GLOBAL AIDS COUNTRY PROGRESS REPORT 2014

BELIZE

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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 Secretariat, 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: 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 and government departments were asked to provide input for the development of the National AIDS Spending Assessment and the National Commitment and Policy Index. Prior to finalization and submission, members of the National Response were asked to register and follow the progress of both the narrative and online tool country submission.

Finally, this report would not be possible without the Regional technical agencies' continued support and assistance.

(b) The Status of the Epidemic;

The extrinsic factors leading to 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 catalyzes the sexual transmission of HIV.

In 2012, data from the Ministry of Health indicate that there were 249 new reported cases of HIV. This reveals a different trajectory, one of increase, in new cases after the recent trend of decrease since 2008 in the general population. Men continue to show a majority of positive results in rapid tests done than women (ratio 1:47 to 1), although they still generally test less than women. The age groups most affected remains the age cohorts between 15-55 years of age who represent the economically viable sectors of the population, with those 45-49 yrs showing a noticeable increase. Lastly, data coming from Ministry of Health Belize, regional and international show a marked concentration of the disease in the MSM population. Locally, the ratio of new infections between

males and females has widened, showing an increase in total number of males and decrease in total number of females recently diagnosed. There were 88 HIV-related deaths in 2012, 57 males and 31 females. Also, the general prevalence rate is now 1.4% with an MSM prevalence rate of 13.85%. Clearly, policy/legislative, social and financial interventions must be specifically designed to approach this particularly vulnerable group in ways that cater to the unique needs of the population.

The country response has remained 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 siloed 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.

(c) The Policy and Programmatic Response; and

The NCPI 2014 indicates the many challenges that yet remain in realizing an enabling environment for HIV/AIDS in Belize. The comprehensive Legislative Review of laws regarding HIV/AIDS has been much awaited in the most recent past, as its potential to begin the change in the landscape and access to services for infected and affected will be a major accomplishment within the discourse on Human Rights, the Law and HIV. While the challenge to Section 53 led by UNIBAM is still inconclusive, there is no questioning of its impact within the society in making human rights and stigma and discrimination a controversial but much studied and discussed topic for all. And, even more noteworthy is that after many years, the government, through the Ministry of Foreign Affairs, will submit a human rights-based Universal Periodic Report (UPR) and draft an International Covenant on Civil and Political Rights report (ICCPR) and send a representative to the Convening of the international Conference on Population and Development. Likewise, the Revised Gender Policy, the Youth Policy draft and the Amended Sexual Offences code speak to a cognizance of the barriers hindering the Response to HIV/AIDS and a desire to adjust the social and political infrastructure from the bottom upwards. Now, too, the HFLE is being piloted in high schools for full roll-out in the coming academic year.

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, general 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. 2013 saw Belize receiving a re-programmed amount of funds from Global Fund to continue this work and target the identified most-at-risk populations, such as: MSMs, SWs, PLHIVs and youth. These programs cover a wide area of response ranging from the production of strategic information to 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 2012 - 2013

<table>
<tr><th></th><th>No.</th><th></th><th>2011-2013</th><th>Comments</th></tr>
<tr><td colspan="5">Target 1: Reduce sexual transmission of HIV by 50 percent by 2015</td></tr>
<tr><td rowspan="5">General Population</td><td>1.1</td><td>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.*</td><td>2011-42.9% (671/1564)</td><td rowspan="5">The MICS 4 focused on the Situation of Children and Women. Data on Men was not collected.</td></tr>
<tr><td>1.2</td><td>Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.</td><td>2011–5.31% (83/1564)</td></tr>
<tr><td>1.3</td><td>Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months.</td><td>2011–2.1% (85/4097)</td></tr>
<tr><td>1.4</td><td>Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse.*</td><td>2011–28.6% (24/84)</td></tr>
<tr><td>1.5</td><td>Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results.</td><td>2011–28.42% (1164/4096)</td></tr>
</table>

	1.6	Percentage of young people aged 15-24 who are living with HIV.	2013- 0.5% (21/3892)	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 Behavioral Surveillance Survey 2011-2012, 80.9% (178/220) of FSW's who responded "Yes" to question 1 only. Also 70.9% (156/220) answered "Yes" to question 2 only. However, no current data is available to respond fully to the indicator.
	1.8	Percentage of sex workers reporting the use of a condom with their most recent clients.	2013- 56.4% (169/299)	
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results.	2013 65.1% (195/299)	
	1.10	Percentage of sex workers who are living with HIV.	2011 – 2012 0.91% (2/219)	
U ouMen who have sex with	1.11	Percentage of men who have sex with men reached with HIV prevention programmes.	2010 66.52% (151/227)	
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.	2011 – 2012 55.12% (70/135)	
	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.	2011-2012 56.62% (77/136)	
	1.14	Percentage of men who have sex with men who are living with HIV.	2011-2012 13.85% (18/130)	
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 results of the study conducted by The National Drug Abuse Control Council in collaboration with UNODC, "The HIV Prevalence Among Drug Users" revealed the use of Alcohol and Marijuana and
2.2		Percentage of people who inject drugs who report the use of a condom at last sexual intercourse.		
2.3		Percentage of people who inject drugs who reported using sterile injecting		

	equipment the last time they injected.		to a lesser extent Cocaine but not through injecting drug.
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results.		
2.5	Percentage of people who inject drugs who are living with HIV.		
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.	2012-100% (44/44) 2013–100% (46/46)	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.
3.1a	Percentage of women living with HIV who are provided with antiretroviral medicines for themselves or their infants during the breastfeeding period.	N/A	As a country it is not recommended that HIV mothers breastfeed their infants.
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth.	2012-100% (42/42) 2013-100% (47/47)	We had a total of three cases of vertical transmission; the three cases were diagnosed as they were older - at 3rd PCR test after week 12.
3.3	Mother-to-child transmission of HIV (modelled).	N/A	
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.	2013-53.4% (103/193)	The denominator 193 are all patients starting ARV therapy during 2013 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 2013.

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.	2013 Numerator-25	The estimated number of incident TB cases is not currently available for Belize. However, in 2013 there were 25 adults with advanced HIV infection who received antiretroviral combination therapy and who started on TB treatment.
Target 6: Close the Global AIDS Resource GAP by 2015 and reach annual global investment of US$22-24 Billion in low and middle income countries			
6.1	Domestic and international AIDS spending by categories and financing sources.	Annex	
Target 7: Eliminating Gender Inequalities			
7.1	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	
Target 8: Eliminating Stigma and Discrimination			
8.1	Discriminatory attitudes towards people living with HIV.	N/A	
Target 10: Strengthening HIV Integration			
10.1	Current school attendance among orphans and non-orphans aged 10-14.*	2006 – 0.66 Part A: 62.1% Part B: 2011-2012 95.03% (1722/1812	
	Proportion of the poorest households who received external economic support in the last 3 months.	N/A	
	National Commitments and Policy Instrument (NCPI)	Annex	

II. Overview of the AIDS Epidemic

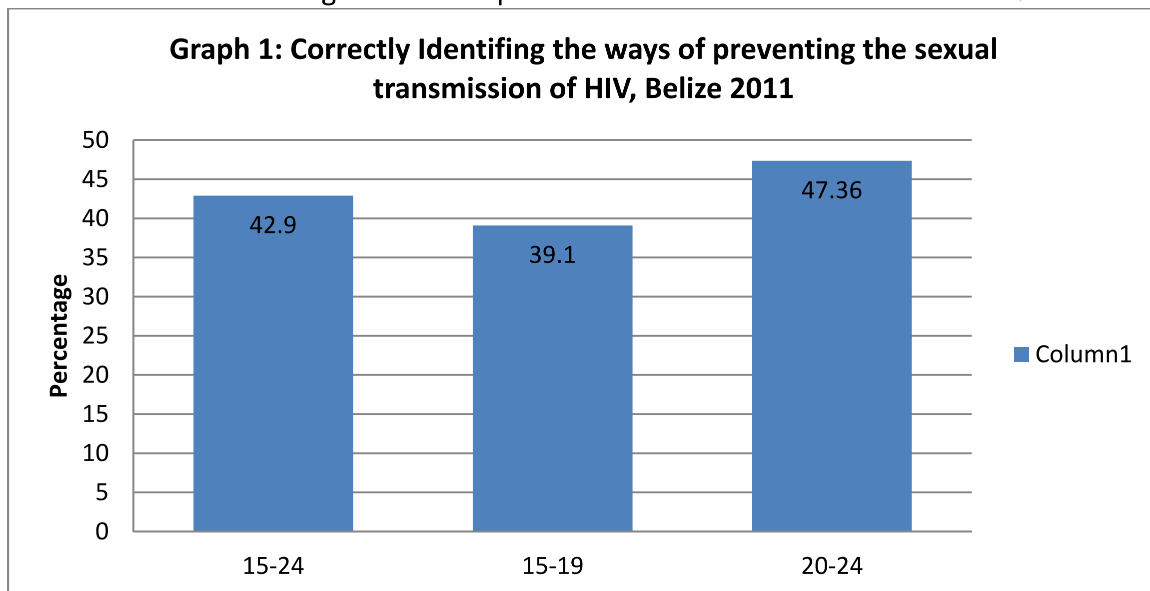
Target 1: Reduce sexual transmission of HIV by 50 percent by 2015

General Population

The adult HIV prevalence rate of Belize was estimated to be 1.4% in 2012, according to the 2012 Statistical Report issued by MoH. This estimate has drastically decreased when compared the previous year. In 2012, the total number of newly diagnosed HIV Infections was 249, indicating an increase when compared to 2011 (226). This increase in number of newly diagnosed HIV infection is greatly as a result of a higher number of tests being carried out through the year. When looking at the positivity rate in males is three times higher than in females. This is so even though females got tested twice as much during 2012. For 2012 there was a greater number of persons being tested which reflects a higher number of new infections but in contrast a lower prevalence rate than the previous year.

Indicator 1.1: Young People: Knowledge about HIV prevention

In 2011, 42.9% of young people aged 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. In comparison to 2009 there was a decrease in the knowledge about HIV prevention. There was a decrease of 7.3%.



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 5.3%, with 83 of the 1,564 young women aged 15–24 interviewed, reporting having had sex before the age of 15. A total 6.7% of the young people surveyed aged 20-24 stated that they had sex before the age of 15. Also important to note is that in the

rural communities saw a higher occurrence of young people having sex before the age of 15 (see Table 2).

Table 2: Sex before the age of 15 by Age Group and Location

Location	Age Group		
	15-24	**15-19**	**20-24**
Total	5.3	4.1	6.7
Urban	5.0		
Rural	5.5		
Source: 2011 MICS			

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 2.1% sexually active women aged 15–49 had sex with more than one partner in the twelve months preceding the survey. A Total of 4,096 women were included in the survey. In the total samples population women aged 15-24 had the highest occurrence of multiple partners with 3.1%. The Urban population sampled showed a higher occurrence rate at 2.9% (see Table 3).

Table 3: Multiple Partners by Age Group and Location

Location	Age Group				
	15-49	**15-24**	**25-29**	**30-39**	**40-49**
Total	**2.1**	**3.1**	**1.9**	**1.9**	**0.4**
Urban	**2.9**				
Rural	**1.3**				
Source: 2011 MICS					

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 15-49 years were at 28.6%. The age group 15–24 reported overall 25.5% of consistent use of condom for sex with their last partner. Overall, persons surveyed in the urban areas showed a higher condom usage 30.7% during the last intercourse when compared to rural at 24.7%. The 2011 MICS indicated that a total of 85 women aged 15-49 had more than one sexual partner in the last 12 months.

Table 4: Condom Use at Last Sexual Intercourse

	15-49	15-24	Urban	Rural
Total	28.6	25.5	30.7	24.7
Source: 2011 MICS				

Indicator 1.5: HIV testing in the general population

The survey showed that a little over one fourth (28.42%) of the population sampled reported receiving an HIV test and knowing their result. 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. Of those aged 20-24, 38.5% reported having gotten an HIV test and know their results. Also in the urban areas 33.8% of the sampled population have taken an HIV test and know their results.

Table 5: Received an HIV test and know their Results

	15-49	15-24	15-19	20-24	25-29	30-39	40-49	Urban	Rural
Total	28.42	25.1	13.7	38.5	35.0	32.6	23.7	33.8	23.6
Source: 2011 MICS									

Indicator 1.6: HIV Prevalence in young people

In 2009, the prevalence rate among 15-24 year old pregnant young women is 0.81% (33/4075), while in 2012, the rate in this age group decreased to 0.31% (12/3869). However in 2013 there was a small increase to 0.54% (21/3892). In 2011, the HIV prevalence among all antenatal clinic attendees was 0.97%, while in 2012 and 2013 it was 0.0.59% and 0.78% respectively. (See table 6)

Table 6: Key indicators of the PMTCT Programme, Belize 2006-2013

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%****
2012	6969	***6454***	***92.60%***	***38***	***0.59%***
		3896		***12***	***0.31%****
2013	6948	***6383***	***92%***	***50***	***0.78%***
		3892		***21***	***0.54%****
Source: MOH ***** 15-24 year old Antenatal Clinic Attendees***					

SEX WORKERS

In 2013, the Pan-American Social Marketing Organisation (PASMO) Belize conducted a third round of an HIV/AIDS TRaC Study, 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[1].

Indicator 1.7-1.1.10: Sex workers

The survey was conducted among 299 FSW, of whom 29.4% were from fixed venue locations and 70.6% were ambulatory. The survey showed an increase in condom use at last sex between FSW with their new clients but showed a decrease with their affective partners and a decrease of condom use with their occasional and regular clients. One of the most significant changes that can be observed from condom usage with different clients was with the latest clients. FSW aged 18-24 showed a significant decrease from a 70.1% in 2010 to a 42.1% in 2013. There was a decrease in the in consistent condom use with all types of clients from 6.4% in 2010 to 64.0% in 2013. This decrease was clearly visible between young FSW from a 73.8% in 2010 to 49.0% in 2013. However for FSW

who were older than 25 years so significant was evident in consistent condom usage with all types of clients as 77.9% in 2010 and 80.2% in 2013 showed consistent condom use. A total of 56.4% (169/299) of FSW in 2013 reported the use of condoms with their most recent clients. There has also been a significant decrease in the use of lubricants in FSW from a 20.7% in 2010 to a 6.6% in 2013. There was no significant change between 2010 and 2013 in relation to HIV testing. For the year 013 65.1% (195/299) of FSW in the sample population have received an HIV test and know there results. The HIV prevalence in FSW for the county is lower than those reported by the other Central American countries. The FSW HIV prevalence for Belize is 0.91% (2/219). FSW prevalence was obtained from the BSS.

