GLOBAL AIDS COUNTRY PROGRESS REPORT

BELIZE

Reporting period: January 2010–December 2011

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Acronyms

AAA	Alliance Against AIDS
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviour Change Communication
BDF	Belize Defence Force
BFLA	Belize Family Life Association
BHIS	Belize Health Information System
BSS	Behavioural Surveillance Survey
CAREC	Caribbean Epidemiology Centre
CCM	Country Coordinating Mechanism
CHART	Caribbean HIV/AIDS Regional Training Network
CITC	Client-Initiated Testing and Counselling
CML	Central Medical Laboratory
CNET+	Collaborative Network of Persons Living with HIV
CSEC	Commercial Sexual Exploitation of Children
DBS	Dried Blood Spots
ELISA	Enzyme-Linked Immuno-Sorbent Assay
EPP	Estimation and Projection Package
FSW	Female Sex Workers
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOB	Government of Belize
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
HSRP	Health Sector Reform Project
IEC	Information, Education, and Communication
ILO	International Labour Organization
LGBT	Lesbian, Gay, Bi-Sexual and Trans-Gender
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MHDST	Ministry of Human Development and Social Transformation

MOEY	Ministry of Education and Youth
MOH	Ministry of Health
MOLLGRD	Ministry of Labour, Local Government and Rural Development
MSM	Men who have Sex with Men
NAC	National AIDS Commission
NAC C&T	NAC Care and Treatment Sub-Committee
NAC IEC	NAC Information, Education and Communication Sub-Committee
NAC M&E	NAC Monitoring and Evaluation Sub-Committee
NAC P&L	NAC Policy and Legislation Sub-Committee
NAP	National AIDS Programme
NASA	National AIDS Spending Assessment
NCD	Non-Communicable Diseases
NCPI	National Composite Policy Index
NGO	Non-Governmental Organization
NMEP	National Monitoring and Evaluation Plan
NOP	National Operational Plan
NSP	National Strategic Plan
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership against HIV/AIDS
PASMO	Pan American Social Marketing Organization
PITC	Provider Initiated Testing and Counselling
PMTCT	Prevention of Mother-to-Child Transmission
PSM	Procurement and Supplies Management
REDCA+	Central American Network of People Living with HIV
SBS	Sexual Behaviour Survey
SMI	
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Workers
UNAIDS	United Nations Joint Programme for HIV/AIDS

UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children Efficiency Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WIN	Women's Issues Network
YES	Youth Enhancement Services
YFF	Youth For the Future
YWCA	Young Women's Christian Association

I. Status at a Glance

(a) The inclusiveness of the stakeholders in the report writing process;

Belize's Global AIDS Response Progress Report which monitors the advancement of the response towards the 2015 targets established in the 2011 Political Declaration on HIV/AIDS was developed using a multi-sectoral and participatory process. The National AIDS Commission (NAC), through the NAC, was responsible for the collation and submission of the report. This submission would not have been possible without all the key actors in the National Multi-Sectoral Response including, the members of the Commission, the Oversight Working Group, the Ministry of Health, and our Development Partners.

Stakeholders, including key non-government organizations, community-based organizations and faith based organizations willingly provided information elaborating this report. During the development of the report, civil society was asked to provide input for the development of the National AIDS Spending Assessment and the National Commitments and Policy Instrument. A national Consensus Building Workshop was held which provide an opportunity for partners and stakeholders in the national response, including civil society to review and comment on this Country Progress Report prior to finalization and submission. In addition, civil society conducted an assessment of the Sexual and Reproductive Health services provided, which also forms a part of this country report.

Finally, this report would not be possible without the essential technical support and assistance of the UNAIDS Country Office and USAID/PASCA Country Office.

(b) The Status of the Epidemic;

The main factor in the persistent HIV transmission in Belize is most likely inconsistent condom use in the presence of multiple partners, early sexual initiation and gender-based violence. Across populations, the feature of multiple partners is evident with varying levels of inconsistent use of condoms with any partner. At the root of unprotected sexual activity are the complex psychological issues that act as determinants sustaining a gap between knowledge and behavior that prevents the sexual transmission of HIV.

In 2011, data from the Ministry of Health indicate that there were 226 new cases of HIV. This reveals a continued downward trend in new cases since 2008. The key age group most affected remains the age cohort 15-55 years of age the economically viable sector of the population. The split between sexes is almost one to one except in youth 20-24 years of age when girls have twice the amount of new infection than boys and in the cohort 40-41 years of age when men have three times the amount of new infection than women in that age cohort.

The country response has remain one of the few worldwide led by a multi-sectoral body demonstrating the government's vision of HIV as a social and developmental challenge rather than a health challenge. The National AIDS Commission coordinates the national response which has been recognized by UNDP for its cohesiveness, comprehensive membership and the meaningful participation of PLHIV.

During the period 2010-2011 much work was accomplished in strengthening the strategic direction of the national response. A new National Strategic Plan 2012-2016 was developed using with maximum stakeholder participation. A Continuum of Care (CoC) was developed as the strategic tool for ensuring and monitoring care treatment and support of PLHHIV on the ground in each district. The NAC and the Country Coordinating Mechanism (CCM) have both expanded their membership to be more inclusive.

(c) The Policy and Programmatic Response; and

During the past two years a major accomplishment was the National Dialogue on Human Rights, the Law and HIV which provided Civil Society an opportunity to raise concerns on the issue of human rights, the law and HIV. The Regional Stigma and Discrimination Unit which is a PANCAP entity has also been implementing a project in Belize which has focused on the empowerment of vulnerable groups through training on human rights. The Ministry of Labour led the movement to introduce new legislation in 2011 which now criminalizes any dismissal based on HIV status. In addition, the MOL has trained another 13 companies in preparation for their development of HIV policies. The Ministry of Education has developed a detailed HIV policy for Education.

The majority of HIV programs in country are organized and implemented by the NGOs, members of Civil Society and Government departments and Ministries who together form the National AIDS Commission. This is the case at the national and district level via the NAC District Committees. In both cases, Community Based Organizations or NGOs establish work plans to address areas in the national response that match their organizational imperatives. These include but are not limited to: providing food, day care and medical support for OVCs, empowerment and rights defense of female sex workers, rights defense, counseling, care and support for men who have sex with men, subsidized SRH services in rural areas, one on one behavior change interventions and prevention outreach to children, women and girls.

In 2011 Belize started to benefit from Round 9 funds of the Global Fund and has been busy implementing the many activities listed in that work plan. These programs cover a wide area of response ranging from the production of strategic information to the empowerment of PWHIV and including prevention outreach, access to SRH services and Health Systems Strengthening.

Programming in the national response is overseen and coordinated by one of the four standing committees of the NAC; Policy and Legislation, Care and Treatment, Information, Education and Communication and Monitoring and Evaluation. These Committees support and inform the deliberations of the NAC and empower the District Committees who implement the National Strategic Plan at the local level in the districts.

(d) GARPR Indicator data in an overview table.

Table 1: Overview of the Global AIDS Core Indicators for Belize 2010 - 2011

	No.		2010-2011	Notes/ Comments
Target 1: Reduce sexual transmission of HIV by 50 percent by 2015				
General Population	1.1	Percentage of young women and men aged 15-24 who 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 during the 2009 Sexual Behaviour Survey (SBS). Updated information will be available via the MICS in 2012.
	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.	2009–7.8% (78/1006)	
	1.3	Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months.	2009–9.4% (287/1006)	
	1.4	Percentage of adults aged 15-19 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse.*	2009–63.1% (181/287)	
	1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results.	2009–36.5% (1,111/3,041)	
	1.6	Percentage of young people aged 15-24 who are living with HIV.	2011- 0.81% (33/4075)	This data is captured manually as it is not fully in the Belize Health Information System.
Sex Workers	1.7	Percentage of sex workers reached with HIV prevention programmes.	N/A	Based on the Belize 2010 TRaC Study Evaluating Condom Use Among FSW in Belize City, Cayo, Orange Walk, Corozal Town and Stann Creek Districts there was 84.5% (214/252) of FSW's who responded "Yes" to question 1 only "Do you know where you can go if you wish to receive an HIV test". However, no current data is available to respond fully to the indicator.
	1.8	Percentage of sex workers reporting	2010–93%	Data collected from the 2010

		the use of a condom with their most recent clients.	(168/181)	HIV/AIDS TRaC Study Evaluating Condom Use Among FSW in Belize City, Cayo, Orange Walk, Corozal Town and Stann Creek Districts.
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results.	2010–66.3% (167/252)	
	1.10	Percentage of sex workers who are living with HIV.	N/A	This data currently not available.
Men who have sex with men	1.11	Percentage of men who have sex with men reached with HIV prevention programmes.	2010–66.5% (151/227)	Data collected from the 2010 HIV/AIDS TRaC Study Evaluating Condom Use Among MSM in Belize City, Cayo, Orange Walk, Corozal Town and Stann Creek Districts.
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.	2010–80.1% (182/227)	The denominator represents data for the last 3 months and not for the last 6 months. Data collected from the 2010 HIV/AIDS TRaC Study Evaluating Condom Use Among MSM in Belize City, Cayo, Orange Walk, Corozal Town and Stann Creek Districts.
	1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results.	2010 – 96% (170/177)	Data collected from the 2010 HIV/AIDS TRaC Study Evaluating Condom Use Among MSM in Belize City, Cayo, Orange Walk, Corozal Town and Stann Creek Districts.
	1.14	Percentage of men who have sex with men who are living with HIV.	N/A	This data is currently not available.
Testing and	1.15	Percent of health facilities that provide HIV testing and counselling services	2010-61.1% (66/108) 2011-59.2% (64/108)	There is a reduction in the number of private facilities offering HIV testing with the close down of Belize Family Life Association clinics; otherwise the figures remain the same.

	1.16	Number of women and men aged 15 and older who received HIV testing and counselling in the past 12 months and know their results.	2010 (21,172) 2011 (25,036)	
Sexually Transmitted Infections	1.17	Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit.	2010 – 90% (5995/6631) 2011 – 92.3% (6698/7258)	
		Percentage of antenatal care attendees who were positive for syphilis.	2010-1% (86/5995) 2011 – 0.82% (55/6698)	This data not currently disaggregated by age group.
		Percentage of antenatal care attendees positive for syphilis who received treatment.	2011 – 67.3% (37/55)	
		Percentage of sex workers (SWs) with active syphilis.	N/A	This data is not currently available as we don't do an active screening process with sex workers/men who have sex with men, and if sex workers/MSMs do come to the health facilities, they may not be identifying themselves as sex workers or men who have sex with men.
		Percentage of men who have sex with men (MSM) with active syphilis.	N/A	
Target 2: Reduce transmission of HIV among people who inject drugs by 50 percent by 2015				
2.1		Number of syringes distributed per person who injects drugs per year by needle and syringe programmes.	N/A	The National Drug Abuse Control Council reports minimal and statistically insignificant evidence of IDU. Results from a study looking at the link between drug use and HIV will be available by mid 2012.
2.2		Percentage of people who inject drugs who report the use of a condom at last sexual intercourse.	N/A	
2.3		Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected.	N/A	
2.4		Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results.	N/A	
2.5		Percentage of people who inject drugs who are living with HIV.	N/A	
2.6		Number of people on opioid substitution therapy.	N/A	This data is currently not available.

2.7	Number of needles and syringes programme (NSP) sites.	N/A	This data is currently not available.
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths.			
3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission.	2010-100% (53/53) 2011–100% (65/65)	We are utilizing country specific indicators and figures for this as we believe that the Spectrum estimates are grossly over-estimating the number of HIV pregnant women given that we have great than 95% HIV testing coverage of all pregnant women.
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth.	2010-100% (54/54) 2011-100% (61/61)	We had a total of four cases of vertical transmission; only two cases were diagnosed within the first two months as the other two were diagnosed as they were older - at 3rd PCR test after week 12.
3.3	Mother-to-child transmission of HIV (modelled).	To be modelled	
3.4	Percentage of pregnant women who were tested for HIV and received their results – during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status.	2010 Numerator-6178 2011-92.2% (6695/7258)	
3.5	Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months.	N/A	This data currently not available.
3.6	Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing.	2010-100% (53/53) 2011 N/A	100 percent of pregnant are put on ARV medication and tested for CD4 levels upon detection; regardless of the CD4 count, all women will be put on ART. Clinical staging is not applicable for the Belize context. Entry into ART treatment programmes is at CD4 count of 350 and very

			soon to be at 500.
3.7	Percentage of infants born to HIV-infected women (HIV-exposed infants) who received antiretroviral prophylaxis to reduce the risk of mother-to-child transmission during pregnancy and delivery (i.e. early postpartum transmission around 6 weeks of age).	2010-98.1% (53/54) 2011-100% (61/61)	All exposed babies into 2011 received ARV prophylaxis at delivery and at least for the first 6 weeks after being discharged from the hospital.
3.8	Percentage of infants born to HIV-infected women (HIV-exposed infants) who are provided with antiretrovirals (either mother or infant) to reduce the risk of HIV transmission during the breastfeeding period.	N/A	In Belize breast feeding among HIV positive women who deliver babies is not encouraged or promoted.
3.9	Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth.	2010 Numerator-54 2011 N/A	The data from 2011 is currently not available. The Ministry of Health has difficulty validating the prescription of CTX as this is not currently in the BHIS.
3.10	Distribution of feeding practices (exclusive breastfeeding, replacement feeding, mixed feeding/other) for infants born to HIV-infected women at DTP3 visit.	N/A	This data is not captured specifically for HIV positive women.
3.11	Number of pregnant women attending ANC at least once during the reporting period.	2010 (6,631) 2011 (7,258)	This data represents both the private and public facilities.
3.12	Percentage of health facilities that provide virological testing services (e.g. PCR) for diagnosis of HIV infants on site or from dried blood stops (DBS).	2010-100% (54/54) 2011-100% (54/54)	All facilities provide basic follow up for HIV exposed infants.
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015			
4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy.*	2010-70.4% (1,053/1496) 2011-90.7% (1,358/1,496)	This data was calculated using the spectrum 2009 estimates and could be recalculated using the more updated estimates.
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	2009-89.4% (119/133)	The denominator 133 are all patients starting ARV therapy during 2008 across all age groups and countrywide as

			reported by the Epidemiology Unit. The numerator is those who were alive and accessing medical services at December 2009.
4.2b	Percentage of adults and children with HIV still alive and known to be on treatment 24 months after initiation of antiretroviral therapy (among those who initiated antiretroviral therapy in 2009).	2010-87.2% (116/133)	The same cohort of 133 patients were followed into 2010 and 3 more deaths were documented so that at December 2010 there were 116 patients alive and accessing treatment.
4.2c	Percentage of adults and children with HIV still alive and known to be on treatment 60 months after initiation of antiretroviral therapy (among those who initiated antiretroviral therapy in 2009).	N/A	This data is currently not available as the first cohort established for follow up is for those starting ARVs in 2008.
4.3	Number of health facilities that offer antiretroviral therapy (ART) (i.e. prescribes and/or provide clinical follow-up).	2010 (13) 2011 (13)	10 public facilities and 3 private facilities.
4.4	Percentage of health facilities dispensing antiretrovirals (ARVs) for antiretroviral therapy that have experienced a stock-out of at least one required ARV in the last 12 months.	2010-100% (0/13) 2011-33.3% (4/12)	
4.6	Percentage of adults and children enrolled in HIV care and eligible for co-trimoxazole (CTX) prophylaxis (according to national guidelines) currently receiving CTX prophylaxis.	N/A	This data is currently not available.
Target 5: Reduce Tuberculosis deaths in people living with HIV by 50 percent by 2015			
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV.	2010 Numerator-24 2011 Numerator-24	The estimated number of incident TB cases is not currently available for Belize. However, in 2010 and 2011 there were 24 adults with advanced HIV infection who received antiretroviral combination therapy and who started on TB treatment.
5.2	Number of health care facilities providing ART services for people living with HIV with demonstrable infection control practices that include TB control.	2010-62% (8/13) 2011 N/A	This data is currently not available for 2011.

