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SOCIAL DIALOGUES FOR THE IDENTIFICATION OF RISKS AND NEEDS RELATED TO THE SUSTAINABILITY OF COMMUNITY RESPONSES TO HIV, TUBERCULOSIS AND MALARIA IN BOLIVIA

BOLIVIA, 2017

SOCIAL DIALOGUES: SUSTAINABLE CIVIL SOCIETY IN BOLIVIA
Report on Risks and Assistance Needs – Action Plan

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EXECUTIVE SUMMARY

This report presents the results obtained from the implementation of the social dialogues[1] methodology in Bolivia for the identification of risks and technical assistance needs related to the sustainability of community responses to HIV, tuberculosis (TB) and malaria. Furthermore, it includes the action plan prepared by civil society to cope with the transition period.

Bolivia is a unitary, social State of Law, plurinational, communitarian, free, independent, sovereign, democratic, intercultural, decentralized and with several autonomies. It is politically divided into 9 departments and 339 municipalities. The country experienced its greatest GDP growth in 2013, with 6.83%. However, it began to register deceleration in 2014, until reaching 4.3% in 2016. Total public expenditure increased between 2010 and 2014, as it went from 9,526 million US dollars in 2010 to 20,544 million US dollars in 2014. Besides, in that same five-year period, public expenditure on health grew, going from USD 420 million to 1,002 million US dollars.

The HIV epidemic in the country is concentrated in two population groups: men who have sex with other men and trans women, with high prevalence in female sex workers as well. Reported cases are concentrated in urban areas of the central axis of the country (departments of La Paz, Cochabamba and Santa Cruz), with 87% of the total amount of cases in the country, and sexual transmission is the main mode of transmission (98% of cases). The reduction of the diagnosis gap is confirmed by the treatment cascade. However, a deeper analysis of that cascade reveals that gaps widen. There are difficulties to ensure linkage of diagnosed people to available services, as well as to ensure access to antiretroviral therapy (ART). Among all of them, the gap in suppression of viral load stands out.

Bolivia spent a total of 49 million US dollars for HIV control in the period between 2010 and 2013. More than 50% of that amount of money came from internal sources. The country allocates most of its funding to the so-called "more accessible population" (clients of STI clinics, high school students and health staff members).

According to TB incidence and burden estimates of the World Health Organization (WHO) corresponding to the period between 1990 and 2014, Bolivia has experienced a decline in TB incidence, going from 251 to 120 per each 100,000 inhabitants. Notified TB incidence shows a discreet yet constant reduction in the last 10 years. According to WHO estimates, the TB mortality rate, without including mortality in people with the HIV-TB coinfection, is of 8.6 per each 100,000 inhabitants, and drops up to 1.6 per each 100,000 inhabitants in people with that coinfection. National expenditure on TB during the 2011–2014 period amounted to 13.8 million US dollars, and 60.5% of that money came from internal sources.

[1] The methodology and results obtained from social dialogues already conducted are available in the following link: https://plataformalac.org/en/2017/03/social-dialogues-sustainable-civil-society/

Bolivia has registered a significant reduction of malaria morbidity as well as the elimination of mortality due to this disease, which is concentrated in the Amazon, with 96% of the total number of cases in the country. In 2016, 5,544 malaria cases were reported, and during the 2011–2013 period, national expenditure on malaria amounted to 14.7 million US dollars, of which almost 50% came from internal sources.

The general objective of the social dialogue for sustainability was to build a shared vision and joint planning regarding social, political and financial changes, as well as the challenges and opportunities they imply for civil society working in the fields of HIV, tuberculosis and malaria in Bolivia. To that effect, a highly participatory methodology was applied.

The main risks for the sustainability of community interventions responding to HIV, TB and malaria were identified during the social dialogue, and they are the following:

- Limited capacities in community organizations for evidence-informed political advocacy, especially regarding TB and malaria.
- Limited capacities and training to implement community strategies to respond to the diseases, especially regarding TB and malaria.
- Limited willingness or capacities for coordination between the different community organizations and movements.
- State's refusal to allocate budget to finance community components of the responses to the diseases.
- Lack of understanding between national programs responding to the diseases and civil society organizations (CSOs).
- Stigma and discrimination towards the diseases, which makes it politically difficult to obtain funding for community responses to the diseases, especially to HIV and TB.
- Lack of new leaders to ensure continuity of advocacy actions and include new demands.
- In the case of the response to malaria, the need for planning an intercultural response is ignored.

To address those risks, consensus was reached on the following technical assistance needs:

1. Capacity-building on evidence-informed political advocacy adjusted to the context of each disease. Special emphasis was put on advocacy to bring about compliance with the obligation to allocate budget to CSOs.
2. Capacity-building on the design and development of community strategies to respond to the three diseases, with special emphasis on TB and malaria.
3. Assistance for the creation of sustainable coordination networks and mechanisms, including monitoring mechanisms allowing to achieve the transition plan's objectives.
4. Assistance for the development of strategies to increase participation of CSOs in decision-making forums, with special emphasis on TB and malaria.
5. Technical and financial assistance for the design and implementation of social communication strategies for the reduction of stigma and discrimination, with special emphasis on TB and HIV.
6. Identification and strengthening of capacities of young leaders of the three movements.
7. Capacity-building for CSOs working in the response to malaria and vulnerable populations to establish links with government agencies responsible for ensuring intercultural interventions in the field of health.

ABREVIATURAS

ADESPROC	Asociación Civil de Desarrollo Social Libertad ("Libertad" Civil Association for Social Development)
AHF	AIDS Healthcare Foundation
API	Annual parasite index
ART	Antiretroviral therapy
ARV	Antiretroviral medicines
ASPACONT	Asociación de Pacientes contra la Tuberculosis (Patients Association against Tuberculosis)
CCM	Country Coordinating Mechanism
CIES	Centro de Investigación, Educación y Servicios (Research, Education and Service Center)
CPE	Political Constitution of the State
CRAT	Regional Technical Support Centre for Latin America & the Caribbean
CSO	Civil society organization
DOTS	Directly observed treatment, short course
DR-TB	Drug-resistant tuberculosis
FSW	Female sex worker
FUNDIEH	Fundación para la Docencia e Investigación de Enfermedades del Hígado (Foundation for Liver Diseases Teaching and Research)
GDP	Gross Domestic Product
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GO	Grassroots organization
HIV	Human immunodeficiency virus
ICALMA	Fundación de Cuidados Integrales (Foundation for Comprehensive Care Services)
IHD	Institute for Human Development
INE	Instituto Nacional de Estadística (National Institute of Statistics)
MDR-TB	Multidrug-resistant tuberculosis
MEFP	Ministry of Economy and Public Finance
MoH	Ministry of Health
MPD	Ministry for Development Planning

NASA	National AIDS Spending Assessments
NGO	Non-governmental organization
ONAEM	Organización Nacional de Activistas por la Emancipación de la Mujer (National Women's Rights Advocates Organization)
OTNB	Organización de Trabajadoras Nocturnas de Bolivia (Bolivia's Female Night Workers Organization)
OTRAF	Organización de Travestis, Transgéneros y Transexuales Femeninas de Bolivia (Bolivia's Transvestites, Transgenders and Female Transsexuals Organization)
PAHO	Pan American Health Organization
PDES	Economic and Social Development Plan
PEI	Institutional Strategic Plan
PGE	General State Budget
PNCT	National Program for Tuberculosis Control
POA	Annual Operational Program
PSDI	Comprehensive Sectoral Development Plan
PSP	Productive Social and Community Project
REDBOL	Red Nacional de Personas que viven con HIV y Sida en Bolivia (National Network of People Living with HIV and AIDS in Bolivia)
REDTRASEX	Red de Mujeres Trabajadores Sexuales de Latinoamérica y el Caribe (Network of Female Sex Workers from Latin America and the Caribbean)
RS	Respiratory symptomatic
SAFCI	Intercultural Community Family Health
STI	Sexually transmitted infection
SWOT	Strengths, weaknesses, opportunities and threats
TB	Tuberculosis
TB ALL FORMS	Tuberculosis in all its forms
TLGB	Trans, lesbians, gays and bisexuals
TREBOL	Trans Red de Bolivia (Trans Network of Bolivia)
TW	Trans woman
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
US dollars	United States dollars
WHO	World Health Organization

INTRODUCTION

This report presents the results obtained from the implementation of the social dialogues methodology in Bolivia for the identification of risks and technical assistance needs related to the sustainability of community responses to HIV, TB and malaria.

The first section of this report explains the national context of the diseases and the financing scheme for the responses to them. The next one shows the objectives set for this process and then explains the methodology applied. The main section presents the results of the process, particularly with respect to the consensus reached to build a shared vision on the situation of the diseases and the existing needs to respond to them from the communities. The mapping of key actors comes next (the results of the evaluation survey to participants appears in Annex 2), and then, the action plan. It starts with the general and specific objectives, and then continues with the strategic lines and action lines for each of the four specific objectives, which are followed by a timetable and a description of the mechanism for the plan's implementation.

Activities for the dialogue's preparation and implementation had place between October and November 2017.

1. NATIONAL CONTEXT OF THE DISEASES AND THEIR FINANCING SCHEMES

1.1. GENERAL INFORMATION

The Plurinational State of Bolivia, located in the heart of South America, has an area of 1,098,580 km² and three ecological floors determined by the Andes Mountain Range: highland, valleys and tropical plains (which cover the largest part of the country). In 2017, Bolivia had a population of 11,191,000 inhabitants and a very low population density of 10 inhabitants per km², concentrated in the cities of the central axis (La Paz, Cochabamba and Santa Cruz)[2].

Within the framework of its political constitution[3], the country is a unitary, social State of Law, plurinational, communitarian, free, independent, sovereign, democratic, intercultural, decentralized and with several autonomies. It is politically divided into 9 departments (La Paz, Cochabamba, Santa Cruz, Tarija, Chuquisaca, Potosí, Beni, Pando and Oruro) and 339 municipalities. Sucre is the constitutional capital of the country, while La Paz is the seat of government. On the economic front, it is currently considered as a lower-middle-income country[4], where more than 38% of the population lived in poverty in 2015[5] and at least 1 out of 5 inhabitants, in extreme poverty.

The population pyramid below (Illustration 1) shows that a significant reduction of birth and mortality rates is expected for the year 2030, which could lead to an increase in non-transmissible diseases.

[2] INE (2017)
[3] Political Constitution of the Plurinational State of Bolivia
[4] https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups
[5] https://datos.bancomundial.org/pais/bolivia

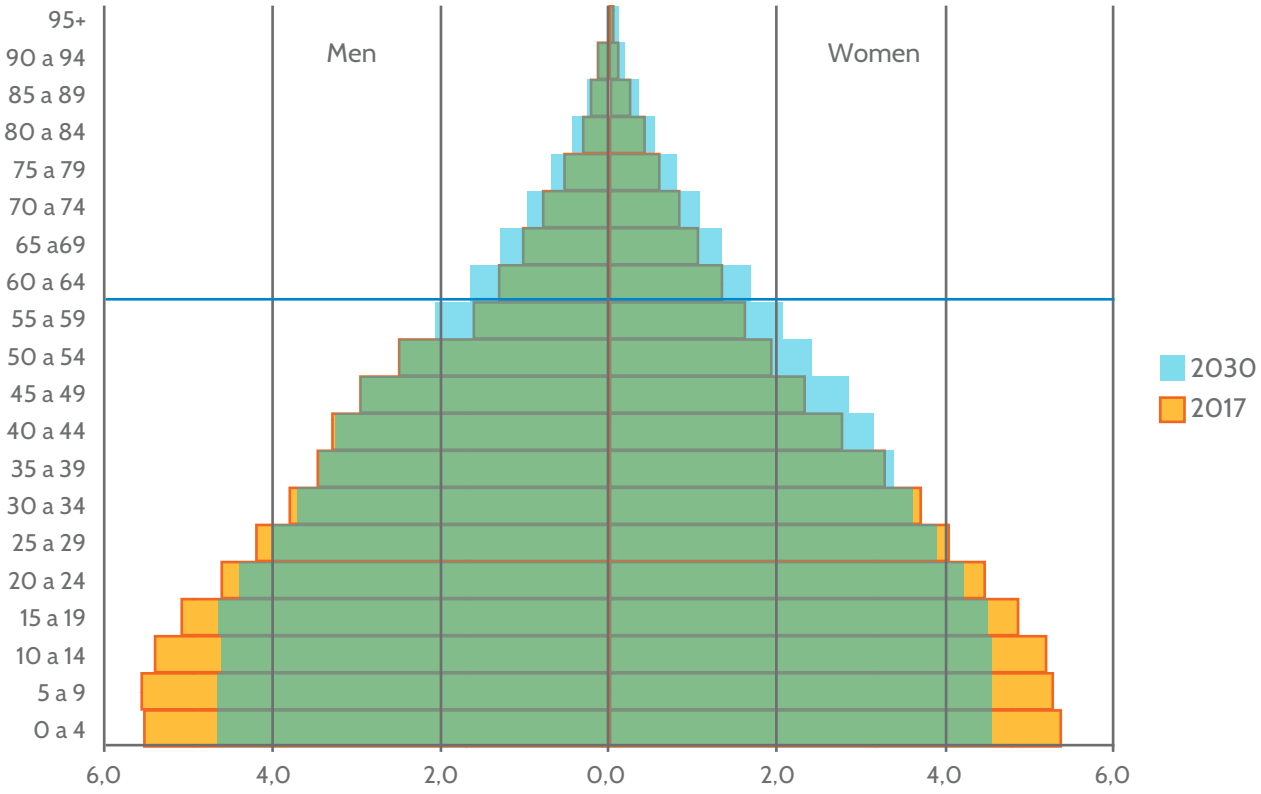


Illustration 1. Population pyramid: by age group and sex, 2017–2030 projections.
Source: National Institute of Statistics (INE), 2014 review.

