community (EEC) have allocated \$176,000 and \$80,000 respectively for AIDS prevention activities. Similar funding is expected from these sources in FY1992. In addition, Holland is

considering providing \$200,000 for the blood banks and UNICEF is considering an undefined amount of support for HIV prevention. The PAHO AIDS advisor has agreed that additional funds, from these and other donors, should be sought for developing and supporting blood banks, purchasing condoms, and purchasing antibiotics for the treatment of STDs.

2. Blood Banks

Guaranteeing a safe blood supply is often viewed as a politically attractive and highly visible priority for AIDS prevention funding. However, in a country that still has a relatively low prevalence of HIV infection, most prevention experts would agree that targeted interventions with high risk groups will yield a more cost-effective approach for protecting the general population. Any significant activity in this area will have to be supported by major funding from other donors.

Currently, Bolivia has no systematic process for the collection, testing, fractionating, or storage of blood or blood products for emergency or programmed purposes. The common practice, when transfusions are necessary, is to solicit donors on the spot, often paying for their services. In addition to HIV and STDs, other important endemic infections transmitted through blood in Bolivia include Chagas, hepatitis, and malaria. The costs involved in developing and operating a blood bank system which addresses the geographic, epidemiologic, organizational, and social requirements of Bolivia surpass the financial resources available to the present project.

Within the context of the AIDS/STD Prevention and Control Project, the national and regional program committees will review the feasibility of establishing blood banks in the major population centers. Plans will be developed in coordination with PAHO and related USAID activities and will likely include the Bolivian Red Cross. The improved AIDS/STD reference laboratories will have the capability to test blood samples on demand. Also, several low cost procedures will be encouraged for private clinics and public hospitals, including the strict control of disposable transfusion equipment and the use of screening questionnaires and HIV rapid tests.

PAHO and the MOH will be encouraged to convene a donors meeting to explore interest and support for a future comprehensive blood bank program. Potential funding sources would include the Interamerican Development Bank, the World Bank, and the governments of Japan and Holland. Particularly in the case of the banks, a lead time of several years will be necessary.

D. LOCAL SOURCE PROCUREMENT JUSTIFICATION

Local source procurement in Bolivia with appropriated funds will be necessary under the Project in order to successfully implement all three project components. Since two of the target groups of this Project are Bolivian exporters and producers of exports, technical assistance, credit and other studies will be provided in a Bolivian context, which will require expenditures in Bolivian local currency.

Within the Technical Assistance Component, the U.S. contractor will have local expenses for Bolivian staff, office in Bolivia, travel MOH training, local condom marketing, and NGO sub-projects. CDC likewise, although a U.S. Government institution, will have similar local expenses for staff and office.

Except for condoms of U.S. source and origin funds for USAID/B project support (secretary office, office expenses, evaluations, studies and audits) will be spent in local currency in Bolivia.

Under the Administrator's Buy America Policy ("ABAP"), as last restated in the final implementation guidance cable, 90 State 410442, para 8, a waiver authorizing local cost financing ("LCF") by categories of procurement transactions must be included in project authorization documentation, for non-exempt categories of transactions. An analysis of the Project budget and justification for the waiver included in the project authorization for such non-exempt categories of procurement transactions follows an explanation of the exemptions.

According to the final implementation guidance cable, 90 State 410442, paras 9-22, the following types of transactions are exempt from the ABAP, and no waiver is required to authorize or finance the following types of local costs:

1. Professional Service Contracts \$250,000 or less in value;
2. Construction Service Contracts \$5 million or less in value;
3. Locally available (local source), U.S. Origin goods, up to \$100,000 per transaction;
4. Any transaction below \$5,000 in value;
5. Handbook 13 Grants and Cooperative Agreements, including Grants to PVOs: no special waivers are required because the Standard Provisions state source and origin rules;
6. Fixed Amount Reimbursement (FAR) disbursements;
7. Intermediate Credit Institutions (ICIs).

8. Commodities and Services Available only Locally

No specific local source procurement waiver is required for the following items available only in the local economy:

- a) Utilities: including fuel for heating and cooking, water disposal and trash collection;
- b) Communications: telephone, telex, fax, postal and courier services;
- c) Rental costs for housing and office space;
- d) Petroleum, oils and lubricants for operating vehicles and equipment;
- e) Newspapers, periodicals and books published in the cooperating country; and
- f) Other commodities and services (and related expenses) that, by their nature or as a practical matter, can only be acquired, performed, or incurred in the cooperating country.

CHAPTER IV.

IMPLEMENTATION PLAN

A. TIMETABLE

The final decision as to how this project will be implemented is still open because they buy-in/add-on contractor has not yet been selected and the final instrument has not yet been negotiated. The CDC PASA option seems viable only for those portions of the project that relate to its specialties (e.g., STD laboratory testing, etc.). The rest of the project components should be implemented via the S&T/H/AIDS contractor that can manage all other aspects (e.g., education, equipment purchases, etc.).

1. Start Up: Months One to Six

- a. Assemble committees which will coordinate the work of the entire project, and which will be involved in overseeing the work of each clinical center. These committees will also serve functions of coalition building.
- b. Develop plans for building administrative capacity for STD/HIV control. Recruit and hire MOH and project staff as stipulated.
- c. Evaluate options to provide STD/HIV control services within the current context of health care delivery, and develop detailed implementation plans.
- d. Develop laboratory capabilities: order equipment, supplies, and reagents and develop training plans for MOH and NGO personnel. Order condoms and negotiate SM contract with PROSALUD.
- e. MOH and project staff will begin working with short term epidemiologists and the program committees to develop a program of epidemiologic research on STD/HIV, including studies of prevalence and of knowledge, attitudes, and behaviors.
- f. Begin laboratory-based surveillance systems for STD/HIV, and compare data from existing surveillance systems, with laboratory-base surveillance.
- g. Begin implementing pilot STD/HIV education programs for adults and schoolchildren, and educational programs for health care providers.
- h. Implement epidemiologic and operations research activities coordinated by Bolivian investigators.

3. Consolidation: Months 13-24

- a. Continue prevalence studies to support expansion of activities.
- b. Extend STD control services to additional sites, improve existing services, and market these services to the population.
- c. Strengthen existing laboratory capabilities at sites such as hospitals and free standing laboratories, and develop capabilities at other laboratories.
- d. Evaluate acceptability of recently implemented services with additional surveys of knowledge, attitudes, and behaviors.
- e. Plan for independent administration of STD/HIV control programs.
- f. Implement national surveillance strategy.
- g. Evaluate education and training programs, and modify if necessary.
- h. Continue epidemiologic and operations research activities, plan additional studies to support program activities, and seek additional sources of funds to support research and program activities.

B. PROCUREMENT PLAN

The procurement plan for the Project is explained in Chapter III. Cost Estimate and Financial Plan and Annex 6 - Detailed Procurement List. USAID/B will procure the services of cooperating agencies under S&T/H/AIDS and PASA to CDC. The add-on to the new central cooperative agreement (AIDS Technical Project) will cause no significant management burden for USAID/B, because AID/W will perform procurement and accounting for these components. Normally, AID/W requires a one or two page PIO/T for these procurement actions, and adds the funds available in PIO/Ts from USAIDs, because each central cooperative agreement already has a detailed scope of work and budget. Accessing the central cooperative agreement should be a very easy procedure. Additionally, the PASA management with CDC should be equally easy and accessible.

Similarly, project funded condoms will be procured through the AID/W procurement system; S&T/POP/CPSD will assist the Mission in determining types, quantities, and delivery dates needed. USAID/B will send proforma PIO/Cs to AID/W. Shipment, delivery and distribution may be through GOB/moh, an experienced NGO (under the Reproductive Health Project), or SOMARC.

The laboratory equipment, supplies, reagents as detailed in Annex 6 will be procured either by the AID/W Cooperating Agency, CDC or USAID/B direct.

All management/logistical procurement will be handled by USAID/B by direct contracts under the FAR and AIDAR. The Bolivia PSC will be selected utilizing the simplified procedures states in the AIDAR and class justification for PSCs. Logistical support (project communications) will be procured through small purchase procedures (FAR Part 13) when the value of goals or services is \$25,000 or less. Contacts for evaluations, special studies, etc. over \$25,000 in value shall be competed under Part 15 of the FAR. There is no construction planned under this project. The authorized geographic codes for the Project are 000 (USA) and cooperating country (Bolivia). The standards and procedures to be followed in the procurement of goals and services will be those of Handbooks 1B, 11, 14 and 15.

CHAPTER V.

MONITORING/EVALUATION PLAN

A. PROGRAM AND FINANCIAL MANAGEMENT

The USAID/B HHR office will assign one USDH officer and one PSC secretary to manage the Project who together with temporary evaluation and technical assistance personnel will constitute the Project Management Unit with USAID/B. The project will be implemented by assessing technical assistance, as described above.

B. STD/HIV MANAGEMENT AND CONTROL STRATEGIES

The INLASA reference laboratory and model clinic will be equipped and personnel trained early in Year One of the project so it will acquire the capacity to diagnose the major STDs expected to be found in Bolivia.

Once the INLASA lab is ready to diagnose the major STDs in La Paz, descriptive epidemiological studies can commence. Initial data will be collected to describe the prevalence of STDs and the profile of antibiotic sensitivities for specific STD patients in La Paz. Minimally, an analysis should be made of the STD profile in prostitutes and all other patients, symptomatic and asymptomatic individuals.

From this data, using project technical assistance, it will be possible to develop treatment algorithms that are consistent with good medical practice, STD patient behavior patterns, and program budgetary constraints.

By the end of Year One, standard Operating Procedures (SOPs) for the INLASA lab and its satellite clinic(s) will be in place. At minimum, SOPs will deal with:

- patient intake procedures;
- diagnosis and treatment flow;
- diagnosis and treatment algorithms;
- pre- and post-test counseling;
- inventory controls and purchasing of reagents, supplies and pharmaceuticals;
- data collection and analysis of service statistics;
- patient record maintenance, storage and
- security (confidentiality);
- data collection and analysis for sentinel

- surveillance;
- confidentiality/anonymity requirements;
- legal/ethical standards;
- personnel rules and regulations;
- financial records and accounting.

In addition, mechanisms will be in place for:

- receiving and adjudicating patient/client and staff complaints;
- for handling the presence of medical, nursing, psychology, sociology, laboratory and other students;
- quality assurance procedures for STD/HIV diagnosis, STD treatment and STD/HIV counseling.

By the end of Year One, decisions will have been taken as to the type and extent of patient follow-up, partner notification, fee-for-service charge schedules, and condom provision.

The national STD/HIV Program Committee will have to make the politically difficult decision as to the degree, if any, that project funded resources will be used for testing of STD/HIV biological samples coming from non-project supported clinics.

All procedures will be reviewed periodically and amended as necessary. As the client population grows, its profile can be expected to change; as the educational programs cause behavior change in service area populations, the mix and chronicity of STDs will change. Sentinel and other epidemiological studies will reflect these changes and with appropriate feedback, may have profound effects on diagnosis and treatment algorithms, and possibly on the range of STDs treated. As the knowledge level and attitudes of client populations change, counseling "curricula" and procedures should change commensurately. These feedback loops can also be expected to force a regular review and adjustment of budget planning for the project.

The STD/HIV Program Committees will maintain oversight of the clinic and laboratory STD/HIV activities. They will also make policy decisions, such as whether to provide condoms, community outreach, partner notification; whether to implement fee-schedules and how to manage derived funds. Most other decisions and policies will be made by the clinic/lab professionals themselves. Technical assistance from project and from other sources can be expected to simplify and accelerate the policy-making process.

The Santa Cruz (CENETROP) and Cochabamba (CUMETROP) lab/clinic constellations, will be developed in an analogous manner to INLASA but on a deferred schedule. However, in order to reduce expenditures, much of the training for the staff at the three lab/clinic constellations will take place at the same time. Many of the policies developed for the

project will need to be different at the three lab/clinic sites, owing to different disease profiles and different socio-economic and political environments.

Members of certain "marginalized" groups (e.g. some gay males, sex workers who avoid registration) may be unwilling to seek diagnosis and treatment until the clinics have demonstrated their ability to provide care in a non-stigmatizing manner and to maintain confidentiality. NGOs that have gained the confidence of these groups must be given assistance in the collection and transport of biological specimens to the clinic/lab closest to them. Depending on the appropriateness of diagnostic and treatment algorithms used, funds may be in some cases be provided to these NGOs to assist in diagnosis.

In Year Four of the project, planning will take place in all major areas of lab/clinic activities to consider:

- sources, amounts and types of future funding;
- supportable activities at the end of the project;
- activities that can be implemented outside of the three reference lab/clinic constellations, and
- future research needs.

C. STD/HIV QUALITY ASSURANCE SYSTEMS

A good quality assurance (QA) system serves a number of important functions:

1. It is part of the required monitoring system or process evaluation that is needed to satisfy the funding source that funds are being spent appropriately.
2. In technical performance areas it serves to give rapid feedback to management and staff that technical processes are being implemented correctly and can provide measurable standards for making individual or group comparisons.
3. A QA system can be used to provide standards that individuals and groups have to attain, and which can then be raised in order to improve overall performance.
4. If designed with input from the individuals to be reviewed, a QA system can help produce "ownership" within the work setting of the major goals of the enterprise, which in turn will improve the utility of the QA system itself.

For this project it is important that the QA systems developed are not over-ambitious, duplicative or burdensome. They must be dynamic, relate directly to project goals and be easily measured, quantified and analyzed. Results must be shared rapidly with those whose performance is being measured and there must be an opportunity for negative results to be explained and alternative theories of cause tested.

This project will introduce QA systems in both the laboratories and the clinics. For the laboratory, at a minimum, periodically a random selection of lab samples needs to be set aside for retesting according to the testing protocol and results compared. Should result vary, comparisons can be made of who or which group, is producing the variation, and further analysis done to determine why. Individuals who have been trained in a certain diagnostic technique should be regularly tested by evaluating blinded known true positives and true negatives (for example HIV). If test results are not binary the individuals can be tested against blinded samples with known values. Where possible reagents that are subject to contamination or decay can be periodically compared to reagents that are known to be fresh, by performing the tests with both sets of reagents.

Other aspects of lab function can be subject to a formal QA system, such as handling of specimens in a safe and timely fashion; speed of delivery of results to the clinic; confidentiality and security of lab results. Once a lab function has reached consistently, an agreed, acceptable performance level, frequency of QA of this function should decrease and other areas of function be subject to quality assurance mechanisms.

A reference laboratory also has the responsibility to compare in a formal, reproducible manner, practices and procedures at the satellite labs. INLASA as the national reference lab is also responsible for the reference lab functions supported by this project in Santa Cruz and in Cochabamba.

Clinic functions will be subject to similar QA systems. Sampled patient records will be reviewed for consistency with clinic-based diagnostic and treatment algorithms. Initially records can be sampled by presenting symptom or by treatment prescribed or by some demographic or social characteristic of the patient. Once it appears that staff have achieved the standard set by management for a particular type of patient situation, the QA system can shift to another area. Where problems are discovered they can be ameliorated by continuing education or by staff meetings to discuss ways of eliminating the problem, followed by review of the issue to determine whether the problem is solved.

To be successful this project must keep STD patients coming back if they have renewed infections and have STD patients recommend the services to others who are or may become infected. Consequently, techniques will be

designed to obtain information from clients as to the aspects of clinic function that are good and bad in the eyes of the consumers. Where possible changes will be introduced into clinic function in an operations research mode to attempt to raise consumer satisfaction with the clinics.

This last point is particularly relevant to the counseling function within the clinic as this will be one of the important determinants of behavior change within the clinic population.

In addition to all the on-going operations research studies, surveillance studies, epidemiological studies, quality assurance systems, monitoring discussed above, two external evaluations are planned (mid-term and final. The major thrust of the mid-term evaluation will be to assess where the project is in reaching indicators and the final evaluation will assess the quality of technical assistance, lessons learned and program implementation.

CHAPTER VI.

SUMMARIES OF ANALYSES

A. TECHNICAL ANALYSIS

The technical analysis for the AIDS/STD Prevention and Control Project was carried out by George Schmid, William Boyd, and William Levine of the Division of STD/HIV Prevention, Centers for Disease Control (CDC). The analysis, though not specified in their report, was obviously based on extensive interviews, the review of clinic and laboratory reports, and official documents of the Ministry of Health in La Paz, Santa Cruz, and Cochabamba. (See Annex 5.1)

In addition to discussing the Bolivian health care system and the current situation regarding sexuality, STDs and prostitution, the consultants reviewed the areas of services for patients with STDs, blood banking and needle reuse, laboratory facilities, STD/HIV prevalence, and surveillance. Due to the lack of accurate prevalence data and quantitative information regarding the knowledge, attitudes and behaviors of high risk populations, the consultants' conclusions of apparent need are based on known (from other countries) patterns of transmission and the lack of adequate diagnostic, screening and treatment services in Bolivia.

B. FINANCIAL ANALYSIS

The bulk of project funds and activities will be managed by the eventual contractor of the AIDS Technical Support Project (No. 936-5972), whose capabilities will be closely scrutinized prior to the award of that central contract. Additional services will be provided through a PASA with the Centers for Disease Control. A small amount of funds will be managed directly by the Health and Human Resources Office of USAID/Bolivia.

No funds allocated under this project amendment are expected to be passed to the Government of Bolivia. However, approximately \$562,000 (16% of AID funds) have been earmarked for sub-project grants to local non-governmental organizations (NGOs) to carry out information, education, and communication (IEC), social marketing (SM) of condoms, and operations research (OR) activities. Prior to the award of these grants, the above-mentioned buy-in contractor will establish an (USAID) approved procedure which guarantees that the appropriate analysis of the prospective grantee's administrative and accounting capabilities will be done.

Summary Project budgets are presented and discussed in the "Cost Estimate and Financial Plan" of the PP; detailed budgets for components are available to the Mission as supplementary materials. Budgetary summaries reveal, among other points, the relative sizes of the Project components and their resource inputs (with relative costs), the distribution of financial support among sources, and pace of financial activity over the years of the Project.

Sustainability of the Project is discussed in the Financial Analyses Annex. After an analysis of recent developments concerning Bolivian national budgets of the Central Government and The Ministry of Health and a consideration of the uncertain future prospects for the economy, it is concluded that full coverage of recurrent costs after PACD could be problematic unless the GOB prioritizes this type of health activity. USAID will continue to discuss the GOB commitment to the health sector and to this Project with the Ministry of Planning throughout the Project's five-year life. Evaluations will identify those costs which are most important for the GOB to absorb after PACD so that progress achieved during the Project is not lost when USAID development assistance funding terminates. In the event that there is some gap at PACD between GOB resources and recurrent costs, the most critical costs will have been identified so that community participatory activities (village committees and the operations and maintenance programs) and the delivery of the key interventions (as determined by evaluations) can be continued in priority sites. The sustainability issue, therefore, will be an important component of USAID/GOB dialogue during and after the life of this Project.

Alternative sources of funding include other donors and levels of government, quasi-public organizations (e.g., the Departmental Development Corporations), and various private means. Discussions with these sources will continue throughout the Project's life.

Another part of the Financial Analysis concerns the capacity of the Government of Bolivia to manage the finances of the proposed Project. Based on the original project, it appears that the Government, through the Ministry of Health, is capable of managing its part of the Project's financial details at the national and lower levels. However, technical assistance will be required at all levels to facilitate the handling of funds and the maintenance of appropriate records.

C. ECONOMIC ANALYSIS

The economic analysis (Annex 5.3.) was written by Oscar Antezana of the USAID Economic Office and was based on a review of relevant literature from other countries and the analyst's knowledge of Bolivia. The analysis focuses on the adverse economic and social effects that STD/HIV infections will cause if left to advance unchecked.

In terms of economic development, a significant increase in AIDS and STDs will have a negative effect on the labor force and in turn of the gross domestic product (GDP). The government will be hard pressed to increase expenditures, particularly for the Ministry of Health, thereby taking needed resources away from other priority areas. AIDS/STD also threatens to reverse the advances made in child survival. Pregnant (i.e. sexually active) women will experience increases in syphilis, gonococcal, and HIV infections, which take their toll not only on the women but also on the newborn children. Infant and under five mortality rates will also rise.

