# A Situational Assessment of the National Response to HIV/AIDS in Belize

Report Produced by:

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## BACKGROUND

The overall goal of the national response to HIV/AIDS is to reduce its impact on the economic, social, and cultural context in Belize.

The National Strategic Plan provides a guide to Belize's scaled-up national response to HIV/AIDS. It sets out the fundamental principles, the broad approaches, and the actions needed to achieve its strategic objectives.

In order to achieve this overarching goal, three priority areas were identified to guide the HIV/AIDS response: Harmonization, Prevention and Mitigation. Each of these priorities in turn, further identifies the key target impact and outcome indicators, which are to be achieved in order to address these priority areas.

Thus, further expansion is needed if the spread of HIV/AIDS in Belize is to be halted. Efforts toward putting a joint National Operational plan of action into effect must involve all sectors of the population of Belize. It is precisely because of these reasons that an appropriate response to HIV/AIDS that is both comprehensive and sustainable is required. The implementation of the strategic plan will adopt a multi-sectoral approach that demonstrates that an effective response to HIV/AIDS does not rely on individual ministries or agencies. The plan is built on a clear understanding of the comparative advantage of each entity, and the opportunities for integration among the various entities to achieve a truly comprehensive, national expanded response, where new partners are mobilized, and where activities are well coordinated and prioritized.

For this reason, the implementation of the NSP must be a coordinated effort involving the National AIDS Commission, its Secretariat, the UN Theme Group and other partners. In its role as the coordinating body for the Commission and the implementation of the NSP, the Secretariat undertook a qualitative assessment of commission members and other partners, with the purpose to identify gaps in the National Response based on the strategic objectives outlined in the National Strategic Plan, and to identify areas for a more focused, and better coordinated National Response that is in alignment with those strategic objectives.

**METHODOLOGY**

During the period of May 26th to June 10th, 2008, the NAC Secretariat conducted a qualitative assessment of commission members and partners. This assessment consisted of 37 different organizations from the entire country working within the national response. A structured questionnaire was given to all partners to fill out. A follow up visit was then conducted and an interview was carried out to probe more in depth responses to the questionnaire and also to collect any additional supporting information on the work being carried out by the organizations. Data was collected on the work being carried out in the three key priority areas, Harmonization, Prevention and Mitigation. Information was also collected in the areas of Monitoring & Evaluation, capacity needs and challenges faced by each organization.

In spite of attempts by the Secretariat, there were a number of agencies that did not respond to the questionnaire or were not available for the consultation process. The findings presented below reflect the information obtained by those respondents that completed both processes.

## KEY FINDINGS

### 1. Prevention

Almost all of the respondents (93 %) claim they are engaged in at least one prevention activity, except two, – NCFC (only engage in M&E) & PAHO (technical assistance which is expected for these agencies. Regarding the actual implementing partners, their involvement is not uniform or equal in intensity. The following Table shows how many or the organizations are involved in how many prevention activities:

**Table 1. Number of Respondents Engaged in 0< Prevention Activities**

| # of prevention activities | # of respondents * |
|---|---|
| 0 | 1 |
| 1 | 3 |
| 2 | 5 |
| 3 | 9 |
| 4 | 3 |
| 5 | 3 |
| 6 | 2 |
| 7 | 1 |

*** Total Number of Respondents = 27**

The average of all the activities performed is 3.5 activities per organization. This is a good effort in the part of the organizations engaged, especially those affirming they carry on six activities either as an organization or as participants in an AIDS Committee.

The activity most frequently mentioned was the education/ promotion/ distribution of condoms (78%). This is an encouraging finding as it suggests that the majority of the partners do not just simply carry out information/awareness efforts, but also form part of a condom distribution network, taking the action from promotion to actual service provision. The concentration of prevention efforts reported focused on youth, since 70% of the organizations claim to have programs addressing KAP among this population; a very important group of the population at risk since this segment is most likely to engage in unprotected sexual activity.