MEN WHO HAVE SEX WITH MEN

In 2012, Ministry of Health (MoH), Belize, carried out a Behavioural Surveillance Survey (BSS) of HIV/STI Prevalence and Risk Behaviours in Most-at-Risk Populations in Belize. This survey included Female Sex Workers (FSW), Persons with HIV, and Men who have sex with men (MSM). This study was done on a Respondent Driven Sampling (RDS).

Indicator 1.11-1.1.14: Men who have sex with men

The survey was conducted among 136 MSM, out of these only 130 underwent and HIV test. In 2012 a total of 98.8% (133/136) of MSM know where to get an HIV. Also in 2012 68.4% of the sample population received condoms. Of the sample population surveyed 55.12% (70/135) stated that they used a condom the last time they had anal sex with a male partner. Out of 136 MSM 77 (56.62%) responded that they had received and HIV test in the last 1 months and know their results. The percentage of MSM who are living with HIV is 13.85% (18/130). Overall 40.4% of the respondents reported having had their first sexual encounter before the age of 15. Also a third of those interviewed reported having been forced to engage in sex at some point in their lives and 8% reported that their first sexual encounter had been a forced one. The use of condoms with an occasional male partner was reported at 62%. MSM reported condom use with commercial male partners at 50% and up to 70% with clients. In relation to the myths of HIV transmission and prevention 57% of the respondents reported understanding in this area.

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

During the year 2012 NDACC indicated that there were no documents injecting drug users in the country. This indicates that the indicator is not relevant to the context of the epidemic in Belize. In 2011, according to NDACC, there were a total of 379 addiction 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.

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 2012 there were 38 positive pregnant women and 2 babies who were HIV-positive; in 2013 there were 50 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. In 2013 the babies that were diagnosed with HIV all obtained then after delivery. The country does not promote the breastfeeding of HIV positive mothers to their children. The PMTCT program offers assistance to these mothers through nutritional packages and also milk for the infants. During 2012 AND 2013 100% of HIV pregnant mothers received antiretrovirals to reduce the risk of mother-to-child transmission. Another major accomplishment for 2012 and 2013 is that 100% of babies born to HIV positive women received a virological test within 2 months of birth.

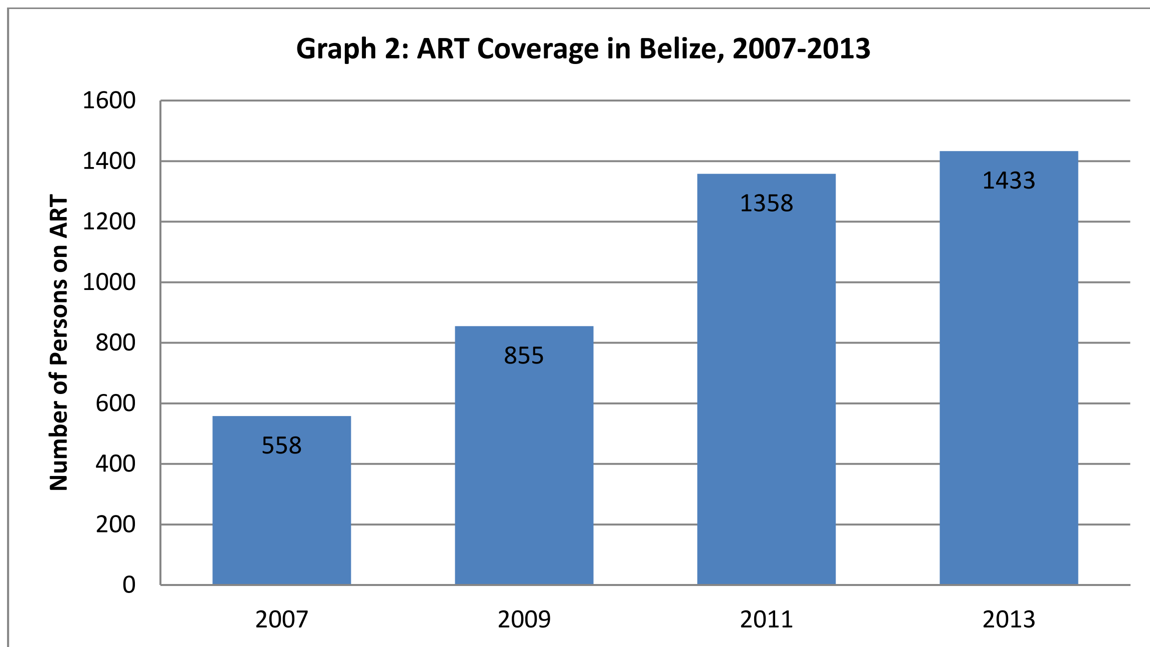
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015

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. 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 updated 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 have informed 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. The number of HIV positive persons receiving ART is 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 500.

As the number of newly reported HIV infections shows an upward 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.



In 2013, 237 persons initiated ART therapy, to give a total of 1,433 on ART. The coverage of children was not reported on b y the MoH this year. However out of all the persons on ART therapy 50.2% (720) are males and 49.8% (713) are females. As can be seen ART therapy distribution among the general population is almost at 50% between males and females. There are still indications that there could be improvement in children with HIV obtaining treatment. This process could see improvements once the proper monitoring and evaluation process are being enforced. During 2013 MoH started to offer ART to persons with a CD4 count <500. This indicates that in Belize there is a relatively high ART coverage as more persons living with HIV are now on therapy. This important as the countries new guidelines call for all persons with a CD4 count <500 to be on ART. This new investment by the country will help to provide more scientific evidence that the early initiation of ART as the potential to reduce viral loads and therefore will translate into lower transmission rates.

Table 7: 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%
2013	**All**	1433	N/A	N/A
	Males	720	N/A	N/A
	Females	713	N/A	N/A
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 2013, the 12 moth retention rate on treatment was estimated to be 53.4%. This estimate in particular is very low as for 2011 it was estimated to be at 89.47%. For this reporting period the 12 month retention is below standard as the minimum international standard is of 90%. This is a clear indication that there needs to be an expansion in the adherence programme. The number of persons that died during the reporting period was 28. This figure increased by 100% when compared to the year 2011 when only 14 people died. There is still no documented evidence that the retention estimates have a direct correlation with the deaths to people on ART. When looking at the 24 month retention on ART 43.6% (102/234) is the estimated retention rate for 2013. This sees a further decrease when compared to the 12 month retention rate. In 2013, the retention rate for 60 months decreased further to 37.8% (45/119).

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

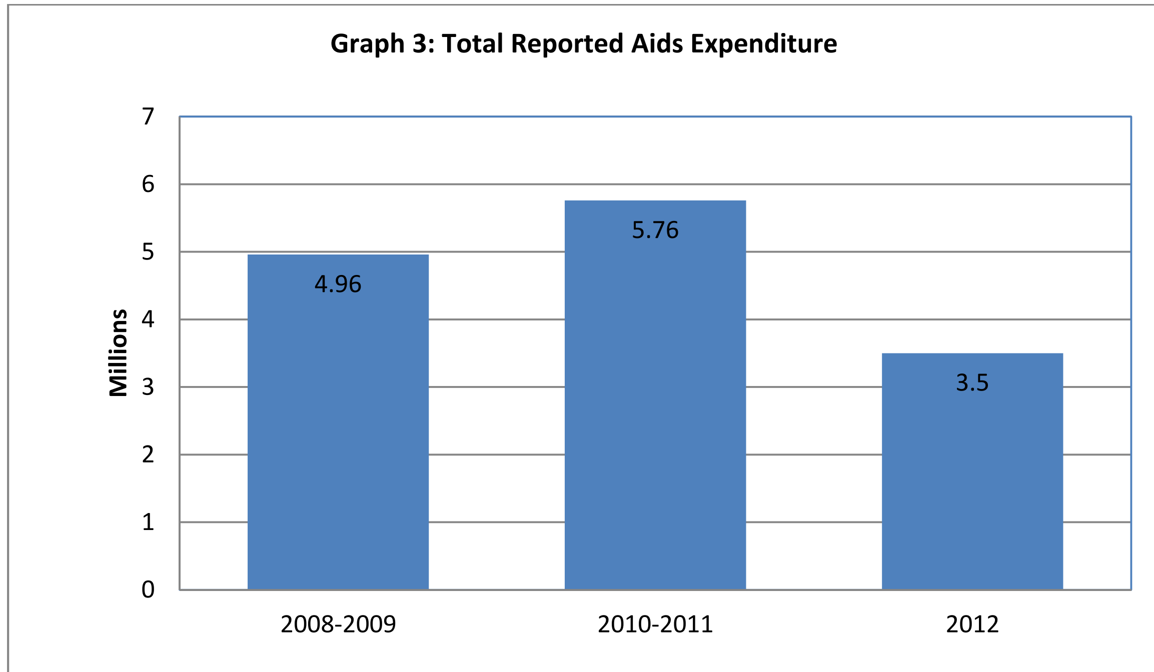
In 2013, there was a slight increase in documented cases of HIV/TB co-infection, which may have resulted from more active case finding of tuberculosis cases in persons with HIV. In 2012 there were 19 new TB cases that received treatment for both TB and HIV. In 2013 there was an increase in with a reported 25 new cases of TB that received treatment for both diseases. 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: Close the Global AIDS resource GAP by 2015 and reach annual global investment of US$22-24 Billion in low and middle income countries.

During 2012 Belize invested BZ$5.7 million (US$2.85 million) in the National HIV Response. Total HIV spending was 3.8 percent of the national health expenditure and one fifth of one percent of Gross Domestic Product (GDP) estimated at BZ$3.04 billion. Per capita expenditure is US$8.37 calculated on an estimated total population of 338,996 as at April 2012. Financing estimates for Belize's National Strategic Plan (NSP) was US$5.3 million showing a funding gap of 46.5 percent in 2012.
Belize's National HIV response remains heavily dependent on external funding with 64 percent or BZ$3.6 million of HIV expenditure being financed by external sources.

Domestic public expenditure financed 29 percent or BZ$1.7 million of total HIV expenditure while the private sector invested 7 percent or 415k. Belize remains vulnerable to the adverse effects of sweeping cuts in external funding.



Expenditure by Financing Source

Belize's National HIV response remains heavily dependent on external funding as evidenced by the chart below, which shows that 64 percent or BZ$3.6 million of HIV expenditure was financed by external sources.

Domestic public expenditure financed 29 percent or BZ$1.7 million of total HIV expenditure while the private sector invested 7 percent or 415k.

Belize remains vulnerable to the adverse effects of sweeping cuts in external funding.

The Government of the United States was the single largest bilateral external donor primarily through the Presidential Emergency Package for AIDS Relief (PEPFAR), and USAID agencies including USAID/PASCA, USAID/PASMO, and USAID/IntraHealth International.

The Global Fund, through its Principal Recipient UNDP, was the second largest external donor funding 31 percent of foreign funds. Multilateral agencies (UN) accounted for 10 percent of external funds.

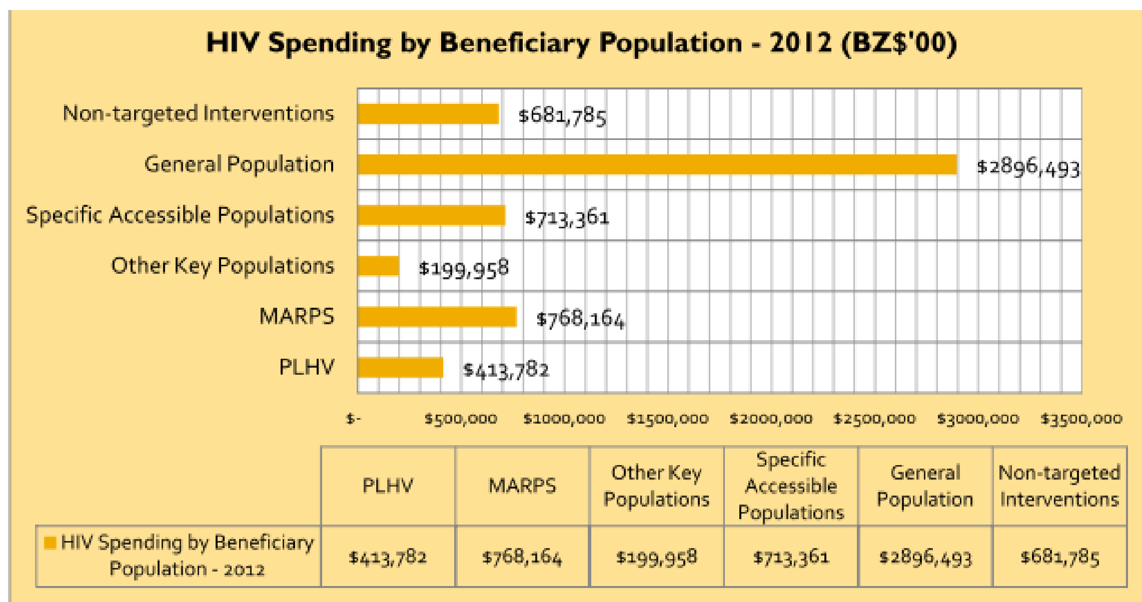
Expenditure by Beneficiary Population (BP)

HIV spending shows a higher concentration within the 'General Population,' 'Non-targeted Interventions,' and 'Specific Accessible Populations' where 75% of total resources were deployed. However, and within the ''Specific Accessible Populations,'' interventions were targeted at students, primarily and the junior and high school levels, the military and uniformed services.

Interventions among 'Other Key Populations' were targeted primarily at orphans and vulnerable children and children and youth out of school.