At present, Bolivia has inadequate health care coverage, in spite of the increased services offered by non-governmental organizations (NGOs). AID/STD will overwhelm the current limited capacity of the health care system in both the treatment and preventive areas. AIDS by its immuno-depressing nature will cause increases in the prevalence of other infectious diseases. The social structure will become stressed as stigmatization, fear, and financial burden splits families and communities. The increased need for caregivers will take family members out of the labor force.

D. SOCIAL SOUNDNESS ANALYSIS

The social soundness analysis was done by Paul Raza, an AIDSCOM consultant. (See Annex 5.4.) The methodology was not specified but the discussion concentrated on the social feasibility of the project, the direct beneficiaries and spread effects. The two areas are interrelated as project feasibility, in terms of acceptance by individuals and community, will depend on what the implementors do or do not do to avoid and overcome potential pitfalls.

Potential religious opposition (to condoms and open discussions on sexuality) are expected to be tempered by emphasizing the reductions in STDs and sexual partners. To avoid stigmatization and discrimination, which will lead to avoidance of testing and treatment, the project will need to emphasize unsafe sexual practices rather than stereotyped labels like "homosexual" and "prostitute." There will likely be increases in clinic loads for testing and treatment, which compounds the problems of and need for confidentiality and anonymity. Given the wide use of pharmacists and traditional healers in Bolivia, the analysis raises the issue of incorporating and training these practitioners in symptomatic diagnosis and timely referral.

The project is expected to reach directly 80,000 patients through the STD/HIV clinics and laboratories. In addition, the urban residents of La Paz, El Alto, Santa Cruz, and Cochabamba (approximately 2.5 million people) will be the targets of mass media information, education, and communication efforts. Care should be taken to locate the clinics in areas of accessibility to high risk groups. Also, different groups will require "safe," non-threatening, and anonymous settings. Much of the success of the clinics will depend on word-of-mouth spread, for better or worse, among the target groups.

E. ADMINISTRATIVE ANALYSIS

The administrative analysis was extracted from a consultant report by William Boyd of the Centers for Disease Control. (See Annex 5.5.) The analysis emphasizes the chronic insufficiencies of administrative support at the national level of the Ministry of Health for service programs. The comprehensive "Midterm Plan for AIDS Surveillance and Prevention in Bolivia" (MTP) has yet to receive adequate financing and be implemented. Another critical aspect is the need to provide adequate support for the national and regional AIDS/STD advisory committees.

The report also commented on the current educational efforts aimed at STD/HIV prevention. These were found to be too general in content and to use terminology inconsistent with that used by the specific groups which were targeted. There is also little funding in the MTP for locally developed educational materials.

Although the initial project provided funds to the MOH, this amendment does not include additional direct funds for the MOH, therefore, an administrative and accounting capability assessment was not done for this amendment.

F. INITIAL ENVIRONMENTAL EXAMINATION

Generally, population, health and nutrition projects fall under 22.C.F.R. Section 216(c) (2)(viii), Categorical Exclusions, as types of projects that do not require an Environmental Impact Analysis or further environmental review. The Initial Environmental Examination (Annex 5.6), undertaken by John Wilson, LAC Deputy Chief Environmental Officer, determined that the present project "consists of activities for which there are no foreseeable, direct, significant impacts on the environment" and recommended a Categorical Exclusion. The recommendation was concurred by the Bolivia Mission Director on June 7, 1991.

G. REVIEW OF SUB-GRANT PROPOSALS

Mr. Raza also reviewed 24 proposals (Annex 5.7.) which had been solicited from non-governmental organizations (NGOs) interested in undertaking STD/HIV activities in information, education, and communication (IEC), social marketing (SM) of condoms, and operations research (OR). The proposals exhibited a wide range of completeness and quality and some did not have a corresponding budget.

The analysis recommends that the eventual project implementors develop appropriate technical and contextual criteria for the selection of proposals and systematically review subsequent proposals against these criteria. It is likely that project technical staff and consultants will have to work closely with potential grantees in the design of sub-grant projects.

CHAPTER VII.

CONDITIONS AND COVENANTS

A. The Project Grant Agreement Amendment signed with the GOB will grant permission to the Cooperating Agencies and PASA involved in the Project to maintain offices and staff in Bolivia in order to operate here and implement the Project. Imported Project goods will be tax-exempt. All original conditions and covenants stand.

3546H

ANNEX 1.

USAID/BOLIVIA ACTION PLAN
FY 1992-1993
March 1991

(Appendix B, Section B.2, pp.4-5)

PROJECT AMENDMENT DESCRIPTION

LAC Bureau Objective

III. Respond to needs for international cooperation in addressing specific challenges to the attainment of broadly based sustainable economic growth and the evolution of democratic societies.

Subobjective:

Support USG foreign policy initiatives that can benefit from AID resources and expertise, such as disasters, epidemics, and resettlement of displaced persons.

Project Title:

AIDS/STD Prevention and Control Project

Project Number:

511-0608

Funding:

FY 91: \$204,000: Health LOP: \$4.0 million
\$400,000: AIDS

Type of Funding:

AIDS Account

A. Consistency of Project with Mission Strategy

The project is consistent with our concern for individuals and the development of their economic and social well-being and our provision of humanitarian assistance to those who suffer from natural or man-made disasters.

B. Relationship to A.I.D. and Other Donor Activities

USAID will continue to closely coordinate with other donors (PAHO, UNICEF, bilateral donors) to assure implementation of the GOB's national AIDS plan.

C. Relationship of Project to Overall A.I.D. Policy Objectives

The project coincides with AID's policy objectives by reducing the incidence and transmission of AIDS and Sexually Transmitted Diseases (STDs), especially because of their potential to undermine child survival efforts.

D. Project Description

The major project components will include prevention, education, blood screening strategy, HIV/STD testing, training, and quality control in laboratories and blood banking systems, surveillance, and treatment.

This amended project will be redesigned to establish a capacity to develop and implement cost-effective surveillance, information, education, and intervention strategies in support of projecting future trends in reducing the transmission of STDs, HIV infection, and AIDS. The project shall assist participating government and non-government organizations in related activities specified in the national medium-term plan for AIDS prevention and control. Technical assistance will allow the Ministry of Health to treat the extent of the problem as well as to establish a system that will track the characteristics of HIV transmission and AIDS and STDs cases.

The project will focus on the design and implementation of activities regarding educating the public and relevant professional groups about AIDS and STD prevention, and develop and implement prevention and intervention strategies to reach those most at risk, including pregnant women and young adults.

The project also will introduce new interventions which may become available with the changes in the epidemiology and treatment of AIDS and STDs.

E. Planned Implementation Arrangements

The project will work through a number of implementing agencies such as AIDSTECH, AIDSCOM, CDC, which will provide technical assistance in epidemiology, training, public health communications, laboratory and blood banking systems, sexually transmitted disease diagnosis and treatment, applied and behavior research, information, communication strategies and methods for control and prevention of AIDS and STDs.

F. Sustainability

Efforts will be made to make the project sustainable. Innovative small projects will charge fees for services. These projects will be aimed specifically at AIDS/STD prevention, education, and control, especially with community based organizations whose active participation may be critical to effective program management and implementation.

G. Mission Management Role

Since the project will be implemented by AID Contractors/Cooperating Agencies/PASAs, the Mission role will be to define, monitor, and coordinate project implementation activities.

H. Potential Issues

The terms of the GOB's national medium term plans should be revised to include the prevention and control of AIDS and STDs under one project. AID support will be limited to components which USAID/Bolivia can readily access technical assistance in order to implement major program areas.

ANNEX 2.

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY: 1991 to FY 1995
Total U.S. Funding: \$3.5 million
Date Prepared: 20 June 1991
Page 1

Project Title & Number: AIDS/STD Prevention and Control, Nr. 511-0608

SECTOR GOAL	GOAL MEASURABLE INDICATORS	GOAL MEANS OF VERIFICATIONS	GOAL ASSUMPTIONS
Improvement in the health status of Bolivians, especially women of child bearing age and their offspring	<ol style="list-style-type: none">1. Reduction of the percentage of selected currently untreated STDs in sentinel populations in three target areas2. Reduction of the potential for reinfection of STD/HIV infected individuals through testing and counseling	<ol style="list-style-type: none">1. Target clinics services statistics2. Equipment installed and reagents used3. Sentinel surveillance studies4. National demographic and health surveys data (as available)5. National Health Statistics from the MOH/Epidemiology unit	<ol style="list-style-type: none">1. Government of Bolivia supports the project2. No major national disruption or disaster3. USAID's assessment that there are a high number of untreated STDs cases is correct

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY: 1991 to FY: 1995
Total U.S. Funding: \$3.5 million
Date Prepared: 20 June 1991
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Project Title & Number: AIDS/STD Prevention and Control, Nr. 511-0608

PROJECT PURPOSE	END OF PROJECT STATUS (EOPS)	MEANS OF VERIFICATION OF EOPS	PURPOSE ASSUMPTIONS	
To expand access to, and use of, effective STD/HIV control services and education in La Paz, Santa Cruz and Cochabamba	1. Three reference STD/HIV laboratories strengthened in La Paz, Santa Cruz and Cochabamba	1. Service statistics in the three target clinics and labs	1. Timely provision of Technical Assistance	
	2. Three reference STD/HIV clinics strengthened in La Paz, Santa Cruz and Cochabamba	2. Reports of site visits to reference laboratories by the project central operation personnel	2. Rational distribution of project resources	
	3. 1,500,000 condoms sold through social marketing program	3. KAP surveys and focus group research among target area populations	3. Ability of selected laboratory and clinic structures and NGOs to absorb project assistance	
	4. 500,000 condoms distributed free	4. End of project evaluation	4. Timely hiring and placement of key workers	
	5. 32,700 HIV tests conducted		5. Operations research will identify problems and facilitate introduction of improved intervention strategies	
	6. 78,900 Gonorrhea tests conducted		6. Other donors will continue to provide complementary support for public and private sector activities	
	7. 5,200 Herpes tests conducted			
	8. 5,200 Trichomoniasis tests conducted			
	9. 87,700 Syphilis tests conducted			
	10. 14,900 Chlamydia tests conducted			
	11. 22,800 Hepatitis tests conducted			
	12. 3,600 Chancroid tests conducted			
	13. 80,000 clinic patients counseled		14. Increased awareness of, and knowledge about preventive measures against STD/HIV, among the target area populations	

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY: 1991 to FY: 1995
Total U.S. Funding: \$3.5 million
Date Prepared: 20 June 1991
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Project Title & Number: AIDS/STD Prevention and Control, Nr. 511-0608

PROJECT OUTPUTS	OUTPUTS MEASURABLE INDICATORS	MEANS OF VERIFICATION	OUTPUTS ASSUMPTIONS
1. Improved identification of STD/HIV high risk population in three target areas 2. A programatically useful profile of STD/HIV service users 3. Enhanced Laboratory capacity to diagnose HIV and major STDs in three target areas 4. Development of broad strategies for STD/HIV management and control in the target service areas 5. Development of Quality Assurance for STD diagnosis and treatment and for HIV testing and counseling in target areas (continued)	1. KAP Survey Instruments 2. Project service statistics system 3. Number and type of Standard Operating Procedures for project clinics and labs 4. Results of Quality Assurance monitoring 5. Number and type of health worker trained (by gender) 6. Knowledge accrued via training 7. Number and types of IEC messages disseminated 8. Number and types of clients counseled in target service delivery units 9. Number of condoms distributed free 10. Number of condoms sold	1. Results of KAP surveys and of focus group research 2. Project Service Statistics 3. Standard Operating Procedures for project clinics and labs 4. Quality Assurance qualitative and quantitative reports 5. Project training statistics 6. Training evaluation reports 7. USAID/Bolivia project records 8. CDC reports and records 9. End of project evaluation	1. Institutions targeted for strengthening provide suitable space and personnel for project 2. Suitable trainees identified in sufficient numbers 3. Community acceptance of services provided 4. Stable or increased support from international donors to institutions targeted by this project

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PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY: 1991 to FY: 1995
Total U.S. Funding: \$3.5 million
Date Prepared: 20 June 1991
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Project Title & Number: AIDS/STD Prevention and Control, Nr. 511-0608

PROJECT OUTPUTS	OUTPUTS MEASURABLE INDICATORS	MEANS OF VERIFICATION	OUTPUTS ASSUMPTIONS
6. Better trained health workers, more effective in : <ul style="list-style-type: none">- STD/HIV diagnosis- STD/HIV management- STD/HIV risk assessment and counseling- STD/HIV epidemiological and social research- STD/HIV communication strategy design for knowledge, attitude and behavior changes			
7. Enhanced implementation of STD/HIV education/prevention programs			
8. Widespread and appropriate administration of Social Marketing of condoms			

PROJECT DESIGN SUMMARY
LOGICAL FRAMEWORK

Life of Project:
From FY: 1991 to FY: 1995
Total U.S. Funding: \$3.5 million
Date Prepared: 20 June 1991
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Project Title & Number: AIDS/STD Prevention and Control, No. 511-0608

PROJECT MAJOR ACTIVITIES	PROJECT INPUTS	INPUTS MEANS OF VERIFICATION	INPUTS ASSUMPTIONS
<p>USAID/Bolivia provided :</p> <ol style="list-style-type: none"> 1. Technical Assistance 2. In country training, conferences and workshops 3. Equipment and commodities 4. Local staff and operations support 5. MHR management support 6. IEC, SM and OR sub-project grants <p>GOB provided :</p> <ol style="list-style-type: none"> 1. Staff 2. Facilities 3. Partial local costs 4. Existing equipment <p>NGOs provided:</p> <ol style="list-style-type: none"> 1. Staff 2. Facilities 3. Partial local costs 4. Existing equipment 	<p>USAID/Bolivia: \$3,500,000 over a period of 4 years to be used as follows:</p> <ol style="list-style-type: none"> 1. 4 P/Y long term TA 2. 32 P/M short term TA 3. 8 P/Y local senior project personnel 4. 2,000,000 condoms 5. \$649,000 lab equipment and reagents 6. Local transportation and communications 7. \$613,000 small grants for IEC, SM & OR 8. \$108,000 training 9. 1 midterm and 1 final evaluation <p>GOB: \$1,596,000 over 4 years</p> <ol style="list-style-type: none"> 1. \$254,000 in-kind facilities, equipment and personnel support 2. \$730,000 for personnel and operational cost 3. \$612,000 for lab reagents and medicines <p>NGOs:</p> <p>\$80,000 in-kind sub-project support</p>	<ol style="list-style-type: none"> 1. Project disbursement and audit reports 2. Technical assistance reports and records 3. GOB contractual agreement and annual reports 4. NGOs contractual agreements and annual reports 5. External end of project evaluation 6. Internal monitoring documents 	<ol style="list-style-type: none"> 1. USAID/Bolivia funds and procurement are obligated and disbursed on a timely basis 2. Timely provision of Technical Assistance 3. Rational and timely distribution of project resources

5C(2) - ASSISTANCE CHECKLIST

ANNEX 3

Listed below are statutory criteria applicable to the assistance resources themselves, rather than to the eligibility of a country to receive assistance. This section is divided into three parts. Part A includes criteria applicable to both Development Assistance and Economic Support Fund resources. Part B includes criteria applicable only to Development Assistance resources. Part C includes criteria applicable only to Economic Support Funds.

AID/STD Prevention and Control Project

No. 511-0608

CROSS REFERENCE: IS COUNTRY CHECKLIST UP TO DATE?

A. CRITERIA APPLICABLE TO BOTH DEVELOPMENT ASSISTANCE AND ECONOMIC SUPPORT FUNDS

1. Host Country Development Efforts (FAA Sec. 601(a)): Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions.

The goal of the project is to improve the health status of Bolivians, especially women of child-bearing age and their children.

The project purpose is to expand access to, and use of, effective STD/HIV control and prevention services and education in the departments of La Paz, Santa Cruz and Cochabamba.

2. U.S. Private Trade and Investment (FAA Sec. 601(b)): Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).

A private U.S. firm and/or the Centers for Disease Control (CDC) will provide technical assistance to the project. U.S. firms will also provide laboratory equipment, supplies, computers, and reagents.

3. Congressional Notification

a. General requirement (FY 1991 Appropriations Act Secs. 523 and 591; FAA Sec. 634A): If money is to be obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified (unless the notification requirement has been waived because of substantial risk to human health or welfare)?

A Congressional Notification will be sent to Congress before the obligation of funds.

No funds will be obligated until AID/W advises USAID/Bolivia that the CN has expired without objection.

b. Notice of new account obligation (FY 1991 Appropriations Act Sec. 514): If funds are being obligated under an appropriation account to which they were not appropriated, has the President consulted with and provided a written justification to the House and Senate Appropriations Committees and has such obligation been subject to regular notification procedures?

N/A

c. Cash transfers and nonproject sector assistance (FY 1991 Appropriations Act Sec. 575(b)(3)): If funds are to be made available in the form of cash transfer or nonproject sector assistance, has the Congressional notice included a detailed description of how the funds will be used, with a discussion of U.S. interests to be served and a description of any economic policy reforms to be promoted?

N/A

4. Engineering and Financial Plans (FAA Sec. 611(a)): Prior to an obligation in excess of \$500,000, will there be: (a) engineering, financial or other plans necessary to carry out the assistance; and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?

(a) Yes

(b) Yes

5. Legislative Action (FAA Sec. 611(a)(2)): If legislative action is required within recipient country with respect to an obligation in excess of \$500,000, what is the basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of the purpose of the assistance?

Not required

6. **Water Resources** (FAA Sec. 611(b); FY 1991 Appropriations Act Sec. 501): If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) N/A
7. **Cash Transfer and Sector Assistance** (FY 1991 Appropriations Act Sec. 575(b)): Will cash transfer or nonproject sector assistance be maintained in a separate account and not commingled with other funds (unless such requirements are waived by Congressional notice for nonproject sector assistance)? N/A
8. **Capital Assistance** (FAA Sec. 611(e)): If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed \$1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? Yes
9. **Multiple Country Objectives** (FAA Sec. 601(a)): Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. The goal of the project is to improve the health status of Bolivians, especially women of child-bearing age and their children. The project purpose is to expand access to, and use of, effective STD/HIV control and prevention services and education in the departments of La Paz, Santa Cruz and Cochabamba.
10. **U.S. Private Trade** (FAA Sec. 601(b)): Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). A private U.S. firm and/or the Centers for Disease Control (CDC) will provide technical assistance to the project. U.S. firms will also provide laboratory equipment, supplies, computers, and reagents.

11. Local Currencies

a. Recipient Contributions (FAA Secs. 612(b), 636(h)): Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars.

a. The Government of Bolivia provides local currency to all AID-GOB projects in conjunction with the Balance of Payment Program. The U.S. does not own Bolivian currency.

b. U.S.-Owned Currency (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

b. No

c. Separate Account (FY 1991 Appropriations Act Sec. 575). If assistance is furnished to a foreign government under arrangements which result in the generation of local currencies:

(1) Has A.I.D. (a) required that local currencies be deposited in a separate account established by the recipient government, (b) entered into an agreement with that government providing the amount of local currencies to be generated and the terms and conditions under which the currencies so deposited may be utilized, and (c) established by agreement the responsibilities of A.I.D. and that government to monitor and account for deposits into and disbursements from the separate account?

(1) Yes, the 1991 ESF agreements and procedures approved by USAID comply with all these requirements.

(2) Will such local currencies, or an equivalent amount of local currencies, be used only to carry out the purposes of the DA or ESF chapters of the FAA (depending on which chapter is the source of the assistance) or for the administrative requirements of the United States Government?

(2) Yes

(3) Has A.I.D. taken all appropriate steps to ensure that the equivalent of local currencies disbursed from the separate account are used for the agreed purposes?

(3) Yes

(4) If assistance is terminated to a country, will any unencumbered balances of funds remaining in a separate account be disposed of for purposes agreed to by the recipient government and the United States Government?

N/A

12. Trade Restrictions

a. **Surplus Commodities (FY 1991 Appropriations Act Sec. 521(a)):** If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?

a. and b.

Section 559 (a) (3) of the FY 91 Appropriations Act provides a waiver of Section 521 restrictions for Bolivia, for the purpose of reducing dependence upon the production of crops from which narcotic and psychotropic drugs are derived.

b. **Textiles (Lautenberg Amendment) (FY 1991 Appropriations Act Sec. 521(c)):** Will the assistance (except for programs in Caribbean Basin Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work gloves or leather wearing apparel?

13. **Tropical Forests (FY 1991 Appropriations Act Sec. 533(c)(3)):** Will funds be used for any program, project or activity which would (a) result in any significant loss of tropical forests, or (b) involve industrial timber extraction in primary tropical forest areas?

