

Case UPD-ABP-489

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE

A = Add
 C = Change
 D = Delete

Amendment Number
TWO

DOCUMENT CODE

3

2. COUNTRY/ENTITY BOLIVIA

3. PROJECT NUMBER

511-0608

4. BUREAU/OFFICE
 LATIN AMERICA AND CARIBBEAN
 (LAC)

05

5. PROJECT TITLE (maximum 40 characters)

AIDS/STDs PREVENTION AND CONTROL

6. PROJECT ASSISTANCE COMPLETION DATE (PACD)

MM DD YY
03 31 98

7. ESTIMATED DATE OF OBLIGATION

(Under "B." below, enter 1, 2, 3, or 4)

A. Initial FY 95 B. Quarter 3 C. Final FY 98

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

A. FUNDING SOURCE	FY 88 FIRST-FY TO DATE			LIFE OF PROJECT		
	B. FX	C. L/C	D. Total	E. FX	F. L/C	G. Total
AID Appropriated Total	1,750	2,051	3,801	2,000	3,400	5,400
(Grant)	(1,750)	(2,051)	(3,801)	(2,000)	(3,400)	(5,400)
(Loan)	()	()	()	()	()	()
Other U.S.						
1.						
2.						
Host Country			---		1,813	1,813
Other Donor(s)						
TOTALS	1,750	2,051	3,801	2,000	5,213	7,213

9. SCHEDULE OF AID FUNDING (\$000)

A. APPRO. PRIATION CODE	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		2,897	---	1,599		4,496	
(2) HE	520	563		904	---			904	
(3)									
(4)									
TOTALS				3,801	---	1,599		5,400	

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 BWB
 B. Amount

13. PROJECT PURPOSE (maximum 480 characters)

To reduce the prevalence of STDs/HIV/AIDS in high risk behavior groups in La Paz, El Alto, Santa Cruz and Cochabamba.

14. SCHEDULED EVALUATIONS

Interim MM YY Final MM YY
1 1 9 5

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 FP Amendment.)

The USAID Controller concurs with the methods of implementation and financing proposed in this Project Paper Amendment.

[Signature] 4-14-95
 Richard J. Goughnour, Controller

17. APPROVED BY

Signature *[Signature]*
 Title Lewis W. Lucke
 Acting Director

Date Signed MM DD YY
4 14 95

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

MM DD YY

PROJECT AUTHORIZATION AMENDMENT No.2

Name of Country: Bolivia
Name of Project: AIDS/STDs Prevention and Control
Number of Project: 511-0608

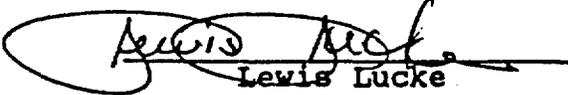
Pursuant to Section 104 of the Foreign Assistance Act of 1961, the AIDS/Sexually Transmitted Diseases (STDs) Prevention and Control Project was authorized on July 26, 1988 and amended on July 19, 1991. The authorization is hereby amended as follows:

Paragraphs 1, 2 and 4 of the authorization are revised to read:

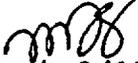
1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the AIDS/STDs Prevention and Control Project for Bolivia, involving planned obligations not to exceed Five Million Four Hundred Thousand United States Dollars (\$5,400,000) in grant funds over a ten-year period, subject to the availability of funds, in accordance with the USAID OYB/Allotment process. The planned life of project is extended to be approximately ten years. A new Project Assistance Completion Date (PACD) of March 31, 1998 is therefore established.
2. This project will contribute to the goal of improving family health throughout Bolivia. The amended purpose of the project is to reduce the prevalence of STDs/HIV/AIDS in La Paz, El Alto, Santa Cruz and Cochabamba. The amended project is designed to: (1) reduce the prevalence of STDs in CSWs to below 10% and in MWM by 20% over the baseline; (2) to develop three STD reference laboratories and four STD clinics, and train 580 health professionals in diagnosis and treatment of STDs; (3) develop direct counseling and outreach programs for high risk behavior groups, train 1000 individuals in prevention, distribute educational materials, and develop three telephone information hot-lines; (4) establish two national condoms distribution systems. In addition, the amended project will focus on sustaining project impact.
4. a. Source and Origin of Commodities, Nationality of Services

Commodities financed by USAID under the project shall have their source and origin in the United States (USAID Geographic Code 000), and Bolivia (in accordance with USAID Handbook I, Supplement B, Chapter 18, "Local Procurement"), except as USAID may otherwise agree in writing. Except for ocean shipping and motor vehicles, the suppliers of commodities or services shall have the nationality of the United States (USAID Geographic Code 000) and Bolivia (in accordance with USAID Handbook I, Supplement B, Chapter 18, "Local Procurement"), except as USAID may otherwise agree in writing. Ocean shipping financed by USAID shall be financed only on flag vessels of the United States. Motor vehicles financed by USAID under the Project shall, except as USAID may otherwise agree in writing, have their origin in the United States.

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


Lewis Lucke
Acting Director
USAID/Bolivia

3/27/95
Date


Drafted by:HHR:MISTout:3/15/1995

Clearances:

HHR:PEhmer	<u>131</u> for Date <u>3/16</u>
PD&I:PNatiello	<u>an</u> Date <u>3/18</u>
DP:RKhan	<u>peh</u> Date <u>3/21</u>
ECON:KBeasley	<u>hm</u> date <u>3/22/95</u>
for CONT:RGoughnour	<u>enr</u> Date <u>3/24</u> (*)
RCO:MKidd	<u>+</u> Date <u>3/24</u>
RLA:DJames	<u>DJ</u> Date <u>3/24</u> - see change prior p.
DD:ESzepesy	<u>R</u> Date <u>3/27</u> • changes p. 26-27 7PP 5-AP

605MEM/LOP

511-0608 Proj Amend #2-

- (*) ① See change made at Page 27.
- ② Due to time constraints + urgency of this amendment, Annex 4 has not been reviewed by CONT.

PROJECT PAPER SUPPLEMENT
AIDS/STDs PREVENTION AND CONTROL PROJECT
No. 511-0608

March 1995

TABLE OF CONTENTS

		PAGE NO.
I.	Executive Summary	4
II.	Amended Project Background and Rationale	5
III.	Amended Project Description	13
IV.	Amended Project Implementation.....	23
V.	Cost Estimate and Financial Plan	26
VI.	Other Donor Contributions.....	35

ANNEXES

- 1. NAD APPROVAL**
- 2. LOGICAL FRAMEWORK**
- 3. PROJECT EVALUATION SUMMARY - AIDSCAP
- KING HOLMES**
- 4. SUSTAINABILITY ASSESSMENT & STRATEGY**
- 5. PROCUREMENT PLAN**
- 6. INITIAL ENVIRONMENTAL EXAMINATION WAIVER**
- 7. STATUTORY CHECK LIST**
- 8. HOST COUNTRY LETTER REQUESTING ASSISTANCE**

ACRONYMS

AF	:	DARK FIELD
AIDS	:	ACQUIRED IMMUNO DEFICIENCY SYNDROME
AIDSCOM	:	ACADEMY FOR EDUCATIONAL DEVELOPMENT AIDS COMMUNICATIONS PROJECT
AIDSTECH	:	FAMILY HEALTH INTERNATIONAL AIDS TECHNICAL PROJECT
CDC	:	UNITED STATES CENTERS FOR DISEASE CONTROL AND PREVENTION
CEASS	:	CENTRAL DE ABASTECIMIENTO DE SUMINISTROS
CENETROP	:	CENTRO NACIONAL DE ENFERMEDADES TROPICALES, SANTA CRUZ, BOLIVIA
CIETS	:	CENTRO DE INVESTIGACION DE ENFERMEDADES DE TRANSMISION SEXUAL
CSWs	:	COMMERCIAL SEX WORKERS
ELISA	:	ENZYME-LINYED IMMUNOSORBENT ASSAY
EOPS	:	END OF PROJECT STATUS
GOB	:	GOVERNMENT OF BOLIVIA
HIV	:	HUMAN IMMUNODEFICIENCY VIRUS
HHR	:	HEALTH AND HUMAN RESOURCES OFFICE (USAID)
IECC	:	INFORMATION, EDUCATION, COMMUNICATION AND COUNSELING
IFA	:	IMMUNO-FLUORESCENCE ASSAY
INLASA	:	INSTITUTO NACIONAL DE LABORATORIOS DE SALUD MPSSP - LA PAZ, BOLIVIA
JHU/PCS	:	JOHNS HOPKINS UNIVERSITY/POPULATION COMMUNICATION SERVICES
LOP	:	LIFE OF PROJECT
MSH	:	MANAGEMENT SERVICES FOR HEALTH
MWM/MSM	:	MEN THAT HAVE SEX WITH MEN
NGOs	:	NON GOVERNMENT ORGANIZATIONS
NSH	:	NATIONAL SECRETARIAT OF HEALTH
PACD	:	PROJECT ASSISTANCE COMPLETION DATE
PAHO/WHO	:	PAN AMERICAN HEALTH ORGANIZATION/ WORLD HEALTH ORGANIZATION
PASA	:	PARTICIPATING AGENCY SERVICE AGREEMENT
POPTECH	:	POPULATION TECHNICAL ASSISTANCE PROJECT
PSC	:	PERSONAL SERVICES CONTRACT
RSH	:	REGIONAL SECRETARIAT OF HEALTH
RPR	:	SEROLOGIC TEST FOR SYPHILLIS
SIDA	:	SINDROME DE IMMUNODEFICIENCIA ADQUIRIDA
SOMARC	:	SOCIAL MARKETING
STD	:	SEXUALLY TRANSMITTED DISEASE
TA	:	TECHNICAL ASSISTANCE
UNICEF	:	UNITED NATIONS CHILDREN'S FUND
UNFPA	:	UNITED NATIONS POPULATION FUND
USAID/B	:	UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT, MISSION TO BOLIVIA
URES	:	UNIDAD REGIONAL DE SUMINISTROS DE SALUD
VDRL	:	VIRAL DISEASE RESEARCH LABORATORY
WB	:	WESTERN BLOOD TEST

I. EXECUTIVE SUMMARY

The AIDS/STDs Prevention and Control Project was originally authorized in July 1988, to provide \$500,000 for laboratory service and research support to the Ministry of Health. In July 1991, the project authorization was amended to add \$3.5 million and four years to the LOP, to develop an STDs/AIDS prevention model. This Project Paper Supplement provides the basis for the second and final amendment to the Project Authorization, to add \$1.4 million to the LOP and extend the PACD to March 1998, in order to consolidate and extend the coverage of the prevention model.

The goal of the Project is to improve family health throughout Bolivia. The amended purpose of the Project is to reduce the prevalence of STDs/HIV/AIDS in La Paz, Santa Cruz, El Alto and Cochabamba. The project directly supports the Agency's goal of "Stabilizing Population Growth and Protecting Health," and the Mission's Family Health strategic objective of "Improved Family Health Throughout Bolivia."

The project addresses the problem of a high prevalence of STDs in Bolivia, which could lead to high HIV/AIDS prevalence. Given the strong causal relationship between STDs and HIV/AIDS, the project employs an STD/HIV/AIDS prevention strategy based on the following three pronged approach recommended by the World Health Organization and the USAID/W AIDSCAP project: diagnosis and treatment of STDs, behavior modification through Information-Education-Communication-Counseling (IECC) interventions, and marketing of condoms. The model is based on early intervention with commercial sex workers (CSWs) and homosexual men (MWM) to delay the spread of HIV/AIDS into the general population.

The model has been successfully developed under the current AIDS/STDs Prevention and Control Project and is being implemented in La Paz, El Alto and Santa Cruz. In the area of diagnosis and treatment and with assistance from the Center for Disease Control (CDC) in Atlanta, two world class STD/HIV/AIDS laboratories and three model clinics have been established. In the area of behavior modification, the CDC and Johns Hopkins University have assisted in the development and implementation of a direct counseling and education strategy for CSWs and MWM. Finally, project-funded social marketing and government condom distribution systems have resulted in a 300% annual increase in condom distribution nationwide. The project has accomplished or surpassed all but one of its originally programmed EOPS target levels.

The project prevention model was evaluated by AIDSCAP in October 1993, and by Drs. King Holmes and Martin Fishbein of the Universities of Washington and Illinois in March 1994. Although the two evaluations presented some conflicting findings regarding prevention, the Mission chose to maintain the original project design and strategy, concentrating on diagnosis and treatment of

STDs, together with IECC and condom distribution as preventive interventions.

To date, the project has received \$3.8 million of the \$4.0 million authorized. Through an amendment to the Project Authorization, LOP funding will increase by \$1.4 million to a new total funding of \$5.4 million, and the PACD will be extended to March 1998. The extension will consolidate the STDs/HIV/AIDS prevention model as described above, and will extend its coverage by: (1) developing an additional reference laboratory and clinic in Cochabamba; (2) integrating the project preventive model into the reproductive and primary health care systems; and (3) training public and private sector health professionals in the three-pronged STDs/HIV/AIDS prevention and treatment model described above. In addition, the amended project will address the following sustainability issues: institutionalization of project activities and cost recovery of the STD clinics and the condom distribution systems.

Project management will continue to require a US Direct Hire or PSC professional at the Mission level. This function is presently undertaken by the Office Chief of the Health and Human Resources Office. Technical direction will continue to be provided by the CDC through an existing PASA. An additional buy-in or contract may be executed with another institution for direction of the IECC component. Project activities will continue to be carried out by project staff in La Paz, El Alto, Santa Cruz, and in the fourth project site, Cochabamba. Management and financial oversight will continue to be provided by the Community and Child Health Project (CCH), who will conduct local procurement activities in accordance with Handbook 11, Host Country Contracting, and Handbook 1, Chapter 18, Local Procurement.

The Project will continue to coordinate with the National and Regional Secretariats of Health, and with other donors -- Pan American Health Organization, UNFPA, UNICEF-- through the National Inter-Agency Coordinating Committees established under the project.

II. AMENDED PROJECT BACKGROUND AND RATIONALE

A. Amended Project Background

The Acquired Immuno-Deficiency Syndrome/Sexually Transmitted Diseases (AIDS/STDs) Prevention and Control Project has been operating in Bolivia since 1988. USAID/Bolivia funded the first three years of the project at a total level of \$500,000 to cover a series of small-scale sentinel sero-prevalence studies in potential high risk behavior groups, to support the Bolivian National Secretariat of Health (NSH, the former Ministry) AIDS Program, to improve NSH laboratory services, to market condoms and to conduct educational activities.

This first phase was implemented with technical assistance from the AIDSTECH and AIDSCOM projects, as well as from the Pan American Health Organization (PAHO).

In 1991, and based on the findings of the initial project, USAID/Bolivia authorized an amendment to extend Life of Project (LOP) funding to \$4 million and the Project Assistance Completion Date (PACD) to September 1995. The amended project was designed to (a) collect reliable epidemiological data to define and track the extent of Human Immunodeficiency Virus (HIV)/STD/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 injectable drug use among high risk behavior groups, and (d) make condoms accessible on demand.

The purpose of the amended project was to expand access to, and use of effective STD/HIV/AIDS control and prevention services and education in the departments of La Paz, Santa Cruz and Cochabamba. It incorporated the following significant changes.

- It focused on the diagnosis and treatment of STDs as a means of preventing the spread of HIV/AIDS.
- It limited initial intervention to three cities, La Paz, Santa Cruz and Cochabamba, to increase impact by concentrating resources in key locations.
- It applied the three-pronged preventive approach recommended by the World Health Organization (WHO) and AIDSCAP: treatment of STDs, behavior modification, and marketing of condoms.
- It focused on high risk behavior groups -- commercial sex workers (CSWs) and men who have sex with men (MWM) -- as a means of slowing the entrance of HIV/AIDS into the general population. This is a model suitable for Bolivia with a low prevalence of AIDS and a high prevalence of STDs.

A PASA was signed with the Centers for Disease Prevention and Control (CDC) of Atlanta to provide technical assistance and project implementation, including purchase of medical supplies and equipment. The CDC had a long-term Technical Advisor in AIDS and Child Survival (TAACS) on board in Bolivia, who became also the technical director for the project.

Project activities started in February 1992 with the arrival of the CDC advisors to develop STD clinic and laboratory services. The first project clinic was established in La Paz, at the RSH Centro Piloto facility used to monitor STDs in registered CSWs. A STAT (immediate results) laboratory was developed as part of the Centro Piloto service, and a reference STD laboratory was developed at INLASA, the national reference laboratory. Project personnel in

the medical area were trained locally, and in the CDC centers in Atlanta and Puerto Rico.

In mid-1992, under contract with the Johns Hopkins University/Population Communications Center (JHU/PCS), the project started an educational intervention focused on research as the basis for behavior modification. Formative, qualitative and quantitative research was carried out to learn about CSWs and MWM in La Paz and Santa Cruz. Behavior modification interventions were then designed focused on two desired changes in behavior in the target population: increasing condom use and attendance at the STD clinic. Two main approaches were developed: counseling sessions at the STD clinics for more educated CSWs and outreach interventions in their environment for the less educated CSWs and MWM.

While the technical interventions proceeded in 1992 at an energetic pace and with the highest degree of technical quality, the management of project activities by CDC was problematic from the beginning. At the heart of the problem was the lack of a mechanism in CDC to transfer and manage funds in Bolivia. To solve the situation, USAID/HHR negotiated an agreement with the Community and Child Health (CCH) project whereby all local operations were transferred to a project administrative unit under CCH supervision, and the PASA with CDC was amended to retain only the short term technical assistance portion of the original agreement. The TAACS advisor remained as technical director of the project.

By the end of 1992, the project had identified that 57% of CSWs in La Paz and Santa Cruz had at least one STD, (rates comparable to Uganda and other African countries where the AIDS epidemic is devastating); that 40% of gonorrhea cases were penicillin-resistant; that only 35-40% of CSWs reported using condoms, and that the CSWs more at risk were those working in second and third-class brothels. No AIDS infected CSWs were found. The project focus on STD diagnosis and treatment as an HIV/AIDS prevention strategy was validated by these findings.

Activities in Santa Cruz, the second city of the project, started in February 1993 and included development of the STD clinic and STAT laboratory for CSWs, and strengthening of the STDs reference laboratory in CENETROP, the Santa Cruz-based reference laboratory. IECC activities focused on behavior modification interventions carried out at the STD clinic, as opposed to the brothel-based interventions developed for the more difficult-to-reach CSWs of La Paz. Special emphasis was placed on development of promotional material to break social barriers and facilitate condom negotiation in brothels.

Also early in 1993, the project started an intervention with the gay community of Santa Cruz. A US MPH/Nurse was hired to work with and to start collecting qualitative information on this very

inaccessible group. Qualitative data obtained by the project showed the existence of a mini-HIV/AIDS epidemic among the gay in Santa Cruz, as well as the need to find a network to work with the group. A telephone "hot-line" was initiated in late 1993 to provide information and offer referral to a network of trained physicians where the gay community can receive confidential STDs/HIV/AIDS treatment.

El Alto was chosen in late 1993, instead of Cochabamba, as the third site for project activities, as a natural extension of activities from La Paz. A third STD clinic and STAT lab were developed and integrated to the RSH. No reference laboratory was developed in El Alto because of the easy access to INLASA in La Paz.

Distribution of condoms at the national level was institutionalized in 1993 through social marketing efforts in the private sector, and through the NSH distribution system in the public sector. Condoms were sold at STD clinics at subsidized prices, and a national distribution system was firmly consolidated. For the first time ever, the social marketing program placed condoms for sale outside pharmacies, in neighborhood convenience stores.

The project was evaluated in October of 1993 by an AIDSCAP team of three and by one USAID/Washington AIDS Officer. The results of the evaluation were controversial and originated from technical differences between AIDSCAP and the CDC on the approach to prevention. AIDSCAP has a strong orientation towards primary prevention which focuses on educational interventions. CDC is more inclined toward secondary prevention focusing on diagnosis and treatment of STDs as a means of preventing the spread of HIV/AIDS. In addition, the evaluation team felt the whole project was focused on research and had not built the means to transfer the project over to Bolivia.

Because of the basic disagreement about the strategy selected for this project by USAID/Bolivia under CDC technical guidance, a decision was made to solicit a "second opinion," and Dr. King Holmes, Director of the Center for AIDS/STDs of the University of Washington, and Dr. Martin Fishbein, a behavioral specialist from the University of Illinois, were invited to evaluate the project in Bolivia.

In March of 1994 Drs. Holmes and Fishbein spent two weeks in country, studying the project in Bolivia. Their report, included as Annex 3.B., describes this project as "one of the best existing examples to date in which the WHO/USAID/AIDSCAP strategy is being pursued as intended." Specifically, the Holmes evaluation reinforced the project focus on STDs as a prevention mechanism, the concentration on "core" groups (CSWs and MWM), and the research base of the project.

On the basis of the Holmes evaluation, USAID chose to maintain the original STD management focus of the project and concentrate on institutionalizing activities within the NSH and expanding the coverage of the project. The AIDSCAP recommendations concerning "bolivianizing" project staff, strengthening the administration and financial capacity of the project, and its ties to USAID, were also given priority by the project management and have been satisfactorily resolved.

Thus, 1994 was a year of intense negotiations with the National and Regional Secretariats of Health to integrate the prevention model developed by the project into the Bolivian public health structure and to disseminate lessons learned. Substantial progress has been made in this area in La Paz and El Alto. Negotiations are underway in Santa Cruz. Working agreements have been signed with all three RSH and a Bolivian National Director was hired to lead the project.

At present the project has emerged as the leading authority in STD/HIV/AIDS management and a substantial amount of training was offered to public and private sector entities. CDC and the Latin American Union Against STDs have proposed that the La Paz STD clinic be a regional training center for countries in the Americas. The NSH requested that the project prevention model be presented to the twelve Bolivian regional secretariats of health for their information and adoption, and that the model be documented and presented to other donors for replication in the rest of the country. These two activities are currently under way.

B. Amended Project Rationale

Epidemiological studies worldwide have shown that HIV/AIDS is spread from homosexual men to bisexual men, from bisexual men to CSWs, and from CSWs to the general population. In addition, research has shown that STD prevalence is a critical factor in the spread of HIV/AIDS. In 1989, GOB studies reported that only 1% of CSWs had a gonococcal infection and that STDs were not a problem in this population. These findings were startling given the poor health indicators of the population in general. As a result, the original project was designed to better determine STD/HIV/AIDS patterns for Bolivia, focusing on high risk groups including CSWs and MWM.

Early project studies refuted the above-mentioned GOB study, identifying 57% of brothel CSWs infected with one or more STDs in La Paz, and high STD prevalence in El Alto and Santa Cruz. These rates are comparable with those of Uganda and other African countries where the AIDS epidemic has been devastating. In addition, preliminary findings from project-financed research suggest a mini-AIDS epidemic among MWM in Santa Cruz.