At the MARPS level, resources were distributed across three groups – female sex workers and their clients (FSW), men who have sex with men (MSM), and MARPS not disaggregated by type. Among people living with HIV (PLHV), the bulk of resources were directed to children less than 15 years of age including boys and girls.

Graph 4: Total Expenditure by Beneficiary Population



	PLHV	MARPS	Other Key Populations	Specific Accessible Populations	General Population	Non-targeted Interventions
HIV Spending by Beneficiary Population - 2012	$413,782	$768,164	$199,958	$713,361	$2896,493	$681,785

Expenditure by Production Factor (PF)

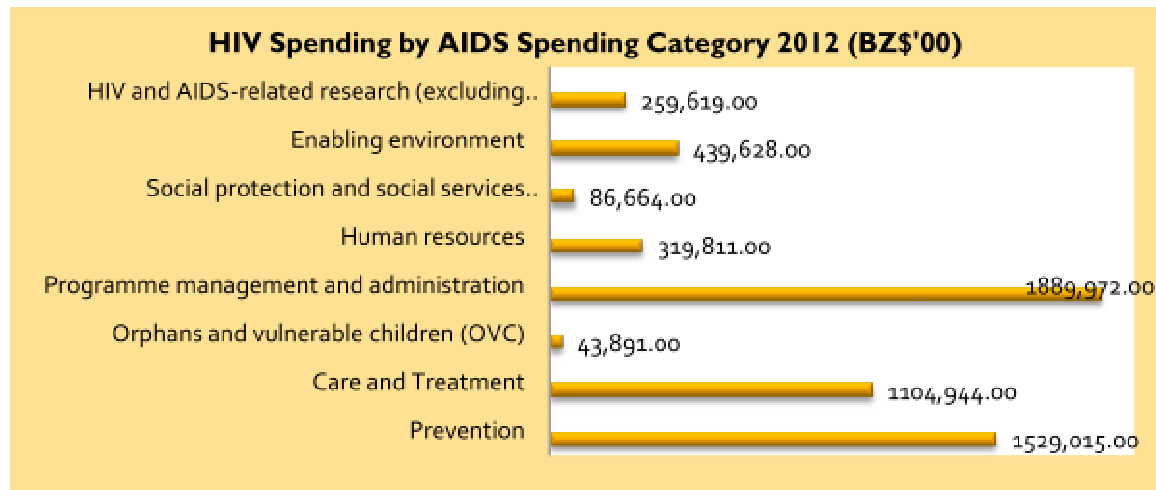
Over 80 percent (82%) of critical inputs were distributed in four areas – wages including labour income, and administrative services (26%), drugs and pharmaceuticals, condoms and reagents and materials (24%), services associated with programmatic activities and including transportation and travel, logistics and catering, housing and other services (20%), and consulting services (12%).

Table 8: Total Expenditure by Production Factor

Production Factor - Sub-Functions		Expenditure	%
		5673,544	100.0
Wages	$	1113,581	19.63
Social contributions	$	95,864	1.69
Non-wage labour income	$	52,966	0.93
Labour income not disaggregated by type	$	73,131	1.29
Labour income n.e.c.	$	19,500	0.34
Antiretrovirals	$	9,000	0.16
Other drugs and pharmaceuticals (excluding antiretrovirals)	$	30,600	0.54
Medical and surgical supplies	$	571,956	10.08
Condoms	$	462,087	8.14
Reagents and materials	$	306,718	5.41
Food and nutrients	$	85,193	1.50
Material supplies not disaggregated by type	$	84,195	1.48
Administrative services	$	220,782	3.89
Maintenance and repair services	$	9,967	0.18
Publisher-, motion picture-, broadcasting and programming services	$	258,056	4.55
Consulting services	$	660,712	11.65
Transportation and travel services	$	377,420	6.65
Housing services	$	32,289	0.57
Logistics of events, including catering services	$	478,950	8.44
Services not disaggregated by type	$	224,475	3.96
Services n.e.c.	$	6,557	0.12
Current expenditures not disaggregated by type	$	66,079	1.16
Current expenditures n.e.c.	$	60,272	1.06
Laboratory and other infrastructure upgrading	$	11,172	0.20
Construction of new health centres	$	246,483	4.34
Buildings n.e.c.	$	10,875	0.19
Vehicles	$	9,623	0.17
Information technology (hardware and software)	$	15,334	0.27
Laboratory and other medical equipments	$	75,679	1.33
Equipment not disaggregated by type	$	1,754	0.03
Equipment n.e.c.	$	2,274	0.04

Expenditure by Category

Graph 5: HIV Spending by AIDS Spending Category



Overall Spending by Categories

Eighty percent of AIDS spending was concentrated in three categories – Programme Management and Administration (33%), Prevention (27%), and Care and Treatment (20%). Very limited resources were directed at Orphans and Vulnerable Children and Social Protection and Social Services.

Programme Management & Administration

Aside from 20 percent of resources which were directed toward construction and upgrading of infrastructure, and 7 percent for monitoring and evaluation activities, the bulk of spending was for planning, coordination, and programme management activities.

Prevention

More than half of total prevention expenditure (55.2% combined) was spent on communications – health and non-health related and for social and behavioural change. Condom social marketing combined for another 27.3 percent of total prevention expenditure.

Care and Treatment

The two main spending categories for Care and Treatment are those services not disaggregated by intervention (58.6%), and specific HIV-related laboratory monitoring by the Central Medical Lab (27.2%).

Target 7: Eliminating Gender Inequalities

7.1 Prevalence of recent intimate partner violence

Data on the proportion of ever married or partnered women 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months is not available in the country.

Target 8: Eliminating Stigma and Discrimination

Discrimination of people living with HIV is simply the abusing of HIV positive persons human rights. it is also prohibited by law in most countries. Discrimination of persons living with HIV is not enforced in all countries. Some countries only have discrimination in their constitution but not related to HIV. In Belize much work is being done to address this issue in relation to our constitution. However, the country has not moved forward as much as i would have wanted due to the long process by which the constitution has stipulated for change. In regards to this indicator no study has been done in the country that actually responds to this indicator to its fullest. In regards to the first question of the indicator, about buying vegetables from a person living with HIV, no study has been made with this question included. The second question, should children with HIV attend school with negative children, no study has been made in this regard either. Hand in Hand Ministries over the reporting year have had several cases in which they would have to intervene in schools that were about to dismiss children from their school based on their HIV status. The country does not have enough data to report on this indicator even though it is relevant to the country.

Target 10: Strengthening HIV Integration

10.1 Current school attendance among orphans and non-orphans (10-14 years old, primary school age, secondary school age).

During the years 2011-2012 out of the number of children who had lost both parents 62.1% attend school. This percentage is a little over 50% which is a strong indication that children are accessing education even though they have lost both parents at some point in their lives. This also shows us that the country can improve a lot more in relation to children accessing education when they have lost both parents. Children living with one or both of their parents who are attending school is 95.03% (1722/1812). This shows that only 4.97% of the children who are living with at least one parent are not attending school. This is a strong indication that our country is becoming more education oriented. This also shows that children born to an HIV parents are particularly not receiving an education. This can be attested to with this indicator as it is the point in the lives of the children born to HIV positive parents are most likely to be left without a parent or parents due to HIV.

10.2 Proportion of poorest households who received external economic support in the last three months

In regards to this indicator the country does not have data to report. There is no documented data that speaks to poorest households receiving external economic support. As country this indicator is relevant. Indicating to us that there is much more work need to be done in this area.

III. National Response to the AIDS Epidemic

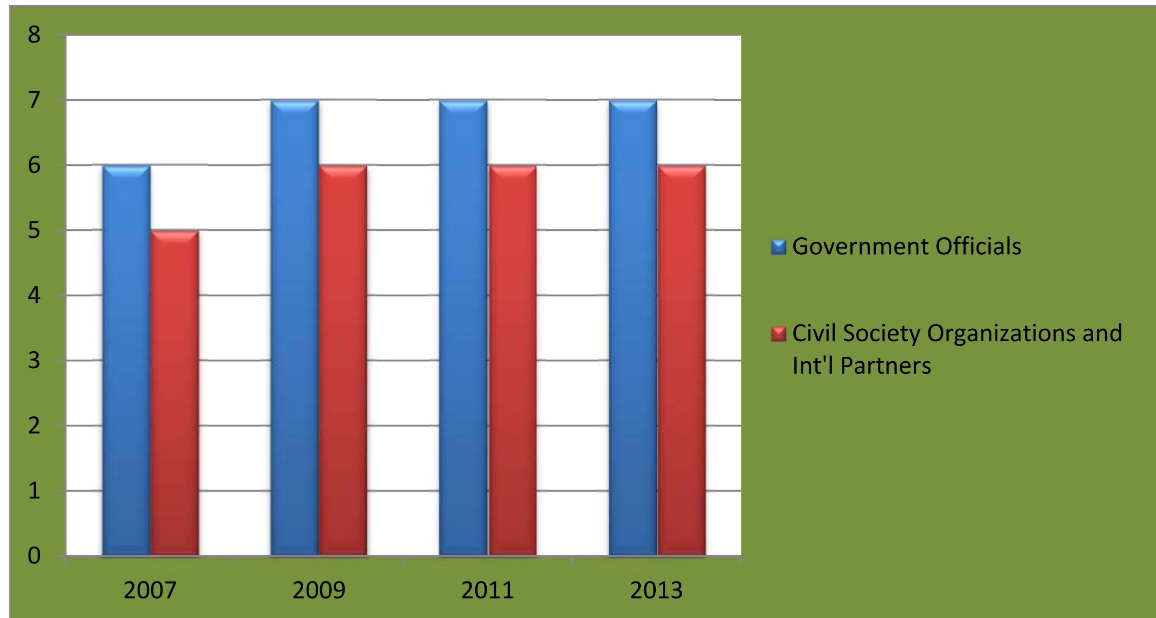
Prevention, Knowledge and Behaviour Change

The operationalizing of the National Strategic and Operational plans has been acknowledged by both civil society and government departments through many prevention and behaviour change and communication strategies and initiatives of the NGOs, FBOs, government departments and district committees since the last NCPI exercise was conducted. To date, organizations at the national and district levels have attempted 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 and persons living with HIV. Key participants stated that there is more support for the provision of prevention services in the area of training, education, human rights and sexually transmitted infections through the involvement of entities such as the US Embassy, USAID-PASMO and a few other sources. The NCPI 2014 indicated that the majority of persons in need of sexual and reproductive health education, prevention and risk reduction interventions still do not have adequate access to these services, including youth, women, men, PLHIV, MSM and their partners. Conversely, prevention services such as testing and counselling and PMTCT are mostly available to the majority of persons who need them.

Challenges identified in the 2013 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.

Care, Treatment and Support

Graph 6: Implementation of prevention Programmes

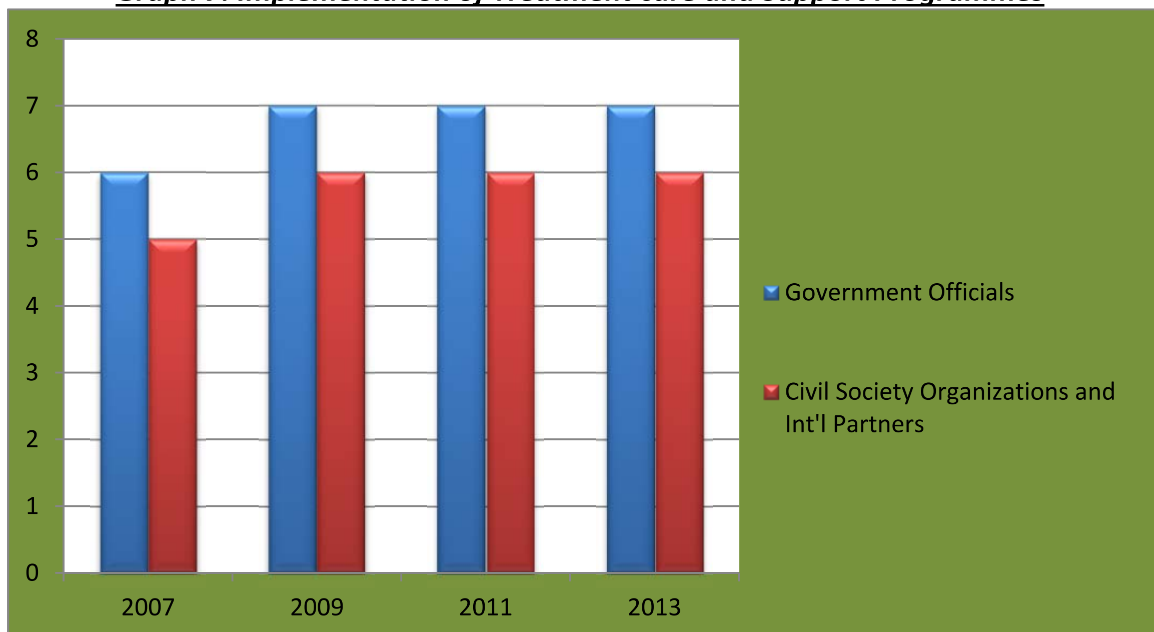


The NCPI 2012 indicates that there have been a number of achievements in the area of treatment, care and support over the past two years. These include the continued provision of free antiretroviral medications to all persons eligible from the Ministry of Health. There is also increase in the use of combination ARV therapy and increased access to CD4 testing and some viral load tests. Likewise, there is the increase in 3rd line paediatric ARVs. While another major challenge identified by many respondents was the lack of a comprehensive package of support for PLHIVs, the BOOST program through the Ministry of Human Development, collaboration between Hand in Hand Ministries and Ministry of Health and support received from Claret Care and POWA (other Faith-based and Civil-society organization) have made some inroads in the needs of OVCs. Scale-up in ARV distribution at district-level pharmacies is another achievement as some of them have even started to provide service at nights for convenience or to stave off stigma and discrimination. Initiatives such as the USAID-Central American Capacity Project that 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 has been successful. 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 HIV 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 2014 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 respondents 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. 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 HIV laws, there is no protection for these populations resulting in low utilization of public health services and high stigma and discrimination. The NCPI indicates that in 2013 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. Similar 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)