5.3	Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT).	N/A	This data is currently not available.
5.4	Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit.	N/A	This data is currently not available.
Target 6: Reach a significant level of annual global expenditure (US$22-$24 billion) in low – and middle – income countries			
6.1	Domestic and international AIDS spending by categories and financing sources.	Annex 1	
Target 7: Critical Enablers and Synergies with Development Sectors			
7.1	National Commitments and Policy Instruments.	Annex 2	
7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.	N/A	While these indicators are relevant to Belize, we currently do not have any data available. Updated information will be available via the MICS in 2012.
7.3	Current school attendance among orphans and non-orphans aged 10-14.*	2006 – 0.66 Part A: 62.1% Part B: 93.6%	
7.4	Proportion of the poorest households who received external economic support in the last 3 months.	N/A	

II. Overview of the AIDS Epidemic

Target 1: Reduce sexual transmission of HIV by 50 percent by 2015

General Population

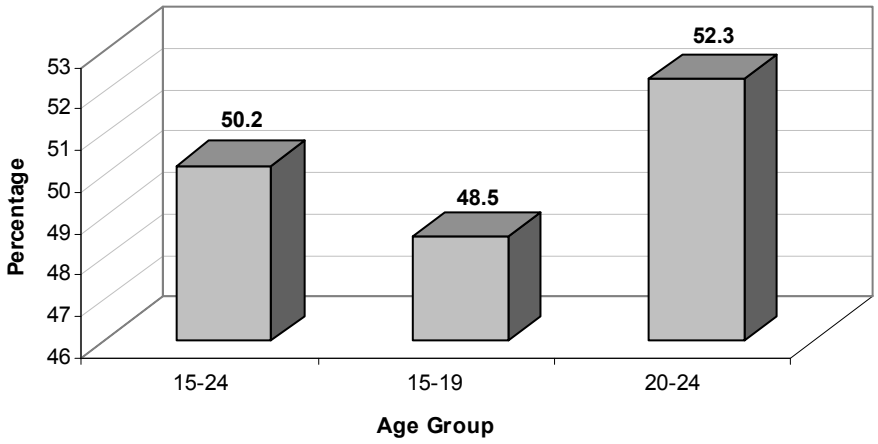
The adult HIV prevalence rate of Belize was estimated to be 2.3 [2.0-2.8][1] in 2009, using the Spectrum Modelling Software. This estimate has remained relatively unchanged compared to the rate in 2001 of 2.2 [1.9-2.6]. In 2011, the total number of newly diagnosed HIV Infections was 226, indicating a decrease of 7.4% in the number of newly diagnosed HIV infections, compared to the year 2010. Compared to 2009, the total reduction of new HIV infections over these three years is around 38.1%.

Indicator 1.1: Young People: Knowledge about HIV prevention

In 2009, 50.2 % of young people 15-24 years of age correctly identified both consistent condom use and having one uninfected partner, who has no other partners, as ways of preventing the sexual transmission of HIV. The scores in the age groups 15-19 and 20-24 were 48.5% and 52.3%[2] respectively.

[1] Global report: UNAIDS report on the global AIDS epidemic, 2010
[2] Sexual Behaviour Survey (SBS) 2009

Graph 1: Correctly identifying the ways of prevention the sexual transmission of HIV, Belize 2009



Source: Sexual Behaviour Survey, Belize 2009

Indicator 1.2: Sex before the age of 15

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 2).

Table 2: 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			

Indicator 1.3: Multiple sexual partnerships

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 3). 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 3).

Table 3: Multiple Partners 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				

Indicator 1.4: Condom use at last sex among people with multiple sexual partnerships

An assessment of reported consistent condom use during sex with multiple partners and during sex with non-regular partners shows that rates reported by persons 25-49 years were low with females reporting lower percentages than males. The age group 15–19 reported overall higher levels of consistent use of condom for sex with multiple partners and non-regular partners than the age group 20-24. Overall, females reported lower levels of consistent use of condoms with non-regular partners and multiple partners than males, with the exception of 20-24 year olds with multiple partners. The 2009 SBS indicated that approximately 36% of persons aged 15-24 reported having an HIV test in the 12 months prior to the interview and knowing their result.

Table 4: Consistent Condom Use With Multiple Partners and Non-Regular Partners

	Age Group	Sex		
		Both	Male	Female
Consistent Condom Use with multiple partners	15-19	73.7	80.8	58.3
	20-24	71.6	70.4	76.9
	25-49	58.0	60.7	50.0
Consistent Condom Use with non-regular partners	15-19	60.5	69.2	41.7
	20-24	56.7	59.3	46.2
Source: SBS, Belize 2009				

Indicator 1.5: HIV testing in the general population

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.

Indicator 1.6: HIV Prevalence in young people

In 2009, the prevalence rate among 15-24 year old pregnant young women is 1.01% (34/3375)[3], while in 2011, the rate in this age group decreased to 0.81% (33/4075). In 2009, the HIV prevalence among all antenatal clinic attendees was 0.99%, while in 2010 and 2011 it was 0.86% and 0.97% respectively. (See table 5)

Table 5: Key indicators of the PMTCT Programme, Belize 2006-2010

Year	Pregnant Women	Pregnant Women Tested for HIV	HIV Testing Coverage	HIV+ Pregnant Women	HIV Prevalence among Pregnant Women
2006	7,218	6,290	87%	61	0.97%
2007	7,017	6,325	90%	62	0.98%
2008	7,045	6,552	93%	65	0.99%
2009	7,018	6,310	90%	63	0.99%
		3,375		***34***	***1.01%****
2010	6,626	6,178	93%	53	0.86%
2011		6,695		65	0.97%
		4,075		***33***	***0.81%****

Source: MOH

**** 15-24 year old Antenatal Clinic Attendees***

SEX WORKERS

In 2009, the Pan-American Social Marketing Organisation (PASMO) Belize conducted a second round of an HIV/AIDS TRaC Study[4], evaluating condom use among FSW and MSM in Belize City, Cayo, Orange Walk, Corozal Town and Stann Creek districts. Condom use among these groups showed diverging directions, however, both studies highlight that the consistent use of condoms has decreased[5].

Indicator 1.7-1.1.10: Sex workers

The survey was conducted among 252 FSW, of whom 88% were from fixed venue locations and 12% were ambulatory. The survey showed a decrease in condom use at last sex between FSW with their new clients as well as their affective partners, but an increase of condom use with their occasional and regular clients. Overall condom use among FSW interviewed increased slightly from 93.3% in 2007 to 95.8% in 2009. 36.7% of FSW reported consistent condom use with their affective partners in the last month compared to 87.2% with their occasional clients. Notably, the percentage of FSW carrying a condom on them at the time of the interview, decreased from 77.5% in 2007 to 46.9% in 2009. Overall consistent condom use in the last

[3] Belize UNGASS Report 2010

[4] Population Service International. Belize HIV/AIDS TRaC Studies Evaluating Condom Use among MSM & FSW: Second Round. Washington, DC: PSI, 2009

[5] idem

month with any partner or client decreased to 35.3% in 2009 compared to 60.1% in 2007. The percentage of FSW reporting having had an HIV test in the year prior to the interview also decreased to 68.5% in 2009 compared to 75.8% in 2007. Knowledge of ways of preventing HIV improved over the period 2007 to 2009, however, this did not result in corresponding improvements in the behaviour change indicators. There is limited data available about FSW in rural areas, where access to HIV and SRH services is limited.

MEN WHO HAVE SEX WITH MEN

Indicator 1.11-1.1.14: Men who have sex with men

The TRaC study also surveyed 227 MSM, of whom 72% identified themselves as gay; 21.5% as bi-sexual; 4.0% as heterosexual; and 2.5% as trans-gender. Reported condom use at last sex with occasional partners decreased, but increased with all other partners. Overall, reported condom use at last sex decreased from 85.4% in 2007 to 79.6% in 2009. Reported consistent condom use in the last month with any partner decreased from 72.0% in 2007 to 63.6% in 2009. In 2009, 77.4% of MSM interviewed reported having had an HIV test in the year prior to the interview and 61.7% of them reported having a condom on them at the time of the interview. MSM reported an average of 10.7 sexual partners in the last month in 2009, up from 8.6 in 2007.

TESTING AND COUNSELLING

Indicator 1.15-1.16: Testing and Counselling

In 2011, 25,036 women and men aged 15 years and older who received HIV testing and counselling in the past 12 months knew their results, showing an increase of 18.2% (3,864). There was a reduction of the number of health facilities offering HIV testing and counselling by 3.03%, from 66 in 2010 to 64 in 2011, due to the reduction in the number of private health facilities.

SEXUALLY TRANSMITTED INFECTIONS

Indicator 1.17: Sexually Transmitted Infections

Ninety percent of antenatal clinic attendees are tested for syphilis with a stable prevalence of around 1% per annum, which coincides with the HIV prevalence among pregnant women. There is limited data published on the incidence and prevalence of opportunistic infections in people with HIV in Belize.

Target 2: Reduce transmission of HIV among people who inject drugs by 50 percent by 2015

Indicator 2.1-2.7: People who inject drugs

In 2011, according to NDACC, there were a total of 379 addition cases documented, however, there is no scientific evidence indicating that HIV infection is related to injecting drug use in Belize. The National Drug Abuse Control Council (NDACC) has been working civil society partners in the National Response, by referring HIV-positive addicts to access services. As a part of a regional initiative, in 2011 the National Drug Abuse Control Council in collaboration with the University of Belize and the United Nations Office on Drugs and Crime (UNODC) initiated a study looking at the link between drug use and HIV within the Rehabilitation Centres, the Kolbe

Foundation and Remar. Preliminary findings of this study are expected to be available by mid 2012.

Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths

Indicator 3.1- 3.3: Prevention of Mother-to-Child Transmission

Over 90% of pregnant women in Belize utilize the antenatal care at the public facilities and more than 95% of all births occur in hospitals, assisted by skilled attendants, the decision was taken at the inception of the programme to integrate PMTCT services into the Maternal and Child Health (MCH) Programme. In 2007 there were 62 positive pregnant women and 17 babies who were HIV-positive; in 2008 there were 65 HIV-positive pregnant women and 3 HIV-positive babies. The HIV-infected babies were born predominately to HIV-infected mothers who did not access appropriate antenatal care. There was also significant improvement of the treatment protocol, moving from the single dose nevirapine, offered during active labour and to their newborns, to the provision of prophylaxis to pregnant women at 14 weeks of gestation. The programme also included the integration of a strategy to reduce congenital syphilis into the PMTCT programme.

Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015

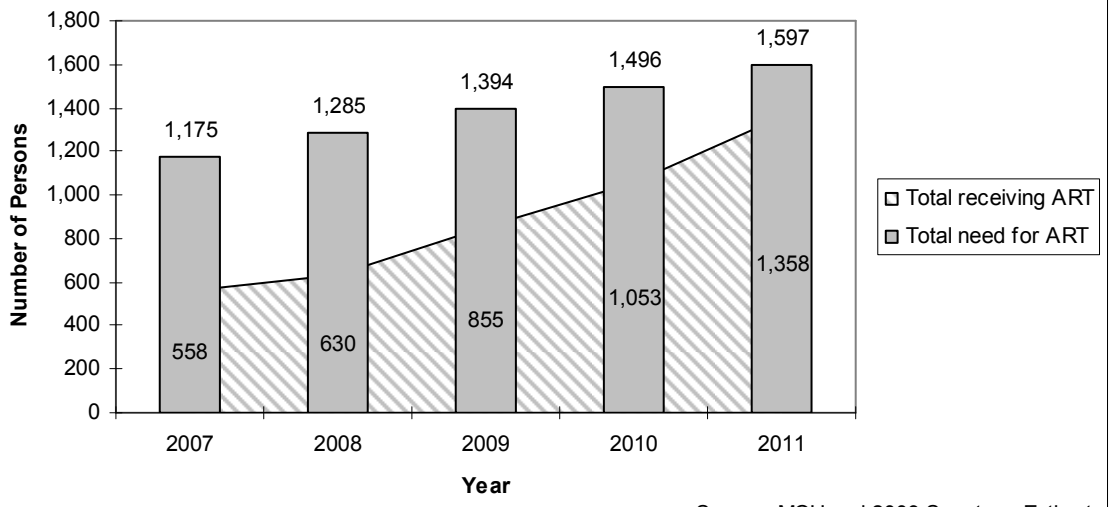
The Government of Belize (GOB) initiated the programme to provide free ARVs to persons with HIV, in accordance with national treatment guidelines established in 2003. By 2005, the programme was providing free Antiretroviral Therapy (ART) to almost 300 persons. Since the initiation of the ARV scheme, the national programme has demonstrated a significant uptake in placing new patients on ARV treatment. In 2010, MOH had thirteen (13) regiments ARV regiments in Belize, eleven (11) adult and two (2) paediatric, to over a thousand patients. Since 2003 the treatment guidelines have not been updated and as a consequence MOH has opted to use the Caribbean Guidelines for the Care and Treatment of Persons with HIV Infection, developed by the CAREC/PAHO and Caribbean HIV/AIDS Regional Training Network (CHART). In an effort to improve quality of life outcomes GOB has recently embarked on an initiative to update the existing treatment guidelines, with the aim of improving efficiencies in treatment regiments as well as moving the threshold for treatment eligibility from CD4 <350 to CD4 <500. The new guidelines will inform the initiation of ART, the initial regimen chosen, adherence, treatment preparedness, patient monitoring (including for treatment failure, second line regimen, as well as salvage treatment), treatment for OIs (including TB and hepatitis co-infection) and other HIV co-morbidities. It is expected that when the new national guidelines are applied, the number of HIV positive persons receiving ART will be significantly higher. The programme also continues to expand its therapeutic options and has started acquiring newer fixed dose combinations to enhance adherence to treatment.

Indicator 4.1: HIV treatment: antiretroviral therapy

Spectrum-EPP calculates the estimated number of persons in need of treatment on basis of parameters and data from national programme monitoring and a CD4 threshold of 350. Based on the estimated number of persons in Belize in need to ART, the ART coverage has grown from 47.5% in 2007 to 85% in 2011. While the number of newly reported HIV infections shows a downward trend, the number of persons in need and entering ARV therapy is expected to increase exponentially until the prevalence of HIV plateaus and begins to decrease in the country. The coverage rates for females have been consistently higher than that of males.

In 2011, 307 persons initiated ARV therapy, to give a total of 1,358 on ART. The coverage of children with HIV is 86.4% and almost 85.1% of adults needing treatment are covered. It must be noted that MOH also uses the patients' monitoring and history, e.g. patients showing rapidly declining CD4 numbers, as trigger to start ARV treatment. The high coverage numbers in children may also indicate under-estimation and/or under-counting of children with HIV over the years. With improvements in the monitoring systems, due to the roll out of the BHIS, these

Graph 2: ART Coverage in Belize, 2007-2010



Source: MOH and 2009 Spectrum Estimate

inconsistencies are expected to diminish. The continued trend of improvement of this Universal Access indicator indicates that ART coverage in Belize is relatively high. However, new investments will become necessary to counteract increased drug-resistance and to provide follow up to the scientific evidence that early initiation of ART has the potential to reduce viral loads and, therefore, transmission rates.

Table 6: ART Coverage for 2008 - 2011

		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	1,285	49.0%
	Males	307	653	47.0%
	Females	323	632	51.1%
	<15	64	78	82.1%
	15+	566	1,207	46.9%
2009	**All**	855	1,394	61.3%
	Males	444	708	62.7%
	Females	411	686	59.9%
	<15	80	87	92.0%
	15+	775	1,307	59.3%
2010	**All**	1,053	1,496	70.4%
	Males	523	760	68.8%
	Females	530	736	72.0%
	<15	105	94	111.7%
	15+	948	1,402	67.6%
2011	**All**	1,358	1,597	85.0%
	Males	657	811	81.0%
	Females	701	786	89.2%
	<15	88	104	84.6%
	15+	1,270	1,493	85.1%
Source: Belize 2010 UNGASS Report, 2010 Universal Access Report, 2009 Spectrum Estimates and MOH Reports				

Indicator 4.2: Twelve Month retention on antiretroviral therapy

In 2009, the 12 month-survival rate on treatment was estimate for the first time at 89.4%, which does not meet the minimum international standard of 90%. It is expected that this indicator would improve with the rapid scale-up of treatment and the expansion of adherence programmes. In 2010, the 24 month-survival rate on treatment was estimate for the first time at 87.2%, which is significantly higher than the 12-month survival rate. This provides a clear

indication that adherence to treatment improves health outcomes and survival rates. More studies on adherence and resistance to treatment in Belize are needed to optimize treatment outcomes.

