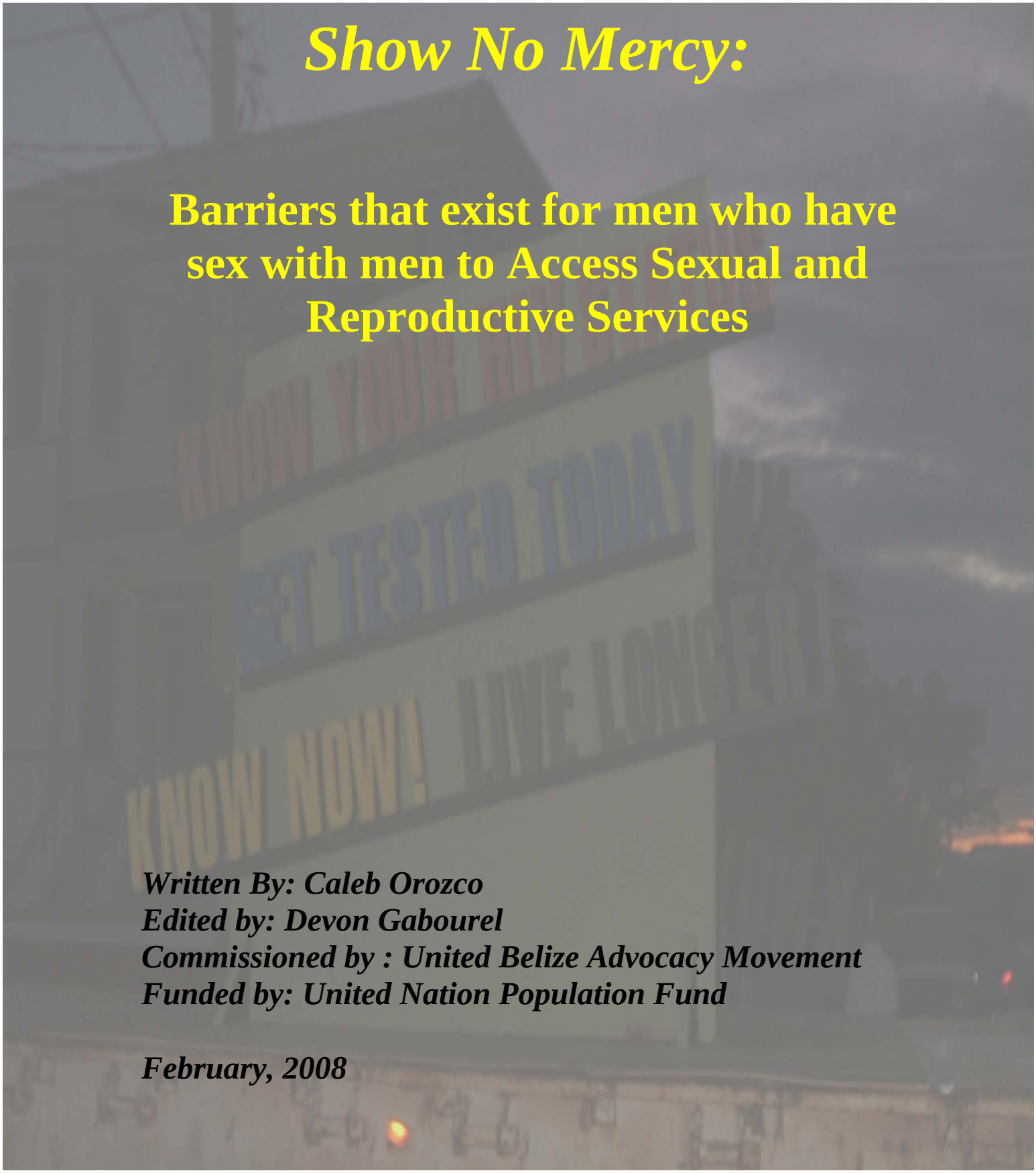

Show No Mercy:

Barriers that exist for men who have sex with men to Access Sexual and Reproductive Services

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Executive Summary

Access to equitable and humane medical services reduces the risk of at risk populations to HIV/AIDS. However, barriers exist for the MSM population to access public health Prevention, Care, Treatment and Support services in Belize. The study goal is to examine the practices and attitudes of the health and medical establishment towards the MSM clients while studying the perceptions, attitudes and behavior of the MSM community to access the services provided by the health and medical establishment in Belize.

UNIBAM researchers employed the research tools of literary review, focus groups, site visits, site surveys, interviews, and survey questionnaires to identify what barriers existed and how the MSM and Health/Medical establishment contributed to or were influenced by these barriers to equitable and humane access to prevention, care, and treatment and support.

The study allows UNIBAM to establish the following observations:

- Stigma and Discrimination of persons who are MSM is entrenched in Belize while human rights needs are ignored as a population;
- The Health/Medical community's HIV/AIDS prevention education is influenced by misconceptions about the dynamics of sex, sexuality and sexual orientation.
- The Health/Medical establishment ignores the need to integrate psycho-socio-sexual issues that affect the MSM population with existing Care, Treatment, Prevention and Support interventions.
- Health information and data collection is primarily heterosexual based

- Sexual health services use interventions (eg ABC Prevention Model) that tend to ignore the psycho-social and sexual needs of the MSM population.
- The gaps that exist in policy, intervention design and service delivery create an environment that encourages MSM individuals to access services abroad- and use private clinics in Guatemala, Mexico and other regional countries.
- MSM individuals prefer cross-district travel to access local services.
- The lack of lubricant supply and distribution threatens to undermine the effectiveness of prevention information, especially in rural communities.
- Cultural barriers affect the development of a common policy or protocol to provide health information, treatment, support and privacy for YMSMs.
- For the most part, MSM individuals are motivated by curative rather than preventative access. Fears about privacy being violated, losing jobs; rejection from friends and family; losing one's home and the formalization of such fears legally have a cumulative effect of individuals avoiding health services as much as possible.

UNIBAM concludes that key to overcoming barriers to reach MSM individuals are to promote active representation of MSM issues in the health planning process including research and the creation of integrated prevention messages and interventions; to incorporate MSM psychosexual and psychosocial knowledge into training conducted in Prevention, Care, Treatment and Support services; and implement transparent Monitoring and Evaluation system for public health and medical services to aid the creation of targeted and realistic policies and interventions.

Part I - Introduction

Baseline Research on Barriers to MSM Accessing Sexual and Reproductive Services

Background
Problem
Significance
Definition of Terms

Background

Belize has developed a multi-sectoral response to HIV/AIDS: legislating for one national authority, developing a National HIV and a World of Work Policy, and designing a national strategic plan. Some critics have commented that the plan and policies were approved without legislative teeth or human rights mechanism to make them more effective and enforceable on the ground. Observers point to the gap in knowledge of how effectively healthcare providers are providing services, especially HIV related, to MSM individual across the country. How MSM individual access services or don't, has not been documented at all. Critical to the success of HIV and AIDS interventions is the principle of non-discrimination. This issue may have more political commitment (as reflected in the policies) in regards to discrimination based on health status, but not necessarily if the discrimination is based on homophobia. These points are fundamental in understanding ground level health care provider capacity to provide psycho-social and psychosexual support.

The issue of barriers becomes important when looking at modes of transmission and the increases in infected persons. The third quarter report of 2007 from the Ministry of Health stated that there were 4,131 persons infected cumulatively since 1986, but, the report does not reflect data collection efforts that reflect the men who have sex with men actual prevalence rates, nor does it reflect how much access VCT Services across the country. The data that have been collected on MSM is 10 years or more old and suggests that there was a 22% cumulative rate of infection. This opacity represents an example of how administrative processes can become a barrier to reaching the population effectively.

In an effort to update data on the MSM population in Belize, the Multi-Centric Study was launched. Though admirable, the study failed to improve the health system's understanding of the MSM population. The Multi-Centric Study did not have direct involvement of the MSM population in the design and development of the study, a process that was further complicated by logistic clashes and a shortage in personnel. Such processes reflect inadequate institutional capacity, preparation and understanding of the practices and needs of the population.