**Table 2. The No. of Organizations providing service in the following Key Prevention Areas**

| Key Prevention Area | # of Organizations | % of Respondents * |
|---|---|---|
| Maintenance of Safe Blood Products | 1 | 4 |
| PMTCT Services | 8 | 30 |
| Integrated STI diagnosis and Treatment Services | 5 | 19 |
| Distribution and access to condoms | 21 | 78 |
| VCT Services | 11 | 41 |
| PEP for Health Care Workers and Survivors of sexual abuse | 4 | 15 |
| Programs addressing KAP among youth | 19 | 70 |
| Programs addressing KAP among high risk and vulnerable groups (MSM, CSW, Uniformed Services) | 14 | 52 |

*** Total Number of Respondents = 27**

As noted above, the activity most frequently mentioned was the education/ promotion/ distribution of condoms (78%).

There is a noted discrepancy in the area of Maintenance of Safe Blood Products as shown in Table 2. Although it is recognized that MoH via the Central Laboratory is directly responsible for this activity, the representative of the National AIDS Program did not report it as such since it falls outside of his programmatic area.

It should also be pointed out that the PMTCT services in row two do not reflect direct provision of PMTCT services, but rather a distribution between those organizations that counsel, promote, or referrer their clients to PMTCT (5 out of 8) and those actually offering the services (3). The NSP calls for further expansion of PMTCT services that are integrated within the Primary Care Level. There is therefore room for strategies that will promote this expansion. Similar patterns are noted in the offer of VCT services since only five of the 11 organizations carry out the full service, while the remaining 6 do counseling, promotion and referrals to a VCT site.

Surprisingly half (52%) of the organizations are in one way or another engaged in some type of activity addressing KAP among high risk and vulnerable groups. What could not be ascertained was the level of coverage and service provision. However, at least three organizations reported addressing each one the MSM, the CSWs, and the Uniformed Forces. Given that the mode of HIV transmission is predominantly sexual in Belize, and that both CSWs and MSM tend to have multiple partners on a regular basis (include a reference to support this statement), it should be noted that the number of organizations addressing these segments of the population is rather low. A specific strategy to encourage more

organizations to address these populations should be designed and put into practice soon.

**Table 3. Program Areas Under Prevention**

| Organization | Maintenance of Safe Blood Products | PMTCT Services | Integrated STI diagnosis and Treatment Services | Distribution and access to condoms | VCT Services | PEP for Health Care Workers and Survivors of Sexual Abuse | Programs addressing KAP among youth | Programs addressing KAP among high risk and vul. groups | Policy | *Total Prev. Activities per Organiz.* |
|---|---|---|---|---|---|---|---|---|---|---|
| Belize Red Cross | | | | x | | | x | x | | *3* |
| Alliance Against AIDS | | | | x | | | x | x | | *3* |
| Toledo AIDS Committee | | | | x | x | x | x | x | | *5* |
| Belmopan AIDS Comm. | | (C/R) x | | x | x | x | x | x | | *6* |
| Cornerstone Foundation | | | | x | x | | x | | | *3* |
| BFLA | | (T) x | x | x | (T) x | | x | x | | *6* |
| MOH | (?) | (T) x | x | x | (T) x | x | | | | *5* |
| O. Walk AIDS Comm. | | | | x | | | x | x | | *3* |
| NCFC | | | | | | | | | | *0* |
| Women's Dept. | | | | x | | | x | | | *2* |
| Hand in Hand Min. | | (P/R) x | | | | | | | | *1* |
| Labour Dept. | | | | x | | | x | x | x | *4* |
| CARE Belize | | | | | | | | x | | *1* |
| PAHO | | TA | TA | | TA | TA | TA | TA | | *TA* |
| HECOPAB | x (?) | (P) x | | x | (P/R) x | | x | x | | *7* |
| YFF | | | | | | | x | x | | *2* |
| BCCI-BCCHA | | | | | | | | | x | *1* |
| VCT San Ignacio | | x | x | x | x | x | | | | *5* |
| Bze City Council | | | | x | | | x | x | | *3* |
| San Pedro AIDS Comm. | | | | x | x | | x | | | *3* |
| Equity House Bze | | | x | x | x | | x | | | *4* |
| Claret Care | | | | x | x | | x | x (CSW) | | *4* |
| POWA | | (C/R) x | | x | | | x | | | *3* |
| YES | | (P/R) x | | x | | | x | | | *2* |
| YWCA | | | | x | | | x | | | *2* |
| MoE HFLE Unit | | | | (P)x | | | x | | | *2* |
| UNIBAM | | | | x | x | | | x (MSM) | | *3* |
| ***TOTAL Organizations per Prevention Area*** | *1* | *8* | *4* | *21* | *11* | *4* | *19* | *13* | *2* | |