Target 5: Reduce Tuberculosis Deaths in People Living with HIV by 50 per cent by 2015

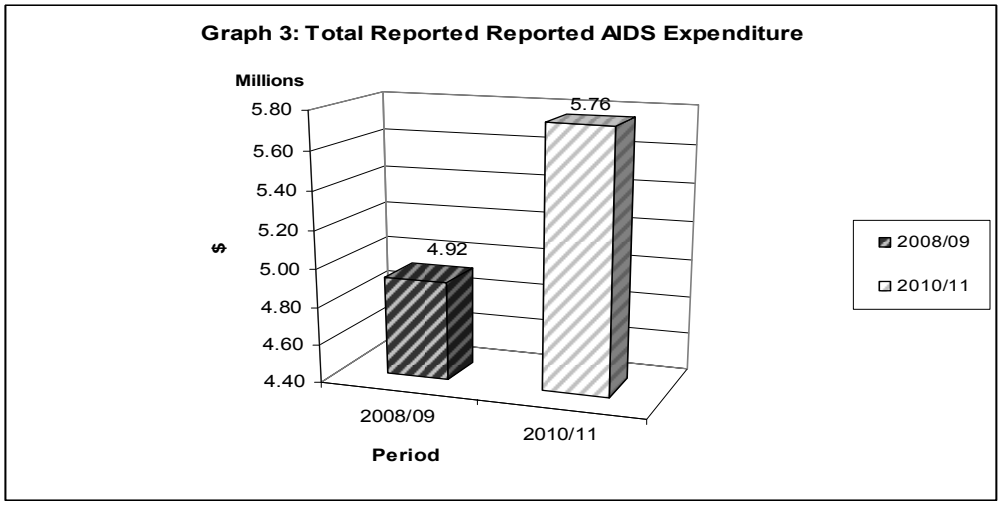
Indicator 5.1: Co-management of tuberculosis and HIV treatment

In 2010, there was a slight increase in documented cases of HIV/TB co-infection, which may have resulted from more active case finding of tuberculosis cases in persons with HIV. The number of HIV/TB co-infections among males is significantly higher than females. 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 an effort to further address this co-infection issue, the TB programme is now managed jointly with HIV and efforts are currently underway for further integration in all programmatic aspects of both programmes.

Target 6: Reach a significant level of annual global expenditure (US$22-$24 billion) in low – and middle – income countries (NASA Results)

Indicator 6.1: Domestic and international AIDS spending by categories and financing sources

The National AIDS Expenditure reported for the fiscal year 2010/11was BZ$5.76 Million. This represents a 16.9% increase over the reported AIDS expenditure of BZ$4.92 Million in the 2008/09 assessment. Calculated as a percentage of 2010 Gross Domestic Product (GDP) of BZ$2.86 Billion, total AIDS expenditure for 2010/11 is 0.20% of GDP. Calculated on per capita basis, total AIDS expenditure was BZ$18.40 (US$9.20) based on population of 312,000. Furthermore, total AIDS expenditure was 3.9% of National Health Expenditure of BZ$149.0 Million and 6.3% of total Ministry of Health expenditure of BZ$91.0 Million.



Expenditure by Financing Source

The Government of Belize was responsible for 51% of total AIDS expenditure; this is consistent with the Global Fund Report which states that domestic expenditure is the largest source of HIV financing globally today, accounting for 52% of resources for the HIV response in low- and middle income countries. The Government of Belize financing stream comprises of recurrent expenditure within five ministries – Health (National AIDS Programme), Human Development & Social Transformation (NAC), Education, Defence including Police, and Labour.

The Bi-lateral agencies, comprising mostly of the US Government was the second largest single contributor to Belize's total AIDS expenditure accounting for 18% of total AIDS spending. International agencies comprising of not-for-profit and non-faith-based and not-for-profit and faith-based organizations accounted for 21% of total expenditure while multi-lateral agencies represented by UNDP, UNICEF, and UNFPA financed 10% of the national AIDS spending.

Expenditure by Beneficiary Population (BP)

The adult population – general, male, and female – represents the largest beneficiary population accounting for 28.6% of total AIDS expenditure or BZ$1,641,470. The second largest beneficiary group is general population not disaggregated by gender accounting for 18% of AIDS expenditure or BZ$1,038,359. PLHIV was the third largest beneficiary population receiving 10.8% of AIDS spending or BZ$620,762. The MARPS population accounted for 6% of AIDS expenditure and just marginally below expenditure for orphans and children (6.1%).

Table 7: Total Expenditure by Beneficiary Population

		$	%
	Total	**5,755,995**	100
BP.01.01.02	Adult and young women (15 years and over) living with HIV	8,505.305	0.1
BP.01.01.98	Adult and young people (15 years and over) living with HIV not disaggregated by gender	472,683.4	8.2
BP.01.02.98	Children (under 15 years) living with HIV not disaggregated by gender	43,573.31	0.8
BP.01.98	People living with HIV not disaggregated by age or gender	96,000.92	1.7
BP.02.02.01	Female sex workers and their clients	69,885.83	1.2
BP.02.02.98	Sex workers, not disaggregated by gender, and their clients	76,622.92	1.3
BP.02.03	Men who have sex with men (MSM)	132,593.4	2.3
BP.02.98	"Most at risk populations" not disaggregated by type	70,829.62	1.2
BP.03.01	Orphans and vulnerable children (OVC)	220,878	3.8
BP.03.02	Children born or to be born of women living with HIV	130,481	2.3
BP.03.06	Indigenous groups	6,000.229	0.1
BP.03.10	Children and youth gang members	37,691.15	0.7
BP.03.11	Children and youth out of school	70,898.04	1.2
BP.03.12	Institutionalized children and youth	12,614.15	0.2
BP.03.98	Other key populations not disaggregated by type	141,597.8	2.5
BP.04.02	Elementary school students	108,769.9	1.9
BP.04.03	Junior high/high school students	73,484.38	1.3
BP.04.04	University students	56,562	1.0
BP.04.05	Health care workers	250,468.5	4.4

BP.04.07	Military	236,957.5	4.1
BP.04.08	Police and other uniformed services (other than the military)	8,791.335	0.2
BP.04.99	Specific “accessible ” populations not elsewhere classified	1,070.041	0.0
BP.05.01.01	Male adult population	115,102	2.0
BP.05.01.02	Female adult population	595,964.3	10.4
BP.05.01.98	General adult population (older than 24 years) not disaggregated by gender	930,404.3	16.2
BP.05.02.98	Children (under 15 years) not disaggregated by gender	22,142.66	0.4
BP.05.03.02	Young females	285,238.7	5.0
BP.05.03.98	Youth (age 15 to 24 years) not disaggregated by gender	303,298.9	5.3
BP.05.98	General population not disaggregated by age or gender.	1,038,359	18.0
BP.06	Non-targeted interventions	112,005	1.9
BP.99	Specific targeted populations not elsewhere classified not elsewhere classified	26,721.6	0.5

Expenditure by Production Factor (PF)

Wages and administrative services combined are the largest source of production factors totalling BZ$1,675,663 or representing 29.1% of total PF costs. Second was condoms with 14% or BZ$807,829 followed by Reagents and Materials 10% or BZ$576,408.

As a standalone Antiretroviral accounted for 9% of PF expenditure or BZ$516,277.

Combined, activities associated with capacity building and training workshops, conferences and forums, and stakeholder sessions and including consulting services account for 20.3% of expenditure or BZ$1,173,240.

Table 8: Total Expenditure by Production Factor

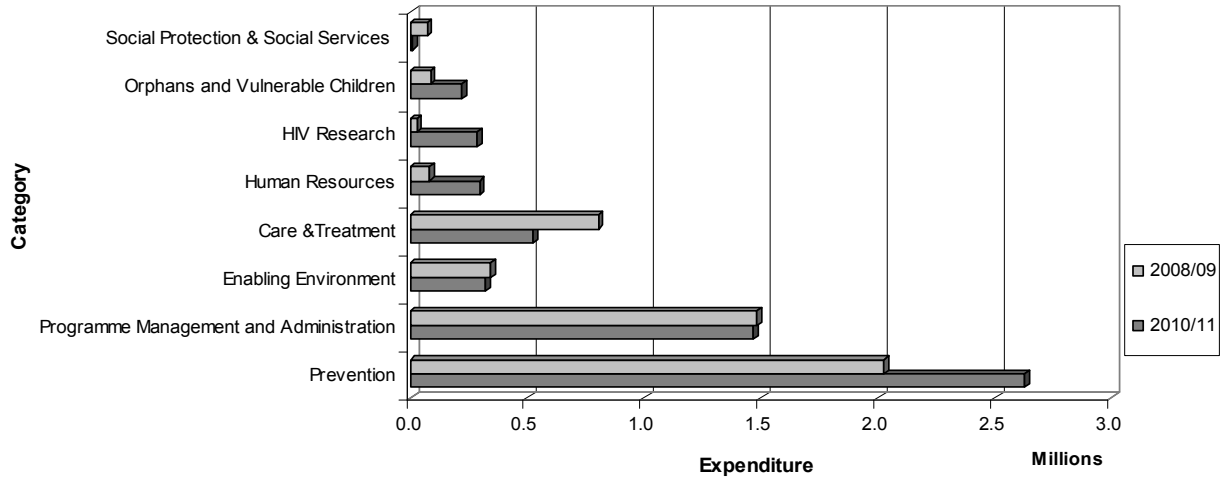
		$	%
	Total	**5,755,995**	100
PF.01.01.01	Wages	1,172,454	20.4
PF.01.01.02	Social contributions	14,022	0.2
PF.01.01.03	Non-wage labour income	240	0.0
PF.01.01.98	Labour income not disaggregated by type	74,824	1.3
PF.01.02.01.01	Antiretroviral	516,277	9.0
PF.01.02.01.02	Other drugs and pharmaceuticals (excluding antiretroviral)	31,938	0.6
PF.01.02.01.04	Condoms	807,829	14.0
PF.01.02.01.05	Reagents and materials	576,408	10.0
PF.01.02.01.06	Food and nutrients	121,685	2.1
PF.01.02.01.98	Material supplies not disaggregated by type	41,900	0.7
PF.01.02.01.99	Other material supplies not elsewhere classified	23,986	0.4
PF.01.02.02.01	Administrative services	503,209	8.7
PF.01.02.02.02	Maintenance and repair services	12,817	0.2
PF.01.02.02.03	Publisher-, motion picture-, broadcasting and programming services	221,216	3.8
PF.01.02.02.04	Consulting services	412,818	7.2

PF.01.02.02.05	Transportation and travel services	197,265	3.4
PF.01.02.02.06	Housing services	51,400	0.9
PF.01.02.02.07	Logistics of events, including catering services	290,541	5.0
PF.01.02.02.08	Financial intermediation services	3,000	0.1
PF.01.02.02.98	Services not disaggregated by type	190,191	3.3
PF.01.02.02.99	Services not elsewhere classified	276,916	4.8
PF.01.98	Current expenditures not disaggregated by type	12,400	0.2
PF.01.99	Current expenditures not elsewhere classified	75,788	1.3
PF.02.01.98	Buildings not disaggregated by type	30,970	0.5
PF.02.01.99	Buildings not elsewhere classified	150	0.0
PF.02.02.01	Vehicles	11,510	0.2
PF.02.02.02	Information technology (hardware and software)	62,360	1.1
PF.02.02.03	Laboratory and other medical equipments	10,000	0.2
PF.02.02.98	Equipment not disaggregated by type	6,474	0.1
PF.02.99	Capital expenditure not elsewhere classified	5,408	0.1

Expenditure by Category

For the fiscal year 2010/11, and of the eight spending categories, Prevention registered the highest expenditure accounting for 45% of total spend or BZ$2.62 Million. The second highest expenditure category was Programme Management & Administration (PMA) accounting for 25.5% of total spend or BZ$1.48 Million. The third highest expenditure category was Care & Treatment (9.1%) followed by HIV/AIDS Related Research (4.9%). In terms of expenditure in absolute dollars, actual expenditure was higher in all categories except care and treatment, social protection and social services, and enabling environment although the latter was minimally lower. Of significance is the increased expenditure in HIV/AIDS related research linked

Graph 4: Total Reported AIDS Expenditure by AIDS Spending Categories



	Prevention	Programme Management and	Enabling Environment	Care &Treatment	Human Resources	HIV Research	Orphans and Vulnerable Children	Social Protection & Social Services
2008/09	2,027,745	1,481,661	341,722	803,921	80,619	28,353	86,550	71,974
2010/11	2,624,103	1,470,355	323,667	524,302	297,047	283,277	220,878	12,366

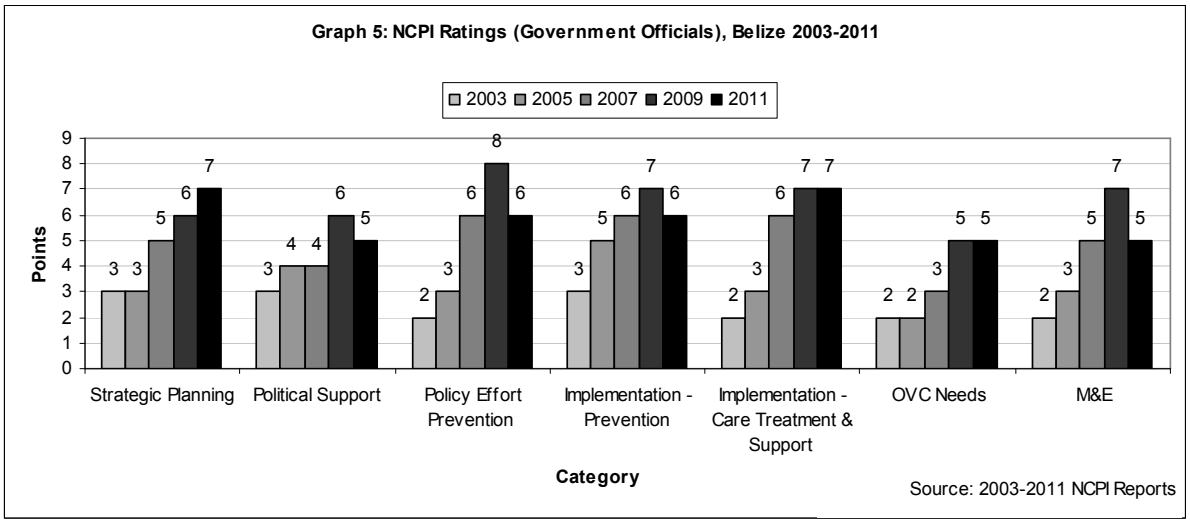
to epidemiological and behavioural studies.

Target 7: Critical Enablers and Synergies with Development Sectors

Indicator 7.1: National Commitments and Policy Instrument

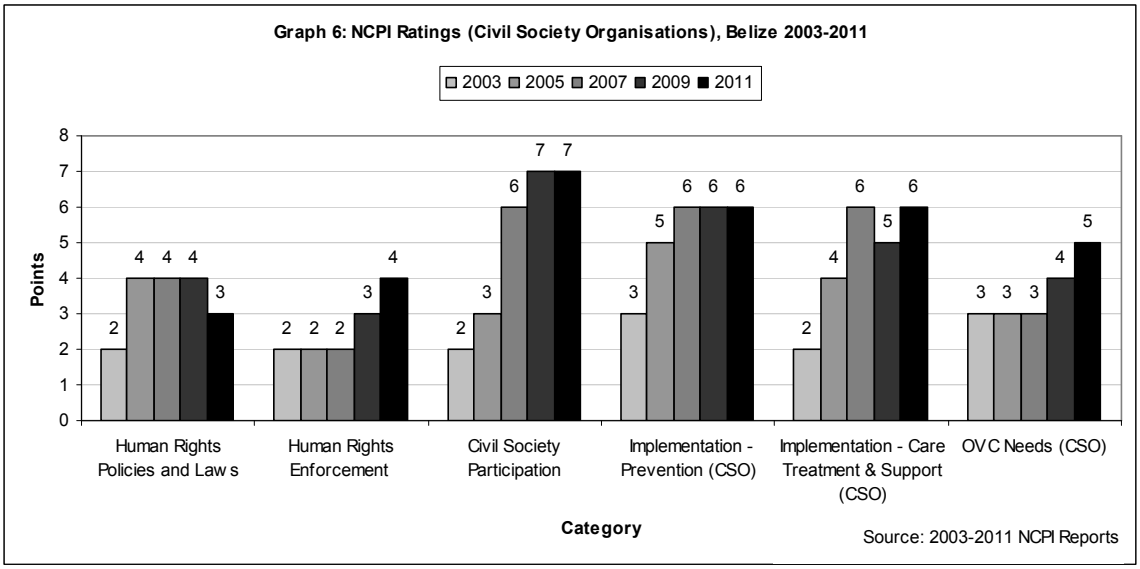
Since the 2009 UNGASS report, Belize has continued its efforts to achieve the "Three Ones" principles and maintain its commitment to accelerate an effective response to HIV in Belize. The National Commitment and Policy Instrument 2012 (NCPI) indicates that Belize has accomplished some progress in regards to these goals while there continue to be challenges in specific areas. The NCPI shows that the country has one National Strategic Plan (NSP) which has recently been revised for the years 2012-2016, One National AIDS Coordinating Authority which has increased its efforts to coordinate government and civil society initiatives in one multi-sectoral response and one National Monitoring and Evaluation Plan which needs to be aligned with the new strategic plan and operationalized.

