Mainstreaming Gender into HIV/AIDS Programmes in Belize

Health Sector

Debra J. Lewis
For the National AIDS Commission
With the support of UNIFEM

September 2010

Table of Contents

1) Introduction

HIV/AIDS continues to be a critical public health issue in Belize. The National AIDS Commission (NAC) is the statutory body in Belize charged with the responsibility for coordinating and overseeing the national response.

There have been many documents, including NAC's National Strategic Plan, that have acknowledged the importance of gender to the development of policies and programmes on HIV. However, the integration of gender has been sporadic at best. This is particularly problematic because of clear gender concerns in the development of the epidemic, including the following:

- As is true in many other places, Belize is experiencing the feminization of the epidemic, with heterosexual transmission the main mode of infection.
- Young women aged 15 – 24 have substantially higher rates of infection than young men in the same age bracket.
- World Bank research has shown that high rates of gender inequality correlate with high rates of HIV infection.
- While acknowledgement of the connection between gender-based violence and HIV has been promoted through public awareness campaigns, this recognition has not translated into policies or programmes that address the particular vulnerability of victims/survivors.
- Women's role in providing home and community based care for PLWHA has been largely unrecognized.

NAC is currently working on a multi-sectoral operational plan to strengthen the response to HIV and looking ahead to the development of a new National Strategic Plan which will come into effect in 2012. It has committed itself to more effective gender mainstreaming as part of this process. This document is intended to assist with the realization of that commitment.

2) Methodology

The purpose of the current project is to develop guidelines and indicators for mainstreaming gender in HIV policies and programmes in Belize's health sector[1]. In addition, the project focuses attention on specific groups who may be at particular risk and/or who are often marginalized in the delivery of programmes and services: women, youth, survivors of domestic violence, MSM[2], sex workers and PLWHA[3].

Several important assumptions were used in developing the methodology for the project. These included:

- Input to the process must bring together the perspectives of planners, service providers and service recipients.

[1] A separate project is looking at mainstreaming gender into education sector programmes on HIV/AIDS.
[2] Men who have Sex with Men
[3] People Living With HIV and AIDS

- In developing recommendations for policy and programme development, it is essential to identify concerns in policy and programme guidelines as well as how these are implemented in practice.
- It is important to recognize differences in the delivery of services by district and to incorporate input from different parts of the country as much as possible within the time and resources available.

Based on these assumptions, three sources of input were used.

a) Literature Review

Three types of documents were reviewed:

- Documents outlining current policy, plans and programme guidelines for the health sector response to HIV in Belize (including Ministry of Health documents and documents setting forward the overall policy and strategy for Belize through the National AIDS Commission).
- Other documents on HIV in Belize, particularly those addressing issues related to gender or specific marginalized or at risk groups.
- Documents on the development and implementation of a gender-sensitive, human rights based approach to health services and HIV programmes.

A complete list of the documents reviewed for the project can be found in Appendix A.

b) Key Informant Interviews

The selection of key informants for the project focused primarily on policy makers and service providers within the public health system. Eight people were interviewed for the project, including:

- the Executive Director of the National AIDS Commission
- the Director of the National AIDS Programme[4] in the Ministry of Health
- the Technical Advisor to the Maternal and Child Health Programme in the Ministry of Health (who has responsibility for implementation of the PMTCT programme as well as the National Sexual and Reproductive Health Policy and Plan)
- the primary physician providing treatment for PLWHA at Karl Heusner Memorial Hospital in Belize City
- three nurses and one social worker from the Voluntary Counseling and Testing sites of the Ministry of Health

Two additional interviews were also carried out as supplements to the focus groups described below. These informants included:

[4] In recent years, the programme has been renamed the National TB, HIV/AIDS and other STIs Programme. However, when discussion programmes relating specifically to HIV, the programme is commonly referred to as the National AIDS Programme, and for convenience this is the name used throughout this document.

- The Executive President of UNIBAM[5] who was unavailable to participate in the focus group for NGOs.
- The Support Service Coordinator for Alliance Against AIDS who was interviewed specifically on issues related to home care for PLWHA.

c) Focus Groups

Two focus groups were organized to obtain input from service recipients and those infected and affected by HIV. The first focus group brought together people from civil society organizations working with specific groups including survivors of gender based violence, MSM, sex workers, PLWHA as well as women and youth generally. The focus group discussed issues related to the implementation of a Human Rights Based Approach in the health sector response, as well as issues in health programmes for those specific groups. The group included 11 participants from Alliance Against AIDS, Belize Family Life Association, Hand in Hand Ministries, Haven House Shelter for Women, PASMO[6], the San Ignacio Support Group, and the Youth Advocacy Movement[7]. Participants came to the focus group from the Belize, Cayo and Orange Walk districts.

The second focus group included 11 women from Dangriga who are infected or affected by HIV. This group was organized through POWA[8]. Dangriga was chosen as the site for the group because of the high rate of infection there and POWA's specific experience on HIV. The group looked at issues related to the delivery of health care services, particularly to women, as well as the issues facing those providing care for PLWHA in the home.

There were several ***methodological challenges*** to be faced in carrying out this project. First, there is no ongoing, systematic review of programme delivery in the area of HIV by the National AIDS Programme, as the Programme relies on external projects to evaluate programmes. In addition, efforts to obtain a copy of reports from the current project (Capacity Project/USAID) were unsuccessful and another programme assessment conducted by PAHO has not been endorsed or officially released by the Ministry due to concerns about some of its content. This means that it is not possible to look at how gender is (or is not) addressed in programme evaluation. In addition, information on service delivery generated by both this project and other reports relies primarily on anecdotal evidence. Nevertheless, the qualitative data provided by focus groups and interviews through this project and others can help to identify problem areas in the development and implementation of services in the health sector.

3) Context Issues

Although this project is designed to look specifically at mainstreaming gender into health sector policy and programming, there are a number of broader issues that provide the context for this work. More importantly, if these issues are not taken into consideration, initiatives on gender

[5] United Belize Advocacy Movement
[6] Pan American Social Marketing Organization
[7] YAM is the youth arm of Belize Family Life Association
[8] Productive Organization of Women in Action, a community-based women's group working on issues relating to HIV/AIDS, gender based violence and poverty in the Stann Creek district

and on strengthening the human rights based approach to the delivery of health sector programmes are likely to be limited at best.

a) Policy and Planning for HIV

In principle, the response to HIV in Belize has been consistent to the UNAIDS model of the "Three Ones" – One HIV/AIDS National Framework (the National AIDS Policy and the National Strategic Plan); One national AIDS coordinating body (the National AIDS Commission) and one agreed-to national monitoring and evaluation system (implemented through the National AIDS Commission). In practice, however, informants in the National AIDS Commission, the Ministry of Health and in service delivery agreed that there is a disconnect between the principles of the Three Ones and the reality in Belize. To date, the planning processes of the various sectors, including the Ministry of Health, in terms of the response to HIV have not meshed. With respect to the Ministry of Health, planning of the National AIDS Programme uses the National Health Agenda is its initial reference point.

The National AIDS Commission is currently developing a Multi-Sectoral Operational Plan with the participation of all sectors. The Commission hopes that the process will not only produce a practical implementation plan, but will also provide direction for the development of the next National Strategic Plan which will begin in 2012. Key to the success of this process will be the extent to which it eliminates the disconnect between the National AIDS Commission and individual Ministries.

b) Programme Implementation

Just as there is a disconnect between planning at the national level and within individual ministries, so too is there often a gap between policies and programme guidelines and implementation. In addition to this gap, programmes in Belize (in the health sector and elsewhere) often do not have a clear definition of entitlements – that is, what services and resources do you have a right to access and from where. The result is that the quality of programme implementation is uneven.

This makes it difficult to know where to target interventions to have the greatest impact. Changes in policy and programme guidelines may not translate into more effective service delivery. Training of front line workers is often ineffective if not tied to an ongoing plan for capacity building and an assessment of how training has improved (or not improved) programme implementation. This situation not only calls for better implementation processes from top to bottom, it also highlights the need for effective monitoring and evaluation of programme delivery, including the involvement of front line workers in monitoring the performance of their own programmes..

4) A Gender-Responsive, Human Rights Based Approach

Both the National AIDS Policy and the National Strategic Plan call for developing a response to HIV/AIDS that recognizes Belize's international commitments on human rights and translates those principles to develop "an enabling environment free of stigma and discrimination"[9]. In

[9] National AIDS Commission, *Strategic Plan for a Multi-Sectoral National Response to HIV/AIDS in Belize (2006-2011)* p 12

addition, both documents acknowledge the particular vulnerability of women and girls, as well as the importance of gender as a cross-cutting issue in the development of policies and programmes.

In practice, however, there is no consensus on what it means to have a gender-responsive, human rights based approach to HIV. This lack of common understanding has a number of practical implications for the health sector. First, consideration of human rights and gender concerns in health sector policies and programming is inconsistent at best. Implementation of these principles often appears to be based more on the individual interpretation of those planning and delivering programmes rather than a set of criteria defining this approach. An assessment of how well programmes achieve gender and human rights goals is impossible without agreement on what those criteria should be.