**C= Counselling** **P= Promotion** **TA= Technical Assistance**
**R= Referral** **T= Treatment**

The District Committees reported being involved in many areas under prevention [see Table 3]. Although the Committees should not necessarily implement activities as an entity in its own right what they are reporting is consistent with what the head offices are reporting. This is an important validation as the district committees are comprised of representatives of these 'head offices', and merely reflect this type of engagement but at the district level. Of interest though, is that 3 of these committees reported provision of PEP services. It is important to specify where these services are actually located and contact information.

FBO's do have a fair showing (indicate how?), especially in terms of programs addressing KAP among youth. There is only one FBO, Claret Care, which said they had some form of programs addressing KAP among high risk and vulnerable groups. Their main focus however is on CSW's.

There is generally good distribution and access country wide to prevention services. For example, the organizations most engaged in prevention activities and services have branches at the district level in all or nearly all districts. In addition, those organizations that should be providing the services they are best equipped to handle, are doing so. For example, you can clearly see from this table that MoH, VCT, BFLA, Equity House offer both clinical services, as well as psycho-social and IEC services. However, you will note that where the MoH and the VCT Sites don't offer services in particularly as it relates to support services, there are many other organizations that do. This is good, because it means that we have the capacity to take a person from the prevention message (becoming aware) to taking a test, to then seeking out more information or resources, etc. which is taking action.

However, it must be clear that this assessment is on who is doing what, what is being done, and with whom they are doing it. It does not look at the scope of the work being done, that is, if the activities are effective, if they are reaching the intended target audience, etc. So though we have continuum in the provision of prevention related services and activities, we do not yet know to what extent this continuum is actually functioning. For example, the prevention message we send out can prompt someone to go get tested, which in its own right, is an effective prevention activity. However, while testing sites are available country wide, our clients may hesitate to go to the VCT center due to stigma surrounding the site. So while we certainly have the capacity to take the person from point A to point B, it is not sure how effectively we are doing this and what are some of the challenges to getting the desired outcome. Though we would like to know this data, it is not being measured through this assessment. Hopefully we will be able to see this soon down the road.

## 2. Mitigation

The answers of the partners to the area of Mitigation was equally revealing as those of Prevention. It is useful to have an overview of all of the possible Mitigation areas which all respondents had access to.

**Table 4. General Program Areas Under Mitigation**

| | AAA | Toledo AIDS Comm. | Belmopan AIDS Comm. | MOH | O. Walk HIV/AIDS Comm. | Women's Dept. | Hand in Hand | CARE | PAHO | HECO-PAB | BCCI-BCCHA | VCT San Ignacio | Belize City Council | Equity House Bz | Claret Care | POWA | YES | UNIBAM | **Total** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical services for HIV/AIDS case management, diagnosis and treatment of opportunistic infections, and palliative (symptomatic) care | | 1 | | 1 | | | | | 1 | | | 1 | 1 | | | | | | 5 |
| Procurement, distribution and management of ARVs | | 1 | | 1 | 1 | | 1 | | 1 | | | 1 | | 1 | 1 | | | 1 | 9 |
| **Delivery of support services:** | | | | | | | | | | | | | | | | | | | |
| a. Health care and supplies | | 1 | 1 | 1 | | | 1 | | 1 | | | 1 | | 1 | 1 | | | 1 | 9 |
| b. Counseling from a trained counselor | 1 | 1 | 1 | | 1 | 1 | | | 1 | 1 | 1 | 1 | 1 | 1 | 1 | | | | 12 |
| c. Companionship and emotional or spiritual support | 1 | | 1 | | 1 | 1 | 1 | 1 | | | | | 1 | 1 | 1 | 1 | | 1 | 11 |
| d. Socioeconomic (clothing, food, financial, support, etc) | 1 | 1 | 1 | | 1 | | 1 | | | | 1 | 1 | 1 | 1 | 1 | | | 1 | 11 |
| e. Help with housework, caregiver support, home-based care | 1 | | 1 | | | | 1 | 1 | | | | | | | 1 | | | | 5 |
| f. Terminal care | | | | | | | | | | | | | | | 1 | | | | 1 |
| g. Legal services | | | | | | | | | | | | | | | 1 | | | | 1 |

Majority of the focus in the area of Mitigation lies within the services of Health care and supplies, counseling from a trained counselor, companionship and emotional or spiritual support, socioeconomic (clothing, food, financial, support etc.