Overall NCPI A administered to government officials and international partners indicates an increase of 1 point from 6 to a 7 for strategy planning during the past two years while it indicates a 1 point fall in the area of political support and a 2 point fall in the area of policy efforts in HIV prevention (*see graph 1*). There was a decrease in the scores in the area of Prevention from 6 to a 5 while in treatment, care and support maintained the same score of 7 since the last reporting period. Efforts to address the needs of OVCs remained the same at a score of 5 while monitoring and evaluation decreased by 2 points from a 7 to a 5 (*see graph 2*).



There were some similarities in the scores provided by the civil society respondents and government/international partners but in some instances there were marked differences. Even though efforts to increase civil society participation were scored relatively high in 2011 by civil society, this score remained the same at 7 with no marked difference. Overall the scores from civil society respondents a steady increase over the years in civil society participation since the first report in 2003. Efforts in Policies and Legislation have remained low and constant since 2003 similarly to the implementation of human rights policies and legislations. In 2011 efforts in policies and legislation actually decreased by 1 point to 3 since the reporting periods of 2005, 2007 and 2009 which indicated a constant score of 4 (see graph 3). Policies and legislations to

protect human rights decreased by 1 point from a low 4 to a lower 3 while the implementation of human rights policies increased by 1 point Overall civil society respondents indicated an



increase in treatment, care and support by 1 point from a 5 to a 6 while prevention programmes remained the same from the last reporting period at a 6. In efforts to implement treatment, care and support services for OVCs, civil society scored the response at a 5 which is a marked increase of 1 point since the last reporting period. (See graph 4).

In a comparative analysis of the scores provided in 2011 civil society scored Prevention efforts at a 6 which is similar to the government and international partners score. In treatment, care and support, civil society scored the efforts at 1 point less than what government/international partners had scored it 6 and 7 respectively. In the area of policies and legislation in general there was a marked difference of 3 points as civil society provided a score of 3 while government and international partners scored efforts in this area at a 6.

III. National Response to the AIDS Epidemic

Prevention, Knowledge and Behaviour Change

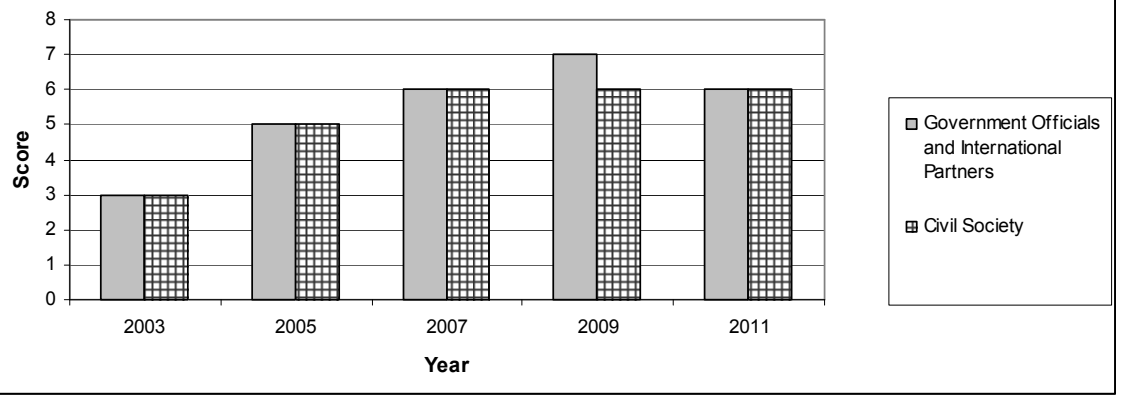
During the period January 2010-December 2011 there has been sustained implementation of prevention programs by both civil society and government. Organizations at the national and district level have continued to implement IEC, BCC, peer education and stigma and discrimination initiatives with key populations such as men who have sex with men, sex workers, young persons, women, men, the uniformed services and persons living with HIV. Key informants stated that there is more support for provision of prevention services in the area of training, education, human rights and sexual transmitted infections through the involvement of entities such as the US Embassy, USAID/PASMO among others. The NCPI 2012 indicated that the majority of persons in need of sexual and reproductive health education, prevention and risk reduction interventions still do not have access to these services, including PLHIV, MSM and their partners. Conversely, prevention services such as testing and counselling and PMTCT are available to the majority of persons who need them. The key informants also were of the opinion that there is increase of availability of free or affordably-prices condoms while there has

been increase of public awareness and media campaign on condoms in the media. A prevention strategy within the military through the PEPFAR project has also been introduced during the past two years.

Challenges identified in the 2012 NCPI include the need for targeted interventions with key populations; the uneven implementation of the Health and Family Life Education curriculum due to conflicts in the church-state education system; positive prevention and education for PLHIV; monotonous prevention strategies which lack innovation; and the lack of an evidenced based prevention strategy. There is a need to increase prevention initiatives in the rural areas and among the indigenous groups. In particular there is a need to link HIV and poverty-alleviation in the most affected areas of the city and country. The NCPI indicates that in 2011 both government and civil/society organizations scored efforts in prevention programmes at a 6. In 2009 civil society had scored this area at a 6 while government/international partners had scored it at a 7. There was a decrease of 1 point in the score provided by the government/international partners. Based on the results of the NCIP there is a clear indication that both sectors are of the opinion that there was no marked increase in efforts to implement prevention programmes since 2009 even though there was no major decrease in the efforts (see graph 6).

Care, Treatment and Support

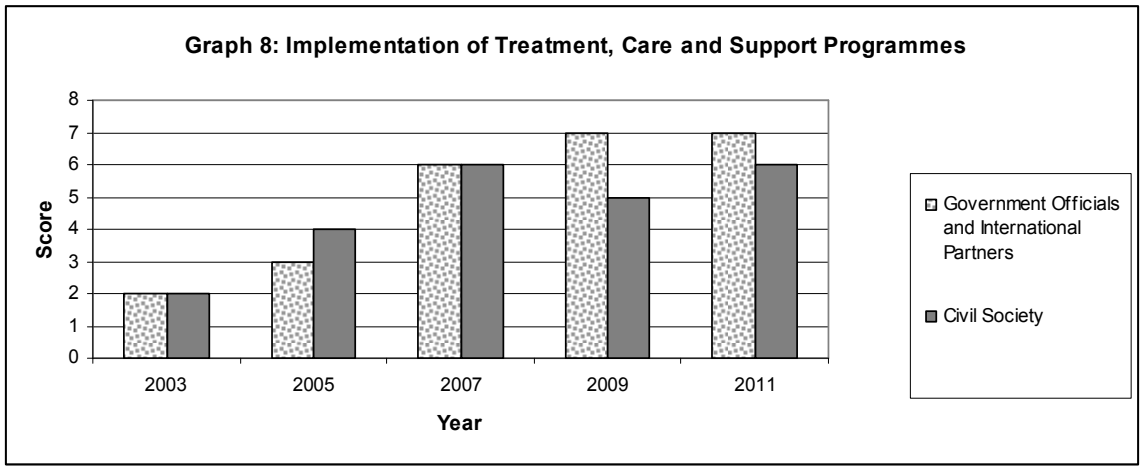
Graph 7: NCPI: Implementation of Prevention Programmes



The NCPI 2012 indicates that there have been a number of achievements in the area of treatment, care and support over the past two years. These include the continued provision of free antiretroviral medications to all persons eligible. There is also increase in the use of combination ARV therapy and increased access to CD4 testing. Initiatives such as the USAID/Central American Capacity Project which has sought to improve the continuum of care by providing training and performance monitoring for public health care professionals providing services to PLHIVs and other vulnerable groups. One important focus of the project has been on reducing stigma and discrimination within the health system through sensitization training and performance management. Another achievement has been the revision of the treatment guidelines and the updating of the national TB guidelines to reflect HV as a component. The post-exposure protocols now include non-occupational exposure such as sexual assault. The Ministry of Health is implementing the provider initiated testing and counselling initiative as a proactive approach to increasing testing in the population. As a part of the Ministry of Labour's Workplace project an employer's guide on HIV and AIDS has been developed which provides

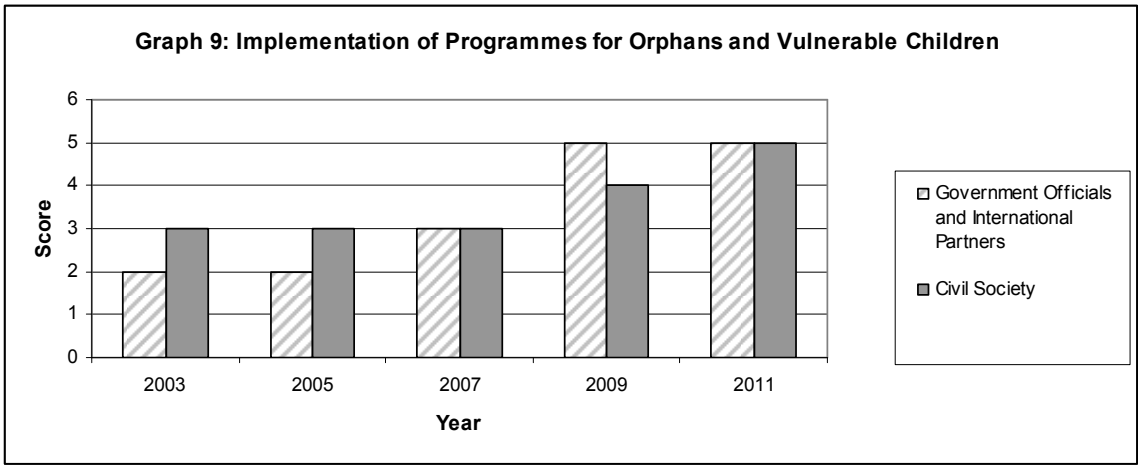
guidance to employers and employees in the area of care and support for persons affect by HIV in the workplace setting. This was accomplished through the support of the US Ambassador's HIV fund. The establishment of a national Network of Persons Living with HIV is recognized as an achievement as it will provide a mechanism for advocating for monitoring the provision of quality treatment, care and support to PLHIVs and others affected.

The findings of the NCPI 2012 indicate that there are still challenges in the area of treatment, care and support in spite of progress made over the past two years. Even though the continued provision of free ARVs is highlighted as an achievement there are still concerns regarding the medications being provided. Some key informants stated that the best treatment options are still not available in country as second-line medications provided in Belize are still seen as first-line in other countries. Adherence continues to be a challenge as persons living with HIV do not have access to proper nutrition or due to travel distance are unable to access their medications on time. There is the need for a strategy to address this situation urgently. There are still concerns regarding the need for viral loads to be available in country as these tests need to be processed in neighbouring countries resulting in higher cost. Several of the key informants were of the opinion that protocols and policies have been developed but are not effectively implemented since the majority of persons needed them are not benefitting. Other challenges identified include violation of rights of persons living with HIV and other vulnerable populations due to lack of confidentiality and discrimination. Due to the lack of an HIV law, there is no protection for these populations resulting in low utilization of public health services available to them. There is a need to assess whether integration of services will greater affect this low utilization rate by contributing to stigma and discrimination. One major challenge identified by many key informants is the lack of a comprehensive package of support. There are still gaps in the provision of psychosocial support to PLHIV and their families which have not been addressed since the past reporting period. The NCPI indicates that in 2011 both government/international partners and civil society provided similar scores in the area of efforts in the implementation of treatment, care and support. In previous years there have been some disparities in scores with government/international scoring the efforts a lot higher than civil society. In 2003 there was a marked difference of 5. Similarly to Prevention there seems to be a consensus between government/international and civil society that efforts in implementing treating, care and support programs remains at a score of 6 (see graph 7).



Impact alleviation

One of the major achievements during the past two years and in the last reporting period 2009 is the work of Hand in Hand Ministries, a faith-based organization that provides services to OVC and their families in Belize.. During the past two years HHM has continued to provide support to an estimated 90% (87 cases) of documented OVCs in the country. They have scaled-up their services which include: ARV delivery at their centre for persons who are unable or unwilling to access their medications at the public Pro-Care and Treatment Centre. Other services provided by HHM over the past two years include: health monitoring, medication checks, lab services, education, emotional support, hospital visits and a day care centre. HHM has been able to expand its services to southern Belize where they collaborate with local agencies such as Claret Care and the Productive Organization for Women in Action (POWA). Another achievement is the strengthened collaboration between the Ministry of Health and Hand in Hand Ministries. Hand in Hand Ministries is privy to the Belize Health Information System and this provides them an opportunity to monitor their cases. The Boost Program of the Ministry of Human Development, Social Transformation and Poverty Alleviation has also been identified as a major achievement. Through the Boost Program low-income families receive a monthly allowance from the government. As a part of the Global Fund Round 9 project, funds are provided to families that are affected by HIV. In particular, an allowance is provided for each child that is affected in the family. An achievement that is noteworthy is the completion of an Impact Assessment of OVCs in Belize that was conducted in 2011. The 2012 NCPI identified a number of challenges remain which a number of challenges that were encountered over the past two years. These included: adherence to medications, the lack of comprehensive laboratory services in Belize for example, viral loads, lack of professional counsellors and the need for a hospice and palliative care centre for persons living with HIV. Other challenges identified include the lack of proper nutritional care which leads to non-adherence to medication and other complications. Key informants also identified other challenges such as the fact that children are not being removed from dangerous situations which put them at greater risk. Adolescents that need social services are placed at the Youth Hostel which is a home for delinquent teenagers because the Children's Home only caters to orphans of a younger age. This places the adolescents at greater risk. Another challenge identified is the lack of a comprehensive strategy and policy to address the needs of OVCs. The new strategic plan includes this population as vulnerable but greater emphasis needs to be placed on developing strategies that will effectively reach all orphans across the country and provide better coordination between the Ministry of Health, Ministry of Human Development and civil society organizations providing support to this population.



Policy/ Strategic Development

The process of developing the new HIV Strategic Plan for Belize has been described by the majority of key informants as the most inclusive and participatory in the history of the response in Belize. Informants stated that they feel a sense of ownership and responsibility with the new NSP as they were involved in the process of developing and validating it. The process was based on evidence as data from a multitude of recent assessments as well as the Belize Health Information Systems was used to guide and inform the process. The process also allowed for greater involvement of key vulnerable populations such as persons living with HIV, men who have sex with men and sex workers. Civil Society played a major role as consultations were held at the community and the national levels and they were invited to provide input, make suggestions and recommendations based on their specific situations. The NCPI B indicates that civil society respondents scored the participation of civil society in the development of the NSP at a score of 3. The new NSP is also more human rights based and gender responsive. In previous years the process was guided by external consultants. This most recent exercise was guided by the multi-sectoral National AIDS Commission with the support of a working group and two national consultants who are familiar with the situation of HIV and the dynamics of the response in the country. There was also continued involvement and input on the part of technical partners such as the UN Theme Group, USAID and PANCAP. This new NSP is more targeted in its approach to key populations such as young persons in and out of school, orphans and vulnerable children, women in difficult circumstances and men. It was developed in a bottom's up methodology and is anchored in a wider more comprehensive desk review of assessments and commitments. It went through a more comprehensive validation process which makes it most responsive, relevant and realistic to the present situation.