1.1.1. Economic Overview

The country experienced its greatest GDP growth in 2013. However, it began to register deceleration in 2014, until reaching 4.3% in 2016[6]. The fall in natural gas exports has contributed to this set back in the country's economic growth. In fact, it was one of the reasons behind the 6.7% fiscal deficit registered in 2016. With this, for the third consecutive year, operations of the public sector show a negative balance and display a tendency not to improve.

Despite major losses of export revenues, the imports level has remained significantly high and, if anything, above the exports level. This is another reason behind the deficit in the balance of trade registered in 2015 for the first time, after eleven years of continuous surpluses.

In spite of the above, Bolivia's growth rate is above the regional average, and it is one of the least affected countries by the economic crisis.

[6] INE (2017), *óp. cit.*

1.1.2. Public Expenditure on Health

Sources of financing provide resources from public, private and external funds.

1. **Public funds** enter directly in the form of credits, donations, taxes, fees, patents and royalties from bilateral and multilateral agencies, public and private companies, and households.
2. **Private funds** are resources from private companies and households aimed at financing health services for their employees and families.
3. **External funds** are resources from overseas which are not part of the General State Budget (PGE). This means that they do not enter directly into the national treasury, but they are rather channeled through non-governmental organizations (NGOs), churches and foundations related to the sector. It is important to mention that in recent years, due to the rise in overseas migration, inward remittances being added to the family budget of households have increased, and they can be used and distributed for expenditure on health, education and housing, among others.

Subsequently, the sources of financing (the central government, public and private employers, households and external sources) channel available resources to the financial agents in charge of their administration.

1. The **central government**, as the main public policy-making body concerning health matters, provides resources to the public sector through the PGE. It also transfers resources to comply with its assurance policies, which are reflected on public health insurance programs and on Law N° 475 on comprehensive health service provision by the Plurinational State of Bolivia.
2. **Public and private employers** channel resources through employers' contributions to the short-term social security system, and only in the case of **private employers**, also through primes paid to insurance companies.
3. **Households** as sources of financing channel their resources to managing agencies belonging to the short-term social security system through voluntary contributions to insurance companies (in the form of primes or monthly installments) and themselves (in the family budget, of which a certain percentage is used for health services and, in some cases, they incur in catastrophic expenditure[7]).
4. **External sources** channel resources for NGOs, churches and foundations through donations, and then those institutions implement public health programs or projects, or provide some form of social health service.

The financing agents previously described decide where the collected resources go and how they are used, which is normally for payments to–or expenditure on–the different health service suppliers in the country.

Public health institutions generate revenue from the services they provide to managing agencies in places where the latter do not offer services (generally rural areas). Public health insurances are another source of revenue for these health institutions. The third source of revenue for the public sector are resource transfers so that those institutions can operate. They are carried out through the

[7] A family incurs in "catastrophic expenditure" when their health expenditure exceeds a specific percentage of the family income (generally 20%).

autonomous departmental and municipal governments (human resources, infrastructure, basic services, etc.). Moreover, NGOs make donations in cash or in kind to some public health institutions to support and reinforce some areas of their operations.

Furthermore, Bolivia's "Cajas de Salud" (Health Funds) generate revenue from the services they provide to public health insurances by virtue of agreements in force (Law N° 475), and they also receive budget allocations from the managing agencies so that they can provide health services to their insured population.

With respect to for-profit private services, they generate revenue from insurance companies, from managing agencies who do not provide some form of ancillary service and from households, through out-of-pocket expenditure.

Regarding traditional medicine, it generates revenue from households, while non-profit private services receive resources from NGOs, from public health insurances with which they have signed agreements and from households. It is important to note that the cost of health services in these health care facilities is much lower than in private practices.

Total public expenditure increased between 2010 and 2014, as it went from 9,526 million US dollars in 2010 to 20,544 million US dollars in 2014. Besides, in that same five-year period, public expenditure on health grew, going from USD 420 million to 1,002 million US dollars[8]. If both variables are taken into account, it can be stated that, on average, in those five years 4.5% of the total public expenditure was allocated to health. A further analysis allows to indicate that since the introduction of the Framework Law on Autonomy and Decentralization in 2011, autonomous departmental governments increased their expenditure on health from 12.1% in 2010 to 18,8% in 2011, until representing 22.7% of their total expenditure in 2014. During that same five-year period, autonomous municipal government registered an average health expenditure level of 10.9% of their total expenditure.

In Bolivia, public expenditure on health represents 4.6% of its GDP, which is above the regional average (3.7%), while private expenditure on health represents 2.1% of its GDP, which is far below the regional average (3.5%)[9].

[8] MEFP (2017)
[9] *Ibíd.*

1.2. EPIDEMIOLOGY OF HIV, TUBERCULOSIS Y MALARIA IN BOLIVIA

1.2.1. The Situation of HIV

Since the HIV/AIDS epidemic appeared in 1984, Bolivia has registered a continuous growth in the number of cases, the youth being the main population affected by it. National HIV prevalence in the general population (people between the ages of 15 and 49) is estimated to be 0.3%[10]. Until June 2017, a cumulative number of 19,151 cases of HIV/AIDS have been reported[11], with a constant increase in the notification of cases thanks to the expansion of HIV testing coverage, the implementation of a new diagnosis algorithm (use of rapid tests) and improvements in notification systems. UNAIDS estimates[12] suggest that in 2017 there would be 19,000 people living with HIV in the country.

Before the year 2000, almost 40% of cases were diagnosed in the AIDS stage. Nevertheless, this percentage declined to 32% between 2000 and 2010, and to 16% after 2010. This reflects and improvement in access to diagnosis, with a higher percentage of early-diagnosed cases.

Reported cases are concentrated in urban areas of the central axis of the country (departments of La Paz, Cochabamba and Santa Cruz), with 87% of the total amount of cases in the country. Santa Cruz is the city with the largest percentage of cases–47.3% of the total number of cases. Men have a higher infection rate than women. The 25 to 34 age group used to present the highest number of cases until 2010, but after that year, the 15 to 24 age group had the highest number of notified cases. In 98% of cases, HIV is transmitted by sexual transmission, while in 2% of cases, by mother-to-child transmission (this percentage remains the same today). No HIV cases transmitted through blood transfusions have been registered.

According to the UNAIDS classification, the country has a concentrated epidemic, as there are specific groups presenting a prevalence above 5%. Groups with a higher burden of the disease are gay men, bisexuals, trans people, men who have sex with other men (GBT-MSM) and trans women (TW). Female sex workers (FSWs) are another group meriting special attention, since their prevalence is above the average prevalence in the country's general population (Chart 1). HIV prevalence estimated by UNAIDS[13] is slightly higher (4.3%), but it does not reach 5% either.

[10] UNAIDS (2016)
[11] National STI/HIV/AIDS and Viral Hepatitis Program
[12] UNAIDS (2017). UNAIDS Data 2017. Geneva, Switzerland.
[13] UNAIDS (2017), *óp. cit.*

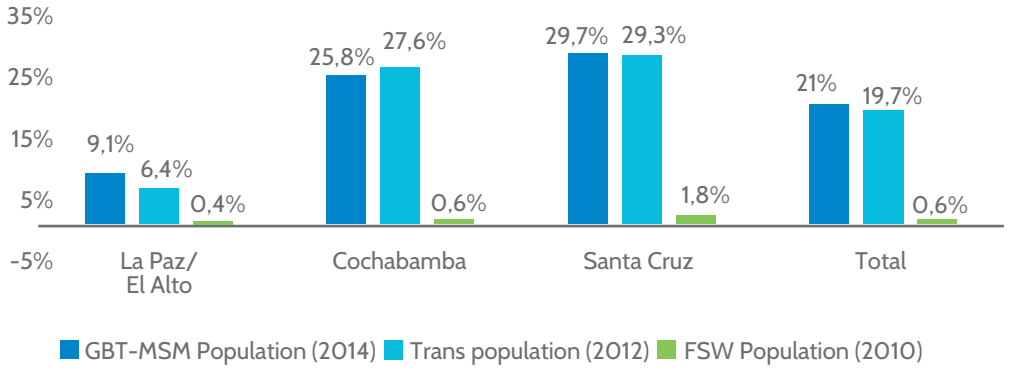


Chart 1. HIV prevalence in key populations in Bolivia. Last year available. Ministry of Health.

Regarding the HIV-TB coinfection, HIV testing coverage among patients with TB surpassed 70% in 2014, and 263 cases of HIV-TB coinfection were registered, while the ARV and TB treatment coverage among people with HIV-TB coinfection reached 68%.

The reduction of the diagnosis gap is confirmed by the treatment cascade (Chart 2). However, a deeper analysis of that cascade reveals that gaps widen. For instance, there are difficulties to ensure linkage of diagnosed people to available services. Another major gap is the access to ART, as only 42% of the expected proportion of the population has had access to it. Finally, the gap in suppression of viral load stands out (with 71%), particularly if we consider the fact that this is the ultimate goal of health care for people living with HIV.

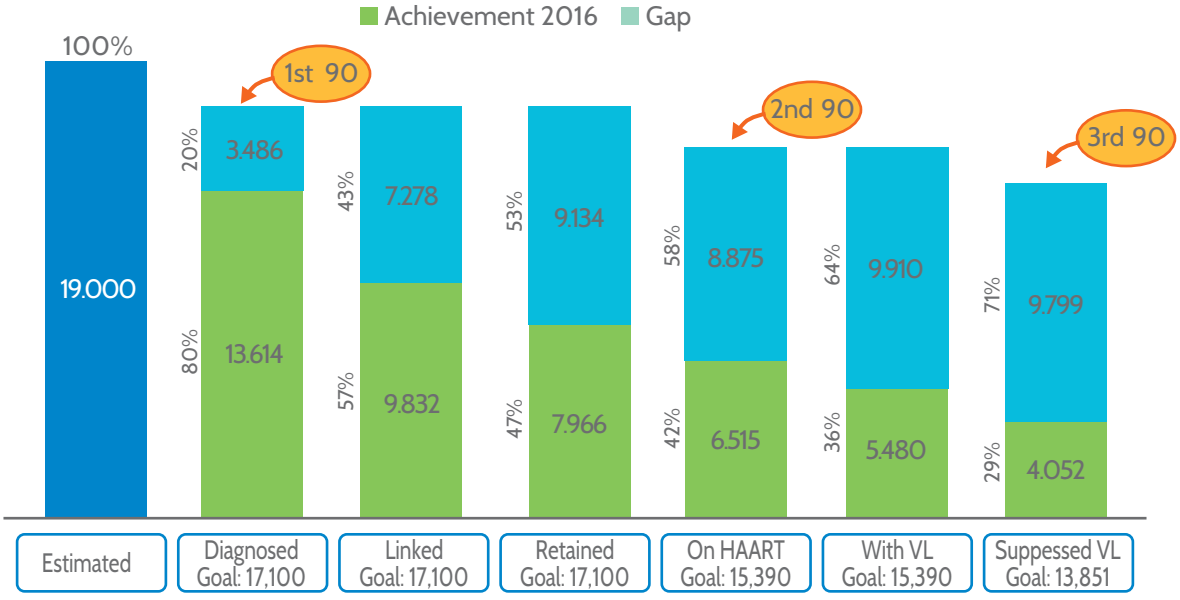
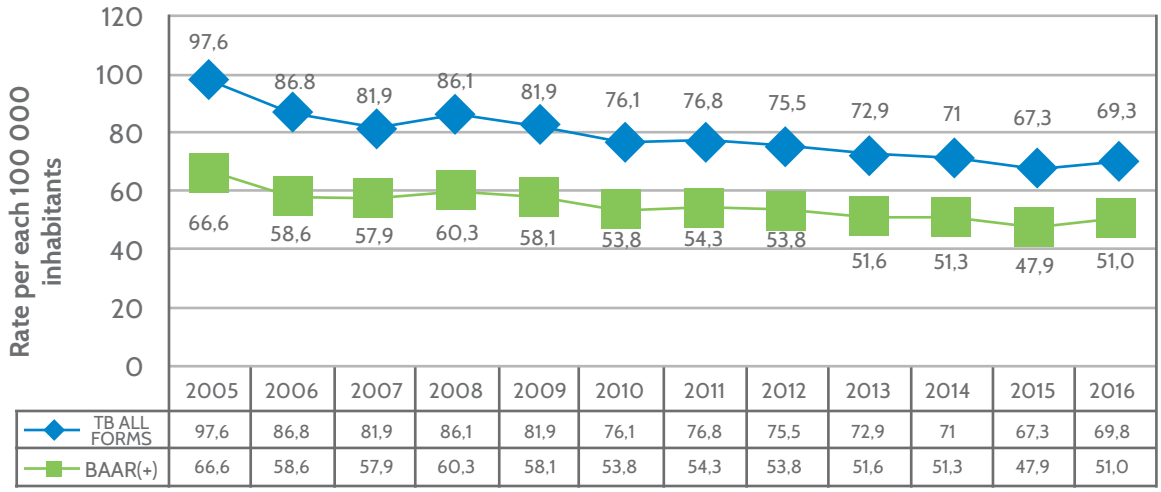


Chart 2. HIV treatment cascade, 2016. STI/HIV/AIDS National Program.

