UNGASS COUNTRY PROGRESS REPORT
BELIZE

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ACRONYMS AND ABBREVIATIONS

AAA	**Alliance Against AIDS**
AIDS	**Acquired Immunodeficiency Syndrome**
ART	**Antiretroviral Therapy**
ARV	**Antiretroviral**
BCC	**Behaviour Change Communication**
BFLA	**Belize Family Life Association**
BHIS	**Belize Health Information System**
CAREC	**Caribbean Epidemiology Centre**
CCM	**Country Coordinating Mechanism**
CML	**Central Medical Laboratory**
CNA	**Community Nurse Aide**
CSW	**Commercial Sex Worker**
HFLE	**Health and Family Life Education**
HIV	**Human Immunodeficiency Virus**
HIVOS	**Humanistisch Instituut voor Ontwikkelingssamenwerking**
ICD	**International Classification of Diseases**
IDU	**Injecting Drug User**
IEC	**Information Education Communication**
ILO	**International Labour Organisation**
IPPF	**International Planned Parenthood Federation**
LACCASO	**Latin American and Caribbean Council of AIDS Service Organization**

LBGT	**Lesbian Gay Bisexual Transgender**
MARP	**Most-At-Risk Population**
MCH	**Maternal and Child Health**
MDG	**Millennium Development Goals**
M&E	**Monitoring and Evaluation**
MOH	**Ministry of Health**
MOE	**Ministry of Education**
MOL	**Ministry of Labour**
MOU	**Memorandum of Understanding**
MSM	**Men who have sex with men**
NAC	**Belize National AIDS Commission**
NAWG	**National Advocacy Working Group**
NAP	**National AIDS Program**
NASA	**National AIDS Spending Assessment**
NCFC	**National Committee for Families and Children**
NCPI	**National Composite Policy Index**
NGO	**Non-Governmental Organization**
NHISU	**National Health Information and Surveillance Unit**
NPT	**New Prevention Technology**
NSP	**Belize National Strategic Plan**
OI	**Opportunistic Infection**
OVC	**Orphans and Vulnerable Children**
PAB	**Project Advisory Board**
PAHO	**Pan American Health Organization**

PANCAP	**Pan Caribbean Partnership against HIV and AIDS**
PASMO	**Pan-American Social Marketing Organization**
PCR	**Polymerase Chain Reaction**
PITC	**Provider Initiated Testing and Counselling**
PLHIV	**People Living With HIV**
PMTCT	**Prevention of Mother-to-Child Transmission**
POWA	**Progressive Organisation for Women in Action**
PR	**Principal Recipient**
SBS	**Sexual Behaviour Survey**
SHS	**Sexual health and Sexuality**
SRH	**Sexual and Reproductive Health**
STI	**Sexually Transmitted Infection**
TB	**Tuberculosis**
TWC	**Together We Can**
UNAIDS	**Joint United Nations Programme on HIV/AIDS**
UNDAF	**United Nations Development Assistance Framework**
UNDP	**United Nations Development Program**
UNFPA	**United Nations Population Fund**
UNGASS	**United Nations General Assembly Special Session**
UniBAM	**United Belizean Advocacy Movement**
UNICEF	**United Nations Children's Fund**
USAID	**United States Agency for International Development**
VCT	**Voluntary counselling and Testing**
WIN	**Women's Issues Network of Belize**

YES **Youth Enhancement Service**

YWCA **Young Women's Christian Association**

I. Status at a Glance

During the period 2008-2009, Belize has made several strides toward realizing its commitments made in the UNGASS Declaration on HIV and AIDS in 2001. An increase in coordination of the national response, surveillance, prevention and involvement of civil society have allowed the country to increase the number of indicators reported as well as record improved performance in key UNGASS indicators. As a small, developing country in Central America, Belize continues to be innovative in mobilizing support for the national response to HIV/AIDS. The government of Belize funds its multi-sector national response by covering the full operational cost of the National AIDS Commission Secretariat, the National Health Surveillance and Epidemiological Unit of the Ministry of Health, which includes the program for HIV/AIDS, TB and other STIs. This funding guarantees free HIV counselling and testing and antiretroviral treatment for all person who require treatment. Additionally, the HIV Units in the Ministries of Labour and Youth, the HFLE Unit in the Ministry of Education and the Human Services Department in the Ministry of Human Development are also fully funded.

The Government provides limited support to the work of several Civil Society Organisations, to respond to the emergency needs of PLHIV, support prevention programs, technical support, in-kind contributions, and cover some administrative costs. In addition, members of the multi-sector national response also procure financial support from many international donor agencies, organizations, foundations and the United Nations Agencies. While Belize's national response recorded key improvements in its overall performance during 2008-2009, the experiences of this period also highlight several key areas that need more attention as the country moves its national response to HIV/AIDS forward, such as improved evidence-based planning and coordination of the national response, achieving universal access, progress sexuality and HIV education training for young people, monitoring national AIDS spending, reducing stigma and discrimination, and mainstreaming meaningful involvement of PLHIV. These challenges provide a clear blueprint for future funding and coordinated efforts.

Belize's national response continues to be led by the National AIDS Commission with the institutional support of its Secretariat and is made up of representatives from Civil Society Organisations, Government agencies, Private Sector, District Committees of the Commission, PLHIV and Technical Partners. The Commission allows for increased participation in the national response by incorporating members from outside the Commission. One sound example is the coordinated collaboration in the 2010 UNGASS reporting process and as a result Belize is submitting one UNGASS report in which Civil Society and PLHIV were represented on the UNGASS Working Group. The civil society's assessment of the country's performance toward the provision of Sexual and Reproductive Health is also summarized in the report and the full report is annexed.

During the period 2008-2009 the Ministry of Health implemented the Belize Health Information System (BHIS) which collects and report health data pivotal in monitoring and responding to the national response to HIV/AIDS. This database is now being used at all VCT clinics throughout the country, public hospitals, the national prison, and NGO-managed health care providers. This system improves the Ministry of Health's ability to provide reliable data on infection rates, adherence, and ARV inventory. Another milestone in data collection was the completion of a new Sexual Behaviour Survey at the end of 2009. The Ministry of Health has initiated the process of identifying and estimating the size of the most-at-risk populations in Belize. This process started in late 2009 and expected to be completed by mid 2010. In addition, the research agenda for Round 9 of the Global Fund Grant is set to include behavioural studies in both the general and at-risk populations as well as sero-prevalence surveillance for young people.

The country's advancement in prevention of mother-to-child transmission has been recognized as a Best Practice in the Latin America and Caribbean region. With as many as 93% of pregnant women receiving VCT services in 2008 and 90% in 2009, the Ministry of Health's Maternal and Child Health Care program has established itself as a benchmark of excellence.

Over the past two years, the Ministry of Education (MOE) has made significant advances in strengthening the HFLE programme in schools. The Ministry continues to conduct extensive

teacher training and provide the needed HFLE resources to the schools. In 2008 and 2009, a total of 1,658 Primary school teachers were trained countrywide, increasing their capacity to teach the Health and Family Life Education (HFLE) curriculum. HFLE officers in the districts provided direct monitoring and support to the teachers in the classroom. With the support of the Global Fund Round 3 Project, which culminated in October 2009, the Ministry was able to exceed its target for reaching primary schoolers with comprehensive sexuality education through HFLE in schools. Apart from the primary school students reached, MOE was able to train 152 secondary school students as peer educators in the Stann Creek and Toledo Districts and plans to expand the HFLE program to Secondary Schools.

Table 1: Overview of UNGASS Indicators for Belize 2008 - 2009

NATIONAL INDICATORS	2008-2009	NOTES/ COMMENTS
National Commitment and Action		
1. Domestic and international AIDS spending by categories and financing sources	See Annex 2	
2. National Composite Policy Index	See Annex 3	
National Programs		
3. Percentage of donated blood units screened for HIV in a quality assured manner	2008 – 100% 2009 – 100%	The Central Medical Laboratory has a standard algorithm that is used for HIV screening and the external quality assurance is done through CAREC.
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy[1]	2008 – 49.0% (630/1285) 2009 – 61.3% (855/1394)	The numerator in both cases is taken from the National Programme's data and refers to the actual number of persons on ARV therapy. The denominator in both cases is taken utilizing Spectrum data estimated in 2009. See disaggregation in Table 3.
5. Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission	2008 – 84.3% (59/70) 2009 – 87.0% (60/69)	The women who received prophylaxis and are included in the numerator all received triple therapy prophylaxis as per national protocol. For the denominator the total number of women who gave birth in the last 12 months was multiplied by the national estimate of HIV prevalence in

[1] MDG Indicator

		pregnant women. Belize has PMTCT coverage of 93.0% and 89.9% for 2008 and 2009 respectively, with 90.8% and 96.8% of women testing positive receiving ART during pregnancy. We are confident in the PMTCT program coverage and therefore did not use the estimates from Spectrum to calculate this indicator.
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	N/A[2]	TB patients are routinely screened for HIV countrywide; however routine screening for TB in HIV patients is not done unless the patients are symptomatic. Belize does not routinely estimate the number of incident TB cases in PLHIV. However, the country detected 17 cases of co-infection in 2009, all of which received TB and HIV treatment.
7. Percentage of women and men aged 15 -49 who received an HIV test in the last 12 months and who know their results.	2009 - 36.5% (1,111/3,041)	Data collected from the Sexual Behaviour Survey (SBS) conducted in 2009. Data disaggregated by age groups and sex is shown in Table 5.
8. Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results.	N/A[2]	Belize is currently designing a sizing exercise for assumed at- risk populations in the country. It is expected that after the population sizes have been estimated behavioural and sero-prevalence surveillances would be conducted in these populations.
9. Percentage of most-at –risk populations reached with HIV prevention programs.	N/A[4]	-Same As Above in Indicator 8-
10. Percentage of orphaned and vulnerable children aged 0 -17 whose households received free basic external support in caring for the child.	Not Applicable	Belize HIV prevalence is less than 5% (estimated to be 2.4%) therefore this indicator is not applicable.
11. Percentage of schools that provided life skills-based HIV education in the last academic year.	2008 Total -39.6% (133/336) 2009 Total -38.0% (131/345)	The estimates were calculated from Ministry of Education Program data. Although the Health and Family Life Education Program (HFLE) is in all Primary schools, the data represents the schools that were monitored by the HFLE Officers in 2008 and 2009. There is no established life skills-based HIV education in secondary schools, however a number of organisations work with the secondary schools providing some life skills education, but

[2] Not Available

		these not standardize and are heavily based on funding availability. 2008: Primary – 46.5% (133/286); Secondary - 0% (0/50) 2009: Primary – 44.6% (131/294); Secondary - 0% (0/51)
Knowledge and Behaviour		
12. Current school attendance among orphans and among non-orphans aged 10 -14.[3]	2006 – 0.66 Part A: 62.1% Part B: 93.6%	This indicator was calculated from data collected during the 2006 MICS. Another MICS survey is scheduled to be conducted in 2010. The school attendance rate of children whose mother and father are both dead was reported as 62.1%, while the school attendance rate of children whose parents are alive and who live with at least one parent was reported as 93.6%.
13. Percentage of young women and men 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	2009 - 50.2% (505/1006)	Data collected from the Sexual Behaviour Survey (SBS) conducted in 2009. Data disaggregated by questions, age groups and sex is shown in Table 6, 7 and 8.
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	N/A[4]	Belize is currently designing a sizing exercise for assumed at- risk populations in the country. It is expected that after the population sizes have been estimated behavioural and sero-prevalence surveillances would be conducted in these populations.
15. Percentage of young women and men aged 15 -24 who have had sexual intercourse before the age of 15.	2009 - 7.8% (78/1006)	Data collected from the Sexual Behaviour Survey (SBS) conducted in 2009. Data disaggregated by age groups and sex is shown in Table 9.
16. Percentage of women and men aged 15 – 49 who have had sexual intercourse with more than one partner in the last 12 months.	2009 - 9.4% (287/3,041)	Data collected from the Sexual Behaviour Survey (SBS) conducted in 2009. Data disaggregated by age groups and sex is shown in Table 10.
17. Percentage of women and men aged 15 – 49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse.[3]	2009 - 63.1% (181/287)	Data collected from the Sexual Behaviour Survey (SBS) conducted in 2009. Data disaggregated by age groups and sex is shown in Table 11.

[3] MDG Indicator
[4] Not Available

18. Percentage of female and male sex workers reporting the use of a condom with their most recent clients.	N/A[5]	Belize is currently designing a sizing exercise for assumed at- risk populations in the country. It is expected that after the population sizes have been estimated behavioural and sero-prevalence surveillances would be conducted in these populations.
Knowledge and Behaviour		
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.	N/A[5]	-Same As Above in Indicator 18-
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse.	N/A[5]	Anecdotal information suggests that IDU is not a problem in Belize. However there is no scientific evidence to support this theory. More research into the correlation between drug use and the risk of HIV transmission needs to be conducted in Belize.
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected.	N/A[5]	-Same As Above in Indicator 20-
Impact		
22. Percentage of young women and men aged 15 -24 who are HIV infected[6]	2009- 1.01% (34/3375)	The Ministry of Health calculated this data for the first time in 2009. Of the 3,375 15-24 year old antenatal clinic attendees tested for HIV in 2009, 34 of them had test results that were positive.
23. Percentage of most-at-risk populations who are HIV infected	N/A[5]	Belize is currently designing a sizing exercise for assumed at- risk populations in the country. It is expected that after the population sizes have been estimated sero-prevalence surveillances would be conducted in these populations.
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	2009 - 75.6% (90/119)	The Ministry of Health is reporting this indicator for the first time. However we believe that the survival rate must be followed for a time period beyond the 12 months required here.
25. Percentage of infants born to HIV-infected mothers who are infected.	2008 – 14.2% (24/169) 2009 – 13.8% (23/167)	Although the indicator is relevant to Belize and can provide insight into the progress made in eliminating mother-to-child transmission, we do not feel that the estimate calculated provides an accurate representation of the situation in Belize, primarily because of the number of assumptions

[5] Not Available
[6] MDG Indicator

		made and number of regional data using in calculating the estimate with Spectrum.

II. Overview of the AIDS Epidemic

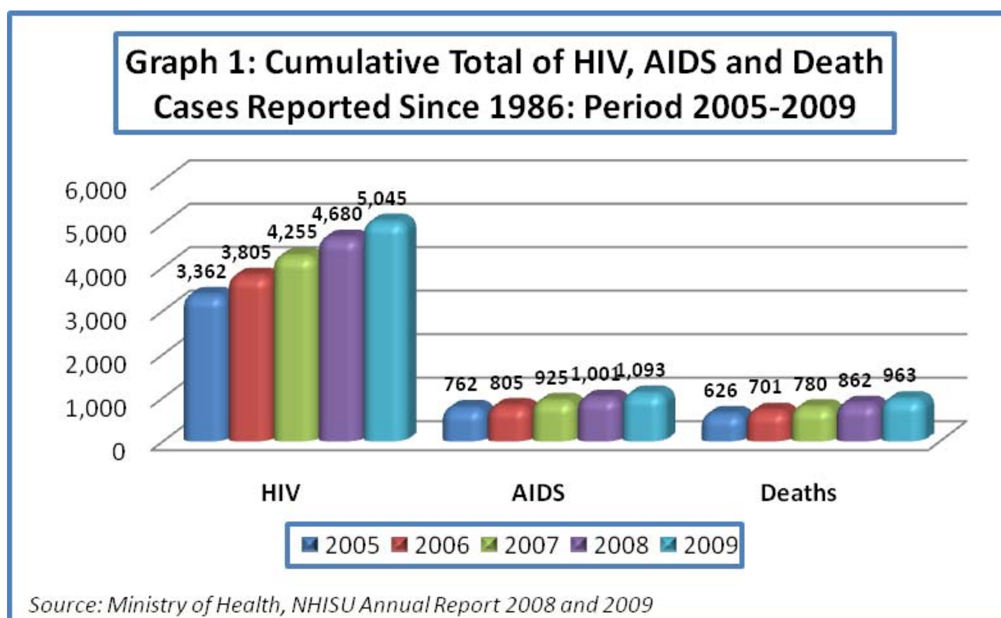
2.1. Background

In 2009, the mid-year population estimate of Belize was 333,200, with a male: female ratio of 1:1 and a population density of 37.6 persons per square mile. The annual population growth of Belize is estimated at 3.4%. Half the population (51.9%) lived in the urban areas. The Belize District is the largest administrative district (30.0% of the total population), followed by the Cayo district (24.2%)[7]. The demographic profile is of a young population. In 2009, 36.8% of the population is under 15 years of age and 48.4% was 19 years and under. The elderly (60 years and older) accounted for 7.1% of the total population. Women of child-bearing age (15-49 years) accounted for 46.2% of the total female population. The dependency ratio was 45.2 in 2005 as compared to 82.4 in 2002[7].

2.2. HIV/AIDS Situation

Beside the many social and economic challenges faced by the country, Belize has been experiencing an HIV/AIDS epidemic that has gradually posed serious challenges to the health care system. The total number of reported HIV infections from 1986 to the end of December of 2009 was 5,045. In 2009, the total number of new HIV Infections was 365 indicating a relative decrease of 14.1% of newly diagnosed HIV infections when compared with 2008 data (425 cases). The total number of reported AIDS Cases since 1986 to the end of December 2009 was 1,093. The total number of new AIDS Cases for the year 2009 was 92. In the previous year 2008, it was 76 indicating a relative increase of 21% for new AIDS cases. The total number of AIDS deaths for the year 2009 was 101 while in the previous year 2008 it was 82 indicating a relative increase of 23%. It is likely that these increases are due to the newly introduced use of the ICD-10 classification in an effort to standardize AIDS cases and deaths which provided more accurate figures than in previous years.

[7] Statistical Institute of Belize (SIB): Mid-year Population Estimate 2009. Belize. July 2009



The reported total number of AIDS deaths from 1986 to the end of December 2009 was 963; the estimated number of persons with HIV/AIDS at the end of 2009 was 5,175 (*see Table 2*). The upward trend seen in the number of new AIDS cases and AIDS deaths reported may be a result of the improved Belize Health Information System (BHIS) which assist in better management of patients' records, visits and the quality of disease diagnosis entered and coded. The BHIS assists the Surveillance Unit to better link patient records nationally and to identify duplicated records. The trend seen is important to note because of its impact in program mitigation; it can help to determine whether the services available are critical services that meeting the current health needs of those infected and affected.[8]

Table 2: Summary of the HIV/AIDS Epidemic in Belize 2008 - 2009

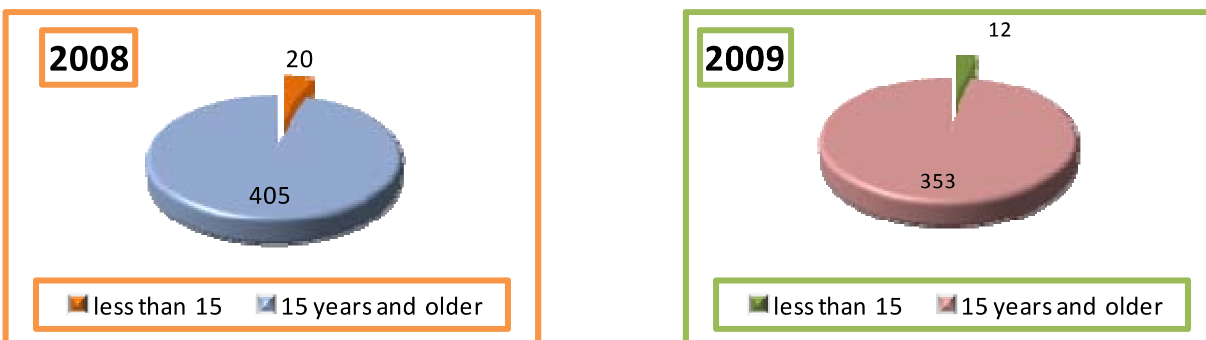
Indicators	Jan – Dec 2008	Jan - Dec 2009
Total number of new infections for the year	425	365
Total new AIDS cases reported for the year	76	92
Total new AIDS deaths for the year	82	101
Total reported HIV infections since 1986	4,680	5,045
Total reported AIDS cases since 1986	1,001	1,093
Total reported Deaths since 1986	862	963

Source: NHISU, *Ministry of Health 2008 and 2009 Yearly Report*

[8] Ministry of Health , NHISU HIV/AIDS Yearly Report 2008 and 2009

In 2008, 20 of those who tested positive for HIV were under the age of 15 while 405 were 15 years and older (*see Graph 2*). Of these 20 positive cases, 13 were females (65.0%) while 7 (35.0%) were males. In the 15 years and older age group 211 (52.1%) were females while 194 (47.9%) were males. Men accounted for 47.3% of all new infections in 2008 as compared to 52.7% among females.

Graph 2: Number of persons testing positive in 2008 and 2009 below 15 years and 15 years and Older



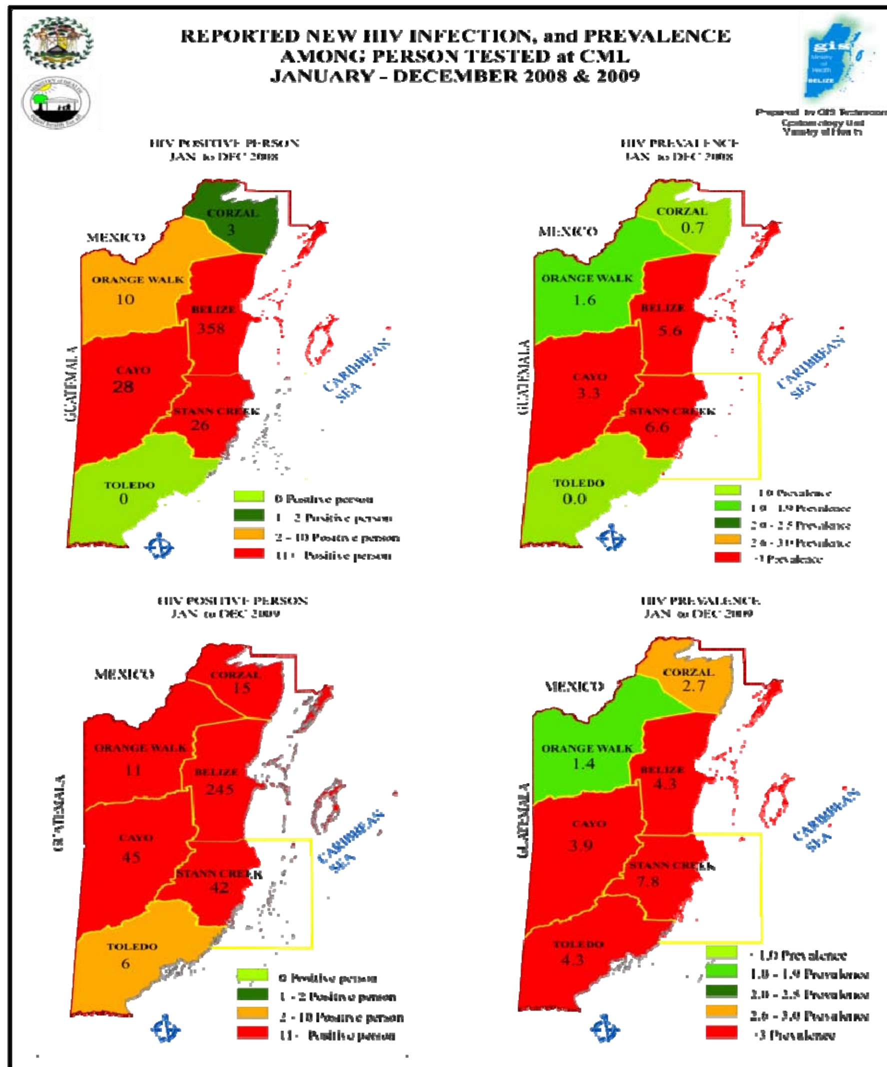
Source: NHISU*, Ministry of Health 2008 and 2009 Yearly Report*

In 2009, 12 of those who tested positive for HIV were under the age of 15 while 353 were 15 years and older. Of these 12 positive cases, 6 were females (1.6%) while 4 (1.1%) were male and 2 (0.5%) whose sex wasn't documented. In the 15 years and older age group 180 (49.3%) were females while 173 (47.3%) were males. Men accounted for 48.5% of all new infections in 2009 as compared to 51.5% among females. This signifies a male to female infection ratio of 0.95: 1.00.