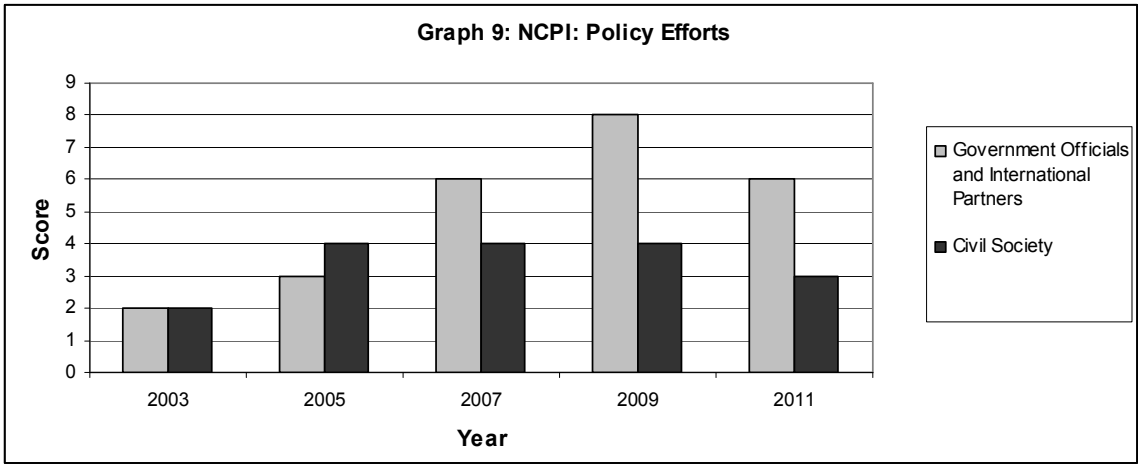
The goals of the revised NSP are more achievable and concise. It includes an operational plan which is a concise and detailed outline of objectives, activities, persons responsible, time frames and resources. The priority areas have been slightly changed to focus on the present situation and to be more gender and stigma and discrimination are given more attention. The socioeconomic impact of HIV is given more attention. It provides an opportunity for more harmonization as partners were provided an opportunity to include their present priorities and plans included resources available and gaps. The process of developing the NSP has provided a stronger sense of collaboration, networking and ownership. It builds on the successes and challenges of the previous NSP as were identified in the Policy Implementation Monitoring Tool

2007 and the AIDS Implementation AIP. The previous NCPI 2009 indicated that there were a number of challenges which needed to be address during the next two years. These included the lack of a formal operational and resource mobilization plan for the NSP; the need for greater involvement of vulnerable populations such as PLHIVs and MSMs and the need for targeted approaches in the area of prevention and treatment, care and support. The process of developing the revised 2012 – 2016 HIV Strategic Plan for Belize and its Operation Plan addressed the challenges identified in the previous NCPI report and ensured that the end products reflect a significant improvement of the last strategic plan. The 2012 NCPI indicates that there was an increase in the score for Strategic Planning in this reporting period. Graph 5 shows a constant increase in the scores for efforts in strategic planning over the years since the first reporting period when it received a score of 3. The country now has a revised and strengthened strategic plan with an operation plan which provides a comprehensive guide for the implementation of the national response to HIV in Belize. Efforts need to be made now to synchronize the monitoring and evaluation plan and develop a resource mobilization plan to ensure the effective implementation of this multi-sectoral national strategic plan.

The NCPI indicates that there was a marked disparity between government/international partners' scores and that of civil society in relation to policy and legislation. In 2011 civil society gave a score of 3 while government provided a score of 6 in this area which is a difference of 3 points. Key civil society informants were of the opinion that there was not much effort made in the implementation of policies and legislation in support of the implementation of human rights and prevention programmes. Respondents stated that the legal review was one step forward but it has not translated into an HIV law due to bureaucracy and "red tape". During the past two years there have been a number of consultations and workshops on the legislative review as well as on the topic of human rights. However some informants are of the opinion that there has been no investment done in neither promoting nor implementing human rights related policies, laws and regulation because there is still no legislation. One of the achievements was the National Human Rights Dialogue on Human Rights, the Law and HIV which provided civil society an opportunity to raise concerns on the issue of human rights, the law and HIV. The Regional Stigma and Discrimination Unit which is a PANCAP entity has also been implementing a project in Belize which has focused on the empowerment of vulnerable groups through training on human rights. In collaboration with the National AIDS Commission and as a part of the Global Fund Round 9 the RSDU embarked on the development of a community-driven human rights campaign. This has provided opportunities for capacity-building on human rights, advocacy and working with the media. Another initiative was the development of a Youth Policy conducted by the Youth for the Future which brought together key agencies working with young persons to develop a policy which also included an HIV component. An important achievement was the revision of the Labour Act 2011 which specifically prohibits dismissal or the imposition of disciplinary action against workers based on the HIV status in addition to protection from dismissal for victims of sexual harassment or pregnancy.

The present NCPI indicates that there are still challenges remaining in this area. During the past two years there have been a number of challenges in the area of laws, policies and regulations to promote human rights. There are still laws and policies which pose barriers to access to HIV prevention and treatment services for some vulnerable populations. Even though the legislative review of the National AIDS Commission was conducted in 2008, the recommendations have still not translated into an HIV law. There have been a number of policies developed but there yet there is still no legal framework to make these effective and provide the protection necessary

for vulnerable groups. Some key informants were of the opinion that even when there are laws they are not enforced yet the laws that are discriminatory are always enforced. The challenge continues to be the enforcement of policies since policies are there but there are no mechanisms in place to enforce them. For example, even though some workplaces have a policy they still require persons to get tested for employment purposes. Some key civil society informants are of the opinion that no matter how much is done in the area of human rights, if there is no legislation to protect vulnerable populations their human rights will never be respected and protected. Policies without laws are ineffective.



IV. Best Practices

The national response to HIV in Belize has seen several stellar accomplishments that may prove helpful to partners in the region. These programmes and initiatives, though successful, do not necessarily have sufficient empirical data to classify them as best practices. The country will continue to monitor their success with the intention that these promising practices can evolve into best practices in time for the next report.

V. Major Challenges and Remedial Actions

(a) Progress made on key challenges reported in the 2008/2009 UNGASS Country Progress Report, if any;

Evidence Based Planning

Several studies have been completed which provide evidence to inform decision making and prevention initiatives. These include two TRaC studies, one for MSM and one for FSW. In addition, the MOH has started a comprehensive Behaviour Surveillance and Population Size Estimation study to produce much needed population size estimation and sero-prevalence data on Belize's vulnerable populations. The study has completed its preliminary qualitative pilot phase and is well underway with data collection. In the case of OVC's the relevant data on the services provided to OVCs as well as population size is now being uploaded directly to the Belize Health Information Services database managed by the Ministry of Health. In tracking adult

prevalence the Ministry of Health now uses case management to produce its figures of adherence. This more accurate figure was used for the first time in 2011 to estimate our national prevalence. Finally, the new National Strategic Plan 2012 – 2016, which was developed between June 2010 and January 2012, includes strategies to improve public private partnership. Furthermore, the costed operationalization of this new guiding document is well underway and should be completed together with its M&E Plan by early June 2012.

The country continues to face challenges in procuring testing and treatment data from the private sector via the Belize Health Information System (BHIS); in integrating Maternal and Child Health data into the BHIS; in the development of a comprehensive and responsive national research agenda. In addition, the timely dissemination of detailed analysis of epidemiological data is pivotal to continued improvements in evidence based planning.

Achieving Universal Access

The establishment of a collaborative network of PWHIV that is involved in all aspects of the national response is worthy of note. This national NGO, C-NET+, working closely with the Ministry of Health and other relevant partners in the national response, has facilitated national discussions among PWHIV which have resulted in the development of an advocacy plan and a respectful dialogue with service providers.

There isn't enough appropriate monitoring and evaluation of the ongoing PITC initiative in the MOH to determine its level of success.

Sexuality and HIV Education for Young People

In 2011, the Ministry of Education, with grant funds from Round 9 of the Global Fund, completed a national assessment of the instruction of Sexual and Reproductive Health in high schools. The Ministry has advanced to the second phase of this initiative to adapt a suitable regional model for implementation in high schools across the country. In respect to out of school youth, the Youth for the Future Unit of the Ministry of Education and Youth has completed a national consultation with young people to identity their prioritized development needs. The results of this consultation will inform the Unit's development of appropriate SRH education for out of school youth. In addition, the unit has also conducted a detailed marketing research and produced a series of profiles of youth to whom their out of school SRH messages are targeted.

There remains concern about how well the existing HFLE curriculum is being taught in primary schools. There is equal concern over the organized opposition to the provision of sexuality education in public schools including efforts to influence policy makers.

National Spending for HIV and AIDS

In 2011 the Secretariat of the NAC initiated ongoing efforts to coordinate multi-national funding. The 2010-2011 National AIDS Spending Accounts Exercise (NASA) has also been completed. The new NSP also mandates annual review of HIV/AIDS spending and the use of such analysis in decision making. The staff of the Secretariat at the National AIDS Commission has been trained to take a leading role in the preparation of future NASA reports.

There continues to be a major challenge for partners in the national response to be able to report their AIDS spending in the required categories by financing sources. It is necessary for the

national response to determine the true barriers to financial reporting and design appropriate strategies to overcome them and institutionalize the preparation of the NASA every two years.

Coordination of the National Response

Great strides have been made in coordinating donor support and reducing duplication of efforts. These include the development of a national coordination calendar, a platform for ongoing multi-sector discussions and collaborations to minimize duplication of efforts and the collaborative development of the new NSP. Stakeholders throughout the national response have been sensitized to the value of the NSP and are now expected to anchor their institutional work plans in this document. The input and role of community based groups has been enhanced via the establishment of very clear terms of reference, capacity building and the establishment of M&E systems for district committees as guardians of the Continuum of Care. In addition the CCM membership has been expanded to include relevant partners who can help improve the management of the existing Global Fund Grant and the NAC has invited official, non-voting participants to further broaden its representation.

Stigma and Discrimination and Involvement of People Living With HIV in the National Response

There have been great inroads made toward to overcome this major challenge. C-NET+, the new National NGO of PWHIV, has empowered a growing number of people participate in meaningful ways in the national response. Belize has also benefited from being a pilot country for the Regional Stigma and Discrimination Unit of PANCAP, (RSDU). The project has conducted a five sector stigma and discrimination assessment whose results indicate fewer stigma experienced by PWHIV than suggested in the previous UNGASS report. The Ministry of Labour's Workplace HIV Policy and Education program has been expanded to cover a new cohort of 13 companies that are in their final stages of training and development of HIV action plans.

A new concern is the potential negative impact of a church based movement against abortion, homosexuality, sexual and reproductive health education and services to young people. This kind of organized counter voice stands to influence public opinion and pressure politicians which may retard ongoing efforts of the Commission towards legislative change aligned with the goals of the new NSP.

(b) Challenges faced throughout the reporting period (2010 – 2011) that hindered the national response, in general, and the progress towards achieving targets, in particular; and,

Sustainability of NGO's

Many NGOs, regardless of their focus, now face severe sustainability challenges that have led to closures, staff reductions, restriction of services and various degrees of diversion from their intended mission in order for them to obtain other sources of funding.

The funding challenge is made worse by a shift in global funding priorities and also changes in global economy. Insufficient coordination among NGOs leads to competition for scarce funds between NGOs and sometimes between government agencies.

Care and Treatment

The Ministry of Health is faced with an unexpected resistance to integration of HIV services from stand-alone VCT sites into the comprehensive medical services provided throughout public health facilities. This resistance has surfaced among previous staff of VCT clinics whose function have changed and from staff members in the public health facilities whose function have changed to incorporate care and treatment of HIV. The national response seeks to remove this resistance so that thorough integration can be given a chance to respond to the needs of PWHIV.

For their part, many PWHIV have also expressed dissatisfaction with integration citing concerns about increased chances of encountering stigma and discrimination because of the increased number of new staff members they will have to approach to get the services they need. PWHIV also cite discomfort with seeking new sources of psycho-social support and sharing their status with several new staff members. They report of preference of gaining all these services from the VCT staff with whom they have already established strong bonds of trust, comfort and convenience.

Though the country has experienced significant strides in care and treatment, especially in access to ART, there remains a long standing gap in access to appropriate diagnostic testing. During 2011 the National AIDS Program in the Ministry of Health acquired two more CD4 Machines to increase access to and reduce turn-around time for these tests. This is well acclaimed as an example of the significant strides being made in care and treatment. The next goal of providing access to Viral Load tests is the most sought treatment support which has proven most difficult to achieve. Without this pivotal test, Doctors continue to find it difficult to ensure the optimal case based ART and clients find that the impact of their adherence is lessened.

Policy Efforts

The 2012 NCPI shows that the members of the national response have continuously rated our HIV policy efforts low and decreased our rating over the past two years. In discussion at the validation workshop stakeholders cited exasperation at policies not being implemented in many cases and not turning into laws in other cases. The fact that the landmark legal review started over three years ago has still not been completed nor spawned any new laws protecting the rights of those vulnerable to HIV was noted as a particular low point in our policy efforts. There remains a resounding cry for advocacy and action to add teeth to existing policies and to create a new expanded legal framework to support the enabling environment called for in the NSP.

Prevention Efforts

The NCPI of 2012 shows that even though there are a few NGOs conducting sustained efforts in BCC and the Ministry of Education and Youth continues to conduct satellite tables to reach out-of-school youth, there are still challenges in the overall prevention initiatives of the national response. These include:

- Limited assessment of the gaps noted between HIV prevention knowledge and risky sexual behaviour
- Lack of confidence that current prevention initiatives are targeting the right audience
- Limited coordination of funding, planning and implementation of prevention interventions

- Lack of a national quality standard for education and prevention messages and social marketing
- Limited gate keeping function being provided by the Information, Education and Communication (IEC) Committee of the NAC

(c) Concrete remedial actions that are planned to ensure achievements of agreed targets.

Sustainability of NGOs

An inventory and assessment of NGOs and the services they offer in Belize and open dialogue to provide opportunities to coordinate NGO and government actions for more efficient use of limited resources.

Exploration of new income generation and expense reduction models for NGOs.

Exploration of new financing opportunities available to NGOs through government, especially the Ministries of Foreign Affairs and Finance.

Care and Treatment

There is a need for implementation of change management initiatives in the management of public health facilities affected by integration. This should include an assessment of the reaction of staff members, the understanding of staff members of the expected benefits of integration and the acknowledgement of the ground work done by the previous VCT staff and the invaluable contribution they have made to developing systems of client care, psycho-social support of clients, reduction of stigma and discrimination and adherence counselling. In addition, the MOH, with help from partners in the national response, can study best practices in managing change related to integration of HIV services in peer countries in the region and apply appropriate recommendations.

To help determine the best way to manage the changes that integration brings for PWHIV, the national response should conduct a needs assessment of clients' response to integration. This assessment must include but should not be limited to satisfaction surveys among Positive clients at all public health facilities that have undergone integration. The results of these assessments should be used to engender discussions among the Positive population to determine the best step forward. These evaluations can also provide valuable feedback to health staff on the success of their efforts to provide client-centered care and treatment free of stigma and discrimination to PWHIV.

The national response has included the provision of viral load tests in the National Operational Plan for 2012 – 2016 and is poised to establish a small strategy team to overcome the obstacles to operationalizing a viral load machine donated to the country in 2011 by CAREC. It is imperative that this team be multi-sectoral and it has to have the full support of the NAC to be able to achieve its goal to make viral load tests available to PWHIV in 2012.

Policy Efforts

To make sure that the national response does not let two more years pass with no improvements in policy development and implementation, the national response is calling for specific strategic conversations to analyze the results of the NCPI, NASA and the Global AIDS Response Report. The Secretariat is committed to making sure these discussions happen at the level of the National AIDS Commission. In tandem there is a need for scaled up and targeted

advocacy using the input and voice of a broad membership in the national response to create the most possible impact on legislators to defend existing policies and introduce new ones, especially those to defend the rights of access to sexual and reproductive services and education for young people. Finally, the results of these assessments and progress reports will be used to complete the National Operational Plan and its corollary M&E Plan.

Prevention Efforts

It is expected that as the new M&E Plan becomes functional, it will call for a thorough assessment of strategic information gaps throughout the national response. Once this kind of assessment and information is produced it will clarify the profile of transmission and provide confidence in the minds of those responsible for steering the prevention response. Steps must be taken to ensure that such strategic information will include psychological assessment of the gaps noted between knowledge and behaviour. Once this information is established the national response will follow common standards under the stewardship of the empowered IEC Committee

VI. Support from the Country's Development Partners

In Belize, the Joint UN Team (UNJT) on AIDS organizes the United Nations development assistance to the National HIV response. During the period 2010/2011 the work of the UNJT was centered around the five thematic areas in line with the recommendations of the UN Secretary General Bann Ki-moon leading up to the High Level Meeting on AIDS. These are HIV prevention revolution, achieving universal access to prevention, treatment, care and support, cost effectiveness, efficiency and sustainability of HIV programmes, health human rights and dignity of women and girls, and translating commitments into action.