Also in the procurement, distribution and Management of ARV's. These areas have at least 8 organizations out of the 19 respondents doing work in them. However only 1 organization does work with in the area of Legal services or terminal care.

Activities in Table 2 which are geared to OVC's. Just as in the first table the majority of the focus lies within the services of Health care and supplies, counseling from a trained counselor, companionship and emotional or spiritual support, socioeconomic (clothing, food, financial, support, which includes school fees, etc. There are at least 5 organizations involved in each one of these activities.

However only 2 work with household work, caregiver support and only 1 does work with childcare and legal services.

**Table 5. Program Areas under Mitigation specific to OVC's.**

| | AAA | Toledo AIDS Comm. | Belmopan AIDS Comm. | MOH | O. Walk HIV/AIDS Comm. | Women's Dept. | Hand in Hand | CARE | PAHO | HECO-PAB | BCCI-BCCHA | VCT San Ignacio | Belize City Council | Equity House Belize | Claret Care | POWA | YES | UNIBAM | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Delivery of services offered to OVC's:** | | | | | | | | | | | | | | | | | | | |
| a. Medical support, medical care and supplies | | **1** | | **1** | | | **1** | | | | | | | **1** | **1** | | | | **5** |
| b. School-related assistance, including school fees | **1** | | **1** | | | | **1** | | | | | | | | **1** | **1** | **1** | | **6** |
| c.Emotional/psychological support, including counseling from a trained counselor, or emotional/spiritual support | **1** | | **1** | | | | **1** | | | | | **1** | | **1** | | | | | **5** |
| d. Other support, including socioeconomic (clothing, food, financial support, shelter) | **1** | | **1** | | | | **1** | | | | | | **1** | | **1** | **1** | **1** | | **7** |
| e. Help with household work, caregiver support | **1** | | | | | | **1** | | | | | | | | | | | | **2** |
| f. childcare, legal services | | | | | | | **1** | | | | | | | | | | | | **1** |

Activities in the Table 6 are geared to PWHA's. In the 4 areas of work there is work being done with food support and support groups.

However when it comes to income generation or microfinance programs and housing and shelter there are only 2 and 4 organizations working in this respectively

**Table 6. Program Areas Under Mitigation specific to PWHA's**

| | AAA | Toledo AIDS Comm. | Belmopan AIDS Comm. | MOH | O. Walk HIV/AIDS Comm. | Women's Dept. | Hand in Hand | CARE | PAHO | HECO-PAB | BCCI-BCCHA | VCT San Ignacio | Belize City Council | Equity House Belize | Claret Care | POWA | YES | UNIBAM | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Services and programs targeting PLWHA: | | | | | | | | | | | | | | | | | | | |
| a. Income generation or microfinance | 1 | | | | | | | | | | | | | | | | | 1 | 2 |
| b. Food support | 1 | 1 | 1 | | 1 | | 1 | | | | | | 1 | | 1 | | | 1 | 8 |
| c. Housing/shelter | 1 | | 1 | | | | 1 | | | | | | | | 1 | | | | 4 |
| d. Support groups | 1 | 1 | 1 | | | | 1 | | | | | | | | 1 | | | 1 | 6 |

There is a generalized lack of services when it comes to support and care for PWHA and OVC's (vulnerable groups).

There is not enough support for people when they are in the terminal stage or when financial problems arise.
Only 1 organization does work with in the area of Legal services or terminal care.

There are only a couple of organizations working in income generation or microfinance programs and housing and shelter.

Only 2 work with household work, caregiver support and only 1 does work with childcare and legal services.