In 2008 for the age group <1year there were 2 (1.0%) males who were reported as positive. Within the age group 15-24 years there were 66 (15.5%) women and 22 (5.2%) men resulting in 20.7% of all HIV infections (425) that year. In the age group 15-49 years there were 191 (44.9%) women and 154 (36.2%) males resulting in 81.2% of all HIV infections reported in 2008.

For 2009 for those <1 year there was 1 (0.6%) male infected. Within the 15-24 year age group there were 49 (13.4%) women and 19 (5.2%) men resulting in 18.6% of all HIV infections (365). In the age group 15-49 years there were 163 (87.6%) women and 137 (77.4%) men resulting in 82.2% of all HIV infections reported in 2009.

Chart 1: New Reported HIV Infections and Prevalence, 2008 and 2009



Source: NHISU, *Ministry of Health 2008 and 2009 Yearly Report*

2.3. <u>Anti-retroviral Therapy</u>

By the end of 2009, there were 11 treatment sites in Belize. Two in each of the Southern, Northern and Western Health regions and five sites in the Central Health region out of which one is being done by a faith based organization (Hand in Hand Ministries) and another is managed by the health facility with the Belize Central Prison (Kolbe Foundation).

In 2008, a total of 630 persons were on ART at the end of that year with 64 (10.2%) being less than 15 years of age while 566 were 15 years and/or older. Of the 64 who were below 15

years, 22 were male and 42 were female. Of the 566 who were 15 and older, 285 (45.2%) were males and 281 (44.6%) were females. When utilizing Spectrum estimates for the number of people with advanced HIV infection needing ART, the ART coverage is approximately 49.0% of the estimated population that should have been in treatment (*see Table 3*).

Table 3: Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy for 2008 - 2009

		Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy	Estimated number of adults and children with advanced HIV infection	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy (Percent)
2008	**All**	630	1285	49.0%
	Males	307	653	47.0%
	Females	323	632	51.1%
	<15	64	78	82.1%
	15+	566	1207	46.9%
2009	**All**	855	1394	61.3%
	Males	444	708	62.7%
	Females	411	686	59.9%
	<15	80	87	92.0%
	15+	775	1307	59.3%

Source: NHISU*, Ministry of Health*

By the end of 2009, a total of 855 persons were on free ART with 80 (9.4%) patients under 15 years of age. Of the 80 who were under 15 years, 36 were males and 44 were females. Of the 775 who were 15 and older, 408 (47.7%) were males and 367 (42.9%) were females. The coverage rate of the estimated population in need by Spectrum was 61.3% at the end of 2009. These data represent an increase of 25.6% in ART coverage when compared with 2008 data and represents a marked increase in the overall coverage rate.

Another impact indicator calculated for the first time in 2009, the survival rate 12 months after having initiated treatment. The estimate of 75.6% seems fairly high; however there is no basis for comparison given that this is the first time that this indicator is being calculated. Additionally, the Epidemiology Unit does not disaggregate data by advanced and non-advanced

HIV infection. MOH utilizes the clinical staging, as established by the WHO criteria, for starting ART and/or a CD4 count of 350 or lower. Aside from the ARV treatment offered at specific treatment sites, the government buys medications for most opportunistic infections at no cost to the patient.

2.4. HIV and Tuberculosis Co-infection

The country routinely screens all TB patients for HIV; however not all HIV patients are screened for TB, unless they appear symptomatic. As in the case with ARV therapy, the medications for TB are provided free of cost to all patients identified.

In 2009, 17 cases of co-infection (TB/HIV) were identified in country and all patients received joint treatment. In an effort to further address this co-infection issue, the TB programme is now co-jointly managed within the same programme and efforts are currently underway for further integration in all programmatic aspects of both programs.

2.5. Sexually Transmitted Infections (STIs)

HIV has traditionally been treated and managed separately instead of considering it as another sexually transmitted infection. There is an attempt to now manage the other STIs under the HIV/AIDS programme although much work needs to be done as the country currently only manages STIs with a syndromic approach. The medications for these STIs are now procured by the same programme.

2.6. Maternal and Child Health (MCH) Program

According to the Maternal and Child Health's PMTCT indicators for 2008, there were a total of 7,045 women registered as pregnant (*see Table 4*). All 7,045 women were counselled for HIV and 6,552 (93.0%) women agreed to take an HIV test.

In 2008, sixty five women were positive, out of these 44 were newly documented HIV cases and 21 were women who knew they were positive and became pregnant in that calendar year. Fifty nine (90.8%) of these women received ARV prophylaxis while pregnant and all the 65 women received anti-retroviral medication upon delivery. Sixty three (63) newborns received ARV

prophylaxis upon delivery and three cases (4.8%) were documented as positive from vertical transmission in that year.

Table 4: Prevention of Mother to Child Transmission of HIV Program data for 2008 and 2009

Characteristics	2008	2009
Pregnant Women	7,045	7,018
Pregnant Women Tested for HIV	6,552	6,310
HIV+ Pregnant Women	65	62
HIV Prevalence among Pregnant Women	0.99%	0.98%
Estimated Number of HIV+ Pregnant Women	70	69
Received ARV Prophylaxis	59	60
Percentage of the estimated number of HIV+ pregnant women receiving ARV treatment	84.3%	87.0%
Percentage of HIV+ pregnant women receiving ARV treatment based on program data	90.8%	96.8%

Source: *Ministry of Health*

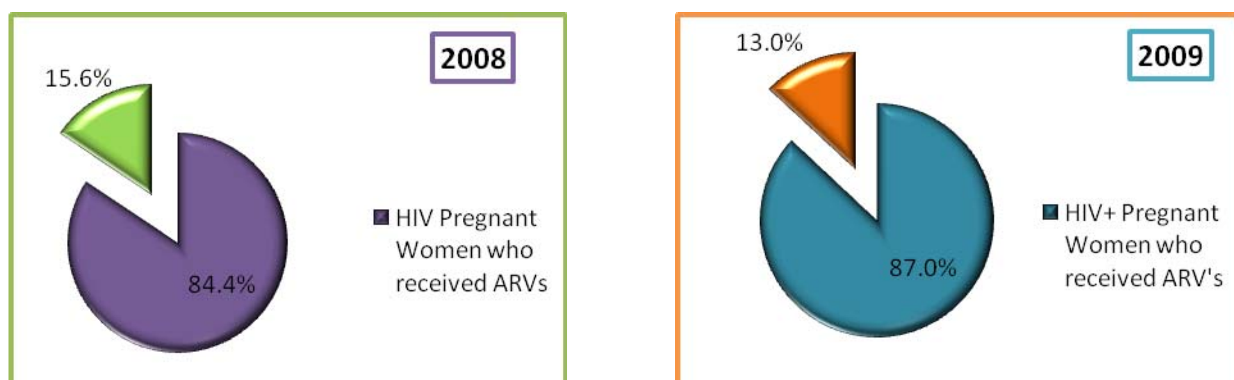
In 2009, there were 7,018 pregnancies in the country. Of these, 7,015 received counselling for HIV; however three females did not access the appropriate health services. A total of 6,310 (89.9%) females received an HIV test and a total of 60 women were documented as positive and 52 delivered during 2009. Of these, 36 (58.3%) were newly documented as positive and 26 (41.7%) females were known as HIV patients who became pregnant during this year. A total of 51 (94.2%) women testing positive received ARV prophylaxis and 49 of them also received ARV at the time of delivery.

The HIV prevalence among pregnant women in 2008 and 2009 were 0.99% and 0.98% respectively. When applied to the entire population of pregnant women for those two years the estimated number of HIV+ pregnant women was 70 for 2008 and 69 for 2009. Using this data, an estimated 84.3% of HIV+ pregnant women received ARV treatment in 2008 (*see Graph 3*).

Applying the estimated number of HIV+ women for 2009, an estimated 87.0% of pregnant women needing ARVs received it in 2009. Additionally, forty eight (48) babies (out of 52 deliveries) received prophylaxis at the time of delivery; 3 patients were un-booked at the

antenatal clinics, so their status was unknown by the health care attendants at the time of delivery and one baby was delivered at home.

Graphs 3: HIV+ pregnant women who received ARVs in 2008 and 2009



Source: NHISU*, Ministry of Health*

2.7. Sexual Behaviour Survey

A Sexual Behaviour Survey (SBS) was conducted over a four week period in 2009 attached to the Living Standards Measurement Survey (LSMS) by the Statistical Institute of Belize. A three–staged sample design, of approximately 2,708 households was used, which resulted in 3,041 people being interviewed. The survey instrument used was a questionnaire that had a total of 25 questions: 24 closed–ended questions and one (1) mixed question (closed–ended with an opportunity for open–ended response). These questions on the questionnaire were designed to obtain responses that would allow for the collection of some demographic information of the respondent as well as to compute and analyze international indicators that were based on Knowledge, Attitudes and Practices (KAP).

2.7.1. Limitations of the Survey

- The survey was attached to a lengthy population survey, which could have contributed to respondent fatigue and the low response rate.
- It is uncertain whether the interviews were done interviewers that were sympathetic and of the same sex and age bracket of the respondents.
- It is uncertain whether privacy and confidentiality were assured for all respondents.
- There was number of missing data for the age and sex variable.

- The methodology for the Sexual Behaviour Survey conducted in 2006 is unclear and therefore reliable comparison could not be carried out.

2.7.2. Testing and Counselling

The survey showed that less than two fifths (36.5%) of the population sampled reported receiving an HIV test and knowing their result (*see Table 5*). The percentage of the population who know their HIV status can be a reflection of several factors including the number and location of testing sites, the number of activities geared towards education persons on the need for HIV testing, the individual's attitude towards HIV and AIDS and the level of stigma and discrimination associated with HIV and AIDS.

Table 5: Percentage of People Aged 15-49 Who Received an HIV Test in the Last 12 Months and Who Know Their Results by Age Group and Sex

Sex	Age Group			
	15-49	15-19	20-24	25-49
Total	36.5	13.7	42.9	41.3
Male	30.1	12.0	32.0	34.8
Female	41.7	15.2	52.3	46.3

Source: 2009 Sexual Behaviour Survey

2.7.3. Prevention of Sexual Transmission of HIV

The survey sought to assess respondents' knowledge on ways of preventing the transmission of HIV. Approximately half (50.2%) of the sampled population had a basic understanding of how HIV is transmitted and were able to reject major misconceptions about HIV transmission (*see Table 6*).

Table 6: Percentage of people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who rejected major misconceptions about HIV transmission by Age Group and Sex

Sex	Age Group		
	15-24	15-19	20-24
Total	50.2	48.5	52.3
Male	47.0	47.1	46.8
Female	53.0	49.7	57.0

Source: 2009 Sexual Behaviour Survey

Overall, males in the age group 20-24 were least likely to correctly identify ways of preventing the transmission of HIV and were more likely to accept major misconceptions of the transmission of HIV. The largest misconception about the transmission of HIV detected in this study relates to condom use (*see Table 7)*, with 19.4% of the respondents answering no when asked the question *"Can a person reduce the risk of getting HIV by using a condom every time they have sex?"*

Table 7: Percentage of people aged 15-24 who both correctly identify the two main ways of preventing the sexual transmission of HIV by Age Group and Sex

		Percentage of Persons who Identified that the risk of HIV transmission can be reduced by					
		Having sex with one uninfected partner who have no other partner			Using a condom every time they have sex		
	Sex	Female	Male	Both	Female	Male	Both
Age Group	15-19	86.4	84.6	85.6	81.0	82.2	81.6
	20-24	88.0	87.0	87.5	88.1	83.7	86.1
	Total	87.1	85.7	86.5	84.2	82.9	80.6

Source: 2009 Sexual Behaviour Survey

Females aged 15-19 were least likely to identify consistent condom use as a means of reducing the risk of HIV transmission. Young people aged 20-24 were most likely to identify consistent condom use as a way of reducing the risk of HIV transmission.

When asked if "*a person reduce the risk of getting HIV by having sex with one uninfected partner who have no other partner?"* 86.5% of the respondents answered yes. Males aged 15-19 years were least likely to identify monogamy as a means of reducing the risk of HIV transmission.

Two other misconceptions were that "*sharing food with someone who is infected*" can result in HIV transmission and that *"a person can get HIV from mosquito bites"* with 10.1% and 17.5% answering yes when asked these questions respectively (*see Table 8*).

Table 8: Percentage of people aged 15-49 who rejected major misconceptions about HIV transmission by Age Group and Sex

		Percentage of Persons who knew that:								
		A healthy looking person can have HIV			A person could not get HIV from a mosquito bite			A person could not get HIV from sharing food with someone who is HIV infected		
	Sex	Female	Male	Both	Female	Male	Both	Female	Male	Both
Age Group	15-19	99.3	94.7	97.6	84.7	80.3	82.7	89.3	88.9	89.1
	20-24	96.4	96.9	96.7	83.0	80.0	81.7	90.6	87.2	89.1
	Total	98.0	95.7	97.0	83.9	80.2	82.2	89.9	88.1	89.1

Source: 2009 Sexual Behaviour Survey

Males aged 20-24 were more likely to believe that HIV could be transmitted through mosquito bites, while males aged 15-19 answered yes more often when asked if a person can get HIV by sharing food with someone who is HIV infected.

2.7.4. Early Sexual Initiation

The occurrence of reported sexual initiation before the age of 15, among young people in Belize is 7.8%, with 78 of the 1,006 young men and women aged 15–24 interviewed, reporting having had sex before the age of 15. Males were more likely to report initiating sex before the age of 15 than females (see Table 9).

Table 9: Percentage of Young Men and Women aged 15-24 who have had sex before the age of 15 by Age Group and Sex

Sex	**Age Group**		
	15-24	**15-19**	**20-24**
Total	7.8	6.8	9.1
Male	10.8	8.3	13.8
Female	5.3	5.5	5.1

Source: 2009 Sexual Behaviour Survey

2.7.5. Multiple Partners and Condom Use

A small percentage of the surveyed population reported more than one sexual partner in the last 12 months. An estimate of 9.4% sexually active men and women aged 15–49 had sex with more than one partner in the twelve months preceding the survey (*see Table 10*).

Table 10: Percentage of Men and Women aged 15-49 who had sex with more than one partner in the last twelve months by Age Group and Sex

Sex	Age Group			
	15-49	15-19	20-24	25-49
Total	9.4	7.1	15.3	8.9
Male	15.4	10.7	26.6	14.1
Female	4.9	4.1	5.5	5.0

Source: 2009 Sexual Behaviour Survey

In the total sampled population men were three times more likely to have more than one sexual partner than women. Among the women, 4.9% reported having more than one sexual partner in the last 12 months, while 15.4% of men reported having multiple partners in the previous 12 months. Males in the age group 20-24 had the highest percentage of persons reporting having more than one sexual partner in the last 12 months (*see Table 11*).

Table 11: Percentage of Men and Women aged 15-49 who reported having had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse by Age Group and Sex

Sex	Age Group			
	15-49	15-19	20-24	25-49
Total	63.1	73.7	71.6	58.0
Male	65.8	80.8	70.4	60.7
Female	55.6	58.3	76.9	50.0

Source: 2009 Sexual Behaviour Survey

Young men (20-24) reported having multiple partners at higher rates than other age groups. In the total sampled population men were three times as likely to have more than one sexual partner when compared to women. Of the men and women aged 15-49 who reported having sex with more than one partner in the last 12 months, 63.1% of them also reported using a

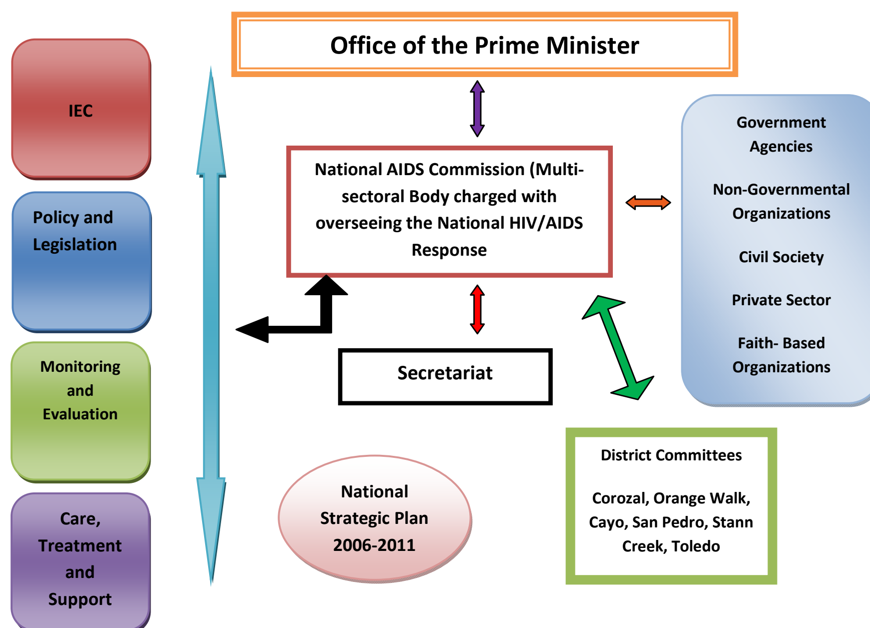
condom the last time they had sex. Females aged 25-49 who had more than one partner where least likely to report the use of a condom the last time they had sex, while young men aged 15-19 were most likely to report the use of a condom the last time they had sex.

III. National Response to the AIDS Epidemic

3.1. National Commitment

The reduction of the prevalence and the alleviation of the impact of HIV/AIDS in Belize have the highest level of commitment at the uppermost decision making and planning levels in the country. The Office of the Prime Minister is the entity responsible for advancing the HIV/AIDS response in Belize. In 2004, the National AIDS Commission (NAC) was commissioned and legislated by Cabinet to facilitate, coordinate, and monitor the prevention and control of HIV/AIDS in Belize. The NAC is also expected to report progress on the international agreements, facilitate the creation of linkages with regional and international organizations involved in the fight against the HIV/AIDS pandemic and assist in formalizing the direct link of all such partners both locally and internationally to effectively guide the National HIVAIDS response (see Chart 2).

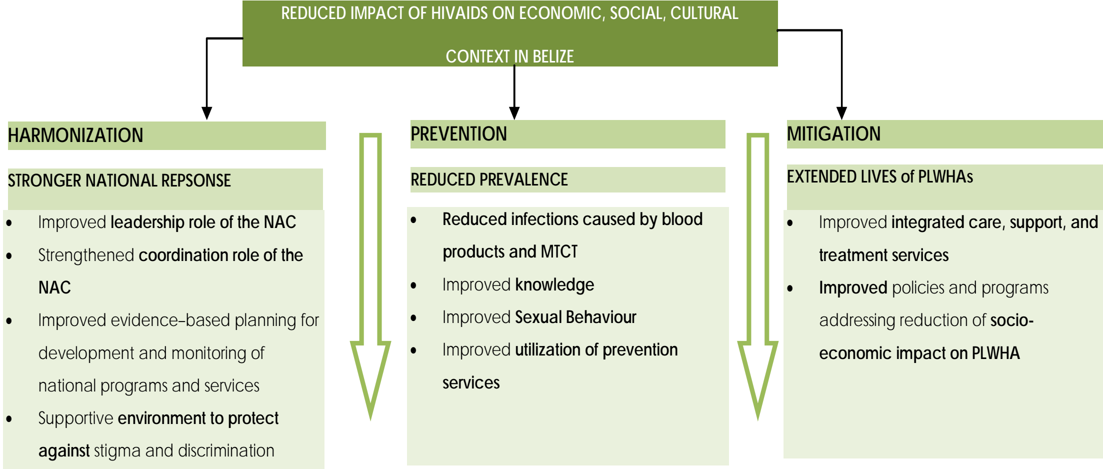
Chart 2: Structure of the National Response to the HIV/AIDS epidemic in Belize



Source: National Monitoring and Evaluation Plan 2006-2011

The Secretariat of the NAC was been established to support the work of the commission. The NAC Secretariat will be responsible for facilitating the overall coordination, monitoring, and evaluation role of the commission and ensures the effective implementation of the National Strategic Plan. The National Strategic Plan (NSP) for Belize is valid for the years 2006-2011. The overall goal of the national response is to reduce the impact of HIV/AIDS on the economic, social, and cultural contexts in Belize (*see Chart 3*).

Chart 3: Goals, Priority Areas, Objectives and Strategies of the NSP



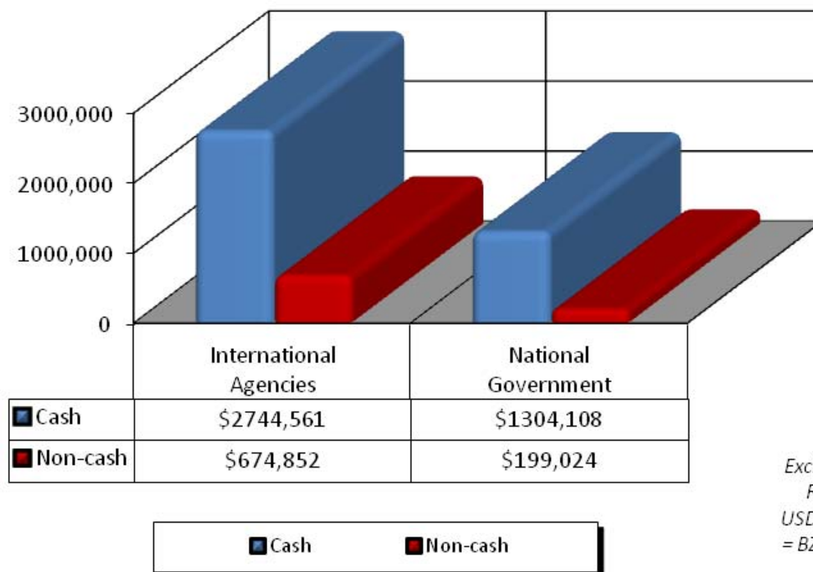
Source: National Strategic Plan for HIV/AIDS 2006-2011

In order to achieve this overarching goal, three priority areas were identified to guide the HIV/AIDS response: Harmonization, Prevention and Mitigation. Each priority areas have objectives and strategies aimed at realizing the overall goal of the NSP.

3.2. National AIDS Expenditure

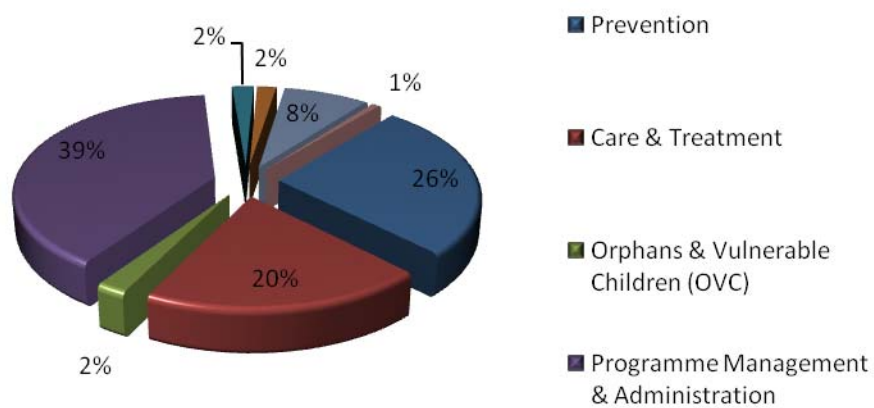
For the fiscal period 2008/2009, the national AIDS expenditure totalled BZ$4,922,545. This total represents 6.84% of the national health budget of BZ$72 Million for the same period.[9] The Government of Belize contributed 32.2% or BZ$1,304,108 to the total cash spending, while international Donor Agencies contributed 67.8% of the national spend or BZ$2,744,561 (*see Graph 4*). Of the total, 82.2% were direct cash contributions, while 17.8% were non-monetary donations.

