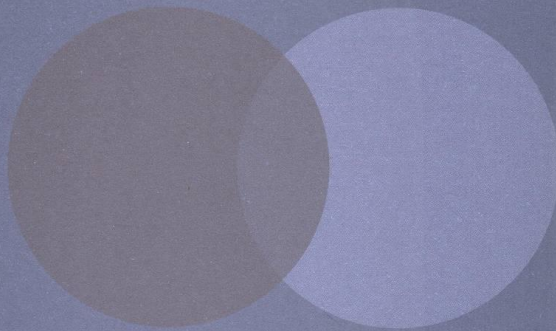




BELIZE



RAPID ASSESSMENT OF SEXUAL AND REPRODUCTIVE HEALTH AND HIV LINKAGES



This summary highlights the experiences, results and actions from the implementation of the *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages* in Belize¹. The tool – developed by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives in 2009 – supports national assessments of the bi-directional linkages between sexual and reproductive health (SRH) and HIV at the policy, systems and services levels. Each country that has rolled out the tool has gathered and generated information that will help to determine priorities and shape national plans and frameworks for scaling up and intensifying linkages. Country experiences and best practices will also inform regional and global agendas.

RECOMMENDATIONS

What recommendations did the assessment produce?

- Engaging the Ministry of Finance and senior officials in the Ministry of Health (MOH) in the benefits of SRH and HIV integration, so that they can sanction the process and provide the necessary resources.
- Clearly defining the roles and responsibilities of regional managers of health facilities with regard to the provision of SRH and HIV services and the promotion/monitoring of integration.
- Fast-tracking the development of anti-discrimination laws for people living with HIV (PLHIV) and other vulnerable groups.
- Developing and disseminating a clear statement on the SRH rights of PLHIV.
- Restructuring mother and child health (MCH) clinics into community and family clinics; merging the programmes for National TB, HIV and Other STIs and MCH to accommodate this new approach and reducing their vertical management; reorienting all PHC services and developing a package of SRH services, allowing for the consolidation of already limited human and financial resources.
- Using existing frameworks such as the Model of Care for integrating HIV into PHC. Expanding this to include SRH integration into PHC and re-evaluating the timeframe for its implementation.
- International funding agencies providing resources to civil society to advocate for greater SRH and HIV integration, including within PHC.
- Making efforts to integrate the SRH needs of both men and women throughout the life cycle.
- Supporting the NAC initiative to develop anti-discrimination legislation aimed at reducing stigma and discrimination against vulnerable and most-at-risk populations.
- Reviewing the Alliance Against AIDS (AAA) draft code of practice for health care providers and ethical guidelines for medical professionals and using them as a base for discussions. Adapting them to suit the needs of the MOH in reducing stigma and discrimination against PLHIV and most-at-risk populations.
- Continuing to access opportunities for staff training and sensitization on SRH and HIV integration and reduction of stigma and discrimination; focusing on the need to increase the integration of gender-based violence (GBV) and abortion services with sexually transmitted infection (STI)/HIV services and vice versa.
- Documenting the experience of Belize Family Life Association (BFLA) as a good-practice case for SRH and HIV integration.
- International development agencies providing the MOH with access to best-practice cases of SRH and HIV integration and facilitating exchange visits with successful countries.

1. This summary is based upon: *Report: Sexual and Reproductive Health and HIV Linkages in Belize*, Belize ISIS Enterprises and UNFPA, May 2010.

PROCESS

1. Who managed and coordinated the assessment?

- The assessment was carried out by Belize ISIS Enterprises Ltd, supported by UNFPA. Support was provided by the Ministry of Health (MOH), Belize Family Life Association (BFLA), United Nations Children's Fund (UNICEF), National AIDS Commission (NAC) and Pan American Health Organization (PAHO)/World Health Organization (WHO).
- The assessment took place during November 2009 to January 2010.