The Problem

Belize does not collect data on the men who have sex with men population because of a design flaw in software that is used within the Ministry of Health. For instance, MSM individuals that access VCT Services are not documented from pre-counseling interviews done. While some data on the men who have sex with men population does exist up to 1998, the data does not reflect realities on the ground regarding the population's evolving needs as a population.

Furthermore, since there is insufficient data, the many problems experienced by the MSM population remains invisible to the national health system and hence hamper the ability of the system to make decision in resource distribution and service delivery to the reach the population. It is within this context that the United Belize Advocacy Movement commissioned this report to examine barriers affecting the MSM population as well as how healthcare providers contribute to those barriers.

Purpose and Significance

To identify barriers affecting how the men who have sex with men population access health services and examine how public healthcare providers in Belize contribute

to existing barriers in service delivery. Health care providers, non-governmental organizations, social planners, Ministry of Education, Ministry of Health representatives from the Epidemiological Office, National AIDS Program, Commissioners from the National AIDS Commission, the media, and policymakers can use the information to make evidence based decisions and to formulate strategies to reach the men who have sex with men population with a goal to improve access to services. Ultimately the authors of this report aspire to contribute to the multisectoral efforts to reduce stigma and discrimination towards the MSM population in Belize.

Abbreviations and Definition of Terms

AMFAR-American Foundation for AIDS Research

BCC-Behavior Change Communication

CARICOM-Caribbean Community

COC-Cayo AIDS Committee

DAC-District AIDS Committee

FHI-Family Health International

HFLE-Health and Family Life Education

HIV-Human Immunodeficiency Virus

ILGA-International Lesbian and Gay Association

Ix Qui Winq- man-woman

MOE-Ministry of Education

MOH-Ministry of Health

MSM-Men who have sex with Men

MSW-Male Sex Worker

SEA-Southeast Asia

SIB-Statistical Institute of Belize

SRH-Sexual and Reproductive Health

STI-Sexually Transmitted Infection

UNAIDS-Joint United Nations Programmes on HIV/AIDS

UNFPA-United Nation Population fund

UNGASS-United Nations General Assembly on HIV/AIDS Second Session

Unibam-United Belize Advocacy Movement

VCT-Voluntary Counseling and Testing

YMSM-Young man who have sex with another man

Part II-Literature Review

Baseline Research on Barriers to MSM Accessing Sexual and Reproductive Services

International MSM Assessment

National MSM Assessment

International MSM Review

The issue of discrimination as it relates to human rights violations is discussed by Lena Sundh, representative of the United National High Commissioner for Human Rights shared on January of 2007, in her speech:

> *The fundamental starting point in international human rights law is, of course, the Universal Declaration of Human Rights. The Preface to the Declaration emphasizes "the inherent dignity and … the equal and inalienable rights of all members of the human family"; Article One states that "(a)ll human beings are born free and equal in dignity and rights"; and Article Two states that "(e)veryone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."*

The issue of rights is especially important as it relates to Care and Treatment, Prevention and Support**.** The recent creation of the Yogyakarta Principles in 2007 defined 29 principles in international law that already exists on the applications of international human rights law based on sexual orientation and gender identity and establishes that protections of sexual rights are already in international and some domestic laws, but enforcement is the problem.

Beyond this, many governments are vigorously opposed to– and vow to never recognize- LGBT rights and employ institutionalize homophobia. The best known hate speech was done by President Mugabe of Zimbabwe in 1995 arguing that gays and lesbians were unnatural, subhuman and "***behave worse than dogs and pigs***" In Uganda, president Yoweri Museveni announced in a speech that he had told the Criminal Investigations Department "***to look for homosexuals, lock them up and charge them."*** In March 2001, then president, Sam Nujoma of, Namibia stated … "***the country does not allow***

homosexuality or lesbianism here. Police are ordered to arrest you, and deport you and imprison you too". In Jamaica the then Opposition Leader Bruce Golding vowed in 2006 that "**homosexuals would find no solace in any cabinet formed by him."**

Homophobia as it relates to health is more clearly highlighted in a report done by Human Rights Watch on Jamaica in 2004.

The Human Rights Watch Report called, "***Hated to Death: Homophobia, Violence and Jamaica's HIV/AIDS Epidemic***" pointed out a few fundamental points in regards to barriers experienced in Prevention, Care, Treatment and Support against the men who have sex with men population in accessing health services. Among these were the following:

- Health workers forcing MSM individuals to wait extended periods of time to be seen.
- Treatment that included abusive or degrading manners while providing inadequate care, or denied them treatment altogether.
- Health workers violating privacy by disclosing sexual orientation and HIV status.
- Deep stigma was keeping men from seeking medical treatment from existing prevention services, driving them to engage in unsafe and unprotected sex.

Stigma against the MSM population is reflected institutionally across the English speaking Caribbean and the international community. The International Lesbian and Gay Association report in 2007 cements the point; it reported that 85 United Nations member countries had laws that criminalizing consensual sex between adults. Belize remains one

of those countries along with the English speaking Caribbean states in the United Nations System. Though, not all the countries with anti-homosexual laws systematically enforce these laws, it is important to note that their mere existence formalizes cultural and institutional stigmatization that forces the men who have sex with men population into invisibility by making it publicly and socially important to deny their sexual rights as human beings. This invisibility translates into high HIV prevalence rates.

The data below collected in the Caribbean provides a snap shot of the vulnerability of the MSM population in specific countries.

Table 1 MSM HIV prevalence rates across the Caribbean

Country	***Region***	***Year of Study/data collection***	***% of Prevalence***
Dominican Republic	Santo Domingo	1994	11.7%
Jamaica	National	1996	30.0%
Jamaica	St. Andrews	1995	33.6%
Jamaica	n/A	2004	25.0%
Martinique	n/a	1988	39.1%
Trinidad& Tobago	n/a	1984	40.0%
Guyana	n/a	2004	21.2%

Source: Michel de Groulard, Caribbean UNAIDS Regional Technical Adviser

In addition to the table above, a Suriname study found that there was a sero-prevalence rate of 18% for MSM individuals who participated in the study and of those person who self-identified as an MSM, 30% were engaged in sex with women as well. Beyond this, a recent study was conducted by John Hopkin's University in 38 low and middle-income countries found MSM's have 19 times greater chance of getting infected than the general population. For the MSM populations in Trinidad and Tobago, specifically, the odds of getting infected were found to be 4 to 8 times more likely than

the general population. In meetings led by Family Health International across Asia in 2005 it was found that Thailand, HIV prevalence among its MSM increased from 17.3 % in 2003 to 28.3% in 2005 in Bangkok

Globally, fewer than one in 20 MSM has access to HIV prevention, treatment, and care services (www.amfar.org). Kevin Frost of AMFAR, reflecting on the importance of the epidemic and the issue of stigma, said "…. ***if we don't overcome institutional prejudices and treat this epidemic seriously in the populations that are most affected, we will never beat AIDS."***

In the Caribbean, according to, "***Keeping the Score Report***," the region received $518 million, to address HIV and AIDS. Yet there is no data, on how much resources have been invested in preventions strategies that included psychosocial or psychosexual information in health systems of member countries in CARICOM that reached the MSM population.

While "***Keeping the Score***" reported that there was increasing political commitment, partly reflected in increasing funding since 2002. In that same report, it also estimated that 1/10 of the infection occurred with sex between men and points out that despite large investment made there are gaps that remain. The issue is further reinforced in the St. Kitts & Nevis UNGASS report in the following quote:

> *"[In] St.Kitts and Nevis…while the National Plan identifies key vulnerable populations such as men who have sex with men (MSM) for targeted intervention 'very few programmes exist' for MSM….".*

The issue of infrastructural weakness and the issue of stigma are reflected in this quote from Jamaica:

> *'Despite a well established national surveillance system, collection of data in some high risk groups remains sparse. MSMs do not readily*

> *reveal sexual orientation due to stigma and discrimination. This leads to reduced access to prevention interventions…… "*

Poor prevention, care, treatment and support strategies fail to reach the population. Furthermore, finding by the International HIV/AIDS Alliance report found that in Kunming, Yunnan, Chengdu and Sichuan Province of China poor awareness about safe sexual behaviors; multiple sexual partners; inadequate institutional capacity; an unclear policy to support community group interventions were affecting intervention activities.