(a) No

(b) No

14. **Sahel Accounting** (FAA Sec. 121(d)): If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? N/A
15. **PVO Assistance**
- a. **Auditing and registration** (FY 1991 Appropriations Act Sec. 537): If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? Yes
- b. **Funding sources** (FY 1991 Appropriations Act, Title II, under heading "Private and Voluntary Organizations"): If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? Yes
16. **Project Agreement Documentation** (State Authorization Sec. 139 (as interpreted by conference report)): Has confirmation of the date of signing of the project agreement, including the amount involved, been cabled to State L/T and A.I.D. LEG within 60 days of the agreement's entry into force with respect to the United States, and has the full text of the agreement been pouched to those same offices? (See Handbook 3, Appendix 6G for agreements covered by this provision). N/A, because agreement is for less than \$25 million.
17. **Metric System** (Omnibus Trade and Competitiveness Act of 1988 Sec. 5164, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance activity use the metric system of measurement in its procurements, grants, and other business-related activities, except to the

extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage?

Yes

Yes

Yes

18. Women in Development (FY 1991 Appropriations Act, Title II, under heading "Women in Development"): Will assistance be designed so that the percentage of women participants will be demonstrably increased?

19. Regional and Multilateral Assistance (FAA Sec. 209): Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs.

No. However, USAID/Bolivia is coordinating with the Panamerican Health Organization in all AIDS/STD activities in Bolivia.

20. Abortions (FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 525):

a. Will assistance be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization?

a. No

b. Will any funds be used to lobby for abortion?

b. No

21. Cooperatives (FAA Sec. 111): Will assistance help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life?

No. The project will assist the Ministry of Health and work with NGOs in AIDS/STD prevention and control.

22. U.S.-Owned Foreign Currencies

The U.S. does not own any significant amount of Bolivian currency.

a. Use of currencies (FAA Secs. 612(b), 636(h); FY 1991 Appropriations Act Secs. 507, 509): Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services.

b. Release of currencies (FAA Sec. 612(d)): Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?

No

23. Procurement

a. Small business (FAA Sec. 602(a)): Are there arrangements to permit U.S. small business to participate equitably in the furnishing of commodities and services financed?

Yes

b. U.S. procurement (FAA Sec. 604(a)): Will all procurement be from the U.S. except as otherwise determined by the President or determined under delegation from him?

Yes

c. Marine insurance (FAA Sec. 604(d)): If the cooperating country discriminates against marine insurance companies authorized to do business in the U.S., will commodities be insured in the United States against marine risk with such a company?

Yes

d. Non-U.S. agricultural procurement (FAA Sec. 604(e)): If non-U.S. procurement of agricultural commodity or product thereof is to be financed, is there provision against such procurement when the domestic price of such commodity is less than parity? (Exception where commodity financed could not reasonably be procured in U.S.)

No procurements of agriculture commodities are planned.

e. Construction or engineering services (FAA Sec. 604(g)): Will construction or engineering services be procured from firms of advanced developing countries which are otherwise eligible

- under Code 941 and which have attained a competitive capability in international markets in one of these areas? (Exception for those countries which receive direct economic assistance under the FAA and permit United States firms to compete for construction or engineering services financed from assistance programs of these countries.) No
- f. Cargo preference shipping** (FAA Sec. 603): Is the shipping excluded from compliance with the requirement in section 901(b) of the Merchant Marine Act of 1936, as amended, that at least 50 percent of the gross tonnage of commodities (computed separately for dry bulk carriers, dry cargo liners, and tankers) financed shall be transported on privately owned U.S. flag commercial vessels to the extent such vessels are available at fair and reasonable rates? No
- g. Technical assistance** (FAA Sec. 621(a)): If technical assistance is financed, will such assistance be furnished by private enterprise on a contract basis to the fullest extent practicable? Will the facilities and resources of other Federal agencies be utilized, when they are particularly suitable, not competitive with private enterprise, and made available without undue interference with domestic programs? Yes
- h. U.S. air carriers** (International Air Transportation Fair Competitive Practices Act, 1974): If air transportation of persons or property is financed on grant basis, will U.S. carriers be used to the extent such service is available? Yes
- i. Termination for convenience of U.S. Government** (FY 1991 Appropriations Act Sec. 504): If the U.S. Government is a party to a contract for procurement, does the contract contain a provision authorizing termination of such contract for the convenience of the United States? Yes

- j. Consulting services** Yes
 (FY 1991 Appropriations Act Sec. 524): If assistance is for consulting service through procurement contract pursuant to 5 U.S.C. 3109, are contract expenditures a matter of public record and available for public inspection (unless otherwise provided by law or Executive order)?
- k. Metric conversion**
 (Omnibus Trade and Competitiveness Act of 1988, as interpreted by conference report, amending Metric Conversion Act of 1975 Sec. 2, and as implemented through A.I.D. policy): Does the assistance program use the metric system of measurement in its procurements, grants, and other business-related activities, except to the extent that such use is impractical or is likely to cause significant inefficiencies or loss of markets to United States firms? Yes
 Are bulk purchases usually to be made in metric, and are components, subassemblies, and semi-fabricated materials to be specified in metric units when economically available and technically adequate? Will A.I.D. specifications use metric units of measure from the earliest programmatic stages, and from the earliest documentation of the assistance processes (for example, project papers) involving quantifiable measurements (length, area, volume, capacity, mass and weight), through the implementation stage? Yes
- l. Competitive Selection Procedures** (FAA Sec. 601(e)): Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? Yes
- 24. Construction**
- a. Capital project** (FAA Sec. 601(d)): If capital (e.g., construction) project, will U.S. engineering and professional services be used? N/A
- b. Construction contract** (FAA Sec. 611(c)): If contracts for construction are to be financed, will they be let on a competitive basis to maximum extent practicable? N/A

- c. Large projects, Congressional approval (FAA Sec. 620(k)):** N/A
 If for construction of productive enterprise, will aggregate value of assistance to be furnished by the U.S. not exceed \$100 million (except for productive enterprises in Egypt that were described in the Congressional Presentation), or does assistance have the express approval of Congress?
- 25. U.S. Audit Rights (FAA Sec. 301(d)):** Yes
 If fund is established solely by U.S. contributions and administered by an international organization, does Comptroller General have audit rights?
- 26. Communist Assistance (FAA Sec. 620(h)).** Yes
 Do arrangements exist to insure that United States foreign aid is not used in a manner which, contrary to the best interests of the United States, promotes or assists the foreign aid projects or activities of the Communist-bloc countries?
- 27. Narcotics**
- a. Cash reimbursements (FAA Sec. 483):** Yes
 Will arrangements preclude use of financing to make reimbursements, in the form of cash payments, to persons whose illicit drug crops are eradicated?
- b. Assistance to narcotics traffickers (FAA Sec. 487):**
 Will arrangements take "all reasonable steps" to preclude use of financing to or through individuals or entities which we know or have reason to believe have either: (1) been convicted of a violation of any law or regulation of the United States or a foreign country relating to narcotics (or other controlled substances); or (2) been an illicit trafficker in, or otherwise involved in the illicit trafficking of, any such controlled substance?
 Yes. USAID/Bolivia has developed a certification form for contractors grantees and borrowers under Sec. 487 by which USAID and the U.S. Embassy can check the appropriate narcotics records to ensure compliance.

28. **Expropriation and Land Reform** (FAA Sec. 620(g)): Will assistance preclude use of financing to compensate owners for expropriated or nationalized property, except to compensate foreign nationals in accordance with a land reform program certified by the President? Yes
29. **Police and Prisons** (FAA Sec. 660): Will assistance preclude use of financing to provide training, advice, or any financial support for police, prisons, or other law enforcement forces, except for narcotics programs? Yes
30. **CIA Activities** (FAA Sec. 662): Will assistance preclude use of financing for CIA activities? Yes
31. **Motor Vehicles** (FAA Sec. 636(i)): Will assistance preclude use of financing for purchase, sale, long-term lease, exchange or guaranty of the sale of motor vehicles manufactured outside U.S., unless a waiver is obtained? Yes
32. **Military Personnel** (FY 1991 Appropriations Act Sec. 503): Will assistance preclude use of financing to pay pensions, annuities, retirement pay, or adjusted service compensation for prior or current military personnel? Yes
33. **Payment of U.N. Assessments** (FY 1991 Appropriations Act Sec. 505): Will assistance preclude use of financing to pay U.N. assessments, arrearages or dues? Yes
34. **Multilateral Organization Lending** (FY 1991 Appropriations Act Sec. 506): Will assistance preclude use of financing to carry out provisions of FAA section 209(d) (transfer of FAA funds to multilateral organizations for lending)? Yes
35. **Export of Nuclear Resources** (FY 1991 Appropriations Act Sec. 510): Will assistance preclude use of financing to finance the export of nuclear equipment, fuel, or technology? Yes

36. **Repression of Population** (FY 1991 Appropriations Act Sec. 511): Will assistance preclude use of financing for the purpose of aiding the efforts of the government of such country to repress the legitimate rights of the population of such country contrary to the Universal Declaration of Human Rights?

Yes

37. **Publicity or Propoganda** (FY 1991 Appropriations Act Sec. 516): Will assistance be used for publicity or propoganda purposes designed to support or defeat legislation pending before Congress, to influence in any way the outcome of a political election in the United States, or for any publicity or propoganda purposes not authorized by Congress?

No

38. **Marine Insurance** (FY 1991 Appropriations Act Sec. 563): Will any A.I.D. contract and solicitation, and subcontract entered into under such contract, include a clause requiring that U.S. marine insurance companies have a fair opportunity to bid for marine insurance when such insurance is necessary or appropriate?

Yes

39. **Exchange for Prohibited Act** (FY 1991 Appropriations Act Sec. 569): Will any assistance be provided to any foreign government (including any instrumentality or agency thereof), foreign person, or United States person in exchange for that foreign government or person undertaking any action which is, if carried out by the United States Government, a United States official or employee, expressly prohibited by a provision of United States law?

No

B. CRITERIA APPLICABLE TO DEVELOPMENT ASSISTANCE ONLY

1. **Agricultural Exports (Bumpers Amendment)** (FY 1991 Appropriations Act Sec. 521(b), as interpreted by conference report for original enactment): If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities: (1) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in that third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (2) in support of research that is intended primarily to benefit U.S. producers?

Section 559 (a) (3) of the FY 91 Appropriations Act waives Section 521 for Bolivia.

2. **Tied Aid Credits** (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund"): Will DA funds be used for tied aid credits?

No

3. **Appropriate Technology** (FAA Sec. 107): Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?

Yes

4. **Indigenous Needs and Resources** (FAA Sec. 281(b)): Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government.

The project will develop the capacities of local NGOs to design information, education, and communication programs in at least one indigenous language (Aymara or Quechua).

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5. **Economic Development** (FAA Sec. 101(a)): Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?

Yes

6. **Special Development Emphases** (FAA Secs. 102(b), 113, 281(a)): Describe extent to which activity will: (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries.

- (a) The poor will benefit from STD/HIV prevention and control activities.
- (b) The project will work with local NGOs.
- (c) The project will work with the MOH and with STD/HIV high risk groups.
- (d) Women are included in a number of high risk groups.
- (e) The success/failures of the AIDS/STD program will be shared with other Andean activities.

7. **Recipient Country Contribution** (FAA Secs. 110, 124(d)): Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?

Yes, 32%

8. **Benefit to Poor Majority** (FAA Sec. 128(b)): If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority?

Yes

9. Abortions (FAA Sec. 104(f); FY 1991 Appropriations Act, Title II, under heading "Population, DA," and Sec. 535):

- a. Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? No
- b. Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilizations? No
- c. Are any of the funds to be made available to any organization or program which, as determined by the President, supports or participates in the management of a program of coercive abortion or involuntary sterilization? No
- d. Will funds be made available only to voluntary family planning projects which offer, either directly or through referral to, or information about access to, a broad range of family planning methods and services? Yes
- e. In awarding grants for natural family planning, will any applicant be discriminated against because of such applicant's religious or conscientious commitment to offer only natural family planning? N/A
- f. Are any of the funds to be used to pay for any biomedical research which relates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? No
- g. Are any of the funds to be made available to any organization if the President certifies that the use of these funds by such organization would violate any of the above provisions related to abortions and involuntary sterilization? No

10. **Contract Awards** (FAA Sec. 601(e)): Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?

Yes

11. **Disadvantaged Enterprises** (FY 1991 Appropriations Act Sec. 567): What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)?

These organizations may bid for contracts or grants directly or for subcontracts under the project.

12. **Biological Diversity** (FAA Sec. 119(g)): Will the assistance: (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

- (a) N/A
- (b) N/A
- (c) N/A
- (d) No

13. **Tropical Forests** (FAA Sec. 118; FY 1991 Appropriations Act Sec. 533(c)-(e) & (g)):

a. **A.I.D. Regulation 16**: Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16?

Yes

b. **Conservation**: Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent

N/A

feasible: (1) stress the importance of conserving and sustainably managing forest resources; (2) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (3) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; (4) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (5) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (6) conserve forested watersheds and rehabilitate those which have been deforested; (7) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (8) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (9) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network of protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate protected areas; (10) seek to increase the awareness of U.S. Government agencies and other donors of the immediate and long-term value of tropical forests; (11) utilize the resources and abilities of all relevant U.S. government agencies; (12) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land; and (13) take full account of the environmental impacts of the proposed activities on biological diversity?

All N/A

c. Forest degradation: Will assistance be used for: (1) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; (2) actions which will significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotic plants or animals into such areas; (3) activities which would result in the conversion of forest lands to the rearing of livestock; (4) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undergraded forest lands; (5) the colonization of forest lands; or (6) the construction of dams or other water control structures which flood relatively undergraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development?

All No

d. Sustainable forestry: If assistance relates to tropical forests, will project assist countries in developing a systematic analysis of the appropriate use of their total tropical forest resources, with the goal of developing a national program for sustainable forestry?

N/A

e. Environmental impact statements: Will funds be made available in accordance with provisions of FAA Section 117(c) and applicable A.I.D. regulations requiring an environmental impact statement for activities significantly affecting the environment?

Yes

14. **Energy (FY 1991 Appropriations Act Sec. 533(c)):** If assistance relates to energy, will such assistance focus on: (a) end-use energy efficiency, least-cost energy planning, and renewable energy resources, and (b) the key countries where assistance would have the greatest impact on reducing emissions from greenhouse gases?

N/A

15. **Sub-Saharan Africa Assistance (FY 1991 Appropriations Act Sec. 562, adding a new FAA chapter 10 (FAA Sec. 496)):** If assistance will come from the Sub-Saharan Africa DA account, is it: (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; (b) to be used to promote sustained economic growth, encourage private sector development, promote individual initiatives, and help to reduce the role of central governments in areas more appropriate for the private sector; (c) being provided in accordance with the policies contained in FAA section 102; (d) being provided in close consultation with African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in Sub-Saharan Africa; (e) being used to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to bring about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; (f) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks,

N/A

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to maintain and restore the renewable natural resource base in ways that increase agricultural production, to improve health conditions with special emphasis on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas?

16. **Debt-for-Nature Exchange (FAA Sec. 463):** If project will finance a debt-for-nature exchange, describe how the exchange will support protection of: (a) the world's oceans and atmosphere, (b) animal and plant species, and (c) parks and reserves; or describe how the exchange will promote: (d) natural resource management, (e) local conservation programs, (f) conservation training programs, (g) public commitment to conservation, (h) land and ecosystem management, and (i) regenerative approaches in farming, forestry, fishing, and watershed management.

N/A

17. **Deobligation/Reobligation (FY 1991 Appropriations Act Sec. 515):** If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same region as originally obligated, and have the House and Senate Appropriations Committees been properly notified?

N/A

18. **Loans**

a. **Repayment capacity (FAA Sec. 122(b)):** Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest.

N/A

b. Long-range plans (FAA Sec. 122(b)): Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities?

N/A

c. Interest rate (FAA Sec. 122(b)): If development loan is repayable in dollars, is interest rate at least 2 percent per annum during a grace period which is not to exceed ten years, and at least 3 percent per annum thereafter?

N/A

d. Exports to United States (FAA Sec. 620(d)): If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise's annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest?

N/A

19. Development Objectives (FAA Secs. 102(a), 111, 113, 281(a)): Extent to which activity will: (1) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (2) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (3) support the self-help efforts of developing countries; (4) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (5) utilize and encourage regional cooperation by developing countries?

(a) The poor will benefit from STD/HIV prevention and control activities.

(b) The project will work with local NGOs.

(c) The project will work with the MOH and with STD/HIV high risk groups.

(d) Women are included in a number of high risk groups.

(e) The success/failures of the AIDS/STD program will be shared with other Andean activities.

20. **Agriculture, Rural Development and Nutrition, and Agricultural Research (FAA Secs. 103 and 103A):**

a. **Rural poor and small farmers:** If assistance is being made available for agriculture, rural development or nutrition, describe extent to which activity is specifically designed to increase productivity and income of rural poor; or if assistance is being made available for agricultural research, has account been taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made.

N/A. The project is oriented to urban areas.

b. **Nutrition:** Describe extent to which assistance is used in coordination with efforts carried out under FAA Section 104 (Population and Health) to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value; improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people.

The project will prevent and reduce infectious diseases.

c. **Food security:** Describe extent to which activity increases national food security by improving food policies and management and by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

N/A

21. **Population and Health (FAA Secs. 104(b) and (c)):** If assistance is being made available for population or health activities, describe extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of

The project will strengthen STD/HIV reference laboratories and clinics.

mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach.

22. Education and Human Resources Development (FAA Sec. 105): If assistance is being made available for education, public administration, or human resource development, describe (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities.

(a) The project will support AIDS/STD information, education and communication activities.

(b) The project will train MOH and NGO personnel in STD/HIV prevention and control.

23. Energy, Private Voluntary Organizations, and Selected Development Activities (FAA Sec. 106): If assistance is being made available for energy, private voluntary organizations, and selected development problems, describe extent to which activity is:

a. concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and facilitative of research on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment;

N/A

b. concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations;

The project will work with NGOs for information (IEC), social marketing (SM) of condoms, and operations research (OR) activities.

c. research into, and evaluation of, economic development processes and techniques; N/A

d. reconstruction after natural or manmade disaster and programs of disaster preparedness; N/A

e. for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance; AIDS/STD prevention and control activities.

f. for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development. The project will seek to prevent the negative effects of STD/HIV infectious on the urban labor force and GDP.

24. Sahel Development (FAA Secs. 120-21). If assistance is being made available for the Sahelian region, describe: (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multidonor development plan which calls for equitable burden-sharing with other donors; (b) whether a determination has been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom). N/A

C. CRITERIA APPLICABLE TO ECONOMIC SUPPORT FUNDS ONLY

1. **Economic and Political Stability** (FAA Sec. 531(a)): Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? Yes
2. **Military Purposes** (FAA Sec. 531(e)): Will this assistance be used for military or paramilitary purposes? No
3. **Commodity Grants/Separate Accounts** (FAA Sec. 609): If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? N/A
4. **Generation and Use of Local Currencies** (FAA Sec. 531(d)): Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106? Yes
Yes
5. **Cash Transfer Requirements** (FY 1991 Appropriations Act, Title II, under heading "Economic Support Fund," and Sec. 575(b)). If assistance is in the form of a cash transfer: Funds obligated in this project will not be cash transfer assistance.
- a. **Separate account:** Are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds? N/A

b. **Local currencies:** Will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account, and has A.I.D. entered into an agreement with that government setting forth the amount of the local currencies to be generated, the terms and conditions under which they are to be used, and the responsibilities of A.I.D. and that government to monitor and account for deposits and disbursements?

N/A

c. **U.S. Government use of local currencies:** Will all such local currencies also be used in accordance with FAA Section 609, which requires such local currencies to be made available to the U.S. government as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the purposes for which new funds authorized by the FAA would themselves be available?

N/A

d. **Congressional notice:** Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance?

N/A

DRAFTER:GC/LP:EHonnold:4/11/91:2169J

ANNEX 4

B/G REQUEST FOR ASSISTANCE



DGS/644/91

MINISTERIO DE PREVISION SOCIAL Y SALUD PUBLICA

La Paz-Bolivia

La Paz, 7 de Junio de 1991

Señor
Carl Leonard
DIRECTOR DE USAID/BOLIVIA
Presente

De mi consideración:

De acuerdo a convenios de Cooperación que recibe el Ministerio de Previsión Social y Salud Pública, para el programa de SIDA, nos permitimos solicitar la ampliación de este apoyo al Programa de Enfermedades de Transmisión Sexual, con énfasis en Prevención y Educación, para los próximos 5 años.