1.2.2. The Situation of Tuberculosis

According to TB incidence and burden estimates of the World Health Organization (WHO) corresponding to the period between 1990 and 2014[14], Bolivia has experienced a decline in TB incidence, going from 251 to 120 per each 100,000 inhabitants (a total decline of 52% and an annual decline of 2.3%). Moreover, according to the records of the National Program for Tuberculosis Control (PNCT)[15], the rate of new notified cases of tuberculosis in all its forms (TB ALL FORMS) dropped from 86.8 per each 100,000 inhabitants in 2006 to 69.8 per each 100,000 inhabitants in 2016 (Chart 3). Since the implementation of the DOTS strategy in Bolivia during the 1999 administration, and thanks to the Round 3 grant of the Global Fund in 2003, the DOTS strategy was expanded across the country. Finally, in 2008, the Stop TB strategy was implemented with the support of the Round 9 grant, which helped reinforce the community, DOTS and specific and distinct activities for groups of people deprived of liberty and indigenous population.



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
TB ALL FORMS	97,6	86,8	81,9	86,1	81,9	76,1	76,8	75,5	72,9	71	67,3	69,8
BAAR(+)	66,6	58,6	57,9	60,3	58,1	53,8	54,3	53,8	51,6	51,3	47,9	51,0

Chart 3. New notified TB ALL FORMS cases per each 100,000 inhabitants. Bolivia, 2006-2016. Ministry of Health (2017).

Notified TB incidence shows a discreet yet constant reduction in the last 10 years. The rate of new TB cases dropped from 57.9 per each 100,000 inhabitants in 2007 to 51.0 per each 100,000 inhabitants in 2016. As for the rate of new TB ALL FORMS cases, it reached 75.5 per each 100,000 inhabitants in 2012, but it decreased to 69.8 per each 100,000 inhabitants in 2016. With respect to the incidence of TB with positive bacilloscopy, it reached 53.8 per each 100,000 inhabitants in 2012, but in 2016, it dropped to 51.0 per each 100,000 inhabitants.

In 2016, the average of respiratory symptomatics (RS) detected per each case of positive bacilloscopy was of 17.9, while the average of positive bacilloscopy cases among RS examined was of 2.7, a level close to the national average, which is 3.

[14] WHO (2014).
[15] MINISTRY OF HEALTH (MoH) (2017). National Program for Tuberculosis Control.

In 2016, the notified incidence of TB ALL FORMS in the country was of 68.9 per each 100,000 inhabitants. Departments with an incidence above the national incidence were Santa Cruz (102.7), Beni (75.9) and Tarija (72.3). As for the way cases were distributed across the country, 78.7% of all new cases and relapses notified in the country in 2016 were in the departments of Santa Cruz (41.2%), La Paz (22.6%) and Cochabamba (14.9%). That same year, the 15 to 24 age group presented the highest number of incident cases (new cases and relapses), of which 37.2% (646 cases) were diagnosed in women and 62.8% (966 cases), in men.

In 2015, the cure rate was of 84.4%, which was very close to the national goal (more than 85%). The rate of treatment completion without bacilloscopy for TB control was of 1.5% of cured cases, which was above the national goal (0%). As for the treatment abandonment rate, it reached 5.0% (above the national goal of less than 3% and the failure rate). The number of notified adverse reactions to anti-tuberculosis drugs was of 268 cases in 2012. It increased until reaching 295 cases in 2014 (the year with the highest number of cases) and in 2016, 265 cases were notified.

According to WHO estimates[16], the TB mortality rate, without including mortality in people with HIV-TB coinfection, is of 8.6 per each 100,000 inhabitants, and drops up to 1.6 per each 100,000 inhabitants in people with that coinfection.

Key Populations and Groups of Key Populations at Higher Risk of Exposure to Tuberculosis

The 2016–2020 Multisectoral Strategic Plan for Tuberculosis Control in Bolivia[17] presents initiatives in benefit of key populations. This plan prioritizes the following groups:

- ✓ Key populations: people deprived of liberty and indigenous or native population.
- ✓ Groups of key populations at higher risk: contacts of people with TB or diabetes, kidney transplant patients and other immunocompromised patients, health staff members, people living with HIV and patients with low adherence.
- ✓ The plan has a strategic partner: Asociación de Pacientes contra la Tuberculosis (ASPACONT, Patients Association against Tuberculosis). This association conducts self-help and treatment adherence support actions.
- ✓ The plan supports ASPACONT's managing board to strengthen the association and ensure continuity of the support it provides.

[16] https://extranet.who.int/sree/Reports?op=Replet&name=%2FWHO_HQ_Reports%2FG2%2FPROD%2FEXT%2FTBCountryProfile&ISO2=BO&LAN=ES&outtype=html
[17] 2016–2020 Multisectoral Strategic Plan for Tuberculosis Control in Bolivia

1.2.3. The Situation of Malaria

Bolivia has registered a significant reduction of malaria morbidity as well as the elimination of mortality due to this disease[18], which is concentrated in the Amazon (96% of the total number of cases in the country), which has a population of 253,140 inhabitants who represent 2.5% of the country's population. This region has an area of 123,721 km² and a population density of 2.2 inhabitants per km². Municipalities of the Bolivian Amazon have widely dispersed populations and 149 primary health care institutions (health posts and health centers) in three (3) departments: Pando (with 14 municipalities and 76 health care institutions), Beni (with 4 municipalities and 65 health care institutions) and La Paz (with the municipality of Ixiamas at the northern part of this department and 8 rural health care institutions). Finally, it is important to note that this geographic area has seven (7) Health Networks Coordinating Agencies.

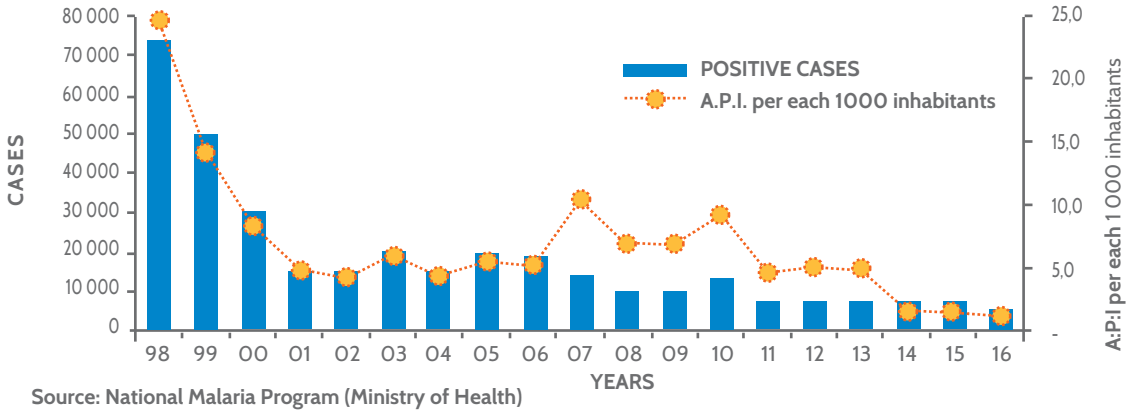


Chart 4. Number of malaria cases and annual parasite index between 1998 and 2016. Ministry of Health.

In 1998, 74,350 malaria cases were notified (62,936 were *Plasmodium vivax* cases and 11,414 were **Plasmodium falciparum** cases), registering 27 deaths and an annual parasite index (API) of 24.8 per each 1,000 inhabitants exposed to the disease. In 2015, only 96 **Plasmodium falciparum** cases were notified and, in 2016, although 5,544 cases were notified, with an API of 1.2 per each 1,000 inhabitants exposed to the disease, none of them were indigenous cases. This way, Bolivia entered the malaria elimination phase.

In 2016, 69% of the cases in the 15 to 49 age group were in men, while the other 31% were in women. The number of confirmed cases at a country level was of 5,553 cases, and national incidence was of 1.2 per each 1,000 inhabitants exposed to the disease. No deaths due to malaria have been notified since 1999 in the region's network of health care institutions, and institutions responsible for keeping vital records have not notified them either.

The rest of cases (4%) were notified in the inter-Andean valleys; the regions of El Chaco corresponding to the department of Tarija, Santa Cruz and Chuquisaca; the valleys of Cochabamba and La Paz, and part of Potosi. In this area, cases are notified sporadically, which promotes the entrance into a pre-elimination and elimination phase, in accordance with the recommendations of the Pan American Health Organization (PAHO) and WHO.

[18] MINISTRY OF HEALTH (MoH) (2017). National Malaria Program.

1.3. FINANCING FOR THE RESPONSES TO THE THREE DISEASES

1.3.1. Expenditure on HIV

Bolivia spent a total of 49 million US dollars for HIV control in the period between 2010 and 2013. More than half of that amount of money (52.2%) came from internal sources and the rest, from external sources (Chart 5). With respect to resources from external sources, 56.2% of them came from grants of the Global Fund and the rest, from other 18 sources. According to the 2010–2012 NASA survey, Bolivia allocates most of its funding to the so-called "more accessible population" (clients of STI clinics, high school students and health staff members), and people living with HIV come second (21.5%). Only 2% of the funding is aimed at most-at-risk populations and 4%, to other key populations.

FINANCING AGENCIES	2010	%	2011	%	2012	%	2013(P)	%	2010-2013	%
EXTERNAL	4 563 148	45,4%	7 798 156	56,3%	4 867 919	41,4%	6 173 382	46,1%	23 402 606	47,7%
HIPC II	32 535	0,3 %	35 054	0,3 %	36 340	0,3 %	40 068	0,3 %	143 996	0,3 %
Global Fund	1 935 738	19,3 %	4 807 746	34,7%	2 897 508	24,6 %	4 715 637	35,2 %	14 356 628	29,3 %
UNAIDS	53 035	0,5 %	133 305	1,0 %	26 216	0,2 %	27 527	0,2 %	240 083	0,5 %
PAHO	106 835	1,1 %	157 926	1,1 %	169 673	1,4 %	53 950	0,4 %	488 385	1,0 %
UNFPA	241 134	2,4 %	352 926	2,5 %	206 121	1,8 %	37 000	0,3 %	837 181	1,7 %
UNICEF	233 785	2,3 %	281 290	2,0 %	238 594	2,0 %	205 275	1,5 %	958 944	2,0 %
USAID	444 764	4,4 %	263 616	1,9 %	61 609	0,5 %			769 988	1,6 %
Misión Alianza Noruega	142 864	1,4 %	160 641	1,2 %	136 537	1,2 %	143 363	1,1 %	583 405	1,2 %
MSI London	16 405	0,2 %	29 261	0,2 %	32 406	0,3 %	26 024	0,2 %	104 096	0,2 %
Family Care International	3 000	0,0 %	37 000	0,3 %	60 000	0,5 %	33 333	0,2 %	133 333	0,3 %
Institute for Human Development	707 738	7,0 %	653 035	4,7 %	430 489	3,7 %	422 014	3,2 %	2 213 275	4,5 %
IGUALDAD	99 310	1,0 %	39 592	0,3 %	36 464	0,3 %	38 287	0,3 %	213 653	0,4 %
National Working Board	26 823	0,3 %	42 115	0,3 %					68 937	0,1 %
REDVIHDA	137 956	1,4 %	130 385	0,9 %	114 001	1,0 %	109 701	0,8 %	492 042	1,0 %
Other external agency			150 000	1,1 %					150 000	0,3 %
VIVO POSITIVO	247 645	2,5 %	404 311	2,9 %	288 538	2,5 %	202 965	1,5 %	1 143 460	2,3 %
OXFAM	25 000	0,2 %	7 000	0,1 %	250	0,0 %			32 250	0,1 %
Tearfund-UK	26 243	0,3 %	38 599	0,3 %	46 631	0,4 %	37 158	0,3 %	148 630	0,3 %
World Vision	82 339	0,8 %	74 357	0,5 %	86 543	0,7 %	81 080	0,6 %	324 318	0,7 %
INTERNAL	5 481 989	54,6 %	6 048 599	43,7 %	6 899 026	58,6 %	7 217 031	53,9 %	25 646 644	52,3 %
Households	1 314 837	13,1 %	1 760 436	12,7 %	2 013 952	17,1 %	2 114 649	15,8 %	7 203 874	14,7 %
Specific resources, others	442 666	4,4 %	386 697	2,8 %	317 495	2,7 %	462 245	3,5 %	1 609 104	3,3 %
Specific resources, municipalities	76 784	0,8 %	35 575	0,3 %	129 986	1,1 %	23 050	0,2 %	265 395	0,5 %
Royalties	265	0,0 %			15 186	0,1 %	283	0,0 %	15 734	0,0 %
General National Treasury (TGN)	2 177 282	21,7 %	2 225 649	16,1 %	2 382 823	20,3 %	2 501 964	18,7 %	9 287 719	18,9 %
TGN – Direct Tax on Hydrocarbons	55 226	0,5 %	39 974	0,3 %	95 126	0,8 %	130 784	1,0 %	321 110	0,7 %
TGN – Tax Co-participation Funds	1 231 123	12,3 %	1 332 346	9,6 %	1 566 480	13,3 %	1 614 096	12,1 %	5 744 045	11,7 %
Social Security Resources	117 274	1,2 %	200 500	1,4 %	279 630	2,4 %	293 612	2,2 %	891 017	1,8 %
Private Resources	66 531	0,7 %	67 421	0,5 %	98 347	0,8 %	76 348	0,6 %	308 647	0,6 %
Total from financing agencies	10 045 137	100 %	13 846 755	100 %	11 766 945	100 %	13 390 413	100 %	49 049 250	100 %

Chart 5. Expenditure on HIV/AIDS during the 2010–2013 period in Bolivia. Source: MEFP (2010–2012 NASA).