Findings from The Honghe, Brothers Care MSM Working Group found MSM fear of the potential result of an HIV test from VCT helped in their staying away. Of those who did accept VCT, many of those who receive positive results refuse treatment for fear of damaging their family's reputation by being exposed as PLWHA.

Despite, the fears about damaging family reputations, risky behavior remains high while intervention coverage remains low; links between prevention, testing, care, support and treatment programs are weak or non-existent. These problems exist along with no political will to address comprehensive regional or national strategies. Despite the understanding of the MSM population needs in Southeast Asia, 40% of countries still did not have a formal plan to reach the MSM population; 75% did not have any public investment to reach the population and none had a scaling up plan. Most countries spent overall less than 1% of their AIDS budget on MSM population where it accounted between 5 to 20% infection. More specifically public prevention budgets for the populations ranged from 0% in China to 4% in Thailand.

National MSM Review

For Belize a study was done, but never completed, in July 2005, by Chad Martin, Centre's for Disease Control representative, he interviewed 37 MSM using focus groups and individual interviews. In his preliminary report, he found, that 20% interviewed shared stories of friends being forced from their homes, 75% expressed a sense of duty and commitment to live up to family expectations, with the interviewed expressing a view that they feared being forced to leave their homes. 60% expressed friends being abused as a result of being too openly gay. The issue of abuse and violence leads to a disintegration of trust in the authorities. According to Martin:

> *"The perceived existence of abandoned responsibility in one's profession, like that of the police, of protecting the community, gives rise to concern of future problems among the authorities.*"

From a focus group organized in 2007 for BFLA, researchers pointed out the following:

> *"The MSM group reported a feeling that the outreach programs are inadequate for their population. It is believed that the official outreach is approached from a particular value system that alienates their group and presents certain natural biases and prejudices against their group. They agree that cultural and societal norms operate against them, but admit that there must be planning sessions that seek to establish programs that combat those established and accepted prejudices."*

The BFLA report point out how natural biases affect Behavior Change Communication efforts and that overcoming natural biases is essential if risk exposure is going to be reduced among the population. The bias and mistrust is exacerbated by the criminal code of Belize.

For those living in Belize the Criminal Code Chapter 101 Revised Edition 2003 states in section 53: ***"Every person who has carnal intercourse against the order of nature with any person or animal shall be liable to imprisonment for 10 years."***

When asked about other fears, 54.1% or 20 of the participants expressed fears about being fired without cause. 16.2% or six of the men reported knowing someone who lost their jobs as a result of discrimination and 18.9% or seven expressed a further sense of isolation that triggered suicidal thoughts.

The psychosocial and psychosexual limitations of service delivery are further limited by awareness about organization that supports the minimal delivery of prevention information. According to the report only 35% of participants were aware of the services that were available to them. For those who did testing, 13.5% expressed situations where the employers and family knew about the results before they got it back themselves, most did not seek or knew the location of services in health systems, some proceed to travel to other districts or out of country for health services.

Health and human rights was not discussed much in the study, but economic and social rights issue was reflected in the conversations of the study. It reinforced the importance of a right based discussion in health and the need to deal with stigma and discrimination in a holistic way that incorporates all aspects of human rights.

Part III – Research Design

Baseline Research on Barriers to MSM Accessing Sexual and Reproductive Services

Sample
Methodology
Data Collection and Limitation

Sample:

Comparative analyses of two large samples were conducted along with a smaller sample size and follow-up interviews. The first sample was made up of 115 men from a rapid survey; the second was from a sample of 200 men from UNIBAM field logs. Follow-up interviews were done with 26 MSM across the country and three focus groups, two in Corozal and one in Orange Walk, were conducted. Interviews and site visits were also conducted with public and private sector health providers across Belize. The total numbers of interviews conducted was 300 persons. 83.3% or 250 were MSM while 16.7% were health providers.

The first set of information collected was from 115 MSM individuals done through a rapid survey that consisted of 9 questions and conducted in 5 districts from June to December 2007. An assessment was done for an additional 200 persons from 4 districts who were interviewed separately over 2007 using UNIBAM field logs. Of that 200, 88 were targeted for deeper analysis. Follow up interviews were done in the districts of Orange Walk, Cayo, Punta Gorda, and Dangriga in late 2007 and early 2008. Three MSM focus groups were conducted in groups of 8 persons. Of the focus groups, Corozal had two groups while one was done in Orange Walk.

Beyond this, 50 nurses, support staff and doctors who work in public and private facilities in both rural and urban areas were interviewed. Of the original 68 medical persons planned to be interview, 50 were reached (73.5% of the intended goal).

MSM participants were contacted using available social networks that exist across the country with the support of a lesbian, MSW, and YMSM. With the support of existing Ministry of Health outreach efforts to provide Comprehensive Care in rural areas

(Double Head Cabbage, Hillsbank, St. Pauls, St. Ann, Lucky Strike, Bomba, Maskall) the authors interviewed health personnel on their health activities. Additionally, the polyclinic in San Antonio Toledo, the Punta Gorda Hospital, Northern Regional Hospital, and the VCT/MOH in Corozal was also visited and personnel interviewed.

Private Providers like the Hillside View Clinic in Toledo and the Presbyterian Medical Clinic in Patachakan Corozal, Northern Plaza in Orange Walk, were also interviewed along with branches of BFLA in Stann Creek and Punta Gorda Districts.

Methodology:

The results of the data collected are intended to be qualitative and serves only as framework to be built upon by future research activities as the needs of the MSM population is always evolving. The process of data collection from the MSM population was done over one year.

The three focus groups were utilized to capture qualitative data on sexual debut, awareness about free testing sites and commodities available in the areas MSMs reside. For the first focus group in Corozal participatory educational activity was conducted with eight MSM individuals, their ages ranged from 16-40 years old. Participants were from Guinea Grass, Santa Clara, San Jose, San Narsicio and Corozal Town. For Orange Walk, participants were from the town.

In Belize interviews were done in person, online and over the phone by a YMSM individual to reach the 18 and under population. In Dangriga, interviews were done in person with the aid of a taxi driver, while in Punta Gorda; interviews were done late into the night with the support of a male sex worker and a taxi driver who introduced clients or friends separately.

Data Collection and Limitations:

The study process limited itself to finding MSM specific data that existed up to 2007. It looked at work from South East Asia, Senegal, Nigeria, and seven countries from the Caribbean and accepted the possibility that data would be more than 10 years old from the Caribbean and that it was important to make a global comparison of recent data. The researcher utilized internet sites from UNAIDS and the Global MSM Forum and available data collected by The United Belize Advocacy Movement field work in Belize since 2006 from its Behavior Change Communication efforts.

While the focus of data collection was on barriers, it was also important to collect data on behavioral issues along with awareness of services and commodities by MSM; an effort was also made to look at one insurer and medical provider's contribution to existing barriers in the public and private sector.

As a result of the effort, the study came across issues that were beyond the scope of data collection. The issues identified were sexual abuse; domestic violence, community violence, lack of recognition for a young person sexual rights.

The limitation of the study is that it does not look at sero-prevalence, nor does it go in-depth sufficiently into psycho social or psycho-sexual information on risky behaviors, but sought only to establish that baseline information can be collected, and that it requires innovative efforts and a long term commitment to research action.

We caution, that any data collection done in the MSM population requires, patience, flexibility, money, inclusion of the population in the design and development of the research from beginning to end, with great care taken to follow-up on the population results. Failure to document the psychosocial and psychosexual perceptions and practices

of the population before embarking on a sero-prevalence study will result in distrust and extreme difficulty in collecting data.