## 3. Harmonization

As to how intense is the coordination with other organizations, the survey showed a very high number of organizations with whom the coordination/ collaboration of activities and projects is carried out. A total of 57 organizations were mentioned by one or several organizations that they were carrying out such coordination/ collaboration (See full list of organizations mentioned in Appendix 1). Not all of the organizations named had equal number of mentions. It ranged from one organization being mentioned to another organizations being mentioned by 14 other organizations. The overall distribution of those 57 mentioned is the following:

**Table 7. Organizations doing coordination/ collaboration**

| Number of different organizations that were mentioned by name | # of times they were mentioned coordination was made with them |
|---|---|
| 37 | 1 |
| 10 | 2 |
| 4 | 3 |
| (PASMO, WIN) 2 | 5 |
| (VCT) 1 | 7 |
| (MoH, AAA) 2 | 11 |
| (BFLA) 1 | 14 |
| Total 57 | |

Of these, the organization most mentioned with whom other organizations are doing coordination was the Belize Family Life Association (BFLA) with fourteen mentions, followed by the MoH and Alliance Against AIDS (AAA) with 11 organizations mentioning them. The number of mentions drops significantly to 7 organizations saying they coordinate/ collaborate with NAC, followed by PASMO and WIN Belize being mentioned each by 5 organizations. It is interesting to note then, that the private/ NGO sector takes the lead in being more pro-active and coordination/ collaboration more than the public sector. This was done by BFLA and AAA.

But the fact that 47 organizations mentioned another organization only once (37) or twice (10) seems to indicate that there are too many organizations working by themselves without much coordination with other potential partners which could either complement or amplify their own work. It does show, in the positive aspect, that there is an impressive number of local organizations working in HIV/AIDS activities, although they may be limited in coverage and coordination/ collaboration with other partner organizations striving to carry out their HVI/AIDS activities. It is also true that the majority of the mentioned

organizations are also concentrated in offering preventive activities, and a limited number in treatment, care, and mitigation support.

### *3.1. Monitoring and Evaluation*

There is a high level of M&E when it comes to input such as program resources, activities and processes. There is also strong monitoring on outputs, which are the products or services delivered. There is a need to conduct further assessment as we can not ascertain whether this is a lack of monitoring at the outcome and impact level because of a deficiency of human resources with the capacity to carry this out within institutions, if there is an unwillingness to move beyond this level, or weather they lack the systems to expand.

Even though there is a reporting of 95% on Input and 84% on Outputs there is no real system put in place where all this data can be gathered or seen. This system is lacking within both the organizations and at a national level. Therefore doing M&E at the impact level is almost impossible to do.

At the program level, service providers should be able to report at the very least on level of coverage and target groups reached. More in depth analysis can then follow on the effectiveness of the interventions which go beyond reporting of coverage.

Only a few entities could actually report on the basic coverage indicators.

### *3.2. Capacity building Needs*

The various activities carried out by the partner organizations are meritorious in as much as many of them claimed to be in dire need of infrastructure, equipment, transportation and capacity building. The overall view of their present status is the following (see table below):

**Table 8. Capacity Building needs**

| | Total Responses : 61 | |
|---|---|---|
| | N | % |
| Staff Sufficient in Number and Capacity | 7 | 26 |
| Capacity Building Needs: | | |
| a. Equipment and Other Work Materials | 5 | 8 |
| b. Training | 28 | 46 |
| c. Financial Resources | 3 | 5 |
| d. Human Resources | 4 | 7 |
| e. Staff Sensitization | 3 | 5 |

| Existing Facilities: | | |
|---|---|---|
| a. Own offices w/ Equipment | 9 | 14 |
| b. Rented Building, no or few equipment | 4 | 7 |
| c. None | 5 | 8 |

Of the twenty seven organizations responding, only 7 (26 %) reported that they had an adequate number of staff to carry out their work. In the area of capacity building, the majority expressed a strong desire for further training. Since one organization could have multiple training requests, nevertheless twelve categories of training were mentioned.