2. Who was in the team that implemented the assessment?

- The assessment team was made up of the lead researcher from Belize ISIS Enterprises Ltd and five researchers who had worked with the Women's Department of the Belize Ministry of Human Development, Women's Issues Network of Belize (WIN-Belize), Alliance Against AIDS (AAA), University of Belize and NAC. They were all trained in conducting social research on SRH and HIV.

3. Did the desk review cover documents relating to *both* SRH and HIV?

- The desk review covered national policies, programme documents and research studies on SRH, HIV, gender and poverty, as well as international research on SRH and HIV integration.

4. Was the assessment process gender-balanced?

- The assessment team members were all women. The research was conducted at a time when most of the men trained in social research were unavailable due to study commitments.
- Most of the clients interviewed (86 per cent) were female, because SRH services are perceived by public sector service providers and clients to be part of MCH services. HIV services are similarly equated with voluntary counselling and testing (VCT). All public sector health care institutions (the majority of institutions that participated) referred the assessment team to their MCH or VCT clinics to conduct client interviews.

- In the private health care institutions, again more women clients were willing to participate. This trend of higher female participation in SRH services is confirmed by PAHO research.

5. What parts of the Rapid Assessment Tool did the assessment use?

- The three parts of the Tool were administered: Policy Framework (modified to meet the country-specific needs), Systems Functioning and Service Delivery.
- Belize had piloted the Rapid Assessment Tool in 2008. In 2009, it started implementation by modifying the policy section to address the country's specific context.
- The policy section was used with policy planners, through individual interviews and one focus group. The services section was applied through surveys among service providers and service users from government-run health facilities and one non-governmental organization (NGO).

6. What was the scope of the assessment?

- 16 health facilities (an estimated 53 per cent of relevant entities) participated: four NGO facilities (BFLA), providing a range of SRH- and HIV-integrated services; eight public health facilities, providing MCH; and four private health facilities providing a basic package of health services to those qualifying for National Health Insurance (NHI) and prioritizing MCH.

7. Did the assessment involve interviews with policy-makers from *both* SRH and HIV sectors?

- The assessment involved interviews with: MOH Coordinator responsible for National Sexual and Reproductive Health Policy and Strategic Plan of Action; MOH Director of National STI/HIV/AIDS Programme (formerly National AIDS Programme); Executive Director of BFLA; Director of WIN-Belize; Director of NAC; PAHO Technical Expert on Gender, HIV and AIDS; and regional managers of health facilities.

- Information from policy makers was also taken from *Assessment of STI/HIV/AIDS Programmes within the Health Sector* (PAHO, 2009) and *Piloting of the SRH Assessment Tool* (UNFPA, 2008).

8. Did the assessment involve interviews with service providers from both SRH and HIV services?

- Yes – the survey involved 31 service providers at: public hospitals (7 providers); private hospitals (4); polyclinics (6); urban health clinics (4); urban NHI clinics (3); BFLA facilities (4); and rural health posts (3).

9. Did the assessment involve interviews with clients from both SRH and HIV services?

- A total of 102 service users from both SRH and HIV services participated in exit interviews.
- The majority of the service users were women (86 per cent) and aged 20–29 years (52 per cent).

- About half identified themselves as Roman Catholic. They identified their ethnicities as Mestizo/Hispanic (39 per cent), Creole (32 per cent), Garifuna (12 per cent), Maya (8 per cent) and East Indian (5 per cent).

10. Did the assessment involve people living with HIV and key populations?

- The client survey involved people living with HIV (PLHIV) as well as men who have sex with men (MSM) and sex workers. Involving these clients often meant meeting them at non-public settings to discuss the SRH issues affecting them.
- The involvement of a researcher from AAA helped to mobilize PLHIV and MSM participation. Similarly, a researcher with over 5 years' experience in providing SRH information to sex workers was able to mobilize information from this population.