As input to an analysis of how to more effectively mainstream gender and human rights principles into health sector policy and programmes, it was important to establish standards that would define a human rights based approach and see how the health sector currently performs on these criteria. In addition, it is important to establish what we mean when we talk about being gender-responsive and consider the challenges in mainstreaming gender into policies and programmes.

a) Defining and Implementing a Human Rights Based Approach

As mentioned above, there is no general agreement in Belize on what it means to use a human rights based approach to HIV in the health sector. When informants from within the health sector were asked to describe what this means to them, there were a variety of responses. Some acknowledged the need to be proactive on a range of human rights issues – for methods to focus on specific marginalized groups, for health care providers to recognize how their own ideas and identity might influence their work, or for clients being empowered to make decisions with respect to their own care. On the other hand, others focused more generally on the need to make services available to clients in general. The National AIDS Programme bases its work on the Ministry of Health's slogan, "Equal Health for All" and interprets this slogan as inconsistent with an approach that focuses on the needs of specific groups. Instead, their strategy focuses on strengthening health services for all recipients.

One service provider pointed out that if there is no system to monitor service delivery, it is not possible to know whether human rights principles are being translated into practice. An informant from civil society said that the human rights approach is largely a "hollow effort" without enforcement teeth. Given the range of opinions about the application of human rights in health care and considerable skepticism on whether the system can deliver on the promise of a human rights approach, building a consensus on what this should mean in practice is long overdue.

The current project draws from recent work by UNFPA to define a human rights based approach to programming in the health sector[10]. This model begins from the understanding that this approach assumes that programmes should further the realization of human rights as set forth in international conventions. Central to this realization is strengthening the ability of "duty-bearers" to meet their obligations and "rights-holders" to claim their rights.

[10] UNFPA, *A Human Rights Approach to Programming*, UNFPA and Harvard School of Public Health, 2010

A human rights based approach differs from a needs based approach in several key ways. Making human rights central to the development of policies and programmes means acknowledging the state's responsibility to translate the recognition of rights into a concrete, meaningful response. It also means recognizing that rights can only be realized through empowerment of those who would claim those rights. This contrasts with a needs based approach which may meet immediate needs without empowering those whose needs are being met. The motivation behind action is charity, with the result that needs that are being met today reappear tomorrow, because nothing has really changed.

These criteria[11] were used in assessing the extent to which the health sector's response to HIV is consistent with a human rights based approach:

A Human Rights Based Approach…

- Emphasizes the ***processes*** as well as the outcomes of programming.
- Draws attention to the ***most marginalized populations***.
- Works toward ***equitable service delivery***.
- Extends and deepens ***participation***.
- Strengthens the ***accountability*** of all actors.

In addition, when applied specifically to the health sector, a human rights based approach supports the adoption of the 3AQ[12] model which defines the minimum standards of the right to the highest attainable standard of health. It says that states are obligated to insure that:

Public health services, as well as medicines and health care staff…

- Are made ***available*** to all;
- Are ***acceptable*** to all;
- Are ***accessible*** to all, and respect the privacy of individuals;
- And the ***quality*** of all services should be of a consistent standard for all communities and all individuals within those communities.

Together, these two sets of criteria provided a framework for assessing the health sector's current response.

i) Process and Outcome

A human rights based approach focuses on ***how*** things happen as well as ***what*** happens as a result. Health practitioners, representatives of civil society and service recipients all report that processes are organized for the convenience of the Ministry rather than the needs of service recipients.

There is a significant degree of distrust of the health care system, particularly among those infected or affected by HIV/AIDS. Issues such as a perceived lack of confidentiality, isolation

[11] Adapted from UNFPA, *op cit*, Module 2, p 3-4
[12] Adapted from UNFPA, *op cit*, Module 2, p 8

during hospitalization and the lack of adequate information given to patients all contributed to a negative response to health services. This distrust is often increased for specific groups such as MSM who report that discriminatory attitudes and behaviour are often experienced in the health sector.

Service recipients did acknowledge that there are some bright spots in the system. Some specific nurses and counselors were identified as demonstrating the perspective, training and commitment needed. In the districts, some nurses were seen as doing the best they could under difficult circumstances – for example, having other responsibilities in addition to the VCT, a lack of support from other parts of the health system, etc. The point is, however, that there are no clear, practical guidelines on what a human rights based approach means in health care settings; inadequate training to address the deeply ingrained attitudes that lead to stigma and discrimination; no monitoring and evaluation at the service delivery level to learn about what works and what doesn't work. In the absence of these, it is impossible to build on experience and strengthen the process of service delivery.

Improving the process of service delivery is a positive goal in itself and critical to the implementation of human rights based approach. In addition, however, it is linked to the realization of outcomes such as adherence to medications and behaviour change. As long as there are serious concerns with ***how*** services are delivered, the results are likely to be limited at best.

ii) Marginalized populations

There are significant differences among planners, health care providers and service recipients on how to insure that marginalized populations are well-served by the health sector. The National Strategic Plan includes specific reference to most-at-risk populations, including marginalized groups such as MSM. commercial sex workers, and the prison population, but does not outline the specific strategies that might effectively reach these groups. Although the NSP calls for applying gender as a cross cutting theme, victims of gender-based violence are not included as an at risk or vulnerable group.

Of even greater immediate concern, however, is the lack of consistency among the various players on the how the health sector should approach marginalized populations. Many health care providers, as well as service recipients, acknowledge the need to take particular groups into account in the development and delivery of services. However, the position of the National AIDS Programme is that the Ministry of Health's slogan, "Equal Health for All" precludes a focus on specific groups and calls for a more generalized strengthening of health services. As a result, informants reported that everyone has their own idea of what constitutes a "marginalized" group and delivers services based on that.

More fundamental, however, is the question of whether what informants called a "one size fits all" approach is consistent with Belize's stated commitment to human rights. The UNFPA framework points out that achieving equality may require giving "priority to those suffering discrimination and disadvantage"[13] Other studies have stressed the practical importance of targeted interventions for marginalized groups such as sex workers[14]. Some health care providers talk about the need to directly address issues of stigma and discrimination within the

[13] UNFPA, *op cit*, Module 2, p 6
[14] For example, Ministry of Health and UNFPA, *Sexual and Reproductive Health for Sex Workers: The Rapid Needs Assessment*

health system and for support for providers to examine their own experience and identity in strengthening the response to specific groups. Civil society organizations working with specific groups reject the idea that a one-size model can effectively bring equal health to all.

The lack of consensus on the health care response to marginalized populations is yet another disconnect in the response to HIV in Belize. It reinforces the belief that a human rights based approach is largely window dressing. Any progress is the result of the commitment of individuals working within the health sector rather than an overall commitment by the sector as a whole. Progress made on that basis is not consistent or sustainable.

iii) Equitable Service Delivery

Both service providers and service recipients report a disparity in the delivery of HIV services. One clear example is the access (or lack there of) to a physician by PLWHA. In Dangriga, there is currently no doctor seeing patients for HIV. In other districts, PLWHA report that they are only able to see a doctor in an emergency and prefer to come to Belize City to see the doctor because they know he has experience in the area and will provide a higher standard of care. Of course, that option is only available to those with the financial means to travel to the city and who are not too ill to make the trip.

Service recipients pointed out that HIV is the only chronic illness where it is often not possible to see a doctor for care and treatment – it is assumed that people suffering from diabetes or hypertension can see a doctor as a matter of course. This means that PLWHA are discriminated against by the public health system because they are treated differently than people with other diseases. One informant pointed out that doctors engaged by the Ministry of Health should not refuse to see patients because they are HIV positive. At the same time, there is a need to provide training for physicians in basic regimens for HIV care and treatment so that physicians throughout the system can provide the initial response. While in theory this should be accomplished through the process of integrating HIV services into the broader primary care system, in practice the lack of a clear timeline and process for accomplishing this means that inequities in service delivery persist.

iv) Participation

Participation in the development of the health sector response is weak. This was acknowledged by planners, service providers, representatives of NGOs and service recipients, including those from marginalized groups. There were differences, however, in what various groups identified as particular problems in this area. From the perspective of the National AIDS Programme, concerns focused on the lack of participation in planning across the Ministry of Health. Health service providers reported that the benefit of their experience is lost in programme development because there is no meaningful communication and participation in the planning process of the Ministry of Health. Civil society organizations and service recipients (including those from marginalized groups) describe participation as both superficial and selective.

Once again, one challenge in making participation more effective is that there is no definition of what this should mean in practice. For example, more than one report on HIV in Belize has called for forging a stronger relationship between the health sector and relevant NGOs. But there is no description or guidelines on what needs to happen to make this stronger relationship a reality[15]. This means that there is no way to measure progress towards a participatory

[15] Of course, this situation is not unique to the health sector.

process, nor is it possible to hold decision makers responsible for the lack of participation in policy and programme development.