Part IV - Data Presentation and Analysis

Demographic Profile
MSM Interviews
Health Provider and Community-Based responses

Demographic Profile

With the first set of data collected from 115 MSM, no data was collected in regards to ethnicity. The table below outlines where the data was collected across the country:

Districts Interviews and Locations in the following 11 communities:

Table 2 Districts Interviews and Locations

Locations	***District***
Unitedville	Cayo
Blackman Eddie	Cayo
Santa Elena	Cayo
San Ignacio	Cayo
Teakettle	Cayo
Santa Clara	Corozal
San Narcisicio	Corozal
Orange Walk Town	Orange Walk
Belize City	Belize
Placenica	Stann Creek
Benque	Cayo

Using the rapid survey information a comparative analysis was done with the 2006 - 2007 UNIBAM field logs of 200 persons. The logs contained questions in regards, to sexual practice, service used, HIV knowledge and other issues we believed were affecting the MSM population in 4 districts. Of the sample reviewed from the logs, 42.5% were gay, 47.5% were bisexual, and 5% straight that combine together to reflect the term MSM while 1% was self- labeled a hustler or MSW. Of the number interviewed,

50.5% were from Cayo, 20% were from Belize and 10 % Corozal. The table below shows the remainder from other districts:

Table 3 BCC District Interviews

Period of interviews:	**21/12/06-3/11/07**	
# of interviews done	**200**	
Districts	# of interviewed	Percentile
Corozal	20	10%
Orange Walk	9	4.5%
Belize	40	20%
Cayo	101	50.5%
Stann Creek	2	1%
N/A	21	10.5%

Of those interviewed 52% were between the ages of 20-29 while 29.5% were 19 and under. Of the sample of 200 persons from the filed logs 88 were chosen for deeper analysis and it was discovered that 58% have had sex under the influence of alcohol and 4.5% have been forced to have sex with another person. When asked if they would have sex if they were HIV positive, 59.1% would not stop having sex while 10.2% were not sure if they would stop having sex. Of the same 88 persons, 62.5% would keep their status a secret, suggesting that they are keenly aware of the possibility of being treated different if someone found out their status. Despite this awareness about being stigmatized, based on health status, 25% reported that they would still not be using condoms or only use it sometimes, indicating low-risk perception. This is despite 88.6% knew about how HIV is transmitted to another person. Further breakdown of the field logs can be found in annex 4 and 5 at the end of this document.

MSM Interviews Results

The issues of sexual debut, age, and the rights of a person to privacy, community mores and practice, and access to treatment and prevention education arose throughout the interviews with MSM making these issues prominent in cases of discrimination.

From a local study of 384 participants from the general population done in 2004, promoting male sexual and reproductive services, 6.3% of men reported being forced into sex as children.

The issue of sexual abuse seemed to be a major factor that arouse from various districts focus groups. Five cases come to mind that became striking; one from Orange Walk, two Belize City, and two from Corozal. A social worker in Belize shared that years ago she had a cousin that was raped at age 6. When her mother found out, she proceeded to beat the cousin for the incident. The social worker shared that she never forgave her mother for the incident and shared that the person she mentioned was now 45 years old, gay and HIV positive. Upon interviewing two MSM in Corozal in a second focus group on New Years 2008, one shared that he was kidnapped and raped when he was 10 years old. When his mother found out, she proceeded to tell him that he deserved what he got

Table 4 Sexual Debut of MSM in Focus Group

District	*# in focus group*	*Follow-up interviews*	*Sexual Debut of MSM*	*Note:*
Orange Walk	*8*	*N/A*	*5-19*	*In the Belize HFLE 1999, general sexual debut was 16-17 years while prisoners reported sexual debut between 13-15 years old. The SIB 2006 sexual behavior survey reported sexual debut at 7-24 years.*
Corozal	*16*	*N/A*	*10-17*	
Belize	*N/A*	*2*	*12-17*	
Stann Creek	*N/A*	*5*	*13-20*	
Cayo	*N/A*	*4*	*11-18*	
Toledo	*N/A*	*15*	*11-15*	

for he was warned not to go with strangers. The gentleman proceeded to share a decade later that he was raped to his mother, but instead of expressing empathy for his rape as a child, she wrote him a letter admonishing him for his attraction to men. The other shared that he was raped when he was 4 years old by a cousin. He shared that he was never treated the same by his older brother and sister after the incident and since his family found out he was gay, they have not spoken to him. During this interview, a transgender man who lives and works as a woman, recalled how she was raped by her uncle as a child and never shared the experience with her mother. She often sees the uncle and fears that their might be other children going through the same experience in her village. Last, was an MSM who is HIV positive that was raped as a child along with his brother and sister. Understanding the risk perceptions of men is critical for effective interventions. This need is reflected also, in data collected in a 1999 project called Health and Family Life Education on Males which had a sample size of over 1773 men. Generally, the highest percentage of men who believe themselves to be at some risk for HIV infection was (42%) in the 20-24 age groups, the lowest is (60-64) group (12%).

Risk perception is also reflected in age. In Punta Gorda the researcher was introduced to a 14 year old boy who denied he was gay, but may had as much as 6 sexual partners before leaving primary school. Such experiences, challenges how sex education is delivered to young people, but more importantly challenges present cultural barrier to address concerns of young people.

Beyond this, researchers from the University of California Center for AIDS Prevention found in the United States in 2001 that of the 20.6% MSM that experienced sexual abuse they tend to have a higher rate of prevalence than the general population and

that those who are survivors had higher rates of sex under the influence of alcohol and drugs. From an Australian Study published in the September edition of the HIV medicine 2003, found that men with major depression were less likely to report unprotected anal sex.

During our data collection in Corozal several points, was identified about those living in the rural areas. For example, it was shared that the Paraiso Clinic, in Corozal gets donations from time to time of a lubricant called Yahu and that most villages do not have a pharmacy nearby, that there were several places that did testing and one of those was the Seldise Lab and the Paraiso Clinic. However, no pre-counseling is done at the latter, but monthly testing is done nevertheless. A common complaint in the rural communities is that commodity support is sporadic and unreliable. For instance access to condoms is limited and lubricants non-existent at the community clinic. Shops in all the rural communities that the researcher visited were small and did not supply lubricants.

Within the context of the rapid survey that reached 115 MSM's, question 1 below provides some prospective about HIV testing among MSM's:

Table 5 Interview Question: Where do you Get HIV Testing done?

Question 1:	***Where do you Get HIV Testing done***	
# of Private Test	***30***	*26.1% just tested privately*
Not tested at all	*36*	*31.3% have not gotten a test*
# of Public Test	***39***	*33.9% tested in Public spaces only*
Other	***10***	*8.7% were not sexually active or did not want to get parental consent*
# of interviews	***115***	

Of the 115 persons interviewed in our rapid survey, 60% cumulatively have gotten a test, but what cannot be ascertained is how many returned for their results. Of the first focus group done in Corozal, only three got tested at the Health Center in Corozal Town while others got tested in Orange Walk and Belize City.

On the issue of disclosure of sexual orientation to health workers, only 22.6% of the men reported having honest disclosure. Question 3 below, provides a breakdown percentile of responses:

Table 6 Interview Question : Do you tell the VCT counselor always that you have sex with men?

Question 3:	***Do you tell the VCT counselor always that you have sex with men?***	
# that do not tell	***57***	***49.6% did not say they sleep with men***
# that are honest	***26***	*22.6% are honest about sleeping with men*
# that say sometimes or counselor don't ask	***11***	*9.6% sometimes they share who day sexual partners*
No answer	***9***	*7.8% did not give information*
other	***12***	*10.4% have not been tested*
# of interviews	***115***	

When asked why they aren't honest about their sexual orientation, a total of 30.4% cumulative combined, said that they feared the counselor attitude, or was concern about the counselor knowledge and felt it was none of their business. Still, 59.1% did not answer the question, a gap that cannot be ascertained and needs further analysis. The eldest in the Corozal focus group sought to clarify that it was "***Nobody's business***" for any public medical provider to ask him if he was sleeping with a man and that he preferred to access a private doctor than go to the public hospital. For further review of reasoning, question 4 is in table format.

Table 7Interview Question : If no, why don't you tell the counselor that you sometimes sleep with men?