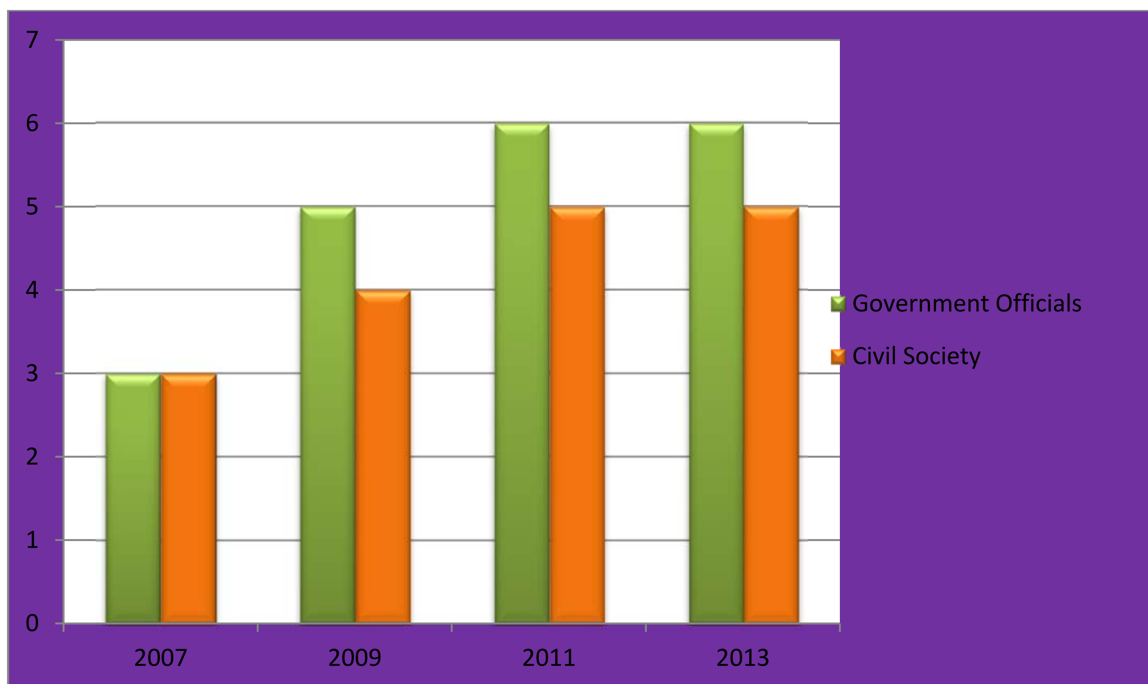
<u>Graph 7: Implementation of Treatment care and Support Programmes</u>



Impact alleviation

One of the major achievements in the past is the work of Hand in Hand Ministries, a faith-based organization that provides services to OVCs 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 has access 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. The 2013 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 participants also identified other challenges such as the fact that children are not being removed from dangerous situations which put them at greater risk. Adolescents who 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.

Graph 8: Implementation of Programmes for Orphans and Vulnerable Children



Policy/ Strategic Development

The past process of developing the 2012-2016 HIV Strategic Plan for Belize had been described by the majority of respondents as the most inclusive and participatory in the history of the Response in Belize. Respondents stated that they felt a sense of ownership and responsibility with the NSP as they were involved in the process of developing and validating it. The process was based on evidence as data from many 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 in its much iteration 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.

Nevertheless, two years after, the NCPI 2014 indicates that there has been a decrease from 8 to 6 in perceptions of strategic planning efforts by the National Response. Even though the development of the Strategic Plan was hailed with much success, mobilization of resources to sustain the HIV response has been challenged. And while there has been an emphasis on conducting greater consultations at different levels of the national response including the district committees and most at risk and vulnerable populations; a focus on prioritizing sustainability and focusing efforts to develop an investment case to present to government with the objective of increasing national funds to sustain the HIV response; a heightened focus on monitoring and evaluation to build strategic information and greater emphasis has been placed on evidence-based

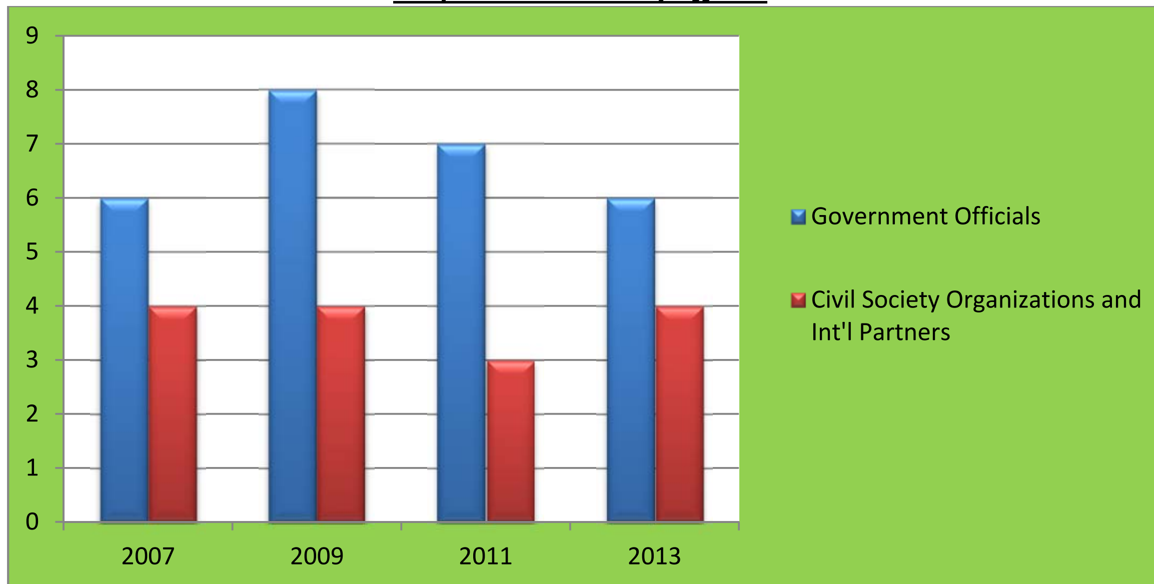
planning through the Ministry of Health and the National AIDS Commission with support from key technical partners such as UNAIDS, USAID and the Global Fund Project, one of the greatest challenges to strategy implementation was greater involvement and consultation with the community-based HIV committees.

One of the key achievements between 2012 – 2013 has been greater validation of the work of civil society in particular district committees and the networks of vulnerable populations such as the Collaborative Network of Persons Living with HIV and the United Belize Advocacy Movement (UNIBAM). Key respondents shared that they felt that coordination has improved and that there is more networking among civil society organizations as they collaborate on similar projects and capitalize on limited resources. There is greater representation at the NAC level as civil society organizations sit on key sub-committees while the district committees have been receiving more support from the NAC and other partners. The Collaborative Network of Persons Living with HIV has been playing a major role in the provision of psychosocial support to persons living with HIV at the national level as well as conducting key research such as Risk Profile Assessments and the Stigma Index. CNET+ launched its first-ever Strategic Plan under the auspices of the National AIDS Commission and the support of USAID/PASCA. This is an accomplishment, which provides a more formalized and strategic approach to the work of the grass root organization. Line Ministries such as the Education, Health, Human Development, Labour and Tourism have continued to implement their HIV programs during this past two years and have made some efforts to ensure that these are aligned with the National Strategic Plan. Civil Society organizations such as Hand in Hands Ministry, Red Cross, Belize Family Life Association and the Women Issues Network of Belize have also continued to implement their programs in collaboration with the National AIDS Commission but the reality is that they are mostly guided by the objectives of their funding agencies and international partners.

In spite of the successes reported in 2012 and 2013 in the area of strategic planning, there is an indication that there has not been any perceived change or impact between 2012-2013 due to a number of existing challenges. Respondents indicate that one of the challenges continues to be the lack of ownership and a sustained commitment to implementing the National Strategic Plan on the part of all partners including government, civil society and international partners. Key implementing partners also indicated that there are still limited human resources, funds and appropriate infrastructure that pose challenges to the implementation of the strategies. Another major challenge continues to be the need to utilize existing data to inform planning and conduct further research to gather data on how to plan targeted programs for key vulnerable populations. Even though the country has been successful over the years in gathering evidence through the Information System, research and other assessments, the findings of these are yet to translate into strategic information to guide an evidence-based response.

Some of the key participants also pointed out the low level of political support to some of the civil society organizations working with vulnerable populations such as MSM and sex workers. They stated that due to legal and political barriers the National AIDS Commission does not take a visible stance in support of key populations such as MSM and other vulnerable populations especially over the past two years when the debate over the rights of LGBTs in Belize has become a major issue. They were of the opinion that their support needs to be visible and that the participation needs to be significant. One major challenge continues to be the lack of support for salaries for those involved in work with vulnerable populations since most of the work is done at a voluntary level. Some of the informants also stated that civil society organizations lack training opportunities in areas such as strategic planning, research, policy analysis, monitoring and evaluation and human rights. Human and financial resources continue to be the greatest challenge for civil society organizations that do not receive any funds from the national budget to carry out their work in the country. The National AIDS Commission has been successful in mobilizing resources through the Global Fund which has been funding the multi-sectoral project to strengthen the Response to HIV in Belize.

Graph 9: NCPI: Policy Efforts



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) Challenges faced throughout the reporting period (2012-2013) that hindered the national response, in general, and the progress towards achieving the targets, in particular; and,

The challenges faces during the reporting period (2012-2013) are the same as the ones that were reported in (2010-2011).

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 which 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

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

Sustainability of NGOs

Two recent actions planned and those in process to achieve agreed targets are:

1. Investment Case. This exercise was initially led by UNAIDS while still in-country and is intended to incorporate all three sectors of the society as partners in HIV/AIDS financing, but with more robust financing potential through strategic investment buy-in and planning coming from local government. It is envisaged that the exercise will successfully prove to the government in dollars and cents

how much it would save in the future by investing in prevention, care and treatment and policy and legislative strategies today.

2. M&E core group of trained personnel in the National Response. Through training received in monitoring, HIV indicators, health economics, evaluation and the like, a collaboration among INCAP, USAID-PASCA and Universidad de San Carlos de Guatemala has made available a group of 22 who will now guide better, m ore effective sustainability—output, outcomes--of the work of the NGOs in the country.

Care and Treatment

The achievement towards agreed targets in care and treatment has come a long way in the recent past. The Stigma Index conducted through the Collaborative Network of Persons Living with HIV in Belize and the Stigma and Discrimination Gallup Poll Results through USAID-PASCA will go far is highlighting the need for increased advocacy and awareness for health care personnel working with infected and affected persons in Belize and more widely the general population. It is expected too that the results and recommendations coming from these two polls will strengthen the initiatives in care and treatment coming from both government and civil society organizations.

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.

It can also be added that the viral load test area is now being commissioned by the Ministry of Health through collaboration with the UNDP. Work should begin on the area shortly, and it cannot be stressed what benefit these tests will add to the development value in the country and the working and health potential of persons in need of these services now or in the future.

Policy Efforts

Specific expert groups, such as: uniformed services, education, legal, health and business/insurance were invited to public consultations were held earlier this year in the furtherance of the comprehensive Legislative Review of HIV laws for Belize. There are only two special meetings remaining with the Insurance industry and Ministry of Health remaining before the first draft of the Cabinet Paper is prepared for authorization by the Oversight and Executive committees of the NAC before second draft and submission to the Cabinet.

Prevention Efforts

In line of prevention efforts, there are several noteworthy actions geared at reaching agreed targets still in progress:

1. A Modes of Transmission study has been supported through the Ministry of Health

2. A Population Sizes estimate will begin within the next month

3. A National Prevention Strategy with particular attention to Most-at-Risk Populations is being contracted now

4. The costing of NSP-NOP/M&E plans is being done now, essentially to identify gaps

5. Work is now to prioritize coordination of National Response in country.

VI. Support from the Country's Development Partners

The United Nations support on HIV/AIDS through the UN Joint Team on HIV catalysed around reducing HIV transmission (youth, MSM and SW) and supporting the realization of Human Rights.

UNFPA supported research on comprehensive sexuality education for out-of-school youth, developed an accompanying referral guide, and established youth friendly spaces. UNDP as the principal recipient for the Global Fund, supported low-literacy peer education for youths in two geographic locations with higher prevalence rates (Belize and Stann Creek Districts), supported the development of a health and family life curriculum for secondary schools, and combination prevention services for men who have sex with men and sex workers. UNICEF supported the development and implementation of an HIV prevention programme for adolescents and youth in and out-of-school in the Stann Creek district as well as provided support to the Ministry of Health to strengthen PMTCT efforts to bring to zero the number of children born with HIV.

In the area of human rights, UNFPA supported the development of model legislation for the provision of services for to young people 16 to 18. The Secretariat and UNDP joined efforts with the REDCA+ (principal recipient for a regional Global Fund grant) to support the execution of the PLHIV Stigma Index. The Secretariat conducted a public opinion poll on attitudes towards HIV testing, homosexuality, sex work, punitive legislation, gender, violence and child abuse. In closing the resource gap the Secretariat supported

sustainability discussions in Belize that led to the initiation of a national investment case for Belize.

Some of the challenges that remain for Belize that the UN will continue to provide support for include:

1 - Access to comprehensive sexuality education and other prevention interventions for young people in and out of school, including access to sexual and reproductive health services for young people under the age of 19. There is disconnect between the age of legal consent to sex and the age of legal access to services without parental consent.

2 - A number of punitive laws still exist in Belize that affects the demand for services critical to achieving HIV targets and goals. These include the criminalization of the transmission of HIV, the criminalization of unnatural acts (including same sex relations) and the rendering of homosexuals as prohibited immigrant. These laws pose impediments to the uptake of services such as PMTCT, Testing and Treatment.

3 - Financial constraints associated with stand-alone HIV programmes. Like the rest of the world the effects of the global economic crisis as well as competing development priorities such as climate change and non-communicable diseases have affected funding for HIV programmes in Belize. Additionally, Belize's classification as an upper middle income country also affects its ability to source donor funds.