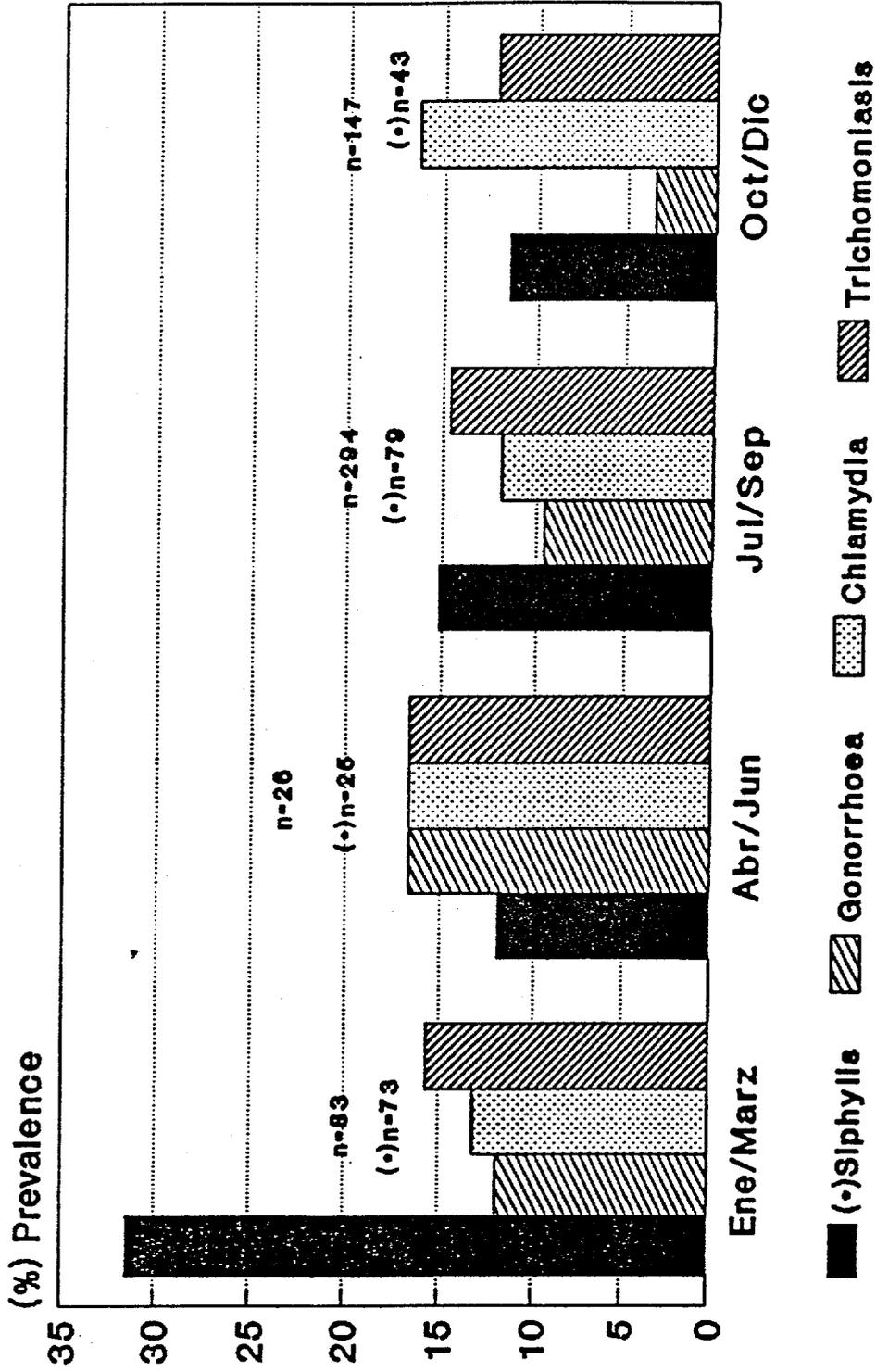
As a result of the above-mentioned findings, the rationale for the project is to finance STDs/HIV/AIDS diagnosis/treatment, IECC, and condom distribution activities which reduce the prevalence of STDs in high risk behavior groups. By reducing the prevalence of STDs in Bolivia, the AIDS/STDs Prevention and Control Project will delay and ameliorate an AIDS epidemic. This three pronged strategy is the only major donor intervention currently addressing this problem in Bolivia.

USAID/Bolivia and the project technical advisors agree that the project is just now beginning to make an impact on STDs/HIV/AIDS diagnosis and treatment and on the health of the Bolivian population. For the first time ever, the NSH has included STDs/AIDS as a priority in its portfolio and the model created by the project has been adopted for replication and dissemination by the GOB. Figures 1. and 2. demonstrate the positive impact of project activities on STD prevalences for CSWs in La Paz. An estimated 30-month extension and \$1.4 million are necessary to consolidate the STDs/HIV/AIDS three pronged prevention model, expand its coverage to Cochabamba¹, and to institutionalize its achievements.

¹ At the date of this writing, Cochabamba is the most likely target city to which project activities will be expanded, although Sucre, because of its large student population, is also being considered.

FIGURE 1

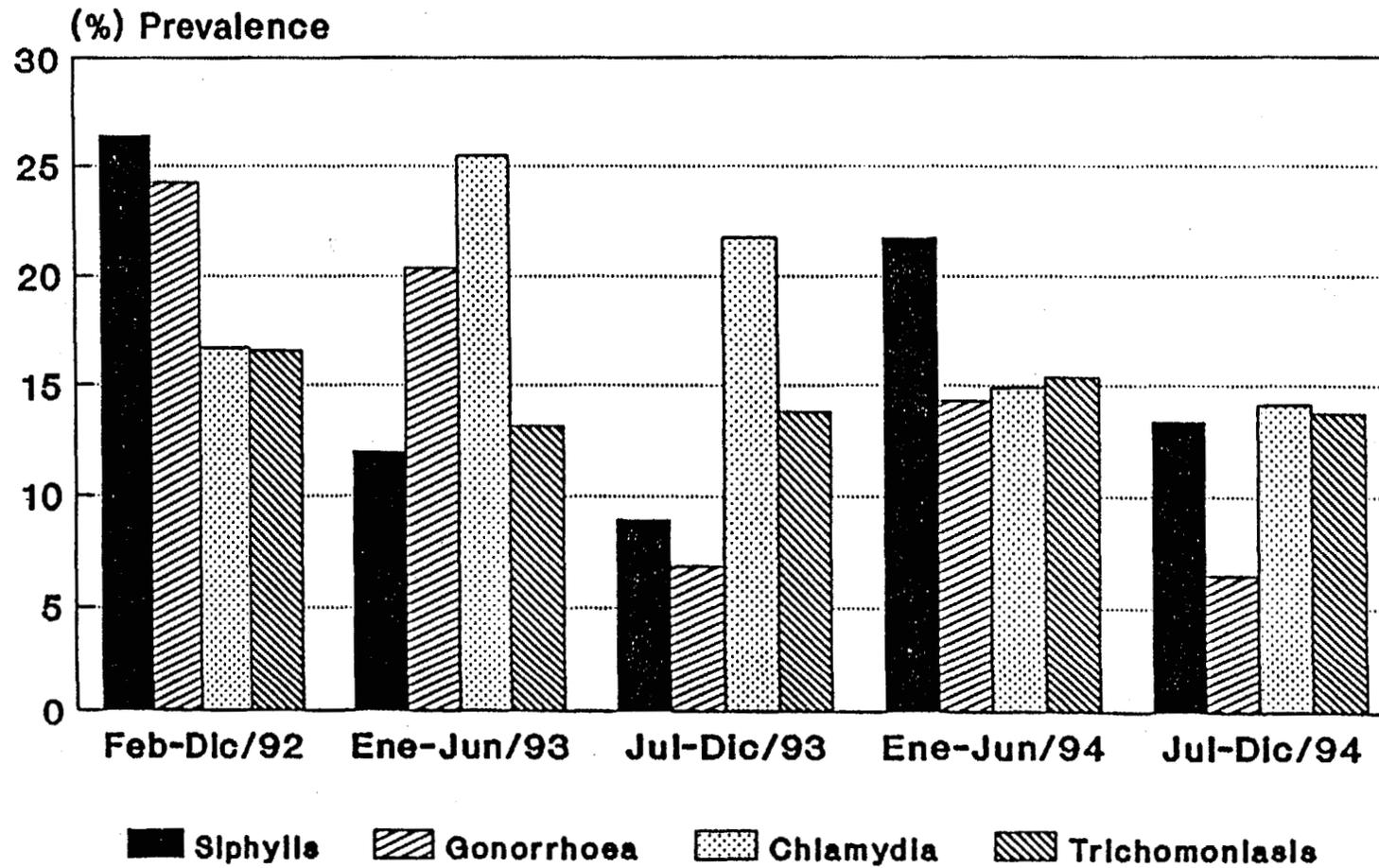
STD PREVALENCE IN CSWS LA PAZ 1994



AIDS/STDs Prevention and Control Project
USAID-BOLIVIA

FIGURE 2

STD PREVALENCE IN CSWs LA PAZ 1992 - 1994



AIDS/STDs Prevention and Control Project
USAID-BOLIVIA

III. AMENDED PROJECT DESCRIPTION

A. Project Goal, Purpose, and EOPS Indicators

The project goal is to improve family health throughout Bolivia. The purpose of the amended project is to reduce the prevalence² of STDs/HIV/AIDS in high risk behavior groups in La Paz, Santa Cruz, El Alto and Cochabamba.

The project purpose³ will be achieved in the four target cities when:

1. the average prevalence of gonorrhea drops from 10% to 7% in CSWs, and by 20% over the baseline in MWM;
2. the average prevalence of trichomoniasis drops from 15% to 10% in CSWs;
3. the average prevalence of syphilis drops from 15% to 10% in CSWs, and by 20% over the baseline in MWM;
4. the average prevalence of chlamydia drops from 15% to 10% in CSWs, and by 20% over the baseline in MWM;
5. HIV prevalence is maintained at less than or equal to 0.02%; and
6. a sustainability strategy is being implemented in the four STD clinics by FY 97.

As a precondition to achieving the project purpose, the following major project outputs will be produced by the new PACD of March 31, 1998.

1. Four programs established for diagnosis and treatment of STDs. This includes development of STD reference laboratories, and development of STD clinics in La Paz, El Alto, Santa Cruz and Cochabamba. Two laboratories have been developed in La Paz and Santa Cruz and three STD clinics in La Paz, Santa Cruz and

² Prevalence is defined as the total number of persons with a disease at any time during the year divided by the population at risk of having the disease over the same period. (Project purpose level prevalence indicators are measured in a sample of high risk subjects. These measurements can then be extrapolated to the larger population using accepted statistical practices).

³ Objectively verifiable indicators for the project purpose and output end of project status are included in the Logical Framework, Annex 4.

El Alto. Increased funding under the amended project will finance an additional STD reference laboratory and STD clinic in Cochabamba. A sustainability strategy for the four clinics will be developed by the project by FY 96. Frequency of clinic use by registered CSWs will have increased 100% in the four STD clinics by 1998.

The extension will also fund training of 560 health professionals in diagnosis and treatment of STDs. 380 are RSH professionals and 180 correspond to twelve public and private sector institutions, including PROSALUD, CIES, Fundacion San Gabriel and other NGOs. By training these individuals and strengthening these institutions, project successes can be replicated outside the NSH system, and be extended beyond high risk groups to the general population.

2. Four STDs/HIV/AIDS IECC programs for high risk behavior groups operating in La Paz, El Alto, Santa Cruz and Cochabamba. These include: (a) direct counseling and outreach education programs for CSWs and MWM; (b) development and distribution of educational material; and (c) training of 300 health educators, peer-counselors and trainers in IECC activities. Full IECC programs currently exist in La Paz and Santa Cruz. The project extension will fund IECC program development in El Alto and Cochabamba.
3. Two condom distribution systems established. The project has developed a social marketing condom distribution system with PROSALUD/SOMARC, and a GOB distribution system with the Central for Distribution of Health Supplies and Pharmaceuticals, CEASS. The amended project will consolidate these two systems at the national level and increase condom distribution by 100% by the PACD, from 1 to 2 million condoms/year.

B. Project Strategy

The strategy for the amended project will continue to focus on high risk behavior groups and will maintain its three-pronged approach to STD/HIV/AIDS prevention, but will change from a research orientation to a dissemination approach. The proposed extension will focus on: (1) increased coverage; and (2) sustainability.

(1) **Increased Coverage:** will be pursued by expanding the project prevention model to the RSH in Cochabamba and by strengthening a target of twelve Bolivian public and private sector health care providers to carry out the three pronged STD/HIV/AIDS prevention model in the four target cities and beyond. The twelve health care providers will include the social security sector and will receive training and technical assistance in laboratory and clinic development, IECC, and condom distribution. These

institutional strengthening activities will be done in close collaboration with USAID/Bolivia's Reproductive Health Services Project (511-0568), the Self Financing Primary Health Care Project/PROSALUD (511-0607), and the Child Survival PVO Network/PROCOSI (511-0620).

(2) **Sustainability:** The amended project will strive for the sustainability of low prevalence rates after the PACD. The following avenues will be pursued: (a) institutional sustainability through training and integration of project activities into the structure of public and private health institutions; (b) financial analysis of clinic and condom distribution operations as the basis to develop and implement a cost-recovery strategy in the STD clinics and the social marketing systems; and (c) development of inter-institutional coordinating committees.

(a) **Institutional Sustainability** is being realized by training health professionals in the public and private sectors, by transferring management responsibility for the clinics and laboratories to RSH counterparts, and by involving counterparts in the processes of programming, monitoring, and evaluating project activities.

Project activities carried out for the period 1992-1994 were heavily focused on training of human resources in medical, laboratory and behavioral interventions. Project Medical staff was initially trained in STD management by CDC, and in behavior modification by CDC and Johns Hopkins University. This staff has in turn trained a significant number of health professionals, (two hundred and thirty eight, from seven of the twelve health regions of Bolivia). Training provided includes diagnosis, testing and treatment of STDs in the medical area; syphilis, gonorrhoea, chlamydia and trichomoniasis testing in the laboratory area; and behavior research, counseling and outreach techniques in the behavioral area.

In La Paz and Santa Cruz, the STD clinics have become training centers for private and public sector medical staff. In La Paz ninety-one professionals were trained in 1993 and 1994 at the STD clinic, the Centro Piloto; thirty-six from the RSH, twenty from the Social Security and thirty-one from the police and the penitentiary systems. Staff from the project and the Centro Piloto have also conducted training for medical staff in two rural districts of La Paz. CDC technical advisors visiting the center in November of 1994 reported that the quality of care and the training provided at this clinic is superior and that the Latin American Union Against STDs is considering appointing Centro Piloto as a regional training center for all of South America. In Santa Cruz forty-five professionals were trained in 1993 and 1994 at the STD clinic, CIETS, five from the RSH and thirty-two from private the social security and voluntary organizations.

Professional and support staff have also been trained at the National Reference Laboratory in La Paz, INLASA, and at the Regional Reference Laboratory in Santa Cruz, CENETROP. In both institutions world class capacity now exists to develop culture media, test STDs and provide quality control. At the STD clinics in La Paz and Santa Cruz, STAT labs (on-site testing, immediate results) have been developed. These facilities permit immediate diagnosis and treatment of patients. Both the reference and the STAT laboratories are linked to the CDC quality control network and serve as training centers for health professionals in the public and private sector. The project will develop one additional reference laboratory in Cochabamba and will staff the laboratory in El Alto that recently received a donation of equipment from the Japanese government.

Project activities have also focused on training of behavior professionals -- almost eight hundred psychologists, researchers, counselors, medical staff and outreach workers -- to do formative research on the structure of the sex industry in Bolivia and carry out interventions with the population at highest risk of infection. Two main approaches have been developed -- counseling for the more educated CSWs that are more responsive to behavior change, and outreach in their environment for the less educated CSWs and MWM. Peer counselors among CSWs, MWM, police and jail inmates have been trained to continue and intensify the preventive messages of the project.

The project training focus has been a key factor in fostering the strong institutional sustainability needed for preventing and treating STD/AIDS cases. Professionals trained by the project are capable of managing STDs/HIV/AIDS prevention. They can now replicate training in their respective institutions, and are committed to maintaining quality of care in the programs with which they are associated.

Institutional sustainability is also pursued by transferring responsibilities and involving the National and Regional Secretariats of Health in the management of the STD/HIV/AIDS programs. At the national level the project works in close collaboration with the National Secretary and Sub-Secretaries of Health and the National AIDS/STDs Program Director in design of policy and development of strategies through the Inter-Agency Coordinating Committee and the Regional Coordinating Committees described below. Policy and strategies adopted specifically from the project include implementation of a decree to make condoms available at brothels and motels, confidentiality of HIV testing, on-site treatment of STDs for infected CSWs in lieu of suspension of work permits, syndromatic treatment protocols, dissemination of STD norms, and change in STD treatment approaches. At the regional level in La Paz, the STD clinic developed by the project is run by the RSH and programmatic and evaluation activities are jointly developed with the project. In Santa Cruz, the STD clinic is now

completely administered by the RSH and project staff maintain a presence for quality control only. In El Alto, the RSH has offered to absorb two of the four project financed positions by 1996 and the other two by 1997. All counterpart RSHs are currently considering formulas to include behavioral professionals in their staff and institutionalize the three-pronged model of the project. In the area of condom promotion, the team responsible for distribution has been placed inside the NSH Central Supply Distribution Agency (CEASS). The Agency has pledged to cover 20% of condom distribution costs in 1995.

(b) **Financial sustainability:** Sustainability of the four RSH clinics will be pursued by implementing recommendations from the financial assessment of clinic operations, conducted in February of 1995 by the USAID Evaluation Officer at the request of project management (See Annex 4). The sustainability assessment was conducted at the La Paz STD clinic as the basis for negotiating a cost recovery strategy with the NSH and RSHs. The assessment included a financial analysis of clinic operations to determine operating costs, proceeds from fees, reinvestment of proceeds and recommendations for better cost recovery and reinvestment. Five major recommendations resulted from the assessment:

(1) Reinvestment into the STD clinic of income obtained from the sale of health cards, which would cover an estimated 27% of variable costs.

(2) Increase charges levied for syphilis tests, which would increase coverage of variable costs to 60%

(3) Decrease weekly visits to bi-monthly, permitting greater number of individuals to be seen, which would increase coverage of variable costs to 71%.

(4) Limit the use of the health card to the three months for which it is valid.

(5) Explore funding from other sources, including contributions from brothel owners.

On the basis of these recommendations the project is preparing a presentation to the NSH and RSHs. The objective is to engage in policy dialogue and obtain a commitment from health secretariat officials to develop a cost recovery strategy and identify alternative sources of funding to sustain the STD clinics and the laboratories. If appropriate, technical assistance will be requested from PROSALUD to develop the sustainability strategies. It is foreseen that the strategy will determine a more exact target for cost recovery. The strategy will be applied first at the La Paz STD clinic, and will include a phase-out plan for project-financed activities as well as efforts by the RSH to gradually absorb them. The pilot strategy will then be applied to the other

STDs clinics in El Alto, Santa Cruz and Cochabamba. By the EOPS it is expected that the RSHs will have adopted a cost-recovery strategy to cover part of clinic costs in the four cities of the project. Financial sustainability of the condom distribution systems is underway through implementation of cost recovery mechanisms. By the EOPS it is expected that the non-government social marketing system will be totally self-sufficient and that the GOB system will cover at least 30% of its operations with product-generated income.

Indicators for institutional and financial sustainability have been included in the project's revised logical framework.

(c) **Inter-Institutional Committees:** Committees have been developed nationally and in Santa Cruz and La Paz to engage in AIDS/STDs policy dialogue with the GOB. The committees have been successful at mobilizing and coordinating resources for STD/HIV/AIDS prevention. The Inter-Agency Committee at the national level was sponsored by USAID and is now responsible for developing policy, strategies and technical norms for STDs/HIV/AIDS prevention, and for coordinating the work of the GOB, international donors and NGOs. The regional Committees in Santa Cruz and La Paz group the local authorities and representatives of medical, educational and civic institutions concerned with STDs/HIV/AIDS prevention. The project will replicate these successes in El Alto and Cochabamba. Although the committees do not receive or require project funding to function, technical assistance and limited resources for their formation and proper functioning may be provided by the project in the future.

Project management believes that the above described training, cost recovery, and inter-institutional committees will strengthen the human resources and institutional mechanisms necessary to continue the delivery of quality STD/HIV/AIDS prevention and treatment services after the PACD. Continued use of the three-pronged model after the PACD by public and private health care providers will help sustain the low STD prevalence rates achieved by this project.

C. Project Actions

During the remainder of FY 95, project management will concentrate on negotiating an agreement with the RSH to expand the project prevention model to Cochabamba, and to develop information systems for internal management. In Santa Cruz project integration with the RSH will be completed. In the medical area, two visits from CDC experts are programmed to review laboratory and clinic procedures and analyze STD prevalence data. In the behavioral component, technical assistance is required to analyze the behavioral data obtained by the project and to document findings. A short term contractor with a PhD in Psychology will be hired through to focus on this task. Project management will concentrate

on obtaining strategic direction for the behavioral component from a contractor in the US. The project intervention for MWM in Santa Cruz will be replicated in La Paz. Existing systems to distribute condoms will continue to operate, but the volume of condoms distributed is expected to increase substantially. A cost-recovery strategy to support sustainability efforts will begin at the STD clinic in La Paz.

The second mid-term evaluation will be carried out in FY 96. Project activities will focus on developing the project prevention model in Cochabamba and on training of NSH health professionals. STD management will be extended to the reproductive health and primary health care systems in the four cities of the project. NGOs involved in providing health care services will also benefit from training by project staff. Dissemination of project findings will be given special attention to target other donors. Two visits from CDC experts are expected. Behavioral interventions will be transferred to the NSH and a cost recovery system will be in place in two project STD clinics. The second AIDS hot-line will be operating in La Paz. Condom distribution will be generating enough income to self-sustain 30% or more of its operational budget.

In FY 97 the project will initiate phase-out of activities. The STD clinics and laboratories in La Paz and Santa Cruz will require a minimal project presence and will be at least 50% self-sustained. The laboratory and clinics in Cochabamba and El Alto will have started cost-recovery interventions. Condoms distributed will be at least 2 million/year. The RSHs will have adopted the project model and will have apportioned resources for behavioral modification activities with risk behavior groups. Other donors will absorb some of the project activities. The third AIDS hot-line will be operating in Cochabamba. The MWM intervention will be functioning in the four cities of the project.

In FY-98 project activities will be completed. A final evaluation and audit will be carried out. Lessons learned will be documented and disseminated. See chronogram of activities on pages 20 and 21.

D. Program Considerations

The AIDS/STDs Prevention and Control Project supports the Agency goal of "Stabilizing Population Growth and Protecting Health." The project directly supports USAID/Bolivia's strategic objective of "Improved Family Health Throughout Bolivia" by addressing an area of critical impact for the health of the Bolivian population -- the prevalence of sexually transmitted

diseases (STDs). STDs, including HIV/AIDS, are major contributors to mortality and morbidity among adults and infants in developing countries.

The project will finance activities which impact upon and produce data for measuring Mission progress on the three Family Health strategic objective program outcomes: (1) improved development and implementation of health policy; (2) improved institutional capabilities within the public/private sectors to deliver preventative and curative health services; and (3) improved health knowledge, attitudes and practices among Bolivians.

E. Gender Impact

The AIDS/STDs Prevention and Control Project is focused on prevention and on population segments whose behavior places them at higher risk of STDs/HIV/AIDS infection. Project activities are therefore concentrated on women who are engaged in prostitution who, because of their multiple sex partners, are more likely to acquire a sexual disease. Moreover, women who engage in prostitution are at the bottom of the socio-economic ladder and this excludes them from access to services. This project is one of the few interventions directed at this population.

STDs are a major contributor to women's mortality and morbidity. Most STDs are asymptomatic in women and remain untreated for prolonged periods of time causing serious complications. This project will contribute to improve the health of women in the general population by developing an STD diagnosis and management capacity in the social security, the reproductive health and the primary care systems in Bolivia.