Question 4:	***If no, why don't you tell the counselor that you sometimes sleep with men?***	
# fearing counsellor attitude	***15***	*13% feared counselor attitude*
# of Attitude and counselor knowledge	*3*	*2.6% shared both attitude and knowledge of counselor was a concern*
Other	***17***	*14.8% None of their business*
# that did not answer the question	*68*	*59.1% did not answer the question*
Other- not gotten tested	*12*	*10.4% did not get tested*
# of interviews	***115***	

The issue of the level of HIV Education among MSM individuals was also assessed. The majority of respondents were aware that condom gives a 98% rate of protection when used consistently and correctly. However, if they are using oil-base lubricants, that protection is undermined. Question 8 points out that MSM individuals were using oil-based lubricants or nothing during sexual intercourse. An important note was, despite awareness of the effects of oil-based lubricants on condoms, it was discovered that of those that use water-based lubricants, 13% also use oil-based lubricants as well, suggesting they are picking up any commodity that is available and are not pre-planning in supporting their need for lubricants. In a focus group organized in 2007 in Orange Walk for the BFLA, their report pointed out a motivation in the following:

> *"The group reported that Belizeans in general did not demonstrate knowledge on the usefulness in the application of lubricants during sexual intercourse. One participant reported that among the MSM population and Belizean adults in general the use of lubricants appears minimal."*

Recognizing the importance of this question, the use of lubricants was asked in question 8 below. What the table reveals is that MSM individuals are aware of lubricants and recognizes its necessity to sexual activity, but its use, is more complicated than awareness.

Table 8 Interview Question: What kind of lubricants do you use during sex?

Question 8:	***What kind of lubricants do you use during sex?***	
# that use KY/Vive	***62***	*53.9% used water-based lubricants*
#baby oil/ grease/ lotion	***36***	*31.3% oil base lubricants*
# use saliva or nothing	*17*	*14.8% use nothing or saliva*
# of interviews	***115***	

Note of those that use water-based lubricants 15 persons or 13% reported using oil-base lubricants as well.

This particular practice of using oil-base lubricants is especially important when we look at consistent and correct condom use. While 78.3% reported consistently wearing condoms, 31.3% have been using oil-base lubricants, suggesting that prevention information is not effectively getting to the MSM population and that more work has to be done in reaching the population. From our focus group in Corozal they were asked how they learnt about lubricants. One said a sex shop that existed in the Corozal Free Zone, but most shared that they saw lubricants for the first time when outreach was done with them. Despite this, one person shared he never used lubricants, because he liked sex dry.

For those who are sexually active over a lifetime the cumulative total sexual partner ranged was as low as 11 partners and as high as 200 plus. The cumulative percentile stood at 41.7% of our interview sample that remains sexually active, and opens up the possibility that inconsistent and incorrect condom use due to lubricant usage maybe increasing exposure risk of HIV and STI to partners over time. This is especially important when we look at the amount of lifetime partner individuals may accumulate. Question 6 below points out to a range:

Table 9 Interview Question : How many partners have you had over a lifetime?

Question 6:	***How many partners have you had over a lifetime?***	
0-10	***56***	*48.7% had less than 10 partners*
11-50	***43***	*37.4% had between 11 to 50 partners*
51-100	***1***	*.87% over 51 partners*
100-150	*1*	*.87% had over 100 partners*
151-200 plus	*3*	*2.6% had up to 250 partners*
N/A	***11***	*9.7% simply did not answer*
# of interviews	***115***	

When asked about accessing VCT, participants reported that for them to access the VCT for a first test it was important that their friend to be involved when it was sought, otherwise they would not get tested by themselves. Despite this, MSM individuals do access healthcare, but for minor conditions like cholesterol levels or throat infections. Such access is non- intrusive and does not confront an individual's sexuality. The focus groups also reported that work schedules often affect their frequency in how they access health care and as such their accessing in curative not preventative.

In Punta Gorda a male sex worker was utilized (***see annex 2 details***) to interview other MSM in the community 10 of his clients were introduced to the researcher over 2 nights, the other interviews were facilitated by a taxi driver and support staff from BFLA in Punta Gorda. The male sex worker pointed out that he has never entered a clinic for testing, but that he does pick up information from the street and from television. Other individuals shared they got tested only when there was a health fair.

The issues in Punta Gorda Toledo highlighted communal stigma to access sexual and reproductive health services and compounded factors of economic and social rights being violated individually. More specifically, a particular business owner shared his concerns about losing his house and business if people found out that he was homosexual.

As a result, this person shared that he accesses health services in Puerto Barrios, a border town in Guatemala, with the aid of a friend who owns a boat that takes him for free. He pointed out that he has been adopted into a family and have been given a house and was setup in business, but if the family patriarch ever found out that he was gay he

feared losing everything. In one Maya Community of Indian Creek men who have sex with men are derided as ***Ix Qui Winq***, a man-woman.

Individuals were asked what kind of HIV Education they got at school. Some shared that only condoms were discussed in High Schools at Toledo Community College, but not lubricants as far as one could remember. Another reported, as a teacher, that curriculum design is the problem when doing in-depth discussion of sex and sexuality that Catholic schools along with Seventh Day Adventist did not like to discuss about condoms in Toledo.

When confronted even with another like themselves, a number of individuals refused to use the term gay or homosexual. MSM respondents shared that people they know tend to like euphemisms:

- "Do you want to go drink and hang out?"
- "I have my girl friend you know, I no like try this thing"
- "How much would you pay me to do you?"
- "I only want to try this once"

What influences this dialogue seems to be alcohol. Of the persons we interviewed from our UNIBAM log of 2006-07, 58% of the 88 shared that they had sex under the influence. Despite this, close male friends in their teens and early twenties tend to still play games like ***"grab the cherries"*** outside of the group there is a stigma attached to such sexual games.

Health Providers and Community-based Responses

The health personnel interviewed exhibited varying degrees of knowledge about MSM needs and commodities use by this population in their communities. The researcher was able to speak to 50 persons that were health providers or support staff working with or within the MOH. Following this review, an assessment of the Cayo AIDS Committee, Stann Creek AIDS Committee, Corozal AIDS Committee suggest administrative weakness that exists tends to be a barrier, rendering local responses in the districts weak or ineffective.

The Office Assistant/Educator at BFLA-PG shared that parents are in so much denial about their children having sex, that they have voiced this concern at PTA's and ask that sex not be taught in school. The result is that young people tend to feel less comfortable talking to parents about sex and tend to try and access BFLA-PG office to get contraceptive information and support, but because they are student, their choices remain limited, especially for the women. For the few MSM that access BFLA-PG, they tend to discover that the office does not have lubricants, but are assisted by the office assistant who goes to the pharmacy to buy it on their behalf.

The issue of maintaining lubricant supplies at the BFLA office was brought up with the Centre Manager, she shared that she did not know that lubricants were available for distribution through BFLA. Another issue arose in our conversation of how prevention messages were delivered. The respondent mentioned that she does outreach with schools, but that someone from the recent Adventist school management was complaining about her discussing condoms in the school system. She denied the accusation, and proceeded to share that there were a group of the nurses belonging to the

parishioner's nurses association who goes out and do field work, but in their prevention messages, this group do not discuss condoms. She shared that this has been a long standing position of Catholic missions. Information collected revealed that the nurses collective organize a Health fair once a year, but do not display condoms.

At the public hospital, the psychiatric nurse Jane Avila was interviewed and she shared that she has never met an individual who is a man who have sex with another man at her clinic or amongst her friends because the subject matter does not come up. She shared that prevention messages have to be done with both men and women in a general because one cannot tell who is an MSM.

With the advent of the Health and Family Life Education that does ongoing training with teachers, Nurse Avila shared that sometimes the teachers are still not comfortable discussing certain issues related to HFLE, so they would call her to do education work. Programmatic action to reach the most vulnerable has focused on mother to child transmission. The focus, Nurse Avila believes helps to explain why more women access services than men. This belief was further reiterated by the personnel at the polyclinic in San Antonio, Punta Gorda. They shared that unless men cannot bare their pain they don't access the clinic. Further inquiry at the San Antonio Polyclinic revealed knowledge capacity issues of three of the health personnel that reflected a lack of understanding about sexuality and commodities. One of the health personnel, for example, showed the researcher a fungal cream for vaginal itch rather than an example of a lubricant. What was surprising was that the community health nurse knew that a lubricant can be used to palpate a baby, but she did not realize that it could be use for sex. During the interviews at the San Antonio clinic, it was learnt support for testing of blood

for HIV/AIDS was drawn at the polyclinic, but blood samples were normally taken to the Punta Gorda Hospital for testing to one Mr. Ack. There was no indication about changes in testing processes.