Under the umbrella of the Central America Regional Partnership Framework to reduce HIV/AIDS incidence and prevalence in the Central American region signed between the Government of the United States and Belize as well as other Central American countries, the USAID| Central America Capacity Project has been providing technical assistance for Health Systems Strengthening particularly the health workforce capacity through Optimizing Performance and Quality (OPQ).

USAID/PASCA currently operates a five year HIV Project in Central America, including Belize. USAID/PASCA´s overall objective is to ensure that HIV policies are effectively implemented and the project has three result areas, including costed, implemented, monitored and evaluated Regional and National Strategic Plan; Regional and national advocacy agendas that are effectively implemented, and eeffective involvement of the private sector in the National Response to HIV. The thematic issues of gender based violence and working with populations at risk of HIV infection are mainstreamed throughout. The use of strategic information and evidence-based planning are also cross-cutting.

The UNJT supported the development of a Joint UN Project for Adolescent girls under the leadership of UNICEF and UNFPA under the guidance of the Population Council, which focused on gathering strategic information on access to services. Additionally support was provided to the development of edutainment, media and SRH educational sessions for out of school

population in conjunction with the Youth for Future with direct technical support from the Joint Team lead by UNDP.

An integral part of PASMO's support to the National Response includes Behaviour Change Communication interventions with the country's most vulnerable populations. In an effort to better track success PASMO implemented a new voucher system to track interventions with individuals. This new system uses Unique Identification Codes composed of letters and numbers that is assigned to an individual upon participating in a BCC intervention. This will facilitate the collection of data on the number of person reached with BCC that access biomedical services. This is possible through collaboration with both BFLA and multiple VCT that collect the PASMO vouchers; the number of times (on average) an individual needs to be encountered for them to access biomedical services and, thus, the costs associated with BCC interventions; and the types of complementary services individuals receives such as: family planning services, mental health services, and other social services.

With the aim of revitalize the universal access thrust, the Joint Team supported the preparation and validation of Universal Access Consultation and Reporting at country level, which included stakeholder consultations and feedback. Additionally, under the leadership of UNDP and PAHO/WHO, support was given to the revision of the National Treatment Guidelines for the Clinical Management of HIV and AIDS. This achievement is an important contribution from the UN system to the qualitative improvement of the continuum of care for patients living with HIV in Belize, in order to reach international standards in both, treatment regimens and proper care to patients living with HIV. During this period, advocacy actions supported by USAID/PASCA influenced positive changes in care and treatment policies developed by the Ministry of Health.

Understanding that the greater involvement of People living with HIV was essential to achieving UA, the Joint Team under the leadership of UNAIDS and UNDP, and in collaboration with REDCA, supported the Collaborative Network of Persons Living with HIV (C-NET+) to become a formally registered NGO and for conducting their 1st General Assembly of Persons Living with HIV and planning sessions. In an effort to address the need of increasing access to important health information for persons living with HIV or AIDS PASMO Belize, with support from US Ambassadors HIV Prevention Program, in 2011 began efforts to create an essential package of information. This package of information will be disseminated to persons living with HIV or AIDS at public healthcare centres. Persons targeted will be those most vulnerable with emphasis on those who lack access to readily available sources of information such as internet.

A significant part of the development partners' support to the HIV response was to the development of a new HIV strategy for 2012-2016 and its accompanying operational plan. With the changing funding dynamic for HIV and the need to prioritize funding to effective and efficient high impact HIV programmes the Joint Team stressed the importance of shared responsibility and accountability in cultivating a robust and sustainable HIV response. Additionally, USAID/PASCA supported the development of a Situation Analysis on HIV in Belize, an analysis of Most at risk Populations, research on stigma and discrimination, analysis of Belize's progress with the implementation of the HIV policy response, the development of a basic package of HIV indicators and the National AIDS Spending Assessment.

In line with the need for accountability the Monitoring and Evaluation Systems Strengthening workshop was in early 2011 as part of the enabling activities for the implementation of the

Round 9 Global Fund grant with funding from UNDP and USAID/ PASCA and technical support from UNAIDS. This included an assessment of existing bottlenecks in effective monitoring and evaluation and the development of a comprehensive action plan for creating a more effective HIV related monitoring and evaluation system in Belize.

For the first time the National AIDS Commission and National Women's Commission joined forces with the support of the Joint Team to launch the Agenda for Women, girls, gender equality and HIV in Belize. As a part of the immediate enabling actions, identified at the Launch of the Agenda for Women and girls, UNDP, UNAIDS and UN Women hosted the first ever Leadership Development Programme in Belize with support from the entire Joint Team. The Leadership Development Programme was proposed as an excellent opportunity for women's empowerment and capacity building actions with the aim of developing strong human rights advocates within the community.

Translating commitments into action led to the 1st National Dialogue on Human Rights, HIV and the law, organized by Women's Issues Network (WIN) Belize. The purpose was to advance human rights-based and HIV-sensitive legal reform in the country; to strengthen knowledge on human rights and HIV-related legal issues; and to sensitize decision makers and the population at large on human rights and HIV. The National Dialogue was built on the outcomes and methodology of the Caribbean Regional Dialogue of the Global Commission on HIV and the Law. For the first time in Belize, a wide representation of members from the various vulnerable groups attended and advocated publicly on issues related to HIV and the law, such as people living with HIV, men who have sex with men, female sex workers and transgender people.

The USAID| Central America Capacity Project has accompanied Belize's Ministry of Health during the OPQ measurements at six institutions across the country. These institutions include Corozal Community Hospital, Northern Regional Hospital, Karl Heusner Memorial Hospital, Cleopatra White Polyclinic II, Southern Regional Hospital, and Punta Gorda Community Hospital. The project has also been present during BFLA's OPQ measurements done in Belize City. Through the year support has been provided to close multiple knowledge, skills and attitude gaps across the country.

As part of the national response to HIV, the USAID| Central America Capacity Project has also supported the revision of University of Belize's Faculty of Nursing Allied Health and Social Work curricula to include HIV topics, supported trainings and activities on counselling and testing for HIV in UB's student health fairs, and provided training for lecturers in Learning for Performance. Support was also provided for the Continuum of Care for HIV or networking for an integrated management of HIV and applying OPQ to fortify networking. After a national consultation a pilot was done at the Northern Health Region and its NAC district committees.

VII. Monitoring and Evaluation Environment

(a) An overview of the current monitoring and evaluation (M&E) system;

National AIDS Commission (NAC)

The National AIDS Commission has the responsibility of coordinating, facilitating and monitoring the National Response to HIV/AIDS. The NAC Secretariat has the task of monitoring the day-to-day management, coordination and monitoring of the implementation of the National Strategic Plan 2012 – 2016, with technical guidance and support from the NAC Monitoring and Evaluation Sub-Committee and the NAC M&E Officer.

National Strategic Plan (NSP) 2012 – 2016

The National Strategic Plan (NSP) 2012 – 2016, delineates its three priority areas: i) Ending New HIV-Infections (Prevention); ii) Improving Health and Well-being (Treatment, Care and Support); and iii) Creating an Enabling Environment (Coordination of the National Response) and postulates four main goals:

1. By 2016, Belize has halted and began to reverse HIV incidence rates, especially among young people, men who have sex with men and sex workers.
2. By 2016, AIDS-related deaths, especially among men living with HIV in Belize will have decreased by 30%.
3. By 2016, systems will be in place to fully understand the essential features of the epidemic in Belize.
4. By 2016, Belize will have significantly reduced discrimination against persons vulnerable to HIV.

The three priority areas are provided with specific Strategic Objectives that provide a scope of content and direction of the sub-areas and each strategic objective is accompanied by a set of expected results at outcome or output level. Expected results enable the performance monitoring and the plan therefore includes a rudimentary set of key performance indicators that constitute the foundations for the NSP's monitoring and evaluation plan.

National Monitoring and Evaluation Plan 2012 – 2016

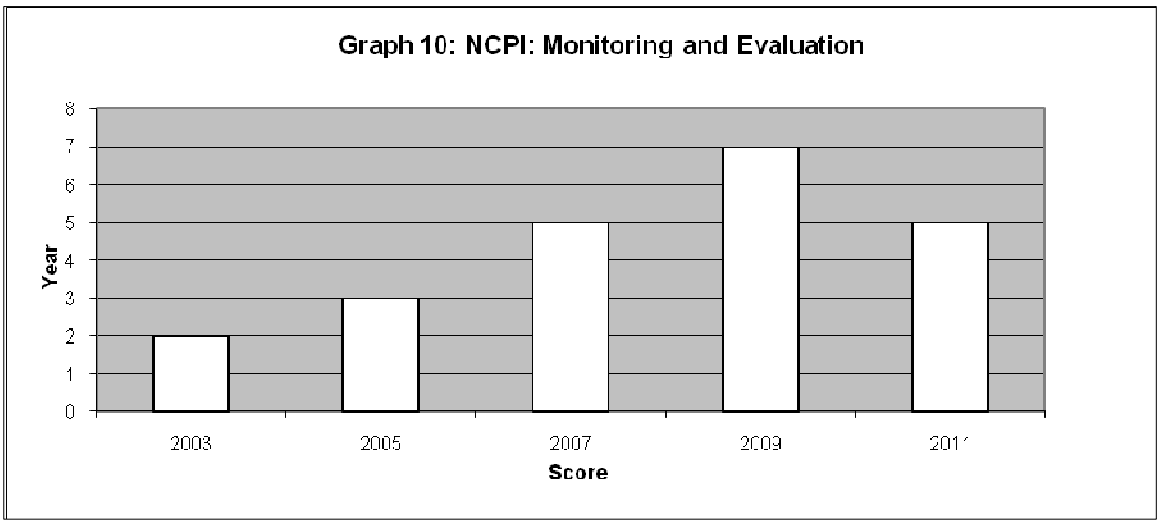
The updated National Monitoring and Evaluation Plan 2012 – 2016 in alignment with the NSP 2012 - 2016, will be the guide and tool for monitoring the NSP and the National Operational Plan (NOP), and consist of three key elements, the indicator framework, the M&E calendar, and a time line of major activities. Other critical components to be included in the M&E Plan are i) an implementation plan; ii) a data collection strategy including guidelines and tools and iii) a knowledge management strategy including a plan for data dissemination and use.

National M&E System

The national M&E system, upon operationalization, will deliver a fully functional system that provides timely, accurate and pertinent data. The national M&E system, contains five critical M&E components, i) Surveillance; ii) Referral and Client Management Tracking Systems; iii) Project Implementation; iv) Research; and v) Financial Management M&E.

The NCPI 2012 indicates that in the area of Monitoring and Evaluation Belize continues to score low in view of the fact that is an important component of the "Three Ones". The NCPI respondents were of the opinion that since the last reporting period 2009, Belize has made very little progress in the implementation of its Monitoring and Evaluation Plan. There still is no functional monitoring and evaluation system and reports are not being submitted by partners to the NAC. The NCPI indicates a score of 5 which is a decrease of 2 points since the last reporting period. In 2011 the NCPI indicates a score of 5 for efforts in monitoring and evaluation. In 2002 years 9 when the first-ever Monitoring and Evaluation Plan was developed the country received a score of 7. However, during the past two years this plan was not operationalized. However, there were a few achievements highlighted. In fulfilment of the requirements of the Global Fund Round 9 project approval the National AIDS Commission engaged in a Monitoring and Evaluation Systems Strengthening exercise in 2011 which provided the opportunity to identify challenges and make concrete recommendations. This is timely as the country prepares to launch its HIV strategic Plan for 2012- 2016. There is an NSP now that will provide an opportunity to update the M&E and facilitate implementation of the plan The USAID/Central American Capacity Project in Belize has also been engaged with the Ministry of Health in assessing standards of service delivery and providing performance monitoring. This project has been helpful during the past two years in providing some form of monitoring and evaluation in the area of HIV service delivery within the public system. Even though there has not been a functional M&E unit at the National AIDS Commission for most of the past two years, Belize has been able to submit international reports and access data to respond to specific indicators with the support of the Ministry of Health.

The NCPI indicates that are still some challenges in this area. During the past two years the post of Monitoring and Evaluation Officer has either been filled briefly or vacant. There is now a full-time Monitoring and Evaluation Officer at the NAC Secretariat. One of the challenges identified is the lack of national expertise in the area of monitoring and evaluating HIV programs. At the organizational level monitoring and evaluation is only done as a part of reporting to funders and not as a part of a greater national M&E system. In regards to surveillance, the Belize Health Information System has been recognized as a model for the region. The challenge remains in the analysis and use of the vast amount of data that is collected through this system. Key informants were of the opinion that an opportunity was being missed due to lack of human resource and expertise to analyze the data that is available. With the introduction of a new strategic plan there is a need to update the present monitoring and evaluation plan to ensure that new indicators are included and that the plans are synchronized. There is also need for the M&E plan to be costed as a part of this process. Key informants stated that a major challenge will be the implementation and adoption of the recommendations and action plan which resulted from the Monitoring and Evaluation Strengthening Systems exercise in 2011. The NCPI indicates that there has been some increase in the scores since 2003 when efforts in monitoring and evaluation were scored at a low 3. However, considering the importance of monitoring and evaluation a score of 5 in 2011 indicates a low rate of improvement and in addition the fact that the score reduced by 2 points since the last report period indicates an urgent need to address monitoring and evaluation of the HIV response in Belize (see graph 11).



Graph 11: Efforts in Monitoring and Evaluation

(b) Challenges faced in the implementation of a comprehensive M&E system;

In 2011, UNDP, as the Principal Recipient (PR) for the Round 9 Global Fund grant, in close collaboration with the NAC, National AIDS Program (NAP) from the Ministry of Health, PASACA/USAID and UNAIDS organized and facilitated the Belize HIV Monitoring and Evaluation System Strengthening Workshop, with the participation of a wide range of key stakeholders in the National Response. The aim of the workshop was to assess the critical elements of the national HIV Information, Monitoring and Evaluation system and identify gaps needs and barriers to an active culture of M&E to guide the national efforts to improve the national HIV Information, Monitoring and Evaluation system. Key challenges and barriers identified in the MESS workshop are echoed in the NCPI of 2012 and appear below.

- Partners not making the time to submit data for monitoring
- Some leaders of partner organizations, departments or agencies don't support M&E efforts
- Limited analysis of national monitoring reports
- Lack of a relevant and responsive research agenda
- A need for more capacity building to create more positive attitudes toward M&E functions and increase the efficiency of M&E efforts
- The BHIS needs to get direct input of data from departments such as the MCH program and NGOs eventually procuring similar input from the private sector
- A need for sustainable funding of implementation of the national research agenda
- A practical action plan to implement knowledge management
- A need for funding to support non-research M&E functions at the organizational and District Committee level
- The lack of a strategic system including reporting tools to ensure that the national response monitors its HIV Performance adequately to be able to report its progress using the accepted national and international indicators

(c) Remedial actions planned to overcome the challenges; and

Action Plan for HIV M&E System Strengthening (0-12 months)

- Update M&E plan with an aim toward explicitly incorporating indicators that attend to national and local stakeholder strategic information needs.
- Data collection instruments, data flow and related processes should be developed for the Global Fund Grant with involvement of all relevant stakeholders.
- UNDP to incorporate M&E capacity building within the context of developing the M&E system for the GF grant. Sub-recipients should be trained with the roll-out of the reporting tools.
- HIV stakeholder institutions to examine their staffing patterns and structures to identify areas for possible adjustment to strengthen M&E functions.
- Create inventory of data and databases used by all partners.
- Each organization to examine its own budget to identify human and financial resources that could be allocated to M&E.
- Clearly identify current strategic information needs to allow reporting of comprehensive HIV response and to inform strategic planning and programming. This should be accompanied by mechanisms for the collection and analysis of said data.
- NAC and M&E sub-committee to prepare inventory of data and reports collected by each organization.
- UNDP and GF sub-recipient organizations to develop organizational M&E workplans aimed at meeting GF reporting requirements.
- Disseminate and facilitate analysis of any existing reports or information that are readily available.
- NAC and stakeholders to use existing M&E data to inform strategies of revised NSP and operational plan.