1.3.2. Expenditure on Tuberculosis

National expenditure on TB during the 2011–2014 period amounted to 13.8 million US dollars, which represents an average of 3.4 million US dollars per year (Chart 6). Internal sources financed 60.5% of total expenditure, while external sources financed the remaining 39.5%, of which contributions from the Global Fund represented 87.3%.

FINANCING AGENCIES	2011	%	2012	%	2013	%	2014	%	2011-2014	%
EXTERNAL	1 647 252	47,2%	1 815 331	47,8%	657 356	24,0%	1 324 792	35,2%	5 444 730	39,5%
HIPC II	6 897	0,2 %	26 586	0,7 %	991	0,0 %	3 786	0,1 %	38 260	0,3 %
Global Fund	1 441 965	41,3 %	1 502 026	39,5 %	608 158	22,2 %	1 203 858	32,0 %	4 756 007	34,5 %
UNDP	164 031	4,7 %	170 863	4,5 %	247	0,0 %	1. 704	0,0 %	336 846	2,4 %
PAHO	8 367	0,2 %	11 984	0,3 %	13 403	0,5 %	15 355	0,4 %	49 109	0,4 %
UNICEF			74 694	2,0 %					74 694	0,5 %
Red Cross	25 992	0,7%	29 178	0,8%	34 556	1,3 %	100 088	2,7%	189 814	1,4 %
INTERNAL	1 840 906	52,8 %	1 983 671	52,2 %	2 078 551	76,0 %	2 33 802	64,8 %	8 336 930	60,5 %
Specific resources, others	685 284	19,6 %	681 825	17,9 %	649 602	23,7 %	890 867	23,7 %	2 907 579	21,1 %
Specific resources, municipalities	639	0,0 %	3 260	0,1 %	7 923	0,3 %	8 275	0,2 %	20 096	0,1 %
Royalties	3 463	0,1 %							3 463	0,0 %
General National Treasury (TGN)	1 099 740	31,5 %	1 209 305	31,8 %	1 302 482	47,6 %	1 404 341	37,4 %	5 015 868	36,4 %
TGN – Tax Co-participation Funds	11 939	0,3 %	17 037	0,4 %	22 864	0,8 %	50 774	1,4 %	102 614	0,7 %
TGN – Direct Tax on Hydrocarbons	10 914	0,3 %	14 922	0,4 %	40 492	1,5 %	28 045	0,7 %	94 372	0,7 %
TGN – Papers	28 927	0,8 %	57 322	1,5 %	55 187	2,0 %	51 501	1,4 %	192 937	1,4 %
Total from financing agencies	3 488 158	100 %	3 799 002	100 %	2 735 907	100 %	3 758 594	100 %	13 781 660	100 %

Chart 6. Expenditure on tuberculosis during the 2011–2014 period in Bolivia. Source: MEFP.

1.3.3. Expenditure on Malaria

National expenditure on malaria during the 2011–2013 period amounted to 14.7 million US dollars, which represents an average of 4.9 million US dollars per year (Chart 7). During this period, internal sources financed 47.1% of total expenditure, while external sources financed 52.9%. In 2013, the financing scheme changed. Before that year, contributions from external sources were higher than those from internal sources, but in 2013, 50.1% of total expenditure was financed by internal sources, and external sources financed 49.9%. This change in the financing scheme was mainly due to a decrease in contributions from the Global Fund and to an increase in resource transfers to sub-national governments (departmental and municipal levels) with respect to the previous year.

It is to be noted that contributions from the Global Fund during the aforementioned three-year period represented 96.8% of the resources provided by external sources.

FINANCING AGENCIES	2011	%	2012	%	2013	%	2011-2013	%
EXTERNAL	2 525 611	54,3 %	2 854 063	54,5 %	2 404 846	49,9 %	7 784 520	53,1 %
Global Fund	2 422 774	52,1 %	2 767 025	52,8 %	2 314 923	48,0 %	7 504 722	51,2 %
HIPC II	1 686	0,0 %	3 191	0,1 %	3 952	0,1 %	8 830	0,1 %
PAHO	101 151	2,2 %	50 198	1,0 %	24 643	0,5 %	175 992	1,2 %
UNDP			33 649	0,6 %	61 328	1,3 %	94 977	0,6 %
INTERNAL	2 126 370	45,7 %	2 386 155	45,5 %	2 417 960	50,1 %	6 867 309	47,3 %
General National Treasury (TGN)	1 080 313	23,2 %	1 094 260	20,9 %	1 158 479	24,0 %	3 333 052	22,7 %
TGN – Tax Co-participation Funds	34 576	0,7 %	61 971	1,2 %	100 657	2,1 %	197 205	1,3 %
TGN – Direct Tax on Hydrocarbons	25 434	0,5 %	184 959	3,5 %	231 017	4,8 %	441 410	3,0 %
TGN – Papers	5 000	0,1 %	5 395	0,1 %			10 395	0,1 %
Royalties	104 553	2,2 %	308 861	5,9 %	277 245	5,7 %	690 658	4,7 %
Specific resources, municipalities	7 995	0,2 %	17 306	0,3 %	31 001	0,6 %	56 302	0,4 %
Specific resources, others	843 602	18,1 %	693 165	13,2 %	601 520	12,5 %	2 138 286	14,6 %
Social Security Resources	4 515	0,1 %	765	0,0 %	1 548	0,0 %	6 827	0,0 %
Resources from NGOs	20 321	0,4 %	19 417	0,4 %	16 427	0,3 %	56 165	0,4 %
Private Resources	61	0,0 %	58	0,0 %	65	0,0 %	183	0,0 %
Total from financing agencies	4 651 980	100 %	5 240 218	100 %	4 822 806	100 %	14 651 829	100 %

Chart 7. Expenditure on malaria during the 2011–2013 period in Bolivia. Source: MEFP.

2. OBJECTIVES OF THE SOCIAL DIALOGUE

The social dialogue in Bolivia had one general objective and four specific objectives.

2.1. GENERAL OBJECTIVE

To build a shared vision and joint planning regarding social, political and financial changes, as well as the challenges and opportunities they imply for civil society working in the fields of HIV, tuberculosis and malaria in Bolivia.

2.2. SPECIFIC OBJECTIVES

1. To provide civil society with knowledge on projections regarding the behavior of the HIV, tuberculosis and malaria epidemics until 2020.
2. To provide civil society with knowledge on internal and external financing perspectives for the three diseases in Bolivia until 2020.
3. To strengthen dialogue between civil society and communities about the risks and technical assistance needs of civil society for achieving a sustainable transition in Bolivia.
4. To prepare an action plan allowing to address challenges and seize the opportunities transition processes imply, detailing the training and assistance needs for their implementation.

3. METHODOLOGY

The social dialogues methodology for the sustainability of community strategies responding to HIV, TB and malaria proposed by the Regional Technical Support Centre for Latin America & the Caribbean (CRAT) was applied in this social dialogue (see agenda in Annex 1).

Seeking to reach as large a number of social organizations and community groups implementing those strategies in the country as possible, the social dialogue was conducted through Bolivia's Country Coordinating Mechanism (CCM), where the populations affected by each of the diseases and those vulnerable to them are represented. For administrative and logistics matters, an agreement was reached with a local organization called "Hábitat Verde" (Green Habitat) so that it could facilitate the methodology's implementation.

Given the country's wide geography, its relatively large population and the inclusion of the three diseases in the social dialogue, it was decided to add methodological steps which had not been present in previous dialogues, but were considered necessary to achieve the objectives set. They were mainly informative sessions before the dialogue and they were aimed at organizations and groups working in the response to each of the diseases.

Those informative sessions took place before the working sessions. They included discussions to reach a consensus to build a shared vision on projections and needs regarding the work conducted by civil society, as well as working sessions for joint planning.

The informative session on malaria took place in the city of Riberalta, in the department of Beni–one of the most affected departments by the disease,– to facilitate greater participation. The informative sessions on HIV and TB took place in the city of Cochabamba, where joint discussion and planning sessions regarding the three diseases were also held.

To prepare the action plan, a participatory methodology was used, which included a collective SWOT analysis. Based on that analysis agreed upon by participants (see the social dialogue report), the plan's general and specific objectives were set, as well as expected results.

For the strategic lines proposal, a cross-analysis of the aspects agreed upon for each of the SWOT components was conducted and, this way, the strategies for achieving the objectives were established.

Since this strategic plan would be implemented by a wide variety of actors who already have their own planning systems, it was decided not to establish actions. This way, the monitoring of the plan's

implementation will help verify the extent to which the actions carried out by each actor correspond to the established strategic lines.

The strategic lines proposal was sent by e-mail to the representatives of each of the populations affected by each of the diseases and those vulnerable to them. Then, they submitted their comments and these were included in the proposal.

To manage the comments with respect to the strategic lines proposal and coordinate the plan's implementation, a coordinating mechanism was established during the workshop. Representatives of each of the populations affected by and vulnerable to the diseases were appointed as members of a coordinating committee whose duty is to ensure that grassroots bases receive timely information regarding the plan's preparation and to monitor this plan once it has been approved.

4. RESULTS OF THE SOCIAL DIALOGUE

4.1. SUMMARY OF THE INFORMATIVE WORKSHOPS ON HIV, TUBERCULOSIS AND MALARIA

Two informative workshops were held, as planned in the agenda. The informative workshop on malaria, held in Riberalta, in the department of Beni, on November 14th 2017, included presentations on malaria and its vector, by Dr. Gilván Ramos, CCM Monitoring Coordinator, and on the situation of the disease in the country and in the Amazon region, and on the response to it, by Dr. Omar Flores, Head of the National Malaria Program of the Ministry of Health. Dr. Génesis Marca made a presentation on the Mobile Team of Experts (MTE) strategy for malaria prevention and diagnosis, as well as the results obtained to date thanks to this strategy.

Attendants participated very actively, and that revealed a profound lack of knowledge on the disease, its transmission mode and forms of prevention despite being in the most affected region of the country.

A presentation about the Global Fund, its program for malaria in Bolivia and the CCM was added. A large majority of participants were unaware of the Global Fund's and the CCM's existence, which is why they thought this session was very useful.

Finally, a group discussion was held with the aim of getting to know the participants' opinions regarding the chances of sustainability of what had been presented to them.

The informative workshop on HIV and TB followed a similar sequence, with generic presentations on the diseases by Dr. Ramos, who also explained to participants what the Global Fund and its CCM in Bolivia are.

The Head of the HIV program, Dr. Carola Valencia, and the representative of the TB program, Dr. Carmen Arraya, made presentations on the situation of those diseases and the programmatic strategies currently under implementation. Participants were particularly impressed by the treatment cascade and the large gaps still existing in Bolivia.

4.2. IDENTIFIED POLITICAL AND SOCIAL RISKS AND THREATS FOR HIV, TUBERCULOSIS AND MALARIA CONTROL IN THE NEXT 5 YEARS

It is to be noted that this was the first time that more than 120 representatives of populations affected by and vulnerable to the three diseases had the opportunity to get together and hold discussions in a real social dialogue.

The first day of the social dialogue focused on building a shared vision on the context in which social organizations and community groups find themselves, as well as on short and medium-term financing and political perspectives.

To that effect, a SWOT analysis was conducted. For this, participants worked in teams, by disease. This was because the point of departure was that the current contexts and situations are highly dissimilar for each of the diseases.

Each team was asked to analyze only the situation of their disease, so that results obtained could be analyzed afterwards to identify common aspects among the three diseases and aspects specific to one of them. All of this should result in common and distinct strategies in the action plan.

The social and political threats and opportunities of the SWOT matrix are presented below. These components have already been cleaned after having discarded findings not related to the sustainability of community strategies, but rather to the current response needs.

Since the analysis was the basis of the subsequent action plan, teams were asked to prioritize findings and include only those where there was consensus, putting emphasis on the need to reduce threats to a maximum number of three (3) to address them in a realistic way.