La Dra. Sigrid Anderson Subdirectora de la división de Salud y Recursos Humanos, ha estado evaluando esta Cooperación con consultores del Centro de Control de Enfermedades de Atlanta U.S.A., Family Health International -AIDSTECH - AINSON y nuestro Ministerio (Epidemiología e Inlisa).

Con este motivo, agradecemos la cooperación y reiteramos las seguridades de nuestra alta consideración.

JOS/erh.


Dr. G. K. Toledo Bolta
DIRECTOR GENERAL DE SALUD
Min. Prev. Social y Salud Pública

ANNEX 5

PROJECT ANALYSES

- 5.1. **Technical Analysis**
- 5.2. **Financial Analysis**
- 5.3. **Economic Analysis**
- 5.4. **Social Soundness Analysis**
- 5.5. **Administrative Analysis**
- 5.6 **Environmental Analysis**
- 5.7. **Review of Sub-Grant Proposals**

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AIDS/STD PREVENTION AND CONTROL PROJECT

5.1. TECHNICAL ANALYSIS

By George P. Schmid, William Boyd, and
William C. Levine
Centers for Disease Control

Background on Bolivia and its Population

The population of Bolivia is approximately 6,500,000, and is ethnically quite diverse. About 60% of the populace is autoctonous, belonging to one of two groups, Aymara or Quechua; these groups speak their own language and many understand Spanish. About 30% of the populace is mestizo (mixed Indian and European descent), and about 10% of European ancestry. Small numbers of Japanese are concentrated in Santa Cruz, as are small numbers of blacks in the Yungas zone of La Paz. There is a general class structure along ethnic and economic lines, with Indians.

Similarly Bolivia has diverse geography. The west of the country is the altiplano, or high plains, which is the most heavily populated portion of the country. To the east lie the highland valleys, which divide the altiplano from the tropical remainder of the country, which borders Brazil and Argentina. There are three major cities in the country: La Paz in the altiplano, Cochabamba in the highland valleys, and Santa Cruz in the tropics. There is currently considerable immigration from Brazil into Santa Cruz, which has become a thriving city during the last 30 years, in part because of the wealth of natural resources in this area and in part because of drug trade. The country is divided into 9 political "departments", which coincide for the most part with the Ministry of Health's eleven (11) sanitary of health regions.

After Haiti, Bolivia has the lowest per capita income of any country in the Western Hemisphere. Educational resources available to much of the population are not good, as much of the population is rural and teachers are poorly paid and often on strike over wages. Much of the populace does not complete an elementary education and are probably functionally illiterate.

The Bolivian Health Care System

Health care is also a major problem. Delivering adequate care to rural areas is difficult, although medical school graduates are required to practice in areas of need for two years before receiving their medical degree. Complete immunization, which includes BCG, is achieved in less than one half of the rural populace.

Major health problems include lack of adequate water supplies, malnutrition, lack of adequate immunization, diarrheal diseases, lack of sanitary

facilities, tuberculosis, malaria, and Chagas disease. Chagas disease constitutes a major threat to much of the population of Bolivia who reside outside the Altiplano and is the subject of intense governmental control efforts. An estimated 40% of the population may be infected, and 5-15% of infected individuals develop serious late manifestations of Chagas disease.

The health delivery system of Bolivia is a combination of public and private care, with nongovernment organizations (NGO) playing an increasing role in the private sector. There is a form of national health insurance for workers. Individuals who have jobs can seek outpatient or inpatient care at any public hospital, where insurance pays their expenses, although they may need to pay some fee. In La Paz there is a public hospital which sees individuals without insurance. Such hospitals probably exist in other cities and likely the small hospitals found in small cities serve both purposes. Some physicians work part of each day at the public hospitals and then have private practices in addition to their government duties because of the relatively low wages at the government hospitals.

Private physicians are readily available in the larger cities on a fee for service basis (said to be about 50 Bs a visit). Private hospitals and clinics for hospitalization also exist, in association with the private practices, and a hospitalization day costs somewhat over 100 Bs. Because of the high cost and inaccessibility of medical care to much of the populace, NGOs have begun to play an increasingly important role in the health structure of the country. These organizations, some with religious affiliations, provide primary care at regularly scheduled clinics and hospitalization at affiliated hospitals if necessary. In general, these organizations are as well if not better equipped and staffed than government facilities and are playing increasingly important roles in outreach activities for such areas as antenatal care and family planning services. Care at the NGOs is not free (a visit appears to be less than 5 Bs), but partial payment is accepted if full payment cannot be made. Laboratory tests will not generally be performed, however, if payment cannot be made.

The use of health care by Bolivians ranges from home remedies to reasonably sophisticated medical care, based on accessibility, payment ability, and custom. In probably all areas of the country, home remedies, e.g. teas, are used for many conditions. Traditional medicine healers remain a vital part of health care in rural areas and it is likely the outlying areas of cities where the poor cluster. It is likely that patients with a possible STD may consult a healer, we are unsure of the remedies they prescribe. A unique facet of Bolivian health care includes injection centers, staffed by a nurse. These centers are consulted by individuals with various ailments, and injections are administered (with reused needles, per some opinions). Other than glucose, what constitutes the injections is unclear.

Non-physician-prescribed antibiotics play a significant role in treatment of ailments and are available from at least two sources: pharmacies and the black market. Pharmacies are numerous in cities, found on essentially every block. A wide range of oral and injectable antibiotics, e.g. benzathine penicillin,

procaine penicillin, amoxicillin, ampicillin, trimethoprim/sulfamethoxazole, metronidazole, tetracycline, oxacillin, streptomycin, cephalexin, may be requested by the individual or prescribed/recommended by the pharmacist. Thus, it is extremely common for patients to self-administer antibiotics for varying ailments, including STDs. Antibiotics prescribed by physicians are also dispensed in pharmacies, and it appears that physicians do not stock antibiotics themselves. Injectable antibiotics are administered at the pharmacies, whether prescribed by the patient, pharmacist, or physician, and it is believed that previously used needles are at least occasionally used. Antimicrobials are also available at markets, with drugs sold openly at least twice weekly in Santa Cruz.

The diagnosis of STDs by private physicians is, except in unusual circumstances, based upon clinical grounds; it is likely that a speculum exam is usually not performed on female patients but the symptoms and quality of vaginal discharge (if any) are considered. It appears that a microscope is not part of a physician's equipment and that all laboratory testing is performed by the many laboratory services which operate in the vicinity of physician's offices and pharmacies. We do not know the quality of services offered by these laboratories but, for STDs, is probably at best a Gram stain or serologic test for syphilis. The patient, who has usually failed treatment, is sent to the laboratory for testing to be performed, with treatment to be subsequently rendered based upon the results; physicians may be paid money for referring a patient to a laboratory. The large majority of patients with a possible STD seen at a physician's office are probably treated without a laboratory test being performed.

The range of laboratory tests for the diagnosis of STDs within Bolivia is limited. In La Paz, INLASA, the major reference laboratory for the country, offers hepatitis B, HIV-1 and VDRL testing, but HIV reagents are not always available and no confirmatory syphilis testing is performed. INLASA's bacteriology section offers gonococcal and chancroid culture to patients referred to the laboratory, but uses a single chocolate agar plate without antibiotics to culture for either; iodometric beta lactamase testing is performed on isolates. Selective gonococcal agar is reportedly available at several laboratories in La Paz and perhaps elsewhere in the country, but isolates are not referred to INLASA. Syphilis serology is likely available at many facilities. Among other diseases, with the exception of possible research studies, testing for chlamydia (two studies), herpes simplex virus (no studies), trichomoniasis (no studies outside of wet prep), bacterial vaginosis (no studies), and human papilloma virus (HPV), outside of PAP smears is seldom offered within the country.

Sexuality, STDs and prostitution, in Bolivia

Few studies have been performed to determine the health-care seeking behaviors of individuals with STDs. Hence, we do not know the significance that symptoms of an STD might have for an individual, although several anecdotal

reports confirm that in one geographic area, the acquisition of an STD by a male is associated with machismo. It was also reported that to cure an STD a male must have sexual intercourse with a virgin.

The majority of diagnosed STDs occur in women, and these appear to be diagnosed because of screening activities of prostitutes or women seeking care for symptoms or antenatal care. Syphilis is diagnosed more frequently than gonorrhea, possibly because syphilis screening is more frequent. Two sources indicated that pelvic inflammatory disease was common, suggesting that gonorrhea and/or chlamydia are common infections. Few males are seen with an STD and there is no clear medical facility or type of physician for males to go to. We interpret these findings as suggesting that most individuals do not seek care if the symptoms of an STD are present and that, particularly for males, self treatment with antibiotics is commonly employed and probably successfully so in the majority of cases.

There is apparently little firm information about the sexual attitudes, habits, and beliefs of the Bolivian populace, nor their attitude toward STDs; a recent study has gathered some information. These are clearly important areas of future knowledge for the development of culturally appropriate educational and intervention programs. It is very likely that there are differing attitudes by ethnic and social group. Among the Indian populace (as related by a tour guide), the age of 18 marks the socially appropriate time of marriage. It is not known if sexual activity occurs before this age. A man and woman may then cohabit for one year, with the intention of producing a pregnancy. If pregnancy occurs, marriage follows. If no pregnancy occurs, the woman is considered infertile, the couple is free to part, and the male finds another partner. If no pregnancy ensues from this cohabitation, the male is considered infertile. During either the cohabitation or ensuing marriage, sex outside of these relationships is apparently uncommon.

It appears that a somewhat differing set of sexual mores occurs among the mestizo or European populace. There appears to be no set age for marriage and, indeed, it is said that the advent of AIDS has caused marriage to occur at a younger age, as males and perhaps females, are less willing to pursue multiple partners prior to instituting marriage. How common sexual activity is prior to marriage is unclear, and one doctor's practice includes a significant amount of premarital sexual counseling, including group counseling, for the sexually uninitiated. Another report, however, indicates that cocaine use (snorting) and probably sexual activity is occurring among upper class youth. After marriage, sex outside of marriage may occur. Friday night is particularly considered an evening when considerable sexual activity may occur, at least on the male's part.

Prostitution is clearly an open and regulated part of Bolivian sexual activity. Prostitutes are loosely classified into two groups: "high" and "low" class. High class prostitutes, which are strictly regulated by the government, generally work at clubs, e.g. strip clubs, and openly fraternize with customers. The owner of the club is responsible for the compliance of

these prostitutes with government health regulations. These regulations include a weekly external genital examination (which appears to happen about every two weeks) and quarterly testing for syphilis (and at least sometimes HIV); these tests are performed at a government STD-oriented clinic. If the external examination is suspicious of a disease, a speculum examination is performed, a diagnosis made upon the basis of clinical findings or perhaps microscopic examination of vaginal secretions, and treatment rendered (see Prevalence). The prostitute must have a card stamped by the police, indicating that she has been successfully examined. At times, the examination is avoided by the payment of money to police. The STD clinic at La Paz (Centro Piloto) is undergoing remodeling plans, which includes the presence of the police at the clinic.

Low class prostitutes are less well regulated, probably because they do not work out of clubs and are more difficult to control. These women probably are unlikely to participate in the government regulations. It was estimated that between 5-10% of all women who work as prostitutes participate in the government regulations. For La Paz, where the clinic examines 400 women per week, this would indicate that there are a minimum of 1,200-2,400 women involved in prostitution.

Another aspect of prostitution is seen in a group of female street youths. Like the United States' "throwaway youth", these girls often come from disrupted homes where they are not, or at least they do not feel, wanted. As young as 8 years of age, they have no home, may use drugs and trade sex for money frequently. CIES has recently conducted studies with this group.

In addition to beliefs of the populace, religious beliefs, the position of religious organizations and political considerations will play prominent roles in the ability to deliver sexual education to the general public and within schools. Currently, sexual education does not occur within the Bolivian school system. There will need to be a general coalition of agreement by multiple parties, perhaps centered around the threat of AIDS, to determine the appropriate avenues of educational approach.

The apparently successful condom distribution program offers significant hope of success. Condoms are being increasingly distributed throughout the country. In a 5-pharmacy poll which was conducted, the range of condoms sold per week was 10-500, and the price of a "three pack" of one brand was 1-1.50 Bs (approximately \$0.30 - \$0.50). The pharmacies indicated that sales were increasing, and that the use of a vaginal suppository was also apparently being used for contraception.

The concepts that Bolivians have about STDs will be important in determining intervention methods.

Before seeking care, individuals with an STD, they must first develop symptoms, recognize that the symptoms are abnormal and then successfully seek appropriate medical care. Many individuals with varying STDs are asymptomatic

and can only be found by partner notification activities or screening—generally labor intensive activities, in the latter case involving medical personnel. Many people have inapparent infections, i.e. the symptoms are not recognized as being abnormal or perhaps considered "virtuous". Many women in developing countries have a vaginal discharge, often associated with an STD, but consider it normal and do not seek care. Even if symptoms are considered abnormal, medical care may not be available to the individual, or poor sources of medical care consulted. Thus, an evaluation of the attitude, health seeking behaviors, and availability of care to the population will be important.

Physician Services for Patients with STDs

There is one categorical STD clinic in Bolivia,...in La Paz. This clinic operates five days a week and services only food handlers, and prostitutes, for whom periodic physical screening is mandatory. Serologic testing for syphilis and HIV is mandatory for both groups. Others with STDs, therefore, seek treatment from healers, physicians, and so forth. There is not a recognized, or at least active, specialty of STDs in Bolivia. STD specialist in the care of patients with STDs follow the European system of dermatovenerology, but the specialty is really one of dermatology with an interest in venereology. Even at the dermatology clinic of the Universidad Nacional, STD patients constitute only an estimated 5% of their patient population. We met two dermatologists in La Paz who have specific interests in STDs, identified on business cards— their training in STDs was received in Argentina and Brazil. Even in these practices patients with STDs constitute probably a minority of their practice. Instead, because of a relative lack of teaching about STDs and sexuality to the populace, premarital counseling or counseling of young people about sexual relations and STDs are an important part of their practice.

A monograph discussing the examination and treatment of individuals with STDs has been produced for distribution to physicians by the Union Boliviana Contra las Enfermedades de Transmisión Sexual. A wall chart, organizationally similar to the wall chart produced by CDC but with at least differing treatments, was prominently displayed in several physician and clinic offices.

There is a national organization of dermatologists which could serve as a nidus for control activities. Similarly, there is a national organization of gynecologists which might organize for the same purpose. Other organizations, such as a Bolivian medical association, probably exists and could provide important lobbying and educational efforts to both physicians and populace.

Laboratory Facilities

The laboratory infrastructure of Bolivia is not well coordinated. There are three major reference laboratories that are government operated: in La Paz (INLASA), in Cochabamba (Unidad Sanitaria) and in Santa Cruz (CENETROP). These laboratories are government affiliated. Of the three, INLASA serves as the major reference laboratory for the country and is fully government supported.

INLASA: INLASA is divided into five reference areas: immunology, general bacteriology, enterobacteriology, parasitology and tuberculosis.

The Immunology section of INLASA, under the direction of Dr. Ronald Andrade, receives varied serum specimens for serologic testing, and is the major HIV serologic laboratory (National Reference Laboratory). The laboratory employs about one biochemist three laboratory technicians, and is equipped with three (full) -20 C freezers, two centrifuges (without aerosol protection), two incubators (one at 37 C for ELISA testing and one that does not work), a water bath, two refrigerators and an ELISA reader. Unfortunately, reagents are not always available and the laboratory is unable to exert strong central direction for the country. Nevertheless, INLASA has coordinated several serologic surveys involving samples obtained throughout the country (see Prevalence). This laboratory could, with proper equipment and its record of performing several successful studies, play a prominent role in serologic testing for STDs because of Dr. Andrade's strong interest in such a role.

The General Bacteriology section of INLASA, under the direction of Dr. Armassa, serves as a reference laboratory for microbiologic specimens and, uniquely, cultures patients who are referred to its doors-including the performance of pelvic examinations by a doctor who is on call. The laboratory has an additional doctor and two laboratory technicians. It is equipped with brightfield, darkfield and immunofluorescence microscopes, an incubator (without CO₂) kept somewhat unreliably at 35-37 C, iodometric testing for NG, no antimicrobial susceptibility work, and a refrigerator with freezer. No viral work is done at INLASA. All media is made in the laboratory using glass plates, because of the expense of buying premade media, and the range of culture media used is not great (for example, a single chocolate agar without antimicrobials is used for all specimens requiring chocolate agar). Dr. Armassa indicated that few laboratories in the country do bacterial culture, and he doubts that gonococcal media is used by any laboratory. This laboratory has a keen interest in expanding its functions, as exemplified by its interest in chancroid culture and the important role it is playing in characterizing the chancroid outbreak.

CENETROP Santa Cruz:

The main function of CENETROP (Centro Nacional de Enfermedades Tropical(es)) is to study tropical diseases such as Chagas, Leishmania, leprosy, toxoplasmosis, general bacteriology, tuberculosis, STDs and AIDS. Contact staff are as follows: Dr. Benjamín Ribero González is the Director of CENETROP. Dr. Carlos La Fuente is the head of the laboratory, assisted by Dr. Beatriz von Poser, who is in charge of the HIV laboratory at CENETROP. Dr. Dolly Antules is in charge of the STD laboratory, and Dr. Mario Recacocha currently serves as Clinical Director at CENETROP, Santa Cruz.

CUMETROP - Cochabamba:

CUMETROP (Centro Universitario de Medicina Tropical) will participate through LABIMED (Laboratorios de Investigación Médica), which is organized into several sub-directions of research. The current Director of LABIMED is Dr. Faustino Torrico. The Sub Direction of Immunology is responsible for HIV testing and is headed by Dr. Evaristo Venegas. The Sub Direction of Bacteriology currently plays a prominent role in STD testing and is headed by Dra. María Estrilla - Zapata. A model clinic will be identified for the Project. The main function of CUMETROP is to study Chagas, leishmaniasis, toxoplasmosis, STDs, and AIDS. CUMETROP functions based on an agreement/contract between the Unidad Sanitaria of Cochabamba (MOH) and the University of Cochabamba.

Other laboratories: Numerous private laboratories exist, but it is unlikely their STD resources extend beyond Gram stain or wet mount capability of secretions, or nontreponemal syphilis serologic testing and, possibly, HIV testing. The cost of a gonococcal culture and one laboratory which has such capability is 40 Bs.

Hospital laboratories may be better equipped than private laboratories to perform bacteriologic tests, but it is unlikely their serologic test resources are better than what is available at the reference laboratories.

STD/HIV Prevalence

The prevalence or incidence of STDs and HIV in Bolivia is difficult to determine because of the unevenness of surveillance information and the general lack of unbiased prevalence studies. National data are available for syphilis, gonorrhea and HIV; studies have examined prevalence in varying populations of chlamydia (two studies), chancroid (one case series), hepatitis B (one study), and HIV (one study).

Syphilis: In 1989 (1990 data are unavailable), 4,200 cases of syphilis were reported; the data are not broken down by stage of syphilis. The 4,200 cases is a rate of 59/100,000 persons. The male: female ratio is 1:1.25. This preponderance of female cases suggests, when coupled with our awareness that

males do not access the health care system, that the diagnosed cases of syphilis are primarily the result of screening activities and are very likely, therefore, latent cases. Further, in the absence of a national control program it is likely that some of these cases are not new but, rather, previously treated cases with residual titers found by screening.

Gonorrhea: In 1989, 0 cases of gonorrhea were reported. This number is very likely even a greater underestimation of the number of cases that occur because of the lack of diagnostic services and, hence, the unavailability of screening services for gonorrhea which are available for syphilis. Data from the ---- STD clinic in La Paz, which serves almost exclusively food handlers and prostitutes illustrate how syphilis cases can be reported more readily. In 1990, this clinic examined 15,410 individuals and the diagnoses were:

Table 1. Prevalence of Diagnoses;
STD Clinic, La Paz 1989

<u>Disease</u>	<u>Number</u>
Gonorrhea	15 (0.1)
Syphilis	214 (1.4)
Trichomoniasis	408 (2.6)
Condyloma	55 (0.4)
Yeast	67 (0.4)
Other	1123 (7.3)

Although we do not know what findings are represented in the "Other" category, it is quite unusual that the numbers of cases of syphilis would exceed those of gonorrhea, particularly by 1,327%. This ratio undoubtedly arises from the lack of diagnostic testing for gonorrhea performed at this clinic (where we found a gonococcal prevalence of 36%).