Action Plan for HIV M&E System Strengthening (12+ months)

- Secure funds for M&E system development and implementation in accordance with M&E plan.
- Develop a dissemination strategy that will engage all stakeholders. Distribute to all stakeholders; convene meetings, etc to ensure that stakeholders are aware of the content, their roles, contributions and structure of the M&E system.
- Conduct an M&E capacity assessment of all HIV stakeholders. Develop an M&E capacity development plan to address needs of HIV stakeholders.
- NAC and M&E sub-committee to strive for standardization and integration of databases with linkages as they coordinate the implementation of the updated M&E plan.
- MOH, NAC and development partners (UN Theme Group, USAID, CDC etc.) to conceptualize system for institutionalizing HIV/AIDS M&E systems and incorporating into broader HIS.
- Each organization to develop costed annual M&E workplans.
- Include periodic M&E system review and production of periodic reports in revised/updated M&E plan.
- Include list and plan for preparing all reports (internal and external) that should be produced in updated M&E plan.
- Ensure that policies and programme adjustments are informed by both evidence/data from the M&E system and consultations from relevant stakeholders.

(d) Highlights, were relevant, the need for M&E technical assistance and capacity building.

The detailed list of challenges and remedial actions listed above highlight opportunities for support and collaboration from national and international partners. The list below includes prioritized opportunities for assistance to M&E efforts in the national response.

- Funding for small and large scale research to implement the national research agenda
- Technical support in the development of appropriate data collection and reporting tools such as databases
- Training in knowledge management
- Assistance for partner agencies, organizations and departments to develop small scale institutional M&E plans
- Funding for printing and disseminating reports, assessments done at the national or organizational level
- Support for the implementation of non-research M&E functions for the District Committees and NGOs

Sexual and Reproductive Indicators

Belize's Global AIDS Progress Report

2010-2011

By Sheila Middleton-Kerr

For USAID PASCA

March 2012

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 National Public Health System in Belize provides universal access to personal and population based services, essentially at no direct cost to the individual. This includes the provision of pharmaceuticals and other support services. The Government is the main provider of health services, though recently there has been an expansion of the private sector as it relates to personal care. The main financing source for the public sector is the consolidated fund of central government. A system of rural health centres with permanent staff is supplemented by mobile health services, community nursing aides, voluntary collaborators and traditional birth attendants working throughout the rural communities of the country.

A National Health Insurance Agency has been established under the Social Security Board (through the SSB Amendment Act of 2001) as the purchaser of an expanded primary care package of health services from public and private providers.

Primary Care Provider (PCP) clinics have been established in the south side of Belize City and in the southern region of Belize, with staffing ratios based on one General Practitioner (GP) led team per 4,000 population initially (the health care provider to population ratio will improve even further as the service evolves). The optimum size of each PCP has been determined at three GP led teams, with each PCP serving a population of approximately 12,000 Belizeans. The PCPs operate using an urban model in Belize City (where geographic access is relatively easy) and an extended rural model in southern Belize where the challenges presented by extremely low density populations have required the addition of satellite clinics and mobile 'outreach' services to create an equitable environment for access to quality services. The PCPs are sited in geographic zones and are responsible for maintaining the epidemiological profile for the catchment population within that zone and for promoting the health of the community they serve and not limiting themselves to simply treating those who are unfortunate enough to become ill.

2. Does the 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. A National Plan was developed in that year to accompany the Policy. This plan was revised and updated in 2011 with technical support from USAID/PASCA and UNAIDS and through broad based consultation with stakeholders from government and civil society.

The National Strategic Plan 2012-2016, "One Response", outlines 3 priority areas

Ending new HIV infections:

1.Reduced risky sexual behaviour and adoption of personal protection plans most vulnerable to HIV
2.At least an average 10 % annual increase in the number of men and women consenting to HIV testing and returning for their results.
3.Annual increases of 10 (ten) % in reported use of condoms and lubricants by persons 15 – 49, MSM and FSW.
4.The delivery of the curriculum component "Comprehensive Sexuality Education" has an effective coverage of 100 % of boys and girls enrolled in primary education and 60 % of boys and girls enrolled in secondary education.

Improving Health and Wellbeing

5.Increase in the coverage of ART of persons requiring ART based on national treatment guidelines HIV to 85 %.
6. A minimum of 10% annual increase in the number of vulnerable persons, including OVC, utilizing care and support services, including psycho-social support services.

Addressing Critical Enablers

7.All relevant legislation reviewed and revised to provide a legal basis for the HIV policy and the enforcement of non-stigma and non-discrimination principles. .
8.An increase of minimal 10 % of annual resources (people, funds and materials) available to civil society organizations to deliver NSP interventions to key at-risk populations.
9.Improved monitoring, evaluation and operational research will have provided accurate population estimates, biological and behavioural prevalence data and in-depth knowledge about determinants of HIV vulnerability among key populations.
10.More government partners (Finance, Tourism, Police, and Attorney General) recruited into the national response to enhance mainstreaming of HIV/AIDS.
Belize currently benefits from a Global Fund grant that is a major support to the implementation of the strategic plan. However, there is still a funding gap in several areas including pillar 2: achieving health and well-being which poses challenges for the full implementation of the National 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 National Policy on SRH (2002) emphasizes sexual and reproductive rights and the integration of S& RH services. It calls for an end to coercive or discriminatory laws, including laws related to HIV. It promotes: counselling on family planning (FP) options for PLHIV; an ethical and gender sensitive approach to service delivery; and integration of HIV with issues relating to sexual abuse, abortion, ST

The National SRH Strategic Plan aimed for all public health facilities to provide SRH services by the end of 2010. It commits to implementing and maintaining an STI and HIV programme as part of SRH services that are accessible and affordable.

Although a plan was developed to accompany the policy only a few advances have been made in the implementation of the plan. A consultant is currently on board to examine policy and legislation related to adolescent access to S&RH.

The 2010 Gender Policy Situation Analysis noted that "the structure of the healthcare delivery system and having only 1 primary health care nurse and even fewer gynaecologists per 5,000 population, severely limit the health sector's capacity to provide comprehensive SRH services in the manner outlined in the SRH Policy."

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 2007 a National Plan of Action on Gender-Based Violence (2007-2009) was produced for the National Gender-Based Violence Committee, composed of representatives of both public sector and civil society organizations with interest in, or responsibility for, responding to instances of gender based violence. It was intended to provide a strategy for "coordinated and cross-sectional integrated approach…to address the cultural, social and economic obstacles to leading lives free of violence." The Plan of Action sets out a series of actions to be taken with respect to a number of Strategic Goals and Objectives:

1. To reduce the number of gender-based violent crimes in Belize.
2. Promote a Zero-Tolerance approach to gender-based violence throughout Belize.
3. To provide a comprehensive and supportive service to victims of gender-based violence in Belize.

A 2009 assessment indicated that "the objectives are very broad and difficult to monitor because they do not specify exactly what the Plan is intended to accomplish. Furthermore, the actions recommended in each section are very wide-ranging, often vague and unrealistic in the time frame given. Finally, the lack of commitment at various levels limited the degree to which participants in the committee took up the responsibilities as outlined in the plan. Even in those cases where individual government departments were committed, lack of support from the Ministry and Cabinet undermined their ability to take action". Therefore, the report indicated that the plan had only achieved limited success in the achievement of the objectives laid out. Using the lessons learnt from the 2009 assessment, the Women's Department developed a new action plan under the UN Women supported Project "Strengthening State Accountability and Community Action for Ending Gender-Based Violence in the Caribbean".

The Goals and objectives of the 2009-2013 plan of action are:

Goal 1: There is zero-tolerance for gender-based violence in Belize.

Objective 1-1: Police response to survivors of gender-based violence is improved. Complaints concerning police response are reduced. Objective 1-2: Prosecution of acts of gender-based violence is strengthened. Attrition in reported cases that go to trial and result in convictions is reduced by 50%.

Objective 1-3: Survivors of gender-based violence have access to justice, including adequate legal representation.

Goal 2: Survivors of gender-based violence in both urban and rural areas are provided with adequate services and support.

Objective 2-1: All survivors of gender-based violence have access to adequate health services delivered in a supportive, respectful and confidential manner.

Objective 2-2: All survivors of gender-based violence have access to adequate support and advocacy services.

Objective 2-3: All victims of domestic violence in crisis have access to adequate shelter and financial support.

Objective 2-4: Rural women who are victims of gender-based violence have access to justice and support.
Objective 2-5: There is strong cross-sector collaboration in responding to survivors of gender-based violence.
Goal 3: Gender-based violence in Belize is reduced, and ultimately eliminated.
Objective 3-1: Recidivism by perpetrators of gender-based violence is reduced by 30%.
Objective 3-2: There is greater public understanding of the roots of gender-based violence.
Objective 3-3: Men take greater responsibility for understanding the roots of gender based violence and take action based on that understanding.
Goal 4: It is possible to measure both the extent of gender-based violence in Belize and the effectiveness of strategies to respond to it.
Objective 4-1: Systems designed to measure reported cases of gender-based violence capture all reported cases of both domestic violence and sexual offenses. Objective 4-2: A system to measure the incidence, frequency and severity of gender based violence is in place.
Objective 4-3: A method to assess the effectiveness of strategies to respond to gender based violence is in place.

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. This is being implemented in all primary schools in Belize. Although there is no formal curriculum for sexual education at secondary level, the Ministry of Education partners with the Belize Red Cross to implement a peer education programme "Together We Can" which focuses on sexual and reproductive health. With the support of the Global Fund the Ministry of Education is currently doing a mapping of life skills based programmes in secondary schools to inform the development of a comprehensive life skills based programme which will include S&RH.
At the primary level, the Health and Family Life Education programme continues to experience resistance from some denominations. The church-state managed system of education poses many challenges in guaranteeing the delivery of age-appropriate sexual and reproductive health information. As recent as February, 2012 a Christian action group advocating against homosexuality advocated for the establishment of a committee to review an HFLE Manual "Education today for a Healthy Tomorrow, Teacher's Guide Lessons for HFLE Curriculum" which they indicated has questionable content. This is one example of the challenges faced in delivering comprehensive sexual and reproductive health programmes.

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, Cornerstone Foundation, YWCA) administer 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
The Ministry of Health has developed protocols for the Clinical Management of STIs. However, there are no specific policies defined for addressing STIs.

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?

There is no national policy on abortion however the Sexual and Reproductive Health Policy (2002) "Sexual and reproductive rights for men, women, and adolescents" Commitment 18 states " Review laws containing punitive measures prohibiting the accessing of counselling and mental health services for those who have undergone abortion. In no case should abortions be promoted as a family planning method". 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 theses 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?

MCH reports that 25% of the budget is allocated to S&RH recurrent- personal emoluments and 3% to programme costs). The National AIDS Program under got a total of $1,165,222.00 approved for the fiscal year 2010-2011. The monies were assigned to five fiscal categories, personal emolument, travel and subsistence, materials and supplies, operating cost and maintenance cost. The programme funds were mainly spent under the line item "materials and supplies."

The National AIDS Spending Assessment 2010 reported for the fiscal period of 2008/2009 the national AIDS spending totalled Bze $4,922,545. This represents 6.8% of the National Health Budget of Bz $72.8 million for the same period. The government of Belize contributed 31.8% or Bz $1,283,494 to the total cash spending, while international donor agencies contributed 68.2% of the national spending or BZ $2,757,312. The total combined spending 17.9% or Bz $881,739 was non-monetary donations. The 2010-2011 National AIDS Spending reported for that fiscal period 2010-2011 was Bz. $5,755,995.

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

1) Documents

Catzim-Sanchez, *Rapid Assessment of Sexual and Reproductive Health and HIV Linkages,* 2010
Lewis Debra, *Monitoring the Fulfilment of the UNGASS-AIDS Agreements on Sexual and Reproductive Health Phase II – 2009/2010*, Belize Report
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
Gustavo, Perera, National AIDS Spending Assessment FY 2008/2009, April 2010
National AIDS Commission, *National AIDS Policy* (Belize) 2006
National AIDS Commission, HIV National *Strategic Plan: One Response 2012-2016*
Ministry of Health, *Health Agenda, 2007-2011*
Ministry of Health, *Sexual and Reproductive Health Policy, Plan of Action 2006-2010*
Ministry of Health, National TB, HIV and other STI Programme Annual report 2010
Pan American Health Organization (PAHO/WHO), *HIV and Violence Against Women in Belize, Preliminary Report* (Belize) 2009
Women's Department, *The National Plan of Action on Gender-Based Violence (proposed)* (Belize) 2009
Women's Department, *The National Plan of Action on Gender-Based Violence 2010-2013*

2) Information Gathering Civil Society

Carolyn Reynolds	Women's Issues Network of Belize (WIN-Belize)
Karen Cain	Youth Enhancement Services (YES)
Joan Burke	Belize Family Life Association
Marci Martinez Carballo	YWCA

3) Telephone interviews

Dr. Natalia Beer	Maternal and Child Health Programme, Ministry of Health
Dr. Marvin Manzanero	National AIDS Programme, Ministry of Health
Michelle Irving	Productive Organization for Women in Action (POWA)
Rita DeFour	Cornerstone Foundation

BASIC STATISTICS ON THE EPIDEMIC AND ON SEXUAL AND REPRODUCTIVE HEALTH: (PLEASE CONSIDER OFICIAL FIGURES ONLY FOR THE PERIOD 2010/2011)

2010 new infections by sex and age

	Under 15	15 and over	Total
Male	6	120	126
Female	9	109	118
TOTAL	15	229	

This represents a 33.8%% decrease in the total number of new infections compared to 2009

Male to female ratio of new infections: 2010 1.00:1.00

The estimated adult HIV prevalence in Belize has ranged from 2.4% to 2.1%,the highest in Central America, though slightly less than Haiti (2.2%) and the Bahamas (3.0%) in the Caribbean. There is no up-to-date estimate of prevalence rate in Belize; it is normally difficult to calculate incidence rates as these are normally taken from modelling information such as Spectrum. According to the Ministry of Health Surveillance report the number of new infections has decreased two years in a row 2009, 2010.

- ARV-use coverage, by sex

2010	Male	523
	Female	530
	TOTAL	1053

The Ministry of Health surveillance report notes that a contributing factor to the increase in coverage has been the expansion of ARV treatment centres beyond the VCT Centres. ARVs are now available through entities such as the Kolbe Foundation/Belize Central Prison and Hand in Hand Ministries and the Belize Defence Force.

- Maternal Mortality Rate
  2010 – 53.9/100,000 live births
  2011 – zero

It should be noted that Belize's small population means that a very small increase in the number of maternal deaths leads to a dramatic effect on the mortality rate per 100,000 live births. There was no maternal death in 2011.

- Prevalence of Condom Use

  A report from the National AIDS Commission based on the 2009 Sexual Behaviour Survey includes the following:

  Percentage of men and women aged 15 – 49 who reported having had more than 1 sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse.

Male	65.8%
Female	55.6%
Both	63.1%

  Percentage of people aged 15 – 24 reporting consistent use of a condom with non-regular partners in the past 12 months.

Male 62.5%
Female 44.0%
Both 57.5%
Percentage of people aged 15 – 24 who reported they could get condoms on their own.

Male 86.7%
Female 77.0%
Both 81.3%

This last figure in particular is a significant increase since 2006, when the percentage of people in this age group who reported they could get condoms on their own was just 37.8%.

- Prevalence of use of contraceptives
  34% MICS 2006

- Vertical Transmission rate for HIV
  2010 – 4 5.7%
  2011 - NA
  Cases contributing to the virtual transmission rate include mothers who give birth with traditional birth attendants and those who test

negative but become infected during pregnancy. Data for 2012 is not yet available.

- % of births taking place under hospital care regime: 90% 2010/2011
- of births to minors in the age group 14 years old or under and in the age group 15 to 18: 10-14= 25 cases and 15-19=1,420 (2011)

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:
Under the Prevention of HIV Transmission goal of the National Policy there are several groups targeted for specific messages on HIV Prevention:
1. Children and Young People: Promoting abstinence, Delaying sexual activity, understanding gender relations, and healthy lifestyles
2. Adults: promote multiple methods of prevention including abstinence, fidelity, safer sex practices, and correct and consistent use of condoms
3. High Risk and highly vulnerable groups: (does not list a specific focus but talks makes mention of vulnerability reduction and behaviour change)

4. Survivors of sexual assault: provision of information on testing, treatment, care and support services
5. Persons living with HIV and AIDS: provision of information to prevent transmission and reinfection

B) Most-used media and strategies:

A wide variety of media strategies, including broadcast (radio/TV) and print media as well as posters, brochures and other materials are utilized. Health fairs and outreach tables are also used. It is generally felt, however, that most messages are not targeted and the absence of a comprehensive prevention strategy makes it challenging to link the various campaigns to larger behaviour and social change goals.