IV. AMENDED PROJECT IMPLEMENTATION

A. Project Management

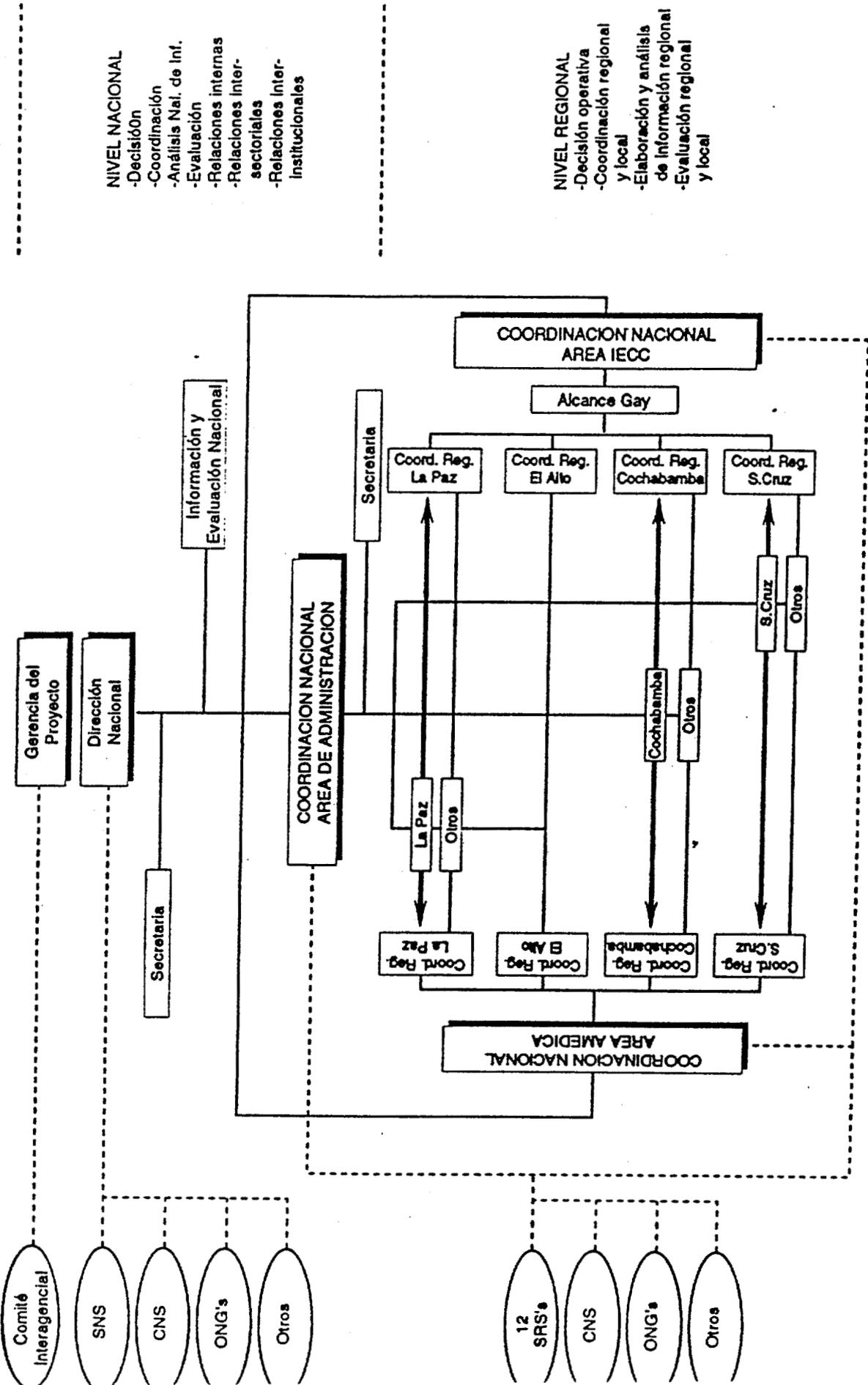
The amended project will continue to be implemented according to the same modality established in 1992. Under this modality USAID/Bolivia/HHR has overall management responsibility for the project. The HHR Director has responsibility for general oversight of the project and a US PSC is responsible for overseeing implementation. Implementation is conducted by a unit created and financed by the project, known as the Programa Colaborativo. This unit operates under the administrative, financial and logistics guidance of the Community and Child Health Project (CCH), a GOB institution financed by USAID/Bolivia under Project 511-0594. Under a Project Implementation Letter, an agreement exists between USAID and the NSH whereby CCH receives and accounts for funds disbursed to the NSH. CCH in turn, oversees the Programa Colaborativo in budgeting, accounting, administration and implementation of the project resources that are allocated to the NSH. Technical guidance for the project will continue to be provided to the Programa Colaborativo and the NSH by the CDC through a PASA arrangement.

The NSH is responsible for sector planning and for establishing and disseminating STD/HIV/AIDS technical norms and guidelines. The National Direction of Epidemiology is responsible for STD/HIV/AIDS prevention and coordinates closely with USAID/Bolivia/HHR, the Programa Colaborativo, and the CDC in programming, monitoring and evaluation of project activities. The project is in the process of developing a sustainability strategy to recommend to the NSH that will allow the NSH to assume gradual management and financing of clinics and laboratories as this project moves toward the PACD.

The Programa Colaborativo is organized according to national and local level functions. At the national level there is a Directorate divided into three areas of coordination: Medical, IECC, and Administration. The national team is in charge of planning, implementing, and monitoring all project activities in the four target cities.

At the local level, there are four Regional Coordinators in each of the sites where the Project performs its activities: these are the coordinators of the diagnosis and treatment, IECC, and Administrative areas. Their responsibilities mirror those of the National Directors, but are more region-specific and grass-roots oriented.

PROYECTO COLABORATIVO ETS/SIDA ORGANIGRAMA



NIVEL NACIONAL
 -Decisión
 -Coordinación
 -Análisis Nal. de Inf.
 -Evaluación
 -Relaciones internas
 -Relaciones Inter-sectoriales
 -Relaciones Inter-institucionales

NIVEL REGIONAL
 -Decisión operativa
 -Coordinación regional y local
 -Elaboración y análisis de información regional
 -Evaluación regional y local

12

Diagnosis and treatment activities in the RSH clinics and the reference laboratories are performed by staff of the Programa Colaborativo in conjunction with RSH personnel. Through this project amendment, responsibility for running the clinics and the laboratories will be gradually transferred to the RSHs, while the predominant role of the Programa Colaborativo is gradually phased out.

IECC activities are performed by staff of the Programa Colaborativo at the RSHs clinics and in the brothels. The project will attempt to transfer this responsibility to the RSHs social workers to build Bolivian capacity to continue IECC interventions after the PACD.

Condoms distribution at both the level of the four clinics and at the national level through CEASS, is the responsibility of the Programa Colaborativo. An additional national distribution system run by PROSALUD provides condoms to the commercial sector.

See attached organizational chart on previous page for a visual explanation of the Programa Colaborativo structure.

B. Project Monitoring

An STDs/HIV/AIDS sentinel surveillance system will be strengthened in FY 95 to monitor project purpose and output level impact. This sentinel surveillance system is already collecting data related to CSWs and will be extended to include MWM, expecting women, students and other at risk populations.

Data collected from the sentinel surveillance system will be used by project management and the NSH to take corrective measures in project implementation. In addition, data collected through the system will be used for project and USAID program reporting purposes, especially for development of project semi-annual reports, and the Mission's Action Plan.

C. Project Evaluations

A mid term evaluation was carried out in October of 1993. With the amendment of the project, a second mid-term evaluation is now proposed for January 1996 and the final evaluation for January 1998. The purpose of the second mid-term evaluation is to guide project management on the impact and appropriateness of project strategies and activities. The final evaluation will gauge success in achieving the project purpose. Special assessments may be scheduled by the USAID/Bolivia as necessary. The new indicators included in the revised logical framework (Annex 2) will provide the bench-marks by which the project is evaluated.

V. COST ESTIMATES AND FINANCIAL PLAN

A. Methods of Implementation

Project funding will be obligated through an amendment to the existing Handbook Three Bilateral Project Grant Agreement signed between USAID and the former GOB Ministry of Health. The amended agreement will authorize USAID to negotiate agreements for the implementation of project activities. Also, under the amended agreement, project implementation letters (PILs) will be signed with the GOB to approve yearly project implementation plans and budgets of the Programa Colaborativo, as well as to authorize specific activities and financial operations.

The GOB through a PIL, has agreed to place the Programa Colaborativo under the administrative, financial and logistic support of the Community and Child Health Project (CCH), a GOB institution supported by USAID financing. As a result, CCH enters into contracts in implementation of the Project.

CCH was formally certified by USAID/Bolivia in August 1991 to manage contracting and financial procedures. In view of the fact that CCH will not enter into contracts of the value of \$250,000 or more each in the implementation of this Project, it is not obligatory (for the purposes of this Project) for CCH to maintain its certification. Nonetheless, considering the large cumulative amount expected to be committed through contracts entered into by CCH, the USAID Controller's Office and the RCO will reevaluate CCH's contracting and financial procedures to confirm that such procedures continue to be acceptable. The Programa Colaborativo benefits from the logistics, administrative, managerial and procurement expertise of CCH.

The Programa Colaborativo operates on a quarterly disbursement schedule and submits financial reports to the USAID/Controllers Office. This procedure will be changed to monthly disbursements during the second quarter of FY-95. Yearly audits according to USAID guidelines are performed to monitor financial management by the Programa Colaborativo. All Programa Colaborativo financial, administrative, logistic and MIS activities are carried out in coordination with and approved by the CCH.

B. Methods of Financing

A total of \$5.4 million will be authorized to carry out project activities necessary for achieving the project purpose. To date, \$3.8 million have been obligated. Additional obligations totalling \$1.6 million will be committed through FY 97.

Procurement under this project will continue to be implemented by USAID/Bolivia and by the CDC/Atlanta in the U.S., and by the

Programa Colaborativo staff in Bolivia, under the CCH, according to Host Country Contracting Handbook 11.

USAID/Bolivia will continue to need a US PSC or equivalent and a Bolivian secretary to manage and administer project activities. Both positions will be covered with project funds. The current HHR USPSC project manager will depart post in mid 1995 and a replacement will be recruited among Mission spouses, USPSCs or qualified Bolivian candidates. A contract with a US PSC may also be implemented through the Programa Colaborativo, under Host Country Contracting of US individuals, to comply with Mission US PSC ceiling restrictions.

US procurement applies to technical services and supplies and equipment. Technical services from the CDC will continue to be accessed through an existing PASA. A PASA extension is programmed to increase the PASA LOP from \$1,100,000 to \$1,300,000 and the PACD from September 1995 through March 1998. An estimated twelve weeks of CDC short-term technical assistance are envisioned for the medical, laboratory, data processing and IECC areas. CDC, through the PASA, will also purchase laboratory and clinic supplies and equipment, especially for the new clinic and laboratory in Cochabamba. The original PASA determination (Determination A76) regarding lack of availability of services provided by CCH in the private sector continues in effect.

Other US procurement may include additional technical assistance in the area of behavior modification to assess progress to date, and to design interventions for the duration of the extended project. This assistance would be accessed through a buy-in with Johns Hopkins University or a similar institution. The second mid-term and final evaluations will also be contracted in the U.S. through buy-ins with appropriate sources (POPTech, AIDSCAP or MSH).

The Project Authorization is being amended to clarify that the authorized USAID Geographic Code is United States (Code 000) and Bolivia (in accordance with USAID Handbook I, Supplement B, Chapter 18) for project procurement. Local source procurement provides for technical and administrative services for the Programa Colaborativo, office support, studies and audits, and occurs in the following manner: (1) funds for the Programa Colaborativo are committed through PILs signed by USAID and the GOB's NSH; (2) funds will be disbursed on a monthly basis in accordance with the annual budgets approved by USAID and CCH; (3) CCH oversees the Programa Colaborativo's compliance with Bolivian and US regulations regarding the expenditure of these funds; and (4) all local CCH contracts for personnel, commodities and/or services are competed using USAID Handbook 11 procedures. No contracts over \$250,000 are programmed under Host Country Contracting.

C. Summary Budget and Disbursement Schedule

The summary budget is arranged by the Project elements, including technical assistance, the CDC PASA, and USAID/Bolivia Office Support and Local Operations.

To date, \$3.8 million have been obligated; \$3.6 million have been committed and \$2.7 million have been spent. The \$3.8 million have been distributed in the following manner:

- \$1.4 million, the largest portion of the funds received, have been allotted to the Programa Colaborativo under CCH, to support the National Secretary of Health. This amount covers salaries, travel, office space, office equipment and supplies, and locally purchased medical equipment and supplies for the STD clinics and labs;
- \$1.1 million has been allocated to the CDC, under a PASA agreement to cover technical assistance and US purchased laboratory and medical supplies;
- \$484,000 have been allocated to the project management unit, in USAID, to cover project manager salary and travel expenses, secretarial support and condom distribution.
- \$480,000 have been allocated to Johns Hopkins University/Population Communication Services to cover long and short term technical assistance in the behavioral area.
- \$200,000 have been allocated to U.S. institutions to provide technical assistance in project design and evaluation.
- \$137,000 have been provided for direct support to the NSH to cover office supervision, educational activities, and purchase of laboratory supplies and equipment.

The remaining \$1.6 million in USAID funding for this project will be provided through the following obligations: \$800,000 in FY 95, and \$800,000 in FY 96. This amount will be allocated as follows:

- \$1.2 million, through PILs, to the Programa Colaborativo under CCH in support of the NSH, to cover local project operations in Bolivia.
- \$200,000 to the CDC under a PASA amendment to cover technical assistance in the medical and laboratory areas.
- \$100,000 to USAID/Bolivia, through Personal Services Contracts and purchase orders, to support management of project activities.

- \$99,000 to Johns Hopkins, or AIDSCAP or a similar institution, through a buy-in to a centrally funded contract, for technical assistance in behavioral interventions.

Summary budget by project element and projected disbursements are shown in the budget tables included herein.

TABLE 1

**AIDS/STDs PREVENTION AND CONTROL PROJECT
PROJECT BUDGET
(\$us 000)**

ELE MENT	DESCRIPTION	OBLIGATED TO DATE	PROJECTED OBLIGATIONS	LOP	COUNTERPART CONTRIBUTION	TOTAL
1	USAID Personnel Support	60		60		60
2	Technical Assistance (Buys-Ins)	142		142		142
3	Laboratory Equipment	15		15		15
4	Laboratory Supplies	75		75		75
5	Educational Material	79		79		79
6	Audit	0	0	0		0
10	Technical Support	100	99	199		199
11	CDC	1100	200	1300		1300
12	USAID/Bol. Office Support	474	100	574		574
13	CCH-Local Operations (1)	1756	1200	2956		2956
	TOTAL	3901	1599	5400	1813 (2)	7213

(1) SEE BREAKDOWN FOR ELEMENT 13 IN TABLE 2

(2) SEE BREAKDOWN FOR HOST COUNTRY CONTRIBUTION IN TABLE 5

TABLE 2

USAID MISSION TO BOLIVIA

Life of Project Cost Estimate and Financial Plan
(\$us. 000)

		CCH/Programa Colaborativo				
		ELEMENT 13			COUNTER PART	TOTAL PROJECT
ELE MENT	DESCRIPTION	DATE 1988-1994	GRAN TOTAL (95 - 98)	TOTAL	TOTAL	
A	Wages, Social Benefits	589	625	1214	483	1697
B	Institutional Contracts	370	0	370		370
C	Personal Service Contracts	0	100	100		100
D	Contracts, Remod. Outreach.	345	120	465	48	513
E	Equip., supplies, rents, profits	268	125	393	912	1305
F	Transportation	82	80	162	370	532
G	Epidemiologic Management	84	120	204		204
H	Audit	18	30	48		48
TOTAL		1756	1200	2956	1813	4769

TABLE 3

**AIDS/STDs PREVENTION AND CONTROL PROJECT
BUDGET DISTRIBUTION
(\$000)**

RECIPIENT	MECHANISM	1988-1990	1991-1994	TO DATE	1995-1998	TOTAL
1. Programa Colaborativo/CCH	PILs	0	1,400	1400	1,200	2,600
2. Centers for Disease Control & Prevention CDC	PASA	0	1,100	1,100	200	1,300
3. USAID/BOLIVIA Management Support	PSCs Purchase Orders	60	424	484	100	584
4. Johns Hopkins University	BUY-IN	0	480	480	99	579
5. Other US Technical Assistance	BUY-INs Contracts	150	50	200	0	200
6. Direct support to the National Secretariat of Health	PILs	74	63	137	0	137
TOTAL		284	3,517	3,801	1,599	5,400

TABLE 4

ESTIMATED BUDGET BY
 STD/AUDS URARD/8 611-0008 PROJECT
 GEOGRAPHIC AREAS AND ELEMENTS
 (MUS. 000)

DETAIL	1985 US\$	TOTAL 1985	1986 US\$	TOTAL 1986	1987 US\$	TOTAL 1987	1988 US\$	TOTAL 1988	GRAN TOTAL
1 GEOGRAPHIC REGIONS BUDGET									
a. LA PAZ									
Clinical Medical LPZ (MA)									
Laboratory LPZ (LA)									
IECC Counseling LPZ (CA)	250		144		140		20		
IECC Women's Outreach LPZ (IAMA)									
Evaluation and Monitoring LPZ (IEA)									
Administrative Unit									
IECC Men Outreach LPZ (IAAH)									
Center									
Epidemiology									
b. SANTA CRUZ									
Clinical Medical SCZ (MA)									
Laboratory SCZ (LA)									
IECC Counseling SCZ (CA)	210		126		90				
IECC Women's Outreach SCZ (IAMA)									
Evaluation and Monitoring SCZ (IEA)									
Administrative Unit (AA)									
IECC Men Outreach SCZ (IAAH)									
Promotion Materials									
c. COCHABAMBA									
	82		80		20				
d. EL ALTO									
	30		30		20				
TOTAL REGIONS		550		350		270		30	1,200
1 BUDGET BY AREAS									
MEDICAL AREA									
Clinical Medical (MA)	170		67		65				
Laboratory (LA)									
IECC AREA									
IECC Counseling (CA)	224		103		74				
IECC Women's Outreach (IAMA)									
Evaluation and Monitoring (IEA)									
IECC Men Outreach (IAAH)									
ADMINISTRATIVE AREA									
Administrative Unit (AA)	60		100		80		20		
CEAS									
CEAS	21		10		5		5		
MIS - Direct Support									
MIS - Direct Support	60		20		20		5		
TOTAL AREAS \$US.		550		350		270		30	1,200

TABLE 5

ESTIMATES OF HOST COUNTRY CONTRIBUTIONS

(\$us. 000)

A. CASH CONTRIBUTION		
1. Salaries	156	
2. Labs and clinics supplies and reagents	134	
3. Utilities	<u>193</u>	
Subtotal		483
B. IN - KIND		
1. Facilities and equipment (depreciation)	572	
2. Infrastructure	48	
3. Vehicles	176	
4. Maintenance, spares and combustible	194	
5. Office Equipment	<u>340</u>	
Subtotal		1330
GRAN TOTAL		<u>1813</u>

D. Counterpart Contribution

The FAA 25% host country contribution requirement will be satisfied by the PACD through a GOB contribution of \$1,813,000. \$1,330,000 of this contribution is in-kind and the balance of \$483,000 will be made in cash.

In-kind contributions include: laboratory and medical equipment, motor vehicles, gas, maintenance and parts, office supplies, and audiovisual materials. Cash contributions will cover medical and laboratory supplies, utilities and salaries. In-kind and cash contributions will be made by the NSH and its twelve RSHs.

Host country contribution monitoring will be the responsibility of the National Secretariat of Health. Quarterly reporting on host country contribution funds will be submitted to the Programa Colaborativo for monitoring purposes, and will be incorporated to Mission financial reports.

E. Audits

During FY 1991 through FY 1992 no funds were spent on audits since this Project was implemented through add-ons to a PASA with the Centers for Disease Control (CDC). PASA audits are not financed with project funds, as they are done in accordance with the U.S. Office and Management and Budget procedures defined in Circular A-133.

Funds for non-recipient audits are included in the budget for CY 1993 through CY 1997, the years USAID auditing requirement apply to this Project. Prior to that, local operations were administered by CDC and are subject to CDC auditing regulations. Currently, CCH, a Bolivian Government Health organization also financed by USAID, is providing administrative/financial/logistics support to the Project and participates actively in audit contracting and monitoring.

VI. OTHER DONOR CONTRIBUTIONS

A. GOB Mid-Term Plan For STDs/HIV/AIDS Prevention:

Thirty two different projects were included by the NSH's General Directorate for HIV/STD's Prevention and Control in its Mid Term Plan for the period 1995-1997. The range of activities vary from conventional preventive measures directed at high risk behavior groups to comprehensive efforts directed at the general population.

The main barrier to implementing the Mid Term Plan's projects relates to limited funding to address such an extensive approach to the limited AIDS/STD's problem in Bolivia. Nevertheless, the Project's technical criteria has been used to address strategies

directed at high risk behavior groups. These activities will continue to be addressed almost entirely by the Project.

According to the NSH, other expenses will be financed by other agencies (PAHO has pledged \$60,000 and UNICEF \$50,000 for CY 1995; the German Foreign Assistance program may provide additional support), mostly to include the general population in the 1995-1997 Government Mid Term Plan.

B. Blood Banks

Funding for development of blood banks was not considered by the project in the past, and will not be included in this amendment. The Bolivian government has been negotiating technical and financial assistance for blood banks for the past several years. In 1993 the International Red Cross pledged to work in this area and political conflicts inside the NSH stalled the project. At present the Dutch Government is reviewing a request for the same purpose. Within the context of the AIDS/STDs project this is a cost-intensive intervention that project resources cannot support at this time.

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ANNEXES

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ANNEX 1

ACTION: AID-1
INFO: CHRON-0 DCM-1 AMB-1

Rec'd 3/6

File: PD&I

DISTRIBUTION: AID
CLASS: AID

Label

VZCZCLPO542
RR RUEHLP
DE RUEHC #3037 0622036
ZNR 000000 ZZH
R 037026Z MAR 95
FM SECSTATE WASHDC
TO AMEMBASSY LA PAZ 3818
BT
UNCLAS STATE 053037

Action: HRR 2
Info: D/DD
EXO
PD&I
RF 2
SF
C

AIDAC

Reply due 3/13

3/13

E.O. 12356: N/A

TAGS:

Action tkn

*NAN - cable included
in PP Supplement package*

SUBJECT: BOLIVIA HEALTH-AIDS/STDS: NAD REVIEW FOR
AMENDMENT TO PROJECT NO. 511-0608

REP: LA PAZ 1513

1. THE REVIEW OF THE NAD FOR A PROPOSED DOLS. 1.4 MILLION AMENDMENT TO THE AIDS/STDS PREVENTION AND CONTROL PROJECT NO. 511-0608 HAS HELD ON FEBRUARY 10, 1995. THE REVIEW MEETING HAS CHAIRED BY LAG/SPM AND WAS ATTENDED BY REPRESENTATIVES FROM PPC, G/PHN/POP, G/PHN/HN/AIDS, AND LAC/RSD. THE REVIEW COMMITTEE RECOMMENDED APPROVAL OF THE NAD. USAID/BOLIVIA IS AUTHORIZED TO DEVELOP AND APPROVE THE PP SUPPLEMENT FOR THE AIDS/STDS PROJECT NO.511-0608 AT THE REQUESTED DOLS. 1.4 MILLION LEVEL. GUIDANCE FOR THE DEVELOPMENT OF THE PP SUPPLEMENT FOLLOWS.