Some informants noted that the lack participation from all groups in policy and programme development has led to an over-reliance on foreign models that do not adequately take the local culture, situation and experience into account. Both service providers and civil society representatives have indicated that planning of the HIV response in the health sector is essentially a top-down process, where decisions are made based on the limited resources available and the needs of the Ministry, rather than the perspectives of service recipients and service providers. Of course, taking resource limitations into account will always be part of any planning process. However, beginning from the point of view of the resources currently available presents a barrier to setting priorities and developing plans based on the realities on the ground, and then making best use of the resources available.

v) Accountability

Accountability is key to the implementation of a human rights approach. Effective systems of accountability require clear roles and responsibilities, transparent decision making processes and decision criteria; access to information; and effective mechanisms to demand accountability[16].

Accountability should apply at all levels of policy and programme development and service delivery. To address accountability at the level of service delivery, in 2009 the Ministry of Health has implemented a new complaints policy. Posters and flyers have been produced outlining patient rights and responsibilities in health care services.

While a more structured approach to making complaints is welcome, there is some way to go before an effective complaints procedure will be in place. The two posters outlining patient's rights and responsibilities are prominently displayed in the Belize City VCT, but in at least one other facility they are not. Posters and flyers do not outline clearly what steps are necessary to make a complaint, despite the fact that the complaints policy requires that this information be prominently posted in health facilities. Those who wish to make a complaint are told to put it in writing, and the VCT sites visited for this project were unaware of a complaints form that should be available to patients.

Informants from within the Ministry of Health acknowledged that more work is needed to insure that service recipients know that they have rights within the system. An information and marketing strategy is needed to insure that people know their rights even before they access health services. This strategy should take into account the fact that most Belizeans are unaccustomed to questioning or challenging health care providers, particularly physicians, and providers often do not encourage this.

When a service recipient does have a complaint, complaint forms should be readily accessible in waiting and reception areas of health services, including VCT sites. It should be clear what will happen after the complaint is made. Because PLWHA currently have limited options for treatment, they often fear that there will be repercussions if service providers know that they have made a complaint, and this needs to be addressed in the complaints process. Complainants should also be informed when they should receive the results of a complaint. The

[16] UNFPA, *op cit*, Module 2 p 7

current policy does not include informing the complainant of the results of any investigation[17]. This step is essential if the system can truly be called accountable.

In addition to its responsibility to be accountable to individual service recipients, a human rights based approach implies an obligation to be accountable in terms of policy and programme development. The National AIDS Programme addresses this by making its budget and regular updates available to key partners. However, both service providers and service recipients report that lack of communication makes accountability a problem. As one informant said, "We only see what is happening when the UNGASS report is prepared."

Availability of information, particularly in the area of monitoring and evaluation of programme delivery, is also a problem. The M and E component of the National AIDS Programme itself focuses mainly on epidemiological data. Reports from the Epidemiology Unit are regularly available, including through the Ministry of Health website. For evaluation of programme delivery the Programme relies on external projects and evaluations. However, it is sometime difficult to obtain the results of these studies (even when they are specifically requested) and in at least one case an assessment was neither endorsed or released by the Ministry because of concerns about its content. This raises the question of whether the Ministry releases information selectively, depending on whether it fits with decisions it has already made.

b) Being Gender-Responsive

The human rights based approach described above applies, of course, to both women and men. In addition, women's rights are human rights, and a true human rights framework must address issues of gender inequality. Developing a gender-responsive approach insures that the interests of both women and men are explicitly included in the development and implementation of policies and programmes.

When the concept of using gender analysis was introduced in Belize some years ago, an often heard phrase was *"Gender means it's about women and men."* While this is true as far as it goes, this overly simplistic description was sometimes used to steer discussion away from the realities of gender inequality and women's subordination.

Gender analysis is based on an understanding of the difference between sex and gender. Sex refers to the different biological and physiological characteristics of females and males. Gender, on the other hand, is a social construct, and includes what a society believes about the appropriate roles, rights, accepted behaviours, opportunities and status of men and women. Gender roles are generally unequal and hierarchical, with women being less valued and having less access to resources such as money, status and power than men. As a result, gender analysis most often calls for actions that focus on women's subordinate position.

This does not mean, of course, that men do not face specific problems or issues that need to be addressed. What it does mean is that using gender analysis to identify and act on those issues must be done within a framework that acknowledges overall patterns of gender inequality and does not reinforce male power at the expense of women.

While gender analysis is a tool to identify issues based on the different experiences of women and men, a gender-responsive approach in intended to actively address those issues. A

[17] Ministry of Health Complaints Policy, January 28, 2009

gender-responsive approach into programming for HIV in the health sector should be based on these criteria:

A gender-responsive approach…

- begins from an understanding of how health issues affect women and girls, men and boys
- analyzes how the social construction of femininity and masculinity create health conditions and outcomes that are different for women and men
- develops and implements policies and programme actions that both recognize and challenge gender inequalities

In short, a gender-responsive response not only identifies and acts on issues affecting women and men differently; it also challenges a system of gender inequality and women's subordination.

i) Women and Girls/Men and Boys

The foundation of a gender-responsive approach is having sex-disaggregated data and other information to document the different realities of women and girls, men and boys. Most available epidemiological data on HIV in Belize is sex disaggregated, and a 2010 publication of the Ministry of Health and PAHO[18] collates and presents that data (along with available statistics on related areas such as STIs and gender-based violence) to present a gender-based analysis of the epidemic in Belize[19]. The data documents a number of previously mentioned trends in Belize, including the feminization of the epidemic and much higher rates of new HIV infections in young women than in young men.

In addition to tracking the epidemiological data that tell us who is being infected, there is also a need for a better understanding both biological and social differences in the experiences of women and men. In terms of HIV transmission, it has been acknowledged that women are more vulnerable to infection than men through heterosexual contact. However, virtually no attention has been paid in Belize to gender differences in the progression of the disease and the implications of this for treatment and care.

ii) Being a Woman/Being a Man

While sex-disaggregated data describes differences between women and men in terms of ***what*** is happening, it does not explain ***why*** those differences exist. To understand the causes of gender disparities, it is important to put these disparities in the context of what it means to "be a woman" or "be a man" in our society – this is sometimes called the social construction of femininity and masculinity.

Gender analysis demonstrates that women and men have different access to society's resources and benefits. The gender division of labour makes women responsible for unpaid work in the home. Women are assumed to be dependent on men, whether they work outside the home or not, and the definition of the male as "head of the household" still persists. Girls

[18] Ministry of Health and PAHO, *A Gender-Based Analysis of HIV/AIDS in Belize*
[19] The report cautions, however, that the available data "cannot be considered representative of the entire HIV/AIDS-affected population in Belize".

are taught to be passive and to have their value defined by their sexuality. Boys are taught to be aggressive and take risks. All of these factors feed into how gender shapes the development of HIV in Belize.

Some of specific ways that gender affects HIV include:

- The unequal power relationship between women and men makes it for women to decide when and with whom she will have sex and to negotiate safe sexual practices.
- Gender-based violence – whose victims are overwhelmingly women – is an extension of that unequal power relationship. Negotiation of safe sex is meaningless for women in situations of domestic violence. Rape, sexual assault, and sexual abuse and exploitation of young women and girls also increase women's vulnerability.
- Women's lower economic status, lower rate of labour force participation, and high rate of unemployment contributes to their dependence on men.
- Women's responsibility for work in the home means that they are the primary caregivers for PLWHA.
- For men, fears of being labeled "soft" may lead to risk-taking behaviour and an unwillingness to use health services that many see as "for women and children".

iii) Recognizing and Challenging Gender Inequalities

A gender-responsive approach means not only recognizing the gender dimension of an issue, but also taking action to challenge the conditions that lead to gender inequality. This means taking both the practical needs and the strategic needs of women into account.

The following description of practical and strategic needs is taken from the World Health Organization's guidelines for integrating gender into HIV programmes.

> *The PRACTICAL NEEDS of women are those that correspond to their immediate, perceived necessities. For example, practical needs arise out of women's responsibility for the health and well-being of their families…HIV/AIDS services that are easily accessible,, confidential, clean and have well trained staff would be considered as meeting women's practical needs.*
>
> *The STRATEGIC NEEDS of women are those that are related to their position as subordinate to men in society. These needs relate to the gender division of labour, power and control…Therefore, programmes, policies or services that meet women's strategic needs go a step further than those that only respond to women's practical needs. In addition to meeting women's basic necessities, such programmes and services also seek to challenges and transform existing harmful gender roles and stereotypes and women's subordination to men. For example, beyond providing male and female condoms to women, HIV programmes and services considered as meeting women's strategic needs would also teach skills to negotiate safe sex, make women aware of their rights and risks related to HIV, and would involve and support men to take responsibility for safer sex.*

While it is important that women's practical needs be met, this alone will not transform their situation. Therefore, actions to also address their strategic needs are equally important if they are to have lasting benefits[20].

This description makes it clear that applying a gender-responsive approach requires specific attention to women's empowerment.