4- Weak absorptive capacity and limited human and institutional capacities to generate and manage credible strategies, policies and programmes which will transform the available aid into positive outcomes.

VII. Monitoring and Evaluation Environment

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

The national M&E System is guided by the "Three Ones" principles and continues to provide critical data for the monitoring of the multi-sectoral response to HIV/AIDS, with the aim of improving the national response. This is made possible through the utilization of information for decision making in the planning, coordination and implementation of the national response.

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. The NCPI 2014, indicates "there has not been a functional M&E unit at the National AIDS Commission for most of the past two years" however, it is important to note that while there is no M&E unit, the functions of the M&E unit has been executed by the NAC M&E Officer, with technical guidance and support from the NAC Monitoring and Evaluation Sub-Committee and other technical partners.

In 2013, the Belize HIV/AIDS Monitoring & Evaluation Plan 2012 – 2016 was developed in alignment with the goals and strategic objectives of the National Strategic Plan 2012 – 2016. The objectives of the M&E Plan is to ensure the generation and use of accurate, timely, and relevant data to monitor and evaluate the national response to HIV/AIDS, and to generate strategic information for decision making in order to continuously improve the national response to the epidemic. The M&E Plan will be updated periodically during the strategic period and aligned with both the mid and end of term reviews. The M&E Plan was developed through a participatory process with stakeholders and the National M&E Sub-Committee, with technical and financial assistance of the Caribbean Public Health Agency (CHRC).

The M&E Plan also details the data collection strategy, including a data collection and data flow plan for the routine collection of M&E data, and the management of data quality mechanisms of the M&E system. The NAC plans to use "di Monitoring" as the main database for the collation and analysis of indicator data. The plan also includes a data dissemination and use plan which links data needed and data collection efforts with specific information products for different audiences, as well as a timetable for dissemination. The results of the NCPI show that there is still a challenge with the collection of data indicating, "That reports are not being submitted by partners to the NAC".

The NCPI 2014, further indicates that a "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 analyse the data that is available". The NAC is committed to increasing the understanding of the HIV/AIDS epidemic and to providing the information needed for the development of evidenced-based strategies to combat the disease through increased data analysis efforts.

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

Costed Belize HIV Monitoring and Evaluation Plan 2012 – 2016
The operationalization of Belize HIV M&E Plan 2012 – 2016 remains a challenge. The annual national M&E work plan that describes the priority M&E activities for the year with defined responsibilities for implementation, costs for each activity, identified funding, and a clear timeline for delivery of outputs has not been developed and costed.

Human Capacity for M&E
The NCPI 2014, indicates "a lack of national expertise in the area of monitoring and evaluating HIV programs". It further states, "Another challenge has been the frequent over-turn of staff and the lack of a pool of trained experts in the area of monitoring and evaluation in the country to satisfactorily fill the post of Monitoring and Evaluation Officer". Over the past two years, monitoring and evaluation trainings have been conducted with stakeholders to build capacity in the area of M&E, however the adequate number of dedicated staff with the right skills remains a challenge.

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

Costed Belize HIV Monitoring and Evaluation Plan 2012 – 2016
The NAC continues to seek financial and technical assistance from its development partners both nationally and internationally to support the costing of the M&E plan which would ensure that financial and human resources are identified and mobilized, allowing for improved monitoring of the progress towards the implementation of one national M&E system.

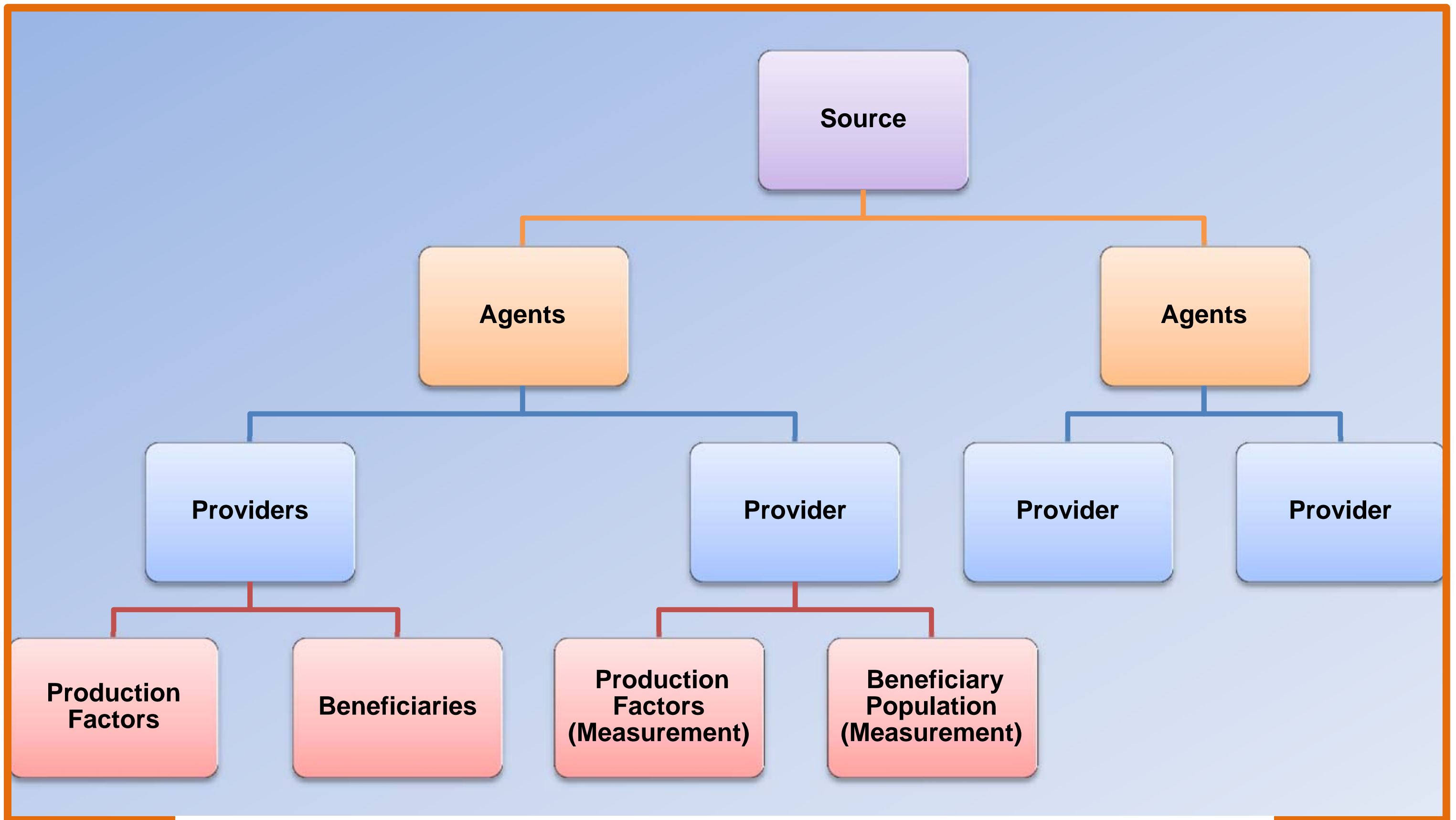
Human Capacity for M&E
The NAC continues to seek financial and technical assistance to capitalize on identified opportunities to further strengthen human capacity for M&E in the national response through initiatives such as, formal training, in-service training, mentorship, coaching and internships.

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

Technical and financial assistance is needed in the following areas to further strengthen the national M&E system:

- Continued capacity building for M&E in the areas of leadership, financial management, facilitation, supervision, advocacy, communication, M&E, and data analysis.
- Costing of the Belize HIV Monitoring and Evaluation Plan 2012 – 2016.

ANNEX 1: National AIDS Spending Assessment



Status at a Glance

Administrator

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LIST OF ACRONYMS

ARV	Anti-retroviral
ASC	AIDS Spending Category
BP	Beneficiary Population
BSS	Behavioural Sexual Survey
FSW	Female Sex Workers
GDP	Gross Domestic Product
MARPS	Most at Risk Populations
MSM	Men who have Sex with Men
NAC	National AIDS Commission
NASA	National AIDS Spending Assessment
NSP	National Strategic Plan
PASCA	Programme to Strengthen the HIV Response in Central America
PEPFAR	Presidential Emergency Package for AIDS Relief
PF	Production Factor
PLHV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counselling and Testing

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EXECUTIVE SUMMARY

The National AIDS Commission (NAC), with ongoing technical and financial assistance from USAID/PASCA, has undertaken the third National AIDS Spending Assessment (NASA) 2012; the baseline assessment dates back to the period 2008/09.

During 2012 Belize invested BZ$5.7 million (US$2.85 million) in the National HIV Response. Total HIV spending was 3.8 percent of the national health expenditure and one fifth of one percent of Gross Domestic Product (GDP) estimated at BZ$3.04 billion. Per capita expenditure is US$8.37 calculated on an estimated total population of 338,996 as at April 2012. Financing estimates for Belize's National Strategic Plan (NSP) was US$5.3 million showing a funding gap of 46.5 percent in 2012.

Belize's National HIV response remains heavily dependent on external funding with 64 percent or BZ$3.6 million of HIV expenditure being financed by external sources. Domestic public expenditure financed 29 percent or BZ$1.7 million of total HIV expenditure while the private sector invested 7 percent or 415k. Belize remains vulnerable to the adverse effects of sweeping cuts in external funding.

The Government of the United States was the single largest bilateral external donor primarily through the Presidential Emergency Package for AIDS Relief (PEPFAR), and USAID agencies including USAID/PASCA, USAID/PASMO, and USAID/Intra-Health International.

The Global Fund, through its Principal Recipient UNDP, was the second largest external donor funding 31 percent of foreign funds. Multilateral agencies (UN) accounted for 10 percent of external funds.

HIV spending shows a higher concentration within the 'General Population,' 'Non-targeted Interventions,' and 'Specific Accessible Populations' where 75% of total resources were deployed. However, and within the "Specific Accessible Populations," interventions were targeted at students, primarily and the junior and high school levels, the military and uniformed services.

Eighty percent of AIDS spending was concentrated in three categories – Programme Management and Administration (33%), Prevention (27%), and Care and Treatment (20%). Very limited resources were directed at Orphans and Vulnerable Children and Social Protection and Social Services.

Over 80 percent (82%) of critical inputs were distributed in four areas – wages including labour income, and administrative services (26%), drugs and pharmaceuticals, condoms and reagents and materials (24%), services associated with programmatic activities and

including transportation and travel, logistics and catering, housing and other services (20%), and consulting services (12%).

Eighty six percent of NASA data was collected from a certified primary source while 12 percent had to be adapted from the primary source and 2 percent through personal communication. However, and although some reporting organizations such as UNDP/PR provided reports for sub-recipients, a few of the sub-recipients did not actually report their data. This was true also for the United Nations Population Fund (UNFPA).

Considering that the National HIV response is heavily financed by external funding sources, there has to be a high level of importance attached to programme accountability since the current trend in donor funding is being built around a results-based management framework.

Against this background, all stakeholders should commit to higher levels of accountability to the Country Coordinating Mechanism (CCM) led by the NAC Secretariat. There is a need for institutionalization of the NASA system and for the National response to take ownership of the process.

As a first step, the NAC Secretariat is being trained to take ownership of the process but the eventual success of a real time NASA reporting system depends on all stakeholder organizations to embrace the process.

1.0 INTRODUCTION

The National AIDS Commission (NAC), with ongoing technical and financial assistance from USAID/PASCA, has undertaken the third National AIDS Spending Assessment (NASA) 2012; the baseline assessment dates back to the period 2008/09.

The NASA is Belize's resource tracking activities and provides key indicators on the country's financial response to HIV/AIDS, supports the monitoring of resource mobilization, and is a useful tool within the financial system that can enhance the national monitoring and evaluation framework.

In the short-term, the NASA provides the UNGASS indicator for domestic public expenditure. The longer-term benefits include more effective monitoring of the National Strategic Plan (NSP), and the attainment of nationally and internationally adopted goals such as universal access to treatment and care, compliance with the principle of 'additionality,' and analysis of structural bottle-necks and absorptive capacity issues that may impede the proper deployment of available resources in the provision of goods and services where they are needed.

Previous NASA reports have been used by key players within the national response to inform advocacy campaigns in policy and human rights and for this reason, USAID/PASCA continues to put heavy emphasis on the value of the NASA as a useful tool for influencing policy and strategic decision-making. PASCA's goal has been to facilitate the transfer of knowledge and technology to the NAC as a means of strengthening the national response and allowing the wider stakeholders to take ownership of the process.

2.0 KEY HIV INDICATORS

2.1 Epidemiological Profile at a Glance

Out of the total number of rapid tests done, and with males undergoing less testing, the majority of those positive cases were in the male group (ratio of 1.47:1) when compared to females. The total figures in 2012 represent a 10% increase in the total number of reported new HIV infections when compared to 2011 data, and this is also of significance as this is the first increase in the last 4 years as the tendency had been to show decreasing numbers of new HIV infections. The male to female ratio of new infections has actually widened with an actual increase in the total number of males and a decrease in the total number of females being recently diagnosed. This ratio has now widened when compared to data from 2011 and is further supportive of the data as reported in the BSS of a notion of Belize having a concentrated epidemic.[2]

Traditionally the group between 20-39 years has had the higher number of new cases but the 2012 data shows a particular spike in the 45-49 yr old group where the highest number of cases was reported for all age groups. The male to female ratio in this age range was 1.69:1 which is a little bit higher than the documented for the overall age groups. This trend is particularly more noticeable for the male groups but we are also seeing a tendency to have older females having a recent diagnosis of HIV; however, this doesn't necessarily reflect that these are new infections and the CD4 data actually suggests that the majority of patients are showing up in the later stages of the disease.[3]

The Belize district reported the highest number of new infections in 2012 with the second highest total number reported by the Cayo District. However, when the rates are calculated by district population size using the 2012 midyear estimates, the Belize District has the highest rate of 14.5/ 10,000 followed by the Stann Creek with 6.6/10,000.[4]

Of the total 88 HIV related deaths, 57 were males who fell within the productive age range 30-34.