2.SUSTAINABILITY: MEETING PARTICIPANTS WERE GENERALLY SUPPORTIVE OF THE ACTIONS THE MISSION IS TAKING TO ASSURE SUSTAINABILITY OF PROJECT ACTIVITIES, AS EXPRESSED IN THE NAD AND IN OTHER COMMUNICATIONS WITH PROJECT STAFF. CONCERN HAS EXPRESSED, HOWEVER, AT THE LACK OF INFORMATION AVAILABLE ON WHAT RECURRENT COSTS THE PROJECT WILL FINANCE. SERVICE DELIVERY AND LABORATORIES TEND TO HAVE

HIGH RECURRENT COSTS. THE MISSION SHOULD TAKE CARE IN DESIGN OF THE SUPPLEMENT THAT ANY RECURRENT COSTS RELATED TO PROJECT ACTIVITIES WILL EITHER BE FINANCED FROM THE OUTSET BY PARTIES OTHER THAN USAID, OR THAT THERE ARE REALISTIC PLANS FOR SUCH FINANCING BY THE END OF THE PROJECT.

3. BASELINES: AS THE TARGET GROUP EXPANDS BEYOND THE RELATIVELY SMALL WELL-DOCUMENTED GROUP OF REGISTERED CSWS,

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ADEQUATE BASELINE DATA ON STD PREVALENCE (INCLUDING HIV) WILL BE NEEDED.

4. INTEGRATION: IN THE VIEW OF REVIEW COMMITTEE MEMBERS, THE ULTIMATE SUCCESS AND LONG-TERM VIABILITY OF PROGRAMS INITIATED UNDER THE PROJECT WILL DEPEND ON THEIR INTEGRATION WITH OTHER REPRODUCTIVE HEALTH SERVICES. IN THIS REGARD, THE NAD IS SILENT ON THE QUESTION OF THE LINKAGE OF THIS PROJECT WITH OTHER MISSION AND COB HEALTH/POP PROGRAMS. THIS IS OF CONCERN SINCE THIS PROJECT IS PROPOSED TO END IN 1998-- A FAIRLY SHORT TIME HORIZON CONSIDERING THE PROBLEMS TO BE ADDRESSED.

5. TARGET GROUPS: WORLDWIDE DATA INDICATE THAT AIDS TRANSMISSION IS LARGELY A HETEROSEXUAL PHENOMENON. IF THIS IS ALSO THE CASE IN BOLIVIA, THE LEVEL OF EFFORT THE PROJECT PROPOSES TO DEVOTE TO MWM ACTIVITIES (UNSPECIFIED IN THE NAD) COULD BE INAPPROPRIATE TO THE EPIDEMIOLOGIC SITUATION IN BOLIVIA. THE MISSION WAS LAUDED FOR FOCUSING PROJECT ACTIVITIES MORE ON HETEROSEXUAL TRANSMISSION, BUT IS NEVERTHELESS ENCOURAGED TO LOOK CLOSELY AT THE QUESTION OF THE TARGET POPULATION TO ENSURE THAT PROJECT RESOURCES ARE BEING DEPLOYED WHERE THE NEED IS GREATEST.

6. FUNDING: THE REVIEW COMMITTEE CONSIDERED THE APPROPRIATENESS OF AIDS FUNDING FOR BOLIVIA, WHICH IS NOT AN AIDS EMPHASIS COUNTRY. THE COMMITTEE DETERMINED THAT THE LEVEL OF FUNDING INVOLVED (DOLS. 1.4 MILLION) IS CONSISTENT WITH THE GUIDANCE OF "LIMITED INTERVENTIONS" IN NON-EMPHASIS COUNTRIES. PPC SUBSEQUENTLY CONFIRMED THAT THE PROPOSED LEVEL OF FUNDING DOES NOT POSE A PROBLEM AT THIS TIME GIVEN THAT THE PROJECT IS PART OF THE MISSION'S OVERALL STRATEGY.

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ORIGIN: AID-1
INFO: CHRON-0 BFO-1 ADM-1 DCM-1 AMB-1

DISTRIBUTION: AIDB
CHARGE: AID
APPROVED: A/D:LWLUCKE
DRAFTED: HHR:ISTOUT:CB
CLEARED: 1.HHR:PGE, 2.PDI:PH, 3.CONT:MR, 4.DP:RK

VZCZCLPI483
RR RUEHC
DE RUEHLP #1513/01 0381300
ZNR UUUUU ZZH
R 071300Z FEB 95
FM AMEMBASSY LA PAZ
TO SECSTATE WASHDC 1730
BT
UNCLAS SECTION 01 OF 03 LA PAZ 001513

AIDAC

FOR: LAC/DR:GORDON BERTOLIN

E.O. 12356: N/A
SUBJECT: NEW ACTIVITY DESCRIPTION: AIDS/STDS PREVENTION
AND CONTROL PROJECT AMENDMENT. PROJECT NUMBER
511-0608.

PDI

MISSION REQUESTS DELEGATION OF AUTHORITY TO THE USAID
BOLIVIA DIRECTOR TO AUTHORIZE AMENDMENT OF THE AIDS/STDS
PROJECT NO. 511-0608. A NEW ACTIVITY DESCRIPTION
FOLLOWS:

1. BASIC DATA:

- (A) ACTIVITY TITLE: AIDS/STDS PREVENTION AND CONTROL PROJECT AMENDMENT
- (B) ACTIVITY NUMBER: 511-0608
- (C) FUNDING SOURCE: DA
- (D) DURATION: ORIGINAL: FY-88 TO FY-95
PROPOSED: FY-95 TO FY-98
- (E) PROPOSED LOP FUNDING: DOLS 5.4 MILLION -
DOLS 4.0 MILLION AS
PREVIOUSLY AMENDED, PLUS
DOLS 1.4 MILLION PROPOSED
ADDITION

HHR 2
D/OD
C
CONT
DP
RF

2. STRATEGIC FIT WITH AGENCY/BUREAU GOALS

THE AIDS/STDS PREVENTION AND CONTROL PROJECT SUPPORTS
THE AGENCY GOAL OF QUOTE STABILIZING POPULATION GROWTH
AND PROTECTING HEALTH UNQUOTE. THE PROJECT DIRECTLY
SUPPORTS USAID/BOLIVIA'S STRATEGIC OBJECTIVE OF

UNCLAS AIDAC LA PAZ 01513

QUOTE IMPROVED FAMILY HEALTH THROUGHOUT BOLIVIA UNQUOTE BY ADDRESSING AN AREA OF CRITICAL IMPACT FOR THE HEALTH OF THE BOLIVIAN POPULATION -- THE PREVALENCE OF SEXUALLY TRANSMITTED DISEASES/STDS. STDS, INCLUDING HIV/AIDS, ARE MAJOR CONTRIBUTORS TO MORTALITY AND MORBIDITY AMONG ADULTS AND INFANTS IN DEVELOPING COUNTRIES. IN BOLIVIA, RESEARCH CONDUCTED UNDER THE INITIAL PHASE OF THIS PROJECT INDICATES THE PREVALENCE OF STDS IS COMPARABLE TO COUNTRIES IN AFRICA LIKE UGANDA, WHERE THE POPULATION HAS BEEN DECIMATED BY THE AIDS EPIDEMIC. WHILE THE NUMBER OF AIDS CASES IN BOLIVIA ARE STILL FEW, 173 REPORTED CASES AT THE END OF 1994, THE HIGH PREVALENCE OF STDS IS A TANGIBLE THREAT TO THE HEALTH OF THE BOLIVIAN POPULATION. WORLD-WIDE EXPERIENCE AND RESEARCH HAVE PROVEN THAT STDS FACILITATE THE TRANSMISSION OF HIV. GIVEN THE STILL LOW LEVEL OF AIDS IN BOLIVIA, WORKING WITH STDS CONTROL HAS THE POTENTIAL OF SIGNIFICANTLY LOWERING POTENTIAL FUTURE PREVALENCE.

3. CONSISTENCY WITH MISSION STRATEGY

A. PROJECT GOAL: THE PROJECT GOAL IS TO IMPROVE FAMILY HEALTH THROUGHOUT BOLIVIA.

B. PROJECT PURPOSE: THE PROJECT PURPOSE IS TO REDUCE THE PREVALENCE OF STDS/HIV/AIDS IN LA PAZ, SANTA CRUZ, EL ALTO AND COCHABAMBA.

OUTPUTS EXPECTED AT THE NEW PACD OF MARCH 31, 1998, BASED ON PROGRESS TO DATE, AND AS A RESULT OF THE ADDITIONAL DOLS 1.4 MILLION IN LOP FUNDING REQUESTED HEREIN, ARE: THREE REFERENCE LABORATORIES AND FOUR STD CLINICS OPERATING IN FOUR CITIES OF BOLIVIA; 500 HEALTH PROFESSIONALS TRAINED, 40 TRAINERS OF TRAINERS REPLICATING THE PROJECT PREVENTIVE MODEL, 100 PEER COUNSELORS WORKING WITH COMMERCIAL SEX WORKERS, CSWS, AND MEN WHO HAVE SEX WITH MEN, MWM, IN SAFER-SEX INTERVENTIONS; A SIGNIFICANT DECREASE IN STD PREVALENCE IN HIGH RISK BEHAVIOR GROUPS, FROM 35 PERCENT TO BELOW 10 PERCENT IN CSWS AND BY 20 PERCENT OVER THE BASELINE DATA IN MWM; A SENTINEL SURVEILLANCE SYSTEM OPERATING AT THE NATIONAL LEVEL; AND CONDOM DISTRIBUTION INCREASED BY 100 PERCENT FROM ONE TO TWO MILLION CONDOMS A YEAR. BEHAVIOR MODIFICATION INTERVENTIONS ARE EXPECTED TO INCREASE ATTENDANCE AT THE STD CLINICS OF CSWS BY 50 PERCENT, FROM 1,000 TO 1,500 IN LA PAZ AND SANTA CRUZ, AND TO INCREASE CONDOM USE, FROM 35 PERCENT TO 65 PERCENT IN CSWS AND BY 30 PERCENT OVER THE BASELINE IN MWM.

C. PROJECT DESCRIPTION:

1. PRESENT ACTIVITIES: THE AIDS/STDS PREVENTION AND CONTROL PROJECT BEGAN IN 1988 WITH A SMALL GRANT TO THE GOB TO LEARN ABOUT THE PATTERN OF HIV IN THE COUNTRY. THIS INITIAL PHASE WAS AMENDED IN 1991 TO APPLY THE THREE-PRONGED APPROACH RECOMMENDED BY THE WORLD HEALTH ORGANIZATION FOR AIDS PREVENTION: DIAGNOSIS AND TREATMENT OF STDS, BEHAVIOR MODIFICATION, AND MARKETING OF CONDOMS. THE PROJECT HAS DEVELOPED A PREVENTION MODEL BASED ON EARLY INTERVENTION WITH CSWS AND MWM TO DELAY THE SPREAD OF AIDS INTO THE GENERAL POPULATION. WITH TECHNICAL ASSISTANCE FROM THE CENTERS FOR DISEASE CONTROL AND

PREVENTION OF ATLANTA, CDC, USAID/BOLIVIA HAS DEVELOPED TWO WORLD CLASS STD REFERENCE LABORATORIES IN LA PAZ AND SANTA CRUZ AND THREE STD MODEL CLINICS IN LA PAZ, SANTA CRUZ AND EL ALTO. THE CLINIC IN LA PAZ HAS ALREADY BECOME A CENTER OF EXCELLENCE, WHERE STD MANAGEMENT TRAINING IS NOW PROVIDED TO PUBLIC AND PRIVATE SECTOR HEALTH PROFESSIONALS. A BEHAVIORAL MODIFICATION STRATEGY ADDRESSED TO RISK BEHAVIOR GROUPS WAS DEVELOPED WITH JOHNS HOPKINS UNIVERSITY AND CDC, AND INCLUDES TWO APPROACHES TO WORK WITH GROUPS AT HIGHER RISK OF AIDS INFECTION: OUTREACH EDUCATION FOR BROTHEL-BASED, LESS EDUCATED CSWS, FOR BROTHEL OWNERS/ADMINISTRATORS AND FOR MWM, AND COUNSELING FOR NIGHT CLUB-BASED, MORE EDUCATED CSWS. TWO NATIONAL CONDOM DISTRIBUTION STRATEGIES HAVE BEEN DEVELOPED THAT RESULTED IN AN INCREASE OF 150 PERCENT IN CONDOMS DISTRIBUTED IN THREE YEARS: A SOCIAL MARKETING INTERVENTION FOR THE COMMERCIAL SECTOR, AND A GOVERNMENT DISTRIBUTION SYSTEM IN THE PUBLIC SECTOR. THE PROJECT HAS ACCOMPLISHED OR SURPASSED THE EOPS TARGET LEVELS ORIGINALLY PROGRAMMED. THE EXCEPTION IS A SENTINEL SURVEILLANCE SYSTEM THAT WAS DELEGATED BY THE GOB TO THE PAN AMERICAN HEALTH ORGANIZATION, PAHO, AND HAS NOT BEEN DEVELOPED TO DATE. BECAUSE OF THE NEED FOR SENTINEL SURVEILLANCE, THE PROJECT WILL REPROGRAM AND AGAIN INCLUDE THIS ACTIVITY UNDER THE EXTENSION.

2. PROPOSED AMENDMENT: TO DATE, THE PROJECT HAS CONCENTRATED ON RESEARCH AND DEVELOPMENT OF AN STDS/HIV/AIDS PREVENTION MODEL FOR BOLIVIA. USAID/BOLIVIA NOW REQUESTS AN ADDITIONAL DOLS 1.4 MILLION TO CONSOLIDATE THE MODEL THROUGH GREATER COORDINATION AND INTEGRATION INTO THE GOB'S STDS/HIV PREVENTION PROGRAM; TO EXTEND IT TO AT LEAST ONE OTHER CITY IN BOLIVIA; TO INTEGRATE

45

LESSONS LEARNED INTO THE GOB'S REPRODUCTIVE AND PRIMARY HEALTH CARE PROGRAMS, AND TO OTHER HEALTH INSTITUTIONS IN THE PUBLIC AND PRIVATE SECTORS; AND TO ADDRESS SUSTAINABILITY ISSUES.

USAID/BOLIVIA REQUESTS AUTHORIZATION TO AMEND THE EXPECTED LOP FUNDING FROM DOLS 4.0 TO DOLS 5.4 MILLION AND THE PACD FROM SEPTEMBER 30, 1995 TO MARCH 31, 1998. DOLS 601,000 OF THIS DOLS 1.4 MILLION ADDITIONAL FUNDING ALREADY IS INCLUDED IN OUR FY 1995 OYB.

D. ANTICIPATED IMPACT ON POVERTY ALLEVIATION AND GENDER IMPACT: THREE OUT OF FOUR BOLIVIANS LIVE BELOW THE POVERTY LINE EARNING A FIFTH OF THE GNP, ESTIMATED AT DOLS 800 PER CAPITA FOR 1994. PROGRAMS WHICH PROMOTE HEALTH ARE ASSOCIATED WITH POVERTY ALLEVIATION BY IMPROVING GENERAL WELL-BEING, AND WITH INCREASING PRODUCTIVITY AND SAVINGS OF SCARCE RESOURCES THAT CAN SATISFY THE MANY OTHER NEEDS OF THE POOR. THIS PROJECT HAS A DIRECT IMPACT ON THE STATUS AND HEALTH OF WOMEN, WHO ARE POORER, MORE VULNERABLE TO DISEASE IN GENERAL, AND TO STDS IN PARTICULAR. STDS TEND TO BE ASYMPTOMATIC AMONG WOMEN, AND THEREFORE, ARE MORE LIKELY TO GO UNTREATED AND AFFECT MORE DRAMATICALLY WOMEN'S HEALTH.

BY REDUCING THE PREVALENCE OF STDS NOW, THE PROJECT WILL CONTRIBUTE TO DELAY THE SPREAD OF HIV/AIDS IN BOLIVIA. THE INVESTMENT IN PREVENTION WILL CONTRIBUTE TO SAVE THE LIMITED RESOURCES OF THE HEALTH SECTOR THAT AN AIDS EPIDEMIC WOULD DEplete.

E. DIALOGUE AGENDA: AN ON-GOING AND POSITIVE DIALOGUE EXISTS BETWEEN USAID AND THE BOLIVIAN GOVERNMENT AT THE NATIONAL AND REGIONAL LEVELS. THE NATIONAL SECRETARY OF HEALTH HAS ASKED THAT USAID/BOLIVIA ASSIST WITH PRESENTATIONS OF THE PROJECT MODEL FOR REPLICATION IN OTHER PARTS OF THE COUNTRY AND FOR FINANCING BY OTHER DONORS. AT THE REGIONAL LEVEL, PROJECT STAFF WORK AT REFERENCE LABORATORIES AND MODEL CLINICS IN DIRECT SUPPORT OF GOB STAFF. IN ADDITION, THE PROJECT HAS DEVELOPED STD THERAPEUTIC AND LEGAL NORMS AFFECTING HE TARGET POPULATION THAT THE BOLIVIAN GOVERNMENT IS IMPLEMENTING. THIS CLOSE DIALOGUE IS EXPECTED TO CONTINUE TO GROW IN THE PROPOSED EXTENSION PERIOD.

FINALLY, THE COST-RECOVERY POTENTIAL OF PROJECT ACTIVITIES WILL BE EXPLORED, AND SUSTAINABILITY ISSUES ADDRESSED AND RESOLVED FOR THE FUTURE.

F. DONOR COORDINATION: USAID/BOLIVIA SUPPORTED THE CREATION OF AN AIDS/STDS INTER-AGENCY COORDINATING COMMITTEE WHERE THE GOB AND DONORS INVOLVED IN AIDS/STDS/REPRODUCTIVE HEALTH MEET TO PROGRAM ACTIONS

AND COORDINATE RESOURCE ALLOCATION. MEMBERS OF THE COMMITTEE IN ADDITION TO USAID ARE: THE NATIONAL

SECRETARIAT OF HEALTH, THE NATIONAL DIRECTOR OF AIDS/STDS CONTROL, THE NATIONAL DIRECTOR OF MATERNAL/CHILD HEALTH, PAN AMERICAN HEALTH ORGANIZATION, UNICEF, UNFPA, THE INTERNATIONAL RED CROSS, CARITAS, A BOLIVIAN PVO INVOLVED IN TREATMENT OF AIDS PATIENTS, AND THE DUTCH GOVERNMENT.

4. POLICY AND DESIGN ISSUES

A. SUSTAINABILITY OF PROPOSED ACTIVITIES: FINANCIAL SELF-SUFFICIENCY OF THE LABORATORIES AND CLINICS DEVELOPED UNDER THIS PROJECT IS FEASIBLE, AT LEAST PARTIALLY, AS SERVICES ARE PROVIDED ON A FEE-FOR-SERVICE BASIS. THE PROJECT IS ASSISTING TWO REGIONAL SECRETARIATS OF HEALTH IN COST/BENEFIT ANALYSIS OF THE STD CLINICS TO SUPPORT SUSTAINABILITY, AND WILL ALSO REQUEST TECHNICAL ASSISTANCE FROM PROSALUD, A BOLIVIAN HEALTH NGO THAT SPECIALIZES IN COST RECOVERY. DISTRIBUTION OF CONDOMS HAS ALSO BEEN QUOTE GRADUATED UNQUOTE FROM FREE DISSEMINATION TO A SALES APPROACH.

B. LINKAGES TO AND UTILIZATION OF GLOBAL RESOURCES AND LAC REGIONAL PROGRAMS: OPPORTUNITY EXISTS TO LINK PROJECT ACTIVITIES TO THE AIDSCAP PROJECT. THE PROJECT MAY BUY INTO THIS RESOURCE FOR TECHNICAL SUPPORT IN DESIGN OF BEHAVIOR MODIFICATION INTERVENTIONS.

C. MANAGEMENT AND SUPPORT REQUIREMENTS: OVERSIGHT OF THIS PROJECT WILL CONTINUE TO REQUIRE A US DIRECT HIRE OR PSC PROFESSIONAL AT THE MISSION LEVEL. THIS FUNCTION IS PRESENTLY UNDERTAKEN BY A USPSC, WHOSE CONTRACT ENDS IN JUNE 1995. THE MISSION PLANS TO CONTRACT WITH A LOCAL HIRE PROFESSIONAL TO MANAGE THE PROJECT AFTER JUNE 1995. THE USPSC POSITION WAS DELETED IN THE MISSION'S USPSC CEILING THIS YEAR. TECHNICAL MANAGEMENT IS SUPERVISED BY THE CDC UNDER A PASA WITH THE MISSION AND PROJECT IMPLEMENTATION IS MANAGED BY PROJECT-FUNDED STAFF.

D. TIMETABLE AND RESOURCE REQUIREMENTS: CURRENT AUTHORIZED LOP FUNDING IS REQUESTED TO INCREASE FROM DOLS 4.0 TO DOLS 5.4 MILLION TO COVER PROJECT ACTIVITIES THROUGH MID FY-98. SOME REPROGRAMMING OF EXISTING FUNDS IS ALSO CONTEMPLATED. THE MISSION HAS DOLS 800,000 IN AIDS FUNDS IN ITS FY 95 OYB (DLS 199,000 UNDER THE CURRENT AUTHORIZATION AND DLS 601,000 WHICH REQUIRE THIS PROJECT AMENDMENT TO AUTHORIZE AND OBLIGATE) AND AN ADDITIONAL DOLS 800,000

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IS BEING REQUESTED IN FY 96 TO SUPPORT CONTINUED
ACTIVITIES AS DESCRIBED ABOVE.

E. RECOMMENDATIONS ON DELEGATION OF AUTHORITY FOR
FURTHER REVIEW AND APPROVAL:

MISSION RECOMMENDS THAT THE AA/LAC DELEGATE PROJECT
AMENDMENT AUTHORIZATION AUTHORITY TO THE USAID/BOLIVIA
DIRECTOR. THIS RECOMMENDATION IS CONSISTENT WITH
DELEGATION OF AUTHORITY NO. 752 DATED SEPTEMBER 14, 1992.

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48

**LOGICAL FRAMEWORK 1995
AIDS/STDS PREVENTION AND CONTROL PROJECT
PROJECT NUMBER: 511-0608**

From FY 88 to FY 98
Total U.S. Funding \$ 5.4 million
Date prepared: 03/13/95

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<p>-Project goal: To improve family health throughout Bolivia.</p>	<p>1. Improved development and implementation of health policy.</p> <p>1.1. Improved institutional capabilities within the public/private sectors to deliver preventative and curative health services.</p> <p>1.2. Improved health knowledge, attitudes and practices among Bolivians.</p>	<p>1. Sentinel surveillance studies</p> <p>2. National demographic and health surveys data (as available)</p> <p>3. Final Project evaluation</p>	<p>1. Government of Bolivia supports the project and replicates project activities nationwide</p> <p>2. Other donor & USAID projects supporting same or similar goal achieve their project purposes as measured by objectively verifiable indicators</p>

19

**LOGICAL FRAMEWORK 1995
AIDS/STDS PREVENTION AND CONTROL PROJECT
PROJECT NUMBER: 511-0608**

From FY 88 to FY 98
Total U.S. Funding \$ 5.4 million
Date prepared: 03/13/95

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<p>PURPOSE:</p> <p>1. To reduce the prevalence <u>1/</u> of STDs/HIV/AIDS in high risk behavior groups in La Paz, El Alto, Santa Cruz and Cochabamba</p>	<p>Conditions that will indicate purpose has been achieved: End of Project Status.</p> <p>In the four target cities:</p> <p>1.1. Reduce the average prevalence of gonorrhoea from 10% to 7% in CSWs, and by 20% over the baseline in MWM</p> <p>1.2. Reduce the average prevalence of trichomoniasis from 15% to 10% in CSWs.</p> <p>1.3. Reduce the average prevalence of syphilis from 15% to 10% in CSWs, and by 20% over the baseline in MWM</p> <p>1.4. Reduce the average prevalence of chlamydia from 15% to 10% in CSWs and by 20% over the baseline in MWM</p> <p>1.5. Maintain prevalence of HIV at < 0,02%</p> <p>1.6. Sustainability strategy being implemented in the four STD clinics by the end of FY 97</p>	<p>1. Sentinel surveillance studies and STD clinic records</p> <p>1.2. Final Project evaluation</p> <p>1.6. Agreements Records</p> <p>2. Final Project evaluation</p>	<p>Assumptions for achieving purpose:</p> <p>1. National and Regional Secretariats of Health adopt project model</p> <p>1.2. Regional Secretariats of Health are successful in keeping Municipalities from closing down brothels</p>

1/ Prevalence: The total number of persons with the disease at any time during the year divided by the population at risk of having the disease over the same period.