It is often difficult to maintain a focus on strategic needs when resources are limited. Furthermore, building strategies that will promote women's empowerment will only be successful if those implementing those strategies have examined how their own ideas and beliefs on gender and recognized the need to work for women's equality. While this is challenging, it is essential if gender-responsiveness is to be more than window dressing.

c) Gender and the National Strategic Plan

The 2006-2011 National Strategic Plan acknowledged gender as a cross cutting issue in the response to HIV/AIDS, but did not effectively translate that recognition into policy or programme direction. A gender analysis of the plan found,

> *The Belize NSP, while implicitly acknowledging gender as a pivotal area of focus in stemming the pandemic, does not explicitly address the gendered dimensions that influence the spread of HIV in Belize. Additionally, it is not clearly stated that the increase in HIV infection through heterosexual transmission and the increase in spread among women is a result of gender inequality. Indeed, in many cases where the differential vulnerability of women and men, boys and girls is noted, the source of this differential risk and vulnerability is not.*[21]

The report goes on to note that strategies identified in the priority areas of harmonization, prevention and mitigation are not gender responsive as they do not consistently incorporate the differential needs and vulnerabilities of women and men, girls and boys. For example, in the area of prevention, the study notes that none of the outcomes address the intersection between gender-based violence/violence against women and its intersection with HIV infection and access to HIV services.

Given that the NSP is entering its final year, the concerns about the disconnect between the plan and sector based work, and that a process is already underway that will feed into the development of the next National Strategic Plan, a more detailed examination of the specifics of the current plan is unnecessary. The major lesson to be learned, however, is that acknowledging the importance of gender issues without developing concrete ways to incorporate them into outcomes and strategies is futile.

d) Gender and Marginalized Groups

The above discussion considers the implications of gender for women and men and, in particular, how a gender-responsive approach is necessary not only to identify and act on problems faced specifically by women and men, but also to recognized and challenge a system of gender inequality and women's subordination.

---

[20] World Health Organization, *Integrating Gender into HIV/AIDS Programmes in the Health Sector, p 3*
[21] National AIDS Commission, *Gender Mainstreaming Belize's HIV and AIDS National Strategic Plan, p 10*

However, gender considerations also impact on specific groups. The same deeply ingrained beliefs about masculinity and femininity that lead to women's subordination also affect attitudes toward and treatment of marginalized groups such as MSM and sex workers.

Homophobia continues to be a deeply entrenched in the attitudes of many Belizeans. It is reinforced by religious dogma, the media and cultural expression. It is experienced on a daily basis on the streets of Belize.

Homophobia both feeds and is fed by stigma and discrimination faced by PLWHA. This stigma and discrimination is a barrier to developing an effective response to HIV. Combating homophobia is not only the right thing to do from a human rights based approach – it is also simply impossible to stop the epidemic without it.

For female sex workers, gender-based assumptions about proper sexual behaviour for women are judged on so-called moral grounds. Women who are seen as breaking accepted roles and expectations of "good" womanhood are seen as less valuable and less deserving of protection and care (this despite the fact that for many women who ***do*** try to follow the rules, protection and care is a myth).

Given the interaction between gender-based roles and expectations, homophobia, stigma and discrimination and marginalization of groups such as MSM and sex workers, it is unrealistic to expect that a "one size fits all" approach to service delivery will work. A greater commitment to this understanding is needed in the development of policies and programmes.

5) HIV and Health Sector Programmes: Gender and Human Rights Concerns

With the exception of Prevention of Mother to Child Transmission, which is implemented through the Maternal and Child Health Programme, delivery of services for HIV in the health sector is in a state of flux. Voluntary Counseling and Testing sites, previously the responsibility of the National AIDS Programme, now fall under the administrative authority of the health region in which they are located[22]. However, the sites continue to look to the National AIDS Programme for information and advice, and it appears that the regional health administrations have not yet taken full ownership of the VCT sites. In addition, some services previously provided through the VCT sites – specifically administering HIV tests and dispensing ARV medications – are in the process of being mainstreamed into the primary health system. However, there is no specific timeline for this integration. Decisions will be made by the each regional management team, although it is unclear what criteria they will use in deciding when and how to complete the implementation process.

a) Prevention of Mother to Child Transmission (PMTCT)

The Prevention of Mother to Child Transmission (PMTCT) programme is a joint endeavor of the Maternal and Child Health (MCH) Programme and the National AIDS Programme, implemented

[22] As of September 2010, the Belize City VCT continues to be the responsibility of the National AIDS Programme, but this should soon change with the site being transferred to the authority of the Central Health Region.

through the Maternal and Child Health (MCH) Clinics. The 2010 UNGASS Report for Belize named the programme as an example of best practices in Belize. It has been successful in significantly reducing the occurrence of vertical transmission, although the programme anticipates some slippage in this year due to adherence issues and some programmatic errors leading to missed opportunities to start treatment at first contact. Nevertheless, PMTCT has seen considerable success carrying out its mandate.

i) Policy and guidelines

PMTCT in Belize is considered to be a "public good" and available free of cost in both the public and private sector. The Ministry of Health supports this by providing supplies for the programme to private as well as public sector facilities. The programme is organized around four "Pillars", including:

- Prevention of HIV in women of reproductive age.
- Promotion of voluntary testing of pregnant women through a PITC[23] model.
- Availability of ARVs
- Testing of infants

To date, most efforts have focused on the second, third and fourth pillars, providing services, treatment and care to pregnant women and their newborn infants. The intention, however, is to now put more emphasis on reaching women before they become infected with the virus. This phase of the programme is still in its formative stages and faces a significant challenge due to limited human resources. Currently, only 60 nurses are responsible for the implementation of maternal and child health services countrywide. This includes pre-natal care (including PMTCT), immunizations, administering micronutrients, etc. While the MCH programme recognizes the need to move to a more comprehensive family and community health approach (that would include HIV prevention activities before pregnancy as well as activities directed to men), accomplishing this with the existing level of staff remains problematic.

In 2009, the Ministry of Health produced the Third Edition of its *Manual for the Prevention of Mother to Child Transmission and Syphilis*. The Manual provides basic information on HIV/AIDS and outlines procedures to be used in the areas of counseling and testing; antiretroviral prophylaxis and treatment; caring for HIV positive women in antenatal. childbirth and delivery; infant feeding recommendations; treatment of symptoms and palliative care; and creating a safe work environment. The manual also includes a separate section defining stigma and discrimination and some suggestions on how health care workers can help reduce stigma and discrimination that PLWHA experience.

Many of the implicit policies of the MCH programme acknowledge human rights principles and the need for a gender-responsive approach. However, many of these policies are not translated into the PMTCT manual. For example, the MCH programme encourages child spacing to reduce the physical stress for women living with HIV but also recognizes the right of women living with HIV to make their own reproductive choices. However, the manual deals only with the child spacing issue without explicitly acknowledging the right to reproductive choice. In addition, the manual does not specifically address how unequal power between women and men or the possibility of domestic violence need to be taken into account in counseling women when encouraging risk-reducing behaviour or disclosure to partners. A revision of the manual to

[23] Provider Initiated Testing and Counseling

make these issues more visible would reinforce to service providers the need to integrate human rights and gender concerns into their work.

In addition to the manual, the PMTCT programme has produced "job aids". These are a series of flash cards outlining the most important part of protocols for the PMTCT programme. This resource recognizes that service providers are more likely to adhere to protocols or guidelines if the most critical information is easily accessible. This type of "job aid" could be developed for other parts of HIV programming and could specifically incorporate the need for attention to gender and human rights concerns.

ii) Practice

The MCH programme acknowledges that there is often a gap between how services should be provided and what happens in practice. There is often a lack of awareness among staff of the importance of gender and human rights issues and how to integrate that understanding into their work. Learning how to deal with gender issues is often a very personal process. More support is needed for MCH staff in gender and human rights issues. In addition, stronger monitoring and evaluation is needed to identify those cases where a gender-responsive, human rights approach is not fully applied.

The issue of reproductive choice for women living with HIV is often a controversial one. One informant described how at a workshop for those working in services for HIV, several participants referred to "evil" HIV positive women who become pregnant. While these individuals quickly back tracked from what they had said, the incident exposed an all too common attitude toward women who are living with HIV. Another informant described a situation of a women living with HIV who wanted to have a child but do so in the most responsible way, but who was "treated like a criminal".

Some women have criticized health services for failing to provide C-sections for pregnant women who are HIV positive and who request the procedure. However, medical authorities elsewhere recommend C-sections only in situations where the woman has not taken effective HIV medications during pregnancy and where her viral load is greater than 1,000[24]. Given that viral load testing is not currently available in Belize and that the goal of the PMTCT programme is to provide ARV treatment for all pregnant women, it is likely that C-sections would only be appropriate in a very small number of cases. However, women need to understand how these decisions are made so they can feel confident that they are receiving the best possible options in care for themselves and their babies. There is a need for a clear policy from the Ministry on if and when C-sections should be provided for women who are HIV positive and communicate this clearly to the women involved.

b) Counseling and Testing

i) Policies and Guidelines

Voluntary Counseling and Testing (VCT) services have been provided primarily through the Ministry of Health. Public sector VCT centres have been stand alone clinics which have provided counseling and testing and dispensed ARV treatment. In recent years, the Ministry of

[24] Information from AIDSinfo, based on recommendations of the U.S. Public Health Service.

Health has also collaborated with some other governmental and non-governmental organizations to offer VCT services[25].