The term ***Ix Qui Winq*** was shared with the two Mayan women at the clinic, one explained that she knew a person like that in the village and that she did not treat him differently. She shared that communal gossip was the way she learnt about the person.

In regards to community base actions through the DAC, some fundamental features have been identified:

1).DAC's are structurally weak in leadership, mission and vision because of a lack of administrative support and resources.

2).Efforts to conduct resource mobilization for community responses have had unintended result of undermining the flexibility of DAC's response to independently address their needs locally.

3).Community-base responses are demand driven, but administration processes tend to interrupt sustained short-term and long-term actions locally.

In interviewing rural health nurses and making observational assessments of infrastructure in all six districts. The following points were reached regarding service delivery:

- Cost to access service or purchase commodities is an inhibitor, as rough roads, irregular transportation contribute as barriers, especially in rural areas where the existing environment encourage curative rather than preventative actions by individuals;

- diagnostic tool are under-utilize by health providers as patients do not necessarily report signs or symptoms of problems as cultural isolation tend to isolate individual living in rural areas from communicating and communication tools;
- comprehensive care and treatment is limited by village isolation, road condition, planning processes, medication and commodity availability;
- attempts at integrating services have not translated to effective behavior change messages for the men who have sex with men population individually nor in a strong communication plan specific to the MSM population;
- nurses have not thought of integrating MSM specific education into their HIV education;
- ideological conflicts between sexual orientation being a sin, a choice, biological in nature, or both is affecting HIV Education delivery to MSM population;
- supply and availability of commodities in rural areas is affected by distribution processes making access and availability an issue that undermines the effectiveness of condom usage and protection;
- utilization of field workers experience in health system is under valued and underutilize in the planning process of Care, Treatment, Prevention and Support;

The points above, is further affected by faith-based activities. The health providers at Hill View shared that they see themselves as a faith-based organization and that their focus was malaria, scabies, diabetes etc and that they try to follow their mission. What this means to them is that they do not discuss condoms and that their liaison officer from the Ministry of Education, helps to screen information to help guide them according to the laws. At the Presbyterian Medical Clinic in Patchakan Village, Corozal, they promote an abstinence only program in four schools called “True Love”, in Cristo Rey, Conception, Orange Walk, Cornerstone High School and can do a quick test for Chlamydia, their main focus is not HIV Education, but to do follow-up on acute care. It must be noted that HIV positive persons received tend to be referred to the Public Clinic.

Where villages do not have Health Centres, mobiles are used for vaccinations and maternal care. For the VCT in Orange Walk, the psychiatric nurse shared, outreach is done four times a month as the vehicle is not always available to the VCT. She shared that there is not basic format for doing health education in outreach. For the BFLA office, it was shared that they get donated lubricants from the University of Loyola, but lubricants isn’t given out from the Orange Walk BFLA branch. On the issue of education prevention, no basic format is used and this researcher cannot ascertain how MSM specific information is disseminated into outreach work done.

What was learnt from this research is that lubricants can be gotten from Belize City, Dangriga and Cayo in small amounts, but not from the other districts. Despite this, BFLA is in a strategic position to provide HIV and STI services to the population and that only 7% of health facilities provide ART while only 29% of our population has been

tested in Belize. Added to this, 57 Doctors have been trained in the clinical management of patients, but only four receive the majority of patients. (Jones, 2007)

On issues related to privacy and applying for insurance, it was revealed that a questionnaire provided asks about sexual practice if a person is homosexual. Certain labs are asked to do testing for the insurance companies and result are sent to the company in a seal envelope. It was shared that a law was passed that allow all insurance companies to share personal information between them. This raises the point of how much this law violates the sexual and reproductive rights to privacy for MSM's individuals and challenges the need of the insurance system against individual rights.

The issues related to developing a comprehensive model that reflect the reality on the ground become important as the profile of our epidemic changes. For the men who have sex with men population, models that leave out how the AIDS epidemic affect the population tends to discourage further institutional programming and hence, further stigmatizes the population into invisibility.

Part V-Conclusion & Recommendation

Baseline Research on Barriers to MSM Accessing Sexual and Reproductive Services

Conclusion
Recommendation

Conclusion

Strategic data management in the public sector to monitor access and the needs of the population is weak and does not utilize existing data as part of an evidence-based management approach in planning. While there have been discussions of integrated services very little or no effort have been made to integrate behavior change communication messages that include MSM sexual practices and needs into Prevention, Care, Treatment and Support.

While the ABC model used in the system is a recognized effort, such a model ignores some fundamental points in Care, Treatment, Preventions and Support. The model ignores the rights of patients; assumes only a heterosexual component of prevention; assumes that all persons reached are HIV negative; ignores the needs of infected persons to strengthen their adherence to medication; and ignores psychosocial and psychosexual needs of the population.

While faith-based organizations have a place in HIV in treatment and support for other populations, the study shows that they can do more harm than good to the MSM individual seeking support and prevention information. For MSM's, faith-based organizations have counter-productive role in prevention efforts, as abstinence-based messages tend to contain values-base heterosexual messages that carry homophobic undertones that isolate and stigmatize MSM individuals.

A link between poor knowledge about safe sex habits, early sexual debut and condom availability puts young MSM individuals in a vulnerable situation as age and cultural expectations becomes a barrier to access commodities and testing services. The issue of HIV testing remains a challenge as it must balance the right of an YMSM to

privacy with the need for parental consent. The right to privacy for YMSM needs to be re-visited as the issue is further complicated by YMSM worries about sexual orientations being revealed to parents. Beyond this, convenient availability of commodities like condoms and lubricants force MSM individuals in rural communities to use whatever is available to them. Village locations, distance from health facilities and marketing distribution chains does not allow for a steady supply of condom and lubricants to reach the population. Hence, a young MSM individual may resort to Vaseline and other oil based lubricants such as baby oil, saliva or nothing. On the issue of information, poor knowledge about how to access lubricants and condoms tend to undermine safe sex messages as the high protection rates of condoms are affected by consistent and correct use of lubricants and make the population even more vulnerable to transmission in the rural areas.

Socio-economic issues like dropping out of school, poverty, unemployment, rural living all contribute to young MSM individual ability to access not only commodities, but testing services as well. The issue of access though, does not end there as internalize homophobia may prevent individuals from opening up as they access services.

Other problems also exist within the population like helping families deal with sexual abuse. Often in our research, homophobia tended to cloud the issue for the family member as well as the counselor who end up focusing on preventing the development of an MSM sexual practice rather than focus on the emotional trauma the person experienced along with empowering the individual to have clear negotiating skills in making appropriate sexual judgments.

Despite this, the concern for monitoring and evaluation in the Health system, the process for evaluating the effectiveness of the models like ABC used in prevention has not even begun.

What is clear is that state run institutions tend to perpetuate Stigma and Discrimination through the design of operational plans. Schools and some social support organizations continue to refuse to integrate discussion of condoms and lubricants into their classrooms or community outreach, and even then censor the information. Ingrained in the system operational culture, is the idea that service delivery is only effective if it reaches primarily a heterosexual population, keeping information, primarily heterosexually-based.

This point is then compounded by the Church-State system of education that tends to violate young peoples' right to updated scientific information reflecting not only a barrier to YMSM individual, but indifference in the education system in regards to the health information needs of YMSM individuals. This is a critical issue as our research point out that sexual debut tends to start as early as 5 years old.

All is not lost for the support that faith-based organization. Partnering with faith-based organization is of some benefit in care and treatment. However prevention education led by faith based organizations may harm efforts to reduce transmission of HIV or to have targeted preventative messages for marginalized groups in Belize because of the resistance to the existence of these groups and the need for recognition of their sexual and reproductive rights. For instance the parishioners nurse's association holds annual health fairs in Punta Gorda without discussing condoms and lubricants. Such

action does no good for MSM individuals who rarely access information from health services.