**LOGICAL FRAMEWORK 1995
AIDS/STDS PREVENTION AND CONTROL PROJECT
PROJECT NUMBER: 511-0608**

From FY 88 to FY 98
Total U.S. Funding \$ 5.4 million
Date prepared: 03/13/95

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<p>OUTPUTS:</p> <p>1. Programs established for diagnosis and treatment of STDs</p>	<p>Magnitude of Outputs:</p> <p>1.1. 4 RSH/STD clinics established: a. La Paz (done) b. El Alto (done) c. Santa Cruz (done) d. Cochabamba (end FY 96)</p> <p>1.2. Increase number of registered CSWs using the clinics from FY 92 through FY 98</p> <p>In La Paz from 500 to 1000 In El Alto from 67 to 300 In Santa Cruz from 500 to 1000 In Cochabamba from 250 to 500</p> <p>1.3. Three reference laboratories: a. La Paz (done) b. Santa Cruz (done) c. Cochabamba (end FY 96)</p> <p>1.4. 12 public and private sector general health care clinics enabled to conduct STD/HIV/AIDS treatment and diagnosis and 180 professionals trained.</p>	<p>1.1. Regional Secretariat of Health records</p> <p>1.2. STD clinic records</p> <p>1.4. Records</p>	<p>1.1. RSHs support project model.</p> <p>1.4. Private & voluntary organiz. allot time & resources to STD/HIV/AIDS programs</p>

51

**LOGICAL FRAMEWORK 1995
AIDS/STDS PREVENTION AND CONTROL PROJECT
PROJECT NUMBER: 511-0608**

From FY 88 to FY 98
Total U.S. Funding \$ 5.4 million
Date prepared: 03/13/95

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS																																																													
<p>OUTPUTS:</p> <p>2. STD/HIV/AIDS IECC programs developed and implemented</p>	<p>1.5. Sustainability strategy for STD clinics developed by the beginning of FY 96.</p> <p>1.6. RSH personnel trained in STDs/HIV/AIDS diagnosis and treatment in PACD:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%;">a.</td> <td style="width: 75%;">La Paz</td> <td style="width: 10%; text-align: center;">-</td> <td style="width: 10%; text-align: right;">180</td> </tr> <tr> <td>b.</td> <td>El Alto</td> <td style="text-align: center;">-</td> <td style="text-align: right;">50</td> </tr> <tr> <td>c.</td> <td>Santa Cruz</td> <td style="text-align: center;">-</td> <td style="text-align: right;">100</td> </tr> <tr> <td>d.</td> <td>Cochabamba and others</td> <td style="text-align: center;">-</td> <td style="text-align: right;">50</td> </tr> </table> <p>2.1. 8 direct counseling programs for high risk groups established:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 35%;"></th> <th style="width: 10%; text-align: center;"><u>MWM</u></th> <th style="width: 10%; text-align: center;"><u>CSW</u></th> <th style="width: 10%; text-align: center;"><u>YEAR</u></th> </tr> </thead> <tbody> <tr> <td>a.</td> <td>La Paz</td> <td style="text-align: center;">X</td> <td style="text-align: center;">X</td> <td style="text-align: center;">FY95</td> </tr> <tr> <td>b.</td> <td>El Alto</td> <td style="text-align: center;">X</td> <td style="text-align: center;">X</td> <td style="text-align: center;">FY96</td> </tr> <tr> <td>c.</td> <td>Santa Cruz</td> <td style="text-align: center;">X</td> <td style="text-align: center;">X</td> <td style="text-align: center;">DONE</td> </tr> <tr> <td>d.</td> <td>Cochabamba</td> <td style="text-align: center;">X</td> <td style="text-align: center;">X</td> <td style="text-align: center;">FY97</td> </tr> </tbody> </table> <p>2.2. 6 Outreach programs for high risk groups established:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;"></th> <th style="width: 35%;"></th> <th style="width: 10%; text-align: center;"><u>MWM</u></th> <th style="width: 10%; text-align: center;"><u>CSW</u></th> <th style="width: 10%; text-align: center;"><u>YEAR</u></th> </tr> </thead> <tbody> <tr> <td>a.</td> <td>La Paz</td> <td style="text-align: center;">X</td> <td style="text-align: center;">X</td> <td style="text-align: center;">FY95</td> </tr> <tr> <td>b.</td> <td>El Alto</td> <td style="text-align: center;">X</td> <td style="text-align: center;">X</td> <td style="text-align: center;">FY96</td> </tr> <tr> <td>c.</td> <td>Santa Cruz</td> <td style="text-align: center;">X</td> <td style="text-align: center;">X</td> <td style="text-align: center;">FY96</td> </tr> </tbody> </table>	a.	La Paz	-	180	b.	El Alto	-	50	c.	Santa Cruz	-	100	d.	Cochabamba and others	-	50			<u>MWM</u>	<u>CSW</u>	<u>YEAR</u>	a.	La Paz	X	X	FY95	b.	El Alto	X	X	FY96	c.	Santa Cruz	X	X	DONE	d.	Cochabamba	X	X	FY97			<u>MWM</u>	<u>CSW</u>	<u>YEAR</u>	a.	La Paz	X	X	FY95	b.	El Alto	X	X	FY96	c.	Santa Cruz	X	X	FY96	<p>1.5. Strategy Report</p> <p>2.1. Project quarterly reports</p> <p>2.2. Project quarterly reports</p>	<p>1.5 National & Regional Secretariats of Health support cost-recovery strategy</p> <p>2. National & Regional Secretariats of Health support and adopt IECC programs</p>
a.	La Paz	-	180																																																													
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63

LOGICAL FRAMEWORK 1995
AIDS/STDs PREVENTION AND CONTROL PROJECT
PROJECT NUMBER: 611-0608

From FY 88 to FY 98
 Total U.S. Funding \$ 5.4 million
 Date prepared: 03/13/95

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<p>OUTPUTS:</p>	<p>2.3 IECC material developed:</p> <p>a. 1.2 million educational units b. 1.1 million promotional units c. 81,000 incentive units</p> <p>2.4. Personnel trained in STD/HIV/AIDS education by PACD:</p> <p>a. La Paz - 338 b. El Alto - 190 c. Santa Cruz - 272 d. Cochabamba and others - 200</p> <p>2.5. Three STD/HIV/AIDS hotlines established:</p> <p>a. La Paz FY 95 b. Santa Cruz DONE c. Cochabamba FY 96</p>	<p>2.3. Project Inventory record</p> <p>2.4. Project quarterly reports</p> <p>2.5. Project quarterly reports - PAHO agreements</p>	<p>2.5. Regional Secretariats of Health allocate resources to hot line management</p>

**LOGICAL FRAMEWORK 1995
AIDS/STDS PREVENTION AND CONTROL PROJECT
PROJECT NUMBER: 511-0608**

From FY 88 to FY 98
Total U.S. Funding \$ 5.4 million
Date prepared: 03/13/95

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<p>OUTPUTS:</p> <p>3. Condom distribution system established</p>	<p>3.1. Frequency of condom use in high risk groups by PACD:</p> <p>a. MWM - Increase of 30% over baseline b. CSW - Increase use 35% to 65%</p> <p>3.2. 1.5 million condoms distributed in FY 95-FY 96 and 2 million distributed in FY 97-FY 98</p>	<p>3.1. Project surveys</p> <p>3.2. PROSALUD/SOMARC records CEASS/NSH records</p>	<p>3.1. Surveys reports are accurate</p> <p>3.2. Condoms will continue to be available under Reproductive Health Project</p>

LOGICAL FRAMEWORK 1995
AIDS/STDS PREVENTION AND CONTROL PROJECT
PROJECT NUMBER: 511-0608

From FY 88 to FY 98
 Total U.S. Funding \$ 5.4 million
 Date prepared: 03/13/95

OBJECTIVES	INDICATORS			MEANS OF VERIFICATION		ASSUMPTIONS	
INPUTS: Project Budget - (IN \$ 000)	(IN \$ 000)			Project Financial Records Cont. Records (IN \$ 000)		Availability of funds (IN \$ 000)	
ELEMENTS	TO DATE	FY 1995	FY 1996	FY 1997	FY 1998	TOTAL	COUNTERPART
1. USAID personnel support	60	0	0	0	0	60	0
2. Technical assistance	142	0	0	0	0	142	0
3. Laboratory equipment	15	0	0	0	0	15	0
4. Laboratory supplies	74	0	0	0	0	74	285
5. Educational material	79	0	0	0	0	79	0
10. Technical support	100	50	50	20	0	220	0
11. CDC	1100	100	60	50	0	1310	0
12. USAID/BOL support	474	0	40	50	20	584	0
13. CCH - Local operation	<u>1706</u>	<u>550</u>	<u>350</u>	<u>280</u>	<u>30</u>	<u>2916</u>	<u>1548</u>
TOTAL	3750	700	500	400	50	5400	1833
ELEMENT 13 BREAKDOWN	TO DATE						
a. Salaries	780	250	210	160	15	1415	
b. Institution Contracts	0	0	0	0	0	0	
c. Personal Services	0	100	0	0	0	100	
d. Contracts, Rent	475	50	30	35	5	595	
e. Equipment, supplies	283	50	40	30	5	408	
f. Transport, travel	66	30	30	15	5	146	
g. Support NSH	84	60	30	30	0	204	
h. Audits	<u>18</u>	<u>10</u>	<u>10</u>	<u>10</u>	<u>0</u>	<u>48</u>	
TOTAL	1.706	550	350	280	30	2916	

A.I.D. EVALUATION SUMMARY - PART I

1. BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS.
2. USE LETTER QUALITY TYPE, NOT "DOT MATRIX" TYPE.

IDENTIFICATION DATA

A. Reporting A.I.D. Unit: HHR		B. Was Evaluation Scheduled In Current FY Annual Evaluation Plan? Yes <input checked="" type="checkbox"/> Slipped <input type="checkbox"/> Ad Hoc <input type="checkbox"/>		C. Evaluation Timing Interim <input checked="" type="checkbox"/> Final <input type="checkbox"/> ExPost <input type="checkbox"/> Other <input type="checkbox"/>	
Mission or AID/W Office <u>USAID/Bolivia</u> (ES# _____)		Evaluation Plan Submission Date: FY <u>94</u> Q <u>1</u>			
D. Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report.)					
Project - No.	Project/Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Mo / Yr)	Planned LOP Cost (000)	Amount Obligated To Date (000)
511-0608	AIDS/STDs PREVENTION AND CONTROL PROJECT	91	9/95	\$4,000	\$3,729

ACTIONS

E. Action Decisions Approved By Mission or AID/W Office Director	Name of Officer Responsible for Action	Date Action to be Completed
<u>Action(s) Required</u>		
1. STD/TA by Dr. King Holmes to provide final recommendations of medical/behavioral interventions of project.	JKuritsky	3/94
2. Hire new Bolivian national director for the project.	IStout	5/94
3. Design strategy to integrate project clinics and labs into National Secretary of Health's (SNS) regular program.	New Project Director	6/94
4. Design strategy to integrate STD/HIVs/AIDS detection/treatment/education into Mission's reproductive health program.	Consultant	5/94
5. Create ad-hoc work group with SNS to review laws and policy affecting CSWs. Strengthen role of Inter-Agency Coordinating Committee.	I. Stout	3/94
6. Extend IEC intervention to street based CSWs. Train peer counselors.	V. Kaune	3/94
7. Expand gay intervention in Santa Cruz. Include sale of condoms, train peer counselors. Promote tel. hotline.	T. Wright	3/94
8. Contract TA to design condom distribution strategy. Strengthen current distribution programs.	E. Lawrence SOMARC	5/94

APPROVALS

F. Date Of Mission Or AID/W Office review Of Evaluation:			(Month)	(Day)	(Year)
			12	10	93
G. Approvals of Evaluation Summary And Action Decisions:					
Name (Typed)	Project Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director	
	Isabel Stout		Anne Beasley	Carl Leonard	
Signature	<i>Isabel Stout</i>				
Date	4-22-94				

ABSTRACT

H. Evaluation Abstract (Do not exceed the space provided)

The original purpose of this Project was to expand access to, and the use of effective STD/HIV prevention services and education in the Bolivia departments of La Paz, Cochabamba and Santa Cruz. It was designed as an early intervention to mitigate the long-term economic and social problems which accompany the spread of HIV and AIDS in this low-prevalence country. This midterm evaluation reviewed progress to date on the Project purpose and provided USAID/La Paz with programmatic guidance on future directions which the program should take.

The Project is being implemented through a Participating Agency Services Agreement (PASA) with the Centers for Disease Control and Prevention. This PASA provides the services of a senior long-term advisor/project director, technical assistance and some administrative support. Management and administration of activities in Bolivia is currently done through the Mission's Community and Child Health Project (CCH). Local collaborating agencies include the Ministry of Health and two Bolivian NGOs.

Principal accomplishments to date have been the establishment of two model clinics for diagnosis and treatment of sexually transmitted diseases (STD) for registered commercial sex workers (CSW) in La Paz and Santa Cruz. On-site diagnostic laboratories and two reference laboratories, as well as quality assurance testing at CDC in Atlanta, Georgia, support these services. Project clinics are located on the same premises as mandatory clinics operated by the Government of Bolivia (GOB), and offer elective, parallel services. The target population comprises between 5%-30% of all CSWs in these two cities, and Project clinics treat approximately 2000 women a year.

In the 18 months prior to the mid-term evaluation, activities in information, education, communication and counseling (IECC) were added to the Project. These are primarily clinic-based interventions designed to increase HIV/AIDS awareness and condom use in the target population, although there is a small outreach component for CSWs working in third-class brothels in La Paz. The Project has also recently developed some IEC materials for CSWs and their clinics.

The evaluation found the project has developed a good base for the future expansion of STD services in Bolivia. Clinical and laboratory services are excellent, and provide good diagnostic and treatment models which could be adapted for other Bolivian health services. Educational and counseling services are average-to-good, although the majority of current activities are probably not cost-effective for adaptation to larger audiences. Condom distribution, which is usually regarded as a major strategy in STD and HIV prevention, is weak and not considered by the Project staff to be a program responsibility. USAID/La Paz has placed high priority on this program component, however, and manages condom distribution for HIV prevention from their own offices. Current efforts in IEC materials development and behavioral research have had many design problems, and were not sufficiently advanced to judge their contribution to the Project's effectiveness.

The majority of recommendations from the evaluation related to the need for transition from the Project's pilot, research-oriented STD diagnosis and treatment activities to interventions which could be adapted and integrated into available Bolivian health services. If implemented, these should bring the project more into line with the Mission's Strategic Objective of improving the health status of the Bolivian population, especially women of child bearing age and their children. They should also increase the probability that HIV/AIDS prevention activities will be sustained, both in the short run through USAID support and, in the longer run, with Bolivian resources.

COSTS

I. Evaluation Costs

Name	1. Evaluation Team	Affiliation	Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S.\$)	Source of Funds
Dr. Melody Trott	AID/W - R&D/H formerly WHO John Snow AIDSCAP		21 days	\$50,000	Project Funds
Dr. John Galloway			14 days		
Mr. Glen Wasek			11 days		
Mr. Michael Stafer			14 days		
2. Mission/Office Professional Staff Person-Days (Estimate) 28 person days			3. Borrower / Grantee Professional Staff Person-Days (Estimate) 35 person days		

A.I.D. EVALUATION SUMMARY - PART II

SUMMARY

J. Summary of Evaluation Findings, Conclusions and Recommendations (Try not to exceed the three (3) pages provided)**Address the following items:**

- | | |
|--|-----------------------------|
| . Purpose of evaluation and methodology used | . Principal recommendations |
| . Purpose of activity(ies) evaluated | . Lessons learned |
| . Findings and conclusions (relate to questions) | |

Mission or Office :
USAID/Bolivia/HHR

Date This Summary Prepared :

Title and Date Of Full Evaluation Report:

1. Purpose of the Activity Evaluated.

The overall goal of the Acquired Immunodeficiency Syndrome/Sexually-Transmitted Disease (AIDS/STD) Project is to improve the health status of the Bolivian population, especially women of child bearing age and their children. The purpose is to expand access to, and use of, effective STD and Human Immunodeficiency Virus (HIV) control and prevention services and education in La Paz, Santa Cruz, and Cochabamba. Specific purposes (Amendment No. 1, July 1991) are to:

- Define and track the extent of the HIV/STD problem in Bolivia;
- Detect, treat, and counsel persons with HIV/STD;
- Develop and disseminate information targeted to promoting safer sexual behaviors; and
- Make condoms available and accessible on demand.

The major outputs for the project are:

- Formation of one national and three regional advisory committees;
- Strengthening of three HIV/STD reference laboratories;
- Development and operation of three model HIV/STD clinics;
- Development of a sentinel surveillance system;
- Training health workers in detection, treatment, and counseling;
- Providing HIV/STD counseling and outreach services;
- Developing and implementing information, education, and communication programs; and
- Social marketing of 2.5 million condoms.

2. Purpose of the Evaluation and Methodology.

The purpose of the evaluation was to assess the implementation strategy which was developed during the first two and one-half years of activity and to provide specific recommendations regarding future program directions in the Project's technical areas.

A four-person team conducted this evaluation in Bolivia from October 4-16, 1993 through a Mission buy-in to the centrally-funded AIDS Control and Prevention Project (AIDSCAP). The team included an STD physician, a condom logistics and financial management expert, an information and communications specialist and a USAID/W technical Advisor experienced in HIV and AIDS program implementation and management. The team was selected by USAID/Bolivia and approved by the Project staff.

A review of Project activities was conducted in La Paz, and a two-day site visit was made to Santa Cruz, Bolivia. In addition, interviews were conducted with various representatives of the public sector, non-governmental organizations (NGOs), and some of the international donors working in the country. Specific Program Areas reviewed included:

- STD case management and prevention practices;
- STD and HIV sentinel surveillance systems;
- Information, education, communication, and counseling (IECC) components;
- Project management and institutionalization;
- Condom promotion and distribution; and
- Financial management.

The evaluation describes each of the program areas and the activities undertaken to date. It further reviews their effectiveness and makes recommendations in order to fully achieve the Project's original goals and objectives.

3. Findings and Conclusions.

Major findings for each of the Project's technical components, and for its management and financial systems are summarized below.

A. General Observations.

- The Project was designed as an intervention, but has been implemented by the CDC as a research activity.
- The Project's primary focus has been on the diagnosis and treatment of STDs rather than prevention.
- The target group of registered commercial sex workers is extremely small and probably comprises no more than 5-30% of the total CSWs in the two cities where activities have been developed. The Project's current impact on STDs and HIV is also quite small.

- Some of the most important linkages that need to be made for sustainability of the Project are not in place.
- The Mission needs to review its current system of management for this activity, and look for ways to have more input and control.

B. STD and Surveillance Interventions.

- The Project has established two model clinics and associated laboratory services. These are excellent, but are built on models which will not be easily extended to the bulk of CSWs in Bolivia.
- Progress has been made toward defining strategies to extend STD services to the larger population of women with STDs, but more work is needed on syndromic diagnosis, national treatment guidelines, simplified laboratory procedures and promotion of behavioral compliance (condoms, appropriate medications, etc.).
- The Project has not yet commenced the surveillance activities required by the Project design. These are not a priority of the Project expatriate staff or CDC Technical Advisors, and there are no current plans to implement a surveillance system.
- A small but innovative and important Project component for men who have sex with men (MWM) has been developed in the city of Santa Cruz.

C. Information, Education, Communications and Counseling (IECC).

- Project IECC activities have been initiated recently, and are interdependent with clinic services. Many activities were still in the development stage at the time of the evaluation.
- The current clinic-based educational and counseling interventions are both time-consuming and costly. It is not clear how much of this work will be applicable to the larger population of CSWs or to other groups whose behavior places them at high risk of STDs and HIV, including clients of CSWs, MWM, and others who have high numbers of casual sex partners.
- Self-reported condom use is the only measure of behavior change which is currently being applied to evaluate effectiveness of these activities.
- The Project has no overall strategic approach to IECC, and both materials and activities are currently being developed in an ad hoc manner.

D. Condom Promotion and Distribution.

- Overall, designated levels of condom distribution defined in the Project paper are not sufficient to affect STD/HIV transmission in Bolivia.
- Condom promotion and distribution objectives are not being adequately addressed within the Project, and staff do not view condoms as a major area of programming responsibility. This Project function has, apparently by default, been assumed by USAID/Bolivia's Office of Health and Human Resources staff.
- Based on conventional methods for estimating CSW condom needs, Project clinics supply only 9.1% of the total needs of their target population.

E. Project Management and Institutionalization.

- The Project is well managed on a daily basis and some components are ahead of schedule. Many important activities, however, have not been started and some are not even contemplated in current Project staff planning.
- The original contractor (CDC/Atlanta) was unable to provide the Project with adequate management support, and USAID/La Paz has had to assume much in-country responsibility for administration. The Project is currently managed through the Mission's Community and Child Health Project, with technical support from CDC.
- Most of the Project's senior management and technical positions are held by expatriates, rather than Bolivians.
- The Project is not linked in substantive ways with the Bolivian health infrastructure, including the Secretariat of Health and NGOs. Institutionalization and Bolivian ownership of activities is probably the largest single issue facing the Project in the future.

SUMMARY (Continued)

F. Financial Analysis and Management.

- Financial data was not made available to the evaluation team until the end of the visit, which precluded detailed financial analysis. This suggests a poor financial management system, and lack of concern about these issues by the Project's senior staff.
- Project planning and financial management appear to have operated independently. There is no consistent pattern of budget-based decision-making during the first two years of Project operations.
- Project financial reporting appeared to have improved in the months prior to the evaluation, but Project senior staff do not appear to be seriously engaged in financial planning against Project objectives.

4. Principal Recommendations.

Major recommendations include:

- A. Expansion of the Project beyond STD care and treatment, where most resources have been focused. The project's future emphasis should be on the IECC and condom promotion program areas, which are currently very weak.
- B. Broadening the Project's target group beyond registered CSWs, who comprise only a small portion of Bolivian CSWs. These should include other groups who are at high risk of STDs and HIV because of unsafe sexual practices such as clandestine CSWs, their clients and men who have sex with men.
- C. Development of a multi-year strategic approach for STD and HIV prevention which extends across all sectors and which plans for the integration and expansion of future Project activities.
- D. Creation of linkages with the public sector and local institutions, including NGOs, as soon as possible, early in order to build sustainability beyond the life of the Project.
- E. Definition of a plan and benchmarks for making the Project's management structure through the recruitment of Bolivians for substantive leadership and technical positions. This should include promotion of training which will reduce the current reliance of foreign technical assistance and an expanded Mission role in Project planning and supervision.