As noted above, there is currently a move to integrate testing and ARV treatment into the general primary health system. The implementation of Provider Initiated Testing and Counseling (PITC) throughout both public and private health services is central to integration. According to the National AIDS Programme, the intention of PITC is to make HIV a routine test, to reduce stigma and discrimination by treating HIV like any other chronic disease, and to increase the population who are tested. While treatment, including ARVs, will be also be integrated into the public health system, PLWHA will be referred to the VCTs for counseling and staff will also be responsible for monitoring adherence to medications and outreach work. Individuals will also continue to be able to access HIV tests through the VCTs, which will continue to function as stand alone sites.

While there are undeniable benefits from integrating HIV testing and treatment into the primary care system, both service providers and service recipients express concern about the move. The PITC model allows much less time for both pre- and post-test counseling. In theory, counseling will continue to be done through the VCT sites. In practice, however, people who are referred to a separate site for counseling may get lost and, in any case, many informants stressed the need for adequate counseling at the time of testing.

The *HIV Counseling and Testing Guidelines (October 2009)* is the primary document directing the implementation of counseling and testing in all health facilities, including public and private health facilities as well as NGOs. It is based on the Ministry's plans to promote services based on both PITC and VCT models, in public and private institutions as well as NGOs.

In the *Guiding Principles for Expanding Access to HIV Testing and Counseling*, the document includes the requirements to "Protect Human Rights", "Be Gender Sensitive", and "Ensure access to services by vulnerable and at risk groups.[26]. However, the rest of the document does little to outline what should be done to translate these requirements from principles into practice.

The *Guidelines* document is written in language that is presented as gender-neutral but has the effect of being gender-blind. Significant differences in how issues affect women and men go unacknowledged and, as a result, no direction is given on how to effectively address those differences in providing counseling and testing services. Some examples of this include:

- Victims/survivors of gender-based violence (primarily women) are not included in the specific groups needing attention in testing and counseling. (p 13)
- The checklist for the pre-test components for VCT includes points on risk assessment and risk reduction, without addressing the issue of the power relationship between women and men in negotiating safe sexual practices. (p 16)

[25] Belize Family Life Association provides VCT services as part of a broader package of sexual and reproductive health services; the BDF provides VCT services to soldiers, the Kolbe Foundation provides counseling, testing and treatment to inmates at the prison, and Hand in Hand Ministries and Equity House provide pediatric VCT services as part of their work with children who are infected and affected by HIV.
[26] National TB, HIV/AIDS and other STIs Programme, Ministry of Health, *HIV Counseling and Testing Guidelines*, p 10. Groups acknowledged as "vulnerable or at risk" include youths, mobile populations and migrants, men who have sex with men, sex workers and drug users.

- The guidelines indicate that effective pre-test counseling will prepare the person for the test by exploring implications for marriage and promoting discussion on sexuality, sexual practices and relationships, without considering how gender considerations should be dealt with in these preparations. (p 19)
- The section on informed consent does not recognize that women may have greater difficulty in saying "no" to health providers. (p 20)
- In the post-test counseling section, encouragement of partner notification does not address potential dangers to women who are victims/survivors of gender-based violence. (p 21)
- In the section outlining counseling options, specific counseling for victims/survivors of gender-based violence is not included, nor is the need to be aware of the potential for violence against women included in sections on couple or family counseling. (p 23)
- Referrals do not include services for victims/survivors of violence.

The National AIDS Programme's approach appears to strictly limit counseling within the PITC model to narrowly defined medical issues, with other issues being more appropriately addressed by other Ministries (such as the Ministry of Human Development) and civil society organizations. While this will limit the resources that the Ministry of Health needs for the testing programme, it avoids dealing with critical concerns. First, lack of attention to issues such as gender-based violence can put women at immediate, serious risk. As one informant said, "When yu dead, yu dead." Furthermore, the Ministry of Health has responsibility for both physical and mental health issues and for PLWHA these two are closely linked. The response of service providers in the health sector is likely to have direct implications for medical objectives such as improving adherence to medications. While other Ministries in the public sector and civil society organizations undoubtedly have roles to play in providing support for PLWHA, in the absence of clearly established responsibilities and secure resources for carrying these out, limiting counseling in health care institutions will have more effect on restricting spending than providing the best response to service recipients.

The *Partner Notification/Intervention Manual*[27] is a recent publication of the Ministry of Health designed to assist service providers in promoting notifying partners and contacts in cases of HIV, other STIs and tuberculosis. Once again, the manual is written in gender-neutral language, making it's approach to partner notification – particularly with respect to HIV and STIs – gender-blind. It seems particularly short-sighted that a document addressing how best to encourage communication with sexual partners does not acknowledge how differences in power between women and men impact on that process, nor does it does it address issues facing marginalized groups such as MSM and sex workers. Not only will this put women at risk and alienate specific groups, it is also likely to have the effect of making partner notification less effective in its stated purposes of reducing the spread of HIV and ensuring that partners/contacts receive treatment.

A gender-neutral/gender-blind approach means that the particular concerns of women are not addressed in the counseling and testing guidelines and, as a result, are unlikely to be

[27] National TB, HIV/AIDS and other STIs Programme, Ministry of Health, *Partner Notification/Intervention Manual*

addressed in practice in a systematic way[28]. Similarly, the invisibility of marginalized groups such as MSM and sex workers in the guidelines means that making counseling and testing facilities both accessible ***and*** acceptable to sexually diverse groups will not happen. Informants report that counseling of MSM often avoids discussion of issues like the use of lubricants and shows no understanding of how roles within same sex relationships (active/passive) affect the ability to negotiate safe sex. Both MSM and sex workers report instances of discrimination from some service providers, and the opening hours and locations of VCT sites (and sexual and reproductive health services in general) often make it impossible for sex workers to access the services they need. The approach of many service providers comes from deeply held beliefs related to homophobia and assumptions about women who do not fit accepted norms of sexual behaviour. Of course, these beliefs reflect attitudes in the society as a whole. In claiming an approach that both protects human rights and ensures access by vulnerable and at risk groups, the Ministry of Health has a responsibility to explicitly challenge those beliefs. At the most basic level, this means explicitly dealing with the needs of marginalized groups in the guidelines and providing training and support to all service providers to examine how their own ideas and beliefs contribute to compromising both service delivery and the human rights of service recipients.

A major issue for young people in accessing HIV testing and counseling (as well as other sexual and reproductive health services) is the legal requirement that persons under 18 have parental consent in order to access health services. This requirement not only compromises young people's right to health, it also has the practical result of blocking access to HIV testing for many young people. In the section of the guidelines dealing with youth below the age of consent, the guidelines state that the health care provider or certified HIV Testing and Counseling counselor "can make a decision whether it is in the interests of the client to have the test done"[29] This would appear to open the door for testing youth, but only some health providers interpret it this way, and it is likely that some, if not most, will be unwilling to take the risk of interpreting the guidelines in the "wrong" way. There is a need for a clear, well publicized policy that entitles young people to access counseling and testing services, and the Ministry of Health should advocate for the removal of any legal restrictions to this,

ii) Practice

As mentioned previously, there is often a significant difference between what guidelines and protocols say and how services are delivered in practice. It is unclear the extent to which service providers in the VCTs consistently use the guidelines and it has been reported that in some cases staff members could not produce the document. This situation is likely to be even more true as services are integrated into the general public health system, as well as into private health institutions and NGOs.

The absence of regular monitoring of service delivery by the Ministry of Health/National AIDS Programme and the lack of access to external evaluation reports means that concerns about service delivery reported through interviews and focus groups conducted by this project and others are essentially anecdotal. Furthermore, lack of access to those reports means that it is impossible to know whether gender concerns and the specific issues affecting marginal populations has been integrated into the evaluation process.

[28] This does not mean, of course, that some individual service providers don't address these gender concerns in their work with service recipients. It does mean, however, that doing so will be dependent on the individual service provider not a requirement of programme implementation.
[29] *HIV Counseling and Testing Guidelines,* p 13

Nevertheless, the qualitative information gathered through this project and others is based on the direct experiences of planners, service providers and service recipients, and hence can be useful in identifying areas of concern. It should not be assumed, however, that these concerns exist in every VCT or in the response of every service provider.

Some concerns expressed about the practice of service delivery include[30]:

- Women using VCTs often report that counseling is inadequate and that issues affecting them as women are not specifically addressed. Women need more information on the biological differences that put women at greater risk. More emphasis needs to be placed on the difficulty that many women face in negotiating safe sex and, specifically, asking men to use condoms. The reality that women may face violence when attempting to negotiate safe sex or when disclosing their HIV status needs to be more explicitly addressed.

- There is nothing in place to reach women who are victims of domestic violence, and little recognition that violence or the threat of violence may limit women's ability to seek testing and access counseling and treatment.

- Men often see health services as being primarily for women and children and therefore do not access counseling and testing for HIV. Some women report that men send their female partners to be tested, on the assumption that their HIV status will be the same.

- There is no consistent interpretation of requirements for parental consent for youth under 18 creating a barrier to accessing services.

- MSM report that services are not friendly. Most counselors do not understand the dynamics of sexual behaviour among MSM (for example, active/passive roles) and as a result are unable to provide counseling services that address these issues. There is little or not understanding that MSM are not a homogeneous group. As a result, transgender individuals, for example, are even more invisible in the provision of services.