What this researcher could not ignore was that homophobia in the form of verbal, physical, sexual abuse, intimidation, harassment from the past tended to shape how much information MSM revealed during their pre-counseling to a healthcare provider. The issue of internalized stigma seems to exist side by side with external stigma. One such issue is communal stigma associated with early sexual debut affecting young people that discourage accessing sexual health services for example BFLA in Punta Gorda. This is coupled with a high degree of misconception by males about what VCT's and Community organizations do in sexual health.

Beyond this, supply management issue in the distribution of lubricants is a problem that has to be improved along with social marketing. This is especially important for individual MSM living in south of the country and in isolated rural villages. MSM awareness of lubricants is almost non-existent in Punta Gorda, as only two of the men interviewed shared that they knew about lubricants. Most did not know about the effects of oil-based lubricants on latex condoms.

Such an issue remains a challenge, along with how the public and private health system does upgraded training for their healthcare providers. In Punta Gorda, for example, it is the belief of the Psychiatric Nurse that she has never had an MSM individual access services for HIV testing in Punta Gorda. This is incredulous. To be fair, not all the VCT Services across the country responded this way, Toledo's, though, stood out.

Future research must factor in the careful use of terms like, gay or homosexual as males do not admit they are gay or homosexual.

A major factor that contributes to vulnerability is level of education: the lower the literacy of the MSM individual the less likely he will access services. Still there is hope in the population as the mobility of the MSM individual is driven by personal resources that helps to seek health care and seek to build social networks far beyond their residence. Persons, who lived in a particular district or town, fearing discrimination, travelled to a neighbouring district or crossed the border to Chetumal, Cancun, Livingston or Puerto Barrios in Mexico and Guatemala respectively to access health care.

Recommendations

There is a need to integrate services as well as integrated HIV Education that reaches all men despite their sexual preference to make BCC effective.

The process of integration must include responding to capacity strengthening with private and public sector health personnel to improve knowledge about sexual dynamics of orientation, socio-cultural attitudes and practices that exists in other parts of the World, and overall psychosexual development.

Integration of services through the NHI system can help in stimulating a primary health package that includes HIV, Care, Treatment and Support. Such a system can alleviate personnel shortages in Care, Treatment, Prevention, and Support and can be a tool to reduce stigma and discrimination.

This brings us to models available to the HIV system one such comprehensive model is called S.A.V.E. the reference is to ***S***afe Sexual Practices; ***A***vailability to Nutritional support and Medication; ***V***CT Services; ***E***mpowerment. The S is a reference to not just ABC, but clean needles, safe blood transfusions, using commodities like lubricants, safe medical and sexual practices; the A is a reference to clean water, food, shelter, and access to research; the V is a reference to testing Services and the E is a reference to promoting social and economic rights of a person along with need for education. (***Source: ACORD International***)

Efforts of prevention have to improve with supply management and distribution channels of condoms and lubricants in rural and urban areas. Otherwise, inadequate commodity support supplies, inadequate communication infrastructure and geography

will continue to make prevention weak and only serves to undermine health strategies for reducing infection rates.

Efforts are needed to strengthen informal support to caregivers that provide home care to infected persons in advance stages of the illness to help improve patient adherence.

Civil society will need to strengthen how they complement the work of the public sector in psycho-social and sexual support and providing integrated messages in HIV Education.

As an issue of continuing service delivery, it's important to continue direct outreach of "The Know you Status Campaign" as it's a tool for improving access to MSM individuals who would not access the VCT. This effort though must exist within the context of re-evaluating the need to uphold an YMSM right to privacy as the position of requiring parental consent has natural consequences.

Institutional planning of service delivery for Prevention, Care, Treatment and Support should follow greater involvement and inclusion from marginalized groups. Inclusive community-based responses allow for long-term resource mobilization, coordination, support and monitoring.

Implementing an effective Human Rights mechanism that supports all marginalized groups with sustainable policies of inclusiveness is important to improve policymakers' understanding and action that is needed to reduce Stigma and Discrimination.

Integrating both heterosexual and MSM specific sexual health information and programs in service delivery is critical in providing effective psychosocial and

psychosexual support in both private and public sector. Such a process is an essential part of empowering the MSM population in valuing existing sexual and reproductive health services.

Sustain SRH outreach in rural communities targeting all men with MSM specific prevention information, while evaluating faith-based organizations' effectiveness in delivering prevention information is critical in preventing isolation of MSM individuals from safe sex practices and accessing services. This cultural bias pervades the society but efforts must be made to assure all clients regardless of sexual orientation that they will receive equitable and humane services- especially from health providers.

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Annex1- Interviews of 50 Health Care Providers

Table 10 Interviews of 50 Health Care Providers

Date of interview	*# of Health Care Provider Interviewed*	*District*	*Village/Town*	*Profession*
11/1/07	***1***	***Corozal***	***Town***	***MOH/VCT***
11/1/07	***1***	***Corozal***	***Town***	***Presbyterian Medical Clinic***
Total Interviews	***2***			
31/10/07	1	Orange Walk	Town	BFLA
11/1/08	1	Orange Walk	Town	BFLA-OW
11/1/08	1	Orange Walk	Town	Northern Plaza
11/1/08	1	Orange Walk	Town	MOH-Northern Regional Manager
11/1/08	1	Orange Walk	Town	Dr. Correa (No testing Done)
11/1/08	1	Orange Walk	Town	Nurse Ortega/MOH
Total Interviews	***6***			
	1	***Belize***	***Double Head Cabbage***	***MOH-Nurse***
16/1/08	***1***	***Belize***	***Maskal***	***Nurse Gallego***
16/1/08	***1***	***Belize***	***Maskal***	***Nurse Neal***
Total Interviews	***3***			
12/1/08	***10***	***Cayo***	***San Ignacio***	***Cayo AIDS Committee***
Total Interviews	***10***			
5/12/07	***1***	***Stann Creek***	***Dangriga***	***VCT/MOH***
5/12/07	***1***	***Stann Creek***	***Dangriga***	***VCT/MOH***
5/12/07	***1***	***Stann Creek***	***Dangriga***	***Dangriga AIDS Society***
5/12/07	***1***	***Stann Creek***	***Dangriga***	***BFLA-Dangriga***
26/1/08	***6***	***Stann Creek***	***Placencia***	***NAP workshop***
2-2-08	***10***	***Stann Creek***	***Dangriga***	***Dangriga AIDS Committee***
Total Interviews	***20***			
2/12/07	***1***	***Toledo***	***Punta Gorda***	***BFLA***
2/12/07	***1***	***Toledo***	***Punta Gorda***	***YFF***
3/12/07	***1***	***Toledo***	***Punta Gorda***	***BFLA***
3/12/07	***2***	***Toledo***	***Punta Gorda***	***HillsideView Personnel***
3/12/07	***3***	***Toledo***	***Punta Gorda***	***San Antonio Polyclinic Personnel***
3/12/07	***1***	***Toledo***	***Punta Gorda***	***VCT/MOH***
Total Interviews	***9***			

Annex 2: MSM Interviews Punta Gorda

MSM Interviews in Punta Gorda from 3rd to 5th December, 2007

Table 11 MSM Interviews in Punta Gorda

# of of Persons	Lubricant awareness	Sexual Debut	Place got tested or information	# of Partners	access other places	Profession	# of male partners	# of Children	Comment
1	none	13	PG-Hospital	36	N/A	Fisherman	15	N/A	• Drinks heavily
2	Low	13	PG-Hospital		Private clinics			3	• Thought being HIV + was a good thing • Drinks and smokes • Migrant • Don't like wearing condoms and don't know where to get them consistently
3	Low	11	Got tested three times at PG Hospital	N/A	Hospital provided help for STI testing	N/A	N/A	none	• Does not work as sister send money for him
4	none	15	Tested at PG Hospital	12	N/A	farmer	N/A	1	• Shared that interest of boys was lashed out of him. • Smokes weed and drinks • Knowledge of HIV was high, but used condoms inconsistently
5	none	N/A	N/A	2	Never got tested	Farm worker	N/A	none	• Did not know where to get lubricants or condoms • Thought HIV could be gotten from sharing plates and tongue sucking

MSM Interviews in Punta Gorda from 3rd to 5th December, 2007 continues…..