Disease	Threats	Opportunities
HIV	Although the government, at its three administrative levels (national, regional and municipal), has the legal obligation to ensure budget implementation with society participation, it does not comply with this obligation. Civil society actions are disjointed due to the existing competition over resources and the lack of a shared vision regarding the problem. The Global Fund has been the main source of financing for community strategies and it is in the process of withdrawing its support, which is why transition is *ad portas.*	Movements have already established strategic partnerships with public servants of the three levels of government which must be exploited and expanded. There are international networks of affected and vulnerable populations with great capacities for advocacy and mobilization of international resources to use them in the country. The decentralization of programs responding to the diseases at departmental levels implies acting in greater proximity to populations. REDBOL (National Network of People Living with HIV and AIDS in Bolivia) has great political advocacy capacities. This has made a budget allocation for the response to HIV in municipalities and governorates possible. There are strong movements in other social sectors (gender and human rights, for example) with which partnerships could be established to broaden the scope of action and further strengthen capacities. There is a law on HIV/AIDS prevention, human rights protection and multidisciplinary comprehensive care for people living with HIV/AIDS (Law N° 3729) and departmental regulations. There is currently a program financed by the Global Fund and it has not entered the transition phase for HIV yet.

Disease	Threats	Opportunities
Tuberculosis	Global Fund grants for TB will soon enter a transition phase. There is no State budget for strategies implemented by civil society. A lack of programmatic coordination between the National Program for Tuberculosis Control (PNCT) of the Ministry of Health and CSOs is observed. The access to accurate and timely information (held by the National Program) is deficient.	There is an Intercultural Community Family Health Model (SAFCI) which institutionalizes community participation in health strategies, as well as the guarantee of protection of health accorded by Articles 35 and 37 of the Political Constitution of the State (CPE). The Ministry of Health has a program aimed at controlling the disease and providing access to treatments. There is a legal possibility of channeling the increase in the health State budget to the response to TB. The organization grouping people affected by TB and organizations grouping populations vulnerable to that disease have already achieved a degree of rapprochement with municipalities and governorates which could be helpful for the implementation of sustainability strategies. CCM Chairmanship shall rotate between the government and CSOs to achieve greater participation.
Malaria	The Global Fund has been the main source of financing for community strategies, but it is in the process of withdrawing its support, which is why transition is ad portas (2023–2025). The Ministry of Health does not pay attention to and is not fully aware of this public health problem or the priorities and needs of the population affected by it. Geographic access to the most malaria-affected areas is difficult, which is why proportionally higher allocation of resources is needed.	There are national policies and plans for malaria control at the three levels of government, and Bolivia wants some parts of its territory to be recognized as malaria-free. The SAFCI model recognizes social participation in health. There are sources of international cooperation other than the Global Fund to which social and community organizations have already had access.

4.3. IDENTIFIED WEAKNESSES AND STRENGTHS OF COMMUNITY GROUPS AND ORGANIZATIONS FOR HIV, TUBERCULOSIS AND MALARIA CONTROL IN THE NEXT 5 YEARS

In this section, findings resulting from the SWOT analysis related to internal weaknesses and strengths of community movements responding to each of the diseases are presented. As in the previous section, the matrix has already been cleaned after having discarded findings not directly related to the responses' sustainability.

As it happened in the previous section of threats and opportunities, teams were asked to prioritize a maximum number of three (3) weaknesses so that they can be addressed in a realistic way in an action plan.

This matrix has been enriched by the content of the discussion held between the movements' grassroots bases and their leaders, which took place during the second day of the workshop, at the planning stage.

Disease	Weaknesses	Strengths
HIV	There is fragmentation and lack of unity between vulnerable populations (men having sex with other men, trans people and female sex workers) and affected populations (people living with HIV), which is why they are not always able to identify joint actions. Community interventions depend heavily on external financing. There is a shortage of new trained and skilled leaders.	CSOs are in a continuous strengthening process thanks to the multiple training opportunities available. Organizations of this movement have proven capacity and vast experience in political advocacy and social mobilization. Part of that political advocacy is possible thanks to existing coordination mechanisms with local and national authorities. Responding to HIV from a prevention and rights-based approach is an area of mutual interest among organizations. There are committed and empowered leaders. Organizations have experience in managing programs and accessing funds. The movement grouping people affected by HIV presents high coordination levels. REDBOL is greatly consolidated and strengthened. There is experience in prison labor in Santa Cruz, which is important for the trans population.

Disease	Weaknesses	Strengths
Tuberculosis	Civil society is little involved in PNCT activities. Civil society does not receive sufficient information on programmatic and training strategies. Economic resources for social participation and mobilization are scarce. A service package of community work in the field of TB is needed.	Civil society knows the disease. The legal structure of the civil society association grouping affected people (ASPACONT) has been strengthened and is continuously gaining presence. In each organization there are people capable of replicating the information they have. There is social participation and control in the shared management system, at least nominally.
Malaria	Civil society does not receive enough training on malaria as a public health problem to conduct political advocacy actions, access sources of financing and achieve social mobilization. A lack of coordination between organizations grouping affected populations and those grouping vulnerable populations is observed. There are volunteers in the program financed by the Global Fund, but they are not involved in the actions conducted by CSOs. There are no articulated strategies of the three programs (the HIV/AIDS, TB and malaria programs).	Organizations know the malaria-affected area and have presence there. Some organizations have already achieved rapprochement with different governmental authorities. Civil society is strengthened and has coordination capacity, although in terms of trade union actions rather than in the field of public health. Civil society is represented in the CCM, so it can discuss about the needs of the population directly with authorities. Volunteers are elected by the grassroots bases. CSOs are represented by organizations recognized at national level as grassroots organizations (GOs), the Harvesters Federation, etc. Organizations use technology for better training and better communication among vulnerable people.

4.4. INTERVIEWS WITH KEY ACTORS

Within the framework of the workshops, a series of interviews with key actors of the responses to the three diseases who could provide information and a strategic view regarding the aspects which influence organizations' sustainability were conducted. The names and positions of each of the interviewees are shown in Table 1.

Table 1. Key actors interviewed for Bolivia's 2017 social dialogue

N°	NAME	POSITION
1	Eva Limachi	CCM Secretary
2	Gilván Ramos	CCM Strategic Monitoring Coordinator
3	Alfredo Rojas Guarena	Chairman of the Asociación de Recolectores de Almendra y Goma (Almond and Rubber Gatherers Association)
4	Julio César Aguilera Hurtado	CCM Vice Chairman
5	Teresa Cruz	ONAEM (National Women's Rights Advocates Organization) Secretary General, REDTRASEX National Coordinator and representative of populations vulnerable to HIV before the CCM
6	Omar Flores Velasco	Head of the National Malaria Program of the Ministry of Health
7	Otomar Ayala Torres	Representative of the population affected by malaria before the CCM
8	Lidia Vaca Roca	Representative of the population vulnerable to malaria before the CCM
9	María Gabriela Flores	1st alternate representative of the population vulnerable to malaria before the CCM
10	Miguel Ruiz Vaca	2nd alternate representative of the population vulnerable to malaria before the CCM
11	Elizabeth Saavedra Arauz	1st alternate representative of the population affected by malaria before the CCM
12	Rocío Ayala Toledo	2nd alternate representative of the population affected by malaria before the CCM
13	Nelson Illanes	Representative of civil society affected TB before the CCM
14	Paola Ariane	1st alternate representative of the population affected TB before the CCM
15	Máximo Romero	Representative of populations vulnerable to TB before the CCM

During the interviews with key actors, several points of consensus were reached and there were similar opinions. Some conclusions apply to the three diseases, while other only apply to one of them. The topics on which a certain degree of consensus was reached are listed below:

- The sustainability of CSOs is at real risk.
- There are other international sources of financing, but their magnitude is not as vast as that of the Global Fund. Besides, communities have limited knowledge on those sources.
- The option of contributions from companies (in the form of social responsibility actions) must be explored and efforts must be made to make the diseases visible in the annual operational programs (POAs) of governorates and municipalities, while ensuring budgets for prevention, particularly for key populations. Municipalities are obliged to prepare a POA with budget, but they have limited capacities to carry out that task.
- There are still funds from the General National Treasury (TGN) for malaria and TB, and advocacy for them must continue, as it happens in the case of HIV, since progress has been made with respect to that disease and that could serve as example. Based on the lessons learned from the HIV process, it can be stated that empowering leaders and training civil society are key factors.
  There is a great lack of resources for coordination and training activities aimed at members of CSOs.
- There are great capacity-building needs, particularly with respect to TB and malaria, and mainly regarding political advocacy. In the case of HIV, a transition plan–prepared by the HIV Program–already exists, and major efforts are being made to achieve that transition, as even several processes have been implemented to allocate budget headings. Nevertheless, this is not happening in the case of the other two diseases.
- There are mechanisms allowing the government to channel funds to CSOs specifically for these three diseases. However, that has not occurred yet. There is a project called "Bolivia cambia, Evo Cumple" (Bolivia Changes, Evo Keeps his Word), managed by the Social Projects Unit of Bolivia's Presidency. Funds have been allocated to other areas, and the response to these diseases could be explored.
- The country has regulations which make community participation in health an obligation, and the SAFCI model is one of them. However, these regulations are not complied with or, when they are, political interference occurs when determining that participation, which is formally limited to the programs' design, but not to their implementation. This problem needs to be addressed through political advocacy.
- Some programs are reluctant to work with civil society, mainly the TB program.
- There are no self-financing organizations generating resources from the activities they carry out. This aspect might need to be explored.
- Stigma and discrimination are a major issue in the case of HIV and TB, and they can be a barrier to secure funding for community interventions.
- There is a shortage of organizations working in the field of malaria. There are two possible ways to cover that deficit. One way would be to create a NGO focused on working in the response to malaria. The other way would be to work in the response to the disease through the existing municipal health agents; however, it would be necessary to legitimize them, as they do not have representativeness because they have not been elected by the community.
- In the case of malaria, one of the goals of the State company called "EBA" is to get the best export prices for Brazil nuts and improve its workers' working conditions and standards of living, among which health matters should be considered.

4.5. Risks for the Sustainability of Community Responses to HIV, Tuberculosis and Malaria in Bolivia

The social dialogue allowed to infer risks affecting the responses to all three diseases, as well as other risks specific to only one of them.

The main risks discussed during the social dialogue are the following:

- Limited capacities in community organizations for evidence-informed political advocacy, especially regarding TB and malaria.
- Limited capacities and training to implement community strategies to respond to the diseases, especially regarding TB and malaria.
- Limited willingness or capacities for coordination between the different community organizations and movements.
- State's refusal to allocate budget to finance community components of the responses to the diseases.
- Lack of understanding between national programs responding to the diseases and CSOs.
- Stigma and discrimination towards the diseases, which makes it politically difficult to obtain funding for community responses to the diseases, especially to HIV and TB.
- Lack of new leaders to ensure continuity of advocacy actions and include new demands.
- In the case of the response to malaria, the need for planning an intercultural response is ignored.

4.6. IDENTIFIED TECHNICAL ASSISTANCE NEEDS

The SWOT analysis and discussions centered on planning and on the mitigation of identified risks led to the following technical assistance needs for the sustainability of community responses to the three diseases.

RISKS	TECHNICAL ASSISTANCE NEEDS
Limited capacities in community organizations for evidence-informed political advocacy. State's refusal to allocate budget to finance community components of the responses to the diseases.	Capacity-building on evidence-informed political advocacy adjusted to the context of each disease. Special emphasis was put on advocacy to bring about compliance with the obligation to allocate budget to CSOs.
Limited capacities and training to implement community strategies to respond to the diseases, especially regarding TB and malaria.	Capacity-building on the design and development of community strategies to respond to the three diseases, with special emphasis on TB and malaria.

RISKS	TECHNICAL ASSISTANCE NEEDS
Limited willingness or capacities for coordination between the different community organizations and movements.	Assistance for the creation of sustainable coordination networks and mechanisms, including monitoring mechanisms allowing to achieve the transition plan's objectives.
Lack of understanding between national programs responding to the diseases and CSOs.	Assistance for the development of strategies to increase participation of CSOs in decision-making forums, with special emphasis on TB and malaria.
Stigma and discrimination towards the diseases, which makes it politically difficult to obtain funding for community responses to the diseases, especially to HIV and TB.	Technical and financial assistance for the design and implementation of social communication strategies for the reduction of stigma and discrimination, with special emphasis on TB and HIV.
Lack of new leaders to ensure continuity of advocacy actions and include new demands.	Identification and strengthening of capacities of young leaders of the three movements.
In the case of the response to malaria, the need for planning an intercultural response is ignored.	Capacity-building for CSOs working in the response to malaria and vulnerable populations to establish links with government agencies responsible for ensuring intercultural interventions in the field of health.

5. MAPPING OF ACTORS

5.1. MINISTRY OF HEALTH

The Ministry of Health is the country's health authority and the governing body of the health sector[19]. The Political Constitution of the Plurinational State of Bolivia establishes the implementation of a Single Health System to achieve universal access to health through the Intercultural Community Family Health Policy[20] and its health care and management model within the framework of Intercultural Community Family Health (SAFCI)[21].