- Sex workers report discrimination from service providers and counselors are often unprepared to deal with the specific realities faced by sex workers. Some sex workers are also victims of human trafficking which makes them reluctant to access services due to fear, lack of identification, etc.

- Women, youth, survivors of gender based violence, MSM, sex workers and PLWHA all report that confidentiality continues to be a significant concern, in VCTs as well as in other treatment settings. Even if, as some planners and service providers maintain, breaches of confidentiality are more the exception than the rule, the perception that counseling and testing services for HIV (as well as other health care institutions) do not protect the privacy of service recipients is a serious problem.

[30] The concerns listed here are those which relate specifically to gender, or specific groups including youth, MSM, sex workers, survivors of domestic violence/gender-based violence and PLWHA. Although informants who were interviewed or who participated in focus groups raised many other issues, a discussion of these is beyond the scope of the current project.

When services are good and when services are poor, both service providers and service recipients believe that a primary reason is related to the attitudes, skills and knowledge of the individual service provider. Of course, individual differences among providers will always have an effect on service delivery. However, it is the responsibility of the health sector as a whole to put in place systems that guarantee minimum standards and provide redress when those standards are not met. Nowhere is this more important than in providing counseling and testing services for HIV, and insuring that those services are both gender-responsive and human rights based.

c) Care and Treatment

For PLWHA, issues surrounding care and treatment relate to both access to care and the quality of care.

i) Policy and guidelines

The first clinical guidelines for the management of HIV infection in Belize were developed in 2003. Subsequently, a decision was made to utilize the Caribbean Guidelines for the Care and Treatment of Persons with HIV Infection. However, apparently neither of the protocols is currently being used by physicians who provide treatment to HIV positive patients. The result is that physicians who are providing care and treatment for HIV do so based on their individual understanding of what needs to be done and how treatment should be carried out.

In the same way that it is the responsibility of the Ministry of Health to insure a consistent standard of service in counseling and testing services, it is also it's obligation to consistency in standards of treatment and care. It has been suggested that a simplified protocol of regimens for basic HIV care should be developed and used as the foundation for improving care and treatment for PLWA in hospitals and clinics countrywide.

ii) Practice

It has already been pointed out that HIV is unlike other chronic illnesses in that patients often do not have access to a doctor for care and treatment. Sometimes, as was the case at the time of this project, there may be no doctor in the public sector attending to patients with HIV. In other cases, PLWHA may only be able to access a doctor when they develop serious symptoms. Furthermore, PLWHA report that they generally prefer to see the physician providing care at Karl Heusner Memorial Hospital in Belize City because they have more confidence in his experience.

In addition to developing and implementing a basic protocol for care and treatment for HIV, there is also a need to build the capacity of local physicians to respond effectively. Both protocols and training need to be developed on the basis of the realities in Belize and draw on the experiences of those already involved in the delivery of care and treatment. Given that physicians in the public health system in the districts are most often volunteers from abroad through technical assistance agreements with Cuba and Nigeria, training cannot be done through "one off" workshops but should be institutionalized on a schedule that reflects the turn over of physicians in each community.

Identifying specific interventions to promote the human rights of PLWHA is difficult given the wide ranging problems in providing effective care and treatment. As one informant said, "It is difficult to talk about human rights when you have to fight to see a doctor." In addition, both

service providers and service recipients are frustrated by continued serious gaps in care and treatment options. These include the inadequacy of ARVs currently available in Belize to deal with issues of side effects and resistance; inconsistent availability of CD4 testing due to lack of reagents and limited personnel at the Central Lab; and the unavailability of viral load testing in Belize. Of course, budgetary limitations may sometimes mean that all of these problems cannot be dealt with immediately. There is a strong feeling among both service providers and service recipients that decisions on how to address these issues need to be made with real participation from those affected.

There has been little consideration of the gender in the clinical response to HIV in Belize. Differences between women and men in the progression of the disease and side-effects of ARVs have not been generally acknowledged. It is beyond the scope or expertise of the current project to analyze these issues from the clinical point of view. However, it has been noted elsewhere that until recently, little research had been done on women and HIV and clinical trials have traditionally included very small numbers of women[31]. This is now changing and more information is becoming available on how both the disease and its treatment have different effects on women and men. Protocols and training related to clinical treatment in Belize need to reflect up-to-date information on the gender dimension of the disease.

In addition to concerns about the availability of medications, testing and treatment in general, many PLWHA report that stigma and discrimination continue to be characteristics of the response of health services. When PLWHA are hospitalized, some informants reported that they do not receive the same care as other patients – they are isolated, they are the last to get food, and some service providers avoid contact with them. There are also reports that once a patient develops AIDS, there is often the attitude that "yu done gone" and the patient is sent home to die. One woman described this situation as "We have treatment, but we don't have care."

Once again, it is important to acknowledge that the concerns raised by service recipients may not occur in all health facilities and by all health care providers. At the same time, more attention is needed to assure minimum standards of treatment and care across the system if human rights are to have any meaning for PLWHA and if both women and men are to receive the best possible clinical response.

iii) Post-Exposure Prophylaxis for Victims of Sexual Assault.

One significant step forward for victims of sexual assault is the change in policy for post-exposure prophylaxis (PEP) for HIV. A protocol for PEP in cases of occupational exposure of health care workers was developed in 2003, but at that time did not include treatment for victims of sexual assault. The policy was revised in 2009 and a handbook outlining the new policy was produced by the Ministry of Health in 2010. In addition to providing PEP, the policy also makes emergency contraceptives (EC) available to female rape survivors of child bearing age. The policy as a whole does not, however, make assumptions about the sex of the survivor in the administration of PEP.

While the policy is now in place, informants say it is not uniformly applied. In addition, the availability of PEP and EC is not well publicized, so survivors may not generally be aware that the treatment is available. This is of particular concern because many survivors do not report sexual assault to the police or access medical treatment, because they often do not believe

[31] The Well Project, *Women and HIV*, p 2

there is any point in doing so. It has been reported that one reason for not publicizing availability is because of concern that women will "abuse" the availability of emergency contraception, in particular. However, if both female and male survivors of sexual assault were aware that treatment is available, more survivors might access medical treatment and hence lower the risk of HIV.

d) Home and Community Care

Much of the care for PLWA takes place outside of health facilities and by persons other than doctors and nurses. The National Strategic Plan promotes the need to "enhance the community response"[32] and emphasized the positive role of home based care. The document does not, however, consider the gender implications of community and home care. Especially in the home, it is almost always women who provide care for sick family members – including themselves. To promote home based care without providing assistance for the women who provide it and without a strategy to encourage more men to be involved caregiving, assumes that women's free labour will continue to subsidize the health care system without recognition or support.

The National AIDS Programme and the Ministry of Health do not have a strategy to support community and home care (except for outreach visits by VCT nurses, often specifically focused on adherence to ARVs). While there is recognition of the need for this care, it is not defined as part of the responsibility of the Ministry of Health.

It is true that a multi-sectoral approach to HIV means that others must be involved in developing community and home based care. However, since this care is central to promoting the health of PLWH, their families and communities, the Ministry does have a responsibility in setting standards, providing training relating to care and treatment issues (including mental health issues), and insuring that community and home care meshes with the care and treatment provided in the formal health sector.

Women report that some of the support they need from the health sector in providing home care for PLWHA includes[33]:

- Information on what to expect as the illness progresses.
- Potential side effects of medications and how to support PLWHA in adherence to medications.
- How to observe and document symptoms, and when medical intervention is necessary.
- Where to turn with questions on providing care.
- How to do physical care such as turning a person in bed without injuring themselves.
- Emotional support for their role as a caregiver.

The importance of this last point should not be underestimated. Caring for PLWHA is often an isolating experience. Caregivers point out that HIV and other chronic illnesses such as diabetes bring out quite different reactions from friends, neighbours and other family members. Caregivers often have nowhere to turn.

[32] National AIDS Commission, *op cit*, p 42

[33] This list includes only that support appropriately provided through the health sector. Other needs such as nutrition and financial support, while obviously having implications for the health of PLWA, more more appropriately addressed by the Ministry of Human Development.

While family members most often provide care in the home, community care is usually defined as that provided by civil society, including NGOs, community based groups and faith-based organizations. Indeed, very good work is done by groups such as Alliance Against AIDS, POWA (Productive Organization for Women in Action/Dangriga) and Hand in Hand Ministries (working with children and families) in providing care and support for PLWHA and their families. The problem, of course, is that this is a scattered, piecemeal approach that does not address the right to a consistent standard of care countrywide – both in and out of the formal health sector. Resources are dependent on grants and donations, and what is offered is often determined by the priorities of donors rather than the needs of communities and caregivers.

A framework for community and home-based care for HIV is urgently needed, based on the priority needs of PLWHA and their caregivers. This framework should specify the particular roles and responsibilities of the Ministry of Health, the Ministry of Human Development, other relevant government ministries, and civil society organizations in providing a minimum standard for community response country wide. The framework should be clear about what PLWHA and their caregivers are entitled to from the various sectors and clear mechanisms for accessing this. Secure consistent resources will be needed by civil society organizations providing services that are part of these basic entitlements.