[9] Source: Abstract of Statistics – 2008; Ministry of Finance



Source: 2010 National AIDS Spending Assessment

Programme Management and Administration was the highest expenditure category, accounting for thirty-nine percent of total cash expenditure (*see Graph 5*). Prevention recorded the second highest expenditure (26%) followed by Care and Treatment (20%).



Source: 2010 National AIDS Spending Assessment

The national spend in the Programme Management and Administration Category comprised primarily of the annual subvention paid to the National AIDS Commission Secretariat, which amounted to BZ$306,000 or 80% of total Programme Management and Administration expenditure. Other spending in this category included Government of Belize subsidies to various ministries including those responsible for the affairs of Women, Youth and Social Transformation.

Of the total national spend of BZ$1,304,108, the actual cash spend within the Ministry of Health was BZ$851,068 representing 65% of national expenditure; the main spending categories were Care and Treatment and Prevention.

The table below includes a listing of international donor agencies and the individual contributions toward the national AIDS spending in Belize. Multilateral Agencies are the leading contributor to AIDS Spending in Belize with the UN Agencies contributing 12.7% and other multilateral agencies combined accounting for 63.3% and The Global Fund (15.1%).

Table 12: AIDS Spending in Belize for the Fiscal year 2008-2009 by International Funding Sources

International Funding Sources	Amount (BZ$)	%
The Global Fund	$ 413,718	15.1
UN Agencies	$ 348,100	12.7
Other Multilateral Agencies	$ 1736,075	63.3
Other International Agencies	$ 246,668	8.9
TOTAL INTERNATIONAL FUNDS (In-Cash)	$ 2744,561	100.0
Exchange Rate USD $1.00 = BZ$2.00		

Source: 2010 National AIDS Spending Assessment

3.3. HIV/ AIDS Policy Environment

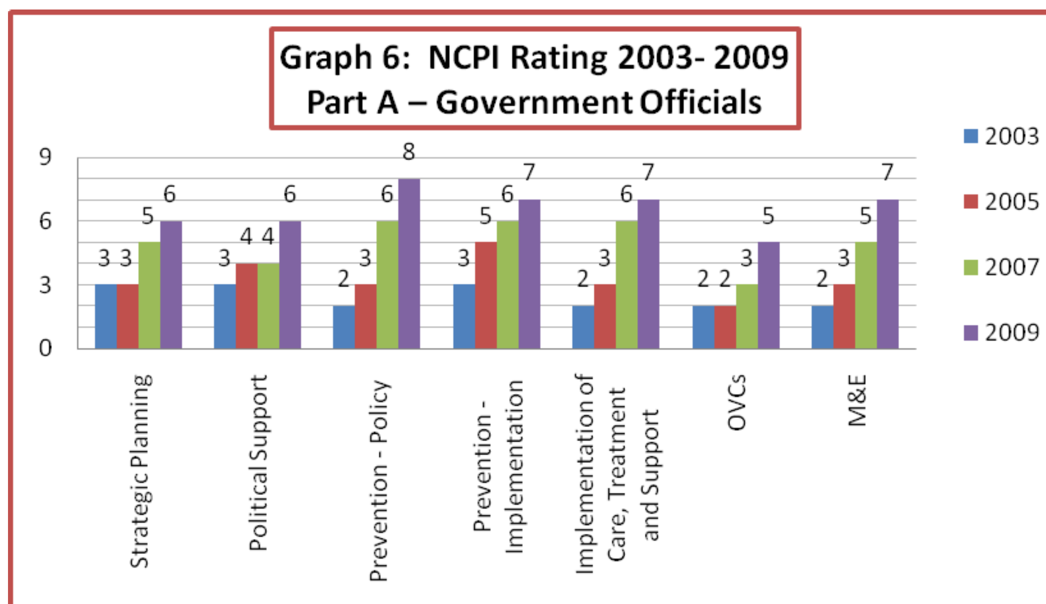
Since the 2008 UNGASS report, Belize has embraced the “three ones” principles and in the last two years has crossed several milestones towards its full implementation. The National Composite Policy Index (NCPI) indicates that Belize’s has realized significant progress with the

"Three ones" Principle since 2007. The country has one National Strategic Plan (NSP), One National AIDS Coordinating Authority and one National Monitoring and Evaluation Plan.

National Strategies:

The country's 2006-2011 NSP which was the product of extensive consultations with key stakeholders and partners, has provided the framework for a unique multi-sectoral response to the epidemic in Belize. This approach promotes harmonization, coordination, greater involvement of civil society and the active participation of PWHA and most at risk populations. The NSP defines for Belize three priority areas to be addressed, which are Harmonization, Prevention and Mitigation. The NCPI indicates that during the past 2 years, there have been improved functions of the Commission in the area of coordination. With the strengthening of the Commission's Secretariat and the reactivation of its four sub-committees, stakeholders report greater collaboration between government and civil society and greater involvement of vulnerable populations.

In regards to the priority area of prevention, the NCPI reports increased access to information, education and communication as a result of targeted initiatives and partnerships among different agencies to reach different populations (*see Graph 6*).



The NCPI highlight the success which has resulted from the scaling-up of two programs coordinated by the Ministry of Health which are the Prevention of Mother to Child Transmission and Voluntary Counselling and Testing. During the past two years, there has been increased involvement of civil society (Belize Family Life Association and Equity House) in the provision of voluntary counselling and testing across the country.

Under priority area three – Mitigation, the NCPI indicates that since 2007 there has been improvement in the effectiveness of treatment, care and support for PLHIV. The involvement of a civil society organization (Hand in Hand Ministries) focusing on orphans and vulnerable children has resulted in a greater emphasis on the provision of adequate treatment of paediatric cases in Belize (NCPI ratings- 2007:3 and 2009:4). NCPI indicates that key stakeholders at the government and civil society level recognize the significant contribution of the 5- year Global Fund Round 3 Project implemented in Belize from 2004 and which culminated in 2009.

Major support was provided through the project entitled: “Strengthening the Multi-sectoral Response to HIV in Belize” which provided coverage for a large component of the objectives and activities of the National Strategic Plan. The NCPI also showed that some donor agencies such as the UN Theme Group through its UN Development Assistance Framework (UNDAF) for 2007-2001 have harmonized and aligned their HIV programmes with the country’s national strategies. A significant accomplishment in 2009 was the completion of the Monitoring and Evaluation Plan for the NSP.

Challenges identified include the lack of a formal operational and resource mobilization plan for the NSP which results in a lack of coordination between HIV activities which are “funds-driven” and the national strategies. In regards to the greater involvement of vulnerable populations such as PLHIVs and MSMs, the challenge lies in building the capacity of these groups to represent and participate in a significant manner in the national planning processes.

The NCPI indicates that the country response is based on the three priority area of the National Strategic Plan and that government has established an effective partnership with civil society in the implementation of the NSP during the course of the past two years rating the strategy

efforts from a 5 in 2007 to a 6 in 2009 and efforts to involve civil society from a 6 in 2007 to a 7 in 2009.

Political Support and Policies:

In Belize the National AIDS Commission (NAC) is the body mandated by government to coordinate the implementation of the National Strategic Plan. As a direct result of Belize's signing of the Declaration of Commitment on HIV/AIDS at the UNGASS in 2001, the NAC was placed under the responsibility of the Prime Minister's Office. This action solidified the leadership of the response at the highest possible level in the country and emphasized the key role of the National AIDS Commission. Since 2004 the Cabinet approved National AIDS Commission Act clearly defines the role, function, composition and operational framework of this multi-sectoral entity. During the past two years the NAC has continued to receive budgetary support through the Ministry of Human Development for the operation of its national secretariat.

The NCPI indicates that during 2007-2009 some government officials have spoken favourably and publicly about HIV efforts at least twice per year and that the Ministry of Health and the Ministry of Education signed on to the Mexico Declaration at the International AIDS Conference in 2008. The NCPI indicates that during 2007-2009 the Ministry of Health; the Ministry of Labour; the Ministry of Education and the Ministry of Human Development, key implementers within the National AIDS Commission, have an earmarked budget received from the national funds for HIV-related activities. The NCPI also indicates that sectors which do not have an HIV budget receive funding and technical support from external sources. The NCPI also reports that national funds provided to civil society for the implementation of their HIV program is minimal to non-existent in some instances.

In regards to policy and legislation, the NCPI shows that there has been marked improvement in the efforts to develop policies and legislation during the past 2 years. In 2006 Cabinet approved the National HIV/AIDS Policy and the National HIV/AIDS Workplace policy. Both these policies adopt a human rights approach, which incorporate the fundamental rights enshrined in the Belize Constitution and the commitments set out in the National Poverty Reduction Strategy

and Action Plan as well as our international commitments in the Millennium Development Goals, (MDGS) and the United Nation's Special Session (UNGASS) on HIV/AIDS in 2001.

As a result of these national policies, several sectors have since elaborated and launched their HIV policy. The NCPI indicates that between 2007 and 2009 the Ministry of Labour successfully mobilized and provided support to twenty-two (22) corporations to develop and launch their workplace policies and commence the implementation of HIV education programs specifically designed for this sector. In addition, the Office of Governance also launched the HIV Policy for the Public Service while the Ministry of Education is in the process of drafting its Education sector which is the product of extensive consultations with students, teachers, parents and key stakeholders within the community. The NAC has also encouraged the NGO and Civil Society agencies actively engaged in the response to HIV in Belize to adopt this policy as well. To date, 2 non-governmental organizations (Alliance Against AIDS and Belize Enterprise for Sustainable Technology) have completed their HIV policies.

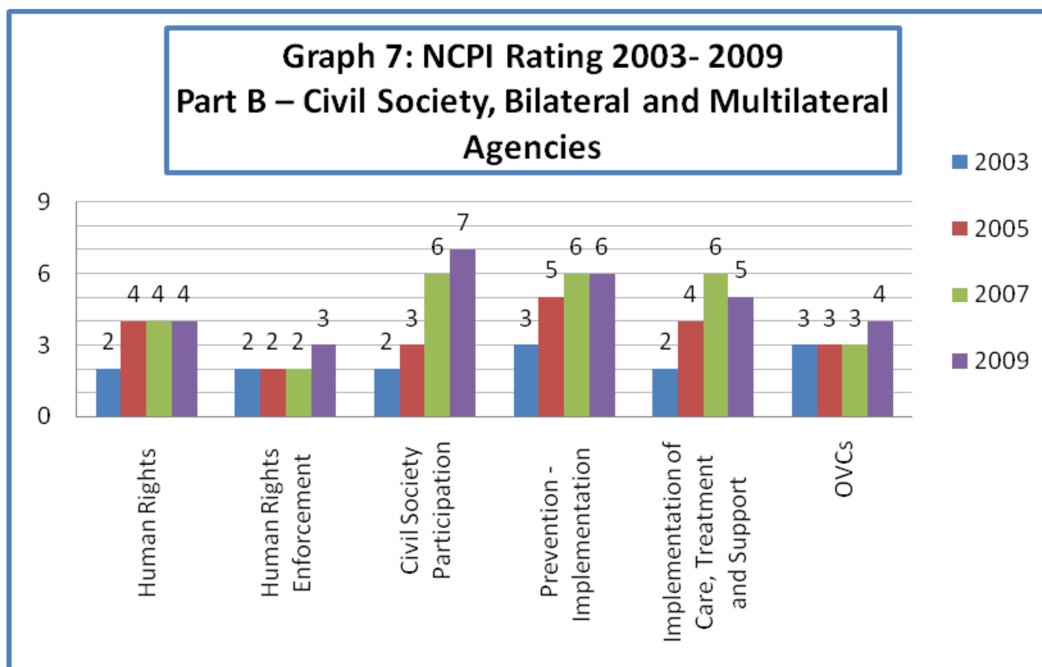
In 2009 the NAC through the Global Fund Round 3 Project entitled "Strengthening of Belize's Multi-sectoral Response to HIV/AIDS" sponsored by the Global Fund to Fight AIDS, Tuberculosis and Malaria, initiated a full review of the legislation in Belize in an effort to identify legislative gaps in the Multi-sectoral Response and to develop draft legislation to address these gaps. The National AIDS Commission plans to conduct nation-wide consultations on this draft in 2010 before forwarding it to Cabinet for approval and introduction as law.

Overall, the NCPI indicates that at an institutional level, Belize has shown consistent political support on HIV and AIDS. However, the challenge identified reflects the need for this political leadership to translate into concrete leadership and support in the area of resource mobilization, policy and advocacy at the national and international level. The NCPI shows an increase in the rating for political support from a 4 in 2007 to a 6 in 2009.

In regards to policy efforts, the NCPI indicates that even though Belize has made some strides in the area of policy development (4 in 2007 and 4 in 2009) the rating for the enforcement of these is a low 3 in 2009 while in 2007 when it was a low 2. The challenges identified by the NCPI highlight the fact that it is difficult to enforce the existing policies as many persons are

unaware of these and there are also no laws to enforce them. There are no redress mechanisms in place to protect persons living with HIV and other vulnerable populations from discrimination (*see Graph 7*).

In summary, the NCPI shows that since the last UNGASS report Belize has made progress in the area of strategies and policies. It also shows that in the field of policy and legislation, some milestones have been reached since 2007. Finally, the NCPI indicates that Belize has the successfully garnered the political support and civil society involvement needed to accomplish its National, UNGASS, Millennium Development and Universal Access goals.



3.4. <u>Sexual and Reproductive Health Policy Environment</u>

The National Sexual and Reproductive Health Policy was established in 2002, and is manifested through the Sexual and Reproductive Health Plan of Action 2006 – 2010. The Plan of Action sets forth a comprehensive set of objectives in the areas of integrated care, safe motherhood, reproductive and sexual rights, gender-based violence, males' participation, reproductive tract and breast cancer, and HIV/AIDS. Responsibility for the development and coordination of the plan rests with the Maternal and Child Health Programme (MCH).

The vision of the Plan is both positive and ambitious. In practice, however, the Plan has not proven to be a practical tool for the promotion of sexual and reproductive health in Belize. It has suffered from objectives that are too generalized and vague. It was also somewhat unrealistic in that it assumed that stakeholders would be willing and able to implement the wide-ranging activities outlined in the plan. It some cases, it is unclear who will take responsibility for implementation of specific activities. The Plan lacks focus and a clear sense of priorities, and it does not identify the resources necessary for implementation. Monitoring and evaluation of the plan has to date been weak, and there is a significant gap between the broad objectives of the plan and implementation.

The lack of a functioning plan has meant that the development of sexual and reproductive health programmes has been uneven. One specific manifestation of this is the lack of a full prevention strategy on sexually transmitted diseases (STIs).

Another problem area is the lack of clear standards of entitlement in the delivery of services. Access to information and services in Belize is often informal and there is a sense that one must "play the system" to receive support. More attention needs to be placed on the development and implementation of a rights based approach to service delivery, where there are clear rules about how the system should work, where people are fully aware of what those rules are, and where there are stronger ways for people to get redress when the system doesn't work as it should.

A rights based approach is also lacking in the provision of services to young people. Legal requirements state that persons under 18 must have parental consent to access sexual and reproductive health services. Not only does this often prevent young people from accessing preventative services, it also leads to a situation where those under 18 will often self-diagnose sexually transmitted infections because they cannot readily access medical care.

Another area directly affecting young people is the uneven application of the school curriculum dealing with sexual and reproductive health issues. The Ministry of Education has a Health and Family Life Education (HFLE) curriculum with a sexual education component. However, the church-state system of education means that it is difficult to achieve a consistent approach in

the implementation of the curriculum, since implementation is in the hands of different school managements. It should also be noted that, while some programmes incorporating sexual education for out of school youth exist, no comprehensive strategy is in place. In rural areas, almost no programming for out-of-school youth is available.

The issue of abortion continues to be largely swept under the table in Belize, largely due to religious objections. Abortion is prohibited in the Criminal Code, although it is allowed under a specific set of circumstances when authorized by two medical practitioners. In practice, however, the law is interpreted extremely conservatively, and virtually no legal abortions are done in Belize. Post-abortion care is available, however, through public facilities, regardless of where the initial procedure was performed.

A number of advances in the area of sexual and reproductive health have taken place in Belize over the past two years – for example, in the area of safe motherhood. However, these advances have been led by the dedication of those in specific programmes or agencies such as the Maternal and Child Health Programme, rather than a focused, effective, multi-sectoral plan that is well mainstreamed through government ministries and that engages civil society agencies as well. The process of reviewing and updating the Plan of Action has been ongoing since 2009 with the intent of fine tuning the existing plan and preparing for a new Plan of Action to take effect in 2011. The Ministry of Health has been open to civil society input into this process. The re-establishment of a Sexual and Reproductive Health Committee including representatives of both government and civil society is also a positive step.

3.5. Prevention

The Ministry of Education (MOE) has made significant advances in strengthening the Health and Family Life Education (HFLE) programme in schools. As young people continue to be faced with many challenges such as crime, violence, teenage pregnancy, HIV infection etc, there is an urgent need to ensure that schools provide the needed education for them to cope with these challenges. A sound HFLE programme in schools can equip students with the requisite knowledge and skills to overcome the challenges they encounter and to ensure a smooth transition to adolescent and eventual adulthood.

Apart from the primary school students reached, MOE was able to train 152 secondary school students as peer educators in the Stann Creek and Toledo Districts. Also at the secondary level, 2 additional Youth Friendly Spaces were opened: one in Belize City and one in San Ignacio. These spaces are designed and used as a safe place where students can access information on HIV/STIs and other issues that affect them from available literature in brochures, documentaries, having peer discussions and other information sharing strategies. They spaces are also used to conduct Peer Education trainings and for the young people to have meetings in a friendly environment.

Despite all these advances, HFLE is still not being fully implemented in all of the schools and some teachers are still not trained to effectively deliver the Life skills based education curriculum. The need still exists for a structured and comprehensive HFLE programme in secondary schools. MOE continues to build the capacity and mobilize resources for the full implementation of HFLE which is enhanced as a response to the Ministry's commitment to the Mexico declaration where new goals and targets have been established. To complement the efforts at the secondary level, stronger and new partnerships are being established with UNICEF and with the Population Council.

The Ministry of Education has collaborated with partners like the Belize Red Cross through the Together We Can (TWC) Peer Education programme on HIV prevention, which provides information and education services to young people in schools, and with the Women's Department through the Safe School Project as examples of extend sexuality education activities.

The Women's Department continued to implement the Gender Awareness Safe School Program in the districts and included interactive sessions on topics such as Domestic Violence, Gender Sensitization, Sexual Harassment, Self-Esteem and HIV/AIDS over the past two years. The program targets primary school children in Standard Five and secondary school students in Second Form and its objective is to set a foundation for gender equality amongst boys and girls inside and outside of school. The program has been running for four years now and is implement each school year on a rotational basis. In some schools the program is offered to

both standard 5 and 6 students at the request of the school administration. The Department was able to secure funding through PAHO, UNFPA and SIF to support the program. In 2008, the program was implemented in eighteen (18) schools reaching over 1,300 students, while in 2009 the program was implemented in seventeen (17) schools reaching over 1,400 students.

Additionally, the Belize Family Life Association (BFLA) has a specific objective to provide youth friendly sexual health and reproductive services to in- and out-of-school youths. Youth Enhancement Services (YES) and Young Women's Christian Association (YWCA) provides young girls who are at risk of early pregnancy as well as HIV infection with advocacy, education, and economic empowerment services.

Prevention initiatives in the other sub-populations assumed to be at risk continues to be guided by anecdotal data, as the only population that is at-risk based on empirical scientific evidence is the prison population, which has a prevalence rate of 4.9%[10] from sero-prevalence surveillance conducted in 2007. Belize is currently undertaking and exercise to estimate the population sizes for MSM, CSW, and Mobile populations, with the aim of conducting behavioural and sero-prevalence surveillance in these populations.

The Alliance Against AIDS (AAA) an NGO which provides services to PWHIV conducts education and prevention programs. In 2008, a Sexual Health and Sexuality (SHS) Education program was introduced as a New Prevention Technology (NPT) for Women in urban and rural areas. The NPT includes education on the proper and consistent use of the Female Condom. A group of female volunteers of the Women Issues Network of Belize (WIN-Belize) were trained as educators on SHS and now conduct outreach to women in poor neighbourhoods and rural villages. Community Nurses Aides (CNAs), youth, MSM, prisoners and PWHIV also benefitted from the SHS Education Program.

The Belize Family Life Association also provides outreach services to sexually diverse populations in Belize. They provided SRH services to over 1,200 clients of this population at their clinic country wide in 2009. They also provide SRH education to youths, MSM, CSW, and

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[10] Gough and Edwards (2004): HIV Sero-prevalence Study on Inmates at the Kolbe Foundation, Belize Central Prison, MOH, Belize.

persons from the LBGT community. The National Comprehensive Clinic of the MOH also provide outreach services to female sex workers in brothels after hours, however MOH does not have a special programs for any high risk group. PASMO is the leading NGO in behaviour change communication with both CSW and MSM; this includes outreach and condom distribution.

Migrant populations move between neighbouring countries and Belize for the purposes of seasonal work, fishing, trucking and even sex work. Poor socioeconomic factors of these populations make them vulnerable to sexually transmitted infections including HIV.

3.6. Care, Treatment and Support

The National HIV/ AIDS Program of the Ministry of Health is responsible for advancing the MOH response to HIV. One of their main areas of work is the clinical management of HIV as a part of the care and treatment program. There are currently many doctors providing care and treatment to persons with HIV in Belize. The number of persons receiving ARVs in Belize has increased significantly in the last two years. However, if Universal Access is to be achieved by 2015, a more proactive approach to patient case management would need to be employed. At the end of 2009, there were eleven (11) sites dispensing ARVs in the country. Only paediatric second line ARVs are currently available in Belize, with a total of twelve (12) children currently on second line ARVs. Clinical management of patients continues to be an area of concern.

Voluntary Counselling and Testing (VCT) services are available in Belize primarily through the Ministry of Health. The public sector VCT centres are generally stand alone clinics, which provide testing and counselling, as well as dispense ARV treatment. In an effort to scale up VCT services available in the country, the Ministry of Health collaborated with other governmental and non-governmental organisations to establish VCT services at their facilities. As a result there are now four (4) VCT centres in Belize. The MOH provides the testing strips and medical supplies needed by the agencies and they in turn supply the epidemiological data to the MOH. The Belize Family Life Association (BFLA) has eight (8) centres countrywide, which provides sexual and reproductive health services as well as VCT services, and are the preferred testing site for MSMs and CSWs. The Kolbe Foundation (prison) provides VCT services through its Medic Centre, as well as care and treatment for inmates that are sero-positive for HIV. Hand-in-

Hand Ministries and Equity House work with children infected and affected by HIV in Belize and provide VCT services through their paediatric programs. They provide HIV testing for children that are exposed as well as ensuring that the basic nutritional and economic needs of these children are met. The Belize Defence Force provides VCT services to the soldiers.