FINDINGS

1. Policy level

National policies, laws, plans and guidelines:

- The national policy framework is comprehensive and supportive of SRH and HIV integration. It also addresses structural determinants, such as gender equality and human rights.
- The National Strategic Plan for HIV/AIDS (2006–11) emphasizes: cross-sectoral programmes; improved sectoral HIV policies, including for SRH; improved access to prevention of mother to child transmission (PMTCT); and improved/integrated SRH services.
- The National Plan for HIV/STI/TB (2008–15) states HIV integration into SRH as an objective. It prioritizes the following: scaling up services for pregnant women; integrating HIV/STI/TB care and treatment package at each level; procuring HIV rapid testing for some private clinics;

linking HIV and GBV services; and doing a baseline study on key populations.

- The National Policy on SRH (2002) emphasizes rights and integration. It calls for an end to coercive or discriminatory laws, including related to HIV. It promotes: counselling on family planning (FP) options for PLHIV; an ethical and gender-sensitive approach; and integration of HIV with issues relating to sexual abuse, abortion, STIs and GBV.
- The National SRH Strategic Plan aimed for all public health facilities to provide SRH services by the end of 2010. It commits to implementing and maintaining an STI and HIV programme as part of SRH services that are accessible and affordable.
- The National Gender Policy aims to reinvigorate attention to SRH issues. The National Action Plan for Gender-Based Violence (2007–09) addresses issues of SRH and HIV.

- The implementation of policies has been slow. For example, there is still no package for integration across primary health care (PMC) and only guidelines for integration into MCH.
- PMTCT has been integrated into the MCH Programme since 2001. A comprehensive PMTCT approach has been used but there has been less attention on Prongs One and Two, i.e. primary prevention of HIV for women of childbearing age, and preventing unintended pregnancies among women living with HIV.
- Sexually transmitted infection (STI) policy development is integrated into the National Programme on TB/HIV and Other STIs.
- There is no HIV-specific legislation. The Constitution cites the right to health and non-discrimination. The Public Health Act (revised 2000) guides the provision for the management of infectious diseases, but has not been updated. The Domestic Violence Act (2007) provides for comprehensive protection. The Criminal Code addresses areas of GBV.
- Donors are increasingly supportive of SRH and HIV integration and some (such as HIVOS and UNFPA) call for such proposals. But, generally, lack of harmonization by UN bodies and other donors (of funding cycles, conditions, etc) remains a challenge. Stakeholders still often have to make separate approaches to resource the components of integrated programmes.
- A past GFATM project, implemented through the NAC, catalysed integrated HIV programming across government and non-governmental organizations (NGOs). A new GFATM project will be coordinated by the NAC and target SRH and HIV services to key populations. The NAC is also developing anti-discrimination legislation, based on the rights of PLHIV and key populations.

Funding and budgetary support:

- Overall, there is a larger pool of resources for HIV than SRH.
- The main source for recurrent expenditure on the MCH and the National TB, HIV and Other STIs Programmes is the national budget, with the funds provided vertically to each. SRH is mostly covered under the MCH budget.
- Funds for SRH and HIV programmes from international partners include UNFPA (mostly to MCH) and PAHO/WHO (mostly to National TB, HIV and Other STIs). Other funders, such as UNICEF and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), provide resources for specific projects.
- Apart from the MOH, key partners such as BFLA are funded from multiple sources, such as IPPF and UNFPA. Others, such as WIN-Belize Secretariat, AAA, Youth Enhancement Services (YES) and Young Women's Christian Association (YWCA) receive funds from donors such as HIVOS, Latin American Council of AIDS Service Organizations, Inter-American Development Bank, Worldwide Young Women's Christian Association, the European Union and the Central American Women's Fund (CAWF).

2. Systems level

Partnerships:

- The SRH and HIV programmes have developed multiple partnerships with government and NGOs, supported by coordinating bodies such as the NAC and National Committee for Families and Children (NCFC). Through the NAC, there is collaboration on policy development, especially anti-discrimination legislation and improved services for key populations. Through the NCFC, HIV issues have been prioritized within national plans for children and youth.
- The programmes also foster partnerships at the community level through collaboration with community groups working directly with PLHIV or women's groups.
- Other partners – such as BFLA, the Women's Department of the Ministry of Human Development, Belize Red Cross Society, AAA and WIN-Belize Secretariat – report SRH and HIV integration.
- Among the international community, PAHO/WHO, UNFPA, UNICEF, UNDP, UNIFEM, UNAIDS, GFATM, Clinton Foundation, USAID and others provide financial/technical support. The closest collaborators are UNFPA, PAHO/WHO, UNDP and UNICEF.