5.1.1. National STI/HIV/AIDS and Viral Hepatitis Program

The National STI/HIV/AIDS and Viral Hepatitis Program develops actions for HIV/AIDS prevention, human rights protection and multidisciplinary comprehensive care for people living with HIV/AIDS[22]. Furthermore, Law N° 3729 creates the National HIV/AIDS Council of the Ministry of Health and all agencies which must be involved in the response to this disease.

The program has the 2013–2018 Multisectoral Strategic Plan for the National Response to HIV/AIDS, whose general objective is to "reduce morbidity and mortality associated with HIV/AIDS." To that effect, it develops strategic objectives aimed at reducing HIV/AIDS prevalence, reducing HIV prevalence and reducing mortality due to HIV-related causes. The program's strategic objectives are the following:

1. To reduce occurrence of new HIV/AIDS cases.
2. To expand coverage of comprehensive health care for HIV, as well as other sexually transmitted infections and opportunistic diseases associated with HIV/AIDS.
3. To eliminate stigma and discrimination, as well as inequalities in access to public services, social security and private services.
4. To promote self-care and improve social co-responsibility for the control of the HIV/AIDS epidemic.

Finally, the program has a "Plan for the Sustainability of the HIV Response in Bolivia," whose goal is to ensure economic resources to respond to this disease and strengthen comprehensive health care and prevention in all its forms.

[19] Article 36 of the Political Constitution of the Plurinational State of Bolivia
[20] Law N° 031, Framework Law on Autonomy and Decentralization
[21] Supreme Decree N° 29601, SAFCI Policy
[22] Law N° 3729 on HIV/AIDS prevention, human rights protection and multidisciplinary comprehensive care for people living with HIV/AIDS

5.1.2. National Tuberculosis and Human Leprosy Program

The National Program for Tuberculosis Control (PNCT) acts within the framework of its 2016–2020 Multisectoral Strategic Plan for Tuberculosis Control in Bolivia. The plan's objective is to "reduce the high burden of tuberculosis and its social determinants through efforts coordinated by different multisectoral management levels and civil society while respecting human rights in order to improve the quality of life of the affected population and society at large."

The plan has six strategic objectives:

1. To strengthen risk prevention and health promotion actions in the population at large and in the most vulnerable populations while respecting gender, generational, cultural, social and sexual differences, and promoting practices favorable to health care.
2. To strengthen universal access–with equality–to timely diagnosis and quality and warm treatment for the population at large and for the most vulnerable populations, while preventing treatment abandonment and promoting effective cure.
3. To strengthen comprehensive health care for drug-resistant tuberculosis (DR-TB) and adverse reactions to anti-tuberculosis drugs.
4. To develop effective and efficient collaborative actions with HIV programs and those focused on non-transmissible diseases.
5. To conduct studies, research and assessments according to the social context and epidemiological profile of tuberculosis in the country.
6. To develop innovative strategies for tuberculosis control, with emphasis on eliminating stigma and discrimination.

In this context, the program has policies and regulations which are explained in the following training modules: Managing the DOTS strategy (5 modules), Clinic Guide of the HIV-TB coinfection, Guide for Management of Adverse Reactions to First-Line Anti-Tuberculosis Drugs, Technical Guide for MDR-TB Management, Technical Manual of the Bacilloscopy Network, Culture Manual and MDR-TB Management Expansion Plan. Furthermore, coordination meetings with the HIV program are held quarterly. There, joint activities to facilitate the diagnosis of coinfection cases, the provision of treatment to coinfected patients and of chemoprophylaxis, the organization of training sessions and the monitoring of treatments to coinfected patients (which include other comorbidities such as diabetes and kidney transplant patients, among others) are analyzed and developed.

5.1.3. National Malaria Program

The National Malaria Program acts within the framework of its Institutional Malaria Strategic Plan. The plan's general objective is to "develop strategies for malaria control in regions with persistence of transmission in the Bolivian Amazon, as well as for its pre-elimination in central and southern regions of the country without or with low transmission, thereby assuring operationally effective interventions and the population's right to malaria prevention and care services in order to improve the quality and coverage of strategies against *Plasmodium falciparum* and *Plasmodium vivax* during the 2015–2019 period."

The program's strategic objectives are the following:

1. To intensify efforts aimed at malaria prevention, surveillance and early detection, as well as outbreak containment in different programmatic contexts.
2. To promote, strengthen and optimize vector control mechanisms and tools.
3. To intensify efforts to achieve universal access to immediate, accurate and quality malaria diagnosis, followed by treatment with effective antimalarial medicines.
4. To foster an environment which enables sustainability and supports collaboration efforts and best practices to fight against the disease.
5. To optimize efforts to strengthen health systems, including strategic planning, monitoring and assessment, operational research and the regions' capacity to address challenges related to malaria in a relevant and appropriate manner.

5.2. MINISTRY OF ECONOMY AND PUBLIC FINANCE

The Ministry of Economy and Public Finance (MEFP) is the country's governing body of the economic and financial sector, whose responsibilities and powers have been conferred on it by means of Supreme Decree N° 29894, related to the organization of the State's executive branch. This ministry monitors the entire public expenditure, including expenditure aimed at the three diseases.

5.3. MINISTRY FOR DEVELOPMENT PLANNING

The Ministry for Development Planning (MPD) is the governing body in the State's comprehensive planning system, whose responsibilities and powers have been conferred on it by the following provisions: Law N° 777, related to the State's Comprehensive Planning System (SPIE), Supreme Decree N° 2645 of 2016, Supreme Decree N° 2514 of 2015, Law N° 516 on investment promotion of 2014, Law N° 466 (Law on public companies) of 2013, Supreme Decree N° 429 of 2010, and Supreme Decree N° 29894 of 2009, related to the organization of the State's executive branch.

It is important to mention Law N° 777 of 2016 (SPIE-related Law) and Law N° 786 of the same year (Economic and Social Development Plan, also known as PDES), which set forth that the different State levels must develop their comprehensive sectoral development plans (PSDIs), institutional strategic plans (PEIs) and national five-year program plans.

5.4. OTHER MINISTRIES

Even if they do not play a key role in the response to HIV, TB and malaria, there are other public institutions, such as other ministries, which can play important roles occasionally. For instance, the Human Rights Defender can be a key actor for guiding and helping in the human rights component of the response to the three diseases. The Ministry of Justice and Institutional Transparency can play a key role in the enforcement of existing legislation and of new laws which may be enacted. The Ministry of Education should be involved in capacity-building on the diseases and their determinants, and the Ministry of Interior should ensure the necessary administrative organization for the responses' implementation.

5.5. CIVIL SOCIETY ORGANIZATIONS

5.5.1. Organizations Working in the Response to HIV/AIDS

- **Asociación Civil de Desarrollo Social Libertad (ADESPROC Libertad, "Libertad" Civil Association for Social Development):** Its goal is to "contribute to the establishment of the gay and lesbian movement at a national level [, and] it has developed actions aimed at ensuring visibility of the reality of the gay and lesbian community, with emphasis on the defense of human rights, integrity and personal growth of members of [this] community."
- **Familia Galán (Galán Family):** Its goal is to "generate spaces for discussion and reflection among activists, theorists and society at large with respect to the political and social presence of trans populations in our country: it is a matter of rights, of our rights."
- **Fundación REDVIHDA (REDVIHDA Foundation):** Its goal is to "ensure access to comprehensive health care without discrimination towards people living [with HIV] and [people] affected by HIV, by implementing positive and effective responses in Bolivia in an HIV/AIDS-free society."
- **Institute for Human Development (IHD):** It has several goals: to reduce risk behaviors enabling HIV transmission in the general population, with emphasis on teenagers; to improve comprehensive health care provision for people living with HIV in Cochabamba; to reinforce the promotion and defense of human rights of people living with HIV and advocate for health and education government agencies to integrate prevention and health care methodologies–with warmth and quality–into services aimed at people living with HIV.
- **EQUIDAD (Equality):** The goal of this organization is to "publicly defend human rights of people with different sexual orientation and/or gender identity [through] educational, organizational and political processes."
- **Trans Red de Bolivia (TREBOL, Trans Network of Bolivia):** Its goal is to "improve the quality of life of trans populations [through] strategic partnerships at national and international level while ensuring the respect for human rights and stressing the importance of equal opportunities for all, without any gender-based distinction."
- **Organización de Travestis, Transgéneros y Transexuales Femeninas de Bolivia (OTRAF, Transvestites, Transgenders and Female Transsexuals Organization):** Its goal is to "contribute to the exercise, promotion and defense of the fundamental human rights of people whose sexual orientation and gender identity is not heterosexual (transvestites, transsexuals, cross-dressers and transgenders [based on] the principle of defense of life and its integrity."
- **Vivo en Positivo (Living as a Positive):** This association is composed by people living with HIV/AIDS. It was created with the purpose of contributing to improve the quality of life of children, women and men living with HIV/AIDS, and reduce the risk of new infections in the general population and vulnerable populations by implementing programs and projects at a local and national level.
- **Red Nacional de Personas que viven con HIV y Sida en Bolivia (REDBOL, National Network of People Living with HIV and AIDS in Bolivia):** It seeks to ensure empowerment of groups of people living with HIV/AIDS to improve their quality of life by facilitating access to information, communication, training activities and comprehensive health care services, and formulating policies and strategies from the perspective of this community which contribute to reduce stigma and discrimination, thereby promoting direct participation of community members as key actors and part of the solution.

- **Colectivo TLGB Bolivia (Bolivia's LGBT Network):** It groups more than 20 LGBTI organizations in the country.
- **Organización Nacional de Activistas por la Emancipación de la Mujer (ONAEM, National Women's Rights Advocates Organization):** It has grassroots bases nationwide and its objectives are aimed at building and strengthening this organization composed by and acting in favor of female sex workers at a national, departmental, provincial and cantonal level; training and educating female sex workers on their rights; fostering leadership training among female sex workers; achieving the recognition of sex work as work; ensuring that sex work can be exercised freely, without pimps and with autonomy; demanding before the corresponding government bodies security and protection for female sex workers while exercising sex work, and promoting actions for women's emancipation in Bolivia.
- **Organización de Trabajadoras Nocturnas de Bolivia (OTNB, Bolivia's Female Night Workers Organization):** It is composed by female sex workers from La Paz, El Alto and the interior of the country. It defends the human, labor and economic rights of female sex workers, and seeks to eliminate sexual, verbal and psychological abuse perpetrated by police officers and sex establishment owners against female sex workers.

5.5.2. Organization Working in the Response to Tuberculosis

- **Asociación de Pacientes con Tuberculosis (ASPACONT, Patients Association against Tuberculosis):** It has been created recently, and it seeks to promote the rights of people affected by TB, as well as the need for political advocacy to improve the response.

5.5.3. Organizations Working in the Response to Malaria

- These are organizations grouping Brazil nut harvesters. They group around 10,000 families from Brazil nut-growing regions of the entire country, but they are weak and poorly organized, mainly due to the type of work they perform.

5.5.4. Non-Profit Organizations

- **Kuratorium:** Within the framework of the agreement entered into by and between this NGO and the community health program called "Tuberculosis", of Bolivia's Red Cross and the Departmental Health Service (SEDES) of Santa Cruz, it used to provide health care services for free in two bronchopulmonary centers and used to mobilize human and financial support for TB prevention, detection and control. By virtue of this agreement, SEDES provides nine items for the program's operation.
- **World Vision:** It has been operating in Bolivia for 35 years now developing programs and projects aimed at children in rural and urban areas, and fighting against inequality and injustice with the purpose of transforming–together with local leaders, authorities and communities– vulnerability conditions of children, teenagers and youth. The activities carried out by this organization follow these lines of action: to be part of networks and build partnerships at different levels to contribute to children's comprehensive development; to contribute to children's empowerment and to their participation in the exercise of their rights; to strengthen the capacities of community-based organizations, prioritizing critical sectors affecting children's wellbeing; and to strengthen knowledge on sexual and reproductive health, STIs and HIV/AIDS.

- **Centro de Investigación, Educación y Servicios (CIES, Research, Education and Service Center):** It is a non-profit social development organization which contributes to ensure the exercise of sexual and reproductive rights with the purpose of improving the quality of life of Bolivia's urban and rural population, with emphasis on vulnerable populations. Its lines of action include sexual and reproductive rights, human rights, community education in health, family planning, safe pregnancy, cervical and breast cancer, domestic violence, adolescent health issues, HIV and STIs, implementation of the SAFCI model and school violence, among others.
- **AIDS HEALTHCARE FOUNDATION (AHF):** It is a global non-profit organization based in Los Angeles, United States, whose work consists in helping strengthen HIV prevention services, as well as access to diagnosis and health care for people living with HIV/AIDS. A pilot project is currently under implementation in coordination with the National STI/HIV/AIDS Program.

The following are other international organizations and agencies working in Bolivia in issues related to the three diseases: Brazilian Agency of Cooperation, Huésped Foundation, ICALMA, FUNDIEH, UNAIDS, PAHO/WHO, UNFPA, UNDP and UNICEF.