5. Lessons Learned.

At present there appears to be little Bolivian ownership of this activity, and it is widely viewed as a positive, but "American" initiative. Unless this is addressed and Bolivians come to view the activities as being their own, it is unlikely that interventions will be sustained.

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A T T A C H M E N T S

K. Attachments (List attachments submitted with this Evaluation Summary, always attach copy of full evaluation report, even if one was submitted earlier; attach studies, surveys, etc., from "on-going" evaluation, if relevant to the evaluation report.)

Attached is the evaluation report entitled "Mid-Term Evaluation of the AIDS/STD Prevention and Control Project" and the comments and rebuttals of staff involved in this project.

C O M M E N T S

L. Comments By Mission, AID/W Office and Borrower/Grantee On Full Report :

The long term technical advisor to this project, Dr. Joel Kuritsky, and his advisors from the Centers for Disease Control and Prevention (CDC) and from the Academy for Educational Development, disagree with the medical/behavioral recommendations of the evaluation on philosophical grounds regarding STDs/HIV/AIDS interventions. The arrival of Dr. King Holmes of the University of Washington at Seattle, a renowned authority in this field who is also in the advisory board to all major institutions working with STDs/HIV/AIDS, is expected to assist in sorting out future courses of action.

Project management agrees with a substantial portion of the recommendations in the areas of Condom Promotion and Distribution, Project Management and Institutionalization, and Financial Analysis and Management. Many of the evaluation's recommendations are being targeted for action as described in Section E. ACTIONS.

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USAID Bolivia AIDS/STD Prevention & Control Project Review

King K. Holmes

Martin Fishbein

March 21-25, 1994

Overview

The present project is a well planned, well designed attempt to develop a three-pronged approach to HIV prevention. Following the recommendations of WHO and USAID/AIDSCAP, the project combines a behavior change and social marketing approach with an STD control program. Equally important, the project is targeted to the two groups that are at highest risk for exposure to, and transmission of, HIV and other STD's -- Commercial Sex Workers (CSW) and Men who have Sex with Men (MSM). There is considerable evidence to support the increased effectiveness of targeting "core" groups rather than the general population. Overall the Bolivia project is one of the best existing examples to date in which the WHO/USAID/AIDSCAP strategy is being pursued as intended.

Behavior Change and Social Marketing

Behavior Change: Two approaches to behavior change are currently being evaluated: counseling and outreach. In Santa Cruz, counseling is offered to all women attending the clinic. In La Paz, women working in night clubs as well as women working in First Class Brothels are offered either individual or group counseling. In addition, in La Paz, an outreach program to educate and change the behavior of women working in Second and Third Class Brothels is also being evaluated. In a somewhat different approach, a hotline has been established in Santa Cruz. The hotline provides information about AIDS and other STD's and, perhaps more importantly, refers callers to testing services and various medical personnel.

Social Marketing: Given that almost all CSW's have ready access to condoms, the social marketing program has appropriately not focused on condom distribution but rather, has developed posters and informational materials designed to change perceived norms and to increase condom use in the brothels. In addition, a number of "ice-breakers" (e.g. key chains, lighters, table-cloths, etc.) have been developed to help the CSW's initiate discussions of condom use with their clients. Posters and other materials (e.g., pocket calendars) have also been developed for MSM's.

Distribution of Resources: Although initial expenditures were necessary for equipment and training to develop the STD control program, recent expenditures have been approximately 1/3 for the STD control program and 2/3 for the combined Behavior Change/Social Marketing program. Given the three pronged approach, this is an appropriate distribution of project resources.

Sustainability: At the present time, there is considerably more infrastructure development for the STD control program (see below) than for the social marketing and behavior change parts of the program. It is important to note however, that the outreach program in La Paz is being conducted by a local NGO. More important, there are now plans to start training CSWs in second and third class brothels to be part of the outreach/intervention teams. In addition, the Santa Cruz hotline/referral service is an important community asset that could eventually be supported by local resources.

Critique of the Midterm Evaluation and some related recommendations: With respect to the social marketing and behavior change elements of the project, the midterm evaluation has a number of factual and conceptual problems. Although little is to be gained by reviewing all elements of the evaluation, there are several key points that need clarification: In particular, and in contrast to the conclusions drawn by the midterm evaluation:

1. The program has a well designed, well planned strategy (i.e., WHO and USAID/AIDSCAP's recommended three-prong approach to HIV prevention).
2. The project is focused on developing and implementing interventions to prevent the spread of HIV and other STD's -- it is not "a research activity." As indicated earlier, in addition to the STD control program (which in itself is an intervention), the project contains a number of ongoing behavior change and social marketing interventions: clinic-based individual and group counseling, outreach, flyers describing proper condom use, posters, and a hotline. In order to develop any of these interventions, formative/operational research/evaluations of the target group(s) are necessary to: (a) identify ways to obtain access to the group(s); (b) better understand the group(s) culture and; (c) identify factors that should influence behavioral change in the group. In addition, once developed, each of these interventions must be evaluated utilizing both process and outcome evaluation procedures.

Recommendation 1. While the project is to be commended on developing both outreach and counseling interventions, the interventions need to become more focused and theory based. More specifically, the interventions (both the outreach programs and the counseling) need to target those variables (e.g. behavioral beliefs, attitudes, perceived norms and self-efficacy) that are most likely to influence condom use in a given segment of the population. That is, the interventions should try to produce changes in the determinants of condom use. Thus, for example, although it is important to provide some basic information about how to recognize different STDs and to provide information about how STD's are transmitted, there is considerable evidence that this type of information produces relatively little change in behavior. Thus, the interventions should spend less time on traditional educational messages about a disease and how it's transmitted, and to focus instead on changing the cognitive determinants of condom use behavior and/or on developing necessary skills for condom use and for overcoming barriers to condom use.

Recommendation 2. While unanticipated events (e.g. the closing of the brothels in La Paz) contributed to the decision to abandon the control sites in La Paz, this decision is problematic vis-à-vis evaluating the effectiveness of the brothel outreach program. Just as the strongest evidence for a drug trial requires a control condition, so too does one need a control condition to evaluate the effectiveness of any behavioral intervention. While a true randomized trial is not possible with most community level interventions, a quasi-experimental treatment versus control design is possible and is strongly recommended. Clearly, evaluating any intervention should be viewed as similar to the evaluation of a new drug or treatment and thus we strongly recommend that wherever possible, such evaluations should involve a comparison between treatment and control sites.

Recommendation 3. The project should hire a programmer analyst to assist in both data management and data analyses. In particular, it would be helpful to have local capability to utilize statistical packages such as SAS or SPSS in addition to current capacity with EPI-info.

3. The project does not have "an extremely small target group." As described above, the project appropriately targets CSWs and MSMs, the two "core" groups most likely to be exposed to and to transmit HIV and other STD's to the general population.

Recommendation 4. The outreach component in La Paz should be expanded beyond the second and third class brothels to the CSW's working the streets. In addition, further attempts should be made to identify clandestine brothels. Similarly, there is a need to develop a comprehensive CSW outreach program in Santa Cruz. Along these same lines, outreach to MSM's who do not gay identify, should also be developed. Generally speaking, an attempt should be made to reach all CSW's and all MSM's.

Recommendation 5. If the behavior change/social marketing component of the study is to be expanded, we would recommend that it NOT be expanded to other populations, but rather to other behaviors in the two core groups (CSW's and MSM's) currently being targeted. Thus for example, you may want to influence intentions to conduct self vaginal/genital exams and/or intentions to seek early treatment for any sign of an STD. Similarly, the hotline could be expanded to attempt to evaluate and to influence people's decisions to follow through on referrals.

STD Control

The STD prevention and control portion of the project includes early diagnosis and treatment of curable STD in female sex workers in La Paz, Santa Cruz, and El Alto; and related laboratory strengthening. As the project matures, information has become available to assist with development of appropriate national guidelines and training to extend the scope of the program.

1. Review of Syndromic Protocol: The protocols for syndromic management of STD advocated by the AIDS/STD Prevention and Control Project conform to those developed by AIDSCAP and WHO/GPA, and depicted in wall chart form by Johns Hopkins. The specific antimicrobials recommended similarly conform to current WHO/GPA guidelines and represent appropriate choices for Bolivia. Syndromic management of urethritis in men and of genital ulcers in men or women, is currently implemented in MOH STD clinics in La Paz, El Alto, and Santa Cruz, and can be extended to other clinics of this type. Additional settings appropriate for implementing syndromic treatment of urethritis and GUD include primary care clinics and in the private medical sector. Syndromic treatment of urethritis in men, together with promotion of condoms and partner treatment, could also be extended to pharmacies, where most men with urethritis seek treatment in Latin America.

Syndromic treatment of symptomatic vaginal discharge and of pelvic pain in women can also be evaluated in primary care settings where symptomatic women seek care, but is less likely to be effective in vertical family planning clinics or clinics for sex workers, which tend to attract asymptomatic women seeking routine care. In these settings, screening tests (e.g. syphilis serology, gonorrhea culture, chlamydia ELISA, microscopy of vaginal fluid) are required to detect STD.

2. Review of SNS Treatment Guidelines: The manual for STD treatment in Bolivia was prepared in 1988 in La Paz. Guidelines were provided for treatment of syphilis (recommendations were adequate), opportunistic infections in HIV infection (guidelines incomplete) and gonorrhea (guidelines outdated, no longer valid for Bolivia). In addition, a short table of drugs used for treating some other STD was included, but was very inadequate (e.g. no guidelines for treating chlamydial infection, pelvic inflammatory disease, no syndromic management guidelines) and was wrong in some recommendations. It is recommended that new guidelines be developed by a national committee, in a simplified version, based upon 1993 WHO recommendations and on results of antimicrobial susceptibility testing carried out by the AIDS/STD Project.
3. Review of Operations at the Centro Piloto in La Paz, and CAIM in Sta. Cruz. At the Centro Piloto, the Project has established a model clinic for clinical and laboratory STD services for a sample of female sex workers (FSW) attending the clinic. Clinical and laboratory training courses were provided at the CDC P & T Center in Puerto Rico and at the CDC for project staff and the Centro Piloto Model Clinic for personnel of the Health Secretariat. The Clinic was renovated. An excellent clinic lab was established, with INLASA back up and CDC quality control, which now serves all FSW attending the Centro Piloto; a pharmacy with packets of recommended drugs provided at subsidized cost is also provided to all attendees.

Vaginal exams and cervical gram stains are provided monthly, chlamydia ELISA and gonorrhea culture every two months, RPR card test monthly, and dark field exam of ulcers when needed. Test performance at the clinic lab and INLASA have steadily improved, relative to CDC test QC results. Among 170 women who underwent 3 exams in 1992-93, the prevalence of gonorrhea fell from 12.9 to 9.5%; and of chlamydia from 14.7 to 6.7%.

Basically, the clinic has been converted from a typical Latin American clinic for FSW that formerly stamped carnets, collected money, and rarely diagnosed STD, and when STDs were diagnosed with nonspecific tests withheld carnets, and wrote prescriptions for drugs which were often inappropriate and often never filled by the FSW -- to a model clinic which provides syndromic management, screening for syphilis, gonorrhea, chlamydia and vaginal infection, surveillance for HIV; subsidized therapy available in the clinic, IEC, counseling, and condoms; and training. Other services (e.g. pregnancy testing) are provided.

Currently, 1200 FSW are registered in La Paz; a brief Delphi survey of 7 public health workers from the Regional Secretariat of Health estimated the total number of FSW actually working in La Paz to be in the range of 1000-5000. It is not unlikely that about 1/3 to 1/2 of the La Paz FSW are registered, and about half of those registered comply regularly with scheduled follow-up exams. Brothel-based FSW have highest rates of STD, and most of these are thought to be registered.

Recommendations: 1) Proceed as planned with integration of the Project's clinical services into the overall clinic operations. This has already happened to a great extent (e.g. stat lab, pharmacy, training), but formalize this. 2) Conduct qualitative research in perceptions of FSW (both those who are and are not registered and compliant participants) about improvements in the services that have been introduced (e.g. how do they feel about actually being examined.) Use the results to motivate better compliance. 3) Continue syndromic management of genital ulcer disease, but rely on continued lab screening for diagnosis of gonorrhea (culture), chlamydia (DFA or ELISA), trichomoniasis (wet mount), and latent or incubatory syphilis (RPR). Increase the frequency of gonorrhea culture to monthly to have greater impact on prevalence. 4) Continue to encourage clinic attendance whenever required for new symptoms, by assuring availability of treatment and never withholding carnets. 5) Link withholding of carnets to non-compliance with clinic exams, not to diagnosis of STD. 6) Assume the need for continued subsidizing of lab and therapeutic services for 5-7 years; however with the Secretariat, conduct forensic accounting of the use of funds currently paid by FSW for health services, to improve long term sustainability.

Santa Cruz. Coincident with this review, changes by the Regional Secretary of Health in administration of the Santa Cruz clinic appear to have interrupted clinical, laboratory, IEC and

condom promotion programs that were achieving success comparable to that of the Centro Piloto in La Paz. The new clinic facilities are attractive, but space allocated to the Project is inadequate and the new program manager presented strongly held unconventional views of the nature of clinical services planned (e.g. monthly HIV testing for case detection at FSW expense). The future direction of the Santa Cruz clinic services is uncertain at this time.

4. Review of Mid Term Evaluation of the Project. The Bolivia AID Mission undertook this project initially with a PASA to the CDC signed in 11/91 to assist in implementing the project. The AIDSCAP evaluation was conducted in October 1993. Dr. John Gallway provided STD expertise to the Review Team. Pages 10-22 review STD and Surveillance Intervention, and pages 50-52 present recommendations for STD interventions. These sections of the report (as opposed to the sections headed Findings (pages 7-10) are generally on target. The major exceptions are:

1. Although quantitative data were not available, it is clear that the Project has begun to extend services of the Centro Piloto to all attendees (e.g. through the services of the clinic lab, and the availability of subsidized medication to all women found to have STD - so that inexpensive prompt therapy now serves as an inducement to participation (replacing withholding of the carnet while women filled a more expensive prescription - which was a disincentive).
2. Clinical and lab services have been developed at a third clinic, El Alto, where 94 FSW are registered. Estimates of health officials suggest this represents 20% to 90% of FSW working in El Alto (who are not already registered in La Paz).
3. Systematic surveillance for prevalence of HIV, syphilis, gonorrhea, chlamydia and trachomoniasis certainly now exists in the FSW in three cities. The most appropriate additional steps for sentinel surveillance could include HIV and syphilis in homosexual/bisexual men and among other high risk groups (for example, military personnel). In Bolivia at present, sentinel surveillance for HIV in low risk populations would have low yield.

The review of the STD/Surveillance activities were otherwise reasonable. However, we disagree with some statements of Section C. Findings.

1) "The project is a research activity, not an intervention." STD/AIDS interventions which do not include strong formative/operational research components at the very beginning are likely to be misguided. For example, in 1990, a paper was presented at a PAHO meeting in Kingston, Jamaica which concluded that FSW in La Paz had almost no STD, and required no STD intervention. The Regional Secretariat expressed skepticism to the reviewer that STD control in FSW was important to STD control or AIDS prevention in Bolivia. However, as a part of the laboratory strengthening which will be essential to control STD in Bolivia, the Project has demonstrated that >60% of brothel-based FSW have at least one STD. Current STD treatment guidelines for Bolivia recommend penicillin for treatment of gonorrhea. The project demonstrated that 40% of La Paz isolates are beta-lactamase producing strains, and another 10% have MICs of penicillin G ≥ 2.0 , indicated that 50% of gonococcal isolates are resistant to penicillin G. The type of initial assessment done by the Project is standard operating practice for initiating a public health intervention which was actually undertaken very quickly in Bolivia. The development of Centers of Excellence, as long advocated by WHO/PAHO, is an essential first step in the long term process of modifying standards of clinical and public health practice.

2. The primary focus has been on diagnosis and treatment of all STDs, rather than prevention.

There are several factual and conceptual problems with this section.

- a) Approximately 1/3 of the local budget has been spent on diagnosis and treatment of STD; the rest has been spent on IEC, counseling and evaluation activities.
- b) The USAID/AIDSCAP strategy for primary prevention of sexual transmission of HIV is a balanced strategy, which attempts to integrate behavior change, condom promotion, and early diagnosis and treatment of STD in high risk populations in urban settings. The Bolivia project is one of the best existing examples to date in which the strategy is being pursued exactly as intended.

- c) Figure 1 is misrepresented as used here. There are versions of this model which show STD control or condoms having the greatest effect - depending upon the assumption used in the model. It is a bad idea for advocates of one or another type of intervention to polarize disciplines by touting the version showing greatest impact of their pet intervention. The point is that only when all three interventions are used together is the greatest impact achieved.
- d) In communicable diseases, early diagnosis and treatment represents primary prevention (of subsequent new infections) as well as secondary prevention (of medical complications). For example, in the US, early diagnosis (by skin testing) and treatment (with isoniazid) has for years been the chosen method (as opposed to BCG vaccine) for primary prevention of spread of TB. And in Europe, it has probably been early diagnosis and treatment (rather than behavior change or increased condom use) that led to near disappearance of curable STD in the 70's and 80's. The issue is not which of these HIV prevention strategies are primary prevention, the issue is what is the level of funding needed to reach an effective threshold of each of these activities.
- e) It is quite unrealistic to expect that an adequate and sustainable level of early diagnosis and treatment of STD in Bolivia, even in FSW, would have been achieved after 2-3 years, when so little infrastructure was available.
3. The project has an extremely small target group. It is very unlikely that the number of registered FSW, for example in La Paz, constitute only 5% of the total FSW population. It is not uncommon to hear of vastly overestimated numbers, which are scaled back when more accurate estimates are attempted. Furthermore, highest rates of STD are usually seen in brothel-based prostitution because they have highest numbers of sexual partners, a large proportion of which are involved in the Project. The AIDSCAP strategy targets high risk populations. However, there is an unresolved point of disagreement between the epidemiology-oriented and mass-media oriented workers in AIDS prevention which will only

be resolved with better data from the epidemiologists on what proportion of the target group can in fact be reached with targeted intervention.

4. Strategic Approach; Linkages; Sustainability; Project Management. This project is attempting a difficult task: to actually implement the AIDSCAP strategy. Is there any country that is not struggling with this task? Is the progress in Bolivia slower paced or more limited in scope than that achieved in Malawi, Senegal, Nigeria, Rwanda, Haiti, Dominican Republic, Honduras, Kenya, India, Brazil, Ethiopia, Jamaica, etc? Our impression is that progress toward these goals has actually been relatively rapid, in part because parallel programs were implemented in advance of clear consensus or long term strategies in linkages, sustainability. The benefits are development of a competent motivated team, a useful foundation of data, and establishment of good models for training. The tradeoff could be more difficulties in operationallizing the models than if a more lengthy consensus developing process had been undertaken. However, a strong case can be made that the important recommendation for establishing linkages and sustainability, and for moving from the generic AIDSCAP strategies to a Bolivian strategic plan can be facilitated by the data, experience, and training accomplished to date. Skeptical, inflexible program managers may be more easily moved by local data and models developed in their own setting.

5. Potential problems of STDs with the Americas, and what might be expected in Bolivia. Bolivia is bordered by Brazil, Peru, Chile, Paraguay and Argentina, and has component regions that can be expected to reflect the epidemiology of STD in these bordering countries. STD surveillance in Brazil deteriorated in the last few years, but shows clear urban concentration of disease, with all STD endemic in some areas. The National AIDS and STD Control Program is a combined program under Dr. Lair Rodriguez. From its new World Bank-funded AIDS Prevention and Control Program, the expenditure for early diagnosis and treatment of STD will be 27 million US dollars over three years, or about 7 cents per capita per year, implemented largely through a series of STD clinics integrated into selected primary care centers serving high risk populations. Chile has one of the most highly regarded STD control programs in Latin America, headed by Dr. Blanca Campos. In Peru, surveys of STD in brothel-based FSW have been conducted in Lima and the Callao district; and a survey of sexual practices and STD seroprevalence was

conducted in a quasi-population based sample in Lima in 1990-91. Pertinent findings were 1) somewhat lower rates of STD in FSW in Lima than in control results in La Paz, probably reflecting poorer quality of services in La Paz before the Project began. 2) As shown in Appendix A, rates of STD in men were most closely correlated with reported sex with FSW without using condoms; while STD rates in women were actually higher than in men, despite much less risk behavior of women. The implication, probably pertinent to Bolivia, that men who have sex with FSW without using condoms probably serve as the core group for transmission of STD to the general population of women; and that the Bolivia focus on control of STD in FSW, and providing condom use by clients of FSW should remain the highest (and most feasible) priority, but extending outreach to high risk men should be a high priority. Paradoxically, though women have highest actual prevalence of the STD (p. 10), the selection provision of services to women, based upon their own perceived risk or on standard risk assessment, may not be as efficient in reducing their STD morbidity as would programs directed further back along the causal pathway, towards FSW and their clients. [Appendix A]

6. Importance of STD as a public health problem. The recent paper by Over and Piot on this topic is enclosed as Appendix B.
7. Talks on STD/HIV. In addition to talks given in Bolivia, a set of slides is provided.
8. Mechanism of Implementing STD Control within Existing Reproductive Health Programs. A book related to this topic, Reproductive Tract Infection in Women by Germaine et al, is enclosed.

A full response to this is very dependent on the current program, the available infrastructure, and the goals of the program. A few guiding principles are:

- a. It is much easier to protect women from STD morbidity by ensuring early effective treatment for men, and by preventing infection in men than by screening millions of women for STD.
- b. The syndromic approach to management of vaginal discharge and pelvic pain,

1. will work better in FPMCH clinics integrated in primary care clinics than in fully vertical FP clinics,
 2. require validation in the local setting; PAHO has algorithm for Latin America.
 - c. Developing partner notification for female partners of men with STD will provide secondary prevention of complications in these partners.
9. Importance of work with high risk populations. As emphasized in the Appendix from Over and Piot, this is more cost effective than attempting STD control in the general population. The current program serving FSW should be extending to high risk men.
10. Review of medical data and future suggestions. Very extensive data were provided by the Project team. The data showing antimicrobial resistance of N. gonorrhoea, and on comparative prevalences of various STD in different categories of FSW, were quite useful. Data from the QC program shows clear improvements in gram stain for gonorrhoea in La Paz (though gram stain seroconverters >50-60% in women are probably not really feasible); culture for gonorrhoea; DFA for chlamydia; and in serologic tests for syphilis. It should be noted that serologic tests for syphilis are used as an indicator by PAHO for general laboratory quality control. These improvements will be absolutely critical for the STD/Reproductive Health Program, and will require a sustained QC effort. CDC is doing an outstanding job on this, and it would be a mistake to cut corners here. In INLASA and at CENTETOP in Santa Cruz, the lab support has been very good and should be sustained.

**COST AND SUSTAINABILITY ASSESSMENT
OF THE AIDS PILOT CENTER
SUPPORTED BY USAID AIDS/STDs
PREVENTION AND CONTROL PROJECT
NO. 511-608**

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EXECUTIVE SUMMARY

The purpose of this assessment is to evaluate several management issues at the AIDS Pilot Center in La Paz which impact on the sustainability of activities carried out at the clinic under the USAID AIDS/STDs Prevention and Control Project No. 511-0608. The assessment examines patient flow and its impact on income and efficient use of resources, service which includes the frequency of lab tests and patient satisfaction, cost recovery which includes percentages of fixed and variable costs covered with income from health card sales and lab tests, and some suggestions or options for developing a more sustainable program.