The most mentioned training request was M&E (5 requests) by further training in Counseling (9 requests). Three categories (project management, proposal writing and home base care training) each one had three requests. The others training categories mentioned had one or two requests; these were: personal communication, clinical management of PLWA, campaign strategies, BCC, and strategic planning (see summary in Table below)

**Table 9. Training needs in …**

| | Total of responses = 27 | |
|---|---|---|
| | N | % |
| Training Needs in: | | |
| M&E | 9 | 33 |
| Counseling (all categories) | 4 | 15 |
| Proposal writing | 3 | 11 |
| Home base care | 3 | 11 |
| Project management | 3 | 11 |
| Personal communication | 2 | 7 |
| Campaign strategies | 1 | 4 |
| Work place requirements | 1 | 4 |
| Strategic planning | 1 | 4 |

What is evident is that most organizations recognized training as one of the most needed areas in capacity building. The above capacity building was confirmed by the categories expressed in the question regarding the challenges they faced.

**Table 10. Challenges**

| Challenges | # of times mentioned |
|---|---|
| Need for more (skilled, trained) personnel | 12 |
| Limited financial resources to carry out interventions | 11 |
| Transportation needs of various types | 5 |
| Stigma and discrimination | 4 |
| Unwillingness of partners to collaborate (turf protection, non-supportive attitudes, loss of trust in system) | 3 |
| Statistics for decision making | 2 |
| Infrastructure/ equipment acquisition | 2 |

The need for more skilled personnel was the challenge most mentioned, followed by the limited financial resources to carry out their implementation. Transportation appears high in their challenges given the fact they have to mobilize personnel to their working areas. Stigma and discrimination follows immediately in importance and infrastructure which could have a higher ranking was actually low in their scale perception.

### *3.3. Statistics Required*

The organizations interviewed were asked to express what type/ kind of statistical information would aid them to do better planning of their activities. This is distribution of the answers obtained.

**Table 11. Data/Statistics Required**

| **Data / Statistics Required to plan their activities**<br>Note = if not specified, each mention was made by one of the responding organizations) |
|---|
| KAP studies in most populations - ( 2 organizations) |
| - Quarterly reports on HIV and AIDS in a timely fashion<br>- Demographic data on persons affected and infected<br>- Number of people infected, affected and prevalence rate in the community with a break down of gender and age.<br>- Disaggregated data of affected persons by demographics (age, ethnic group, urban/rural, married/single etc)<br>- People affected in Toledo (#)<br>- # of infected cases by area (Roaring Creek especially)<br>- Data on STIs/ OI for San Pedro<br>- A prevalence rate per community, calculated from random selection.<br>- Age group affected, population groups most affected by HIV/AIDS |

| |
|---|
| *Youth*<br>- The age group for sexual debut<br>- Frequent country statistics on youth and adolescents<br>- Total male/female population 14-24 yrs by district<br>- total number of in and out-of-school youth (males/females < 25 years)<br>- Info on youths out of school and not in any youth based Organization.<br>- No. schools with no HIV curriculum<br>- Total population considered poor and hard to reach by sex and age. |
| *People infected or directly infected, and subject to S&D*<br>- Total no. of persons accessing VCT/STI services (private or public) by age group, location (2 organizations)<br>- needs of PLWHAs studies<br>- Data regarding OVCs<br>- Data on levels of discrimination<br>- S&D studies<br>- HIV+s satisfaction surveys<br>- Documentation of impact of HIV/AIDS in their lives. |
| - # of positive persons in the work place - (2 organizations)<br>- Financial impact on the business |

The majority of answers were concentrated around obtaining disaggregated data by gender and age group, by demographics and by being affected/ infected (both for HIV and STI). Some of the organizations required it by specific sites such as Toledo, Roaring Creek, and OIs for San Pedro. This felt need should be considered as a Recommendation to be made.

There also a clear emphasis and interest in obtaining data of the youth group by age and gender as well as being in or out of school, in a base youth organization or not.

The last category from which data was requested was from people already infected and affected including OVCs and how S&D impacted their life condition.

It is interesting to note that no organization expressed a need for data regarding legislation and policy as a statistical data requirement.