6. ACTION PLAN OF BOLIVIA'S CIVIL SOCIETY FOR A TRANSITION TOWARDS THE SUSTAINABILITY OF COMMUNITY RESPONSES TO HIV, TUBERCULOSIS AND MALARIA FOR THE 2018–2020 PERIOD

Bolivia is currently implementing programs financed by the Global Fund to respond to HIV, TB and malaria. Due to the burden of each of the diseases and to the country's economic growth, it will start receiving funding for a transition towards the national sustainability of the response to malaria in the 2023–2025 period and soon after for the responses to HIV and TB.

Community interventions are one of the main pillars of the responses to the diseases. For this reason, planning must ensure an orderly transition towards sustainability of those community interventions by using national and international resources other than those from the Global Fund.

This action plan is based on the situational analysis conducted jointly during the social dialogue for a transition towards the sustainability of the responses to HIV, TB and malaria, specifically during the workshops held on November 17th and 18th 2017 in Cochabamba.

The workshop received technical support from the Regional Technical Support Centre for Latin America & the Caribbean (CRAT), and funding from the Strategic Initiative on Communities, Gender and Rights (CGR) of the Global Fund.

The action plan responds to the corresponding priority areas and strategic objectives of the Transition Plan for Sustainability. It particularly responds to priority area number 4 *(sustainable civil society, working jointly with the State and participating effectively in the response),* which corresponds to strategic objective number 4 *(to ensure effective participation of CSOs in the fields of tuberculosis, malaria and HIV/AIDS working jointly with the State).*

The planning matrix shown below indicates the correlation between this plan's strategic lines and lines of action, and the lines of action established for the transition plan.

6.1. OBJECTIVES AND EXPECTED RESULTS OF THE ACTION PLAN

Participants reached consensus that the plan must pursue the following general objective:

To ensure financial and programmatic sustainability of social and community strategies in the responses to HIV, tuberculosis and malaria, with full participation of community organizations and groups in the design, implementation, monitoring and evaluation of strategies aimed at responding to the diseases at all levels.

The aforementioned general objective is broken down into the following specific objectives:

1. To design sustainability strategies for community interventions in response to HIV, tuberculosis and malaria, both individual and joint.
2. To strengthen participation of community organizations and groups in the mechanisms and processes for the design, implementation, monitoring and evaluation of policies, plans and programs in response to HIV, tuberculosis and malaria, at the local, regional and national levels.
3. To expand and strengthen grassroots bases of social movements, mainly those working in the response to malaria.
4. To strengthen capacities of community organizations and groups so that they can participate in the responses to the three diseases.

The plan's strategic lines–which correspond to the specific objectives–will contribute to achieve the following results:

1. Sustainability strategies for community interventions in response to HIV, tuberculosis and malaria–both individual and joint–have been established and agreed upon.
2. Community organizations and groups participate effectively in the mechanisms and processes for the design, implementation, monitoring and evaluation of policies, plans and programs in response to HIV, tuberculosis and malaria, at a local, regional and national level.
3. Grassroots bases of community movements, mainly of those working in the response to malaria, have been strengthened and expanded.
4. Capacities of community organizations and groups to participate in the responses to the three diseases have been strengthened.

6.2. STRATEGIC LINES AND ACTION LINES BY STRATEGIC OBJECTIVE

EO1. To design sustainability strategies for community interventions in response to HIV, tuberculosis and malaria, both individual and joint.

STRATEGIC LINES	ACTION LINES	CORRESPONDING ACTION LINE OF THE TRANSITION PLAN	RESULTS
1. Political advocacy to achieve full inclusion of CSOs in political processes at the three administrative levels.	1.1. To reach a consensus with the existing national programs on sustainability guidelines, so that they are included in the transition plan. 1.2. To take into account the participation of traditional medicine in the response to the diseases. 1.3. To include populations with disabilities in the programming of the response to the diseases.	OE4-LE1.LE4. Advocacy actions to have political incidence within the framework of health programs by means of participatory technical proposals, jointly with CSOs. OE4.LE1.LA3. Development of technical proposals to support the responses to HIV, TB and malaria, with participation of CSOs. OE4.LE1.LA3. Development of technical proposals to support the responses to HIV, TB and malaria, with participation of CSOs.	I. CSOs participate in the responses to HIV, TB and malaria in the most affected areas, at the three administrative levels.
2. Search for alternative domestic and international sources of financing.	2.1. To design and implement a strategy to search for entities which finance community interventions for each of the three diseases, by internet and through international actors present in the country (UNAIDS, PAHO/WHO, international networks, etc.).	OE4.LE5.LA1. Identification of sectors related to the responses to HIV, TB and malaria.	II. Alternative domestic and international sources of financing for the community responses to HIV, TB and malaria have been identified.
3. Design of a strategy to win the CCM Chairmanship	3.1. To prepare and implement an advocacy strategy to participate in the CCM and secure that the TB movement wins the Chairmanship.	OE4-LE1.LE4. Advocacy actions to have political incidence within the framework of health programs by means of participatory technical proposals, jointly with CSOs.	III. The TB sector has been elected for the CCM Chairmanship.

STRATEGIC LINES	ACTION LINES	CORRESPONDING ACTION LINE OF THE TRANSITION PLAN	RESULTS
4. Strengthening of partnerships with international networks to improve coordination among domestic populations.	4.1. To participate in events and discussion forums of regional and international networks of the three diseases. 4.2. To invite regional and international networks to national events and discussion forums on the three diseases. 4.3. To hold a discussion meeting on networking practices and lessons learned with respect to the three diseases in the National Health Forum.	OE4.LE5.LA1. Identification of sectors related to the responses to HIV, TB and malaria. OE4.LE5.LA1. Identification of sectors related to the responses to HIV, TB and malaria. OE4.LE5.LA3. Participation of CSOs in cross-sectoral activities in response to HIV, TB and malaria.	IV. A mechanism for coordination among social movements working in the fields of HIV, TB and malaria has been established.
5. Design of self-financing models for community organizations and groups.	5.1. To establish a discussion board on self-financing models of community organizations and groups in the Health Forum. 5.2. To systematize the results and lessons learned from the board and disseminate them among CSOs.	OE4.LE5.LA2. Efforts for the rapprochement and consolidation of strategic partnerships by means of interinstitutional agreements for the responses to HIV, TB and malaria. OE4.LE5.LA3. Participation of CSOs in cross-sectoral activities in response to HIV, TB and malaria.	V. The self-financing models of community organizations responding to HIV, TB and malaria have been systematized and disseminated.
6. Design of financing application models to meet programmatic needs to submit them–either individually or jointly–before financing entities.	6.1. To hold a joint discussion on the design of projects to apply for funding. 6.2. To design projects and financing applications based on the results of the discussion. 6.3. To design a TB advocacy project to submit it to Stop TB and have an instrument to support civil society.	OE4.LE5.LA2. Efforts for the rapprochement and consolidation of strategic partnerships by means of interinstitutional agreements for the responses to HIV, TB and malaria.	VI. Financing application models to meet programmatic needs of the community responses to HIV, TB and malaria have been designed and disseminated.

EO2. To strengthen participation of community organizations and groups in the mechanisms and processes for the design, implementation and monitoring of policies, plans and programs in response to HIV, tuberculosis and malaria, at the local, regional and national levels.

STRATEGIC LINES	ACTION LINES	CORRESPONDING ACTION LINE OF THE TRANSITION PLAN	RESULTS
7. Strengthening of partnerships with the public sector to take advantage of the opportunities provided by the decentralization process.	7.1. To organize a health forum on the three diseases at the three government levels to achieve sustainability. The forum will start at the grassroots level; the next phase will be the departmental level and finally, the national level.	OE4.LE6.LA1. Advocacy actions before State agencies for the preparation of regulations governing participation of and coordination with CSOs in health programs responding to HIV, TB and malaria.	VII. Partnerships between community movements and the public sector to respond to HIV, TB and malaria have been strengthened.
8. Linkage between the organizations' sustainability plans and the administrative decentralization processes through political advocacy actions.	8.1. To prepare sustainability plans in cooperation with municipal and regional authorities.	OE4.LE6.LA1. Advocacy actions before State agencies for the preparation of regulations governing participation of and coordination with CSOs in health programs responding to HIV, TB and malaria.	VIII. Decentralization processes, mainly the implementation of the SAFCI model, include full participation of community movements working in the response to HIV, TB and malaria.
9. Strengthening of partnerships among movements to make progress with respect to rights and prevention of the diseases.	9.1. To ensure that the Productive Social and Community Projects (PSPs) of the Ministry of Education address the topics of TB, HIV and malaria.	OE4.LE1.LA3. Development of technical proposals to support the responses to HIV, TB and malaria, with participation of CSOs.	IX. Partnerships among community movements working in the response to HIV, TB and malaria include aspects related to human rights and prevention.
10. Design and implementation of a strategy to ensure the visibility of TB and malaria as public health problems and to obtain municipal and regional budget allocations.	10.1. To launch a communication campaign using the media to ensure visibility of the diseases and their impact on public health, with emphasis on the need for action by the public administration.	OE4-LE1.LE4. Advocacy actions to have political incidence within the framework of health programs by means of participatory technical proposals, jointly with CSOs.	X. Municipal and regional budget allocations for community interventions to respond to HIV, TB and la malaria are available.

STRATEGIC LINES	ACTION LINES	CORRESPONDING ACTION LINE OF THE TRANSITION PLAN	RESULTS
11. Advocacy actions to ensure participation in the implementation of community programs applying the SAFCI model, with municipal and regional funds.	11.1. To train CSOs on the opportunities offered by the SAFCI model. 11.2. To implement joint advocacy actions to ensure that community interventions to respond to the diseases are included when implementing the SAFCI model.	OE4-LE1.LE4. Advocacy actions to have political incidence within the framework of health programs by means of participatory technical proposals, jointly with CSOs.	XI. Plans for the SAFCI model's implementation at municipal and regional levels include full community participation.
12. Design and implementation of a strategy to achieve a rapprochement with the existing national HIV, TB and malaria programs, as well as to ensure participation in decision-making forums, with a mechanism to return information to grassroots bases.	12.1. To establish a mechanism to return information to grassroots bases, as well as an accountability mechanism for social movements. 12.2. To design mechanisms to communicate with populations without Internet access.	OE4.LE6.LA1. Advocacy actions before State agencies for the preparation of regulations governing participation of and coordination with CSOs in health programs responding to HIV, TB and malaria	XII. Constant collaboration between the national HIV, TB and malaria programs, with the movements' grassroots bases being fully informed of it and after discussing issues with them.
13. Training aimed at health staff members on HIV, TB and malaria, and on community strategies to respond to them.	13.1. To design and implement a training strategy to support the implementation of projects and programs of community responses to the three diseases which include aspects of the HIV-TB coinfection.	OE4.LE1.LA2. Training for CSOs within the framework of training plans and programs.	XIII. Health staff members of the three administrative levels have participated in training sessions–developed with the assistance of the Global Fund–on how to support community XIV. strategies to respond to HIV, TB and malaria. Staff members of organizations working in the community responses to the three diseases have received training to implement strategies to respond to the three diseases.

EO3. To expand and strengthen grassroots bases of social movements, mainly of those working in the response to malaria.

STRATEGIC LINES	ACTION LINES	CORRESPONDING ACTION LINE OF THE TRANSITION PLAN	RESULTS
14. Rapprochement with other social sectors, such as gender and human rights movements, among others.	14.1. To share information and experiences regarding the response to the three diseases with the rest of movements, including gender and human rights aspects related to the diseases. 14.2. To identify and participate in public discussion forums on gender and human rights. 14.3. To invite those sectors to participate in the National Health Forum, which will include a working board on the cross-sectorality of social movements.	OE4.LE2.LA1. Participation of CSOs in forums for the analysis of local, municipal and national health determinants in the response to HIV, TB and malaria. OE4.LE6.LA1. Advocacy actions before State agencies for the preparation of regulations governing participation of and coordination with CSOs in health programs responding to HIV, TB and malaria.	XV. Movements working in the response to the three diseases and gender and human rights movements share strategic information regularly. XVI. Formal links among movements working in the response to HIV, TB and malaria, and other movements, such as gender and human rights movements, have been established at a national and international level.
15. Use of resources from the Global Fund to support new leaders.	15.1. To ensure the inclusion of funds aimed at training new leaders of the grassroots bases of movements working in the response to the three diseases.	OE4.LE1.LA2. Training for CSOs within the framework of training plans and programs.	XVII. The new programs financed by the Global Fund include specific strategies for training new leaders of movements working in the response to the three diseases.
16. Facilitation of training spaces for the organizations' grassroots bases so that they can understand the diseases and participate in the responses.	16.1 To design and implement training programs aimed at the grassroots bases of each of the movements working in the response to the three diseases. 16.2.. To ensure participation of grassroots bases in national and international events where the responses to the three diseases are discussed.	OE4.LE1.LA2. Training for CSOs within the framework of training plans and programs.	XVIII. Training spaces specifically designed to facilitate access to strategic information on the response to the three diseases for the movements' grassroots bases are developed.

EO4. To strengthen capacities of community organizations and groups so that they can participate in the responses to the three diseases.