The prevention of mother-to-child transmission program in Belize has been very successful in reducing the number of children born with HIV. The program is fully integrated into the Maternal and Child Health (MCH) program and available countrywide. The main components is providing pre- and post counselling to all pregnant women that attend antenatal clinics, PCR screening for children, provision of milk supplements for babies born to HIV infected women and care and treatment for HIV infected pregnant women and their newborns. There are forty eight (48) public health facilities countrywide providing these services. The majority of Belizean pregnant women access antenatal care, and as a result very few babies are born HIV positive. However, strategies should be implemented to encourage all women to access appropriate antenatal services.

The Central Medical Lab provides blood banking services for Belize. They are responsible for screening all donated blood. All blood donors are interviewed to assess whether donors engage in high risk behaviours. Blood is screened for HIV-1 and HIV-2 strains, hepatitis B virus, syphilis, Chagas disease and malaria. Currently blood is not screened for hepatitis C virus or Human T-lymphotropic virus Type I or Type II because equipment is not working. There are plans to resume these tests soon.

Viral load testing is not done in country and patients are only recommended for viral load testing by the doctor based on clinical observation. The services of a private lab outside of the country is used for viral load testing, because of the cost only a limited number of patients receive viral load testing each year. Through efforts made by PAHO, 100 viral load tests were conducted in 2009 and funding is being sought through the Global Fund Round 9 proposal to provide viral load test for 200 patients in the coming year. The recent roll out of the HIV module of the Belize Health Information System (BHIS), which includes an electronic patient record, is expected to significantly improve patient tracking and clinical management. The Early Warning

Indicators are currently being used to monitor resistance to ARV drugs in Belize. A first report on four of the seven early warning Indicators was produced in 2008[11] and the report for 2009 is currently being developed.

A major aspect of the national response to HIV is the psychosocial and socioeconomic support as well as legal aid for persons with HIV. There is no framework to provide a comprehensive package of services for people infected and affected by HIV and AIDS. Psychiatric nurses at the VCT centres provide limited counselling services and persons needing long term counselling are referred to the Psychiatric Clinics in each district. Moreover, civil society organisations doing significant work in providing counselling services and community support. Because most of the work done is dependent on volunteers and external funding support is sometimes inconsistent and unsustainable.

The Caring for Children Protection and Support Network was set up with funding from UNICEF and three implementing agencies, Hand-in-Hand Ministries, Cornerstone Foundation, and Productive Organisation for Women in Action (POWA). Hand-in-Hand Ministries operates an outreach centre and has day care treatment centre as well as outreach activities for children infected and affected by HIV in the Belize District. Cornerstone Foundation has a lunch feeding program as well as provides support services to vulnerable families in the Cayo District. POWA's main activities include an after school program to help vulnerable children with their school work as well as provide them with a meal, and support services to vulnerable children and women infected and affected by HIV/AIDS. The AAA provides food, clothing, and supplies for HIV+ school children and children of PWHA; income generating initiatives and job placement for PWHA. It also provides financial support for urgent medicinal needs of PWHA with support from Living with Hope Foundation. AAA also provides training to PWHA in advocacy, inner stigma, human rights, nutrition and adherence to ARVs.

3.7. Belize Legislative Review

In 2008, through funding from the Global Fund, the National AIDS Commission contracted a consultant to undertake a comprehensive review of all legislation in Belize forming the basis of

[11] Early Warning Indicators Report

the work done by key HIV Stakeholders. The review investigated the specific provisions of relevant legislation as the affect the rights of PLHIV and as they impact the work of the key HIV stakeholders. The findings appropriate to each stakeholder was summarised to provide a glance of the work to be done to facilitate the multi-sectoral response to HIV/AIDS.

The consultative process also produced several recommendations for legislative change. The next step in the process is to take these recommendations to national consultations and the development of a draft law bill. The NAC has secured funding from the Caribbean Development Bank to facilitate this process.

IV. BEST PRACTICE

Two programs have been selected as Best Practices. These include the vertical transmission program and the work place program for HIV.

4.1. Vertical Transmission Program

The Prevention of Mother-to-child Transmission (PMTCT) Program was developed in 2000 after epidemiological data from MOH revealed that approximately 79% of the HIV transmission in the country was a result of heterosexual contacts. The Government of Belize, in recognition and acknowledgment of the experience and advances of the Bahamas in reducing the vertical transmission, collaborated for the development of a similar PMTCT Program in Belize. Through a Technical Cooperation among Countries, a mechanism to transfer knowledge and experience from one country to another, the process of developing and implementing a comprehensive PMTCT Program in Belize was initiated.

In an effort to strengthen and formalize the country's capacity to develop and implement a program which would meet the needs of the Belizean populace, the Bahamas facilitated the process of developing protocols, and training appropriate health care professionals in the country.

The project was piloted between 2000 and 2002, and the PMTCT Program was officially launched and rolled out in 2002. Since over 90% of pregnant women utilize the antenatal care at the public facilities in Belize, coupled with the fact that some 95% of all births occur in

hospitals by skilled attendants, the decision at the inception of the program was to integrate the vertical transmission program in the Maternal and Child Health (MCH) Program. Furthermore, the physical infrastructure for antenatal services including laboratories was already available to support the effective delivery of such services.

Over the years the program has continued to be strengthened and expanded to include private health care facilities. There is a strong collaboration between the public and private health facilities, which results in all pregnant women who access antenatal services, having access to HIV counselling and testing, antiretroviral treatment and PCR testing of the newborn. With the use of rapid testing in the MCH clinics, most pregnant women are able to receive their HIV test results during their visit. This has resulted with approximately 90% of all pregnant women opted to getting an HIV test. In 2007 there were 62 positive pregnant women of which 17 babies were HIV. While in 2008 there were 65 positive pregnant women of which 3 babies were HIV positive. The babies that were born with HIV were predominately from HIV infected mothers who did not access appropriate antenatal care.

The desire of the MCH Program to provide quality services to pregnant women who are HIV positive has resulted in the improvement of the treatment protocol. Since 2006 the treatment has moved from the provision of triple prophylactic therapy offered during active labour and to their newborns, to the provision of prophylaxis to pregnant women at 14 weeks of gestation. A major aspect of the program is the integration of a strategy to reduce congenital syphilis into the PMTCT program. As result of this strategy there have been no cases of congenital syphilis since 2007.

The main feature of the PMTCT program is that it place pregnant women at the centre of care, and for this reason, all pregnant women who are HIV positive receive treatment at the MCH clinics. Follow-up care is also provided after delivery, including family planning services in an attempt to avoid unwanted pregnancies. The impact of the program over the years is high as it clearly has reduced the number of children born with HIV in the country, and by extension, the infant mortality rate.

4.2. HIV Workplace Education Program

The HIV Workplace Education program is a strong example of how political will, coupled with strong project management and coordination and a well executed behaviour change communication strategy can change behaviours and protect the lives of thousands of workers from HIV and AIDS while securing jobs through the creation of a safe working environment.

In 2003, the US Department of Labour awarded a four year grant to the International Labour Organization (ILO) to implement a Global HIV/AIDS Education in the Workplace Programme. Subsequently, the ILO signed a Memorandum of Understanding (MOU) with the Ministry of Labour (MOL) of Belize to implement a comprehensive HIV & AIDS Workplace Education Programme.

The first step of the program is a formative assessment in the workplace; relevant data were collected utilizing qualitative and quantitative approaches which provided key information for the development of targeted education programmes. This data supported the development of a project monitoring plan and a work plan to guide the implementation of the program in Belize.

A focal point from the individual companies served as a liaison between the Project Coordinator and the identified organisation. Focal points were trained in various aspects of HIV and AIDS including behaviour change, advocacy and policy development. This led to the drafting of HIV policies by many participating enterprises.

The development of HIV policies was part of a larger plan to create sustained behaviour change at all levels. All enterprises were engaged in a systematic process which led to the development of a behaviour change communication strategy and complementary plans of actions. This included strategies to increase prevention, access to services, care and support, decrease stigma and discrimination and implement workplace policies.

Key to implementation of the BCC programmes was the recruitment and training of peer educators. Peer educators assumed a pivotal role in the implementation of HIV education in

each company. Peer educators were equipped with manuals and BCC materials to support the implementation of vivacious peer education sessions among co-workers.

The success of the project was hinged on strong tripartite partnership between government, employers, and workers organizations was complemented by representation by the various sectors and NGOs. This unique composition gave rise to the establishment of a vibrant Project Advisory Board (PAB). The project was initially implemented in five sectors after a memorandum of understanding was signed between the enterprises and ILO. At the onset of the programme 18 companies participated in the programme (*see Table 13*).

Table 13: Number of Companies Trained in the First Round of the Workplace Education Program by Sector

Sector	Number of Companies	Number of Employees
Agriculture	5	2,371
Service and Utilities	4	1,176
Banking	1	141
Sanitation	3	621
Tourism	5	305
Total	18	4,614

Source: Ministry of Labour

To ensure that the program and strategies were effective and could now be fully integrated into the national response. The MOL assumed full responsibility for managing the programme through appointment of a dedicated focal point for HIV education in the workplace. The focal point assumed the role of the project coordinator and the PAB transitioned into a Programme Steering Committee with responsibility for technical support and oversight to the programme.

In 2008, MOL signed a MOU with the NAC to implement the workplace education program with an additional group of employers, under the Global Fund Round 3 Project. The funding from Global Fund covered the Behaviour Change Communication, Peer Education and Policy Development training. The funds to conduct the Formative Assessment were provided by PAHO.

To date, 40 companies comprising of over 6,000 employees were involved in the HIV Workplace Education Programme, a more than 50% increase from 2003 when the programme was initiated. The tourism sector who was lagging behind in participation during the early years of the programme now boasts the majority of enterprises participating in the programme. A total of twenty-two (22) companies have signed workplace policies aimed at protecting worker rights while 10 companies are at various stages of policy development (*see Table 14*).

Table 14: Number of Enterprises with Signed HIV Policies by Sector

Sector	Number of Enterprises	Number of Employees
Agriculture	4	1,676
Services and Utilities	1	21
Banking and Insurance	1	6
Sanitation	2	427
Tourism	8	544
Non-Governmental Organisations	1	14
Private Sector	5	553
Total	**22**	**3,241**

Source: Ministry of Labour

V. Major challenges and remedial actions

5.1. Evidence Based Planning

A major challenge in the national response is the limited information available for evidence based planning. While there have been improvements over the years, understanding the national epidemic and developing appropriate interventions is affected by the lack of timely and reliable data as well as research. Research to identify the populations most-at-risk, the driving forces which put them at risk and their impact on the general epidemic is still urgently needed. Other data critical to the strengthening of the national response include comprehensive information on orphans, vulnerable children and adult HIV prevalence. In an effort to address this challenge, the Ministry of Health, through its Epidemiology Unit, in collaboration with stakeholders, has started an exercise to estimate the size of the most- at-risk populations. This exercise includes a definition of sub-populations that are generally considered to be at high risk and follow-up studies to identify Belize's true at-risk populations.

In addition, the expansion of the Belize Health Information System (BHIS) to include data from the Maternal and Child Health clinic is pivotal in studying HIV prevalence. The National AIDS Commission is advocating for the development and enforcement of protocols for the submission of private sector HIV testing and treatment data into the BHIS. The National AIDS Commission will use the results of all new HIV research data to guide the development of the National Operational Plan (2010-2015) and will continue to measure the success of its initiatives via the National Monitoring and Evaluation Plan.

5.2. Achieving Universal Access

Achieving universal access to prevention care, treatment and support remains another challenge. There are still instances where the vertical services for HIV/ AIDS are not patient-centred and thus may perpetuate stigma and discrimination. Through the provision of Provider Initiated Testing and Counselling (PITC), and the integration of HIV and SRH services, it is expected that there will be an improvement in the continuum and quality of care. The National AIDS Commission will establish systems to ensure that all Medical Personnel adhere to HIV care and treatment protocols and also advocate for the establishment of management teams for comprehensive care and treatment for PLHIV.

While the health sector is providing treatment to over 800 persons, a comprehensive care, treatment and support plan including appropriate resource allocation is still not sufficient. The National AIDS Commission will advocate for the full implementation of the National Sexual and Reproductive Health Action Plan. The Commission will continue to empower support groups for PWHA in Belize to meaningfully participate in the national response including advocacy, peer counselling and adherence support.

5.3. Sexuality and HIV Education for Young People

Young people continue to demonstrate a limited knowledge of HIV prevention. While HIV education is included in the Health and Family Life Education Curriculum for primary schools, a similar education package is not currently available for secondary schools students or out-of-school youths. Efforts are being made to strengthen the collaboration between the Ministries of Education and Health to address these gaps and fulfil our commitments to the Mexico City

Declaration. With the anticipated support from the Global Fund Round 9 Grant, the HFLE program, including a full monitoring and evaluation plan, will be expanded to secondary schools. The Commission will advocate for the increased human resources necessary for the effective implementation of the HFLE program in secondary schools and the development of a parallel national program for out-of-school youth.

5.4. National Spending for HIV and AIDS

Governmental and non-governmental organizations receive financial support for a variety of national HIV programs; however, there is no mechanism to effectively monitor aid flow to and utilization in the country. This makes it difficult to track HIV spending in the country, develop an effective aid agenda that fits the specific needs of the country and harmonize international donor support. A National AIDS Spending Accounts (NASA) exercise was conducted in 2009/2010 to document AIDS spending in the country. The National AIDS Commission will include an annual NASA exercise in the National Operational Plan. The Commission will also lobby for increases in government financial support to fill the gaps in the implementation of the national response.

5.5. Coordination of the National Response

The National AIDS Commission has facilitated greater collaboration and strengthened national partnerships in its response to the HIV epidemic, however there remain challenges of maximizing the use of resources, coordinating donor support and avoiding duplication of efforts. The Country Coordinating Mechanism (CCM) was established to reinforce this partnership and will continue to oversee the collaboration of key stakeholders in fulfilment its responsibility to in national response. Additionally, the programs of community-based groups need to be effectively integrated into the national response. It is anticipated that development and implementation of the national operational plan will address these challenges.

5.6. Stigma and Discrimination and involvement of people living with HIV in the national response

The level of stigma and discrimination compromises access to prevention, care, treatment and support programs as well as decreasing the meaningful participation of PLHIV in the national

response. Even though an increasing number of PLHIV have disclosed their status and publicly speak out against discrimination, a significant number are still reluctant to do so. Agencies such as the Alliance Against AIDS (AAA) and UniBAM advocate for, and on behalf of, PLHIV and provide training in advocacy and stigma and discrimination issues. It is expected that the resulting increase in PLHIV openly advocating for appropriate services will lead to more meaningful participation and a reduction in stigma and discrimination.

A wide range of companies and organizations and the public sector continue to benefit from the Ministry of Labour's workplace education program. This program affords them training in behaviour change communication, peer education and policy development, equipping them with the institutional capacity to create and nurture enabling environments in their workplaces for PLHIV.

The AAA, in collaboration with the Ministry of Health through its VCT Program, has established a national inventory of support groups in the country and has facilitated a national gathering of these groups. The National AIDS Commission endorses and will continue to support this initiative in order to establish a national association of support groups.

A civil society National Advocacy Working Group (NAWG) was established in 2009 to help build the advocacy capacity and identify the areas that require advocacy. It is expected that during the next two years the working group will support the advocacy work of the National AIDS Commission.

VI. Support from the Country's Development Partners

The country has forged partnerships with multilateral and bilateral agencies which provide financial and technical support for the strengthening of the national response for HIV. Financial and technical supports are provided from various sources. Some of the major international partners include Universities, United States Ambassador's Fund, Clinton Foundation, and United States Agency for International Development (USAID), Pan-American Caribbean AIDS Project (PANCAP), Global Fund, Latin American and Caribbean Council of AIDS Service Organisations (LACCASO) and PEPFAR among others.

The United States Ambassador's Fund through its HIV program has supported national HIV prevention activities for Ministries of Health and Education, as well as civil society organisations. Emphasis has been placed on supporting community based prevention programs, HIV awareness and education initiatives in primary schools, media campaigns in support of the National HIV Testing Day. LACCASO support capacity building for key ministries and civil society organisations in stigma and discrimination, advocacy, positive prevention, sexual health and sexuality, and policy analysis.

The United Nation System in Belize provides ongoing financial and technical support to the country in many areas. UNICEF has consistently provided support for children affected and infected by HIV; vertical transmission program, while UNFPA has focused on the integration of HIV into sexual and reproductive health services. PAHO/WHO continues to advocate for the integration and decentralization of HIV into the primary care system in support of scaling up services, and the strengthening of the health system to effectively respond to HIV. Support from the UN System is provided through the United Nations Development Assistance Framework (UNDAF) which outlines the collective response of all UN Agencies in Belize to support the national response. Within the framework of UNDAF, agencies have taken the initiative for joint programming on priority areas for HIV which includes PMTCT, care and treatment of HIV, scale-up HIV testing, and the integration of HIV into sexual and reproductive health services. Not only has this mechanism foster cohesion among the agencies, but also prevent duplications of efforts with national counterparts.

VII. Monitoring and Evaluations Environment

7.1. Monitoring and Evaluations Systems

The National Strategic Plan (NSP) 2006-2011 was developed to guide the overall multi-sectoral response to HIV/AIDS in Belize. Incorporated into the NSP is a strategy to effectively monitor and evaluate inputs, outputs, outcomes, and impact at the program level in order to guide implementation, improve program performance, form a basis for policy and legislative changes, as well as meet national reporting requirements. Subsequently, the National Monitoring and

Evaluation (M&E) Plan was developed, which seeks to assess the overall progress in meeting the strategic objectives outlined in the NSP.

The national M&E plan identifies the core indicators that will steer the monitoring and evaluating to the HIV/AIDS response in Belize, including Global Fund, National and UNGASS indicators. These indicators speak to the strategic objectives laid out in the NSP and dictate the improvement of key programmatic areas and their associated initiatives. Monitoring and evaluation of these activities produces data, which informs the improvement of the implementation processes of the activities and strengthens the overall decision and policy making mechanism.

The development of the National M&E Plan was the first step in standardizing the M&E system, which was followed by the National AIDS Commission (NAC) selecting the Dev Info software for modification to house aggregated HIV/ AIDS data in Belize. HIV Info 1.0 has been customized to reflect the look and feel of the national HIV/ AIDS response in Belize and a framework has been developed to echo both national and international HIV/AIDS goals and commitments. The operationalization of the M&E system has already began and it is expected that within the next year a fully functional system that provides timely, accurate and pertinent data would be the outcome.

7.2. <u>Routine Program Monitoring</u>

In an effort to improve data collection and management of health data, the MOH, over the past five years, has been working on developing the Belize Health Information System (BHIS). The BHIS became fully functional in 2008 and includes an HIV module as well as a laboratory Module. The data for 2008 for both modules have been populated into the BHIS system which is expected to improve the effective monitoring of patients.

Non-government partners in the National HIV AIDS response for the most part focus on: BCC activities, IEC development and support services. Mainly input and output level indicators of specific activities are currently tracked at non government facilities, such as, # of training

workshops, awareness campaigns, # of staff trained, # and type of counselling, # and type of referrals and # and type of outreach activities carried out. At the present time, no standardized forms exist that can collect information coming from this sector.

Currently, the only system in place for routine monitoring from the non-governmental partners is between the Principal recipient (PR) and the sub-recipients of the Global Fund Grant. The PR is responsible for collecting information for 15 process and 4 impact indicators of the project, and usually collects this information directly from each sub recipient. The project coordinator and the M&E officer of the PR, the M&E Officer of the NAC, and the MOH/NAP Project officer meet on a regular basis to review project implementation focusing on indicator progress. Main constraint will be the compliance of organizations that need to report on a timely and systematic fashion.

7.3. Outcome and Impact Measurement Systems

Data collection strategies continue to be a significant weakness in monitoring and evaluation of outcomes and impact of the national HIV/AIDS response in Belize. Behavioural surveillance is one of the tools being employed to monitor and evaluate the effectiveness of HIV prevention programs. Although consensus has been built among partners on the importance of this type of data collection and there is significant support in terms of resource mobilization, timely and efficient studies have not been carried out. One of the major hindrances to the process is the lack of capacity both at the coordination and implementation levels. To improve the capacity at the coordination level the NAC has recently contracted a new monitoring and evaluations officer with prior experience in the field. The Ministry of Health has also approved two new posts, a Surveillance Officer and Monitoring and Evaluations Officer, which would improve the countries capacity for impact and outcome monitoring.

7.4. Strengths, Challenges and Next Steps

Table 15: Strengths, Challenges and Next Steps in establishing the National M&E System

Organizational Structures and Human Capacity for HIV M&E	
Strengths	• There are M&E staffs at the National AIDS Commission Secretariat, the Principal Recipient of the Global Fund Project, National Council for Families and Children (NCFC), and the Ministry of Health. • There are also Policy and Planning units in the Ministries Health, Human Development, Education, and Economic Development. • The National M&E plan outlines the job description of monitoring and evaluation staff. • M&E staff exposed to national and regional trainings. • The Planners and Monitoring and Evaluations Officers in the public sector have formed a Community of Practice for Planning, Monitoring and Evaluations which aims to support the enhancement of the Planning and M&E culture in Belize. • M&E focal points at the service delivery levels have recently been trained in basic Monitoring and Evaluations techniques, which is the first stage of advancing their capabilities to managing their planning cycles.
Challenges	• In addition to not having enough M&E staff, there is no human capacity building plan to ensure that the M&E staffs have the required skill set for the M&E work at the national, sub-national and service delivery levels. • There is the absence of a mechanism for routine planning, management, and assessment of the national M&E system and organizational structures. • In-service training and mentorship of staffs responsible for M&E at the service delivery level is still weak. • There is no budget for M&E human resources.
Next Steps	• Develop and cost a human capacity building plan for monitoring and evaluation at the national, sub-national and service delivery levels. • Conduct formal training in the areas of monitoring and evaluation, data management, leadership in M&E, financial management, facilitation, advocacy and communication. • In-house training, mentorship and coaching of service delivery staffs responsible for M&E.
Partnership to plan, coordinate and manage the HIV M&E System	

Strengths	• The National AIDS Commission structure makes provision for a multi-sectoral M & E sub-committee with the mandate to plan, coordinate and manage the development and implementation of the NSP M&E plan.
Challenges	• Participation of member agencies inconsistent and overall low M&E capacity levels with weak, informal structures and mechanisms. • Lack of clear information exchange channels and protocols among stakeholders; weak levels of accountability.
National Multi-sectoral HIV M&E Plan including Annual Costed National HIV M&E Work Plan	
Strengths	• There is a National M&E plan that is linked to the priorities of the NSP and also includes specific indicators for monitoring the national response. These indicators adhere to international and national technical standards.
Challenges	• M&E plan does not include an implementation plan or a resource mobilization strategy. • There is no M&E work plan with specific budgeted activities. • No monitoring report or mid-term assessment of the NSP has been conducted. • M&E system assessment needs to be conducted to inform strengthening.
Next Steps	• Conduct a review of the NSP to determine the level of implementation and to guide revision of the NSP. • Operationalize the M&E plan with an implementation plan, stakeholder engagement strategy, budgeted activities, and resource mobilization strategy.
Advocacy, Communication and Culture for HIV M&E	
Strengths	• M&E is referenced in the NSP and the National policy on HIV/AIDS.
Challenges	• The national HIV communication strategy does not include a specific HIV M&E communication and advocacy plan.
Next Steps	• Updated national communication strategy to include strategies for M&E communication and advocacy.
Data Collection and Data Use	
Strengths	• Protocols for surveys and surveillances are based on international standards. • Population based KAP study 2006 and 2009. • Formative assessment of sexual behaviour and practice for use in HIV workplace policy development conducted on various organizations. • There is a national HIV database (HIV Info 1.0) being developed to warehouse HIV data. • The Belize Health Information System (BHIS) collects and stores

	information from the public health facilities.
Challenges	• There is no research agenda linked to the national M&E plan. • There are limited data user-producer relationships and no national routine program monitoring outside of Global Fund and UNGASS. • Data collection is not entirely linked to stakeholder needs or used for program improvement. • There is no well-functioning biological or behavioural surveillance system. • Linkages between national and sub-national databases not yet achieved. • There is no repository for HIV surveys conducted. • Data quality is not monitored at the national level, outside of verification of data collected for UNGASS and GF reporting. • There is no national system for identifying evaluation/ research gaps relevant to the NSP and for coordinating relevant studies. • There is no standard for national reporting or a data dissemination schedule.
Next Steps	• Develop a research agenda for the national HIV response to M&E plan. • Develop a data collection schedule for biological and behavioural surveillances. • Mobilize resources to conduct routine surveillances, including biological and behavioural surveys essential for determining the drivers of the epidemic, for both the general and the most-at-risk populations. • Develop linkages between national and sub-national databases to enhance the national HIV database. • Capture, verify, analyze, and present findings of HIV data to and from all levels and sectors. • Develop mechanism to monitor data quality and address and obstacles to producing high quality data. • Identify evaluation/ research gaps relevant to the revised National Strategic plan. • Develop a detailed data use plan to be included in the revision of the M&E plan, for the collation and analysis of data which can be used to guide policy formation and program improvements.