6) Recommendations

The following recommendations focus on mainstreaming gender into the health sector, clarifying and reinforcing a human rights based approach, and identifying interventions that are needed in specific programme areas.

There are other, broader issues that will influence the success of the recommendations outlined here, such as those described in the Context section of this document. Addressing these issues will be essential to continuing to advance the response to HIV in Belize, including with respect to gender and human rights concerns, but identifying specific directions is beyond the scope of this document.

A Gender-Responsive, Human Rights Based Approach for the Health Sector

Recommendations in this section address broad issues that affect the development of policy and programme planning in the health sector as well as how this connects to a multi-sectoral response to HIV. Recommendations on gender and human rights concerns in the delivery of health services are included in the following section on HIV and Health Sector Programmes.

Recommendation 1	A common definition of a Human Rights Based Approach should be developed and adopted by the National AIDS Commission and all sectors participating in the response to HIV in Belize, including the health sector. This definition should include the basic criteria outlined in this document, including emphasis on process as well as outcomes, attention to the most marginalized populations, promotion of equitable service delivery, deepening participation and strengthening the accountability of all actors.
Recommendation 2	The National AIDS Commission should include representation from the national women's machinery to promote the perspectives

	of both women and men in multi-sectoral policy and programme development[34].
Recommendation 3	The National AIDS Programme/Ministry of Health should revisit its position on developing an approach to meet the needs of marginalized and at-risk groups to be consistent with a human rights based approach and to insure a uniform interpretation of this across Ministry programmes.
Recommendation 4	Survivors of gender-based violence – including domestic violence and sexual abuse – should be included as an at-risk population in both multi-sectoral and health sector planning and specific strategies should be developed to promote prevention and care for this group.
Recommendation 5	All planning processes of the National AIDS Programme should include meaningful participation by both health service providers and service recipients through organizations working with PLWHA, women, youth, survivors of gender-based violence, MSM and sex workers. At minimum, this process should include forums to do problem solving and provide input into the planning process ***before*** priorities are set and plans are drafted. In addition, the Programme should have ongoing communication with service providers and service recipients as plans are finalized and resource allocations made.
Recommendation 6	The existing complaints policy and process should be fully implemented, strengthened and well publicized, with particular attention to insuring that all VCT sites and other sites providing care to PLWHA fully comply with the policy and process.
Recommendation 7	As part of the strengthening of the complaints policy, the policy should require complainants to be notified of the disposition of their complaint within a specified time period.
Recommendation 8	As part of the strengthening of the complaints policy, complaints forms should be revised to enable monitoring of complaints related to health service response to PLWHA and survivors of gender-based violence.
Recommendation 9	A summary report of complaints received and their disposition should be available to interested organizations and the public. This report must insure confidentiality for individual complainants.
Recommendation 10	All external evaluation reports on the delivery of health services for HIV should be made available to the National AIDS Commission and its component groups.

[34] This will require amendment to the legislation establishing the Commission.

HIV and Health Sector Programmes

Cross Programme Recommendation

Recommendation 11 A training programme in providing services within a gender-responsive human rights based approach should be developed and implemented for all health service providers, particularly those working to provide services for PLWH. Initial priority should be given to providing training for service providers in VCT sites and MCH clinics, and later rolled out to include both public and private sector clinics and hospitals providing PITC and care and treatment for PLWHA. A process to monitor changes in service delivery as a result of this training should be developed and implemented.

PMTCT Programme

Recommendation 12 The PMTCT Manual should be reviewed and revised to provide support for service providers to explicitly address issues related to gender inequality in the counseling, testing and care process. Specifically, the Manual should acknowledge and give guidelines for addressing how unequal power between women and men and the potential for gender based violence affects women's ability to employ risk reducing behaviours, disclose their status and adhere to medications. The manual should also make the implicit policies of the MCH programme clear. This includes clearly recognizing the right of women living with HIV to reproductive choice.

Recommendation 13 The MCH Programme should elaborate a plan for the movement of the PMTCT programme into the "first pillar" – that is, prevention of HIV in women of reproductive age. This should be accomplished within the context of the overall sexual and reproductive health policy.

Recommendation 14 The Ministry of Health should establish a clear policy outlining if and when C-sections should be made available to HIV-positive women. All personnel in MCH clinics should be made familiar with the policy and provide clear information to women inquiring about the possibility of C-section delivery.

Counseling and Testing

Recommendation 15 The Ministry of Health/National AIDS Programme should establish a timeline and uniform standards for the integration of HIV services (including PITC and disbursement of medications) into the primary care system. As part of this process and to achieve full integration, the Ministry should revisit the decision to maintain VCT centres as stand alone sites, in recognition of the needs of service recipients, particularly PLWHA, to access medical services, counseling and support in one location.

Recommendation 16 The National AIDS Programme should review and revise the HIV Counseling and Testing Guidelines to make gender and human rights concerns visible and require service providers to address these issues in the counseling process.

Recommendation 17 As part of the review of Counseling and Testing Guidelines, more detail should be provided on the implementation of the PITC model and how it will mesh with services provided through a reorganized VCT programme. "Job Aid" cards should be developed for use by those providing services though the PITC model, and should include specific reference to gender issues relating to risk reduction and disclosure.

Recommendation 18 The Partner Notification/Intervention Manual should be revised to explicitly address power dynamics based on gender that affect women's ability to safely disclose their status to their partners. Specific attention should be paid to the possibility of gender based violence and service providers should be required to assist women and men in potentially violent situations to develop a plan to insure their safety and security.

Recommendation 19 The Ministry of Health should advocate for the right of youth under 18 to access sexual and reproductive health services, including services related to HIV, without parental consent.

Recommendation 20 The National AIDS Programme should establish a regular system for monitoring service delivery to PLWHA that involves front line workers in the monitoring process.

Care and Treatment

Recommendation 21 An assessment of emerging evidence on the different effects of HIV on women and men, including gender specific side effects of medications should be undertaken with specific reference to how these findings are relevant to the provision of care and treatment in Belize.

Recommendation 22 A basic protocol for the clinical management of HIV should be developed as support for greater integration of care and treatment in the health sector. These protocols should incorporate an understanding of gender differences in treatment regimens.

Recommendation 23 Physicians countrywide should be trained in the use of the protocol. Because the districts outside of Belize are highly reliant on volunteer physicians from abroad who are in the country for a limited time, this training should be offered on an ongoing basis and coordinated with the arrival of new volunteers in the country.

Recommendation 24 A campaign should be established to inform the public of their right to access post-exposure prophylaxis (PEP) and emergency contraception (EC) in cases of sexual assault. The campaign should acknowledge that, while women constitute the majority of sexual assault victims, men can also be targets of sexual violence.

Home and Community Care

Recommendation 25 A framework and strategy for home and community care for PLWHA should be developed. This framework should include a clear statement of the responsibilities of each sector, including the health sector, in providing support for home care as well as clear entitlements of PLWHA and caregivers. The framework should recognize the contributions of women in caring for PLWHA and provide support that recognizes this contribution.

Recommendation 26 As part of the strategy for home care, bi-weekly support groups for caregivers of PLWA should be established in each district. These support groups should provide information on health issues affecting PLWA, training in providing basic at-home care, and emotional support for caregivers. These groups should be held outside of normal working hours, to encourage participation by men in caregiving as well as meet the needs of women who work both outside and inside the home.

Recommendation 27 Support workers/advocates should be trained and certified by the Ministry of Health to provide community based peer-counseling, support and advocacy for PLWH. These support workers/advocates should be drawn from groups working with PLWHA as well as from specific groups working with women, youth, survivors of gender based violence, MSM and sex workers.

Recommendation 28 A fee for service arrangement should be negotiated between the Ministry of Health and civil society organizations providing services and support defined as part of entitlements defined by the framework for home and community care.

7) Action Matrix

This matrix sets out the actions necessary to implement the recommendations outlined in the previous section. It also suggests who should take responsibility for the process, others who should be involved and suggested timing. Indicators for monitoring the outcome and effect of recommendations are also included.