C) Promotion, availability and distribution of condoms:

A limited supply of condoms are available free of cost. During Round 3 of the GF grant free condoms were available to NGO's and Ministry of Health for wide distribution. However, in Round 9 only a limited supply of condoms is being procured. Many centres especially in the districts are reporting stock out of condoms and NGO's are reporting that they do not have a sustained supply for distribution as they did in previous years.

Low cost condoms are available through BFLA and PASMO.

Male condoms are more widely available than female condoms. Female condoms are available for sale in only a few locations and cost of the female condoms is prohibitive. 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:

There has been an increase in the involvement of civil society in planning the national response. Civil Society is represented on the NAC, for example, and a number of sub-committees. However, there is room for improvement as it relates to inclusion of civil society especially at the district level.

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

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?

The country does not have a comprehensive HIV prevention strategy, although prevention is a key feature of the National Plan of Action and Policy. Given the absence of this document, programmes targeting prevention of HIV among women, young people and adolescents are not always strategic and it is not often clear what the goals, targets and messages are. Those that are institutionalized such as the PMTCT programme of the Ministry of Health and the Health and Family Life Education Programme of the Ministry of Education are more effective because they are structured and reach a large percentage of the population. However, other programmes, especially those targeting youths out of school (in particular) are ad-hoc and goals and strategies are unclear.

The participation of young people themselves in the development and implementation of programmes is limited. This is an untapped resource in HIV prevention that needs to be maximized. Many prevention programmes targeting young people are also mundane and do not move young people to action because of the approaches, strategies and messages.

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 see next page

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. The Belize Family Life Association and the Ministry of Health have statistics on STDs for young women and adolescents.

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

There has been an improvement in the capacity of heath service providers to manage the distinct needs of women, young people and adolescents. However, at the level of the government, there is much more training required to ensure that services are friendly especially to young people. Shortage of human resources at government facilities also restricts health personnel from finding the time to provide in-depth counselling and information to young people.
NGO's such as BFLA fill this need in a very effective manner. Friendly services are provided by this institution. However, over the past 2 years, the capacity of BFLA has decreased owing to the close of several of its district clinics. This gap remains unfilled.

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

Yes	No

Through the Capacity Project, the Ministry of Health has been partnering with UB to increase capacity in this area. This initiative was started in 2009. BFLA also provides support to the MOH to train public health nurses and nurses' aides.

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

Yes	No

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

Yes	No

There are no policies in place but there are a number of programmes targeting male heterosexual population. The Belize Defence Force with the support of PEPFAR and Charles Dew University currently has a full scale HIV prevention programme targeting soldiers country-wide. Programmes are also in place at the Central Prison for inmates. Besides these targeted programmes, heterosexual males are a target for prevention programmes in several national prevention efforts targeting males and females such as the Know Your Status Campaign.
There is need for improved targeting in prevention campaign. However, as mentioned above, the absence of a comprehensive prevention strategy makes this rather challenging.

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

Yes	No

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	No

There are no structured programmes specifically targeting ethnic minorities. Organizations like POWA in Stann Creek conduct outreach and education programme for Garifuna women and the Toledo Maya Women's Council incorporate S&RH into their outreach and education for Maya women.
The Pan American Social Marketing Organization (PASMO) has done some programmes for both men and women in Garifuna communities.
It is important to note, however, that over the past few years the government has expanded its health services to include a number of S&RH services which are available through its facilities including polyclinics which are located in some of the rural areas. The expansion of the opening hours of many of the clinics has been helpful in increasing access to services.

II] SEXUAL AND REPRODUCTIVE HEALTH CARE

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

Yes	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 6 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. In 2010 there was 93.2% coverage with HIV testing and 53 women were detected as HIV+. Twenty or 37.7% out of the 53 cases were known HIV cases and 94.3% of women who were HIV+ received ARV prophylaxis/ treatment to prevent MTCT.

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?

Y	No

The Ministry of Health distribute fortified food to pregnant women and women in the postnatal period. They also provide fortified milk and food to children 6-23 months. This service is offered to all in need regardless of their HIV status.

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

Yes	No

The revised PMTCT Protocol requires that 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.

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

Yes	No
Each year, the GOB procures milk supplements for 100% of HIV exposed infants. Mothers that live in rural areas often face the challenge of transportation and may not have the resources to get to the nearest town to pick up the formula.	

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

Yes	No
This service is provided in the MCH package of services in both public and private sector. 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 seropositive 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
HAART is provided. Some psycho social support is provided. However, there is need to improve the capacity of the MOH in providing this type of support.	

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

Counselling is offered on the different types of contraceptive methods available and information is given on method chosen by the women. However, uptake is not well documented.

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

Yes	

Women have the right to choose a method. Counselling is offered and if there are no contraindications, and the patient understands the permanent effects of sterilization then the service is offered.
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 readily available at the private pharmacies, BFLA centres in Orange Walk, Belize City, San Ignacio and Stann Creek. Through the S&RH Committee BFLA negotiated with the Ministry of health to include Emergency Contraceptive in the Emergency Rape Kit (ERK) at all public hospital and emergency units.

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

Yes	No

Because the services are integrated into the health system, the services are provided at each entry point. The stand alone programmes are being phased out.

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?

The Ministry of Health and BFLA do not discourage HIV positive women from having children. However, information is provided on risks of transmission to the child, spacing of children, and the family planning services available.

15. And in the case of serodiscordant—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. Under the

S&RH policy the Ministry of Health is looking at opportunities for addressing access to S&RH by 16 and 17 year olds.
There is an increase in the number of Maya girls and women that are becoming empowered to access condoms and to request condoms use by partners. However, traditional and gender roles in such communities still play a major role in restricting young women's access to and use of condoms.

[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
The law such as the Domestic Violence Act is a good law however there are many issues with effectively executing the law which include the lack of police support and effective and efficient legal system. Additional there is no psychosocial support for victims including women and children. The Domestic Violence Act came into effect in 2008. It calls for the rehabilitation of perpetrations and for stiffer penalties for the breach of protection orders. There is also a Sexual Harassment Act. However, although the Domestic Violence Act is a strong one its impact is retarded by the absence of effective and efficient legal systems, lack of adequate support service for survivors of sexual assault and underreporting of abuse. Over the past 2 years the Women's Department has scaled up its response to Domestic Violence by increasing community awareness through media, provision of training on the domestic violence and child abuse registration systems as well as the use of this registration system by front-line responders to gender-based violence, establishment of two shelters for battered women as well as the establishment of support groups for survivors and mental health services. The situation for sexual offenses is even more serious. Efforts at the level of the police has also been improved including mainstreaming of sensitization on gender-based violence into the training curriculum for new police officers and a gender-based violence unit has been established within the police department. Despite these promising trends, it is generally felt that the laws are not effectively complied with and that government needs to give stronger attention and resources to this growing problem.		

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

	Yes	No
Currently, CSEC is not explicitly stated as a crime under the laws of Belize and in most cases it is not perceived as a crime especially where it "involves adolescents who are seen as or who report that they have consented to sexual relations with an adult in return for cash or food or gifts" Catzim, 2010 In 2010, Belize's Special Envoy for Women and Children lead advocacy efforts including a high level conference to revive public attention to the issue of CSEC. This complemented efforts that previously were led by NGO's such as Youth Enhancement Services which has been engaged in such efforts since 2003.		

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. A draft action plan was also developed as an outcome of the 2010 effort by the Special Envoy. However, this has also not being finalized.
Recently, the Tourism sector has been exploring strategies to address CSEC in their area of work using regional programmes as best practices.
Government must accelerate efforts to address CSEC and increase partnership and networking with NGO's to strengthen legislation and actions in this area.

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

Some services are available however most of the services are centralized leaving out women and girls in the district and rural area.
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 and Poverty Alleviation, 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 also provides 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 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	No
	■	

The Women's Department has led the charge in increasing public awareness on violence against women. Several national campaigns have been on-going and efforts are consistent on the part of the Women's Department. In addition, these issues are highlighted during Women's month which is observed in March of every year as well as during the 16 Days of Activism in November of each year.
There are no government efforts towards increasing public awareness on CESC. This is largely NGO led. YES, as previously mentioned continues to lead strong public awareness campaigns. In recent years, however, owing to availability of funding, these have been decreasing.

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

	Yes	No
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An Act against Trafficking in Persons has been in effect since 2003. The "Act" provides for protection of victims of trafficking in persons (II, page 170, Article 6, Assistance to and protection of victims of trafficking in persons) and mentions the provision of housing, counselling and information, medical, psychological and material assistance and employment, educational and training opportunities, special needs of victims (especially children), and physical safety etc. It also mentions that the state will work with non-governmental organizations to provide these services.
The Trafficking Prohibition Act establishes the criminal offences related to human trafficking. Trafficking in Persons conveys a punishment of a fine of $5,000.00 US dollars or imprisonment of not less than one year and not more than five years. Trafficking in persons includes the recruitment, transportation, harbouring, or receipt of a child, or the giving of payments or benefits to obtain the consent of a person having the control of a child (a person under 18 years) for the purpose of exploitation.
Over the past 3 years there has been some public awareness on the issue of trafficking including mass media message through television and billboards in prominent locations.
There has also been an increase in the arrest of persons engaged in trafficking.
Overall, however, it is felt that this is an area of increased concern and one that government needs to focus more attention and resources in.
Key challenges include:
Border accessibility: The blind spots which are reportedly "countless", and the lack of control over the border and river banks where trafficking takes place by land or following the river flows is facilitated by lack of human resources and technology (computerized system) in both the Police and Migration. This leaves territorial extension requiring mobile vigilance for greater protection.
Geographic make out of the country: The country is small and easy to be covered in small periods of time which helps the purposes of the perpetrators but it also allows greater control

by the authorities. For example, from Belize City you can reach Corozal up to Punta Gorda in a day, it takes 8 hours by car, from Belize to Belmopan it takes only 45 minutes.
Legal jurisdiction: Lack of agreements and regional jurisdiction: The lack of legal jurisdiction of the Belizean Police and Migration regarding foreigners is a problem.
Migration Flows: The fact that high levels of migration flows cross the country daily and from all sides and lack of staff to handle it.

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

There are no reported incidents of this.

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

There are no national strategies that specifically address the issue of boys and girls who are HIV positive. Once diagnosed at the health facility follow-up health care is provided. However, there is a weak system for follow-up and many children are lost to follow-up services. Besides health services there are no specifically designed national programmes to address the other unmet needs such as psychosocial care, education etc. The Ministry of Human Development provides support for vulnerable children overall and children living with HIV may or may not be captured by these services.
Some civil society organizations namely POWA and Hand In Hand Ministries provide specific support to children living with HIV. Hand in Hand provides clinical management, psychosocial support and other social support. However, their services are only available in Belize and Stann Creek Districts.
Special provisions are made in Global Fund Round 9 to support these two civil society organizations in strengthening community level response to children living with HIV. This is being dome through a partnership with the Ministry of Human Development.

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

The Government does have a specific budget for its overall Social assistance programme. However, there is not a specific portion dedicated to children who are living with HIV or orphaned.

9.3. Which sphere of government is directly responsible for their implementation?
Ministry of Human Development Social Transformation and Poverty Alleviation

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?

The main allies in promoting the Sexual and reproductive health of women living with HIV/AIDS in Belize are the Ministry of Health and BFLA. These are the two major service providers. Additionally, a number of NGO's do provide a wide range of support services including information and awareness. These include Alliance Against AIDS, Youth Enhancement Services, Cornerstone Foundation, POWA, Mary Open Doors, and Women's Issues Network.

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

The principal window of opportunity for strengthening the prevention of epidemic among women includes the following:

Young women in school:

The Ministry of Education's current efforts to strengthen the secondary education life skills curriculum including inclusion of S&RH, through support of the Global Fund, provides a strong window of opportunity to ensure that adolescent girls are reached with sexual and reproductive health education

Young women out of school:

The Ministry of Youth is also engaged in efforts to strengthen peer based programme in HIV education targeting young people out of school. The proposed methodology of community based campaigns provides an opportunity to engage with young women in their communities providing them with information and education on HIV and AIDS.

Efforts such as those being made by the Young Women's Christian Association, BFLA, YES and other NGOs provide a good opportunity to strengthen messages targeting vulnerable young women.

The Joint UN Programme on Adolescent Girls which is focusing on addressing Social and Economic Vulnerability of Girls and incudes a wide network of government and NGO partners is also an opportunity to address the larger social and economic conditions that put girls and women at risk for HIV infection.

Women in general:

The Women's Department has improved its efforts in HIV prevention in recent years. There is an opportunity to strengthen partnership with civil society to reach even more women especially at the rural level with prevention information and services.

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?

As noted above there is no lack of policies and plans of action to address sexual and reproductive health, HIV and AIDS and violence against women. However there are a number of factors that makes it challenging to ensure integration of actions related to these policies and plans of action. First and foremost is the absence of coordinated planning spaces where the issue of girls and women's development are dealt with in a comprehensive manner. When coordination does occur it is done around specific issues or policies and not broader development agendas. National and local level capacity to plan strategically and to implement evidence based programmes is also a challenge.
Another challenge is the absence of sustained resources to ensure implementation of actions. Given the limited government investment many programmes are externally funded. These are usually for a defined period of time and if strategies are not put in place during the funding period to ensure sustainability of programmes then it becomes challenging to sustain efforts when funding is no longer available.
Prominence given to these critical issues in the overall national landscape is also a challenge. Many times these issues, critical to women, are competing with other national priorities and are not seen as important enough for government to invest the necessary resources to combat them.

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?

Civil Society is largely active in most of these areas. However, Belize does not have an organized Civil Society in the social sector. This limits civil society's ability to collectively identify concrete priorities or advocacy and action. Additionally, the scope and reach of many of the organizations working in these areas are limited. BFLA, for example is the only organization working at a national level. Even this organization has been facing a number of challenges and was faced to downsize its operation.
Often because of their limited geographic reach, actions by civil society organizations are unable to secure the impact necessary to change the situation for women in a major way. This is why these organizations can benefit from improved coordination and identification of priorities.
In recent years dwindling donor resources has also impacted the ability of organizations to mount sustained actions.

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

1**) Strengthen Planning and Coordination platforms**: Although a National policies and plans of actions exist for Domestic Violence, S&RH and HIV and AIDS efforts towards ensuring the establishment of coordinated goals and strategies must be improved. It is recommended that a mapping of the goals and strategies in these and other related plans be conducted and priority areas for coordination and implementation be identified. This is necessary given the limited human resources available to respond to issues affecting women. Civil Society must play a pivotal role in this effort.

2**. Development and implementation of a National Prevention Strategy**: In tandem with the coordination and planning discussed above there is need for a strong National HIV Prevention Strategy. Advocacy and communication efforts are not informed by any national strategy and

therefore it is difficult to establish what impact these activities are having. A lot of resources are invested in prevention but sustained behaviour and social change can only be achieved through strong evidence based prevention programmes that are informed by a National Prevention Strategy. This strategy will allow space to align and synergize all existing efforts and ensure that the prevention messages are clear, well designed and targeted.

3. **Capacity Building:** resources must be dedicated strategic areas for capacity building identified for government and civil society. Some core areas recommended based on the findings in this report include, evidence based planning and monitoring, behaviour and social change communication and collaborating and networking. These must not be a one off training sessions but must be on-going with opportunity for hands-on implementation of new learning and forum for feedback and sharing.

4. **Joint resource mobilization efforts**: Given the fast dwindling donor resources available to civil society, it is important for agencies to coordinate among each other and identify a few strategic areas for joint fund raising. This will be received more favourably within the donor community.

5. **Accountability mechanisms**: Civil society needs to increase their advocacy ensuring greater accountability to commitments made by government in relevant policies and plans of actions. Many policies and plans of action lay out strong commitments to advancing women's rights. However there is no mechanism in place for oversight and advocacy to hold government accountable.

6. Increased investment in strengthening services: Access to services including S&RH services is critical to the health and well-being of young girls and women. Greater investments must be made to expand services especially to rural communities and to make services friendlier for young people. Government should support civil society by outsourcing some of its services to civil society, especially in the area of adolescent friendly services.