ANNEX 1: Consultation/preparation process for the Country Progress Report

1) Which institutions/entities were responsible for filling out the indicator forms?

a) NAC or equivalent	**Yes**	No
b) NAP	**Yes**	No
c) Others (Please specify)	Yes	No

2) With inputs from Ministries:

Education	**Yes**	No
Health	**Yes**	No
Labour	**Yes**	No
Foreign Affairs	Yes	**No**
Others	**Yes**	No

(Please specify) Ministry of Human Development (Women's Department); Ministry of Youth, Sports and Broadcasting

Civil society organizations	**Yes**	No
People living with HIV	**Yes**	No
Private sector	**Yes**	No
United Nations organizations	**Yes**	No
Bi-laterals	Yes	**No**
International NGOs	**Yes**	No
Others (Please specify)	Yes	**No**

3) Was the report discussed in a large forum?	**Yes**	No
4) Are the survey results stored centrally?	Yes	**No**
5) Are data available for public consultation?	**Yes**	No

Who is the person responsible for the submission of the report and for follow-up if there are any questions on the Country Progress Report?

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ANNEX 2: 2010 National Composite Policy Index (NCPI)

Part A
(to be administered to government officials)

For Strategic Plan and Political Support sections: the Chairman of the National AIDS Commission, the Directors of the National AIDS Program and National AIDS Commission Secretariat, the Voluntary Test and Counseling (VCT) and heads of the AIDS committees in the districts.

1. Has the country developed a national multisectoral strategy to respond to HIV?
(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes	No	Not Applicable (N/A)

Period covered: **2006-2011**

IF NO or NOT APPLICABLE, briefly explain why.

***IF YES*, complete questions 1.1 through 1.10; *IF NO*, go to question 2.**

1.1 How long has the country had a multisectoral strategy? **1999**
Number of Years: **11 years**

1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

Sectors Included in strategy	**Included in strategy**		**Earmarked Budget**	
Health	Yes	No	Yes	No
Education	Yes	No	Yes	No
Labour	Yes	No	Yes	No
Transportation	Yes	No	Yes	No
Military/Police	Yes	No	Yes	No
Women	Yes	No	Yes	No
Young People	Yes	No	Yes	No
Other[12] **Tourism**	Yes	No	Yes	No

[12] Any of the following: Agriculture, Finance, Human Resources, Justice, Minerals and Energy, Planning, Public Works, Tourism, Trade and Industry.

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities? Sectors which do not have an HIV specific budget receive funding and technical support from external sources and in-country international agencies. The 5 year Global Fund Project which culminated in 2009, for example, supplemented budgets as well as provided funds to those sectors which generally do not have an HIV budget. The military, for instance, has received support from the US Southern Command to implement some components of its Strategic Plan. Most non-governmental organizations secure their funding for their programs from external sources.

1.3 Does the multisectoral strategy address the following target populations, settings and crosscutting issues?

Target populations		
a. Women and girls	a. Yes	a. No
b. Young women/young men	b. Yes	b. No
c. Injecting drug users	c. Yes	c. No
d. Men who have sex with men	d. Yes	d. No
e. Sex workers	e. Yes	e. No
f. Orphans and other vulnerable children	f. Yes	f. No
g. Other specific vulnerable subpopulations[13] Tourism	g. Yes	g. No
Settings		
h. Workplace	h. Yes	h. No
i. Schools	i. Yes	i. No
j. Prisons	j. Yes	j. No
Cross-cutting issues		
k. HIV and poverty		
l. Human rights protection	k. Yes	k. No
m. Involvement of people living with HIV	l. Yes	l. No
n. Addressing stigma and discrimination	m. Yes	m. No
o. Gender empowerment and/or gender equality	n. Yes	n. No
	o. Yes	o. No

1.4 Were target populations identified through a needs assessment?

Yes	No

[13] Sub-populations other than injecting drug users, men who have sex with men and sex workers, that have been locally identified as being at higher risk of HIV transmission (e.g., clients of sex workers, cross-border migrants, migrant workers, internally displaced people, refugees, prisoners).

IF YES, when was this needs assessment conducted? Year: **2003-2004**

IF NO, explain how were target populations identified?

1.5 What are the identified target populations for HIV programmes in the country?

1. **Persons living in poverty**
2. **Mobile and migrant populations**
3. **Female and male sex workers**
4. **Persons living with HIV or AIDS and their immediate families**
5. **Persons living with Sexually Transmitted Infections (STIs)**
6. **In and out-out-of-school youth**
7. **Men who have sex with men**
8. **Members of the uniformed services**
9. **Incarcerated populations**

1.6 Does the multisectoral strategy include an operational plan?

Yes	No

1.7 Does the multisectoral strategy or operational plan include:

	Yes	**No**
a. Formal programme goals?		
b. Clear targets or milestones?		
c. Detailed costs for each programmatic area?		
d. An indication of funding sources to support programme implementation?		
e. A monitoring and evaluation framework?		

1.8 Has the country ensured "full involvement and participation" of civil society[14] in the development of the multisectoral strategy?

Active involvement	Moderate involvement	No involvement

IF active involvement, briefly explain how this was organized: The National AIDS Commission which is a multisectoral body includes the full involvement and participation of civil society at different levels of its function. The development of the Multisectoral strategy involved a process of consultations, planning and consensus-building sessions which engaged government, civil society, bilateral and international partners. The

[14] Civil society includes among others: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, sex workers, injecting drug users, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

process of developing and implementing the Global Fund Project "Strengthening of the Multisectoral Response to HIV in Belize" fully engaged civil society participation. The highest level decision-making bodies of the NAC which are the Executive Committee and the Sub-Committees include leadership and membership from civil society organizations. Thus, civil society has played an integral part in the development, vetting and implementing of the NSP.

IF NO or MODERATE involvement, briefly explain why this was the case:

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes No

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners Yes, some partners No

IF SOME or NO, briefly explain for which areas there is no alignment / harmonization and why: Some development partners have aligned and harmonized their programmes with the national Multisectoral strategy. These partners generally consult with the NAC, the NAC Secretariat and/or their specific partners in country upon the inception of their programmes. This is to ensure that the project goals are synchronized with the country's identified priority areas and goals. Belize has on-going relations with a large number of donors such as the UN agencies as well as benefits from its membership in Regional initiatives such as the Pan Caribbean Partnership against HIV/AIDS (PANCAP). The challenge, however, remains for these development partners to maintain a continuous effort of monitoring and evaluating programs to ensure that better joint planning and coordination is taking place. By doing so, existing gaps and duplication of efforts can be addressed and a bottom-up rather than top-down approach can be taken in the harmonization of their programs with the NSP.

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment / UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes	No	N/A

2.1 ***IF YES***, in which specific development plan(s) is support for HIV integrated?

a. National Development Plan	Yes	No	N/A
b. Common Country Assessment / UN	Yes	No	N/A

Development Assistance Framework			
c. Poverty Reduction Strategy	Yes	No	N/A
d. Sector-wide approach	Yes	No	N/A
e. other: National Strategic Plan for Families and Children	Yes	No	N/A
f. other: National Gender Plan of Action	Yes	No	N/A

2.2 ***IF YES***, which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)		
HIV prevention	YES	NO
Treatment for opportunistic infections	YES	NO
Antiretroviral treatment	YES	NO
Care and support (including social security or other schemes)	YES	NO
HIV impact alleviation	YES	NO
Reduction of *gender* inequalities as they relate to HIV prevention/ treatment, care and/or support	YES	NO
Reduction of *income* inequalities as they relate to HIV prevention/ treatment, care and /or support	YES	NO
Reduction of stigma and discrimination	YES	NO
Women's economic empowerment (e.g. access to credit, access to land, training)	YES	NO
Other: Care and Support for Orphans and Vulnerable children	YES	NO

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes	No	N/A

3.1 ***IF YES***, to what extent has it informed resource allocation decisions?

Low High

0 1 2 3 4 5

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes No

4.1 ***IF YES***, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

Behaviour change communication	YES	NO
Condom provision	YES	NO
HIV testing and counselling	YES	NO
Sexually transmitted infection services	YES	NO
Antiretroviral treatment	YES	NO
Care and support	YES	NO
Others: Reduction of stigma and discrimination	YES	NO

If HIV testing and counselling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counselling (e.g., indicate if HIV testing is voluntary or mandatory etc):

The military presently has a policy which stipulates that all recruits and members of the Belize Defence Force are required to take a test. The policy states that persons who test positive while in the army are provided with care and support. Persons interested in joining the military who test positive are not recruited. This has given rise to a major debate with the National AIDS Commission, the body mandated to oversee the implementation of the National HIV Policy and Workplace Policy which state that no one, including the military, should engage in mandatory testing of applicants or employees. The lack of legislation to enforce these policies poses a major challenge to tackling this situation in an effective way.

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes No

5.1 ***IF YES,*** for which subpopulations?

a. Women	YES	NO
b. Young people	YES	NO
c. Injecting drug users	YES	NO
d. Men who have sex with men	YES	NO
e. Sex Workers	YES	NO
f. Prison inmates	YES	NO
g. Migrants/mobile populations	YES	NO
h. Other:	YES	NO

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

The Women's Department of the Ministry of Human Development serves as advocate for the enforcement of the Domestic Violence ACT which was revised in 2008 through client support, court and police advocacy. The Women's Department also accomplishes this through the

training of women and sensitization and training of the public, police and magistracy. Working with the Police Department and the Family Court the Women's Department has embarked on training sessions to sensitize and educate on the psychosocial impact of Domestic Violence and the revised DV Act.

Briefly comment on the degree to which these laws are currently implemented: Even though a larger number of women are seeking legal support for domestic violence, stigma and discrimination based on social and cultural attitudes and beliefs still pose a barrier for women to access or to follow-up on their cases. Thus, even though a law exists, some women prefer to not access this support due to social and economic conditions.

6. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes No

6.1 ***IF YES,*** for which subpopulations?

a. Women	YES	NO
b. Young people	YES	NO
c. Injecting drug users	YES	NO
d. Men who have sex with men	YES	NO
e. Sex Workers	YES	NO
f. Prison inmates	YES	NO
g. Migrants/mobile populations	YES	NO
h. Other:	YES	NO

IF YES, briefly describe the content of these laws, regulations or policies:

In regards to young people accessing sexual and reproductive health services, the law still stipulates that a person 16 and under needs to be accompanied by an adult. Under the unnatural crimes act sodomy and buggery are still consider criminal acts even if it occurs between two consenting adults. These limitations continue to affect interventions with men who have sex with men as this group remains inaccessible due to their fear of stigma and discrimination. Basic human rights legislation on sexual and reproductive health rights, sex work and sexual orientation has not been addressed beyond a national HIV/AIDS policy that is limited and is often not enforced.

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes No

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes No

7.2 Have the estimates of the size of the main target populations been updated?

Yes No

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs	Estimates of current needs only	No

7.4 Is HIV programme coverage being monitored?

Yes No

(a) ***IF YES***, is coverage monitored by sex (male, female)?

Yes No

(b) ***IF YES***, is coverage monitored by population groups?

Yes No

IF YES, for which population groups? Briefly explain how this information is used:

(c) Is coverage monitored by geographical area?
Yes No

IF YES, at which geographical levels (provincial, district, other)? Coverage is monitored at the district level. Briefly explain how this information is used: The data collected is compiled at the central level to estimate current and future needs of antiretroviral at the local and national level.

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes   No

Overall, how would you rate *strategy planning efforts* in the HIV programmes in 2009?											
2009 Very poor										Excellent	
	0	1	2	3	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

Since 2007 the National AIDS Commission has conducted major consultations with stakeholders to finalize the operational plan of the NSP. A review of the strategic plan is scheduled for early 2010 to identify existing gaps and measure level of implementation among stakeholders. The process also seeks to identify costing gaps. In 2009 there was the successful completion of Global Fund Rd 3 with a B1 assessment. A proposal for the Round 9 Global Fund project was developed using a multisectoral and participatory approach using the NSP framework. . Collaborating closely with other partners such as the Pan Caribbean Partnership further support has been mobilized for the implementation of the NSP. There has been greater focus on the NSP as a part of a larger regional response framework both in the Caribbean and in Central America.

What are remaining challenges in this area:

Even though efforts have been made to operationalize the NSP, this process has been started but has not been completed even though the NSP is in its 4th year of implementation. Getting stakeholders to "buy-in" and commit themselves to be a part of the coordinating mechanism is still a major challenge while limited human resources at the Secretariat level pose challenges to the effective and timely completion of the operational plan.

II. POLITICAL SUPPORT

<u>For Strategic Plan and Political Support sections</u>: the Chairman of the National AIDS Commission, the Directors of the National AIDS Program and National AIDS Commission Secretariat, the Voluntary Test and Counseling (VCT) and heads of the AIDS committees in the districts.

Strong political support includes: government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings; allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

President/Head of government	Yes	No
Other high officials	Yes	No

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

Yes No

IF NO, briefly y explain why not and how AIDS programmes are being managed:

2.1 ***IF YES***, when was it created?

Year: February 2001

2.2 ***IF YES***, who is the Chair?

Mrs. Kathleen Esquivel (non-executive) Position/Title: Chairperson

2.3 ***IF YES***, does the national multisectoral AIDS coordination body:

Have terms of reference?	YES	NO
Have active government leadership and participation?	YES	NO
Have a defined membership? ***IF YES***, how many members include civil society representatives? 8 ***IF YES***, how many include people living with HIV? 1 ***IF YES***, how many include the private sector? **2**	YES	NO
Have an action plan?	YES	NO
Have a functional Secretariat?	YES	NO
Meet at least quarterly? Review actions on policy decisions regularly? Actively promote policy decisions? Provide opportunity for civil society to influence decision-making? Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	YES YES YES YES YES	NO NO NO NO NO

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes	No	N/A

IF YES, briefly describe the main achievements:

The National AIDS Commission of Belize is the Multisectoral body mandated by Cabinet to coordinate and facilitate the implementation of the National Response to HIV. The National AIDS Commission Act (NAC) was passed into law on February of 2004. The multisectoral nature of the National AIDS Commission highlights the recognition that HIV and AIDS is not only a health issue but also a developmental one with potentially devastating impacts on every sector of society. A multisectoral approach is therefore adapted to respond to the epidemic in Belize. The Commission is a 23 member body with wide cross section representation of society, including those organizations involved in the fight against HIV and AIDS in Belize. Key stakeholders include governmental departments such as the Ministries of Health, Education, Labour, Human Development and Tourism. Also represented are persons living with HIV/AIDS, the business community, youth, faith-based organizations, other non-governmental organizations, community-based organizations and representatives of the district committees. The multisectoral membership of the NAC in collaboration with the UN Theme Group which comprises PAHO, UNICEF, UNDP and UNFPA in Belize; bilateral; and other international agencies has engaged in successful partnerships to finalize and implement the NSP; develop the Monitoring and Evaluation Plan; advance the policy and legislative agenda; develop the Round 9 Global Fund Proposal among other accomplishments in 2008 and 2009.

Briefly describe the main challenges:

Sometimes there are conflicting agendas and there is always an element of territoriality among some stakeholders. Another challenge is posed by human resource constraints since the same persons are wearing different hats within the different organizations. Thus, full and timely participation is sometimes compromised as key representatives are sometimes engaged with responsibilities that are not HIV-related.

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?

Percentage: **28%**

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	YES	NO
Technical guidance	YES	NO
Procurement and distribution of drugs or other supplies	YES	NO

Coordination with other implementing partners	YES	NO
Capacity-building	YES	NO
Other:	YES	NO

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes No

6.1 ***IF YES***, were policies and laws amended to be consistent with the National AIDS Control policies?

Yes No

Have completed first stage with the draft which was presented to a wide-cross section of stakeholders and accepted; it needs to be presented in nation-wide consultations and the agreed result presented to Cabinet for approval; ***IF YES***, name and describe how the policies / laws were amended: Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies: (there are inconsistencies and these are identified in the revisions; one of these is the mandatory testing for uniformed services; unnatural acts legislation; definitions of sexual crimes definitions; communicable diseases classification;

Overall, how would you rate the *political support* for the HIV programme in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 8 9 10
Since 2007, what have been key achievements in this area: The National AIDS Commission is still a body under the Office of the Prime Minister. There is greater involvement of Chief Executive Officers within the National AIDS Commission as members. Ministers of Health and Education signed on the Mexico City Declaration in 2008 which included some cutting edge commitments for reduction of stigma and discrimination and human rights; by end of 2011 so many schools now have Health and Family Life Education curriculum implemented.

What are remaining challenges in this area: Declarations and commitments need to translate into direct action as reflected in policies, legislation and budgets to support and facilitate the control of HIV in Belize

III. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the *general population*?

Yes	No	N/A

1.1 ***IF YES***, what key messages are explicitly promoted? Check for key message explicitly promoted

a. Be sexually abstinent	
b. Delay sexual debut	
c. Be faithful	
d. Reduce the number of sexual partners	
e. Use condoms consistently	
f. Engage in safe(r) sex	
g. Avoid commercial sex	
h. Abstain from injecting drugs	
i. Use clean needles and syringes	
j. Fight against violence against women	
k. Greater acceptance and involvement of people living with HIV	
l. Greater involvement of men in reproductive health programmes	
m. Males to get circumcised under medical supervision	
n. Know your HIV status	
o. Prevent mother-to-child transmission of HIV	
Other: *[write in]*	

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes No

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes	No	N/A

2.1 Is HIV education part of the curriculum in:

Primary schools?	Yes	No
Secondary schools?	Yes	No
Teacher training?	Yes	No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes No

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions *for most-at-risk or other vulnerable sub-populations?*

Yes No

IF NO, briefly explain:

3.1 ***IF YES***, *which populations* and *what elements of HIV prevention* do the policy/strategy address?

Check which specific populations and elements are included in the policy/strategy

	IDU*	MSM**	Sex workers	Clients of sex workers	Prison inmates	Youth	Women
Targeted information on risk reduction and HIV education							
Stigma and discrimination reduction							
Condom promotion							
HIV testing and counselling							

Reproductive health, including sexually transmitted infections prevention and treatment							
Vulnerability reduction (e.g. income generation)	N/A	N/A		N/A	N/A		
Drug substitution therapy		N/A	N/A	N/A	N/A		
Needle & syringe exchange		N/A	N/A	N/A	N/A		

Overall, how would you rate *policy* efforts in support of HIV prevention in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 8 9 10

Since 2007, what have been key achievements in this area:

In 2006 Cabinet approved the National HIV/AIDS Policy presented by the National AIDS Commission as well as the National HIV/AIDS Workplace policy which was a joint venture between the Ministry of Labour and the National AIDS Commission with support from the International Labour Organization. Both these policies adopt a human rights approach, which incorporate the fundamental rights enshrined in the Belize Constitution and the commitments set out in the National Poverty Reduction Strategy and Action Plan as well as our international commitments in the Millennium Development Goals, (MDGS) and the United Nation's Special Session on HIV/AIDS, 2001 (UNGASS). As a result of these National policies, several sectors have since elaborated and launched their HIV policy. The Chamber of Commerce has launched a Business Coalition for HIV/AIDS. Twenty two business establishments in Belize signed as members of the Coalition with the goal of creating their own HIV/AIDS policies to spread the message against discrimination, educate employers of the rights of their employees and adopting HIV/AIDS education programs within the workplace. To date, 24 of these establishments have met their targets. The Office of Governance has also completed the HIV Policy for the Public Service Sector policy while the Ministry of Education is in the process of formulating its policy for the Education Sector. The NAC is also encouraging the NGO and Civil Society agencies actively engaged in the response to adopt this policy as well. To date, the AAA and BEST have done so and will need to advocate for others to do the same. In 2009 the NAC through the Project entitled "Strengthening of Belize's Multi-Sectoral Response to HIV/AIDS" sponsored by the Global Fund to Fight AIDS, Tuberculosis and Malaria, conducted a full review of the legislation in Belize in an effort to identify legislative gaps in the Multi-sectoral Response and has developed draft legislation to address these gaps.

What are remaining challenges in this area:

One of the greatest challenges is to expedite this process as it has been drawn-out for many

years. Another challenge is to garner public support for the proposed legislation. This draft will then be forwarded to the Solicitor General before it is forwarded to Cabinet for introduction as Law.

4. Has the country identified specific needs for HIV prevention programmes?

Yes No

IF YES, how were these specific needs determined?

Based on the Situational Analysis of 2004 which guided the development of the NSP as well as through on-going consultations with stakeholders and donor agencies.

IF NO, how are HIV prevention programmes being scaled-up?

HIV prevention component	**The majority of people in need have access**		
	Agree	Don't Agree	N/A
Blood safety Agree	Agree	Don't Agree	N/A
Universal precautions in health care settings	Agree	Don't Agree	N/A
Prevention of mother-to-child transmission of HIV	Agree	Don't Agree	N/A
IEC* on risk reduction	Agree	Don't Agree	N/A
IEC* on stigma and discrimination reduction	Agree	Don't Agree	N/A
Condom promotion	Agree	Don't Agree	N/A
HIV testing and counselling	Agree	Don't Agree	N/A
Harm reduction for injecting drug users	Agree	Don't Agree	N/A
Risk reduction for men who have sex with men	Agree	Don't Agree	N/A
Risk reduction for sex workers	Agree	Don't Agree	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	Agree	Don't Agree	N/A
School-based HIV education for young people	Agree	Don't Agree	N/A
HIV prevention for out-of-school young people	Agree	Don't Agree	N/A
HIV prevention in the workplace	Agree	Don't Agree	N/A
Other: *[write in]*	Agree	Don't Agree	N/A

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2009?	
2009 Very poor	Excellent

0	1	2	3	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

Studies conducted by the Pan American Social Marketing Organization show that condom usage has increased while preliminary figures from the Ministry of Health show that the number of new infections continue to decline. The PMTCT program continues to record high levels of success and has been successfully sustained during the past 2 years. The VCT Program of the Ministry of Health also reports that more persons are being tested voluntarily.

What are remaining challenges in this area:

There seems to be complacency among the general population particularly in regards to cases decline. Base-line data on MARPS is still lacking specifically disaggregated by population therefore it's difficult to determine how if there are pockets of higher prevalence and don't know what the obstacles are or if there are obstacles to practice. Thus the lack of evidence-based planning for these populations continues to pose a major challenge.

IV TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes No

1.1 ***IF YES***, does it address barriers for women?

Yes No

1.2 ***IF YES***, does it address barriers for most-at-risk populations?

Yes No

2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes No

IF YES, how were these determined?