Table 1

Indicator	Male	Female	Total
HIV Rapid & Elisa Testing - 2012	9062	17533	26595
New HIV Cases - 2012	101	148	249
Positivity Rate	1.51%	.54%	0.89%
HIV Related Deaths	31	57	88

[2] ***Annual TB, HIV/AIDS, & Other STIs Programme Report- 2012;''*** *Ministry of Health, National AIDS Programme*

[3] ***- IB ID -***

[4] ***- IBID -***

Source: Ministry of Health, Annual TB, HIV/AIDS, & Other STIs Programme Report, 2012			

In 2012, 92.6% of pregnant were tested for HIV with a detection of 17 new HIV cases and 21 previously known cases becoming pregnant. The prevalence rate in this group was 0.59% representing a decrease in both the total number of HIV infections in 2012; out of the total amount of those positive and pregnant, 94.7% of women received prophylaxis. There were a total of 44 deliveries and all exposed infants received ARVs at the time of delivery, similarly all exposed babies received a first PCR screening test. However, the coverage for PCR testing decreased to 64.9% coverage by the 3rd PCR. This highlights the need for adequate follow-up of those patients being lost from the system.

Table 2

PMTCT Report 2012	Total Number	Percentage
Total Pregnant Women	6969	
Total Pregnant Women Tested for HIV	6454	92.6%
New HIV Cases	17	0.26%
Known HIV Cases	21	0.33%
Total HIV Positive Pregnant Women	38	0.59%
HIV Positive Pregnant Women Receiving ARVs	36	94.74%
Deliveries By HIV Positive Women	44	
Infants Received ARVs	44	
HIV MTCT	2	4.54%
1ST PCR Coverage for Exposed Infant	44/44	100%
2nd PCR Coverage for Exposed Infant	44/49	89.80%
3rd PCR Coverage for Exposed Infant	35/54	64.9%
Source: "Ministry of Health – Annual TB, HIV/AIDS, & Other STIs Programme Report – 2012."		

2.2 MDG Indicators

Belize is on track in halting the spread of HIV. This is demonstrated by the significant decline of new HIV cases over the last five years largely due to the Prevention of Mother to Child Transmission (PMTCT) programme and voluntary counselling and testing (VCT). Services including access to condoms and antiretroviral (ARV) drugs coupled with other social actions may have impacted positively on the reduction in the number of new cases.

However, data on young population with correct comprehensive knowledge of HIV/AIDS show a decline but this data was collected via sample surveys where non-sampling errors could skew the results.[5] See Table 3.

Table 3: MDG-HIV Scorecard

Target	Indicators	Baseline 1990	Status 2010	Actual 2012	Comments
Target 6 A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years	0.77% (2009)	0.68% (2010)	0.64% (2011) 0.31% (2012)	Declining with 226 cases in 2011 down from 365 in 2009
	6.2 Condom use at last high-risk sex	———	71.9% (SBS 2009)	65.4% (MICS 2011)	Noted decrease in condom use
	6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	———	71.9% (SBS 2009)	42.9% (MICS 2011)	Noted decline
Target 6 B: Achieve by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection access to ARVs	62% (2009)	70.4% (SBS 2010)	85.1% (MICS 2011)	On target; need to maintain minimum of 2.98% increase per annum

Source: MDG Report & Post 2015 Agenda – Belize 2013

[5] ***"Millennium Development Goals Report and Post 2015 Agenda, Belize 2012;" An Objective Update on MDG Progress Which Represents Belize's People Centred Development Approach, 2013.***

3.0 TOTAL HIV/AIDS SPENDING

During 2012 Belize invested BZ$5.7 million (US$2.85 million) in the National HIV Response. Total HIV spending was 3.8 percent of the national health expenditure and one fifth of one percent of Gross Domestic Product (GDP) estimated at BZ$3.04 billion.

Per capita expenditure is US$8.37 calculated on an estimated total population of 338,996 as at April 2012.

Financing estimates for Belize's National Strategic Plan (NSP) was US$5.3 million showing a funding gap of 46.5 percent in 2012.

Table 4

Total HIV Expenditure (BZ$)	**5,673,544**
Total HIV Expenditure (US$)	2,836,772
- Per capita HIV Expenditure (US$)	8.37[6]
- As % of Total Health Expenditure	3.8%
- As % of Gross Domestic Product	0.2%[7]
- As % of NSP Resource Needs 2011/12	53.5%[8]
- NSP Funding Gap 2011/12	46.5%

[6] ***"Belize Labour Force Survey- Summary Findings, April 2012;" Statistical Institute of Belize – Estimated Total Population of 338,996.***

[7] ***"Budget Speech Presentation, 2012/13" Projected GDP – BZ$3.04 billion***

[88] ***"Health Policy Initiative – Costing Belize's National Strategic Plan for HIV/AIDS;" USAID-HPI, September 2008***

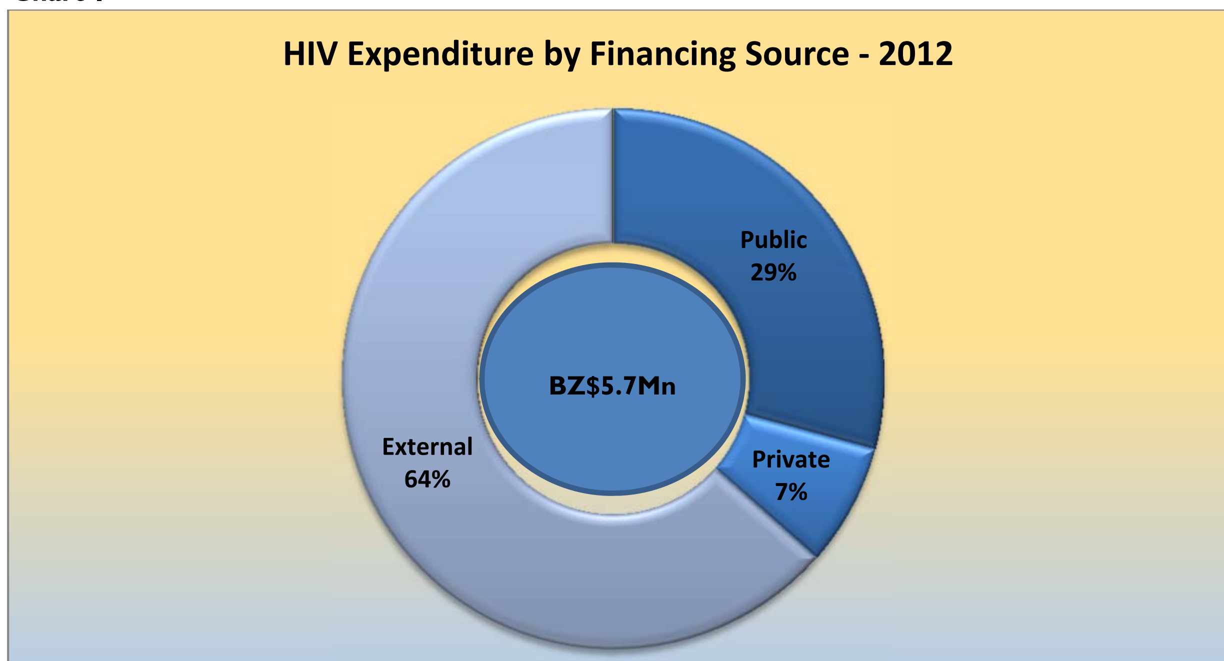
4.0 ORIGIN OF FUNDS – EXTERNAL DEPENDENCY

Belize's National HIV response remains heavily dependent on external funding as evidenced by the chart below, which shows that 64 percent or BZ$3.6 million of HIV expenditure was financed by external sources.

Domestic public expenditure financed 29 percent or BZ$1.7 million of total HIV expenditure while the private sector invested 7 percent or 415k.

Belize remains vulnerable to the adverse effects of sweeping cuts in external funding.

Chart 1



Origin of Funds	BZ$	US$
External	3,600,494	1,800,247
Private	414,837	207,418.5
Public	1,658,213	829,106.5
Total	5,673,544	2,836,772

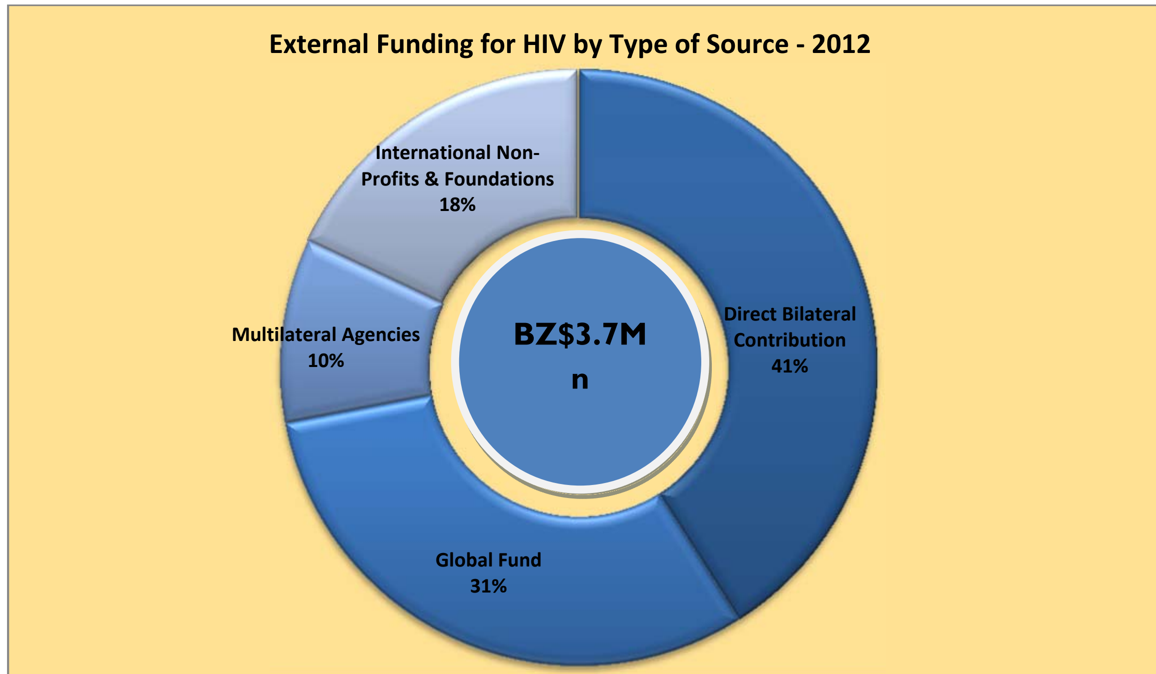
5.0 FOREIGN SOURCES COMPOSITION

The Government of the United States was the single largest bilateral external donor primarily through the Presidential Emergency Package for AIDS Relief (PEPFAR), and

USAID agencies including USAID/PASCA, USAID/PASMO, and USAID/IntraHealth International.

The Global Fund, through its Principal Recipient UNDP, was the second largest external donor funding 31 percent of foreign funds. Multilateral agencies (UN) accounted for 10 percent of external funds.

Chart 2



Direct Bilateral Agencies		
FS.03.01.08	Government of Germany	260,107.00
FS.03.01.22	Government of United States	1110,965.00
Multilateral Agencies		
FS.03.02.08	UNAIDS Secretariat	10,722.00
FS.03.02.09	United Nations Children's Fund (UNICEF)	194,600.00
FS.03.02.17	United Nations Population Fund (UNFPA)	141,044.00
Global Fund		
UNDP/PR		
FS.03.02.07	The Global Fund to Fight AIDS, Tuberculosis and Malaria	**1034,713.00**
	Sub-total	**2752,151.00**
International Non-Profit Organizations & Foundations		612243
		3364,394.00

6.0 RESOURCE TARGETING

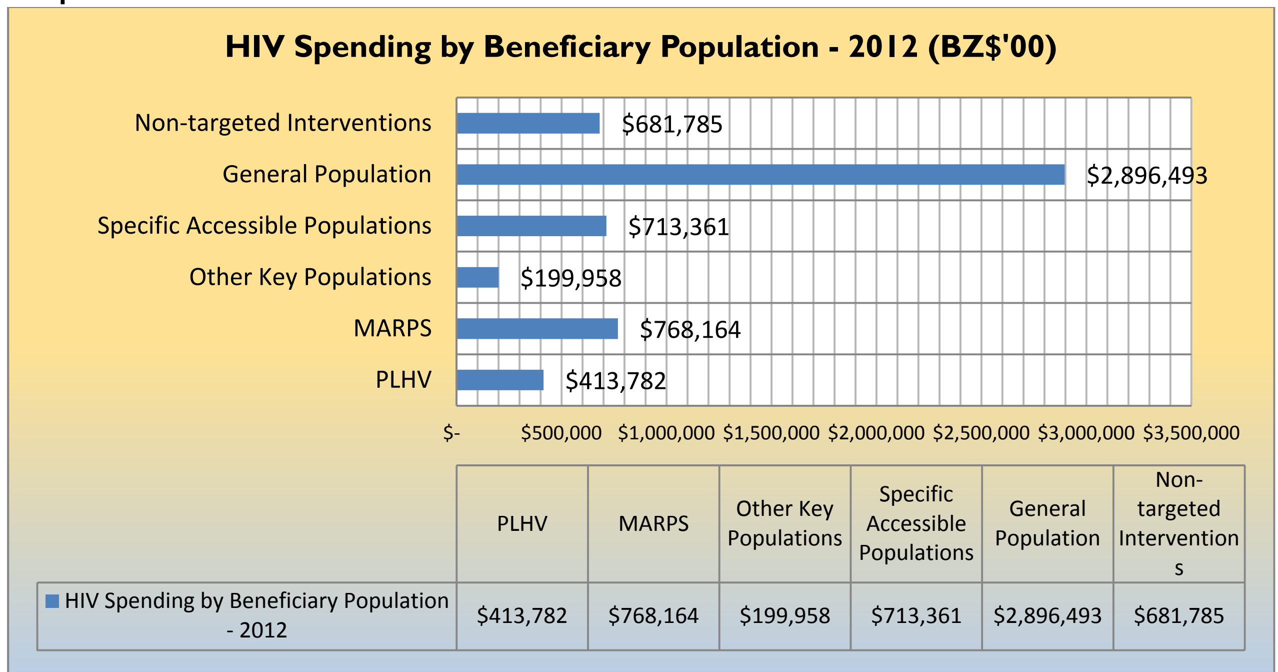
HIV spending shows a higher concentration within the 'General Population,' 'Non-targeted Interventions,' and 'Specific Accessible Populations' where 75% of total resources were deployed. However, and within the "Specific Accessible Populations," interventions were targeted at students, primarily and the junior and high school levels, the military and uniformed services.