Here, women are examined externally for an STD and, if suspicious findings are noted, a speculum examination is performed. Still, even if a speculum examination is performed in that minority of women with gonorrhea who have symptoms, the lack of diagnostic testing makes firm diagnosis impossible (unless the woman is referred to the clinic's microbiologic resource, INLASA--but this rarely occurs). More cases of trichomoniasis were reported than syphilis and gonorrhea combined but, again, wet mount examination of the vaginal secretions is uncommonly performed and, supporting this supposition, trichomoniasis was diagnosed in only 2.6 of attendees, a very low number (see below).

HIV: The number of cases of HIV infection or AIDS in Bolivia is unclear, but is low. In a study presented in 1989, 2 of 1,853 (0.1%) individuals (recluses, prostitutes, homosexuals/bisexuals/and blood donors had positive ELISA tests, confirmed by Western blot. In a second, very nice survey performed in 1990 of 986 individuals from varying risk groups (blood donors, neonates, military recruits, STD patients) and from varying locations in the country, found only one positive individual (from Santa Ana, Beni). No positive individuals were discovered from the La Paz STD clinic in 1990, although it is unclear how many individuals were tested but all food handlers are initially tested, and all prostitutes are tested quarterly).

Trichomoniasis: The CIES clinic in El Alto routinely performed wet mount examination on 24 women; 14 (58%) were positive. In a Pap smear study performed at this clinic over an 8 month period, several had trichomonads identified visually.

Hepatitis B: In the 1989 study above, overall hepatitis B surface antigen carriage among the 1,853 persons was 8.2% (152 persons). Seropositivity rates differed by prisoner (10.9%), homosexual/bisexual (7.3%), prostitute (5.8%) and blood donors (0%).

Chlamydia: Two research studies of the prevalence of CT among individuals, at some of which had symptoms suggestive of chlamydial disease, have been done. One of these, performed with a Pharmacia/Virgo ELISA, is the thesis of a Bolivian medical student and was presented to her faculty advisors on April 5, 1991. Copies of either report were not available. Chlamydia testing may be available in a very limited number of private laboratories.

Chancroid: Before 1990, chancroid was rarely diagnosed in Bolivia. Since then, however, increasingly frequent cases have been diagnosed, with 60 reported between January-December, 1990. At the Dermatology Clinic of the University de Nacionales, chancroid is now more commonly diagnosed than primary syphilis. The laboratory at INLASA, which serves as a reference laboratory for chancroid, sees about 2 cases a week.

Genital warts: There is conflicting data over the prevalence of genital warts and the sequelae of cervical infection with HIV, cervical cancer. In the report of cases seen in 1990 at the La Paz STD clinic, genital warts were diagnosed in only 55 to 15,419 (0.4%) visits. Since the genitalia of all individuals were visually examined by a physician, this prevalence should be accurate. At the CIES clinic at El Alto, however, an estimated 5% of women have genital warts.

In the PAP smear study of 387 women attending the CIES clinic, signs of HPV infection on PAP smear were not sought but, of course, signs of dysplasia/cancer were. The results were:

Table 2. PAP Smear Classification of 387 Smears Over an 8 Month Period

<u>Class</u>	<u>Percent</u>
I	0.6
II	94.8
III	4.4
IV	0.4
V	0.0

Of the Class II smears, 49.3% had nonspecific changes, 46.3% had TV, and 4.4% had yeast (multiple diagnoses possible). In this PAP smear classification, Classes IV and V are cancer. These results would suggest that cervical dysplasia/cancer are not exceedingly common. Yet, anecdotal reports indicate that cervical cancer is common in Bolivia. It is possible HPV prevalence, as well as cervical dysplasia/cancer, vary by population.

Surveillance

The sensitivity of districts' syphilis surveillance systems as measured by staging of syphilis case reports varies. On one had, the Santa Cruz health department assembles generic syphilis case reports directly from serologic screening in the sanitary control and obstetrical programs. Both programs maintain clinical components, yet surveillance does not consider clinical findings in case reporting. The net result is a system exhibiting low sensitivity.

On the other had, Cochabamba's surveillance component manages case counts in a different manner. By systematically comparing clinical findings with serology reports, this district's health department assembles staged syphilis case reports within its sanitary control program. The net result is a system with fair to good sensitivity.

Sensitive surveillance provides accurate case rates according to the age, sex and other demographic variable of those diagnosed. Rates by age in Bolivia are consistent with those in the United States: the highest rates are in the 15-29 year group. As noted above, rates by sex, are of questionnaire accuracy. With Bolivia's case reporting heavily reliant on screening of prostitutes and obstetrical patients, women are clearly overly represented and a men are extremely under represented.

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To achieve a truer representation among men, the focus of intervention activities, led by screening, could be changed. By targeting 15-29 year old men (e.g., prisoners, military recruits, and adolescents), screening may begin to identify higher-risk populations among Bolivian men. By analyzing screening data on food handlers, higher-risk sub-populations may become the focus of a higher-yield screening. And by opening clinics to the general public who now receive clinical services elsewhere, screening within STD clinics may become more representative of the general population.

Improved, sensitivity in surveillance also depends on the quality of diagnoses. While syphilis may be more common an STD than chancroid, lymphogranuloma venereum, granuloma inguinale, or other STDs causing genital ulceration, clinicians must rely on their clinical acumen complemented by diagnostic tests to determine whether an infection is due to one etiologic agent or is of mixed etiology.

Between December, 1989 and March, 1991, greater than 65 cases of chancroid were reported in La Paz. Prior to this time, chancroid, primarily associated with tropical areas, was rarely is ever seen in the altiplano. Initially, clinicians reportedly diagnosed and treated many of these cases as syphilis. Lack of local laboratory capacity and, possibly, lack of clinical experience with choncroid resulted in many inaccurate diagnoses and in treatment delays.

The INLASA STD laboratory in La Paz is able to isolate *H. ducreyi*, allowing the confirmation of chancroid. However, the STD laboratory cannot do the same for syphilis because it lacks the capability to perform confirmatory testing (e.g., FTA-ABS). Such testing capability by ruling in or out syphilis, would provide various benefits. The health department in Cochabamba, unlike the department in Santa Cruz, receives laboratory reports from the private sector. These reports are counted as cases without the health department evaluating them further. Effective evaluation considers the clinical presentation, and the results of confirmatory testing. But, because confirmatory tests are not available, case counts are frequently inflated. Ideally, the evaluation would include a comparison of pertinent case data contained in a case registry from previously reported cases; however, no such registry exists which is another reason for inflated case counts.

Low sensitivity is not limited to syphilis surveillance. Gonorrhea surveillance presents other critical problems to STD control. These problems include the overreliance on non-culture testing, the lack of data on antibiotic resistance, and the availability of antibiotics legally acquired without prescription through pharmacies and on the black market.

The primary method of screening and diagnosis gonorrhea in Bolivia is not by culture, but by the gram-stained smear (GSS). The GSS is known to be a highly sensitive diagnostic test in men and in symptomatic women. However, for screening the GSS is vastly inferior to culture testing. Were culture testing used, surveillance would reflect a higher and truer incidence of gonorrhea.

Non-culture testing also presents another serious constraint to surveillance. Its use precludes conducting studies on gonococcal resistance to the antibiotics used to treat gonorrhea (in Bolivia, primarily penicillin). Studies from the Centro Nacional de Enfermedades Tropicales (CENETROP) laboratory in Santa Cruz have identified that greater than 30% of isolates are resistant to treatment with penicillin. If these data are representative of Bolivia, the implications of this high level of resistance are quite serious: much of Bolivia's gonorrhea is inadequately treated. If true, treatment can no longer depend on penicillin, but rather on more expensive antibiotics. Control would also have to entail improving clinicians' (and pharmacists') knowledge of changing resistance patterns and preferred treatment regimens.

Timeliness of surveillance reports is a particularly important issue in HIV control. As of March 21, 1991, the Santa Cruz health department reported 13 HIV positive and 15 AIDS cases. Control of these HIV infections is the responsibility of the department's epidemiology program. For epidemiology to effect control, whether by referring positives for medical management or their partners for counseling and testing, CENETROP, the local testing laboratory, in timely fashion must transmit testing data to the epidemiology program. To date epidemiology has not received these data soon enough to allow early intervention.

Two barriers prohibit timely transmission of data. One barrier should be short-term. In Santa Cruz, as the rest of the country, testing laboratories since December, 1990, have not had reagents for performing HIV antibody tests. To correct this situation, the MOH will have to exert appropriate administrative authority. When testing resumes, the currently untested serologic specimens will be processed. But the greater than three-month delay may make delivery of some results difficult, if not impossible.

The second barrier may be more persistent. Since late 1988, with HIV testing began in Bolivia, the CENETROP laboratory has received serologic specimens from the district's STD and HIV clinic. CENETROP, however, has steadfastly refused to provide test results by patient name to epidemiology. While the number of known infected persons is small, epidemiology's interventions starting with these 28 known cases has been delayed for nearly two and one half years. Within Santa Cruz's high-risk population, continued delays will result in dire longer-term sequences. To effect control, the MOH must enforce cooperation between CENETROP and epidemiology and assure that the responsibilities of each are clearly understood. Through the cooperative efforts of these two program components, HIV interventions can begin.

In conclusion, surveillance's deficiencies are remediable. Improvement will come through development of resources in the areas of medical management, laboratory surveillance and data management. Realization of the following steps in chronological order should bring about the surveillance required for STD and HIV control.

Blood banking and needle safety

Blood supply: The sterility of blood supplies and the use of sterile equipment for transfusion and injections of drugs are vital to good medical care, because of both the diseases which can be spread by contaminated blood/supplies and the confidence which the population must have in their medical care system. Significant diseases which can be spread by blood and which can be screened for include HIV, hepatitis B, hepatitis C, syphilis (uncommonly) and, most notably in Bolivia, Chagas disease. Thus, ensuring the sterility of the blood supply by screening for these agents will have multiple benefits. Although the cost of screening (reagents, personnel) is significant, the benefit to the populace of cost of disease prevented and confidence in the adequacy of the transfusion supply far outweighs the development and maintenance of a safe blood supply.

The blood bank system is not a primary focus of our report because of already ongoing work due to chagas disease. Briefly, however, the bloodbank system in Bolivia is fragmented. Varying services collect and distribute blood, and probably a minority of units are tested for HIV (and other agents). Even where testing is available, testing is not always conducted. For example, INLASA, has been out of HIV testing reagents since January. The possibility of contaminated blood (with a variety of agents) is heightened because in Bolivia, as in many other countries, donors may be paid and this compensation is a significant source of income of individuals who may be at high risk for having precisely the diseases one wishes to avoid.

Thus far in Bolivia, because of the rarity of HIV infection, cases of HIV infection caused by infusion are probably rare. The potential risk of significant numbers of transfusion cases is, however, real.

Injection equipment: Just as contaminated blood can cause infection in recipients, the use of nonsterile needles and transfusion equipment may as well. It appears that the spectre of AIDS in Bolivia, has increased the use of sterile equipment, both by the broad medical community (with government distribution of sterile needles) and the public (which is aware that contaminated needles can spread HIV). Nevertheless, several opinions were expressed that not all broad medical community services, including probably some physicians, are using sterile needles. In the past, boiling of needles was one practice of cleaning used needles and this practice, and possibly less effective means of cleaning needles, may continue throughout the country. Such a practice may be especially common in remote areas or areas where patients have less money to pay for services (at a pharmacy, a syringe and needle cost about 2 Bs).

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FINANCIAL ANALYSIS

For every major component of the project, a detailed budget was prepared. The budgets were summarized to create the estimated total Project budget tables that are presented in Section III. Cost Estimates and Financial Plan in Annex 8.

The capacity of Bolivia to support the proposed Project financially after the period of AID funding is a crucial question. Sustainability is critical. Assessing the capacity of the Bolivian public sector, especially the national Government, to sustain the proposed Project is complicated by economic problems and statistical limitations. (See the Project Papers "Economic Analysis"). Thus, while the major variables to be considered in arriving at judgments on sustainability can be identified, it is not at all clear what they can tell us now.

The key factors affecting future spending needs of the MOH (in nominal terms) after the Project period will be growth of the target population and inflation. The key factors affecting financial capacity of the MOH are growth on the GDP, changes (if any) in the share of the GDP devoted to the Central Government expectations made by the MOH. Assuming that the MOH budget for existing programs is barely balanced by public revenues through 1993 while the new project is funded mostly by AID, special counterpart sources (PL 480, ESF) and other donors, there are few grounds for optimism in expecting the Ministry to come forward with appreciable new funds from the Government in order to bear much of the burden of the recurrent costs required to continue the full Project beyond 1995.

It appears that the efforts of the Central Government of Bolivia, through the Ministry of Health, to bear the financial burden of this Project after 1995 will not be sufficient, despite best intentions. Therefore, alternative financial sources in Bolivia must be examined. These take the form of other governmental and quasi-public sources of funds and a variety of private means. Of course, other external assistance would represent another potential category of finance due to insufficient Government funds and with quasi-public means limited or non-existent. After examining potential private sources of support, one major possibility is "Cost recovery" through the payment of direct fees by patients to providers or through prepayment schemes, most likely unreasonable for high risk groups. However, direct payments, or fees, have been tried and are worthy of further examination. For example, revolving funds for drugs or medicines are not a new idea in Bolivia. Revolving funds are used in several places to receive payments for medicines from patients and to purchase replenishment stocks.

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Further examination is needed, especially of accounting for and other general costs. More over, it is clear that success will depend on reasonably high capacity utilization at reference laboratories and clinics.

Based on the above, it is quite unlikely, however, that these and the Government's general revenue sources will add up to sustainability of a large share of the total recurrent burden. Therefore, other sources, probably external to Bolivia, must be considered for the current and post project period.

The capacity of the Government of Bolivia to manage the finances of this amended Project is assessed briefly here. Some related matters are covered in the administrative and economic analysis sections of the Project Paper.

Based on the current working relationship, it appears that the MOH is capable of managing its part of the original Projects financial details. However, technical assistance will be required at several levels to facilitate the handling of funds and the maintenance of required, appropriate reporting records.

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AIDS/STD PREVENTION AND CONTROL PROJECT

5.3. ECONOMIC ANALYSIS

By Oscar Antezana
USAID/Bolivia/ECON

The data available on Sexually Transmitted Diseases (STDs) and Acquired Immunodeficiency Disease Syndrome (AIDS) in the developing world portend staggering costs in terms of individual human suffering and death. Control of these diseases offers two major benefits: prevention of the morbidity and mortality associated with STDs, and the slowing of spread of Human Immunodeficiency Virus (HIV) because of the increasing evidence that STDs facilitate the spread of this virus.

In the aggregate, the pandemic threatens to undo much of the progress that has been made in strengthening national economies and improving the overall health status and social well-being of people in developing countries, such as Bolivia. As described below, the potential for major setbacks is particularly evident in four areas: 1) economic development, 2) child survival, 3) health care, and 4) social structure.

I. Economic Development

Selected STDs have been shown to facilitate the acquisition or transmission of HIV infection. They, along with AIDS, occur principally among those 14 to 45 years old, the age group that constitutes the bulk of a country's labor force. This target group represents some 59% of Bolivia's total population, or about 3.8 million people. An increase in adult deaths as a result of AIDS, thus, will reduce the country's available labor force and is likely to have an adverse effect on the Gross Domestic Product (GDP). Additional reductions in GDP could occur as the debilitating conditions associated with STDs and AIDS eventually cause people who are infected to withdraw from the work force. Moreover, because STDs and HIV infection are concentrated in central cities, industrial and commercial enterprises that are key to Bolivia's economic life will be among those hardest hit. Since health conditions and facilities are less adequate in rural areas, agricultural production could also be affected very rapidly. At present, Bolivia is trying to promote tourism - which might become an important generator of needed foreign exchange - and revenues may suffer significant setbacks as travellers become unwilling to visit areas where HIV infection is prevalent.

Another aspect of the economic impact of STDs and AIDS is the need to increase government expenditures for AIDS-related health care and HIV prevention programs. In Bolivia, long term health care, to the extent it is available, is provided largely by the public sector. Public funds assigned to the Ministry of Health, however, are already extremely limited. It would be very difficult to see how the GOB can stretch them still further. The World Bank has estimated that the share of total

government health expenditures required to treat the AIDS cases already reported range from 1 to 2 percent in Botswana to 55% in Uganda.^{1/} These costs do not include government expenditures for screening blood supply or implementing HIV prevention programs. This is particularly frightening when the number of people requiring AIDS-related health care is likely to increase severalfold in the years ahead.

II. Child Survival

The potential for setbacks as a result of STDs and AIDS in this area would be almost catastrophic. Years of effort to promote immunizations, oral rehydration therapy, improved nutrition and others have resulted in significant strides in increasing the health and survival of children in Bolivia. USAID/Bolivia has certainly been one of the main donor agencies in implementing child survival programs. A spread of HIV infection, however, would most likely reverse those gains.

Women with untreated syphilis during pregnancy infect their infant in 100 percent of cases, with stillbirth resulting in 40 percent of cases and a seriously infected infant in many of the remaining infants. Gonococcal infection during pregnancies results in an adverse outcome (including death of the fetus) in 25 to 65 percent of pregnancies; healthy newborns have a greater than 50 percent chance of developing blinding gonococcal eye infection or gonococcal infection of the blood.

A recent analysis of the impact of HIV infection on child survival illustrates the threat AIDS poses to children in the developing world. For example, in Kampala, Uganda, 24 percent of pregnant women attending one antenatal clinic were HIV positive in 1987.^{2/} The study estimated that from 5 to 12 percent of the newborns in Kampala in 1988 were HIV infected at birth. In addition, the study estimates that, by 1992 between one-tenth and one-third of all deaths among children under age five in Kampala will be AIDS related. Such increases in child mortality, which would represent a three-fold increase in Bolivia, point to significant reversals in child survival due to the AIDS pandemic.

III. Health Care

Bolivia's Ministry of Health currently provides nation-wide coverage to only 38 percent of the population. Private practitioners account from 5 to 7 percent of the provision of health services. This limited coverage has encouraged the establishment of a large number of non-governmental organizations, but the inadequate coverage and service in Bolivia is far from being resolved. The issues related to this low coverage include the inefficient organizational structure of the Ministry

^{1/} USAID, "HIV Infection and AIDS: A Report to Congress on the USAID Program for Prevention and Control", July, 1990.

^{2/} Ibid.

of Health; lack of coordination among key public and private agencies; constraints related to the management and utilization of personnel within the regional health post units; inadequate training of medical personnel; and lack of essential medical supplies. Under these conditions, health care providers can be quickly overwhelmed by the need to care for increasing numbers of AIDS patients. Medical experts estimated, for example, that in 1988 close to half the hospital beds in the central cities of Uganda, Zaire, Congo and other African countries were occupied by AIDS patients.^{3/} In the city of El Alto, for example, with an estimated population of about 300,000 inhabitants, there is only one hospital which has a mere 23 bed capacity (compared to the recommended level of 500 beds). An increasing number of AIDS patients would certainly overwhelm not only the current infrastructure capacity, but the training and preventive capacities of Bolivia's health system, and available financial resources. The World Bank, for instance, has estimated that the cost of inpatient and outpatient care for AIDS ranged between \$104 and \$631 per case in Tanzania and between \$132 and \$1,585 per case in Zaire. Currently, the budget of Bolivia's Ministry of Health for administrative, supply, care services and others is about \$11 per year per person. Thus, every additional patient with AIDS requires additional resources far above what the government can provide. Multiplying even the lower range of the estimate by the number of potential AIDS cases and HIV infections results in a staggering health cost for public and private health care providers, as well as for individuals and their families.

Moreover, as HIV infection disables an individual's immune system, the person becomes increasingly vulnerable to other infections, respiratory ailments, and certain cancers. In addition, the link between HIV infection and tuberculosis (TB) activates latent TB infection, making the individual not only ill but a potential carrier of the bacteria to others. Thus, communities and health care providers may have to deal not only with AIDS but also with increasing levels of TB and other diseases.