NAC – National AIDS Commission
MOH – Ministry of Health
CSO – Civil Society Organization
NAP – National AIDS Programme
GBV – Gender Based Violence
MCH – Maternal and Child Health
Specific groups – Survivors of GBV, MSM, Sex Workers

Rec. #	Action	Responsible	Others involved	Suggested Timing	Indictor
A Gender-Responsive, Human Rights Based Approach for the Health Sector					
1	Develop and adopt a common definition of a human rights based approach.	NAC	All Ministries and CSOs involved in the response to HIV, including MOH	Early 2011 with ongoing application	Number of Ministries and CSOs who adopt the definition and actively apply it in programme planning and implementation
2	Amend legislation to include representation from the national women's machinery on NAC.	NAC; Ministry of Attorney General	Women's Department	2011	Position on NAC established
3	Revisit the NAP/MOH position on meeting the needs of marginalized groups.	NAP/MOH		2011	Number of members of groups such as MSM and sex workers accessing services in the public system
4	Include survivors of gender-based violence (including domestic violence and sexual abuse) as an at-risk population and develop strategies to promote prevention and care for this group.	MOH	NAC, other sectors involved in the response to HIV	2011	Number of survivors of gender-based violence accessing counseling, testing and treatment for HIV

Rec. #	Action	Responsible	Others involved	Suggested Timing	Indictor
5	Establish meaningful participation by health service providers and service recipients in all planning processes of NAP.	NAP/MOH	Physicians and other health care providers providing counseling, testing, treatment and care; CSOs working with PLWH, women, youth and specific groups	Annually and as part of multi-year planning cycles	Number of health providers and organizations participating in NAP planning process.
6	Carry out full implementation, strengthening and publicity for the existing complaints policy and insure that all sites fully comply.	MOH	VCT sites and other sites providing care to PLWH	2011	Number of sites in full compliance with the policy and process
7	Revise complaints policy to require complainants to be notified of the disposition of their complaint within a specified time period.	MOH		2011	Percentage of complainants notified
8	Revise complaints form to enable monitoring of complaints related to HIV and GBV.	MOH		2011 with ongoing monitoring	Number of complaints related to HIV and GBV that with a satisfactory result
9	Provide a summary report of complaints received and their disposition.	MOH	NAC and component groups	Annually	Report received
10	Provide all external evaluation reports on the delivery of health service to NAC and component groups.	MOH	NAC and component groups	As available	Percentage of evaluation reports received by NAC

Rec. #	Action	Responsible	Others involved	Suggested Timing	Indictor
HIV and Health Sector Programmes					
Cross Programme Recommendation					
11	Develop and implement a training programme in providing services within a gender-responsive human rights based approach; Implement a process to monitor changes in service delivery as a result.	MOH	Current service providers with training and experience in this approach; CSOs working with women, youth, PLWHA and specific groups	Implemented for staff of VCTs and MCH clinics – 2011-2012; Roll out to clinics and hospitals 2012-2014	Number of service providers trained Number of positive changes in service delivery
PMTCT Programme					
12	Review and revise PMTCT Manual to explicitly address issues relating to gender inequality in the counseling, testing and care process	MCH Programme		2011	Number of MCH clinics using the revised manual; Number of service providers applying gender in their work
13	Develop specific strategies for the prevention of HIV in women of childbearing age within the context of an overall sexual and reproductive health plan.	MCH Programme		2011	Percentage of pregnant women who are HIV positive.
14	Establish a clear policy outlining if and when C-sections should be available to HIV-positive women and ensure that all MCH personnel communicate this clearly to women.	MCH Programme/ MOH		2011	Number of MCH personnel who understand and communicate the policy.

Rec. #	Action	Responsible	Others involved	Suggested Timing	Indictor
Counseling and Testing					
15	Establish a timeline and uniform standards for the integration of HIV services, including revisiting the decision to maintain VCT in stand alone sites	NAP/MOH	Regional Health Managers; physicians and nurses in the response to HIV	Timeline and standards established early 2011; integration according to the timeline	Number of districts where integration is accomplished according to the established timeline and standards
16	Review and revise the HIV Counseling and Testing Guidelines to make gender and human rights concerns visible and require counselors to address these issues in the counseling process	NAP/MOH	Service providers with training and experience in gender and human rights	2011	
17	Provide more detail on the implementation of the PITC model in the Counseling and Testing Guidelines; Develop "Job Aid" cards for use by PITC providers with reference to gender issues relating to risk reduction and disclosure.	NAP/MOH		2011	Number of service providers using "Job Aid" cards
18	Revise the Partner Notification/Intervention Manual to explicitly address power dynamics based on gender; Require service providers to assist women and men in potentially violent situations to develop a plan	NAP/MOH		2011	Number of service providers who assist women and men to develop a safety plan
19	Advocate for the right of youth under 18 to access sexual and reproductive health services.	MOH	NAC, Ministry of the Attorney General	2011-2012	Number of youth under 18 accessing SRH services

Rec. #	Action	Responsible	Others involved	Suggested Timing	Indictor
20	Establish a regular system for monitoring service delivery to PLWH	MOH		2011-2012	Number of sites monitored; Number of positive changes in service delivery
Care and Treatment					
21	Assess emerging evidence on the different effects of HIV on women and men, including gender specific side effects	MOH/PAHO		2011	Availability of evidence to inform development of protocol
22	Develop a basic protocol for the clinical management of HIV that incorporates an understanding of gender differences in treatment regimens	MOH		2011	Number of physicians using protocol to provide care to women and men
23	Train physicians country wide in the use of the protocol	MOH		Starting in 2011 and on an ongoing basis according to arrivals of volunteer doctors	Percentage of PLWHA with access to a doctor for treatment and care in their home district
24	Implement a campaign to inform the public of their right to access post-exposure prophylaxis (PEP) and emergency contraception (EC) in cases of sexual assault.	MOH		2011-2012	Percentage of sexual assault victims attending health services who access PEP and/or EC

Rec. #	Action	Responsible	Others involved	Suggested Timing	Indictor
Home and Community Care					
25	Develop a framework and strategy for home and community care for PLWHA that recognizes the contributions of women in providing home care and provides clear entitlements for PLWHA and caregivers	NAC	MOH, CSOs working with PLWHA	2011	Proportion of entitlements that can be effectively accessed by PLWHA and caregivers;
26	Establish bi-weekly support, information and training groups for caregivers of PLWH	MOH/VCT personnel		2011	Number of caregivers participating in groups;
27	Establish a system of training and certification for support workers/ advocates for PLWHA, drawn from groups working with PLWHA as well as women, youth and specific groups	MOH	CSOs working with PLWH, women, youth and specific groups	2011 and ongoing implementation	Number of trained and certified support worker/ advocates
28	Negotiate a fee-for-service arrangement between MOH and CSOs providing services and support defined as entitlements under the home and community care framework	MOH, CSOs	Ministry of Finance	For implementation in 2012-2013 budget year	Number of PLWHA receiving peer-counseling, support and advocacy from support worker/ advocates

Appendix A: Bibliography

Belize policy and programme documents related to HIV/AIDS (health sector and general)

Ministry of Health, *Health Agenda 2007-2011* (Belize) 2006

Ministry of Health, *HIV Testing and Counseling Guidelines* (Belize) October 2009

Ministry of Health, *Post Exposure Prophylaxis for Occupational and Non-Occupational Exposure to HIV* (Belize) 2010

Ministry of Health, *Prevention of Mother To Child Transmission of HIV and Syphilis: Manual* (Belize) December 2009

National AIDS Commission, *Strategic Plan for a Multi-Sectoral National Response to HIV/AIDS in Belize (2006-2011)* (Belize) n.d.

National TB, HIV/AIDS and other STIs Programme, *Annual Health Report 2009*, Ministry of Health (Belize) 2010

National TB, HIV/AIDS and other STIs Programme, *HIV/AIDS/STIs & Tuberculosis Strategic Plan 2009-2011* (Belize) n.d.

National TB, HIV/AIDS and other STIs Programme, *Partner Notification/Intervention Manual*, Ministry of Health (Belize) 2008

Other Belize documents

Adele Catzim-Sanchez, *The HIV Epidemic in Belize: Evidence of gender related risk factors and impact (draft),* Pan American Health Organization (Belize City)

Katalyst Institute for Public Policy and Research, *The National HIV/AIDS Policy: A Case Study*, Katalyst (Belize City) September 2007

Lewis, Debra J., *Monitoring the Fulfilment of the UNGASS-AIDS Agreements on Sexual and Reproductive Health, Phase II – 2009/2010,* Alliance Against AIDS (Belize) March 2010

Lewis, Debra J., *Walking in the Darkness, Walking in the Light: A National Assessment of Actions on Ending Violence Against Women in Belize,* Women's Department, Ministry of Human Development and Social Transformation (Belize) June 2009

Ministry of Health and Pan American Health Organization, *A Gender-Based Analysis of HIV/AIDS in Belize* (Belize) 2010

Ministry of Health and UNFPA, *Sexual and Reproductive Health for Sex Workers: The Rapid Needs Assessment* (Belize) May 2010

National AIDS Commission, *Gender Mainstreaming Belize's HIV and AIDS National Strategic Plan 2006-2011* (Belize) n.d.

Pan-American Health Organization, *An Analysis of the Health Sector Response to HIV in Belize (unpublished document)* 2010

Other documents relevant to gender and human rights (as applied to the health sector and HIV/AIDS)

EngenderHealth and UNFPA, *Sexual and Reproductive Health of Women and Adolescent Girls Living with HIV: guidance for health managers, health workers and activists,* UNFPA (New York and Brasilia) 2008

Open Society Institute, *Human Rights and HIV/AIDS: Now More Than Ever (Fourth Ed.)*, SOROS (New York) July 2009

UNAIDS, *Interagency Task Force on Gender and HIV/AIDS,* KIT Publishers (Amsterdam) 2005

UNFPA, *A Human Rights Based Approach to Programming*, UNFPA and Harvard School of Public Health, 2010

World Health Organization, *Integrating Gender into HIV/AIDS Programmes in the Health Sector,* July 2009