Interventions among 'Other Key Populations' were targeted primarily at orphans and vulnerable children and children and youth out of school.

At the MARPS level, resources were distributed across three groups – female sex workers and their clients (FSW), men who have sex with men (MSM), and MARPS not disaggregated by type.

Among people living with HIV (PLHV), the bulk of resources were directed to children less than 15 years of age including boys and girls.

Graph I



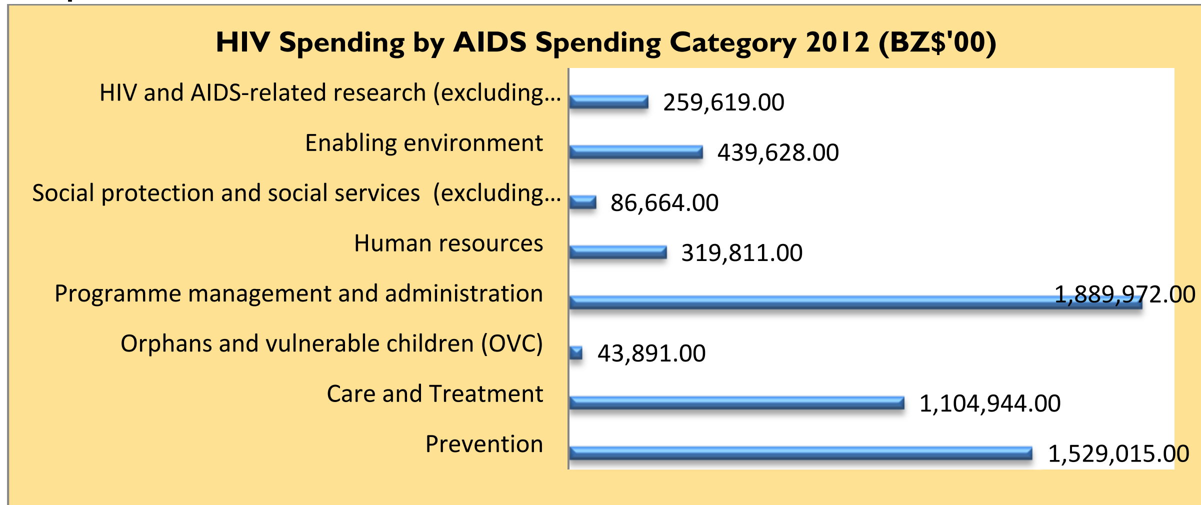
	PLHV	MARPS	Other Key Populations	Specific Accessible Populations	General Population	Non-targeted Interventions
HIV Spending by Beneficiary Population - 2012	$413,782	$768,164	$199,958	$713,361	$2,896,493	$681,785

7.0 SPENDING CATEGORIES

7.1 Overall Spending by Categories

Eighty percent of AIDS spending was concentrated in three categories – Programme Management and Administration (33%), Prevention (27%), and Care and Treatment (20%). Very limited resources were directed at Orphans and Vulnerable Children and Social Protection and Social Services.

Graph 2



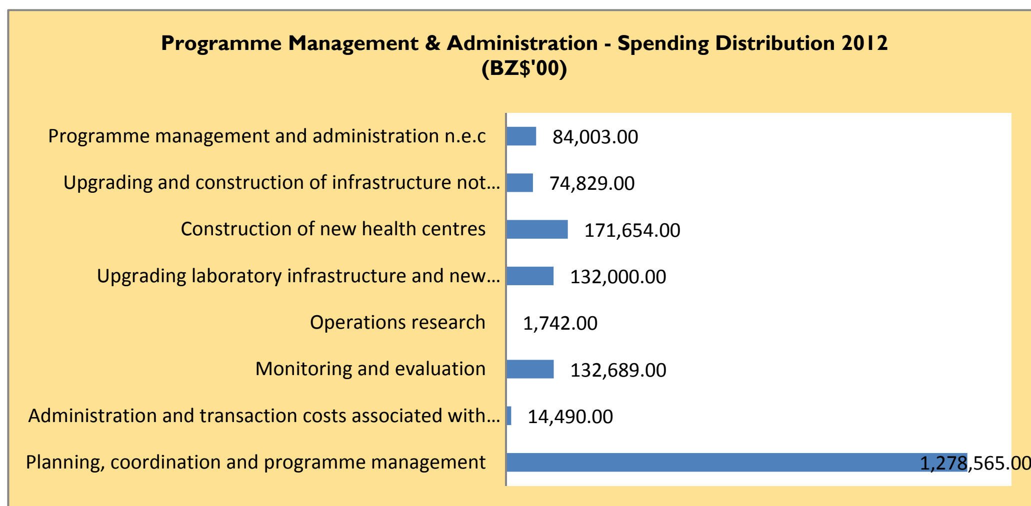
7.2 Programme Management & Administration

Aside from 20 percent of resources which were directed toward construction and upgrading of infrastructure, and 7 percent for monitoring and evaluation activities, the bulk of spending was for planning, coordination, and programme management activities.

Graph 3

7.3 Prevention

More than half of total prevention expenditure



(55.2% combined) was spent on communications – health and non-health related and for social and behavioural change. Condom social marketing combined for another 27.3 percent of total prevention expenditure.

Table 5

	$1529,015.00
Health-related communication for social and behavioural change	810,570.00
Non-health-related communication for social and behavioural change	3,500.00
Communication for Social and behavioural change not disaggregated by type	29,264.00
Community mobilization	31,732.00
Voluntary counselling and testing (VCT)	38,471.00
VCT as part of programmes for vulnerable and accessible populations	8,811.00
Condom social marketing and male and female condom provision as part of programmes for vulnerable and accessible populations	7,634.00
STI prevention and treatment as part of programmes for vulnerable and accessible populations	40,050.00
Other programmatic interventions for vulnerable and accessible populations not elsewhere classified (n.e.c.)	1,728.00
Prevention – youth in school	10,800.00
Prevention – youth out-of-school	37,500.00
Condom social marketing and male and female condom provision as part of prevention of HIV transmission aimed at PLHIV	1,500.00
Behaviour change communication (BCC) as part of programmes in the workplace	49,094.00
Condom social marketing	45,382.00
Public and commercial sector male condom provision	408,360.00
Prevention activities not disaggregated by intervention	4,619.00

7.4 Care and Treatment

The two main spending categories for Care and Treatment are those services not disaggregated by intervention (58.6%), and specific HIV-related laboratory monitoring by the Central Medical Lab (27.2%).

Table 6

	$ 1104,944	100.0
OI outpatient prophylaxis	$ 20,000	1.8
Second-line ART – adults	$ 9,000	0.8
Nutritional support associated to ARV therapy	$ 24,000	2.2
Specific HIV-related laboratory monitoring	$ 300,818	27.2
Dental programmes for PLHIV	$ 1,500	0.1
Psychological treatment and support services	$ 64,818	5.9
Home-based medical care	$ 36,000	3.3
Outpatient care services n.e.c.	$ 1,078	0.1
Care and treatment services not disaggregated by intervention	$ 647,730	58.6

8.0 CRITICAL INPUTS

Over 80 percent (82%) of critical inputs were distributed in four areas – wages including labour income, and administrative services (26%), drugs and pharmaceuticals, condoms and reagents and materials (24%), services associated with programmatic activities and including transportation and travel, logistics and catering, housing and other services (20%), and consulting services (12%).

Table 7

Production Factor - Sub-Functions		Expenditure	%
		5673,544	**100.0**
Wages	$	1113,581	19.63
Social contributions	$	95,864	1.69
Non-wage labour income	$	52,966	0.93
Labour income not disaggregated by type	$	73,131	1.29
Labour income n.e.c.	$	19,500	0.34
Antiretrovirals	$	9,000	0.16
Other drugs and pharmaceuticals (excluding antiretrovirals)	$	30,600	0.54
Medical and surgical supplies	$	571,956	10.08
Condoms	$	462,087	8.14
Reagents and materials	$	306,718	5.41
Food and nutrients	$	85,193	1.50
Material supplies not disaggregated by type	$	84,195	1.48
Administrative services	$	220,782	3.89
Maintenance and repair services	$	9,967	0.18
Publisher-, motion picture-, broadcasting and programming services	$	258,056	4.55
Consulting services	$	660,712	11.65
Transportation and travel services	$	377,420	6.65
Housing services	$	32,289	0.57
Logistics of events, including catering services	$	478,950	8.44
Services not disaggregated by type	$	224,475	3.96
Services n.e.c.	$	6,557	0.12
Current expenditures not disaggregated by type	$	66,079	1.16
Current expenditures n.e.c.	$	60,272	1.06
Laboratory and other infrastructure upgrading	$	11,172	0.20
Construction of new health centres	$	246,483	4.34
Buildings n.e.c.	$	10,875	0.19
Vehicles	$	9,623	0.17
Information technology (hardware and software)	$	15,334	0.27
Laboratory and other medical equipments	$	75,679	1.33
Equipment not disaggregated by type	$	1,754	0.03
Equipment n.e.c.	$	2,274	0.04

9.0 CONCLUSION

Financing of the National HIV response remains heavily dependent on external sources with 64 percent of total expenditure coming from foreign sources. The Government of the United States is the single largest direct bilateral financing source and accounts for 41% of external financing under the PEPFAR umbrella and through various USAID agencies.

The Global Fund is the second largest financing source with 31 percent of external funding flowing through its Principal Recipient (PR) in Belize (UNDP) and Sub-recipients which comprise of Government Ministries and Civil Society Organizations.

Financial resources and programmatic interventions are directed primarily at the General Population, Specific Accessible Populations, and Non-targeted interventions; these three beneficiary groups account for 75 percent of expenditure.

Programme Management and Administration, Prevention, and Care and Treatment spending categories combined account for 80 percent of HIV expenditure. Programme Management and Administration expenditures focus on programme planning, coordination, and implementation activities.

Prevention expenditures focus on communications, drugs, pharmaceuticals, and services, and condom distribution in that order.

Care and Treatment services are not disaggregated by intervention and accounts for 60% of expenditure followed by Specific HIV Laboratory Monitoring with 27 percent.

Over 80 percent (82%) of critical inputs were distributed in four areas – wages including labour income, and administrative services (26%), drugs and pharmaceuticals, condoms and reagents and materials (24%), services associated with programmatic activities and including transportation and travel, logistics and catering, housing and other services (20%), and consulting services (12%).

10.0 CONSTRAINTS & RECOMMENDATIONS

10.1 Information Quality - Data

Eighty six percent of NASA data was collected from a certified primary source while 12 percent had to be adapted from the primary source and 2 percent through personal communication. However, and although some reporting organizations such as UNDP/PR provided reports for sub-recipients, a few of the sub-recipients did not actually report their data. This was true also for the United Nations Population Fund (UNFPA).

10.2 Recommendations

Considering that the National HIV response is heavily financed by external funding sources, there has to be a high level of importance attached to programme accountability since the current trend in donor funding is being built around a results-based management framework.

Against this background, all stakeholders should commit to higher levels of accountability to the Country Coordinating Mechanism (CCM) led by the NAC Secretariat. There is a need for institutionalization of the NASA system and for the National response to take ownership of the process.

As a first step, the NAC Secretariat is being trained to take ownership of the process but the eventual success of a real time NASA reporting system depends on all stakeholder organizations to embrace the process.

11.0 LIST OF REPORTING ORGANIZATIONS

Belize Defence Force
Belize Family Life Association
Belize Red Cross
Central Medical Lab
Claret Care
Community Policing Unit
Cornerstone Foundation
GO BELIZE
Hand in Hand Ministries - Belize
Intra Health International - Capacity Project
MHDST - Women's Department
Ministry of Education - HFLE
Ministry of Education, Youth, & Sports
Ministry of Health - National AIDS

Programme
Ministry of Human Development
National AIDS Commission
National Women's Commission
Private Sector Importers, Distributors, & Agents
Productive Organization for Women in Action
PSI PASMO - Belize
UNICEF-Belize Office
United Advocacy Belize Advocacy Movement - UNIBAM
USAID -PASCA
Women Issues Network Belize
Young Women's Christian Association
Youth Enhancement Services
Young Women's Christian Association (Belize)

12.0 ANNEXES

Annex 1: Beneficiary Population Matrix
Annex 2: Production Factor Matrix
Annex 3: UNGASS Matrix
Annex 4: NASA Outputs – Frequency Tables

ANNEX 2: NCPI A Government Composite

2014 Global AIDS Response Progress Report - Belize
National Commitment and Policy Instrument

NCPI A –
Government Officials

Celia Lizet Aldana
Consultant
February, 2014

NCPI - PART A: Administered to Government Officials and International Partners

Respondents to Part A

#	NAME	Position/Organization	Section
1	Mrs. Kathy Esquivel	Chairperson National AIDS Commission	all
2	Dr. Marvin Manzanero	Director, National AIDS Programme Ministry of Health	all
3	Allison Green	Executive Director National AIDS Commission	
4	Eckert Middleton	Coordinator, HIV Unit Youth for the Future, Ministry of Youth	all
5	Martin Cuellar	Past Executive Director National AIDS Commission	
6	Jamin Castillo	M & E Officer National AIDS Commission	
7	Nelson Longsworth	Director Quality Assurance and Development Services, Min of Education	all
8	Nurse Veronica Ortega	VCT Nurse Northern Regional Hospital	all
9	Clemente Novelo	Corozal Nac District Committe	

1. Has the country developed a national multisectoral strategy to respond to HIV?

Yes No

IF YES, what was the period covered *[write in]*:

2012 - 2016

IF YES, briefly describe key developments/modifications between the current national strategy and the prior one.