Finally, as public and private health care providers face the need to allocate scarce human and financial resources to STDs and HIV prevention and the treatment of AIDS-related illnesses, other health care programs, such as primary health care, health and hygiene education, and family planning assistance, are in danger of losing ground in the competition of resources. As a result, further gains in improving the overall health status of the people will be jeopardized.

IV. Social Structure

AIDS also tears at the social fabric of the nation. In Bolivia, there is a strong tradition of caring for the ill within the extended family system. Mistaken fear of becoming infected, stigmatization of those afflicted with AIDS, and the financial burden of caring for those who are ill, however can split families and communities between providing compassionate care for AIDS sufferers and leaving their care to others. Families that do not take care of the ill must assume the out-of-pocket

costs of that care at the same time that they are faced with the loss of the income-generating labor of patients and those who forego work to care for them.

A growing social problem could also be the number of children who have lost one or both parents due to AIDS. Based on AIDS mortality studies in the U.S., it has been estimated that among women who became HIV positive one year before their most recent pregnancy, 23 percent will die before the offspring's fifth birthday, 50 percent by the tenth birthday, and 78 percent by the child's fifteenth birthday.

V. Conclusions

Unlike cholera, which can be easily discussed with people and the medical community and require a few tests to diagnose, STDs and HIV involve in an intertwined nature, social, educational, religious, political, as well as medical issues. The discussion of, or education in, STDs and AIDS issues may not be socially acceptable, in part because of the need to discuss sexuality. Similarly, there might be significant religious opposition to the discussion and teaching of both topics, as well as political opposition. Moreover, many diseases are asymptomatic, i.e., there are no symptoms or the symptoms are not recognized by the individual, yet the disease may develop complications, and transmission to others may take place. If not effectively controlled at a very early stage, the effects of STDs and AIDS could be fatal and the impact on economic and social progress might be catastrophic.

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AIDS/STD Prevention and Control Project

5.4. SOCIAL SOUNDNESS ANALYSIS

by Paul Raza
AIDSCOM

This project will help build the capacity of Bolivia to diagnose and treat sexually transmitted diseases (STDs) in major urban centers. Increased diagnosis and treatment of STDs will reduce the sexual contagiousness of the human immunodeficiency virus (HIV). Counselling of clients coming to STD/HIV clinics is expected to result in an increased use of condoms. It is expected that at the end of the project Bolivia will have one of the best STD/HIV diagnosis and treatment systems in all of Latin America and will be in a position to help other countries within the region.

Untreated STDs produce significant morbidity and human distress, loss of fertility and fetal wastage. Congenital syphilis which is preventable, produces a significant loss of human potential. Some STDs, by being co-factors for genital cancers, are associated with reduced life expectancy, frequently among individuals at an economically productive stage of their lives.

1. Social Feasibility

Other than abortion there are few more emotionally charged subjects in public health than those found in this project. The AIDS pandemic has been instrumental in catalyzing social conflicts in every country of the world. Bolivia is no exception.

By emphasizing STD/HIV screening and prevention, condom use and STD management, experience from other countries suggests that religious opposition will be tempered. By encouraging fewer sexual partners, moral and religious authority within Bolivia (primarily the Catholic church) will be promoted. This project will encourage adolescents to delay the onset of sexual activity, a message that is supportive of cultural and religious norms.

In order to be effective in slowing the spread of HIV infection this project cannot avoid certain taboo subjects. Men and women who have multiple sex partners and men who have sex with other men are at an increased risk of catching and spreading HIV. It is believed that the majority of men who have sex with men, also have sex with women who in turn are at risk of becoming infected and spreading the disease to their babies and to other sexual partners. By emphasizing sexual practice, rather than stereotyped labels such

as "homosexual" or "prostitute", it will be possible to reduce the potential stigmatization of certain societal groups within Bolivia. Reduced stigmatization and discrimination of marginalized groups will of course be of benefit to these groups.

In addition, society as a whole will gain, because HIV or STD infected individuals will be more likely to seek testing and counselling, that will reduce the probability of infecting others. Much of the implementation of this project will take place at STD clinics. The clinics will be open to all, for diagnosis, treatment, education and behavior modification where feasible. This approach will reduce the stratification of users into marginalized groups, and confidentiality and in some circumstances, anonymity, will be maintained, further strengthening social acceptability of the project.

Many research and prevention activities will take place outside the clinic setting and involve members of high risk groups in the design, testing and implementation of the activity. Communication strategies will be designed for specific target groups in order to increase their effectiveness and acceptability, and reduce the chances of a political or social backlash against the project. In using television and radio, careful attention will be paid to the political acceptability of the messages as well as to their effectiveness for a defined audience.

Currently, there appears to be no data on volunteer STD/HIV clients in Bolivia. Consequently it is unclear what volume of clinic load will be generated by the project. The initial assumption is that patients will be offered an array of free diagnostic and treatment services (but not antibiotics), depending on their needs. Once STD/HIV services have become accepted as a necessary "good," it should be possible to charge for discrete services which will help maintain clinic services once outside funds terminate. The fact that anecdotally many Bolivians seek informal diagnosis and treatment from various sources (e.g. pharmacists), lends credence to the idea that clients will be willing to pay in whole or in part for clinic services. If the project is successful in obtaining a high volume of clients early in its implementation, alternative funding sources (including fee-for-service) will have to be found, or less expensive treatment algorithms will have to be introduced.

None of the proposed new technologies will create a significant problem in the three cities chosen for this project. At a later date, should the project be expanded to other locales, problems may occur with an impoverished infrastructure being unable to support the laboratory needs.

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2. Direct Beneficiaries and Spread Effects

a. Direct Beneficiaries

The primary beneficiaries of this project will be 80,000 STD patients and persons who are required to come to the clinics for regular screening (e.g. registered female sex workers, food handlers). It can be assumed that virtually all clients will be living in or on the outskirts of La Paz, Santa Cruz and Cochabamba. Most of these individuals will be more sexually active than the average Bolivian and therefore at greater risk of catching and spreading HIV/STDs. It can be expected that a large percentage of clients will make repeat visits to the clinics over the course of the four years of the project. The clinics will be based in the urban centers that have the greatest probable HIV/STD prevalence. Consequently, the cost effectiveness of the clinics will be higher based in these urban centers, than in other possible areas with a lower STD/HIV morbidity. Though somewhat based on presumption rather than recent data, this is congruent with research results obtained in other countries.

The clinics will be open to the general public and, as long as they maintain adequate levels of confidentiality/anonymity, they can be also expected to encourage at-risk members of marginalized groups (e.g. homosexual males with multiple sexual partners) to seek services. Available counselling services will help reduce the spread of HIV and STDs in the various high risk groups that attend.

Some research and intervention activities will take place outside of STD clinic settings. Many Bolivian PVOs have access to specific geographic, socio-economic and cultural settings. Where consonant with the overall goals of the project and subject to budget limitations, these PVOs will be encouraged and supported in developing research studies that can be used to help design interventions in groups that are not easily contacted through the three major STD clinics. In addition, to a limited extent, research and intervention (e.g. a multi-channel, mass media campaign) will be carried out with the general population (approximately 2.5 million persons in La Paz, El Alto, Santa Cruz and Cochabamba).

Selected health care providers will benefit from education provided by the project; other specialists and managers will benefit from training and technical assistance given during the development of research and HIV/STD intervention programs.

Assuming that the project adequately maintains confidentiality in its research and treatment programs, and (with the limited exception of registered sex workers, food handlers and perhaps military recruits) all participants act under their own volition and that project activities are conducted within established bioethical guidelines, there are no categories of people or groups

that can be expected to be adversely affected by the project.

b. Spread Effects

Clients of the targeted STD clinics will come from a large number of different geographic, socio-economic and cultural environments within the three target areas. It can be expected that new knowledge, attitudes and behaviors will be spread to others by these same individuals, magnifying the beneficial effects of the project. Similar effects will be derived from PVO and multi-channel mass media activities funded by the project. Over the course of the project knowledge about the value of timely and efficacious treatment of STDs is expected to reach the sexually active populations of La Paz, Santa Cruz and Cochabamba, approximately one million persons.

TV and radio spots will reach communities beyond the three target areas, but persons in these other areas will usually not be able to take advantage of STD/HIV services offered in the supported clinics.

The project has among its objectives the building of skills in areas not necessarily solely related to HIV/STDs. Counselling skills can be utilized in other health care sectors, research skills will be useful in other areas of health, in sociology, anthropology etc. Surveillance system methodologies can be utilized in areas such as immunization and family planning programs. Advanced communication methodologies and social marketing skills learned during the project can be adapted to enhance the effectiveness of other health activities in the future.

By the end of the project it is hoped that Bolivia will be a credible source of expertise for other countries in the area. It is also expected that the Bolivian experience in HIV/STD prevention and control will be to some extent transferable to other countries within Latin America.

AIDS/STD Prevention and Control Project

5.5. ADMINISTRATIVE ANALYSIS

by William Boyd
Centers for Disease Control

With the continued investment of funding for STD/HIV prevention and control in Bolivia, the administrative apparatus at the national level must evolve to ensure a well-focused nationwide effort supportive of the program's mission. The national program with support from USAID is charged with: managing the allocation of funding and the logistical distribution of equipment, expendible and non-expendible supplies; establishment of program policy and norms; program oversight, quality assurance and evaluation; and coordinating MOH and NGO operations.

Service delivery at the local level has the greatest potential in the short- and long-term to intervene and prevent transmission. With the national program assuring an unrestricted and unhindered flow of available resources, however limited those resources may be, the local program's obligation is one of conducting local operations. The main focus of the national program with regard to HIV control has been behavioral change through education coupled with HIV screening of those attending sanitary control clinics. In both efforts administrative support at the national level has been insufficient to ensure maintenance of the local obligation.

Educational interventions which per content (e.g., culture and language specific) and form accord with the intended audience's consumption patterns are those which are most successful. Within Bolivia, however, materials made available to district STD/HIV programs through the national program have nearly uniformly been too general with regard to content, frequently incorporating terminology inconsistent with audiences' abilities to comprehend, and all too often packaged without regard to the more common ways local populations access media information. Exploitation of KAB data, use of locally produced programming, and precise definition as to how people access information and through which medium can overcome this deficiency.

For example, in Santa Cruz, which is laid out in a series of concentric rings ("anillos"), economic advantage for most of the population varies with closer proximity to the city center. Consequently, television may be the most efficient medium for educating middle and upper classes, but for the more indigent, radio is the only medium they have access to.

The local program in Santa Cruz, recognizing local

consumption patterns has opted to develop its own educational material. In doing so, it acknowledges the regional and local culture. Doubtlessly, by making use of locally developed surveillance data, the Santa Cruz program might further its educational objectives. However, it has done this without support from the national program, which in its Plan a mediano plazo para la vigilancia y prevencion del SIDA en Bolivia, identifies a very narrow slice of funding to meet locally defined needs. Clearly, the national program, with additional funding, needs to become more attuned to local considerations.

While local educational interventions may vary district to district, the other pillar upon which intervention rests is HIV screening of high-risk populations. Sizable time investments on the part of local clinic staff and of laboratory personnel, many of whom attended a 5-day MOH-AIDSTECH HIV training course in August of 1990, have been made in support of this intervention. However, for, at least, the past three months, local efforts have ground to a halt because the national program has been unable to assure delivery of the necessary reagents to local testing laboratories.

Although this component needs considerable strengthening through inclusion of pre- and post-test counseling, without the national program's ensuring logistical support, local surveillance and prevention through screening have ceased to exist. Again, the national program with additional funding must become more attuned to local needs.

With assured distribution of these and other resources, accountability for their use becomes a function of district programs and NGOs alike, and, through oversight, of the MOH, in consultation with USAID. Similarly, the myriad of intervention activities, implemented through government and NGOs require not only oversight but also coordination in assuring consistency in the processes used and in application of output data. These major activity areas will also require strengthening of the national programs' administrative apparatus.

Administrative, technical, economic and political support for this effort at the national and local levels should also come through committees, representing a broad constituency, including government, business, labor, local community organizations. Such committees have been formed, due to the burden of organization falling on a small core of dedicated individuals and/or lack of administrative support, they are barely functional. Indeed, the national AIDS Inter-agency Coordinating Committee does not meet. The new project must ensure that this source of citizen input and involvement is not neglected. To this end, some level of funding for administrative support may be required.

Conclusions

1. Through USAID funding, in cooperation with the CDC and the MOH, a position to allow two-year technical assistance through assignment of a Supervisory Public Health Advisor (PHA) will be established; the position will be responsible for assuring coordination and support of all project activities and MOH initiatives; in addition, the project will support the establishment of one administrator position and one staff position, trained and supervised by the PHA to be filled by Bolivian nationals to ensure long-term continuity of the project beyond two years.
2. Through technical assistance provided by CDC, and USAID, in cooperation with the MOH, the project will contract with Prosalud or AIDSTECH to review the administrative component of the MOH's STD/HIV program; this technical assistance will recommend changes in administrative procedures including communications, logistical support, long-term planning, management oversight and evaluation methodology, and data management; pending the outcome of this assistance, the project will consider supporting appropriate funding.
3. Through technical assistance provided by CDC, and USAID, a review will be conducted of the charter, direction and accomplishments of national and local STD/HIV intergovernment, interagency, community-based committees; pending the outcome of this review, the project will consider supporting funding which will be limited to technical and clerical support.

Note:

Although the initial project provided funds to the MOH, this amendment does not include additional funds for the MOH therefore, an administrative and accounting capability assessment was not done for this amendment.

ANNEX 5.6.

ENVIRONMENTAL ANALYSIS

INITIAL ENVIRONMENTAL EXAMINATION

Project Location: Bolivia

Project Title: AIDS/STD Prevention and Control,
Project Amendment

Project Number: 511-0608

Funding: \$4 million

Life of Project: 4 years (FY 91-94)

IEE Prepared by: John Wilson, IAC Deputy Chief
Environmental Officer

I. Project Description

The purpose of the AIDS/STD Prevention and Control Project is to promote the prevention and control of AIDS and other sexually transmitted diseases (STDs). The major project components include prevention, education, blood screening strategy, HIV/STD testing, training, quality control in laboratories and blood banking systems, surveillance, and treatment.

The amended project is designed to establish a capacity to develop and implement cost-effective surveillance, information, education, and intervention strategies in support of projecting future trends in and reducing the transmission of STDs, HIV infection, and AIDS. The project shall assist participating government and non-government organizations in related activities specified in the national medium-term plan for AIDS Health to treat the extent of the problem as well as to establish a tracking system that will track the characteristics of HIV transmission and AIDS and STD cases.

II. Discussion

The project consists of activities for which there are no foreseeable, direct, significant impacts on the environment. These activities fall generally within those classes of actions listed in Section 216.2(c) (2) of A.I.D.'s Environmental Regulations which are not subject to further environmental review, i.e., education, technical assistance and training, and health care services. Therefore, the proposed project is determined to qualify for a Categorical Exclusion.

This Request for a Categorical Exclusion is submitted for review by the IAC Bureau Environmental Officer in accordance with Section 216.2 of 22 CFR 216, Environmental Procedures.

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III. Recommended_Threshold_Decision

USAID/Bolivia recommends a Categorical Exclusion for the AIDS/STD Prevention and Control Project Amendment.

Mission Director's Concurrence: COO-EO

Date: 6/7/91

54641
CLEARANCES Dyde
A/FDI:LModie LM
HHR:SAnderson SA
RIA:SAllen SA
A/DD:ELKarlund EL

TRANSMITTAL MEMO

June 7, 1991

TO: John Wilson, LAC/DR/E
Tom Hourigan, LAC/DR/E
FROM: Mahlon A. Barash, FDI/USAID/Bolivia MB
SUBJECT: IEE for AIDS Prevention and Control Project Amendment
(511-0608)

Attached is the IEE for subject project with appropriate mission clearances. It requests a categorical exclusion for this project.

Agency for International Development
Washington, D.C. 20523

LAC-IEE-91-58

ENVIRONMENTAL THRESHOLD DECISION

Project Location : Bolivia
Project Title : AIDS/STD Prevention and Control,
Project Amendment
Project Number : 511-0608
Funding : \$4 million
Life of Project : 4 Years (FY 91-94)
IEE Prepared by : John Wilson, LAC Deputy Chief
Environmental Officer
Recommended Threshold Decision : Categorical Exclusion
Bureau Threshold Decision : Concur with Recommendation
Comments : None
Copy to : Carl Leonard, Director
USAID/Bolivia
Copy to : Mahlon A. Barash, USAID/Bolivia
Copy to : Howard Clark, REA/SA
USAID/Ecuador
Copy to : Peter Lapera, LAC/DR/SAM
Copy to : Thomas Park, LAC/DR/HPN
Copy to : Bruce Blackman, LAC/SAM
Copy to : IEE File

James S. Hester Date JUN 18 1991

James S. Hester
Chief Environmental Officer
Bureau for Latin America
and the Caribbean

AIDS/STD Prevention and Control Project

5.7. REVIEW OF SUB-GRANT PROPOSALS

by Paul Raza
AIDSCOM

The following list summarizes the public and private sector proposals concerning STD/HIV prevention that had been presented to USAID/Bolivia as of 29 May 1991. These proposals have been further discussed by Ms. Diane Urban in her consultant report on the social communications component.

Most of these proposals are not sufficiently detailed as to permit a complete analysis, either of the pertinence of the subject area or of the capability of the organization presenting the proposal. It is unfair to judge them due to the nature of the way the requests were generated. A few of them, however, are sufficiently detailed to merit immediate consideration. In general, the proposals from AIDSTECH, La Fundacion San Gabriel, and CIES are reasonably well written and pertinent.

We suggest that when the project starts, the agency or agencies involved with IEC activities systematically contact relevant PVOs and publicity agencies with health experience, to develop proposals that fall within the IEC scope of the project. Doing this will produce focussed research and interventions that will fill the gaps that the STD clinic based interventions and SOMARC condom marketing, cannot do. It is obvious that CIES, Fundacion San Gabriel, PROSALUD, and no doubt others, have both the interest and the capacity to do quality work in STD/HIV prevention.

La Paz

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------|-----------|
| 01. CIES: Operations research with female sex workers.
(developed proposal) | \$49,924 |
| 02. CIES: Validation of Dominican Republic peer
promoter training manual for working with
female sex workers. (developed proposal) | \$10,692 |
| 03. Fundacion San Gabriel: Public health training:
(partially developed proposal) | \$407,800 |

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04.	Fundacion San Gabriel: STD prevalence study, treatment, materials development and education of street children. (partially developed proposal)	\$55,250
05.	SIAP: Pilot course on STD/AIDS prevention	\$75,900
06.	Ciudad del Nino: STD/HIV sexuality education for orphans (5-18 yr).	?
<u>Frontier Areas: La Paz PVO</u>		
07.	SOPACOF/COBREHS: KAP in travelling salesmen, Bolivia-Brazil.	\$20,640
08.	Ibid: Ferrocarril clinic STD diagnosis, educational materials, education in women and travelling salesmen (Arg/Chile).	\$49,245
<u>Potosi</u>		
09.	Sociedad de Investigacion de Lucha al Sida de Potosi: HIV sentinel, high risk group education.	\$94,400
10.	Ibid: Transfusion HIV screening	\$71,200
<u>Beni</u>		
11.	Santa Ana de Yacuma, Beni: HIV screening, treatment and education.	\$180,100
<u>Santa Cruz/Cochabamba/La Paz: La Paz PVO</u>		
12.	CIES: Repeat KAP in 3 cities. (partially developed proposal)	\$42,580
13.	? : STD/HIV education, health providers, high risk groups, general population through TV/Radio.	\$200,000
14.	Ibid: ? same program ?	?