STRATEGIC LINES	ACTION LINES	CORRESPONDING ACTION LINE OF THE TRANSITION PLAN	RESULTS
17. Development of training plans and programs aimed at CSOs within the framework of the policies of the HIV, TB and malaria programs.	17.1. To coordinate with other ministries to develop educational and training programs for the different population groups. 17.2. To design and implement a training plan aimed at CSOs and community groups on the implementation of programs in response to the three diseases (including the HIV-TB coinfection), taking into consideration each of the three programs of the Ministry of Health.	OE4.LE5.LA3. Participation of CSOs in cross-sectoral activities in response to HIV, TB and malaria.	XIX. Community organizations and groups working in the response to HIV, TB and malaria have enough capacities to participate fully in the responses to the three diseases.
18. Development of training plans and programs aimed at CSOs on human rights, stigma, political discrimination, leadership and planning to ensure sustainability.	18.1. To design a training plan aimed at CSOs on human rights, leadership and advocacy, including discrimination towards the population with the HIV-TB coinfection. 18.2. To look for international financing or technical support for the project's submission and implementation.	OE4.LE1.LA1. Development of training plans and programs on national policies and regulations related to HIV, TB, malaria and human development, among others. OE4.LE1.LA2. Training for CSOs within the framework of training plans and programs.	XX. Community organizations and groups working in the response to HIV, TB and malaria have technical capacities to identify needs and conduct interventions related to human rights, stigma, political discrimination, leadership and planning with respect to each of the three diseases.
19. Facilitation of spaces for the analysis of the programs' indicators and achievement level to develop actions in support of the responses to HIV, TB and malaria.	19.1. To monitor the programs' implementation closely (Principal Recipient-programs).	OE4.LE2.LA3. Active participation of CSOs in activities carried out by local, municipal and departmental health services as part of the responses to HIV, TB and malaria.	XXI. Community organizations and groups working in the response to the three diseases have information on the implementation of national programs and have been able to share their concerns and recommendations in formal spaces.

7. TIMETABLE

N°	ACTION LINES	2018			2019			2020		
		1st 4m	2nd 4m	3rd 4m	4th 4m	5th 4m	6th 4m	7th 4m	8th 4m	9th 4m
OE1. To design sustainability strategies for community interventions in response to HIV, tuberculosis and malaria, both individual and joint.										
1.1.	To reach a consensus with the existing national programs on sustainability guidelines, so that they are included in the transition plan.	■								
1.2.	To take into account the participation of traditional medicine in the response to the diseases.	■								
1.3.	To include populations with disabilities in the programming of the response to the diseases.	■	■	■						
2.1.	To design and implement a strategy to search for entities which finance community interventions for each of the three diseases, by internet and through international actors present in the country (UNAIDS, PAHO/WHO, international networks, etc.).	■	■	■						
3.1.	To design and implement a strategy to search for entities which finance community interventions for each of the three diseases, by internet and through international actors present in the country (UNAIDS, PAHO/WHO, international networks, etc.).	■								
4.1.	To participate in events and discussion forums of the regional and international networks of the three diseases.	■	■	■	■	■	■	■	■	■
4.2.	To invite regional and international networks to national events and discussion forums on the three diseases.	■	■	■	■	■	■	■	■	■
4.3.	To hold a discussion meeting on networking practices and lessons learned with respect to the three diseases in the National Health Forum.				■					
5.1.	To establish a discussion board on self-financing models of community organizations and groups in the Health Forum.				■					
5.2.	To systematize the results and lessons learned from the board and disseminate them among CSOs.					■				
6.1.	To systematize the results and lessons learned from the board and disseminate them among CSOs.	■	■	■						
6.2.	To design projects and financing applications based on the results of the discussion.			■	■					
6.3.	To design a TB advocacy project to submit it to Stop TB and have an instrument to support civil society.	■								
EO2. To strengthen participation of community organizations and groups in the mechanisms and processes for the design, implementation and monitoring of policies, plans and programs in response to HIV, tuberculosis and malaria, at the local, regional and national levels.										
7.1.	To organize a health forum on the three diseases at the three government levels to achieve sustainability. The forum will start at the grassroots level, the next phase will be the departmental level and finally, the national level.	■	■	■	■					
8.1.	To prepare sustainability plans in cooperation with municipal and regional authorities.					■	■			
9.1.	To ensure that the Productive Social and Community Projects (PSPs) of the Ministry of Education address the topics of TB, HIV and malaria.					■	■	■		

N°	ACTION LINES	2018			2019			2020		
		1st 4m	2nd 4m	3rd 4m	4th 4m	5th 4m	6th 4m	7th 4m	8th 4m	9th 4m
10.1.	To launch a communication campaign using the media to ensure visibility of the diseases and their impact on public health, with emphasis on the need for action by the public administration.									
11.1.	To train CSOs on the opportunities offered by the SAFCI model.									
11.2.	To implement joint advocacy actions to ensure that community interventions to respond to the diseases are included when implementing the SAFCI model.									
12.1.	To establish a mechanism to return information to grassroots bases, as well as an accountability mechanism for social movements.									
12.2.	To design mechanisms to communicate with populations without Internet access.									
13.1.	To design and implement a training strategy to support the implementation of projects and programs of community responses to the three diseases which include aspects of the HIV-TB coinfection.									
EO3. To expand and strengthen grassroots bases of social movements, mainly of those working in the response to malaria.										
14.1.	To share information and experiences regarding the responses to the three diseases with the rest of movements, including gender and human rights aspects related to the diseases.									
14.2.	To identify and participate in public discussion forums on gender and human rights.									
14.3.	To invite those sectors to participate in the National Health Forum, which will include a working board on the cross-sectorality of social movements.									
15.1.	To ensure the inclusion of funds aimed at training new leaders among grassroots bases of movements working in the response to the three diseases.									
16.1.	To design and implement training programs aimed at the grassroots bases of each of the movements working in the response to the three diseases.									
16.2.	To ensure participation of grassroots bases in national and international events where the responses to the three diseases are discussed.									
EO4. To strengthen capacities of community organizations and groups so that they can participate in the responses to the three diseases.										
17.1.	To coordinate with other ministries to develop educational and training programs for the population.									
17.2.	To design and implement a training plan aimed at CSOs and community groups on the implementation of programs to respond to the three diseases (including the HIV-TB coinfection), taking into consideration each of the three programs of the Ministry of Health.									
18.1.	To design a training plan aimed at CSOs on human rights, leadership and advocacy, including discrimination towards the population with the HIV-TB coinfection.									
18.2.	To look for international financing or technical support for the project's submission and implementation.									
19.1.	To monitor the programs' implementation closely (Principal Recipient-programs).									

Note: 4m = four-month period

8. MECHANISM FOR THE PLAN'S IMPLEMENTATION

During the social dialogue workshop, the coordination and communication mechanism allowing to finish the preparation of the plan with full participation of all people belonging to movements working in the response to the three diseases was established.

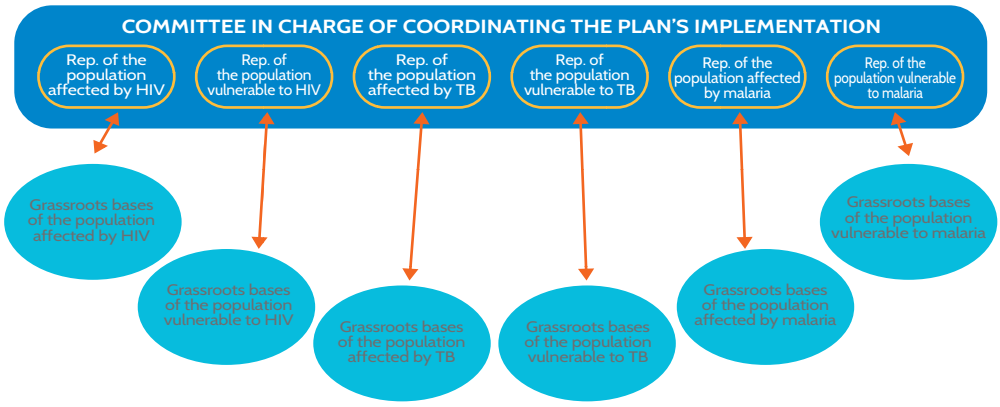
This mechanism was based on a committee composed by representatives of each of the six populations involved (populations affected by the three diseases and populations vulnerable to the three diseases). They agreed upon coordinating with each other to guarantee that all information could flow easily and in a comprehensive manner between the grassroots bases of each movement and the people in charge of coordinating actions.

It was agreed that this mechanism would be maintained for the plan's implementation and monitoring. This way, the committee composed by those six people will be responsible for the plan's implementation. To that effect, each one of them will have to identify the lines of action which correspond to their population, those who are specific to their population and the ones they share with one particular population or the other populations.

In the case of lines of action specific to one population, each representative will have to guarantee coordination with the grassroots bases of their movement for a joint action. In the case of lines of action shared with other populations, representatives will have to coordinate with the other movements involved to guarantee joint action.

Grassroots bases of each movement will have to receive–at least on a monthly basis–information on the progress of the plan's implementation, barriers encountered and possible solutions. Grassroots bases shall be able to give their opinions and make contributions within a reasonable deadline established for that purpose. Each movement may use their own communication channels or use the CCM WhatsApp group, as it happened during the plan's design.

CCM meetings will be used to convene a session of the committee in charge of monitoring the plan's implementation.



ANNEX 1. CONSTRUCTION OF A SHARED VISION AND JOINT PLANNING BETWEEN CIVIL SOCIETY AND COMMUNITIES REGARDING THE CHALLENGES AND OPPORTUNITIES IN THE RESPONSES TO HIV, TUBERCULOSIS AND MALARIA

November 17th and 18th, 2016
Cochabamba

Introduction

The Regional Technical Support Centre for Latin America & the Caribbean (CRAT) collaborates with the Global Fund to assess the risks and needs related to the sustainability of the responses to HIV, tuberculosis (TB) and malaria in countries implementing programs financed by the Global Fund, as well as to plan civil society actions in the context of a sustainable transition after the Global Fund's withdrawal in Bolivia.

In November 2017 informative sessions aimed at organizations and groups working in the community response to the three diseases will take place, both in Riberalta (on malaria) and Cochabamba (on HIV and TB). This workshop for the construction of a shared vision and joint planning of civil society will be held afterwards.

General Objective

- To build a shared vision and joint planning regarding social, political and financial changes, as well as the challenges and opportunities they imply for civil society working in the fields of HIV, tuberculosis and malaria in Bolivia.

Objetivos específicos

1. To provide civil society with knowledge on projections regarding the behavior of the HIV, tuberculosis and malaria epidemics until 2020.
2. To provide civil society with knowledge on internal and external financing perspectives for the three diseases in Bolivia until 2020.
3. To strengthen dialogue between civil society and communities about the risks and technical assistance needs of civil society for achieving a sustainable transition in Bolivia.
4. To prepare an action plan allowing to address challenges and seize the opportunities transition processes imply, detailing the training and assistance needs for their implementation.

AGENDA

Day 1

Time	Topic	Person/entity in charge
8:30	1. Registration	
8:45	2. Welcome and presentation of the initiative	CCM
9:00	3. Participants' expectations	Diego Postigo
9:10	4. Summary of the informative workshops in Riberalta and Cochabamba (one participant of each workshop will be asked to present a ten-minute summary)	Consultant
9:30	5. Identification of institutional and social risks and opportunities, as well as weaknesses and strengths of community organizations and groups for HIV, TB and malaria control in the next 5 years	Teams by disease
10:30	Break	
11:00	6. Teams: discussion and presentation	All
12:00	Lunch	
13:00	7. Discussion on the scalability and sustainability of models with the other organizations and groups	All
16:00	8. Conclusions and closing	CCM

Day 2

Follow-up meeting with the established committee

Time	Topic	Person/entity in charge
8:30	1. Recap of the previous day	Participant
8:45	2. Definition of the objectives of the 2018–2020 action plan for the sustainability of community interventions	Teams
9:15	3. Plenary presentation and discussion	All
9:45	4. Definition of strategies and key actors to achieve the objectives set, based on the SWOT analysis	Teams
10:15	Break	
10:45	5. Plenary presentation and discussion	All
12:00	6. Lunch	
13:00	7. Definition of activities and resources for the implementation of each strategy	Teams
13:30	8. Plenary presentation and discussion	All
14:00	9. Opportunities and mechanisms for the plan's implementation	Plenary discussion
15:30	10. Evaluation survey	All
16:00	11. Next steps and closing	CCM

ANNEX 2. EVALUATION SURVEY TO PARTICIPANTS

Out of the 63 people who completed the evaluation survey, 49 said their expectations were met fully, while 9 claimed their expectations were met only partially, mainly due to the lack of time to complete the agenda.

On the one hand, discussions to complete the SWOT analysis are most frequently cited as the best part of the dialogue, followed by the opportunities to participate in the activities. On the other hand, the lack of time to complete the agenda is most frequently mentioned as the worst aspect of the dialogue.

It can be concluded that the exercise was highly satisfactory and participatory, which made it possible for everybody to make contributions. The agenda might have been little realistic for the limited time available. This could have been the reason why the exercise did not meet all expectations.

It is to be noted that the evaluation survey was completed electronically before the planning work–including the validation session on December 14th–, so the level of satisfaction might have been higher at the end of the process.

vialibre

experiencia y compromiso contigo

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