### *3.4. Policy Issues*

Partners were asked " in which areas or sectors would you like to see policies addressing HIV/AIDS issues ". The categories of the answers were many and varied. Yet, there were a few that has the most mentions These were: policy to address media's involvement, reproductive health as it deals with HIV/AIDS, and family life. Youth was high in the number of mentions, services for them

being included. Workplace policies was the fifth most mentioned area of policy making it clear there is a felt need for policy in this area (tourism sector could be included among them the workplace sites)

**Table 12. Policy Issues Mentioned**

| Areas of Policy issues | Number organizations |
|---|---|
| -Policy addressing media approaches), one organization emphasizing media addressing use of contraceptives (including emergency contraceptives) | 7 |
| Reproductive health | 7 |
| Family life, with one organization emphasizing gender based violence | 6 |
| - Youth , one specifically relating to parental consent (age of sexual consent is 16)<br>- Services to young people | 7<br><br>1 |
| Workplace policies, one organization emphasizing enforcing workplace policies that already exist | 4 |

The rest of the answers were mentioned only once either by the same organization or another. They dealt with many areas of policy ranging from issues regarding the health personnel, the management of people affected by HIV/AIDS, which included children; issues on care and treatment, addressing HIV positives' behaviors, general sexual behavior that affects women and young girls, which implies involving men in the prevention efforts against HIV/AIDS. In separate categories tourism and general education of adults were also mentioned.

**Table 13. Policy Issues Mentioned once**

| |
|---|
| - Training of public officers in HIV/ A policy statements<br>- Policies governing medical personnel and institutions<br>- Stigma and discrimination within the health sector |
| - Policy on quality of care for PLWAs giving them priority when supplies are low.<br>- AIDS orphans. Program for children born HIV before 2002<br>- Protection of rights of infected and un-infected people at all levels.<br>- Policies and protocols for the treatment and care of children<br>- Children's health issues |
| - Care and support, confidentiality,<br>- Distribution of medications and health services<br>- Availability of access to care and treatment services |
| - How to deal/address those that knowingly spread HIV.<br>- Sexual harassments<br>- Laws protecting women and young girls |
| - A push to get men involved in the discussion and prevention of HIV |

| and AIDS. |
|---|
| -Tourism |
| - Better strategic education for adults |

### *3.5. Organizational Plans*

In the Survey there were two very similar questions asked regarding organizational Plans (3.9 and 3.11 ). These were:

- "Does your organization have a Plan of Action or a Sectoral Plan?"
- "Has your organization developed an organizational Plan?"

The answers to these questions are similar since for the first question there was a 63% who gave a "Yes" answer to the first question and a 59% for the second question. The "No" answer rose more in the second question 30% to the 15% of NOs of the first question.

Both answers indicate that about a third of the partner organizations could use TA to improve their drafting of their organizational planning skills. It is well known how critical these plans are to define clearly ( and with achievable objectives) what the organization should and could be doing in their effort to contribute to the fight against HIV/AIDS

Because more than half the organizations (37 of 57) are coordinating/ collaborating with only one other organization in carrying out their specific HIV/AIDS activities, this indicates that such coordination/ collaboration is yet weak and could be improved. The tasks are too big and complex for any organization to work without intensive coordination/ collaboration with as many other organizations that can complement or reinforce their own activities

It is also true that the majority of the mentioned organizations are also concentrated in offering preventive activities, and a limited number in treatment and care. (besides treatment and care, more emphasis should be placed on support services and mitigation activities.

Training in M&E is much requested and needed. Much of the success any organization can claim is based on the possibility of showing clear outcomes, this requires some expertise in collecting relevant data.

**CONCLUSIONS**

According to the MOH, Belize is categorized as having a generalized epidemic with pockets of high risk groups ( primarily CSWs and MSMs), and although there has been a large expansion of partners involved in the HIV&AIDS fight, there is still a need to more effectively address the needs of these vulnerable populations.

While prevention efforts remain the main emphasis of work being undertaken, there is a need to assess the effectiveness of these collective efforts. In addition, as it relates to support services and mitigation efforts, these areas need significant enhancement and expansion.

In order to acertain levels of coverage, respondents need to effectively demonstrate target populations reached and actual level of services provided so we do not get the responses noted earlier related to PMTCT and VCT services. In both cases, partners did not distinguish between being promoters of such services rather than actual providers.

The need to enhance this level of reporting is critical in planning and will serve to guide the more in depth analysis of effectiveness of interventions offered.