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Santa Cruz

- | | |
|------------------------------------------------------------------------------------------------------------------------------------------|-----------|
| 15. Unidad Sanitaria: Report of HIV screening, shortage of reagents, multi-media education. (no specific request) | ? |
| 16. Brigada Juvenil de Lucha Contra el SIDA: Education through dance, music, poetry competitions, plays. (partially developed proposals) | very low |
| 17. PROSALUD/SOMARC: Condom acceptability study in high risk groups and adolescents, condom marketing. (no documentation) | \$40,000 |
| 18. PROSALUD: HIV/STD diagnosis and intervention. (AIDSTECH Small Grants Program; non-funded) | \$50,000 |
| 19. AIDSTECH/CENETROP: STD clinic high risk group intervention. (developed proposal) | \$180,000 |

La Paz/Oruro/Cochabamba/Santa Cruz/Chuquisaca

- | | |
|--------------------------------------------------------------------------------|---|
| 20. FAMES: HIV screening, provider and public education. (no specific request) | ? |
|--------------------------------------------------------------------------------|---|

Santa Cruz/Cochabamba

- | | |
|---------------------------------------------------------------------------------------------------------------------------|----------|
| 21. Programa de Educacion por Radio (PER): Pilot interactive radio education with children 9-11 yrs, HIV/AIDS prevention. | \$47,201 |
|---------------------------------------------------------------------------------------------------------------------------|----------|

National Scope

- | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------|
| 22,23. Adding data sets to the Drug Awareness Project studies and including curricula in the Radio Education Project. | ? |
| 24. AIDSTECH: Condom distribution and research to high risk groups, STD clinics, peer education, national logistics planning. (developed proposal) | \$470,375 |

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ANNEX 6 - PROCUREMENT LIST

TABLE 1. Number of proposed tests to be performed at each of the STD/HIV reference laboratories and model clinics over the life of the project.

TESTS	<u>INLASA</u>		<u>CENETROP</u>		<u>CUMETROP</u>		<u>TOTAL</u>
	Ref.Lab.	Clinic	Ref. Lab.	Clinic	Ref. Lab.	Clinic	
GC Media	5,200	20,800	5,200	20,800	2,080	10,400	64,480
PPNG	1,040	2,880	1,040	2,880	416	1,400	9,656
RPR	10,400	20,800	10,400	20,800	10,400	10,400	83,200
TCN/PCN	1,040		1,040		416		2,496
Subculture	1,040		1,040		416		2,496
Chacroid	1,560		1,560		520		3,640
Chlamydia-EIA	5,200		5,200		2,080		12,480
HSV EIA	2,080		2,080		1,040		5,200
Trichomonas	2,080		2,080		1,040		5,200
VDRL	500		500		500		1,500
MHA-TP	1,000		1,000		1,000		3,000
HIV-1 EIA	10,000		10,000		10,000		30,000
HIV-2 EIA	1,000		1,000		400		2,400
HBsAg	6,000		6,000		2,000		14,000
HBcAb	2,000		2,000		400		4,400
HCAb	2,000		2,000		400		4,400
WB HIV-1	100		100		100		300
Chlamydia- CF	1,000		1,000		400		2,400
TOTAL	53,240	44,480	53,240	44,480	33,608	22,200	251,248

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ANNEX 6 - PROCUREMENT LIST

TABLE 2. Summary of estimated LOP costs by year for equipment, supplies, and reagents for strengthening three STD/HIV reference laboratories and model STD/HIV clinical laboratories. (in US dollars)

	<u>INLASA-La Paz</u>		<u>CENETROP-Sta Cruz</u>		<u>CUMETROP-Cbba</u>		<u>TOTAL</u>
	Equipment and Supplies	Reagents	Equipment and Supplies	Reagents	Equipment and Supplies	Reagents	
YEAR 1	36,100	58,772	33,900	58,772	35,300	37,467	260,311
YEAR 2	14,500	58,772	8,800	58,772	8,800	37,467	187,111
YEAR 3	19,500		11,600		10,600		41,700
YEAR 4	10,500		18,600		16,600		45,700
TOTAL	80,600	117,544	72,900	117,544	71,300	74,934	534,822

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ANNEX 6 - PROCUREMENT LIST

TABLE 3. Estimated cost by year for laboratory equipment, supplies, and reagents for strengthening the INLASA STD/HIV laboratory and model clinic in La Paz. (in US dollars)

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTAL
INLASA Reference Lab :					
Equipment and Supplies	22,200	11,100	16,100	7,100	56,500
Reagents	45,632	45,632			91,264
INLASA Model Clinic :					
Equipment and Supplies	13,900	3,400	3,400	3,400	24,100
Reagents	13,140	13,140			26,280
TOTAL	94,872	73,272	19,500	10,500	198,144

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ANNEX 6 - PROCUREMENT LIST

TABLE 4. Facility : INLASA, La Paz
 Laboratory : STD/HIV Reference Lab.
 Purchase : Equipment and Supplies

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	One 286 Portable Computer & Printer	4,000/ea	4,000				4,000
	Computer Supplies and accessories	1,000/yr	1,000	1,000	1,000	1,000	4,000
	One Orbital Shaker (WB)	600/ea	600				600
	One Centrifuge, benchtop	2,000/ea	2,000				2,000
	One Compound microscope for VDRL (low mag.)	2,500/ea	2,500				2,500
	Latex gloves non-sterile	500/yr	500	500	500	500	2,000
	Two sets of adjustable volume pipettors, Range: 10-200 microltr.	500/set	1,000				1,000
	Tips for sets of adjustable pipettors, Range : 10-200 ul	200/yr	200	200	200	200	800
	One -70 C Freezer	6,000/ea			6,000		6,000
	One CO2 Incubator	5,000/ea		5,000			5,000
	CO2 Gas Supply for Incubator Cylinder	800/yr		800	800	800	2,400
	One small dry heat incubator	1,000/ea	1,000				1,000
	One Autoclave	4,000/ea			4,000		4,000
	One water still	3,000/ea				3,000	3,000
	Two Refrigerators	700/ea	1,400				1,400
	One dark field microscope	3,500/ea	3,500				3,500

(Continued)

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ANNEX 6 - PROCUREMENT LIST

TABLE 4. Facility : INLASA, La Paz
 (cont.) Laboratory : STD/HIV Reference Lab.
 Purchase : Equipment and Supplies

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	Two water bath incubators	400/ea	800				800
	One ELISA Reader	2,000/ea			2,000		2,000
	One Rotator (VDRL)	300/ea	600				600
	One eight-channel adjustable volume pipettor, Range : 10-200 microliters	500/ea	500				500
	Tips for multichannel pipettors	100/yr	100	100	100	100	400
	One small centrifuge	1,000/ea	1,000				1,000
	One microscope	2,000/ea		2,000			2,000
	Miscellaneous glassware and Supplies	1,500/yr	1,500	1,500	1,500	1,500	6,000
	TOTAL		22,200	11,100	16,100	7,100	56,500

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ANNEX 6 - PROCUREMENT LIST

TABLE 5. Facility : INLASA, La Paz
 Laboratory : STD/HIV Reference Lab.
 Purchase : Reagents

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	GC Media (50/WK, 2,600/yr)	0,75/test	1,950	1,950			3,900
	PPNG Tests (20% + 520/yr)	0,10/test	52	52			104
	TCN/PCN discs/media (520/yr)	1,00/test	520	520			1,040
	Subcultures (20%, 520/yr)	0,50/test	260	260			520
	Chancroid (15/WK, 780/yr)	2,00/test	1,560	1,560			3,120
	Chlamydia Antigen-EIA (50/WK, 2,600/yr)	4,00/test	10,400	10,400			20,800
	HSV EIA (20 tests/WK, 1,040/yr)	5,00/test	5,200	5,200			10,400
	Trichomonads cult. (20 tests/WK, 1,040/yr)	4,00/test	4,160	4,160			8,320
	Miscellaneous Supplies (\$2,000/yr)	\$2,000/yr	2,000	2,000			4,000
	RPR (100/WK, 5,200 tests/yr)	0,50/test	2,600	2,600			5,200
	VDRL (250 tests/yr)	1,00/test	250	250			500
	MHA-TP (500 tests/yr)	1,00/test	500	500			1,000
	HIV-I, ELISA (5,000 tests/yr)	1,00/test	5,000	5,000			10,000
	ELISA for HIV-2 (Japanese; 500 tests/yr)	1,00/test	500	500			1,000

(Continued)

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ANNEX 6 - PROCUREMENT LIST

TABLE 5. Facility : INLASA, La Paz
 (cont.) Laboratory : STD/HIV Reference Lab.
 Purchase : Reagents

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	HBsAg (Preg/blood; 3,000 tests/yr)	0,67/test	2,010	2,010			4,020
	HBcAb (1,000 tests/yr)	0,67/test	670	670			1,340
	HCAb (1,000 tests/yr)	1,00/test	1,000	1,000			2,000
	WB or IFA for HIV-1 (100 tests/yr)	20,00/test	2,000	2,000			4,000
	Chlamydia CF (500 tests/yr)	4,00/test	2,000	2,000			4,000
	Miscellaneous Supplies	\$3,000/yr	3,000	3,000			6,000
	TOTAL		45,632	45,632			91,264

ANNEX 6 - PROCUREMENT LIST

TABLE 6. Facility : INLASA, La Paz
 Laboratory : STD/HIV Model Clinic
 Purchase : Equipment and Supplies

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	One Refrigerator	700/ea	700				700
	One Rotator (VDRL)	300/ea	300				300
	One CO2 Incubator (small)	2,500/ea	2,500				2,500
	Supply of CO2 Gas	400/yr	400	400	400	400	1,600
	One Centrifuge	1,500/ea	1,500				1,500
	Microscope and dark field	3,500/ea	3,500				3,500
	Compound Microscope	2,000/ea	2,000				2,000
	Miscellaneous Supplies	3,000/yr	3,000	3,000	3,000	3,000	12,000
	TOTAL		13,900	3,400	3,400	3,400	24,100

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ANNEX 6 - PROCUREMENT LIST

TABLE 7. Facility : INLASA, La Paz
 Laboratory : STD/HIV Model Clinic
 Purchase : Reagents

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	GC Media (200 samples/wk, 10,400/yr)	0,75/test	7,800	7,800			15,600
	PPNG (20% + Rate, 1,440/yr)	0,10/test	140	140			280
	RPR (200/wk, 10,400/yr)	0,50/test	5,200	5,200			10,400
	TOTAL		13,140	13,140			26,280

ANNEX 6 - PROCUREMENT LIST

TABLE 8. Estimated cost by year for laboratory equipment, supplies, and reagents for strenghtening the CENETROP STI/HIV reference laboratory and model clinic in Santa Cruz. (in US dollars)

	YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTAL
CENETROP Reference Lab. :					
Equipment and Supplies	20,000	5,400	8,200	15,200	48,800
Reagents	45,632	45,632			91,264
CENETROP Model Clinic :					
Equipment and Supplies	13,900	3,400	3,400	3,400	24,100
Reagents	13,140	13,140			26,280
TOTAL	92,672	67,572	11,600	18,600	190,444

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ANNEX 6 - PROCUREMENT LIST

TABLE 9. Facility : CENETROP, Santa Cruz
 Laboratory: STD/HIV Regional Lab.
 Purchase : Equipment and Supplies

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	One - 70'C Freezer	6,000/ea				6,000	6,000
	One CO2 Incubator	5,000/ea			5,000		5,000
	CO2 Gas Supply, Incubator	800/yr			800	800	1,600
	One Autoclave	4,000/ea				4,000	4,000
	One water still	3,000/ea		3,000			3,000
	Two Refrigerators	700/ea	1,400				1,400
	One dark field Microscope	3,500/ea	3,500				3,500
	Two water bath Incubators	400/ea	800				800
	One Rotator for VDRL	300/ea	300				300
	One ELISA Reader	2,000/ea				2,000	2,000
	One orbital shaker for WB	600/ea	600				600
	One 286 Portable Computer with Printer	4,000/ea	4,000				4,000
	Computer Supplies and Accessories	500/yr	500	500	500	500	2,000
	One bench top Centrifuge	2,000/ea	2,000				2,000
	One compound Microscope	2,500/ea	2,500				2,500
	Latex gloves Non-sterile	300/yr	300	300	300	300	1,200
	Two sets of adjustable volume pipettors Range:10-200microlit.	500/set	1,000				1,000

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ANNEX 6 - PROCUREMENT LIST

TABLE 9.
(cont.)

Facility : CENETROP, Santa Cruz
 Laboratory: STD/HIV Regional Lab.
 Purchase : Equipment and Supplies

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	Latex gloves Non-sterile	300/yr	300	300	300	300	1,200
	Two sets of adjustable volume pipettors Range:10-200microliters	500/set	1,000				1,000
	Tips for sets of adjustable pipettors 10-200 microliters.	200/yr	200	200	200	200	800
	One eight-channel adjustable volume pipettor Range 10-200 microliters.	500/ea	500				500
	Tips for eight-channel pipettors, 10-200 micro-liters.	200/yr	200	200	200	200	800
	One small centrifuge	1,000/ea	1,000				1,000
	Miscellaneous glass- ware and supplies	1,200/yr	1,200	1,200	1,200	1,200	4,800
	TOTAL		20,000	5,400	8,200	15,200	48,800

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ANNEX 6 - PROCUREMENT LIST

TABLE 10. Facility : CENETROP, Santa Cruz
 Laboratory: STD/HIV Reference Lab.
 Purchase : Reagents

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	GC Media (50/wk, 2,600 tests/year)	0,75/test	1,950	1,950			3,900
	PPNG tests (20%+, 520 tests/year)	0,10/test	52	52			104
	TCN/PCN discs/media (520 tests/year)	1,00/test	520	520			1,040
	Subcultures (20%, 520 tests/year)	0,50/test	260	260			520
	Chancroid (15 tests/wk, 780 tests/year)	2,00/test	1,560	1,560			3,120
	Chlamydia Antigen-EIA (50 tests/wk, 2,600 tests/yr)	4,00/test	10,400	10,400			20,800
	HSV EIA (20/wk, 1,040 tests/year)	5,00/test	5,200	5,200			10,400
	Trichomonas Cult. (20/wk, 1,040 tests/yr)	4,00/test	4,160	4,160			8,320
	Miscellaneous supplies (\$2,000/year)	2,000/yr	2,000	2,000			4,000
	RPR (100/wk, 5,200 tests/yr)	0,50/test	2,600	2,600			5,200
	VDRL (250 tests/yr)	1,00/test	250	250			500
	MHA-TP (500 tests/yr)	1,00/test	500	500			1,000
	HIV-1 ELISA (5,000 tests/yr)	1,00/test	5,000	5,000			10,000
	HIV-2 ELISA (Japanese; 500 tests/yr)	1,00/test	500	500			1,000

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ANNEX 6 - PROCUREMENT LIST

TABLE 10.
(cont.)

Facility : CENETROP, Santa Cruz
Laboratory: STD/HIV Reference Lab.
Purchase : Reagents

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	HIV-2 ELISA (Japanese; 500 tests/yr)	1,00/test	500	500			1,000
	HBs Ag (Preg/blood) (3,000 tests/year)	0,67/test	2,010	2,010			4,020
	HBc Ab (1,000 tests/ year)	0,67/test	670	670			1,340
	HC Ab (1,000 tests/ year)	1,00/test	1,000	1,000			2,000
	WB or IFA for HIV-1 (100 tests/year)	20,00/tests	2,000	2,000			4,000
	Chlamydia CF (500 tests/year)	4,00/test	2,000	2,000			4,000
	Miscellaneous supplies	3,000/yr	3,000	3,000			6,000
	TOTAL		45,632	45,632			91,264

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ANNEX 6 - PROCUREMENT LIST

TABLE 11. Facility : CENETROP, Santa Cruz
 Laboratory: STD/HIV Model Clinic
 Purchase : Equipment and Supplies

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	One Refrigerator	700/ea	700				700
	One Rotator (VDRL)	300/ea	300				300
	One CO2 Incubator	2,500/ea	2,500				2,500
	Supply of CO2 Gas	400/yr	400	400	400	400	1,600
	One Centrifuge	1,500/ea	1,500				1,500
	Microscope and Dark field	3,500/ea	3,500				3,500
	Compound Microscope	2,000/ea	2,000				2,000
	Miscellaneous Supplies	3,000/yr	3,000	3,000	3,000	3,000	12,000
	TOTAL		13,900	3,400	3,400	3,400	24,100

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ANNEX 6 - PROCUREMENT LIST

TABLE 12. Facility : CENETROP, Santa Cruz
 Laboratory: STD/HIV Model Clinic
 Purchase : Reagents

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	GC Media (200/wk 10,400/year)	0,75/test	7,800	7,800			15,600
	PPNG (20%+ Rate, 1,400/year)	0,10/test	140	140			280
	RPR (200/wk, 10,400/year)	0,50/test	5,200	5,200			10,400
	TOTAL		13,140	13,140			26,280

ANNEX 6 - PROCUREMENT LIST

TABLE 13. Estimated cost by year for Laboratory equipment, supplies and reagents for strengthening the CUMETROP STD/HIV reference laboratory and model clinic in Cochabamba (in US dollars)

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	YEAR 1	YEAR 2	YEAR 3	YEAR 4	TOTAL
CUMETROP Reference Lab. :					
Equipment and Supplies	21,400	5,400	7,200	13,200	47,200
Reagents	24,327	24,327		48,654	
CUMETROP Model Clinic :					
Equipment and Supplies	13,900	3,400	3,400	3,400	24,100
Reagents	13,140	13,140		26,280	
T O T A L	72,767	46,267	10,600	16,600	146,234

ANNEX 6 - PROCUREMENT LIST

TABLE 14. Facility : CUMETROP, Cochabamba
 Laboratory : STD/HIV Reference Lab.
 Purchase : Equipment and Supplies

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	One -70 C Freezer	6,000/ea					
	One CO2 Incubator	4,000/ea				6,000	6,000
	CO2 Gas Supply	800/yr			4,000		4,000
	One autoclave	4,000/ea			800	800	1,600
	One water still	3,000/ea		3,000		4,000	4,000
	Two Refrigerators	700/ea	1,400				3,000
	One dark-field microscope	3,500/ea	3,500				1,400
	Two water bath incubators	400/ea	800				3,500
	One Rotator for VDRL	300/ea	300				800
	One 286 Portable Computer & Printer	4,000/ea	4,000				300
	Computer Supplies and Accessories	500/yr	500	500	500	500	4,000
	One benchtop centrifuge	2,000/ea	2,000				2,000
	One compound microscope	2,500/ea	2,500				2,000
	One ELISA Reader	2,000/ea	2,000				2,500
	Latex Gloves non-sterile	300/yr	300	300	300	300	2,000
	Two sets of Adjustable Volume Pipettors						1,200
	Range: 10-200 microlitr.	500/set	1,000				
	Tips for sets of Adjustable pipettors, 10-200 ul	200/yr	200	200	200	200	1,000
							800

(Continued)

ANNEX 6 - PROCUREMENT LIST

TABLE 14. Facility : CUMETROP, Cochabamba
 (cont.) Laboratory : STD/HIV Reference Lab.
 Purchase : Equipment and Supplies

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	One eight-channel adjustable volume pipettors, Range: 10-200 microliters	500/ea	500				500
	Tips for eight-channel pipettors, Range: 10-200 microliters	200/yr	200	200	200	200	800
	One small centrifuge	1,000/ea	1,000				1,000
	Miscellaneous glassware and lab supplies	1,200/yr	1,200	1,200	1,200	1,200	4,800
	TOTAL		21,400	5,400	7,200	13,200	47,200

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ANNEX 6 - PROCUREMENT LIST

TABLE 15. Facility : CUMETROP, Cochabamba
 Laboratory : STD/HIV Reference Lab.
 Purchase : Reagents

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	GC Media (20/WK, 1,040 tests/year)	0,75/test	780	780			1,560
	PPNG Tests (20% +, 208 tests/year)	0,10/test	21	21			42
	TCN/PCN discs/media (208 tests/yr)	1,00/test	208	208			416
	Subcultures (20%, 208 tests/yr)	0,50/test	104	104			208
	Chancroid (5 tests/WK, 260 tests/yr)	2,00/test	520	520			1,040
	Chlarydia Antigen-EIA (20 tests/WK, 1,040 tests/yr)	4,00/test	4,160	4,160			8,320
	HSV EIA (10/WK, 520 tests/year)	5,00/test	2,600	2,600			5,200
	Trichomonas cult. (10/WK, 520 test/yr)	4,00/test	2,080	2,080			4,160
	Miscellaneous Supplies	1,000/yr	1,000	1,000			2,000
	RPR (100/WK, 5,200 tests/yr)	0,50/test	2,600	2,600			5,200
	VDRL (250 tests/yr)	1,00/test	250	250			500
	MHA-TP (500 tests/yr)	1,00/test	500	500			1,000
	HIV-I ELISA (5,000 tests/yr)	1,00/test	5,000	5,000			10,000
	ELISA for HIV-2 (Japanese; 200 tests/yr)	1,00/test	200	200			400

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ANNEX 6 - PROCUREMENT LIST

TABLE 15. Facility : CUMETROP, Cochabamba
 (cont.) Laboratory : STD/HIV Reference Lab.
 Purchase : Reagents

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	HBs Ag (Preg/Blood) (1,000 tests/yr)	0,67/test	670	670			1,340
	HBcAb (200 test/yr)	0,67/test	134	134			268
	HCab (200 tests/yr)	1,00/test	200	200			400
	WB or IFA for HIV-1 (50 tests/yr)	20,00/test	1,000	1,000			2,000
	Chlamydia CF (200 tests/yr)	4,00/test	800	800			1,600
	Miscellaneous Supplies	1,500/yr	1,500	1,500			3,000
	TOTAL		24,327	24,327			48,654

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ANNEX 6 - PROCUREMENT LIST

TABLE 16. Facility : CUMETROP, Cochabamba
 Laboratory : STD/HIV Model Clinic
 Purchase : Equipment and Supplies

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	One Refrigerator	700/ea	700				700
	One Rotator (VDRL)	300/ea	300				300
	One CO2 Incubator	2,500/ea	2,500				2,500
	Supply of CO2 gas,	400/yr	400	400	400	400	1,600
	One Centrifuge	1,500/ea	1,500				1,500
	One Dark Field Microscope	3,500/ea	3,500				3,500
	One Compound Microscope	2,000/ea	2,000				2,000
	Miscellaneous glassware and Supplies	3,000/yr	3,000	3,000	3,000	3,000	12,000
	TOTAL		13,900	3,400	3,400	3,400	24,100

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ANNEX 6 - PROCUREMENT LIST

TABLE 17. Facility : CUMETROP, Cochabamba
 Laboratory : STD/HIV Model Clinic
 Purchase : Reagents

Item No./GSA Code	Item Description	Cost per Unit	Year 1	Year 2	Year 3	Year 4	TOTAL
	GC Media (200/WK, 10,400/yr)	0,75/test	7,800	7,800			15,600
	PPNG (20% + Rate, 1,400/yr)	0,10/test	140	140			280
	RPR (200/WK, 1,400/yr)	0,50/test	5,200	5,200			10,400
	TOTAL		13,140	13,140			26,280

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ANNEX 7.