These HIV treatment, care and support services needs have been determined by programme managers within the Ministry of Health. Additionally, these needs have also been identified through consultation processes with clinician as well as by using a needs-based approach. The

Ministry works very closely with the Pan American Health Organization which evaluates existing programs and makes recommendations for improvements within the areas of treatment, care and support services. The Ministry of Health has also applied experiences learnt from of other countries, for example, the establishment of VCT sites and the PMTCT programmes which have both proven to be effective prevention programmes in Belize.

IF NO, how are HIV treatment, care and support services being scaled-up?

2.1 To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	**The majority of people in need have access**		
Antiretroviral therapy	Agree	Don't Agree	N/A
Nutritional care	Agree	Don't Agree	N/A
Paediatric AIDS treatment	Agree	Don't Agree	N/A
Sexually transmitted infection management	Agree	Don't Agree	N/A
Psychosocial support for people living with HIV	Agree	Don't Agree	N/A
Home-based care	Agree	Don't Agree	N/A
Palliative care and treatment of common	Agree	Don't Agree	N/A
HIV testing and counselling for TB patients	Agree	Don't Agree	N/A
TB screening for HIV-infected people	Agree	Don't Agree	N/A
TB preventive therapy for HIV-infected people	Agree	Don't Agree	N/A
TB infection control in HIV treatment and care	Agree	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	Agree	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree	Don't Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	Don't Agree	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't Agree	N/A
Other: *[write in]*	Agree	Don't Agree	N/A

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes No

4. Does the country have access to *regional* procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?

Yes No

IF YES, for which commodities?: *[write in]* ***ARVS and condoms***

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 8 9 10
Since 2007, what have been key achievements in this area: During the past 2 years there have been key achievements in the area of HIV treatment, care and support. There has been scale up in the availability and access to antiretroviral as the number of persons being reached and geographic spread has improved significantly. Additional accomplishments since 2007 include no “stock-out” of ARVs and expansion ARV treatment sites. There has also been an expansion in the number of VCT testing sites. This includes the introduction of provider initiated testing and counselling (PITC) at all public health clinics (43 sites). More clinicians have also been trained in HIV management. In the area of M&E, a full-time post has been incorporated within the National Programme. There is also better use of an electronic health record country-wide (Belize Health Information System with incorporation of HIV/AIDS module). There is now a functional electronic system for monitoring and following up with patients. The involvement of FBOs and CBOs in reaching specific populations with care and support has also contributed to a scale up in the provision of care and support programs. Existing protocols have been updated while new guidelines for partner notification have been introduced. Another major accomplishment in this area is the expansion of second line treatment for paediatric cases. What are remaining challenges in this area: Challenges which still persist include a lack of consistent data on adherence and need to go beyond accessing medication to whether the medications are actually being properly and consistently used. There is also the need for training to ensure that integration in primary health care services will not reduce quality of counselling and care. Another challenge includes the lack of adequate laboratory services in general including re-agents. There is still not comprehensive package of support services for patients as psychosocial support and home-based care and minimal to non-existent.

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

YES	NO	N/A

5.1 ***IF YES***, is there an operational definition for orphans and vulnerable children in the country?

Yes No

5.2 ***IF YES***, does the country have a national action plan specifically for orphans and vulnerable children?

Yes No

5.3 ***IF YES***, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes No

IF YES, what percentage of orphans and vulnerable children is being reached?

% [write in]

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 8 9 10
Since 2007, what have been key achievements in this area: There is assistance provided through Ministry of Human Development through its human services department which places children within the Children's Home as well as manages a Foster home program. There are protocols in place at this level which allow families which are affected to access this program. Legislative change also envisions increased access to education and other services to OVCs. The Ministry of Health has also secured a budget for paediatric ARVs. *What are remaining challenges in this area:* One major challenge in this area is that only one agency (Hand in Hands Ministries) is primarily

focused on this population.

V. MONITORING AND EVALUATION

Monitoring and Evaluation section: Monitoring and Evaluations officers of the National AIDS Commission and Ministry of Health, HIV focal points of other ministries, the national monitoring and evaluation sub-committee members.

1. Does the country have *one* national Monitoring and Evaluation (M&E) plan?

YES	IN PROGRESS	NO

IF NO, briefly describe the challenges:

1.1 ***IF YES***, years covered: **2006-2011**

1.2 ***IF YES***, was the M&E plan endorsed by key partners in M&E?

Yes No

1.3 ***IF YES***, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes No

1.4 ***IF YES***, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, most partners	Yes, but only some partners	NO

IF YES, but only some partners or IF NO, briefly describe what the issues are: The Monitoring and Evaluation Plan has just recently been completed thus there is need to train and familiarize partners on the use of the indicators. There is also a level of lack of involvement from some partners in the area of M&E. Most of the reporting is based on funding requirements rather than to provide evidence for further planning.

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy	Yes	No
IF YES, does it address:		
routine programme monitoring	Yes	No
behavioural surveys	Yes	No

HIV surveillance Evaluation / research studies	Yes Yes	No No
a well-defined standardised set of indicators	Yes	No
guidelines on tools for data collection	Yes	No
a strategy for assessing data quality (i.e., validity, reliability)	Yes	No
a data analysis strategy	Yes	No
a data dissemination and use strategy	Yes	No

3. Is there a budget for implementation of the M&E plan?

Yes In progress No

3.1 ***IF YES***, what percentage of the total HIV programme funding is budgeted for M&E activities?
%

3.2 ***IF YES***, has *full* funding been secured?

Yes No

IF NO, briefly describe the challenges: There is lack of time and human resources at the Secretariat level as there is only one M&E Officer. The M&E plan was just recently completed and it has not been costed as yet.

3.3 ***IF YES***, are M&E expenditures being monitored?

Yes No

4. Are M&E priorities determined through a national M&E system assessment?

Yes No

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves: For the development of the M&E plan, identification of key indicators was based on reporting needs such as UNGASS, Universal Access and the MDGs development goals. Other indicators were identified at the program level and takes into account national indicators and recommendations made in the Capacity Project's Kanter Report (2006) Monitoring and Evaluation of HIV/AIDS Activities in Belize supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria

IF NO, briefly describe how priorities for M&E are determined:

5. Is there a functional national M&E Unit?

Yes	In Progress	No

IF NO, what are the main obstacles to establishing a functional M&E Unit? There is an M&E Officer with responsibility for coordinating the implementation of the Monitoring &Evaluation Plan. There are no resources available or identified to further staff the M&E Unit.

5.1 ***IF YES***, is the national M&E Unit based

In the National AIDS Commission (or equivalent)?	Yes	No
In the Ministry of Health?	Yes	No
Elsewhere? *[write in]*	Yes	No

5.2 ***IF YES***, how many and what type of professional staff are working in the national M&E Unit?

Number of permanent staff:		
Position: ***M&E Officer***	Full time / Part time?	Since when? **Nov. 08**
Position: *[write in]*	Full time / Part time?	Since when?
Number of temporary staff:		
Position: *[write in]*	Full time / Part time?	Since when?
Position: *[write in]*	Full time / Part time?	Since when?

5.3 ***IF YES***, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes No

IF YES, briefly describe the data-sharing mechanisms: What are the major challenges? The M&E Plan has just recently been completed and the NAC is still in the process of training partners and other key stakeholders

6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No	Yes, but meets irregularly	Yes, meets regularly

IF YES, briefly describe who the representatives from civil society are and what their role is: The M&E Committee is made up of 7 members of which 3 represent civil society organizations. The Chairperson of this committee is a representative of a civil society organization based in rural Belize.

7. Is there a central national database with HIV- related data?

Yes No

7.1 ***IF YES***, briefly describe the national database and who manages it *[write in]*

7.2 ***IF YES***, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

a. Yes, all of the above
b. Yes, but only some of the above: *[write in]*
c. No, none of the above

7.3 Is there a functional* Health Information System?

At national level	Yes	No
At sub-national level	Yes	No

*(*regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analysed and used at different levels)*

8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?

Yes No

9. To what extent are M&E data used

9.1 In developing / revising the national AIDS strategy?

Low High
0 1 2 3 4 5

Provide a specific example:

What are the main challenges, if any? The M&E plan has just recently been completed. The M&E system is yet to be formalized.

9.2 For resource allocation?

Low High

0 1 2 3 4 5

Provide a specific example:

What are the main challenges, if any? Same as above

9.3 For programme improvement?

Low High

0 1 2 3 4 5

Provide a specific c example:

What are the main challenges, if any? Same as above

10. Is there a plan for increasing human capacity in M&E at national, sub-national and service-delivery levels?

a. Yes, at all levels
b. Yes, but only addressing some levels: *[write in]*
c. No

10.1 In the last year, was training in M&E conducted

At national level?	Yes	
IF YES, Number trained: *[write in]*	5	
At sub-national level?	No	
IF YES, Number trained: *[write in]*		
At service delivery level including civil society?	Yes	
IF YES, Number trained: *[write in]*	30	

10.2 Were other M&E capacity-building activities conducted other than training?

Yes No

IF YES, describe what types of activities: *[write in]*

Overall, how would you rate the M&E efforts of the HIV Programme in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 8 9 10
Since 2007, what have been key achievements in this area: One of the key achievements in the area of M&E in Belize includes the development of the country's M&E plan which did not exist 2 years ago. The purpose of the M&E plan is to guide, within the framework of the NSP of Belize 2006-2011, in accordance with the UNAIDS Three Ones principle and other international commitments, the core M&E activities to be implemented as a part of the national response to the HIV/AIDS epidemic, providing strategic information on the progress of program implementation and accomplishments, measuring the impact of interventions taken, and enabling the timely and opportune identification of problems for decision making and program planning. Another accomplishment is the re-activation of M&E committee which has started discussions on conducting surveys and collection of data which is vital for planning especially for MARPS and vulnerable population. The Global Fund project contributed significantly to increasing accountability and use of verifiable data which has resulted in more systematic M&E through the creation of an M&E system rather than just answering specific reports indicators. *The NAC has also s*tarted to modify the Development Information (DevInfo.) system which includes a completed template that has been customized to the Belizean context. Other accomplishments included the contracting of an M&E Officer for the National AIDS Program of the Ministry of Health, an M&E Office at the NAC and training on the use of the DevInfo. Among key players such as the Ministry of Health, Statistic Institute of Belize, the Police Department and other partners. What are remaining challenges in this area: Lack of Human resources at the Secretariat as well as the agencies and Ministry's level continue to be a challenge. Lack of funding and M&E advocacy also pose barriers since establishing ownership on the part of stakeholders has proven difficult. In most instances partners report only to funders and do not prioritize reporting to the NAC which is the country coordinating and M&E mechanism.

Part B

[To be administered to representatives from civil society organizations, bilateral agencies, and UN organizations]

For Human Rights section:* officials from the Attorney General's Office, the Office of the Ombudsman and the Office of the Director of Public Prosecution, for questions in Part A; representatives of human rights and civil society organizations and legal aid centers/institutions working in the area of HIV for questions in Part B.

I. HUMAN RIGHTS

1. Does the country have laws and regulations that protect people living with HIV against discrimination? (Including both general non-discrimination provisions and provisions that specifically mention HIV, focus on schooling, housing, employment, health care etc.)

Yes No

1.1 ***IF YES***, specify if HIV is specifically mentioned and how or if this is a general non-discrimination provision: *[write in]*

2. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations and other vulnerable subpopulations?

Yes No

2.1 ***IF YES***, for which populations?

a. Women	YES	NO
b. Young people	YES	NO
c. Injecting drug users	YES	NO
d. Men who have sex with men	YES	NO
e. Sex Workers	YES	NO
f. Prison inmates	YES	NO
g. Migrants/mobile populations	YES	NO
h. Other:	YES	NO

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Briefly describe the content of these laws:

The Women' Department of the Ministry of Human Development serve as advocates for the enforcement of the Domestic Violence ACT which was revised in 2008 through client support, court and police advocacy. The Women's Department also accomplishes this through the training of women and sensitization and training of the public, police and magistracy. Working with the Police Department and the Family Court the Women's Department has embarked on training sessions to sensitize and educate on the psychosocial impact of Domestic Violence and the revised DV Act.

Briefly comment on the degree to which these laws are currently implemented:

Even though a larger number of women are seeking legal support for domestic violence, stigma and discrimination based on social and cultural attitudes and beliefs still pose a barrier for women to access or to follow-up on their cases. Thus, even though a law exists, some women prefer to not access this support due to social and economic conditions.

3. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations and other vulnerable subpopulations?

Yes No

3.1 ***IF YES***, for which subpopulations?

a. Women	YES	NO
b. Young people	YES	NO
c. Injecting drug users	YES	NO
d. Men who have sex with men	YES	NO
e. Sex Workers	YES	NO
f. Prison inmates	YES	NO
g. Migrants/mobile populations	YES	NO
h. Other:	YES	NO

IF YES, briefly describe the content of these laws, regulations or policies:

Even though there are policies, these are not being implemented. Barriers such as stigma and discrimination continue to pose a challenge to populations accessing services at the health centres. Accessibility of services is also made difficult due to transportation issues and the decentralization of services. There also exists an absence of special attention for women and an absence of consideration for a gender approach to services.

Young girls are affected by barriers due to age of consent to access prevention and treatment. Laws that govern educational curricula are not as open to the subject for age-appropriate sex education to young people at earliest age. In regards to migrants immigration laws prohibit the freedom of these persons. Their application for citizenship still requires an HIV test and persons who are found to be positive are refused entry into the country. In regards to MSMs – sodomy and buggery laws need to be repealed. The public health laws do not recognize the needs of vulnerable populations. Sex workers is not illegal in Belize but there is a need to work on legalizing it and making it legal for establishments to offer a place for this trade to take place in a controlled and safe environment Also in section 53 of the Criminal Code there is a specific consideration to sodomy act which is from a legal aspect an obstacle to effective prevention and intervention HIV work with men who have sex with men.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:

Even though the National HIV policy and HIV Policy for the World of Work are based on human rights principles in practice policy makers and key decision-makers have not been committed to develop human rights strategies.

The entire national policy which still lacks a legal framework and approaches to care treatment and support from a human rights standpoint. It stipulates that the rights of all humans will be respected at all levels within the health and education system. The challenge is to introduce and enforce HIV legislation that will ensure that these rights are truly respected.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most-at-risk populations and/or other vulnerable subpopulations?

Yes No

IF YES, briefly describe this mechanism:

There is no mechanism in place to record, document and address cases of discrimination. The Ministry of Health is in the process of establishing a complaint mechanism to monitor health care services. The purpose is to document and follow-up on complaints of persons accessing services. There is also an initiative on the part of civil society within the NGO community to draft a report format and establish a mechanism for redress especially in the case of HIV discrimination. This is being coordinated through the newly formed National Advocacy Working Group (NAWG).

6. Has the Government, through political and financial support, involved people living with HIV, most-at-risk populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?

Yes No

IF YES, describe some examples:

To some extent policy design at the national level has had the involvement of PLHIVs and MARPS. The NAC has also made efforts to involve the NGOs and CBOs sectors representing in

different discussions such as the national consultation for Legislative amendments and the development of the Global Fund Project Even though there have been some accomplishments some persons are of the opinion that the involvement of MARPS such as MSMs are merely done as a form of "tokenism" whereby these representatives are involved just because it is a requirement of the funders or reporting mechanisms. In most instances, the PLHIVs, MSMs and sex workers are present but do not truly understand the process because they have not been trained and informed properly to participate in an effective and significant manner.

7. Does the country have a policy of free services for the following?

a. HIV prevention services	YES	NO
b. Antiretroviral treatment	YES	NO
c. HIV-related care and support interventions	YES	NO

IF YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

In 2003, the government approved free ART for any person in need of it, but still some constraints such as lack of easy accessibility and stigma and discrimination are posing barriers for persons in need of accessing free ARVs.

8. Does the country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes No

8.1 In particular, does the country have a policy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes No

9. Does the country have a policy to ensure equal access for most-at-risk populations and/or other vulnerable subpopulations to HIV prevention, treatment, care and support?

Yes No

IF YES, briefly describe the content of this policy:

Even though the National Strategic plan mentions most-at-risk populations, the National Communication Strategy does not include interventions with men who have sex with men. Efforts undertaken with this population are fragmented and driven by NGOs interested in different populations. The policy doesn't specifically address the needs of the populations and strategies on how to reach them it merely makes mentions of these populations.

9.1 ***IF YES***, does this policy include different types of approaches to ensure equal access for different most-at-risk populations and/or other vulnerable sub-populations?

Yes No

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, and termination)?

Yes No

11. Does the country have a policy to ensure that HIV research protocols involving human subjects are reviewed and approved by a national/local ethical review committee?

Yes No

11.1 ***IF YES***, does the ethical review committee include representatives of civil society including people living with HIV?

Yes No

IF YES, describe the approach and effectiveness of this review committee:

12. Does the country have the following human rights monitoring and enforcement mechanisms?

– Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes No

– Focal points within governmental health and other departments to monitor HIV-related human rights abuses and HIV-related discrimination in areas such as housing and employment

Yes No

– Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes No

IF YES on any of the above questions, describe some examples: There is a focal point within the Ministry of Labour who is responsible for overseeing the implementation of the National Workplace Policy. This focal point is also responsible for addressing issues related to HIV-related discrimination in the workplace. The Ombudsperson's Office is also available to all persons who need mediation in situations where they have been abused. Watch dog organizations such as the NAC, Alliance Against AIDS, Women's Department, and National Women's Commission among others have the responsibility to advocate for and promote policies which stipulate non-discrimination.

13. In the last 2 years, have members of the judiciary (including labour courts/ employment tribunals) been trained or sensitized to HIV and human rights issues that may come up in the context of their work?

Yes No

14. Are the following legal support services available in the country?

– Legal aid systems for HIV casework

Yes No

– Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes No

– Programmes to educate, raise awareness among people living with HIV concerning their rights

Yes No

15. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes No

IF YES, what types of programmes?

Media	Yes	No
School education	Yes	No
Personalities regularly speaking out	Yes	No
Other: *[write in]* **Posters and billboards**	Yes	No

Overall, how would you rate the *policies, laws and regulations* in place to promote and protect human rights in relation to HIV in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 8 9 10
Since 2007, what have been key achievements in this area: Since 2007 there have been some important actions in the country, such as the Legislative review promoted by the NAC as well as the new workplace policies developed by the private sector and supported by the Ministry of Labour. The Alliance Against AIDS has also conducted human rights workshops specifically for PLHIVs and support groups across the country. AAA also developed a manual written by a PLHIV which includes a model to teach health care providers and PLHIVs the issue of stigma and discrimination. What are remaining challenges in this area: The HIV legislation continues to be drafted. This legislation is long over-due as it has been in draft form for the past 36 months. Another challenge is in developing a non discriminatory legal framework for MARPs and to incorporate human rights based approach to the national strategies and policies. Another outstanding challenge is the general lack of awareness in the population about HIV polices. Policies are in place but no implementation is happening for example, treatment of PLHIVs which is still affected by the stigma and discrimination which still exists.

Overall, how would you rate the efforts to enforce the existing *policies, regulations and laws and regulations* 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 8 9 10
Since 2007, what have been key achievements in this area: It is difficult to enforce the existing policies as many persons are unaware of these and there are also no laws to enforce them. What are remaining challenges in this area: The legislation agenda has been on table for too long. Even though there is a policy in place there is no legislation to enforce and enact these policies.

II. CIVIL SOCIETY PARTICIPATION

For Civil Society Participation section: key representatives of major civil society organizations working in the area of HIV These specifically include representatives from networks of people living with HIV and from most-at-risk and other vulnerable populations.

1. To what extent has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

Low					High
0	1	2	3	4	5

Comments and examples:
There needs to be much more involvement. The voices of representatives of civil society have been strong in calling attention to certain legislation as well as insisting that draft or the law is with a human rights approach. But, the legislation is still in draft form.

2. To what extent have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

Low					High
0	1	2	3	4	5

Comments and examples:

The NAC sub-committee include Policy and Legislation; Care and Treatment; Information-Education and Communication; Support Services; Community-based Response; and, Monitoring and Evaluation. The membership of these committees includes significant representation from civil society. Civil society representation at the NAC level has increased significantly as representatives also hold leadership posts within the NAC executive and sub-committees. Civil Society has been actively involved in consultation and planning sessions such as the development of the NSP, Global Fund Proposals, Legislative Review and the development of the National M&E Plan.

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in

a. The national AIDS strategy?

Low					High
0	1	2	3	4	5

b. The national AIDS budget?

Low					High
0	1	2	3	4	5

c. The national AIDS reports?

* Civil society includes among others: networks of people living with HIV; women's organizations; young people's organizations; faith-based organizations; AIDS service organizations; community-based organizations; organizations of key affected groups (including men who have sex with men, injecting drug users, sex workers, migrants, refugees/displaced populations, prisoners); workers organizations, human rights organizations; etc. For the purpose of the NCPI, the private sector is considered separately.

Comments and examples:
Involvement in consultations in the process of developing the UNGASS report as well as the Universal Access Report.

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?

c. M&E efforts at local level?

Comments and examples:
Civil society is well-represented on the M&E Committee and has been greatly involved in the consultation and planning process of developing the new M&E plan of the NSP.

5. To what extent is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. networks of people living with HIV, organizations of sex workers, faith-based organizations)?

Comments and examples:
There is only one representative of the Council of Churches on the Commission. NGOs that are dealing with poverty are not involved and those that are involved does not include those providing services for IDU. Key education and research institutions such as the University of Belize are also non-involved. A PLHIV is a part of the Commission and represents the network of PLHIVs in Belize.

6. To what extent is civil society able to access?

a. Adequate financial support to implement its HIV activities?

Low High

b. Adequate technical support to implement its HIV activities?

Low High

Comments and examples:
There is lack of human resources such as trained personnel and institutional leadership in coordinating M&E needs of the country

Network of women agencies, for example, need technical support on how to write proposals; socialize self locally and internationally; website design; and, communication strategies;

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for youth	<25%	25-50%	51–75%	>75%
Prevention for most-at-risk populations				
- Injecting drug users	<25%	25-50%	51-75%	>75%
- Men who have sex with men	<25%	25-50%	51-75%	>75%
- Sex workers	<25%	25-50%	51-75%	>75%
Testing and Counselling	<25%	25-50%	51–75%	>75%
Reduction of Stigma and Discrimination	<25%	25-50%	51–75%	>75%
Clinical services (ART/OI)*	<25%	25-50%	51–75%	>75%
Home-based care	<25%	25-50%	51–75%	>75%
OVCs		25-50%		

**ART = Antiretroviral Therapy; OI=Opportunistic infections*
***OVC = Orphans and other vulnerable children*

Overall, how would you rate the efforts to increase *civil society participation* in 2009?											
2009 Very poor										Excellent	
	0	1	2	3	4	5	6	7	8	9	10

Since 2007, what have been key achievements in this area:

The Global Fund process opened the door for civil society involvement especially with addressing the needs of MARPS. There has been an increase in capacity building for civil society in a number of areas such as: advocacy, stigma and discrimination; human rights; monitoring and evaluation; counselling; strengthening administration issues within NGOs; and, sexual health and sexuality. Civil society representatives are of the opinion that the NAC has made great strides in getting more NGOs and CBOs involved in different processes, such as the UNGASS report, legislative reform and development of the Round 9 Global Fund Proposal.

What are remaining challenges in this area:

One major challenge is the gap that exists in the areas of prevention amongst high risk populations. Due to a lack of epidemiological and behavioural data on this population it is difficult to engage in evidence based planning for this population. Baseline studies and research need to be carried out with MARPs, youths and women. This will increase the involvement of civil society organizations that are presently engaged in work with these populations. In addition to providing this support to civil society there is also the need for budgetary support as national funds provided to NGOs and CBOs are minimal to non-existent.

III. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes No

IF YES, how were these specific needs determined?

IF NO, how are HIV prevention programmes being scaled-up?

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	**The majority of people in need have access**		
Blood safety Agree	Agree	Don’t Agree	N/A
Universal precautions in health care settings	Agree	Don’t Agree	N/A
Prevention of mother-to-child transmission of	Agree	Don’t Agree	N/A

HIV			
IEC* on risk reduction	Agree	Don't Agree	N/A
IEC* on stigma and discrimination reduction	Agree	Don't Agree	N/A
Condom promotion	Agree	Don't Agree	N/A
HIV testing and counselling	Agree	Don't Agree	N/A
Harm reduction for injecting drug users	Agree	Don't Agree	N/A
Risk reduction for men who have sex with men	Agree	Don't Agree	N/A
Risk reduction for sex workers	Agree	Don't Agree	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	Agree	Don't Agree	N/A
School-based HIV education for young people	Agree	Don't Agree	N/A
HIV prevention for out-of-school young people	Agree	Don't Agree	N/A
HIV prevention in the workplace	Agree	Don't Agree	N/A
Other: *[write in]* ***Tourism***	Agree	Don't Agree	N/A

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 8 9 10
Since 2007, what have been key achievements in this area: Over the past two years there has been greater inclusion of civil society organizations such as Hand in Hand, Equity House and the Belize Family Life Association in the provision of VCT services especially in rural areas. Testing and counselling services and the Prevention of Mother to Child HIV Transmission have been scaled up with the support of the Global Fund. The Ministry of Education has ensured the inclusion of Sexual and Reproductive Health in HFLE primary school level while the Women's Department has increased its Gender Awareness Safe School Programme at the primary and secondary level across the country. *What are remaining challenges in this area:* One challenge that remains is the implementation of the Provider Initiated Testing and Counselling. Many prevention activities are being implemented but the impact can't be measured due to the lack of a functional monitoring and evaluation system at the national and agency level. The effective integration of the HIV services into the primary health services in

the country also continues to pose a challenge.

1. Has the country identified the specific needs for HIV treatment, care and support services?

Yes No

IF YES, how were these specific needs determined? Specific needs for HIV treatment, care and support services have been identified through evaluation and assessment conducted by the Pan American Health Organization and other UN agencies. PAHO conducts assessments on the Health Sector response to HIV and makes recommendations. Needs have also been identified through the Ministry of Health's internal assessments.

IF NO, how are HIV treatment, care and support services being scaled-up?

1.1 To what extent have HIV treatment, care and support services been implemented?

HIV treatment, care and support service	**The majority of people in need have access**		
Antiretroviral therapy	Agree	Don't Agree	N/A
Nutritional care	Agree	Don't Agree	N/A
Paediatric AIDS treatment	Agree	Don't Agree	N/A
Sexually transmitted infection management	Agree	Don't Agree	N/A
Psychosocial support for people living with HIV	Agree	Don't Agree	N/A
Home-based care	Agree	Don't Agree	N/A
Palliative care and treatment of common	Agree	Don't Agree	N/A
HIV testing and counselling for TB patients	Agree	Don't Agree	N/A
TB screening for HIV-infected people	Agree	Don't Agree	N/A
TB preventive therapy for HIV-infected people	Agree	Don't Agree	N/A
TB infection control in HIV treatment and care	Agree	Don't Agree	N/A
Co-trimoxazole prophylaxis in HIV-infected people	Agree	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree	Don't Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	Don't Agree	N/A
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't Agree	N/A
Other: *[write in]*	Agree	Don't Agree	N/A

Overall, how would you rate the efforts in the *implementation* of HIV treatment, care and support programmes in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 8 9 10
Since 2007, what have been key achievements in this area: During the past 2 years there have been key achievements in the area of HIV treatment, care and support. There has been scale up in the availability and access to antiretroviral as the number of persons being reached and geographic spread has improved significantly. Additional accomplishments since 2007 include no “stock-out” of ARVs and expansion ARV treatment sites. There has also been an expansion in the number of VCT testing sites. This includes the introduction of provider initiated testing and counselling (PITC) at all public health clinics (43 sites). More clinicians have also been trained in HIV management. In the area of M&E, a full-time post has been incorporated within the National Programme. There is also better use of an electronic health record country-wide (Belize Health Information System with incorporation of HIV/AIDS module). There is now a functional electronic system for monitoring and following up with patients. The involvement of FBOs and CBOs in reaching specific populations with care and support has also contributed to a scale up in the provision of care and support programs. Existing protocols have been updated while new guidelines for partner notification have been introduced. Another major accomplishment in this area is the expansion of second line treatment for paediatric cases. There is an increase in Post Exposure Prophylaxis packs and algorithms in the clinic across the country. The newly introduced protocol for PEP has been adapted from Center for Disease Control and UN System. What are remaining challenges in this area: ARVs are available but access in terms of providing services to where people live is a challenge. Services are not accessible due to issues of discrimination especially since stand-alone services still exist in country. This does not make the services accessible to populations that fear stigma and discrimination such as PLHIVs and MARPS. There is also no viral load machine available in country and CD4s are not done in a timely manner. There is still lack of a comprehensive package of support services which includes psychosocial support, nutrition and adherence counselling and home-based care.

2. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	No	N/A

2.1 ***IF YES***, is there an operational definition for orphans and vulnerable children in the country?

Yes No

2.2 ***IF YES***, does the country have a national action plan specifically for orphans and vulnerable children?

Yes No

2.3 ***IF YES***, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes No

IF YES, what percentage of orphans and vulnerable children is being reached?

Overall, how would you rate the efforts to *meet the HIV-related needs* of orphans and other vulnerable children in 2009?
2009 Very poor Excellent
0 1 2 3 4 5 6 7 8 9 10
Since 2007, what have been key achievements in this area: Since 2007 there has been an increase in HIV testing for HIV exposed children. Second line medication for paediatric cases has been introduced and protocols for the PMTCT have been revised. Civil Society organizations such as Hand in Hand have been involved in provision of support to OVCs during the past two years and have successfully advocated and collaborated with the Ministry of Health in providing paediatric ART as well as OIs to HIV positive children. This has resulted in better access to medications and adherence. HHM also provides nutritional support and educational sessions to caregivers in the homes. *What are remaining challenges in this area:* As the civil society is the entity providing support and care to vulnerable and orphan children, there are serious financial restrictions and thus, more financial support is needed in order to reach more people. Another challenge that remains is that HIV positive children receive ART but full support system is not in place, for example, in schools they still have to deal with discrimination. In some instances food and nutrition is not available within their homes. Another challenge is the lack of evidence-based planning and a functional M&E system.

SECTION I

Overview of the national health system and public policies in the fields of sexual and reproductive health and HIV/AIDS

SUGGESTED SOURCES Official documents and interviews with key informants

1. What are the main features of your country's health system? Is there universal access? Is it free-of-charge? Which health services does government provide and which does the citizen have to pay for?

The health system in Belize is a two-tier system, with both the public sector and the private sector providing services.

With respect to the public sector, primary care services are provided through health centres and health posts in rural areas. Secondary services are provided through community and regional hospitals. A wider range of services is provided at the 4 regional hospitals – for example, community hospitals do not provide full surgical facilities. There is one national referral hospital (Karl Heusner Memorial Hospital), located in Belize City. This institution provides tertiary level care and is the national referral hospital in Belize.

There are 7 public hospitals as well as 4 private hospitals in Belize. In urban areas, primary care services are provided through 10 polyclinics and health centres. In rural areas, these services are provided by 32 polyclinics, health centres and rural health posts.

The Ministry of Health operates under the principle that basic health care should be accessible to all without discrimination. With the exception of deliveries and C-Sections, primary health services are free in public facilities. Where fees are charged (as in the case of deliveries) these fees are waived if the individual is unable to pay.

There is a charge for secondary and tertiary services provided through Karl Heusner Memorial hospital, including a US$5 fee for specialist consultations and fees for diagnostic and pharmacy services. These fees, however, are significantly lower than those found at private hospitals and clinics.

In 2003, government introduced the National Health Insurance scheme (NHI) which provides a basic package of primary care services to the poorest areas of Belize, namely the Southern Health Region and the southern part of Belize City. A small user fee (US$1) is applied for some of these services. The Health Sector Reform Programme

2007-2011 proposes to roll out the NHI programme throughout the country.

In recent years, the private sector has increased in size and coverage, particularly in heavily urbanized areas. Government contracts with private institutions to provide some tertiary health care services.

While in principle, public health services in Belize are provided on the basis of equality of access, in practice there is a wide disparity in access to high quality, comprehensive services based on the ability to pay. In the past year, there have been several highly publicized cases of alleged negligence at district hospitals, including those resulting in infant deaths. Some secondary and tertiary services are not available through the public system, requiring people to use private facilities, or travel to Mexico, Guatemala or the United States for care. Pleas for financial donations to pay for medical services are a regular feature in the Belizean media.

2. Does policy on HIV/AIDS include a National Plan with clearly defined strategic actions?

Yes (Please, give a general outline of the Plan.) No

The *National AIDS Policy* was passed on 2006. The national plan is articulated in the *Strategic Plan for a Multi-Sectoral National Response to HIV/AIDS in Belize (2006-2011).* The National Strategy Matrix outlines proposed outcomes and activities in three priority areas: Harmonization, Prevention and Mitigation.

Under Priority Area I (Harmonization), proposed outcomes include:

→ Strengthen leadership role of the National AIDS Commission and District Committees

→ Strengthen coordination role of the NAC Secretariat

→ Improved evidence

→ Creation of a supportive environment

Under Priority Area II (Prevention), proposed outcomes include:

→ Reduced transmission rates among recipients of blood and children born to infected mothers

→ Reduced transmission rates in the general population with emphasis on youth (15-24)

→ Reduced prevalence among most-at-risk populations (MSM, CSW, prison population, uniformed services)

→ To improve utilization of other related prevention services.

Under Priority Area III (Mitigation), proposed outcomes include:

→ Improved effectiveness in integrated care, support and treatment

→ Improved policies and programs addressing reduction of socio-economic impact and infection

While the adoption of the plan was a positive step in the development of strategies to combat HIV/AIDS in Belize, it remains weak in several areas. In the area of mitigation, the plan does not sufficiently address the need for psychosocial support to infected persons. Also, strategies for the provision of home care are not adequately articulated.

In addition, the plan does not adequately address women's concerns. With the exception of specific inclusion of strategies to reduce mother to child transmission, women's needs as women are virtually invisible in the strategic matrix. In addition women's organizations have not been adequately engaged in implementation. The National AIDS Commission is planning to undertake a gender analysis of the plan which will hopefully begin to address this shortcoming.

Implementation of the plan continues to be a concern. Some programmes – such as the Ministry of Labour's workplace activities – are in danger of winding down as external funding ends. The National AIDS Commission needs to play a stronger role in mobilizing resources from both external sources and government. Civil society also needs to step up its efforts to hold government accountable for the implementation of the strategic plan.

3. Is there an official policy on sexual and reproductive health in the country?

Yes (Please, give a general outline of it.) No

The National Sexual and Reproductive Health Policy was established in 2002, and is manifested through the Sexual and Reproductive Health Plan of Action 2006 – 2010. The Plan of Action outlines activities to promote nine objectives:

1) Strengthen existing sexual and reproductive health programs and where needed develop and implement guidelines for the provision of integrated care for male and female adolescents in and out of schools, in urban and rural health facilities and eliminate discrimination against young pregnant women.

2) Increase the effectiveness of the Safe Motherhood Initiative implemented countrywide.

3) Contribute to the dissemination of information on reproductive and sexual rights with emphasis on free and informed reproductive choice.

4) Provide comprehensive legal, social and care services for the prevention of gender based violence and child abuse.

5) Increase males' participation in sexual and reproductive health services and rights issues.

6) Increase the prevention, early detection, management and control of the reproductive tract and breast cancer in males and females.

7) Ensure that the human right of women, including their reproductive rights are fully respected and protected, and enable women to realize those rights.

8) Implement and maintain a comprehensive, gender and culturally sensitive STI/HIV/AIDS programme as part of the SHR services that are accessible and affordable to rural and urban populations.

9) Have a Coordinating Committee overseeing the implementation of the SRH policy.

While the objectives are comprehensive, the Plan has suffered from objectives that are too generalized and vague. It was also somewhat unrealistic in that it assumed that stakeholders would be willing and able to implement wide-ranging activities outlined in the plan. In some cases, it is unclear who will take responsibility for implementation of specific activities. The Plan lacks focus and a clear sense of priorities, and it does not identify the resources necessary for implementation. Monitoring and evaluation of the plan has to date been weak, and there appears to be a significant gap between the broad objectives of the plan and implementation.

The Ministry of Health has been open to civil society input as the Plan is currently being reviewed with respect to the last year of implementation and the development of a new Plan of Action for the period after 2010.

4. Is there any specific public policy for confronting the issue of violence against women?

Yes (Please, give a general outline of them.) No

In 2009, the Women's Department of the Ministry of Human Development and Social Transformation developed a new *National Plan of Action on Gender-Based Violence, 2010-2012*. The Plan promotes a multi-sectoral approach to strengthen the response of the state and civil society to confront the issue of violence against women.

The Plan is organized around 4 goals with specific objectives for each. Goals 1 and 2 address call for zero-tolerance for gender-based violence and the provision of adequate services and support for survivors. Specific activities are designed to improve the response of the police and justice system, the health and social services sectors and civil society groups in providing an improved response. Goal 3 focuses on the reduction and ultimate elimination of gender-based violence. Specific activities are intended to reduce recidivism among perpetrators, increase public understanding of the roots of gender-based violence in a system of gender inequality and women's subordination, and encourage men to take greater responsibility for

understanding the roots of this violence and take action based on that understanding. Goal 4 aims to adequately measure the extent of gender-based violence in Belize and the effectiveness of strategies to respond to it. Activities promote adequate systems to capture reported cases of gender-based violence, a system to measure the incidence, frequency and severity of this violence, and enhanced monitoring and evaluation methods.

The Plan was released to the public in December 2009. In February 2010, representatives of the Women's Department met with CEOs of relevant Ministries to establish their support for the Plan. This was a necessary step in the process of establishing the Plan as official public policy.

Although the Plan provides a comprehensive approach to confronting the issue of violence against women and, if effectively implemented, should result in significant improvements in the situation for survivors of violence in Belize, there continue to be concerns about the ownership of the Plan by government and the extent to which each sector will take full responsibility for the implementation of activities within that sector. The attitude that the issue of violence against women is mainly, of not solely, the responsibility of an overburdened Women's Department persists. The Plan also lays out estimates of the resources necessary to implement activities and reach its objectives and states that adoption of the Plan should imply a commitment to identifying and making these resources available. Given the current economic climate and a legislative assembly that is exclusively men, the prospect of finding the resources necessary to carry out the plan remains uncertain at best. Finally, questions have been raised on whether civil society organizations currently have the capacity to carry out some key responsibilities under the Plan, particularly in the area of supporting the development of community based support and advocacy services for survivors across the country.

5. Are there sexual education programmes implanted in schools?

Yes (Please, give a general outline of them.) No

The Ministry of Education has a Health and Family Life Education (HFLE) curriculum which is a life skills programme with a sexual education component. However, the church-state system of education means that it is difficult to achieve a consistent approach in the implementation of the curriculum, since implementation is in the hands of different school managements. The curriculum includes a range of elements, and schools are selective in what they include in their classrooms. Treatment of sexuality is uneven. Even when these issues are addressed, more attention is often paid to the biological aspects than the psychological/emotional part of sexuality. There are reports that many teachers are uncomfortable with teaching matters related to sex and sexuality. The Anglican and Methodist Schools have implemented a specific HIV prevention curriculum.

6. Are there any sexual education programmes for boys, girls, adolescents and young people that are outside of the school system?

Yes (Please, give a general outline of them.) No

A number of civil society organizations (including the Red Cross, Belize Family Life Association, Youth Enhancement Services, etc.) do programmes and activities with young people in the community. These programmes are highly dependent on external funding. The government agency Youth for the Future also does some programming in this area.

Some faith-based organizations have initiated programmes that are life-skills based with a sexual health component. In most cases, these programmes focus on abstinence, although condom use may be mentioned.

While the availability of these programmes in urban areas is limited by resources, programmes in rural areas are severely lacking. Some civil society organizations do occasional activities in rural villages, but this is very limited. Furthermore, the cultural differences between urban and rural areas means that an approach needs to be developed and implemented in rural areas that is sensitive to those differences.

7. Is there any technical sub-division of the National AIDS Programme solely dedicated to questions involving women and HIV/AIDS?

Yes (Please, give a general outline of them.) No

There is currently no particular focus on women in the National AIDS Programme, and some data is not disaggregated by sex. The primary state response that targets women is in the PMTCT activities in the Maternal and Child Health programme.

8. Have polices been defined for controlling STDs?

Yes (Please, give a general outline of them.) No

While the Sexual and Reproductive Health Policy Plan of Action gives one objective as "to implement and maintain a comprehensive, gender and culturally sensitive STI/HIV/AIDS programme as part of the SRH services that are accessible and affordable to rural and urban populations", the policy lacks focus and does not give details of specific targets or activities to deal with the control of STDs. There is no systematic government campaign for prevention of STDs.

9. What is the country's national policy on abortion? Is there any statistical data from polls revealing public opinion in regard to the right of HIV-infected women to interrupt a pregnancy?

Abortion is an offence under the Criminal Code, with a maximum penalty of 14 years for carrying out an abortion. The Criminal Code does allow for abortions on the recommendation of 2 medical practitioners on specific grounds including risk to life, injury to physical or mental health of the woman or existing children, or the presence of physical or mental abnormalities resulting in severe handicap. In practice, however, this provision is interpreted extremely conservatively, and virtually no legal abortions are performed.

A related policy is that all public health facilities provide post abortion care, including for those terminations that are not carried out in those health facilities.

There is no information available from polls regarding the right of HIV-infected women to interrupt a pregnancy, nor has this issue been aired in the media or other public discourse. Abortion is a largely taboo subject, with public attitudes significantly influenced by religious prohibition.

10. What are the main social-cultural characteristics (beliefs, religions) of your country that interfere in the effective control of HIV?

Stigma and discrimination continue to exert powerful influence in Belizean society. Some specific social-cultural beliefs that interfere in the response to HIV include:

→ Religious beliefs that are opposed to pre-marital sex and adolescent sexuality create problems for many programmes directed at young people. This includes limiting what information is taught in schools managed by some religious denominations.

→ The belief that young people do not have an independent right to access sexual and reproductive health services means that by law parental consent is required for individuals under 18 to receive services.

→ Religious beliefs also lead to prohibitions on condom usage (and hence to education about condom usage) in some faith based organizations.

→ Attitudes that maintain gender discrimination and women's subordination persist. The imbalance in power relationships between women and men significantly impacts women's ability to negotiate safe sex. Studies have also found that significant numbers of women (and probably even greater numbers of men) believe that women do not have the right to deny sex to their husbands.

→ There is a high degree of acceptance of the sexual exploitation of girls and young women by older men, putting these girls and young women at serious risk.

→ Transactional sex is also widely accepted, in particular where girls and young women provide sex to older men in exchange for money, gifts, school fees, etc. In some cases, the families of these girls condone or even encourage this activity.

→ There is a widespread belief that women who are HIV positive should not procreate.

→ There are deeply held, discriminatory attitudes concerning who is responsible for HIV infection and who is spreading it. For example, the idea that HIV is a "gay disease" persists among many people. This attitude is both created by and sustains homophobia in Belize.

→ Related to the above is the religious idea that HIV is a punishment and as a result those who are infected deserve it.

11. What percentage of national budget allocations are dedicated to sexual and reproductive health and combating HIV in your country? Has there been any increase in the amount or a reduction?

No calculation of the percentage of the national budget dedicated to sexual and reproductive health and combating HIV has yet been made. This figure is not easily accessible as activities in this area are spread through various ministries, departments and programmes, and some activities are covered through line items that are not explicitly for HIV/AIDS work. The budget of the National AIDS Programme in the Ministry of Health (2009-2010 fiscal year) is US$554,873, with 63.1% of this amount allocated to medical supplies. The National AIDS Commission is currently carrying out an activity to assess the percentage of government expenditures allocated to combating HIV.

N.B.: PLEASE REGISTER THE SOURCES YOU CONSULTED THAT ENABLED YOU TO ANWER THE QUESTIONS

1) Documents

Griffith, Kendra, *Report on III UNGASS Forum Belize: Monitoring UNGASS-AIDS Goals in Sexual and Reproductive Health* (Belize) September 2009

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

National AIDS Commission, *National AIDS Policy* (Belize) 2006

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

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

Ministry of Health, *Belize Basic Indicators 2008*

Ministry of Health, *National HIV/AIDS Epidemiological Profile 2003-2007*

Ministry of Health, *Sexual and Reproductive Health Policy, Plan of Action 2006-2010*

National Advocacy Working Group (NAWG), Comments on the *Sexual and Reproductive Health Policy, Plan of Action 2006-2010*, unpublished document, 2009

National Advocacy Working Group (NAWG), *Client Satisfaction Survey with Users of Five VCT locations of the Ministry of Health in Belize City, Orange Walk, Cayo and Dangriga*, unpublished document, 2010

National Health Information and Surveillance Unit, *HIV/AIDS Surveillance in Belize, Annual Report 2008*, Ministry of Health (Belize)

National Health Information and Surveillance Unit, *HIV/AIDS Surveillance in Belize, First, Second and Third Quarter Reports, 2009*, Ministry of Health (Belize)

Pan American Health Organization (PAHO/WHO), *HIV and Violence Against Women in Belize, Preliminary Report* (Belize) 2009

Sebastian, Sean, 2009 Sexual Behaviour Survey Report, second draft, unpublished document for the National AIDS Commission (Belize)

Women's Department, *The National Plan of Action on Gender-Based Violence (proposed)* (Belize) 2009

2) Information Gathering Workshop for the UNGASS Civil Society Report

March 10, 2010 (full day workshop)

Participants and Organizations:

Rodel Beltran Perera	Alliance Against AIDS
Stephanie Flowers	Alliance Against AIDS
Edna Novelo	Alliance Against AIDS
Veda Sanchez	Alliance Against AIDS
Melanie Montero	Belize Family Life Association
Ana Reyes	Belize Family Life Association
Louigie Gomez	Belize Red Cross Society
Caroline Ely	Methodist Church
Hertha Gentle	Ministry of Labour

Melissa Sobers	National AIDS Commission
Martha Carrillo	Training on Demand (consultant)
Derrick Flowers	United Belize Advocacy Movement (UNIBAM)
Caleb Orosco	United Belize Advocacy Movement (UNIBAM)
Shelmadine Cacho	Women's Issues Network of Belize (WIN-Belize)
Katie McFarland	Women's Issues Network of Belize (WIN-Belize)
Karen Cain	Youth Enhancement Services (YES)
Maggie Patchett	Youth Enhancement Services/ Methodist Church
Earleth Reneau	Youth Enhancement Services

3) Telephone interviews

Dr. Natalia Beer	Maternal and Child Health Programme, Ministry of Health
Dr. Marvin Manzanero	National AIDS Programme, Ministry of Health
Michelle Vanzie	Acting Director, Policy and Planning, Ministry of health
Michelle Irving	Productive Organization for Women in Action (POWA)

4) Telephone follow-up to information gathering workshops

Ana Reyes	Belize Family Life Association
Rodel Beltran Perera	Alliance Against AIDS
Melissa Sobers	National AIDS Commission

SECTION II

Sexual and Reproductive Health Services Offer

[I] EDUCATION, INFORMATION, COMMUNICATION IN SEXUAL AND REPRODUCTIVE HEALTH

1. What are the main elements of prevention directed at the sexual and reproductive health of women, young people and adolescents included in the National HIV/AIDS Policy?