**RECOMMENDATIONS**

In order to enhance the overall national response, it is important for partners to be able to report on coverage and level of services. The NAC should be able to quantify what is the appropriate level of services that should be provided in order to effectively determine existing coverage and areas for possible expansion. By clearly defining what exactly constitutes the various levels of care and support, partners then can more accurately report on their activities which will also enhance networking.

It is evident that some NGOS are reporting activities in practically all areas. This may not be the best approach and in such cases, partners should be encouraged to identify their "niche" and then establish strong networks and referral services to other partners who can more appropriately address the client's needs.

As it relates to support services and mitigation, there is a need to again define the appropriate package in order to mobilize and advocate for the relevant resources and capacity building needs. This was evident when addressing OVCs. To date the country has not defined what constitutes an appropriate response for this population.

To this end, the NAC will embark on the development of a more detailed Operational Plan that will complement the current NSP. The plan will seek to integrate the key populations that need to be considered in the response and propose based on consultations with key stakeholders the strategies to meet the needs of these populations.

It is critical also for the country to focus attention on conducting relevant baseline studies that define the realities of our vulnerable groups and also offer some insight on the effectiveness of current KAP efforts already on the ground.

A better understanding of the our epidemic is critical to ensuring that resources are effectively being channeled to the most vulnerable groups that have the greatest impact on the epidemic.

APPENDIX 1

| Organizations with whom Coordination has been made | Number of times mentioned | Organizations with whom coordination has been made | Number of times mentioned |
|---|---|---|---|
| 1) BCCI | 1 | 30) Prison | 1 |
| 2) PANCAP | 1 | 31) Belize City Council | 1 |
| 3) YWCA | 3 | 32) POWA | 2 |
| 4) Belize Council for Visually Impaired | | 33) BBFCA | 1 |
| 5) Stella Maris School | 1 | 34) Red Cross | 1 |
| 6) Alliance Against AIDS (AAA) | 11 | 35) BFLA | 14 |
| 7) Ministry of Education, MoE | 1 | 36) NAC | 7 |
| 8) Primary-Secondary Schools, | 1 | 37) Education Department (HFLE) | 2 |
| 9) Youth for Future, (YFF) | 2 | 38) 4H | 1 |
| 10) Labor Department, | 1 | 39) Youth Cadet Corp | 1 |
| 11) Youth Enhancement Services | 1 | 40) Media | 1 |
| 12) My Refuge | 1 | 41) Tubal Vocational Institute | 1 |
| 13) Ministry of Human Development | 2 | 42) Rotary Club, Rotaract | 2 |
| 14) Jubilee Ministries | 1 | 43) Youth Hostel | 2 |
| 15) Women's Department | 1 | 44) PAHO | 3 |
| 16) Nat. Orga. For Prevention of Child Abuse | 1 | 45) WIN Belize | 5 |
| 17)Cornerstone Foundation | 2 | 46) US Embassy | 1 |
| 18) UNFPA | 2 | 47) UNICEF | 3 |
| 19) Police Department | 1 | 48) Belize Defense Force | 1 |
| 20) Ministry of Health, MOH, (DHS) | 11 | 49) VCT Center , (VCT Dangriga, VCT Center Nurses ) | 7 |
| 21)PASMO | 5 | 50) M&E | 1 |

| **Organizations with whom Coordination has been made** | **Number of times mentioned** | **Organizations with whom coordination has been made** | **Number of times mentioned** |
|---|---|---|---|
| 22) Ministry of Human Services | 1 | 51) Labor Department | 1 |
| 23) Women's Dept., | 1 | 52) Maternal and Child Health Clinics | 1 |
| 24) KHMH weekly pediatric clinics | 1 | 53)HECOPAB | 2 |
| 25) UNIBAM, UNIBAMB | 1 | 54) Dangriga HIV/AIDS Society | 1 |
| 26) Stan Creek HIV Network | 1 | 55) Haven House | 1 |
| 27) PG. Council | 1 | 56) FIPRO | 2 |
| 28) Hands in Hands Ministries | 3 | 57) Clinton Foundation | 1 |
| 29) He Intends Victory | 1 | | |