The methodology used consisted of a review of documentation, interviews with clinic and project personnel, and patients. A random sample was drawn of thirty-five patients to determine average number of visits for given time periods, frequency of exams, and general trends of attendance. By determining the average number of visits per month per individual and comparing that with the average number of monthly consultations in the clinic, it was possible to estimate the number of individuals being seen. Income was obtained from the actual figures registered in the clinic for health card purchases and cost per visit was calculated using average number of visits per patient for specific time frames.

This assessment found that although patient flow is relatively steady and that doctors have an estimated 600 consultations per week, in practice the pattern of visits is very irregular. The sample indicated that the trend is for a patient to buy a health card¹, have an average of 2.87 visits per month during a three consecutive month period, go a month or so without visits, and then to once again begin regular visits. In one example the month with the highest number of visits is compared to the month with the lowest number of visits for that client. The average for the highest month is 3.857 monthly visits per patient, while the average for the lowest month is .743 visits. Since patient flow remains constant, the implication is that more than 600 individuals are seen over the course of the year. This study estimates that number to be on the order of 800.

The total monthly cost of operating the clinic is estimated at Bs 52,437.38. Variable costs sum Bs 33,468 or 63.8% of the total whereas fixed costs are Bs 18,969.31 or 36.2% of the total. USAID contributions at Bs 31,907.38 constitute 60.8% of the total while those of the National Secretariat at Bs 20,530 make up the other 39.2%. The monthly cost for lab tests is estimated at Bs 13,539.96. Actual income from the sale of health cards totalled Bs 85,716 for the thirteen month period from January 1994 to January 1995, an average of Bs 6,593 per month, while fees collected for VDRL tests averaged Bs 2,031 per month. This

¹These cost Bs 36 and are valid for three months.



income went to the National Secretariat and was not reinvested in clinic activities. Income from these sources would have covered 16.4% of total costs, 27% of variable costs, and 25.8% of the USAID contribution. If the program is to be sustainable after the USAID project is completed, additional sources of income must be identified and a sustainability strategy developed.

Project personnel should work with the National Secretariat of Health to develop a sustainability strategy. Some of the issues which should be addressed during the development of that strategy include 1) reinvestment of income obtained from the sale of cards into the clinic; 2) increasing charges, especially for lab tests; 3) decreasing the number of required visits; 4) limiting the use of a health card to the time period for which it is valid; 5) identifying other sources of income; 6) cutting operating costs at the clinic by improving efficiency; 7) collaborating with other donors. These options are discussed in the report under Sustainability Issues.

TABLE OF CONTENTS

	Page
Executive Summary.....	i
I. INTRODUCTION.....	1
II. PATIENT FLOW AND ITS IMPACT ON INCOME.....	2
III. SERVICES AND THEIR COSTS.....	4
IV. COST RECOVERY.....	6
V. SUSTAINABILITY ISSUES.....	7
ANNEX A: TABLES	
ANNEX B: PERSONS AND INSTITUTIONS CONTACTED	

LIST OF TABLES

1. AVERAGE NUMBER OF MONTHLY VISITS & COST PER VISIT
2. FREQUENCY OF AVERAGE NUMBER OF MONTHLY VISITS FOR SAMPLE
3. FREQUENCY OF NUMBER OF MONTHLY VISITS FOR SAMPLE USING HIGHEST AND LOWEST MONTHS
4. ESTIMATED NO. OF INDIVIDUAL PATIENTS SEEN PER MONTH AND CORRESPONDING INCOME FROM CARDS
5. MONTHLY COSTS PAID BY USAID PROJECT
6. MONTHLY COSTS PAID BY MINISTRY OF HEALTH
7. FIXED AND VARIABLE COSTS PAID BY USAID AND MINISTRY
8. AVERAGE NO. SYPHILIS TESTS PER WOMAN PER YEAR
9. ESTIMATES OF MONTHLY INCOME FROM VDRL TESTS BY ESTIMATES OF PATIENT FLOW
10. COST COVERAGE WITH INCOME FROM HEALTH CARDS AND LAB CHARGES
11. COSTS OF LAB TESTS PER PATIENT OVER 3 MONTH PERIOD

I. INTRODUCTION

The purpose of this assessment is to evaluate several management issues at the AIDS Pilot Center in La Paz which impact on the sustainability of activities carried out at the clinic under the USAID AIDS/STDs Prevention and Control Project No. 511-0608. Issues addressed in this assessment include patient flow and its impact on income and efficient use of resources, service which includes the frequency of lab tests and patient satisfaction, cost recovery which includes percentages of fixed and variable costs covered, and some suggestions for developing a sustainability strategy. These issues were mentioned in the Midterm Evaluation of the Project, and will be useful to guide activities proposed under the Project Amendment so that activities may be extended to other cities. The assessment was carried out by the USAID/Bolivia Evaluation and Monitoring Specialist from January 26 to February 7, 1995.

The methodology used in the assessment consisted of a review of documentation, interviews with clinic and project personnel, and with patients. A random sample was drawn of thirty-five patients to determine average number of visits for given time periods, frequency of exams, and general trends of attendance at the clinic. Dates of visits and exams over the last eight months were noted, and subsequently these data were expanded based on estimated numbers of individual patients. By determining the average number of visits per month per individual and comparing that with the average number of monthly consultations in the clinic, it was possible to estimate the number of individuals being seen. Income was obtained by looking at the actual figures corresponding to health card purchases and cost per visit was calculated by looking at average number of visits per patient for different time frames. Cost data were gathered from the project accountant housed in the Community and Child Health Project, the administrator at the Pilot Center, and the biochemist who supplied information on the costs of individual exams and estimated the frequency of the three different tests for syphilis.¹

Comparing income and recurring costs provides insight on the cost recovery issue. Gross income from the sale of health cards was compared to total costs of operating the program, those financed by the National Secretariat of Health and the Project, and to only those financed by the Project. Comparing income to variable costs such as lab tests, is an important factor to establish whether or not current charges are sufficient.

Cost analysis feeds into the design of a sustainability strategy to allow activities to continue once the project is completed in

¹R.P.R., V.D.R.L., and FTA-ABS.

1998. Some of the operational costs will probably continue to be funded by the Secretariat of Health. Others may be picked up by donors or by increased usage charges. One issue to be addressed under sustainability is whether income currently collected by the clinic will be available for financing its operations. The current practice is that all funds collected are turned over to the Secretariat where a third are used for production bonuses, and the Secretariat does not return money to the clinic outside of its contribution to providing certain personnel, some supplies, space and utilities. The analyses in this report view the AIDS program in the Pilot Center as a cost center, and report on the proportion of its costs which are being covered by income generated by its users. Suggestions for higher cost recovery are offered and their estimated impacts are discussed.

II. PATIENT FLOW AND ITS IMPACT ON INCOME

Clinic personnel interviewed during this assessment confirmed that patient flow is relatively steady and that doctors see an estimated 600 patients per week or about 2,400 in a given month. Patients pay Bs 36 for health cards which are valid for three months and entitle them to weekly visits during that period. These cards are stamped weekly after the visits. Valid cards with up-to-date stamps are required by law for commercial sex workers (CSWs) who can be arrested without them. A total of 2,381 cards were sold during the thirteen month period from January 1994 through January 1995, generating income of Bs 85,716.²

In theory, 600 individuals would purchase 2,400 cards during a twelve month period, generating Bs 86,400 in income, and if each had an average of four visits per month, the cost per visit would be Bs 3. In practice the pattern of visits is more irregular. The sample indicated that the trend is for patients to buy a card, have an average of 2.87 visits during a consecutive three month period, go a month or so without visits, and then to once again begin regular visits.³ This high variance is illustrated in Table 1. In one example the month with the highest number of visits for a client is compared to the month with the lowest number of visits for that client and is used to calculate the average number of visits for the sample. The average number for the highest month is 3.857 visits per month, over five times the average for the lowest month, of .743 or less than one visit during the month per patient in the sample. Frequency of visits is presented for the sample in Tables 2 and 3. The magnitude of this variance was not reflected in the number of consultations per month nor in the number of cards sold. The implication is

²See Table 10.

³See Tables 1 and 10.

that more than 600 individuals are seen during a month.

Estimates of the number of individuals⁴ seen during a month are presented in Tables 1 and 4. The estimated number of monthly consultations, 2,400, is divided by the average number of visits for a specific time frame. Once again high variance is noted. Given trends noticed on case history cards, i.e. a pattern of regular visits followed by a month or so with visits of one or zero, as well as the number of card purchases, at least 800 individuals are seen over the course of a year, and they probably purchase cards three times a year.⁵ The yearly income generated by these purchases would be Bs 86,400, identical to that generated by 600 individuals purchasing four cards a year. Clinic personnel reported that while a card is valid until a certain date, in practice, if a patient has only used the card for a month, then not visited the clinic, and returns after the card has expired, he/she is allowed to use the expired card until twelve visits have been completed.

Patient flows are regulated by assigning appointments in the morning or afternoon on specific days. Staff estimate that 90% of the patients show up on schedule. When they arrive, they receive a number and are seen on a first-come-first-serve basis. Waiting periods vary from fifteen to forty minutes depending on time of arrival and on whether the patient has had lab tests and is waiting for the results. The average length of a consultation with the doctor is from 5-7 minutes. Hours for appointments are from 8:30 to 12:00 in the mornings and 2:00 to 5:30 in the afternoons.

Staff to handle patient appointments consist of three part-time doctors⁶, the USAID project doctor who fills in as-needed, four part-time auxiliary nurses,⁷ four university graduate nurses, the program director who also fills in as-needed. A part-time physician, according to Secretariat regulations, has a four hour work day of which three hours are to be spent seeing patients, and the fourth hour in preparation or training. During the morning shift once doctor works from 8:30 to 11:30 and the other works from 9:00 to 12:00. In the afternoon the part time doctor

⁴Individuals as opposed to the number of consultations.

⁵Card purchases are not tracked by name, but given irregular attendance patterns, three purchases a year seems reasonable.

⁶All doctors are trained gynecologists. Two work in the mornings and one in the afternoon.

⁷There are five auxiliary nurses listed on the payroll, but only four work in the program on a given day. The fifth rotates between the STD clinic and the vaccination program.

sees patients from 2:30 to 5:30 in the afternoon, and is assisted by the full time physician who begins consultations at 2:00 and finishes at 5:00.⁸ Assuming two doctors in the morning and afternoon, this translates into 60 hours a week, or 6 minutes per patient if 600 patients are seen, or about 5 minutes per patient if 700 patients are seen.

III. SERVICES AND THEIR COSTS

Over the past year this clinic has provided four kinds of service to its patients. These include examinations by trained gynecologists, lab tests frequently with results in a matter of minutes, limited pharmaceutical facilities,⁹ and training.¹⁰ Most of these services are included in the cost of the health card. Additional charges are made for some of the lab tests, especially when they are not done at the clinic.

Internal examinations are typically conducted during her/his regularly scheduled appointments. There is no additional charge for these exams. Physicians examine the patients and look for signs of STDs; if symptoms are present, additional lab tests may be ordered. On the first visit a medical history is recorded for each patient.

Lab tests are administered according to specific schedules. These tests are 1) gonorrhea, primary and complete, 2) FA Chlamydia, 3) RPR, 4) RPR+FTA-ABS, 4) VDRL, 5) gram stain, 6) fresh slide exam, 7) HIV, 8) pap smear.¹¹ Primary gonorrhea, gram stain, fresh slide, and FA Chlamydia are done every two months. In about 20% of the cases, when the patient tests positive in the primary gonorrhea, a complete test or series of cultures is carried out and this doubles the cost. Three tests for syphilis are used: RPR, VDRL, and RPR+FTA-ABS. RPR and VDRL are each administered to all patients once every three months. If a patient tests positive (about 10%), then the RPR+FTA-ABS is done. The cost of VDRL (about Bs 1.78) is less than that of RPR (Bs 3.32); however, the disadvantage of using VDRL, is that once a batch is opened, it must be used within a week. VDRL tests on

⁸The director reported that patients are seen for three and a half hours in both the morning and the afternoon.

⁹A limited variety of medicines are sold at cost in the clinic. Usually these are used to treat the specific STDs identified by the lab tests. They are prepackaged with the correct number for the treatment and are sold at cost.

¹⁰Training is not currently being carried out, but has been in the past.

¹¹See Table 11 for the cost of each test.

done on-site in the lab at the clinic and a charge of Bs 10 is levied. A patient who tests positive is retested in six weeks. Tests for HIV are carried out every six months. The patient is given a prescription at the Pilot Center, but goes to another clinic (ILASA) in Miraflores to have the test done, and is charged there. Pap smears are given on the premises every 12 months.

The quarterly costs per patient of the exams administered at the Pilot Center are listed on Table 11. They range from Bs 42.17 to Bs 73.96, depending on whether or not results on a given test are positive so that more follow-up tests are needed. These costs do not include salaries of lab personnel. The monthly costs of lab tests to the program were calculated using an average of 600 patients a month.¹² Under this scenario the monthly average cost for tests administered on-site is Bs 13,539.96, without including the salaries of the lab technicians or biochemist. The sample was used to calculate the number of times a patient was tested for syphilis each year. The number of tests per patient in a specific time frame was annualized and these were used to determine the average for the sample. If patients were keeping regular appointments, one would expect the average number of tests per year to be four. However, as Table 8 demonstrates, they range from 1.76 to 2.49¹³. Using income received for VDRL tests during 1994¹⁴ to estimate the total number of tests administered, the result is 2,470 tests. This would be approximately the equivalent of 600 patients receiving tests quarterly, or 800 patients receiving tests three times a year.

Patients interviewed expressed satisfaction with the quality of the services. Results from tests for syphilis and chlamydia are available on the spot. Results from tests for gonorrhea are available in forty-eight hours. One person interviewed expressed a desire for more frequent tests and said she would be willing to pay.

Limited pharmaceutical facilities are available at the clinic. These consist of medicines packaged to treat the diseases most often diagnosed. They are sold at cost. A number of clients recommended that more drugs be stocked, including birth control pills.

¹²Although more individuals are treated, their attendance is irregular, and 600 patients each month is the equivalent of 800 patients three quarters of the year.

¹³Averages may be skewed because some patients may have a quarter without visits, and accordingly, without tests.

¹⁴Assuming Bs 10 per test.

Courses are not currently being offered, although they have been during the last year. Training is on-going and includes developing negotiation skills to convince clients to use condoms. It is currently in a transition/planning stage as trainers are working accommodate content materials and schedules to the needs of the women. A full-time trainer is paid by the Secretariat to coordinate these activities. There is no additional charge to the patients for training.

IV. COST RECOVERY

Cost data were collected from the project accountant at the Community and Child Health Project, which handles the HIV/STD project, from the administrator at the Pilot Center, and from other professional personnel at the center, including the biochemist who is in charge of the lab. These costs have been listed by who covers them (see Tables 5 and 6), and subsequently classified as fixed and variable (see Table 7). Fixed costs were defined as minimum personnel, services, supplies and materials necessary for the clinic to provide these services¹⁵, costs pertaining to building maintenance, office supplies, and miscellaneous. Variable costs include salaries to personnel employed to handle increased number of patients, including additional doctors, nurses, auxiliaries, lab technicians, trainers, costs of lab tests, disposable materials, medical supplies, office and educational supplies.

Fixed and variable costs are summarized on Table 7. The total monthly cost of operating the Pilot Center clinic is Bs 52,437.38.¹⁶ Variable costs sum Bs 33,468 or 63.8% of the total, whereas fixed costs are Bs 18,969.31 which is 36.2% of total costs. Contributions from USAID and the National Secretariat of Health¹⁷ are reported in Tables 5 and 6 respectively. USAID contributions at Bs 31,907.38 constitute 60.8% of the total while those of the Secretariat, Bs 20,530 are 39.2% of total costs. The monthly cost of lab tests, estimated at Bs 13,539.96¹⁸, is

¹⁵Fixed costs include salaries and benefits for the director, one full-time doctor, one biochemist, one nurse and one lab technician.

¹⁶Costs were collected for a typical month. Both variable costs and income tend to decrease in months that have extended holidays such as February with Carnival, April with Holy Week, and December with Christmas.

¹⁷The National Secretariat of Health is referred to on the tables as the Ministry of Health in this assessment.

¹⁸This does not include salaries of lab personnel.

40% of variable costs, 42.4% of the USAID contribution, and 25.8% of total costs.

Table 10 presents actual income from the sale of health cards and estimated income from charges for VDRL tests over the thirteen month period from January 1994 to January 1995. It also indicates what proportion of total costs, USAID contributions, and variable costs, would have been covered by total estimated income, had this income returned to the clinic. Estimates show that income covers 16.4% of total costs, 27% of variable costs, and 25.8% of the USAID contribution. Estimated monthly income from VDRL exams during the period averaged Bs 2,031 which only covers 15% of the cost of Bs 13,539.96. To cover estimated variable costs at the current patient level, income would have to increase by 3.7 times; to cover the current USAID contribution, it would need to be 3.9 times greater; to cover half of total costs (a goal mentioned in the project paper amendment) it would have to increase threefold¹⁹. Funds collected from lab charges would have to be 6.7 times greater to cover lab test costs.

Bookkeeping procedures are fairly well institutionalized in the clinic and conform to regulations of the National Secretariat of Health. Accordingly, the accuracy of recorded income figures can be trusted. Patients buy health cards from the clinic's cashier which is located in a section of the building separate from the consultation section. Funds collected are recorded in a log book, and purchasers receive official receipts. The log book is divided into sections according to sources of income, so that funds received from card purchases are recorded in one section whereas those received for VDRL tests are included in another. The clinic is a regional office from which eight different disease control programs are operated including TB, polio, cholera, malaria, yellow fever, leishmaniasis, as well as AIDS/stds. In addition, a vaccination program is run. Income from each of these programs is recorded in the book. The book is closed monthly. Cash collected is deposited in the bank within twenty-four hours after it comes in. The clinic's cashier passes the money to one of two regional cashiers who are responsible for its deposit. Three internal auditors are assigned to the regional clinic; their offices are in Miraflores.

V. SUSTAINABILITY ISSUES

If the program is to be sustainable after the USAID project is completed, additional sources of income must be identified and a sustainability strategy developed. It is expected that the support provided by the Ministry of Health will continue after the project completion date. However, the portion of costs being provided by USAID will need to be covered, or, from another

¹⁹Variable costs are more than half of total costs.

45

perspective, variable costs are only about 5% above the USAID contribution should be covered to attain sustainability.

Developing a sustainability strategy early on during the project extension is imperative. This process should include dialogue with the National Secretariat of Health, to discuss issues identified in this assessment and various options. Some of the issues which should be addressed during the development process are outlined below.

1. Reinvestment of income obtained from the sale of health cards into the clinic. This would provide income to cover about 27% of variable costs.²⁰ The approximately 33% of card income used to pay production bonuses could be used for that salary component of employees at the clinic.
2. Lab test costs are the largest component of variable costs, and charges levied for VDRL tests only cover 15% of these costs. Project personnel should explore the possibility of raising charges for lab tests. Were patients to be charged Bs 36 for a 3-month health card and the full costs of the tests, this would result in income of Bs 13,539.96 a month, which, if added to health card income would total Bs 20,133.50, sufficient to cover 60% of variable costs. However, it would also mean increased charges to the patients of from 89%-139%²¹.
3. Maintaining the health card charge at Bs 36 for three months, but only requiring visits every two weeks would increase income by permitting greater numbers of individuals to be seen. If the number of individuals seen were to increase to 1,200, income from that source could increase by 50% to Bs 10,800 a

²⁰Currently these funds are transferred to the National Secretariat where about thirty-three percent are used to pay salary bonuses. Bonuses are provided to personnel to compensate for specialized training, specific positions, seniority, etc. It is estimated that bonuses increase base pay at the clinic from about 6% to 91%.

²¹This scenario assumes a patient currently pays quarterly Bs 36 for a health card and Bs 10 for a VDRL test. Under the new pricing system the patient would continue to pay Bs 36 for the health card and from Bs 42.17 to Bs 73.96 additional for a lab test. See Table 11.

month²². If, in addition, patients were required to pay the full costs of lab tests, approximately Bs 24,339 would be generated, enough to cover about 71% of variable costs.²³

4. Limit the use of a health card to the time period for which it is valid. This might well encourage patients to visit regularly because they would understand that they had prepaid for services.
5. Look for other sources of income. Currently CSWs pay Bs 40 every three months in matriculation fees for a card from the police. If 75% of this income were to be used for the STD program, that would increase income by an estimated Bs 6000 to Bs 12,594 which would cover about 36% of variable costs. Owners of establishments where the CSWs work might also be asked to contribute to health costs.

Project personnel, along with the Secretariat of Health, should study all of these options and also study ways to lower operational costs of the clinic. Sustainability will probably require using suggestions from a number of the options listed, i.e. raising lab charges, but continuing a subsidies; decreasing the number of required clinic visits, and identifying other sources of income. Other donors could also be identified and approached.

A final aspect is that beneficiaries of this program number far more than the CSWs who visit the clinic. A multiplier factor operates since every partner of the CSWs, and their partners, in turn, benefit from this program. It is estimated that it costs approximately Bs 629,248 or US\$ 133,883 a year to operate the Pilot Center. If one calculates that each of the approximately 800 CSWs has an average of ten partners a week, then that is a cost of Bs 71.50 or US\$ 15.21 per person per year, and with the multiplier factor, the cost to beneficiary ratio decreases more.

²²This is calculated by assuming that 1,200 women would buy cards 3 times a year. Monthly income = $(1,200 \times 3 \times 36)/12$.

²³Patients could be seen during current time slots without hiring another physician. Another lab technician would be needed to process additional tests at a cost of approximately Bs 676 a month.

ANNEX A
TABLES

1. AVERAGE NUMBER OF MONTHLY VISITS & COST PER VISIT

	4th Qtr. CY/94	Last 4 months CY/94	3 consec. months w/ highest # visits from 6/94-1/95	3 consec. months w/ lowest # visits from 6/94-1/95 ²	1 month w/ highest number of visits per patient ³	1 month w/ lowest number of visits per patient ⁴
Avg. # monthly visits per individual	2.124	2.179	2.87	1.77	3.857	.743
Total # estimated individuals ⁵ seen per month	1,130	1,101	836	1,356	622	3,230
Cost per visit ⁶	Bs 5.65	Bs 5.51	Bs 4.18	Bs 6.78	Bs 3.11	Bs 16.15

¹Using case histories, a three month period with the highest number of visits per patient was selected. A monthly average (based on these three months) was calculated for each patient and these in turn were averaged to determine the monthly average for the sample.

²Uses case histories to determine the 3 month period in which each patient had fewest visits. Monthly averages for each patient are calculated and these are subsequently used to determine the monthly averages for the sample.

³Case histories are used to determine the month with the highest number of visits for each patient, and these are used to calculate the monthly average for the sample.

⁴Case histories are used to determine the month with the lowest number of visits for each patient. Total number of visits for the lowest month for each patient are summed and used to calculate the average for all patients in the sample.

⁵To estimate patients seen in a month, 2,400 is divided by the average number of visits per person for the time period.

⁶Assumes that each patient buys a health card which costs Bs 36 and is valid for three months. The average number of monthly visits is multiplied by three and divided into Bs 36.

2. FREQUENCY OF AVERAGE NUMBER OF MONTHLY VISITS FOR SAMPLE¹

	4th Qtr. CY/94	Last 4 months CY/94	3 consec. months w/ highest # visits from 6/94-1/95 ²	3 consec. months w/ lowest # visits from 6/94-1/95 ³
Average no. monthly visits	No. of Patients	No. of Patients	No. of Patients	No. of Patients
< 1	2	2	0	5
1 to < 2	12	13	4	16
2 to < 3	14	12	13	10
3 to < 4	6	7	10	3
4 to > 4	1	1	8	1

¹Sample size: 35 patients

²Using case histories, a three month period with the highest number of visits per patient was selected. A monthly average (based on these three months) was calculated for each patient and these in turn were averaged to determine the monthly average for the sample.