PUBLIC HEALTH ADVISOR : SCOPE OF DUTIES
AIDS/STD Prevention and Control Project

1. As project manager, to facilitate communications among the various national, international and non-governmental organizations involved in STD/HIV intervention and related programs in Bolivia to assure better coordination of research, training and education activities funded through USAID/Bolivia. This will include providing routine periodic monitoring and oversight of all MOH and NGO-implemented research activities. This will also involve providing linkages between MOH and NGO activities.
2. In cooperation with technical advisors provided through USAID/Bolivia, especially TAACS, AIDSCOM/AIDSTECH, and SOMARC, to assist in the design, formulation and implementation of epidemiological, operational, and educational research activities to ensure that they are of practical benefit to the project and provide the operational basis for and be incorporated into disease intervention strategies and to ensure that these activities build local capacity (e.g. training of human resources, protocol design, etc.)
3. In cooperation with the laboratory component of the MOH, ensure that USAID/Bolivia-funded research activities build local capacity through placement of resources (i.e., equipment and material) which will ensure quality infrastructure development within designated regional reference laboratories and local laboratories at the service delivery level.
4. In cooperation with the MOH and the CDC, to ensure training of local staff within the program components of surveillance, education, counseling, and partner-notification activities.
5. To work closely the MOH STD/HIV program management to ensure that STD control become the primary operational basis for HIV control at the national and local levels.
6. To provide a mechanism for USAID/Bolivia and CDC to review intervention priorities and support the MOH effort to prevent and control STD/HIV infection.
7. To recruit, hire, train, supervise, and coordinate one project-supported health administrator, one IEC specialist, and one clerical support person in all pertinent aspects of project administration and operations.

8. To provide management assistance to the CDC project chief and the USAID/HHR project officer; this includes monitoring expenditures, maintaining review and oversight of project-funded activities, writing periodic progress reports, and establishing a protocol (i.e., providing introductions; arranging meetings and schedules; assuring logistical support) for short-term technical advisors assigned to the project.
9. To assist in the development and organization of computerized databases to facilitate all the above activities and provide a means of evaluating the impact of current and future disease interventions.
10. To perform other STD/HIV-related tasks as may be assigned by the CDC project chief and the USAID/HHR project officer.

Requirements

1. PhD/DrPH or equivalent in epidemiology, laboratory sciences, public health or related field.
2. Minimum eight years of professional experience with increasing levels of management, supervisory, and research responsibilities, preferably in communicable disease control and/or public health administration activities.
3. Minimum three years professional experience in Third World countries, preferably in Latin America.
4. Ability to communicate in Spanish in all matters related to this project; minimum FSI 3/3.
5. Ability to work successfully in a team approach, direct and coordinate team/staff members, and negotiate with and counsel Bolivian counterpart professionals.

Relationship to TAACS advisor

USAID/Bolivia/HHR currently benefits from LT/TA services provided by CDC/IHPO through the Technical Advisors in AIDS and Child Survival (TAACS) Project. The success of both TA efforts will depend in part of the expected high degree of coordination and collaboration between the AIDS Prevention and Control LT/PH advisor and the TAACS advisor.

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ANNEX 8.

DETAILED BUDGET EXPLANATION

USAID MISSION TO BOLIVIA
AIDS/STD PREVENTION AND CONTROL PROJECT

TABLE 3.3. Estimated Budget by Object and Program Year, AID Funds (in US dollars).

Management Unit/Object	Notes	Year 1	Year 2	Year 3	Year 4	TOTAL
A. BUY-IN TO AIDS TECHNICAL SUPPORT PROJECT (No. 936-5972)						
1. Technical Assistance:						
Long term PH advisor	a	83,500	86,800	90,300	93,900	354,500
PRA allowances	b	60,500	40,500	44,200	68,600	213,800
Short term TA	c	36,000	37,400	38,900	40,500	152,800
Sub-total		180,000	164,700	173,400	203,000	721,100
2. Commodities:						
Lab equip. & supplies	d	105,300	32,100	43,400	49,400	230,200
Lab reagents	e	155,000	155,000	0	0	310,000
Sub-total		260,300	187,100	43,400	49,400	540,200
3. Local costs:						
Bolivian staff (3)	f	48,000	49,800	51,900	54,000	203,800
Operations	g	93,590	61,700	60,100	66,750	282,140
MOB training	h	25,000	20,800	21,600	22,400	89,800
NGO sub-projects	i	75,000	78,000	81,100	84,400	318,500
Condom marketing	j	75,000	75,000	0	0	150,000
Sub-total		316,590	285,400	214,700	227,550	1,044,240
4. Multiplier @ 20%						
	k	151,378	127,440	86,300	95,990	461,108
TOTAL BUY-IN		908,268	764,640	517,800	575,940	2,766,648
B. CDC PASA						
Short term TA	l	78,000	81,100	56,200	58,500	273,800
Program support	m	10,764	11,192	7,756	8,073	37,784
Overhead @ 20%	n	17,753	18,458	12,791	13,315	62,317
TOTAL CDC		106,517	110,750	76,747	79,888	373,901
C. USAID/BOLIVIA						
Secretary & logistics	o	18,000	19,000	20,000	21,000	78,000
Condoms	p	30,000	31,200	32,400	33,700	127,300
Evaluations & special studies, etc.	q	12,000	62,500	13,000	66,651	154,151
TOTAL USAID		60,000	112,700	65,400	121,351	359,451
GRAND TOTAL		1,074,785	988,090	659,947	777,179	3,500,000

USAID MISSION TO BOLIVIA
AIDS/STD PREVENTION AND CONTROL PROJECT (511-0408), AMENDMENT NO. 1

TABLE 1. Title of Project, Cost Estimate and Financial Plan (\$000s).

INPUTS	A.I.D.			HOST COUNTRY			GRAND TOTAL	PERCENT
	FY	LC	TOTAL	CASH	IN-KIND	TOTAL		
Technical assistance	1239	0	1239	0	0	0	1239	23.9
Training	108	0	108	0	0	0	108	2.1
Commodities	776	0	776	612	0	612	1388	26.9
Local operations	587	0	587	730	254	984	1567	30.3
HR Management support	154	78	232	0	0	0	232	4.5
JEC/SM/DR sub-projects	562	0	562	0	80	80	642	12.4
TOTAL INPUTS	3422	78	3500	1342	334	1676	5176	100.0
Percent	66.1	1.5	67.6	25.9	6.5	32.4	100.0	

USAID MISSION TO BOLIVIA
AIDS/STD PREVENTION AND CONTROL PROJECT (511-0409), AMENDMENT NO. 1

TABLE 1.2. Disbursement Schedule and Projection of Expenses by USG Fiscal Year, AID Funds (\$000s).

INPUTS	FY 1991			FY 1992			FY 1993		
	FY	LC	TOTAL	FY	LC	TOTAL	FY	LC	TOTAL
Technical assistance	173	0	173	302	0	302	399	0	399
Training	0	0	0	43	0	43	39	0	39
Commodities	312	0	312	255	0	255	116	0	116
Local operations	110	0	110	127	0	127	134	0	134
MHR management support	0	9	9	74	19	93	13	19	32
JEP/CM/CS sub-projects	0	0	0	180	0	180	281	0	281
TOTAL INPUTS	595	9	604	981	19	1000	921	19	1000

INPUTS	FY 1994			TOTAL LDC		
	FY	LC	TOTAL	FY	LC	TOTAL
Technical assistance	365	0	365	1239	0	1239
Training	27	0	27	108	0	108
Commodities	93	0	93	776	0	776
Local operations	212	0	212	583	0	583
MHR management support	67	31	98	154	78	232
JEP/CM/CS sub-projects	101	0	101	562	0	562
TOTAL INPUTS	965	31	896	3422	78	3500

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AIDS/STD PREVENTION AND CONTROL PROJECT

Explanatory Notes for Budget Table 3.3.

- a. Base salary of \$55,660 + 25% fringe benefits + 25% post differential, with 4% annual increase.
- b. See attached detail of LT/PHA allowances. Allowances are normal and customary for the USAID/Bolivia mission, including \$37,800 to be disbursed by contractor HQ and \$176,000 to be disbursed by the project field office in Bolivia.
- c. Short term TA calculated at \$12,000 per month (30 days at \$250 per day, including 24 days in the field and 6 days preparation and travel, and \$4,500 travel and per diem) for the first year with 4% annual increase for inflation.

Based on the above, each year represents 3.0 months of ST/TA, including 2.0 months for IEC planning, sub-project design and TA, and evaluative research, and 1.0 months for operations research, cost recovery studies, and other as needed.

- d. See Annex 6 for detailed lists and summary budget of requested laboratory equipment, supplies, and reagents. The CDC draft report recommended the purchase of \$277,450 in lab equipment and computers based on what is ideally needed by standard HIV/STD reference and clinic laboratories. The proposed AIDSTECH laboratory equipment and supply survey will establish that some or many of the items recommended by CDC are already available. For budgeting purposes, the requested amount has been reduced by nearly one-third in anticipation that an equivalent amount of recommended equipment is already in place.
- e. The CDC report estimated \$240,678 for reagents in Year 1 and \$253,678 in Year 2. These figures were also reduced by nearly one-third to \$155,000 for each of the first two years for the reasons discussed above. The purchase of reagents for Years 3 & 4 will be provided by the Ministry of Health.
- f. Includes 1 bilingual secretary @ \$12,000 per year, 1 project administrator @ \$18,000 per year, and 1 IEC specialist @ \$18,000 per year, with annual COL increases of 4%. All personnel will be supervised by the LT/PHA and located at a project office in La Paz.
- g. See attached detail of local operations cost estimates. First year requirements include \$30,240 for local travel, \$3,750 for international travel, \$21,600 for office space

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and operations, and \$38,000 for office equipment and furniture.

- h. Includes in-service training, workshops, short courses and conferences for MOH laboratory and NGO IEC personnel.
- i. NGO sub-projects estimated at \$75,000 per year with a 4% annual increase for inflation. Projects will concentrate on IEC activities but may include OR and special studies, e.g. cost recovery, as needed.
- j. These funds will be used primarily to continue the packaging and promotional efforts begun earlier with the Contraceptive Social Marketing II Project (No. 936-3051) through SOMARC's representative in Bolivia, PROSALUD.
- k. A multiplier rate is estimated at 20%. This should be considered an average as rates for overhead or G&A may vary for personnel, commodities, and in-country operations. In fact, the rates may be reduced or waived altogether considering that much or all of the central costs may be covered directly by the Cooperative Agreement (No. 936-5972). In this case, this line item can be reallocated to other activities and/or held for contingencies.
- l. All CDC ST/TA calculated at \$13,000 per month (\$9,000 salary and benefits, including 2 weeks preparation time for each month in the field, and \$4,000 travel and per diem for each month in the field) for the first year with 4% annual increase for inflation.

Based on the above, Years 1 and 2 each represent 6.0 months of ST/TA actual field time, including 4.0 months Levine, 1.0 month lab trainer, and 1.0 month other ST/TA as needed. In Years 3 and 4, Levine's time will be reduced to 2.0 months per year and the other will remain the same for a total of 4.0 months ST/TA per year.
- m. Calculated at 13.8% of CDC direct expenditures for IHPO administrative and management backstopping.
- n. Current CDC PASA overhead rate is 20% on all direct and program support expenditures.
- o. Secretarial and logistics support in the USAID/HHR office in La Paz.
- p. USAID will purchase direct from S&T/POP 500,000 condoms per year at a cost of \$6 per 100. These will be packaged and marketed/distributed to the STD/HIV clinics and other high risk groups through the SOMARC/PROSALUD program currently operating in Bolivia.

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9. Includes one midterm and one final evaluation of the project and an additional \$50,051 for special studies and unforeseen needs. No local audits are required because all funds will be disbursed either by the AIDS T/S contractor, the CDC/PASA, or USAID/Bolivia.

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Budget Note b:

AIDS/STD Prevention and Control Project
Estimated Costs for LT PHA Allowances

Based on Family of 4 with 2 children in grades 6-12, and adjusted for 4% annual inflation (effective June 1991).

<u>Object</u>		<u>YEAR 1</u>	<u>YEAR 2</u>	<u>YEAR 3</u>	<u>YEAR 4</u>	<u>TOTAL</u>
Storage HHE	(a)	2,850*	2,963*	3,082*	3,205*	12,100
Transportation HHE	(b)	15,900*	--	--	17,885	33,785
Transportation POV	(c)	3,000*	--	--	--	3,000
Unaccompanied Baggage	(d)	1,750*	--	--	1,970	3,720
Housing, utilities	(e)	21,600	22,464	23,363	24,298	91,725
Education	(f)	10,900	9,256	9,626	10,001	39,793
Medical evacuation	(g)	175*	182*	189*	197*	743
R & R	(h)	--	5,658	--	6,119	11,777
Home leave	(i)	--	--	7,913	--	7,913
Family travel	(j)	4,368*	--	--	4,913	9,281
TOTAL		<u>60,543</u>	<u>40,523</u>	<u>44,173</u>	<u>68,598</u>	<u>213,837</u>
Rounded Totals:						
HQ Disbursement		28,000	3,150	3,250	3,400	37,800
Local Disbursement		32,500	37,350	40,950	65,200	176,000

* Expenditures paid by contractor HQ. All others paid by field office.

- (a) Includes storage and insurance.
- (b) 18,000 lbs. x \$1.20 one way less storage costs.
- (c) No return shipment, probable sale POV in Bolivia
- (d) 700 lbs. x \$2.50 one way
- (e) \$1,800 per month, Year 1
- (f) \$4,450 per child plus \$1,000 per child one time registration fee, Year 1
- (g) Medivac insurance, \$175 per family, Year 1.
- (h) R/T airfare to Nassan \$1,260 plus \$100 per person
- (i) R/T airfare to Washington, D.C. + 2 days per diem + 22 lbs. excess + \$100 per person
- (j) One way airfare Washington, D.C. - La Paz + 1 day per diem + 22 lbs. excess + \$50 per person

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Budget Note g:

AIDS/STD Prevention and Control Project
Detail of Local Operations Cost Estimates
 (Year 1, in US Dollars)

1.	Travel, Local:		
	R/T Santa Cruz	\$145 + 5 days x \$101 = \$650	
	2 person-trips per month x 12 months =		\$15,600
	R/T Cochabamba	\$70 + 5 days x \$98 = \$560	
	2 person-trips per month x 12 months =		\$13,440
	Taxis, etc	\$100 per month x 12 months =	\$1,200
	Subtotal:		\$30,240
2.	Travel, International:		
	LT/PHA - 1 trip per year to Washington, D.C. and/or conference		
	R/T airfare	\$1,500 + 15 days x \$150 =	\$3,750
	IEC specialist - 1 trip in each of years 2 & 4 to Washington, D.C. and/or conference = \$3,900 in year 2.		
3.	Office Space and Operations:		
	Rent and utilities at \$500 per month x 12 months =		\$6,000
	Supplies, small equipment, maintenance and printing at \$500 per month x 12 months =		\$6,000
	Shipping, postage, telephone and fax at \$800 per month x 12 months =		\$9,600
	Subtotal:		\$21,600
	TOTAL Recurring Costs		\$55,590
4.	Office Equipment (Year 1 only):		
	Desktop computers, 286/40MB,	2 x \$3,000 =	\$6,000
	HP Laser Jet III printer w/acces.,	1 x \$2,750 =	\$2,750
	Epson FX-1050 printer,	1 x \$500 =	\$500
	Notebook computers, Everex Tempo LX	2 x \$3,000 =	\$6,000
	Canon BJ-10e printers w/acces.,	2 x \$450 =	\$900
	IBM Selectric III typewriter,	1 x \$850 =	\$850
	Telephone line, equipment	2 x \$2,000 =	\$4,000
	Furniture	=	\$10,000
	Fax machine	1 x \$1,500 =	\$1,500
	Photocopy machine	1 x 3,000 =	\$3,000
	Miscellaneous	=	\$2,500
	Total Equipment and Furniture:		\$38,000

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AIDS/STD Prevention and Control Project

Table 3.4 Estimates of Host Country Contributions

A. IN-KIND

1. Facilities & Equipment (depreciation):		
3 ref labs at \$5,000/yr x 4 yrs =	60,000	
3 clinics at \$1,000/yr x 4 yrs =	12,000	
Subtotal	\$72,000	
2. Existing personnel:		
4 technical (P/T) x 3 labs x \$250/mos. x 50%		
x 15 mons/yr x 4 yrs (adjusted for 4% COL) =	95,545	
3 support (P/T) x 6 labs x \$150/mon x 50%		
x 15 mon/yr x 4 yrs (w 4% COL)	= 85,990	
Subtotal	\$181,535	
3. NGO contribution at 33% of 238,875	= \$ 79,625	
Total In-Kind	\$333,160	

B. CASH

1. Sale of condoms:		
1.5 million at 3/pkg x \$.28/pkg		= \$140,000
2. Purchase of reagents (Annex 6):		
Year 3 = 168,000 + Year 4 = 174,000		= \$342,000
3. Purchase of antibiotics, etc (Rx):		
45,000 patients x \$6		= \$270,000
4. Lab & clinic operations (utilities, supplies, maintenance, etc.)		
\$500/mon x 12 mons x 6 labs x 4 years		
(w/4% infl.)		= \$152,870
5. Personnel, clinics:		
1. MD/epidemiologist at 300/mon.	= 300	
3. clinicians at 280/mon.	= 840	
1. secretary at 150/mon.	= 150	
1. data manager at 200/mon.	= 200	
2. auxiliary nurses at 150/mon.	= 300	
2. social workers at 200/mon.	= 400	
Total	\$2,190	
x 15 mon/yr x 3 clinics x 4 yrs (w/4%COL) =		\$418,490

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6. Furniture for clinic staff,

2- lg. desk at 112	= \$225	
6- med desk at 70	= 420	
1- table at 100	= 100	
20- chairs at 30	= 600	
8- shelves at 85	= 680	
2 file cabinets at 400	= 800	
3 exam tables at 1000	= 3000	
3 fans or heaters at 100	= 300	
1 manual typewriter	= 250	
Total Furniture	<u>\$6375</u>	x 3 \$ 19,125
TOTAL CASH		\$ 1,342,485
GRAND TOTAL (4 years)		\$ 1,675,645

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ANNEX 9.

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