Planning:

- The MCH Programme is responsible for the National SRH Policy and Action Plan and the NAC is responsible for the National HIV Policy and Strategic Plan.

- Despite policies that support integration, the planning/management of SRH and HIV remain vertical (with the exception of PMTCT). There are no built-in requirements for cross-programme work, although the programmes on MCH and National TB, HIV and Other STIs have committed to coordination.

Human resources and capacity building:

- The MCH Programme has three technical staff, the National Programme on TB, HIV and Other STIs has two technical staff. Overall, the country's health system suffers from shortages and inequitable distribution of health care workers.
- The National SRH Coordinating Committee seeks to pool human and financial resources to improve the implementation of the National SRH Policy and Action Plan. But inadequate human resources at the primary health level undermine the establishment of a comprehensive SRH and HIV package and there is resistance to accommodating the new model.
- The MCH and the National TB, HIV and Other STIs Programmes invest in in-service capacity building for their staff. There are moves towards a more integrated approach to SRH- and HIV-related training.

Logistics, supply and laboratory support:

- Laboratories service the needs of both SRH and HIV programmes.
- Urban hospitals/clinics have easy access to laboratories, but there are limitations (such as capacity challenges, affecting turnaround time for results). Access is worse in rural areas. The programmes on MCH and National TB, HIV and Other STIs are collaborating to ensure rapid HIV testing in rural communities.
- Limited supplies of contraceptive commodities have caused MCH providers to prioritize vulnerable women, including HIV-positive mothers.

3. Services level

A. SERVICE PROVIDER PERSPECTIVES

NGO facilities:

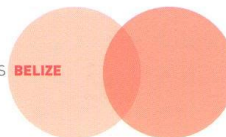
- BFLA, an SRH service provider, showed the highest levels of SRH- and HIV-integrated programme planning and management. Clients can request any of a menu of services and access them from the same provider. BFLA also

provides outreach in rural areas; services to adolescents; a project to increase coverage for MSMs, bisexuals, sex workers and transgender groups. BFLA is also one of the contracted primary care providers of MCH services including PMTCT.

- BFLA has trained staff in VCT and provider-initiated testing and counselling (PITC), services for key populations, SRH rights, gender equality, GBV and comprehensive services for each client.
- According to the providers, the HIV services most often integrated into SRH are VCT, PITC and condom provision. Those least integrated are psycho-social care and prevention for/by PLHIV.
- Most of the SRH and HIV services are provided at the same site, by the same provider and on the same day. For other services, BFLA manages a formal referral system to/from other NGOs, MCH clinics and public hospitals.
- The largest constraint to further integration was identified as the need for more equipment and space. The impacts of integration were cited as reduced costs to the facility; maintaining same cost to clients; increasing efficiency; decreasing stigma; increasing staff workload; increasing time spent per client; and increasing the need for supplies and drugs.

Public health facilities:

- The eight public health service providers said that SRH and HIV services were reoriented to allow for bi-directional integration. The application of the PMTCT+ Guidelines is reported to be adequate. But, besides this, the facilities do not structurally integrate services.
- The facilities focus on pregnant women and their children and do not target key populations.
- The HIV services most often integrated into SRH are VCT into FP and PITC and prophylactic treatment into PMTCT. Condom distribution is integrated into FP and STI services. Half of the facilities do not integrate HIV into services related to GBV or abortion.
- The challenges to integration were identified as staff time, space, equipment and efficiency in service delivery. Such an approach would mean more staff, increased staff time spent with clients, increased need for privacy and space



and an increased need for equipment, supplies and drugs. Less than half of the providers saw an increased workload as a major constraint.