A) Basic contents of the messages:

While the messages are not explicitly included in the HIV/AIDS Policy, the primary government-sponsored campaigns that have been carried out in the past two years include:

→ Know your status (Ministry of Health)

→ Use a condom (Ministry of Labour, Ministry of Health, and Ministry of Human Development)

→ Prevention of Mother to Child Transmission (Ministry of Health)

→ ABC: Abstinence, Be Faithful, Condom (Ministry of Education/HFLE)

B) Most-used media and strategies:

Government uses a variety of media strategies, including broadcast (radio/TV) and print media as well as posters, brochures and other materials. Health fairs and outreach tables are also used.

C) Promotion, availability and distribution of condoms:

Free condoms are generally available through the Ministry of Health as well as NGOs such as Belize Family Life Association. These condoms have been provided primarily through UNFPA. While both male and female condoms are available, female condoms are generally underutilized because of misconceptions about and discomfort with the use of these. Accessibility of both male and female condoms is more problematic in rural areas.

D) Inclusion of civil society in the process of planning actions:

For the most part, inclusion of civil society in planning is not effective. Civil society organizations have generally not been invited to participate in the planning stages of campaigns and activities.

E) Inclusion of civil society in the implementation of activities:

There is occasional inclusion of civil society in the implementation of activities, but this is limited. There is no regular mechanism for the involvement of civil society in either the development or implementation of government-run activities.

2. How would you assess the actions in the field of HIV prevention directed at women, young people and adolescents?

With the exception of the Prevention of Mother to Child Transmission programme, most government-run activities on HIV prevention have lacked a particular focus on women. Most activities that have been directed toward women have been developed and implemented by civil society organizations, and these have been highly dependent on the availability of resources.

In the area of the programmes for young people and adolescents, a major problem has been that programmes are often developed and implemented without involvement from young people themselves. As a result, young people feel little ownership or investment in the programmes, and the activities offered may or may not address the needs and interests of the young people they are intended to serve.

For both women and young people, the situation is particularly difficult in rural areas. While basic information and services are provided through rural health posts, there is little sustained programming in rural villages that addresses the social and cultural issues that are critical to HIV prevention. Furthermore, these villages sometimes do not have access to media used in educational campaigns (television, for example) and language barriers sometimes prevent access to information (particularly for older women).

3. Are there any STD statistics for women young people and adolescents or national campaigns on STDs directed specifically at them? Please comment.

Yes	**No**

There are no prevention campaigns on STDs, and in particular no campaigns directed specifically toward women, young people and adolescents.

A major problem for young people is the legal requirement that individuals under the age of 18 must have parental consent to access sexual and reproductive health services, including treatment for STDs. Young people find themselves turned away from medical facilities and as a result often self-diagnose and access the most common medication from private pharmacies. In instances where this medication does not provide relief, infections may have become worse by the time the individual is able to access treatment.

4. How is the issue of inequality (of gender, race/ethnic group, social class) approached in the educative programmes run by the government for prevention of STDs?

Since there are virtually no government sponsored education programmes on the prevention of STDs, it is difficult to answer this question. Overall, government education programmes have not generally acknowledged issues of inequality based on gender, ethnicity and social class.

5. Are health service staff adequately trained and prepared to offer effective counselling on prevention specifically for women, young people and adolescents? Please comment.

Yes	**No**

Questions such as this are often difficult to answer with a simple “yes” or “no” answer. Some training has taken place, and Belize Family Life Association has provided training in sexual and reproductive health issues for public health nurses and nurses aides at the request of the Ministry of Health. Given that BFLA has many years of experience working with women and young people, and given their commitment to mainstreaming such issues as sexual diversity into their work, there is no doubt that this training will support health service staff to be more effective in counselling women, young people and adolescents. At the same time, there is a significant way to go before it can be said that health service staff are “adequately” trained in this area.

6. Are there any government initiatives underway to provide capacity building in such counselling for health teams? Please comment.

Yes	No

As noted above, the Ministry of Health has enlisted Belize Family Life Association in providing some training for public health nurses and nurse’s aides. Through the National AIDS Programme, nurses were trained abroad in Provide Initiated Testing and Counselling, and the replication of this training in country started in December 2009.

7. Has there been any discussion of male circumcision as a preventive measure in your country? In what terms?

Yes	No (selected)

8. Are there any campaigns, policies or programmes designed to stimulate prevention against HIV directed at the male heterosexual population?

Yes (selected)	No

The government sponsored "Know your status" media campaign included this group. In addition, the "Masculinity" media campaign done by PASMO (Pan American Social Marketing Organization) showed men questioning traditional ideas of manhood to promote greater responsibility among men.

9. Is there any investigation underway into alternative forms of prevention for women (e.g. new designs of female condoms, micro-biocides and others)?

Yes	No (selected)

10. Are there any programmes or actions in sexual and reproductive health or prevention of HIV directed specifically at women belonging to ethnic minorities?

Yes (selected)	No

The Toledo Maya Women's Council (TMWC) conducts a "Healthy Mother, Healthy Baby" educational programme in villages in the Toledo district. The Cacao Growers Association, also working in Maya villages in Toledo, includes women in their work on HIV prevention. TOLCA (Programme for Toledo Children and Adolescents) does sexual and reproductive health workshops with children and adolescents in the Toledo district.

The Pan American Social Marketing Organization (PASMO) has done some programmes for both men and women in Garifuna communities. The Productive Organization for Women in Action (POWA) has also done outreach to women in Garifuna communities.

II] SEXUAL AND REPRODUCTIVE HEALTH CARE

1. Is HIV testing available and accessible to all women throughout the country?

Yes (selected)	No

Voluntary counselling and testing (VCT) sites have been established in all districts. The Ministry of Health operates 8 VCT testing sites and Belize Family Life Association also operates 8 sites. In the past two years, increased access to rapid testing at rural health centres has also been established by the Ministry of Health, through the provision of a centrifuge and rapid testing materials. Testing is also carried out at private hospitals.

All pregnant women attending prenatal clinics are counselled and offered voluntary testing. Almost all of these women (99%) agree to be tested. The incidence rate among this group is .68% and the prevalence rate is .9%. Women who use traditional birth attendants do not have access to this testing.

2. Is HIV testing available in maternity hospitals and maternity wards?

Yes No

Women are generally tested when attending prenatal clinics so that the woman's status is usually known before she attends the hospital. However, if a doctor suspects that a woman is HIV positive when coming to give birth, s/he may conduct a test with the woman's consent.

3. Is good quality counselling associated to all HIV testing carried out in the sphere of the antenatal services?

Yes No

All pregnant women attending pre-natal clinics receive counselling and voluntary testing for HIV. Almost all of these women agree to be tested, and 100% of HIV positive mothers receive appropriate treatment during pregnancy and at childbirth. There is general agreement that the Prevention of Mother to Child Transmission Programme (PMCTC) has been a successful part of programming to combat HIV in Belize. At the same time, there is still the need to strengthen the counselling component of the programme.

4. Is there any nutritional support provided to pregnant women with HIV infections? How is the distribution of nutritional support carried out?

Yes **No**

Pregnant women do receive vitamins and mineral supplements.

5. Is anti HIV prophylaxis at the moment of birth available and accessible throughout the country?

Yes	No

In 2009, through the Prevention of Mother to Child Transmission programme (PMCTC) in medical facilities, 100% of HIV positive mothers and 100% of exposed infants receive ARVs at childbirth. It is generally recognized that the PMCTC programme has been very successful at reducing the incidence of vertical transmission in Belize.

Two groups are currently excluded: women who give birth with traditional birth attendants and women who become infected during pregnancy and/or who are tested during the window period. In 2009, all vertical transmission in Belize involves mothers from these two groups.

6. Is formula milk substitute for the children of HIV infected mothers easily available and readily accessible throughout the country?

Yes	No

Formula milk substitute is provided for HIV positive mothers for 10 months after childbirth.

7. Do the public and private services that deal with pregnant women offer them information, counselling and anti-HIV testing?

Yes	No

Through the Prevention of Mother to Child Transmission programme, services dealing with pregnant women offer all of the above, as well as access to ARV therapy for the mother and the infant at childbirth.

One problem, however, is the need for "one-stop" access to these services for pregnant women. In some locations, women going to the MCH clinic must then go to the VCT Centre for their HIV test and counselling. Even when these services are in the same hospital, women may feel "passed around". A more holistic approach to providing these and other services would provide a more supportive environment for women.

8. In the case of sero-positive pregnant women, is treatment offered to reduce the risk of transmission of HIV from mother to child during pregnancy? Is any psycho-social support made available?

Yes	No

While treatment is available, psycho-social support is limited in public facilities and does not occur in private facilities.

9. What orientation has been given to women infected with HIV in regard to the question of contraception?

In public facilities, women are informed about the health effects of future pregnancies and HIV. Free contraceptives are available to HIV positive women through the government with the support of UNFPA. However, this programme is not well-publicized, nor is it available in private facilities.

More attention needs to be place on ensuring that HIV positive women are fully aware of the consequences of multiple pregnancies and that they have the means to reduce the number of pregnancies if they chose.

10. Is there any form of encouragement given for women to undergo sterilization? (Are there any reports of such encouragement?)

Yes	No

Sterilization is neither encouraged nor promoted. Women are discouraged from considering sterilization.

11. Is emergency contraception readily available and accessible throughout the country?

Yes	No

Emergency contraception is available at private pharmacies but it is not publicized due to concerns that women will “abuse” it.

12. Are there any specific programmes or actions designed to protect the sexual and reproductive health of women living with HIV/AIDS?

Yes	**No**

13. Do women living with HIV have access to assisted reproduction services?

Yes	**No**

14. What advice is given to women living with HIV that wish to become pregnant?

Yes	No

Women who are HIV positive are strongly discouraged from becoming pregnant.

15. And in the case of sero-discordant—one is HIV positive—couples?

Couples in this situation are advised to use condoms to avoid infection of the other partner. If the woman is HIV positive, there are often problems in getting the man to be tested.

16. Are there any legal or traditional (informal, social-cultural) barriers that make it difficult for young women to obtain sexual and reproductive health care and ARV therapy should they prove necessary??

Yes	No

Under the legal age of consent (18 years), young people cannot access sexual and reproductive health services, including HIV testing and ARV therapy, without parental consent.

In the Garifuna culture, for example, women generally do not access contraceptives until after they have their first child. The rate of teenage pregnancy and STIs is high in these communities.

[III] THE CONFRONTATION OF VIOLENCE INFLICTED ON WOMEN:

1. Are the laws specifically designed to prevent violence against women, punish perpetrators and repair the harm done effectively complied with?

Yes	**No**

A new Domestic Violence Act came into effect in 2008, broadening the definition of "spouse" under the law, defining domestic violence as physical, psychological or emotional, sexual or financial abuse, and providing much stiffer penalties for breaches of protection orders and other orders under the act. However, implementation of the law remains uneven and often ineffective. The Chief Magistrate herself has said that the new law is "powerful" but that the lack of legal services for women limits their ability to use the law to its full potential. Protection orders are often not enforced and many women believe that most police officers will protect the men involved rather than enforce the law.

The situation for sexual offenses is even more serious. The response of the justice system to rape, sexual assault and sexual abuse reflects public attitudes that these crimes are trivial or petty matters. It is generally recognized that reporting rates are low. Attrition rates in the courts are high, in part due to the length of time that a case takes to come to trial – generally many months or even years.

2. Are there any specific actions underway against the sexual exploitation of girls and adolescents?

Yes (selected)	No

Laws addressing the Commercial Sexual Exploitation of Children have been "in the draft stage" for the past 3 years, but there is no indication of when they will be passed or implemented. The NGO Youth Enhancement Services (YES) has conducted an ongoing public awareness and advocacy campaign on the sexual exploitation of young women and girls since 2003. In 2007-2008, Youth Enhancement Services implemented a project on the commercial sexual exploitation of children and adolescents, including providing interventions for more than 100 children and training for the staff of the Department of Human Services with the objective that the Department would take responsibility for this work after the period of the project. However, no additional resources were made available by government for this work.

3. Are services in place throughout the country to provide care and address the needs of women and girl victims of violence and/or sexual violence? If the answer is Yes, are such services readily accessible?

Yes	**No** (selected)

Shelters for battered women have been established in only 2 of Belize's 6 districts – Haven House in the Belize District and Mary Open Doors in the Cayo District. Women's Development Officers (WDOs) from the Women's Department, Ministry of Human Development and Social Transformation, provide support and advocacy for battered women in all districts.

There are no specific services for women and girl victims of sexual violence. Where they are available, the shelters provide some response, as do a few NGOs such as POWA in the Stann Creek district. The Women's Department will also provide support to victims of sexual violence.

For girls and young women under 16 years of age, social workers from the Department of Human Services provide support for survivors of sexual abuse, especially for those cases that are going to court.

4. Are prophylaxis against HIV e STDs, emergency contraception and legal abortion made available in those services?

Yes	**No**

A 2008 policy of the Ministry of Health states that both prophylaxis against HIV and emergency contraception should be available at all hospitals. However, a December 2009 report from PAHO indicates that full implementation is pending. There are reports that these are available in some hospitals, especially in cases where the perpetrator of the offense is known to be HIV positive. Given the extremely conservative interpretation of the law in Belize, abortion is not made available to survivors of sexual violence.

5. Is there a public information system for gathering and publicising data concerning violence inflicted on women and girls?

Yes	No

The Ministry of Health has implemented a surveillance system to gather data on the incidence of gender-based violence. However, the system needs to be reviewed and strengthened, especially to ensure that all reported incidents are captured by the system. There is a need to expand the list of agencies that provide input to the system. Furthermore, the system is currently more successful at capturing incidents of domestic violence than sexual violence, so that particular attention is needed to address this concern.

6. Are national campaigns to combat violence against women and the sexual exploitation of girls carried out on a regular basis?

Yes (selected)	No

The Women's Department has implemented a number of campaigns in this area, especially on the issue of domestic violence. The NGO YES has carried out a campaign on sexual abuse and exploitation of young women and girls since 2003, and until 2009 the Women's Issues Network of Belize (WIN-Belize) had sponsored an annual Torch Run against gender based violence and HIV/AIDS. In all cases, campaigns have been dependent on the availability of resources, as evidenced by the cancellation of the 2009 Torch Run due to lack of financial support. At the same time, there is a commitment to sustained public awareness work on these issues. The Women's Department coordinates the annual 16 Days of Activism on Gender Based Violence campaign, with the participation of both public sector and civil society groups.

Over the past 10 to 15 years, there has been a weakening of the women's movement in Belize, with several important women's organizations disappearing (including the Belize Organization for Women and Development/BOWAND, the Belize Rural Women's Association/BRWA, and Women Against Violence/WAV). Since the mid-1990's there has been no NGO focusing on awareness and activism on violence against women issues in Belize. Attention needs to be given to strengthening the women's movement and women's organizations in Belize.

7. Are there any specific actions underway directed at suppressing trafficking in women?

Yes	No (selected)

There is an anti-trafficking committee, but to date it's efforts have been limited and have had little impact. A few raids have been planned, but "tip-offs" are suspected because when the raid happens, no evidence of trafficking is found.

Despite the fact that it is technically illegal, prostitution is generally known to exist in Belize, and even advertised in some cases. Women are brought in to work as "waitresses" in various facilities. There is a feeling that policies in the area of trafficking are hypocritical and cannot be trusted.

8. Are there any records of women living with HIV that suffered violence as a direct consequence of the revelation of their serum status?

Yes	No (selected)

While no incidents have been recorded, participants in the information gathering workshop providing input to this report believe that this does occur.

9. Has your government implanted any strategies to support boys and girls with HIV/AIDS and provide them with psychosocial care, education, shelter, nutrition, health services and guarantees of non-discrimination?

Yes No

Some support is available through the government's Ministry of Human Development, including counselling for these children. However, this support is not available through a specific entitlement for children with HIV/AIDS. Children access support through the general programme for children in need. This means that some children may receive assistance for education, for example, while others do not. Also, the process of vetting each case for eligibility can mean a delay in accessing support – up to a week for immediate needs and from 3 to 6 months for longer term support in some cases.

Civil society organizations such as Hand in Hand Ministries have provided some services. Hand in Hand works in Belize City/Belize District and is currently looking to expand its work to Dangriga (Stann Creek District). These two districts have been the hardest hit by the epidemic in Belize.

9.1. And in the case of orphans? **Yes** No

The situation for orphans is similar to that for children with HIV/AIDS. Some support is available through the Ministry of Human Development. NGOs such as Hand in Hand Ministries and the Liberty Foundation also provide support.

9.2. Are specific budget allocations made for such actions? Yes **No**

9.3. Which sphere of government is directly responsible for their implementation?

Ministry of Human Development and Social Transformation

Section III

Please answer these questions according to the information that has been given above:

1. Who are the main allies in promoting the sexual and reproductive health of women living with HIV/AIDS in your country?

NGOs with a specific interest in women's issues and those who have demonstrated their commitment to focusing attention on the particular needs of women with HIV/AIDS are the main allies in this cause. These include Belize Family Life Association, Alliance Against AIDS, Youth Enhancement Services, the YWCA, and the Productive Organization for Women in Action (POWA). All of these groups are members of the Women's Issues Network of Belize, which provides a forum for increased collaboration on this and other issues.

In the public sector, the Maternal and Child Health Programme in the Ministry of Health is a key ally. The director of this programme is also responsible for the Prevention of Mother to Child Transmission programme and for the development and implementation of the Ministry of Health's Sexual and Reproductive Health Policy.

2. What are the principal windows of opportunity for prevention of the epidemic among women?

Important opportunities that should be pursued include:

→ *Inclusion of HIV prevention in the context of sexuality education in the secondary school curriculum*. This strategy must also include training and other activities to ensure that this aspect of the curriculum is implemented consistently across all school managements.

→ *Strengthening of programmes for out-of-school youths, and especially for out-of-school young women, that include education on sexuality and HIV prevention*. Particular attention should be paid to programmes for teenage mothers and for young women and girls who are survivors of or at risk for sexual abuse and exploitation.

→ *Development of strategies that recognize victims of violence against women as particularly vulnerable to infection*. There is an urgent need to integrate this recognition into national plans for HIV prevention and to support practical measures to reach women who are victims of violence.

→ *Enhanced education provided through Maternal and Child Health Clinics*. Increased attention should also be put on education for the partners of women attending the clinics.

3. What are the main obstacles and drawbacks to the integration of actions designed to promote Sexual and Reproductive Health, prevent HIV/AIDS and confront violence against women, in regard to official policies on AIDS and official policies for women?

Some of the obstacles and drawbacks include:

→ *Insufficient financial support from government*. In tight economic times, increasing financial support to these areas is extremely difficult. Competing financial priorities often find women's concerns low on the list, and resources lost due to corruption shrink the pool of funds available. The fact that the Legislative Assembly is composed exclusively of men makes it even more difficult to get support for women's concerns.

→ *Policies in areas such as sexual and reproductive health and violence against women that are motivated by pressure and/or funding from international agencies*. This means that there is often little political will to follow through with effective implementation and monitoring.

→ *Lack of expertise in the public sector on these issues*. This lack of expertise (combined with the above mentioned lack of political will) means that public sector action tends to fall on a few overburdened individuals and programmes within the government – for example, the Women's Department and the Maternal and Child Health Programme.

→ *Programmes developed from the top down rather than bottom up*. Programme development generally does not engage target groups such as women, youth or rural communities in determining how best to deliver services and educational programmes.

→ *Policy makers who are barriers themselves because of ingrained attitudes about women*. It is widely believed that many policy makers in Belize have attitudes and practices that reflect gender discrimination and the subordination of women. These individual attitudes and practices undoubtedly affect their approach to setting priorities in government.

4. What are the main obstacles and drawbacks to the integration of actions designed to promote Sexual and Reproductive Health, prevent HIV/AIDS and confront violence against women, in regard to the articulation of the various sectors of civil society?

Some of the obstacles and drawbacks include;

→ *Lack of collaboration among existing groups*. At times, territoriality makes improving collaboration difficult.

→ *Lack of long term planning*. The need to identify and access project funding has often meant that civil society organizations do not develop a clear direction for their work.

→ *Organizations not reaching their potential for doing advocacy*. The capacity for organizations to plan and implement ongoing advocacy campaigns continues to be limited. This is in part influenced by the "project" mentality referred to above. It also reflects the need for increased

understanding of the dynamics of social change and how to organize people in the advocacy process.

→ *Disappearance of women's organizations and the lack of strength in the Belize women's movement*. In the past 10 to 15 years, a number of key women's organizations have come to an end. There is currently no general women's NGO in Belize focusing on a rights based approach to gender equality and ending the subordination of women. There is also no NGO focused on violence against women issues, with the exception of the two women's shelters.

→ *Laws that prevent providing services to minors*. The legal requirement that persons under the age of 18 must have parental consent to access sexual and reproductive health services places a barrier to reaching young people and puts those organizations who chose to implement a rights based approach to the provision of services at risk.

→ *Lack of resources*. It is increasingly difficult for civil society groups, and in particular those groups working for women, to access the resources needed to develop and implement programmes.

5. What are the main recommendations for overcoming such obstacles put forward by the UNGASS Forum and Civil Society in your country?

1) A key part of addressing government obstacles must be the ***development of greater capacity and dedication in civil society organizations to plan and implement advocacy campaigns***. It is the responsibility of civil society to hold government accountable for existing commitments as well as to identify and promote new objectives. It has proven difficult for civil society to reach its full potential in this respect in Belize. The pressure to deliver on project services and programmes means that advocacy work is often not prioritized. It is difficult to sustain the long term vision necessary for successful advocacy. To address this, civil society organizations must make a firm commitment to their advocacy work and organized collaboration among organizations must increase. Donors should recognize the essential role that civil society advocacy plays and provide adequate support for sustained development of advocacy campaigns (including generating a broad base of support for their objectives) and the development of capacity within civil society organizations to implement these campaigns.

2) ***Better monitoring and evaluation systems need to be in place, and better use made of existing evidence on the effectiveness of programmes.*** Input into monitoring of programmes should include direct input and involvement of the people they are intended to serve. This is particularly true with programmes developed to promote prevention and/or lead to behaviour change, since these programmes will only be successful if they speak to the physical, psychological and social reality of those involved.

3) ***Issues such as HIV/AIDS, Sexual and Reproductive Health, Violence Against Women and women's rights in general should not be seen as separate, but as interconnected.*** Efforts to address HIV/AIDS, promote sexual and reproductive health and confront violence against women will have limited effects as long as gender inequality and the subordination of women is a fundamental characteristic of Belizean society. Civil society groups in particular need to develop a more complete analysis that situates these issues in their social, economic and political context. The strengthening of women's organizations and the women's movement is an essential foundation for this development.

4) ***Government must more effectively mainstream work on issues such as HIV/AIDS and Violence Against Women throughout relevant Ministries and Departments.*** It is not enough to have policies and plans of action that set forth a "multi-sectoral" approach. Each ministry must take responsibility to develop and take ownership of an internal plan that will make these initiatives a reality. In addition, this will require work on changing the attitudes of those working within the public sector (from the highest level to front line workers) that often hinder efforts for greater action on these issues.

5) ***There must be standardization of access to and quality of services for sexual and reproductive health and HIV.*** A part of this standardization must be a clear statement of what individuals are entitled to. Put simply, people need to know "If I am in this situation, I can go to this place, and I will get this." Once this entitlement is established, it must be well publicized and monitored to ensure that it is equitably applied. Particular attention must be given to the districts and to rural areas.

6) ***More focused and systematic attention must be placed on youth***. This should include comprehensive sexual and reproductive health education in schools, achieving the SRH rights of adolescents, and increased youth involvement in programmes to improve ownership.