

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:						
	Project Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director		
Name (Typed)	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	\$150,000	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.