³Using case histories, a 3 month period with the lowest number of visits for the patient was selected. A monthly average (based on these three months) was calculated for each patient and these in turn were averaged to determine the monthly average for the sample.

**3. FREQUENCY OF NUMBER OF MONTHLY
VISITS FOR SAMPLE¹
USING HIGHEST AND LOWEST MONTHS**

	1 Month with Highest Number of Visits per Patient from 6/94-1/95²	1 Month with Lowest Number of Visits per Patient from 6/94-1/95³
Number of monthly visits	No. of Patients	No. of Patients
< 1	0	18
1 to < 2	0	11
2 to < 3	5	4
3 to < 4	6	1
4 to > 4	24	1

¹Sample size: 35 patients

²Case histories are used to determine the month with the highest number of visits for each patient, and these are used to calculate the monthly average for the sample.

³Case histories are used to determine the month with the lowest number of visits for each patient. Total number of visits for the lowest month for each patient are summed and used to calculate the average for the sample.

21

**4. ESTIMATED NO. OF INDIVIDUAL PATIENTS SEEN PER MONTH
AND CORRESPONDING INCOME FROM CARDS¹**

	4th Qtr. CY/94	Last 4 months CY/94	3 consec. months w/ highest number of visits from 6/94-1/95	3 consec. months w/ lowest number of visits from 6/94- 1/95	1 month w/ highest number of visits per patient	1 month w/ lowest number of visits per patient
AVG. NO. OF INDIVIDUALS SEEN PER MONTH	1,130	1,101	836	1,355	620	3,230
MONTHLY INCOME FROM CARDS	Bs 10,170	Bs 9,909	Bs 7,524	Bs12,195	Bs 5,580	Bs29,070

¹Number of individuals estimated given an average of 600 consultations a week and 2,400 per month. 2,400 was divided by the average number of visits in sample for each time period. See Table 1. Income was calculated using the assumption that each individual purchases 3 cards per year; i.e. estimated number of patients x 36 x 3. Three cards purchased per year seems reasonable given the high variation in number of visits. See Tables 1-3.

5. MONTHLY COSTS PAID BY USAID PROJECT (in bolivianos)

I. SALARIES AND BENEFITS¹

1 doctor (full time)	4,550.00
2 nurses (part time) 1114.72 ea. ²	2,415.22
1 biochemist (full time)	3,671.42
1 lab technician (part time)	676.28
1 lab technician (contracted part time)	524.00
Transportation	460.00
Total	12,296.92

II. LAB EXAMS³

Gonorrhea (primary) ea. 18.84 ⁴	4,521.60
Gonorrhea (complete) ⁵	2,260.00
FA Chlamydia ⁶ ea. 9.42	2,826.00
RPR, ⁷ ea. 3.32	665.94
VDRL ea. 1.775	235.50
FTA-ABS ea. 10.81 ⁸	216.20
Gram Stain ea. 4.70 ⁹	1,401.00
Fresh slide exam ¹⁰ ea. 4.70	1,401.00
Total	13,539.96

¹ Adjusted to include Christmas bonus.

² One works morning shift while the other works afternoon shift.

³ An average of 600 patients was used to estimate monthly costs of exams. However, this may be underestimated because over the course of a year the clinic sees more than 600 patients, since patients tend to visit regularly during the quarter for which their card is valid and then to drop out for several months before returning. However, patients who drop out are replaced by others, and accordingly, in a given month, the patient flow remains regular. It is estimated that from 800 to 1,100 individuals are seen over the course of a year. Exchange rate used to estimate boliviano costs is US\$1 = Bs4.71

⁴ Given every two months. Monthly cost estimated at $18.84/2 \times 600 \times .8$. For about 80% of the clients the primary culture is sufficient. 20% test positive and need the complete culture.

⁵ Requires additional cultures. Given to patients who test positive, about 20% of those given primary test. Accordingly, it is also carried out once every two months. $37.68/2 \times 600 \times 2$.

⁶ Given every two months. Monthly cost estimated at $9.42/2 \times 600$.

⁷ RPR Tests for syphilis; given approximately every 3 months. Estimated monthly cost $3.3297/3 \times 600$. All patients in addition receive VDRL tests for which they pay Bs10. Those with positive RPR tests receive FTA-ABS.

⁸ About 10% of the patients test positive on the RPR and are given the FTA-ABS in addition. Cost = $10.81/3 \times 600 \times .1$.

⁹ Administered every 2 months. Cost = $4.70/2 \times 600$.

¹⁰ Administered every 8 weeks. Monthly cost estimated at $4.70/2 \times 600$.

7. FIXED AND VARIABLE COSTS PAID BY USAID AND MINISTRY¹

FIXED COSTS

Staff & Benefits	13,768.31
Utilities & Repairs	1,417.00
Travel	2,117.00
Miscellaneous	1,467.00
Office Supplies	200.00

Total 18,969.31

VARIABLE COSTS

Staff & Benefits	12,924.61
Lab Tests	13,539.46 ²
Disposable Materials	6,071.00
Medical Supplies	400.00
Office & Educational Supplies	533.00

Total 33,468.07

GRAND TOTAL 52,437.38

¹Fixed costs are defined as minimal costs necessary to run the program whereas variable costs vary according to the number of patients seen during a given period. Fixed staff costs include one director, one full-time doctor, one biochemist, one nurse, one secretary, one lab technician and benefits such as transportation.

²Calculated based on 600 patients seen each month. The probable number of individuals is closer to 800, but they tend not to come every month. 800 patients with regular visits for the equivalent of 9 months a year would result in income and costs equal to 600 patients attending 12 months a year.

8. AVERAGE NO. SYPHILIS TESTS PER WOMAN PER YEAR¹

TIME PERIOD	LAST 8 MONTHS CY 94 (6/94-12/94)	4TH QTR. CY94	LAST 4 MONTHS CY94	LAST 4 MONTHS (10/94-1/95)
AVG. NO. TESTS PER YEAR ²	1.76	2.17	2.49	1.89

**9. ESTIMATES OF MONTHLY INCOME FROM VDRL TESTS
BY ESTIMATES OF PATIENT FLOW³**

ESTIMATED NO. OF INDIVIDUAL PATIENTS SEEN	ESTIMATED MONTHLY INCOME ⁴
1,130	Bs 3,766
1,101	Bs 3,670
836	Bs 2,787
1,356	Bs 4,520
622	Bs 2,073
3,320	Bs 10,767

¹Calculated using sample of 35. Uses various time frames as identified in table.

² Number of total visits was summed and divided by n=35 and then annualized.

³Estimated patient flows identified in table 1.

⁴Assumes each individual is tested quarterly and that cost is Bs 10 per test. Estimated income = # patients x Bs 10/3.

III. DISPOSABLE MATERIALS

	6,071.00
Total	6,071.00
GRAND TOTAL	31,907.38

96

6. MONTHLY COSTS PAID BY MINISTRY OF HEALTH (in bolivianos)

I. SALARIES AND BENEFITS¹

3 doctors (half time) ² 1,200 ea.	3,900.00
2 nurses w/ univ. degree (part time) ³ 1050 ea.	2,275.00
4 nurses aids (part time) ⁴ 618 ea.	2,678.00
Director of Program (full time)	2,383.00
Trainer ⁵ (full time)	2,340.00
Secretary	670.00
Transportation	150.00

Total 14,396.00

II. UTILITIES AND REPAIRS 1,417.00

III. SUPPLIES

Office and Educational	733.00
Medical	400.00

Total 1,133.00

IV. TRAVEL 2,117.00

V. MISCELLANEOUS

Snacks	400.00
Cleaning	580.00
Uniforms	417.00
Communication	70.00

Total 1,467.00

GRAND TOTAL 20,530.00

¹Adjusted to include benefits.

²Half-time as defined by the Ministry of Health means 3 hours a day of patient consultant and using the fourth hour for study or preparation. Two doctors work in the morning and one in the afternoon. There should be an additional half time doctor in the afternoon. Currently, the project doctor fills in, but his duties are coordination and training personnel at other clinics rather than seeing patients. One of the half-time physicians currently earn Bs 1,200 per month. Two have salaries of Bs 712 each, but expect to present documentation showing their certification in gynecology to the Ministry within the next few months so that their salaries will also increase to Bs 1,200 a month paid retroactively to the first of the year.

³Part time is defined by the Ministry as 4 hours of work and 2 hours for study. One nurse works in the morning and one in the afternoon.

⁴Part time as defined by the Ministry is the same for aids, 6 hours a day, of which 4 are spent working with patients. 2 aids work in the morning and three in the afternoon.

⁵The trainer supervises and sets up courses.

10. COST COVERAGE WITH INCOME FROM HEALTH CARDS AND LAB CHARGES

MONTH	TOTAL INCOME FROM HEALTH CARDS ¹	TOTAL NUMBER CLIENTS PURCHASING CARDS	TOTAL INCOME FROM LAB CHARGES ²	PERCENT OF TOTAL COSTS COVERED W/ LAB & CARD INCOME	PERCENT OF USAID COSTS COVERED W/ LAB & CARD INCOME	PERCENT OF TOTAL VARIABLE COSTS COVERED W/ LAB & CARD INCOME
JAN '95	7,560	210	2,330	18.9	31.0	29.6
DEC '94	7,128	198	2,190	17.8	29.2	27.8
NOV	7,560	210	2,330	18.9	31.0	29.6
OCT	6,624	184	2,040	16.5	27.2	25.9
SEPT	6,336	176	1,950	15.8	26.0	24.8
AUG	7,596	211	2,340	18.9	31.1	29.7
JULY	7,560	210	2,330	18.9	31.0	29.6
JUNE	7,020	195	2,160	17.5	28.8	27.4
MAY	6,048	168	1,860	15.1	24.8	23.6
APR	5,148	143	1,590	12.8	21.1	20.1
MAR	6,444	179	1,990	16.1	26.4	25.2
FEB	5,148	143	1,590	12.8	21.1	20.1
JAN	5,544	154	1,710	13.8	22.7	21.6
TOTAL	85,716	2,381	26,410	16.4	27.0	25.8

¹Actual income received as officially recorded. All income is in bolivianos.

²Income collected for charges in Jan. '95 is actual. For all other months it is estimated. All income is in bolivianos.

**11. COSTS OF LAB TESTS PER PATIENT
OVER 3 MONTH PERIOD
(in bolivianos)**

LOW ESTIMATE		HIGH ESTIMATE	
GONORRHEA (primary)	18.84	(complete)	37.68
CHLAMYDIA	9.42		9.42
RPR	3.33	+ FTA-ABS	14.13 ¹
VDRL	1.18		1.18 ²
Gram Stain	4.70		4.70
Fresh Slide	4.70		4.70
Total	42.17		73.96

¹FTA-ABS is given when the patient tests positive on RPR.

²VDRL is required by the Ministry of Health of all patients who are charged Bs 10 for each test. Tests are given once every 3 months.

ANNEX B

PERSONS AND INSTITUTIONS CONTACTED

PERSONS AND INSTITUTIONS CONTACTED

CENTRO PILOTO

Lic. Rita Condorri, Técnico de Laboratorio.
Dr. Eduardo Negrón, Jefe Programa.
Sra. Zaida Tavel, Secretaria.
Lic. Freddy Tinajeros, bioquímico.
Sr. Constantino Vargas, Administrador.
Dr. Juan Vega, ginecólogo.
Dra. Ana Maria Wayar, capacitación.
Lic. Telva Zapata, Supervisión Enfermería.

PROGRAMA DE CONTROL DE ETS/SIDA

Fabio Ortega, Gerente Administrativo del Proyecto.

USAID/BOLIVIA

Paul Ehmer, Chief of Health and Human Resources.
Isabel Stout, Project Coordinator.

PROCUREMENT PLAN 1995

ANNEX 5

IMPLEMENTATION ACTIONS	DESCRIPTION	DATE PIO/T	DATE REQUIRED	AMOUNT	RESPONSIBLE PARTY
AMENDMENT TO BILATERAL PROGRAM	Obligate FY 95 Funds	N/A	03/95	\$ 800,000	HHR/PDI
PROJECT IMPLEMENTATION LETTERS	Approve 1995 Budget	N/A	03/95	N/A	HHR/PDI
PSC CONTRACT	Project Manager for AIDS Project	03/95	06/95	\$ 50,000	HHR/RCO
HCC HBII CONTRACT	Audit 1994	N/A	04/95	\$ 10,000	CCH/ PROGRAM COLAB./ USAID/CONT.
PASA AMENDMENT 511-0608-PHC- 2015	CDC for Technical Assistance in medical, laboratory and IECC areas	04/95	05/95	\$ 100,000	HHR/RCO
BUY-IN	Assessment of behavior interventions	05/95	07/95	\$ 40,000	HHR/RCO
BUY-IN	To be determined	06/95	08/95	\$ 50,000	HHR/RCO
FSN PSC CONTRACT	Extend secretarial services	06/95	08/95	\$ 15,000	HHR/EXO

102

PROCUREMENT PLAN 1996

ANNEX 5

IMPLEMENTATION ACTIONS	DESCRIPTION	DATE PIO/T	DATE REQUIRED	AMOUNT	RESPONSIBLE PARTY
AMENDMENT TO BILATERAL PROGRAM	Obligate FY 96 Funds	N/A	02/96	‡ 800,000	HHR/FDI
PROJECT IMPLEMENTATION LETTERS	Approve 1996 Budget	N/A	02/96	N/A	HHR/FDI
HCC HB II CONTRACT	Audit 1995	N/A	03/96	‡ 10,000	CCH/ PROG. COLABOR/ USAID/CONT.
PASA AMENDMENT 51 1-0608-PHC-2015	CDC for Technical Assistance in medical, laboratory areas	02/96	04/96	‡ 50,000	HHR/RCO
PSC CONTRACT	Extend final project manager AIDS	04/96	06/96	‡ 50,000	HHR/RCO
FSN PSC CONTRACT	Extend final secretarial services	06/96	08/96	‡ 15,000	HHR/EXO
BUY-IN/IOC	Second mid-term evaluation	10/96	01/97	‡ 50,000	HHR/RCO

103

PROCUREMENT PLAN 1997

ANNEX 5

IMPLEMENTATION ACTIONS	DESCRIPTION	DATE TO RCO	DATE REQUIRED	AMOUNT	RESPONSIBLE PARTY
PROJECT IMPLEMENTATION LETTERS	Approve 1997 Budget	N/A	02/97	N/A	HHR/PDI
PASA AMENDMENT 511-0608-PHC-2015	CDC for Technical Assistance in medical, laboratory and IECC areas	02/97	04/97	\$ 50,000	HHR/RCO
HCC HBII CONTRACT	Audit 1996	N/A	03/97	\$ 12,000	CCH/ PROG. COLABOR/ USAID/CONT
PSC CONTRACT	Extend final project manager AIDS	04/97	06/97	\$ 30,000 through 03/98	HHR/RCO
FSN PSC CONTRACT	Extend final secretarial services	06/97	08/97	\$ 8,000 through 03/98	HHR/EXO
BUY-IN/IOC	Final evaluation	11/97	02/98	\$ 50,000	HHR/RCO
HCC HBII CONTRACT	Final audit	01/98	03/98	\$ 15,000	CCH/ PROG.COLABOR./ USAID/CONT.

104

INITIAL ENVIRONMENTAL EXAMINATION
OR
CATEGORICAL EXCLUSION

PROJECT COUNTRY: Bolivia

PROJECT TITLE AND NO.: AIDS/STD Prevention and Control (Amendment)
(511-0608)

FUNDING: \$4.0 million (original); \$5.4 million (as amended)

IEE PREPARED BY: Michael Yates, ENR Officer

IEE APPROVED BY: Lewis W. Lugke, Director, USAID/Bolivia

ENVIRONMENTAL ACTION RECOMMENDED:

Positive Determination	_____
Negative Determination	_____
Categorical Exclusion	XXX
Deferral	_____

SUMMARY OF FINDINGS: The purpose of the AIDS/STD Prevention and Control Project is to reduce the prevalence of AIDS and other sexually transmitted diseases (STDs). Major project components include prevention, education, HIV/STD testing and treatment, training, quality control in laboratories and STD clinics, surveillance, and condom distribution. The project received a categorical exclusion when reviewed on June 18, 1991 (LAC-IEE-91-58), when it was determined that it "consists of activities for which there are no foreseeable, direct, significant impacts on the environment." The review further noted that "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."

The proposed amendment will add additional funding to this successful activity, and extend the project's PACD. No significant substantive changes are proposed. Based on this assessment, USAID/La Paz recommends a categorical exclusion for this amendment to the Project.

CONCURRENCE:

Bureau Environmental Officer:

APPROVED: _____
DISAPPROVED: _____
DATE: _____

105

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 (PY 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

106

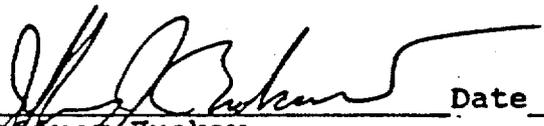


U.S. AGENCY FOR
INTERNATIONAL
DEVELOPMENT

LAC-IEE-95-13

ENVIRONMENTAL THRESHOLD DECISION

Project Location : Bolivia
Project Title : AIDS/STD Prevention and Control (Amendment)
Project Number : 511-0608
Funding : \$ 4 million (original); \$5.4 million (amendment)
Life of Project : 1995 - 1998
IEE Prepared by : Michael Yates, Environmental Officer
Recommended Threshold Decision: Categorical Exclusion
Bureau Threshold Decision : Concur with Recommendation
Comments : None

 Date 3/29/95
Jeffrey Brokaw
Chief Environmental Officer
Bureau for Latin America
and the Caribbean

Copy to : Lewis W. Lucke
Director USAID/Bolivia
Copy to : Mike Yates, Mission
Environmental Officer,
USAID/Bolivia
Copy to : Bruce Kernan, REA/SA
USAID/Ecuador
Copy to : Gordon Bertolin, LAC/SPM
Copy to : Dan Lesmez, LAC/SAM
Copy to : IEE File

INITIAL ENVIRONMENTAL EXAMINATION
OR
CATEGORICAL EXCLUSION

PROJECT COUNTRY: Bolivia

PROJECT TITLE AND NO.: AIDS/STD Prevention and Control (Amendment)
(511-0608)

FUNDING: \$4.0 million (original); \$5.4 million (as amended)

IEE PREPARED BY: *[Signature]* Michael Gates, ENR Officer

IEE APPROVED BY: Lewis W. Lucke, Director, USAID/Bolivia *[Signature]*

ENVIRONMENTAL ACTION RECOMMENDED:

Positive Determination	_____
Negative Determination	_____
Categorical Exclusion	_____ XXX _____
Deferral	_____

SUMMARY OF FINDINGS: The purpose of the AIDS/STD Prevention and Control Project is to reduce the prevalence of AIDS and other sexually transmitted diseases (STDs). Major project components include prevention, education, HIV/STD testing and treatment, training, quality control in laboratories and STD clinics, surveillance, and condom distribution. The project received a categorical exclusion when reviewed on June 18, 1991 (LAC-IEE-91-58), when it was determined that it "consists of activities for which there are no foreseeable, direct, significant impacts on the environment." The review further noted that "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."

The proposed amendment will add additional funding to this successful activity, and extend the project's PACD. No significant substantive changes are proposed. Based on this assessment, USAID/La Paz recommends a categorical exclusion for this amendment to the Project.

CONCURRENCE:

Bureau Environmental Officer:

APPROVED: _____
DISAPPROVED: _____
DATE: _____

APPR: JB 
DRAFT: EF (EF)
CLEAR: ()
CLEAR: ()
CLEAR: ()
CLEAR: ()
CLEAR: ()

UNCLASSIFIED

AID/LAC/RSD/E:EFAJER:EF:IEE95-13.CAB
02/28/95 647-5677
AID/LAC/RSD/E:JBROKAW

ROUTINE LA PAZ, QUITO

AIDAC LA PAZ FOR M.YATES, QUITO FOR B.KERNAN

E.O. 12356: N/A

TAGS:

SUBJECT: ENVIRONMENTAL THRESHOLD DECISION FOR AIDS/STD
PREVENTION AND CONTROL (AMENDMENT) (511-0608)

REF: BOLIVIA FAX, STOUT TO FAJER, 03/16/95

1. LAC CHIEF ENVIRONMENTAL OFFICER, JEFFREY BROKAW, HAS
REVIEWED, AND HEREBY APPROVES MISSION REQUEST FOR A
CATEGORICAL EXCLUSION.

2. IEE NUMBER IS LAC-IEE-95-13. COPY OF ENVIRONMENTAL
THRESHOLD DECISION IS BEING SENT TO MISSION FOR INCLUSION
IN PROJECT FILES. YY

UNCLASSIFIED

109

ANNEX 5.5.

Agency for International Development
Washington, D.C. 20523

LAC-IEE-91-58

ENVIRONMENTAL THRESHOLD DECISION

<u>Project Location</u>	:	Bolivia
<u>Project Title</u>	:	AIDS/STD Prevention and Control, Project Amendment
<u>Project Number</u>	:	511-0608
<u>Funding</u>	:	\$4 million
<u>Life of Project</u>	:	4 Years (FY 91-94)
<u>IEE Prepared by</u>	:	John Wilson, LAC Deputy Chief Environmental Officer
<u>Recommended Threshold Decision</u>	:	Categorical Exclusion
<u>Bureau Threshold Decision</u>	:	Concur with Recommendation
<u>Comments</u>	:	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

1110

AIDS/STDs PREVENTION AND CONTROL PROJECT

NOTE: The Statutory list for this project was prepared for Amendment Number 1 in July of 1991 and the basic findings remain current.

111



MINISTERIO DE DESARROLLO HUMANO
SECRETARIA NACIONAL DE SALUD
Bolivia



0647

Cite Nº _____

SSS/052/95

La Paz. 1 de Febrero de 1995

**FILE COPY
RETURN TO
CENTRAL FILES**

Señor
Paul Ehmer
Director Recursos Humanos
USAID/Bolivia
Presente

FILE	OFFICE	ACTION	INFO
D			<input checked="" type="checkbox"/>
DD			
ECON			
RLA			
RCO			
EXO			
DP			
PD&I			<input checked="" type="checkbox"/>
CONT			
HHR			<input checked="" type="checkbox"/>
ARD			
EO			

Reply due... 2/22
Action tkn.....

De mi mayor consideración:

Cursa en los archivos de nuestro despacho la documentación correspondiente al Proyecto SIDA que USAID/Bolivia ha implementado en Bolivia. considerado como uno de los mas importantes y de mayor impacto.

Como es de su conocimiento este flagelo de la humanidad todavia no se presentó en Bolivia con la dimensión de tragedia como en otros países.

Creo sinceramente que USAID/Bolivia debería promocionar e implementar otros proyectos de apoyo técnico en bien de la salud de la población boliviana y particularmente de la mujer y el niño.

Es de conocimiento nuestro que este Proyecto debe terminar en la presente gestión, razón por la que me permito solicitar por su intermedio a las autoridades de USAID/Bolivia, accedan prolongar el periodo de tiempo de este Proyecto. a fin de alcanzar los objetivos trazados en el Plan a Mediano Plazo propuesto por la Secretaria Nacional de Salud.

Con este motivo. saludo a Ud. con las consideraciones mas distinguidas.

Dr. Javier Casas Guata C.
SUBSECRETARIO DE SALUD
SECRETARIA NACIONAL DE SALUD

06 FEB 1995

112