# of of Persons	Lubricant awareness	Sexual Debut	Place got tested or information	# of Partners	access other places	Profession	# of male partners	# of Children	Comment
6	Medium	N/A	PG Hospital	Over 150	Gotten tested in Puerto barrios and Hospital	Retired pharmacists	6-20 men	At least 1	• Did not know where he could get free lubricants. • Don't do oral sex, but likes receiving • Lives with young girl friend he is 66 years old
7	none	N/A	Primary school	6 partners	No test	Primary school student	6 men	none	• Partner goes up early into 20's • Denies that he is gay.
8	Never used lubricants, but did hear about lubricants and condoms at school	N/A	Get tested once a year	N/A	N/A	teacher	N/A	none	• SDA and Catholics don't like talking about condoms and lubricants • HFLE does not of in depth about sexual practice • Curriculum design is the problem
9	none	N/A	Never got tested Received information from family members	N/A	Puerto Barrios	none	N/A	none	• Rarely got tested because he rarely got sick. Has been to hospital in 6 to 7 years • Has a partner in Livingston
10	Low	12	Never taken an HIV Test	95	No	Sex worker	90	none	• Fears HIV, but has not gotten tested • Has been physically chopped , hand has been broken • Drinks and smokes heavy • Gets educated from off the

									street
11	none	N/A	Never taken a test	N/A	No	Computer clerk	unknown	none	• Felt men needed a place for support • People feared community gossip. • Bike gang of men usually • Played sex games
12	High	unknown	Never taken a test	None at present	Puerto Barrios	business owner	4	none	• Had a couple encounters with male sex workers • Feared losing his economic lively hood
13	none	unknown	Got information from school	none	none	student	none	none	• Mom warn him about gay people • Specific types of sex is not used in discussion
14	none	unknown	Get information from workplace	1	BFLA	student	unknown	none	• Says design of how HIV works tends to turn off interested in testing
15	Low	unknown	Got information from school	unknown	Cayo	Farm worker	unknown	none	• Travel to PG to work but is originally from Cayo • Does testing in Cayo

Annex 3: Summary of Data Finding for 115 MSM Interviewed

Table 12 Summary of Data Finding for 115 MSM Interviewed

Question 1:	***Where do you Get HIV Testing done***	
# of Private Test	***30***	*26.1% just tested privately*
Not tested at all	*36*	*31.3% have not gotten a test*
# of Public Test	***39***	*33.9% tested in Public spaces only*
Other	***10***	*8.7% were not sexually active or did not want to get parental consent*
# of interviews	***115***	

Question 2:	***Do you know you can get free HIV Testing in all districts?***	
# aware of free testing	***79***	*68.7% aware of free testing*
# not aware of free testing	***34***	*29.6 was unaware of free testing*
Information not available	***2***	*1.7% information not available*
# of interviews	***115***	

Question 3:	***Do you tell the VCT counselor always that you have sex with men?***	
# that do not tell	***57***	***49.6% did not say they sleep with men***
# that are honest	***26***	*22.6% are honest about sleeping with men*
# that say sometimes or counselor don't ask	***11***	*9.6% sometimes they share who day sexual partners*
No answer	***9***	*7.8% did not give information*
other	***12***	*10.4% have not been tested*
# of interviews	***115***	

Question 4:	***If no, why don't you tell the counselor that you sometimes sleep with men?***	
# fearing counsellor attitude	***15***	*13% feared counselor attitude*
# of Attitude and counselor knowledge	*3*	*2.6% shared both attitude and knowledge of counselor was a concern*
Other	***17***	*14.8% None of their business*
# that did not answer the question	*68*	*59.1% did not answer the question*
Other- not gotten tested	*12*	*10.4% did not get tested*
# of interviews	***115***	

Question 5:	***How many partners have you had sex with in the past year?***	
# with 1	*21*	*18.3% had one partner*
# with 2	*23*	*20% had two partner*
# with 3	***20***	*17.4% had three partner*
# no sex	*3*	*2.6% Were virgins or did not answer*
N/A	*48*	*41.7% refuse to answer or missed the question*
# of interviews	***115***	

Question 6:	***How many partners have you had over a lifetime?***	
0-10	***56***	*48.7% had less than 10 partners*
11-50	***43***	*37.4% had between 11 to 50 partners*
51-100	***1***	*.87% over 51 partners*
100-150	*1*	*.87% had over 100 partners*
151-200 plus	*3*	*2.6% had up to 250 partners*
N/A	***11***	*9.7% simply did not answer*
# of interviews	***115***	

Question 7:	***Do you consistenly wear condoms when having sex?***	
# consistently wear condoms	***90***	*78.3% wear condoms consistently*
# that inconsistently wears condoms	***21***	*18.3% inconsistently wear condoms*
N/A or virgin	***4***	*3.5% information was not available or persons were virgins*
# of interviews	***115***	

Question 8:	***What kind of lubricants do you use during sex?***	
# that use KY/Vive	***62***	*53.9% used water-based lubricants*
#baby oil/ grease/ lotion	***36***	*31.3% oil base lubricants*
# use saliva or nothing	*17*	*14.8% use nothing or saliva*
# of interviews	***115***	
Note of those that use water-based lubricants 15 persons or 13% reported using oil-base lubricants as well.		

Question 9:	***Do you know of someone who is HIV Positive?***	
# of persons who know	***77***	*67% reported knowing someone who is HIV Positive*
# of persons who don't	***38***	*33% reported not knowing someone who is HIV Positive?*
# of interviews	***115***	

Annex 4: Breakdown of BCC Report from UNIBAM from 2006 and 2007

BCC Report Base on Age

Period of interviews:	**21/12/06-3/11/07**	
# of interviews done	**200**	
Ages Range of Interviewed MSM	# of interviewed	Percentile
19 and under	59	29.5%
20-29	104	52%
30 +	21	10.5%
N/A	16	8%

BCC Report Base on Districts Interviews Were done

Period of interviews:	**21/12/06-3/11/07**	
# of interviews done	**200**	
Districts	# of interviewed	Percentile
Corozal	20	10%
Orange Walk	9	4.5%
Belize	40	20%
Cayo	101	50.5%
Stann Creek	2	1%
N/A	21	10.5%

BCC Report Base on Sexual Orientation

Period of interviews:	**21/12/06-3/11/07**	
# of interviews done	**200**	
Sexual Orientation	# of interviewed	Percentile
Gay	85	42.5%
Bisexual	95	47.5%
Straight	10	5%
Hustler	2	1%
NA	1	.5%

Did anyone force you to have sex?

Period of interviews:	**21/12/06-3/11/07**
# of interviews	**88**

done		
Answer	# of interviewed	Percentile
No	82	93.2%
Yes	4	4.5%
N/A	2	2.3%

BCC Report of those who have sex under the influence of alcohol

Period of interviews:	21/12/06-3/11/07	
# of interviews done	88	
# of acts done	# of interviewed	Percentile
# under influence	51	58%
# not under influence	35	39.8%
N/A	2	2.3%

Does your Family know your gay?

Period of interviews:	21/12/06-3/11/07	
# of interviews done	88	
Answer	# of interviewed	Percentile
No	45	51.1%
Yes	42	47.7%
N/A	1	1.1%

Would you have sex if you were HIV positive?

Period of interviews:	21/12/06-3/11/07	
# of interviews done	88	
Answers	# of interviewed	Percentile
# that would stop	18	20.5%
# that would not	52	59.1%
# not sure	9	10.2%
N/A	9	10.2%

Would you keep your HIV status a secret?

Period of interviews:	21/12/06-3/11/07	
# of interviews done	88	
Answers	# of interviewed	Percentile
# that would reveal status	17	19.3%
# that not reveal status	55	62.5%
N/A	16	18.2%

Do you use condoms everytime you have sex?

Period of interviews:	**21/12/06-3/11/07**	
# of interviews done	**88**	
Answer	# of interviewed	Percentile
# who would use condoms	66	75%
# sometimes or no	14	15.9%
N/A	8	9.1%