Private NHI health facilities:

- At the private facilities, SRH services were being reoriented to include HIV services – by informing clients about confidentiality and routine HIV testing, training medical staff on HIV testing, creating links with NGOs working with PLHIV and specialized clinics for PLHIV.
- Overall, the facilities showed low integration, even though many SRH and HIV services are provided at the same facility and by the same provider.
- According to the four service providers interviewed, PITC was the HIV service most commonly integrated into SRH. Three facilities integrated HIV prevention for the general population into FP, while three also integrated prevention of HIV among women of childbearing age (Prong One of PMTCT) into STI services. None of the facilities provide services specific to key populations.
- The challenges to integration were identified as shortage of staff, staff training and low staff motivation. Regarding changes caused by integration, two of the facilities indicated that there would be no change in stigma or the cost of services. But all four cited increased workload, time spent per client and the need for equipment, supplies and drugs.

B. SERVICE USER PERSPECTIVES

- Among the 76 service users, most accessed facilities for MCH services (34 per cent) compared to FP (16 per cent) and HIV services (11 per cent). Generally, respondents received the services they expected. Where they did not, this was usually due to it not being available on that day or at that facility. NGOs had the highest rate of services offered compared to requested (95 per cent).
- Overall, only 14 per cent of respondents were referred to another facility – most frequently by public and private health facilities that did not provide the service in question. Many clients received additional services, particularly FP- and HIV-related services and especially at NGO facilities.
- Over half of clients were very satisfied with the services they received (54 per cent). The highest rating was given by those attending the private facilities (88 per cent) followed by the NGO (63 per cent).
- Most respondents favoured SRH and HIV services being delivered by the same provider (72 per cent). The benefits were seen to include reduced trips to the facility (44 per cent) and improved efficiency (23 per cent). The disadvantages included increased waiting time (13 per cent) and less confidentiality (8 per cent). Only five per cent cited a decrease in the quality of services and only 1 per cent fear of stigma.

LESSONS LEARNED AND NEXT STEPS

1. What lessons were learned about how the assessment could have been done differently or better?

- The assessment may not have provided a comprehensive picture of all SRH services offered within facilities, due to Belize not having a well structured SRH package at the PHC level: the researchers were referred to the MCH clinics in facilities and largely unable to solicit responses from a wider group of providers.
- The assessment may not have captured the extent to which services related to GBV and post abortion are being provided, due to those services usually being referred to the emergency ward of hospitals.

2. What 'next steps' have been taken (or are planned) to follow up the assessment?

- A workshop was held to present the preliminary findings of the assessment. Over 20 participants (including the MOH, NGOs, BFLA and multilateral agencies) gave feedback and provided recommendations for follow-up actions that were integrated into the final report.
- Workshop participants have since begun to more clearly articulate how they will foster greater integration of services within their existing programmes. For example, WIN-Belize has redefined its priorities to include SRH and developed joint proposals that demonstrate an integrated approach across member agencies. One such proposal is being funded by UNFPA. MOH Technical Advisors for HIV/AIDS and MCH/SRH have begun concrete discussions with the Director of Health Services on the need for integration of services within public health facilities. UNFPA has met with the MOH, UNDP, UNICEF and PAHO to discuss integration, examine the findings of the assessment and determine how best to proceed. One concrete action is to evaluate both the SRH and HIV policies, revising them to address integration.

3. What are the priority actions that are being taken forward as a result of the assessment, at the:

- policy level?
- systems level?
- services level?

Policy level:

- The Draft Proposed National Gender Policy for Belize (2010) has prioritized the development and delivery of SRH services to men/women across the life cycle. It calls for the recognition of SRH rights for key populations such as adolescents, sex workers, MSM, PLHIV and people with disabilities. It also calls for the integration of SRH and HIV services.
- The proposed 20-year National Planning Framework for Belize calls for greater integration of SRH and HIV and for services to be designed to meet the needs of men/women throughout the life cycle. This has already been presented to the Chief Executive Officer (CEO) and senior policy developers and planners in the MOH, as well as CEOs and planners in all ministries.
- The NAC has deepened its attention to the need for integration of HIV services with SRH services and to focus more on needs of key populations. It is updating its strategic plan to reflect this reorientation, which is mainly being proposed by NGOs, including key population organizations. The Women's Department is also a key advocate for gender mainstreaming of SRH and HIV services through the NAC. The approved GFATM Round 9 grant was developed within the context of an integrated model, with a focus on increasing the access of MSM and sex workers to comprehensive SRH and HIV services and strengthening the existing Health and Family Life Education curriculum. The NAC has coordinated the development of a civil society-driven GFATM proposal to Round 10 that integrates SRH and HIV and focuses on most-at-risk populations. UN agencies such as UNFPA, UNDP, and PAHO/

LESSONS LEARNED AND NEXT STEPS CONTINUED

WHO provided technical support for its development.

- Although new policy documents reflect a move towards the integration of SRH and HIV services and an increased focus on the needs of key populations, there is still a need for greater sensitization of key government ministers to enable the effective implementation of proposed policies and programmes. This will require greater information sharing and joint advocacy from the public sector, civil society and international development agencies.
- The NAC is engaging key partners in the development of a national condom policy within the context of dual protection. UNFPA and UNDP are the two key UN agencies involved.

Systems level:

- The MOH is gearing up to implement provider-initiated HIV counselling and testing in public health facilities, guided by an Integrated Model of Care for Primary Health Care.
- National Programme on TB, HIV and other STIs: although the MOH is now making a concrete move to increase the SRH services that it offers (procurement of equipment to provide SRH services via UNFPA), there is still a need for greater articulation of how SRH and HIV services will be integrated at the level of service delivery for men and women across the life cycle (not just pregnant women).
- BFLA continues to integrate SRH and HIV and provide services to key populations such as adolescents, sex workers, PLHIV and MSM.

Services level:

- The MOH is rolling out PITC in PHC facilities.
- The MCH Programme in the MOH has developed guidelines for the delivery of SRH services to adolescents and sex workers, even though the financing of this remains a major challenge.
- The MOH is purchasing additional equipment for the provision of SRH services via the co-financing agreement between UNFPA and MOH.
- The NGO sector, through WIN-Belize, has begun to more actively promote SRH and HIV integration across its member agencies. Several programmes are being implemented to reflect this. The members are AAA, BFLA, Youth Enhancement Services, Young Women's Christian Association, UNIBAM (an MSM organization), POWA (women living with HIV) and others, working together to ensure greater integration at the level of service delivery.

4. What are the funding opportunities for the follow-up and further linkages work in the country?

- For more information about the approved GFATM Round 9 grant, please see 'Lessons learned and next steps', section 3 on priority actions, opposite.
- Belize developed a proposal for Round 10 of the GFATM. This seeks funding from the special reserve for at-risk populations. Both SRH and HIV issues were mainstreamed into this proposal which was developed jointly by technical experts, people from key populations and civil society organizations that work with key populations.
- Within the UN HIV/AIDS Joint Team, there are opportunities for joint programming to further linkages via the Programme Acceleration Fund and the Regional Coordinator budget.

Abbreviations

AAA	Alliance Against AIDS
AIDS	acquired immune deficiency syndrome
BFLA	Belize Family Life Association
CAWF	Central American Women's Fund
CEO	Chief Executive Officer
FP	family planning
GBV	gender-based violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP+	Global Network of People Living with HIV
HIV	human immunodeficiency virus
ICW	International Community of Women Living with HIV/AIDS
IPPF	International Planned Parenthood Federation
MCH	maternal and child health
MOH	Ministry of Health
MSM	men who have sex with men
NAC	National AIDS Commission
NCFC	National Committee for Families and Children
NGO	non-governmental organization
NHI	National Health Insurance
PAHO	Pan American Health Organization
PHC	primary health care
PITC	provider-initiated testing and counselling
PLHIV	people living with HIV
PMTCT	prevention of mother to child transmission
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
WHO	World Health Organization
WIN-Belize	Women's Issues Network of Belize

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