The 2012 Global Progress Response Report indicated that the process of developing the new HIV Strategic Plan for Belize was unanimously described by all key informants as the most inclusive and participatory in the history of the response in Belize. Informants stated that they felt a sense of ownership and responsibility with the new NSP as they were involved in the process of developing and validating it as the process allowed for greater involvement of key vulnerable populations such as persons living with HIV, men who have sex with men, and sex workers. 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 new NSP was also described as being more human rights based and gender responsive. In 2011 the NCPI reported a score of 7 for strategic planning which was an increase of 2 points from 2009.

In 2014 the NCPI reports a score of 6 for strategic planning which is a decrease of 1 point. Overall, the strategic plan continues to be described as a very good plan, however, the concern is that in 2 years the implementation of the plan has not been as effective and significant. Some respondents felt that there have been no actual key developments in the past 2 years with the Strategic Plan and that it continues to be very general. There is also the perception that many of the key partners in the response are still not familiar with the goals and objectives and that these have not been incorporated at the organizational and community level.

IF NO or NOT APPLICABLE, briefly explain why.

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

1.1. Which government ministries or agencies have overall responsibility for the development and implementation of the national multi-sectoral strategy to respond to HIV?

Name of government ministries or agencies *[write in]*:

The multisectoral National Aids Commission has responsibility for the development and implementation of the National Strategic Plan. The National AIDS Commission ACT stipulates representation at the highest level from the Ministry of Health, Ministry of Education, Ministry of

Tourism, Ministry of Security, Ministry of Labour and the Ministry of Human Development, Social Transformation and Poverty Alleviation. In addition the NAC has established district branches within 5 districts including the island of San Pedro.

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

SECTORS Included in Strategy	Earmarked Budget	
Education	Yes	No
Health	Yes	No
Labour	Yes	No
Military/Police	Yes	No
Transportation	Yes	No
Women	Yes	No
Young People	Yes	No
Other *[write in]*:	Yes	No
Tourism	Yes	No

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?

Government agencies included in the national strategy receive their funding through the national budget. However, some government agencies that do not have specific national budgets for HIV use funding from other line items in the Ministry budget. Also, in instances where the funds are minimal or non-existent, resources are mobilized through international donors and technical partners such as the Global Fund, UNAIDS, UNDP, PAHO, UNICEF, UNFPA, USAID, UKAID and other partners based in and out of the country.

1.3. Does the multisectoral strategy address the following key populations/other vulnerable populations, settings and cross-cutting issues?

KEY POPULATIONS AND OTHER VULNERABLE POPULATIONS

Discordant couples	Yes	No
Elderly persons	Yes	No

Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No
Other specific vulnerable subpopulations	Yes	No

SETTINGS

Prisons	Yes	No
Schools	Yes	No
Workplace	Yes	No

CROSS-CUTTING ISSUES

Addressing stigma and discrimination	Yes	No
Gender empowerment and/or gender equality	Yes	No
HIV and poverty	Yes	No
Human rights protection	Yes	No
Involvement of people living with HIV	Yes	No

IF NO, explain how key populations were identified?

1.4. What are the identified key populations and vulnerable groups for HIV programmes in the country [write in]*?*

KEY POPULATIONS

Men who have sex with men, female sex workers, clients of sex workers, intimate partners of vulnerable persons, women and girls, orphans and vulnerable children, persons living with HIV, persons with disabilities, prisoners, young men and women of reproductive age, males at risk and women in difficult circumstances.

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

Yes No

The Belize Defence Force has developed and is in the process of implementing a comprehensive strategy for the military. During the past 2 years the BDF has aligned its strategy with the new National Strategic Plan. The police and other uniformed services do not have a strategy for addressing HIV issues.

1.6 *Does the multisectoral strategy include an operational plan?*

Yes No

1.7. Does the multisectoral strategy or operational plan include:

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

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

Active involvement Moderate involvement No involvement

IF ACTIVE INVOLVEMENT, briefly explain how this was organised:

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

Civil society was actively involved in the elaboration of the new NSP and operational plan. The entire process from the point of data collection to validation of the NSP and NOP included a cross-section of government and civil society representatives. As a part of the National AIDS Commission other civil society organizations such as networks of key vulnerable groups, FBOs and the Private Sector are also regularly engaged in the strategy planning and implementation process. Some of the key informants were of the opinion that civil society needs to be more proactive in its involvement since they are invited to participate but in some instances do not attend the sessions. Even though civil society is well-represented it is felt that other civil society organizations need to be involved as it is usually the same representatives of the same organizations at all the sessions. In addition, it is felt that not all civil society organizations that are members of the Commission are able to meaningfully contribute to the process due to lack of funding and human resources to travel to the meetings which are normally held in the city.

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

Yes No N/A

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

Yes, all partners

Yes, some partners

No N/A

IF SOME PARTNERS or NO, briefly explain for which areas there is no alignment/harmonization and why:

In 2012 it was reported that key external partners such as the Principal Recipient for the Global Fund, UNAIDS, USAID and PANCAP were engaged in the process of aligning their plans with the HIV Strategic Plan 2012-2016. However, two years after it is felt that the National AIDS Commission is not fully aware of what some external partners are doing and the NAC is not always informed of activities to ensure that these are a part of the national priorities. In some instances, it was felt that external agencies have their own agenda and that this is not always aligned with the National Strategic Plan.

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

Yes No N/A

2.1. IF YES, is support for HIV integrated in the following specific development plans? YES

SPECIFIC DEVELOPMENT PLANS

Common Country Assessment/UN Development Assistance Framework Yes No N/A

National Development Plan Yes No N/A

Poverty Reduction Strategy Yes No N/A

Sector-wide approach Yes No N/A

Other *[write in]*: Yes No N/A

Even though the Common Country Assessment/UN Development Assistance Framework includes HIV, it is felt that these are not sufficiently aligned with the current priorities at the national level and thus, are not fully integrated as a part of the national response.

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

HIV-RELATED AREA INCLUDED IN PLAN(S)

Elimination of punitive laws Yes No N/A

HIV impact alleviation Yes No N/A

Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support Yes No N/A

Reduction of income inequalities as they relate to HIV prevention/ treatment, care and /or support Yes No N/A

Reduction of stigma and discrimination Yes No N/A

Treatment, care, and support (including social security or other schemes) Yes No N/A

Women's economic empowerment (e.g. access to credit, access to land, training) Yes No N/A

Other [write in below]: Yes No N/A

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

Yes No N/A

3.1. IF YES, on a scale of 0 to 5 (where 0 is "Low" and 5 is "High"), to what extent has the evaluation informed resource allocation decisions?

LOW HIGH

0 1 2 3 4 5

4. Does the country have a plan to strengthen health systems?

Yes No

During the past two years this has been done through the Policy Analysis and Planning Unit of the Ministry of Health. Through the Belize Health Sector Reform plan there has been increased number of staff in labs and pharmacies. There have also been improvements in the ART distribution system including purchasing of mobile units for testing and the acquisition of CD4 machines. This has also resulted in additional equipment for the Belize Central Medical Laboratory.

5. Are health facilities providing HIV services with other health services?

Area

a) HIV counselling & testing with sexual & reproductive health **Many** **Few** **None**
b) HIV counselling & testing and tuberculosis **Many** **Few** **None**
c) HIV counselling & testing and general outpatient care **Many** **Few** **None**
d) HIV counselling & testing and chronic non-communicable diseases **Many** **Few** **None**
e) ART and tuberculosis **Many** **Few** **None**
f) ART and general outpatient care **Many** **Few** **None**
g) ART and chronic non-communicable diseases **Many** **Few** **None**
h) PMTCT with antenatal care/ maternal & child health **Many** **Few** **None**
i) Other comments on HIV integration:

6. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate strategy planning efforts in your country's HIV programmes in 2013?

Very Poor Excellent

0 1 2 3 4 5 6 7 8 9 10

Since 2011, what have been key achievements in this area:

One of the most significant achievements reported in the past Global Response Progress Report 2012 was the development of the new HIV Strategic Plan for 2012 – 2016 and its accompanying Operational Plan. During the pasttwo years 2011-2013 there has been an emphasis on conducting greater consultations at different levels of the national response. The NCPI 2012 had indicated that one of the greatest challenges to strategy implementation was greater involvement and consultation with the community-based HIV committees. During the past two years efforts were undertaken to address this gaps as there has been a country-wide consultation with the district committees as well as the involvement of most at risk and vulnerable populations. There has been greater focus on implementing strategies which address stigma and discrimination as well as the need for legislative review. Another focus of the strategic planning has been on prioritizing sustainability and focusing efforts to develop an investment case approach. During the past two efforts there has also been a stronger focus on monitoring and evaluation and on evidence-based planning through the Ministry of Health and the National AIDS Commission with support from key technical partners such as UNAIDS, USAID and the Global Fund Project. This is a major accomplishment since the 2012 NCPI had indicated the challenge to limited dating and lack of evidence-based planning.

What challenges remain in this area:

Key informants indicate that one of the challenges continues to be the lack of ownership and a sustained commitment to implementing the National Strategic Plan on the part of all partners involved including government, civil society and international partners. Key implementing partners also indicated that there are still limited human resources, funds and appropriate infrastructure will also pose challenges to the implementation of the strategies if these are not addressed urgently. Another major challenge continues to be the need to utilize existing data to inform planning and conduct further research to gather data on how to plan targeted programs for key vulnerable populations.

POLITICAL SUPPORT AND LEADERSHIP

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

A. Government ministers

Yes No

B. Other high officials at sub-national level

Yes No

1.1. In the last 12 months, have the head of government or other high officials taken action that demonstrated leadership in the response to HIV?

(For example, promised more resources to rectify identified weaknesses in the HIV response, spoke of HIV as a human rights issue in a major domestic/international forum, and such activities as visiting an HIV clinic, etc.)

Yes No

Briefly describe actions/examples of instances where the head of government or other high officials have demonstrated leadership:

The political support was not described as significant during the past 2 years, however, the passing of the Gender Policy and the Amendment to the Sexual Offences Code are recognized as key accomplishments and show of support even though these were not specifically linked to HIV and vulnerable populations .

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

Yes No

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

2.1. IF YES:

IF YES, does the national multisectoral HIV coordination body:

Have terms of reference?	Yes	No
Have active government leadership and participation?	Yes	No
Have an official chair person?	Yes	No

IF YES*, what is his/her name and position title?* Mrs. Kathy Esquivel, Chairperson

Have a defined membership? Yes No

IF YES, *how many members?* 23 members

Include civil society representatives? Yes No

IF YES, *how many?*

Include people living with HIV? Yes No

IF YES, *how many?* 1 representative

Include the private sector? Yes No

Strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?

Yes No

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

Yes No N/A

IF YES, briefly describe the main achievements:

This is accomplished to some extent through the coordination of the implementation of the National Strategic Plan and Operational Plan. Civil society and the government sector also work in collaboration as part of the 5 sub-committees of the National AIDS Commission. The local branches of the NAC at the district level also include representatives from both civil society and government which work in coordination to implement prevention and care and support services at the community level. The Ministry of Health works very closely with the private sector to conduct its HIV Testing Campaign. The Private Sector has collaborated with the Ministry of Labour in a project to develop HIV policies for the workplace

What challenges remain in this area:

Even though some civil society and government entities have made efforts to coordinate at the national and local level during the past 2 years, there continues to be a need for more coordination. Funds are limited and in many instances priorities are lost when agencies take on fund-driven activities rather than strategic ones. Several of the key informants were of the opinion that at the national level it is still a challenge to get the different sectors at the table at the same time when the discussions need to happen.

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

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

Capacity-building	Yes	No
Coordination with other implementing partners	Yes	No
Information on priority needs	Yes	No
Procurement and distribution of medications or other supplies	Yes	No
Technical guidance	Yes	No
Other [write in below]:	Yes	No

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

Yes No

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

Yes No

IF YES, name and describe how the policies / laws were amended

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

There are a number of inconsistencies that have been identified in the 2008 revised Legislative Review of the National AIDS Commission. These include inconsistencies in the following areas: Employment, Housing, Equal educational opportunities, Homecare, Public health facilities and services, human rights issues such as the existing discriminatory laws against men who have sex with men, persons living with HIV and sex workers and the criminalization of HIV transmission. The unavailability to Sexual and Reproductive services to young people below the age of consent without parental permission is still a major issue.

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the political support for the HIV programme in 2013?

Very Poor Excellent
0 1 2 3 4 5 6 7 8 9 10

Since 2011, what have been key achievements in this area:

Specific Ministries such as the Health and Labour state that they are satisfied with the political support received from their specific Ministers as their budgets have always been approved and the support for the implementation of any programs is always forthcoming. The Ministry of Labour reports that it has received very good support from the Minister for the Workplace Project implemented by this ministry in the form of budgetary allocations and involvement in the steering committee. At the national level the Prime Minister has called on the churches to respect the rights of gays in Belize and established commitments to universal periodic review of human rights. The Ministry of Health reports an expansion of the national lab to initiate viral load testing and support for the establishment of a new care and treatment protocol..

What challenges remain in this area:

One of the major challenges continues to be limited funding for civil societies which has decreased dramatically since the focus is not longer on social development programs such as HIV and there are competing priorities at the global level. Based on this reality there is a need for more visible support especially from the Prime Minister and other government officials. There is the need to mainstream HIV within the different government ministries and to establish HIV budgets for these line ministries. The NAC is under the Office of the Prime Minister but to date none of the two PMs have done anything significant in support of the national response to HIV in Belize. They felt that there needs to be more public commitment to addressing HIV by high officials. Another challenge identified is the lack of and effective oversight body to monitor government's performance towards keeping international commitments and agreements. As legislators and policy-makers government leaders have failed to adequately respond to the call of the United Advocacy Movement of Belize which seeks to repeal Section 53 which refers to specific sexual acts between consenting adults as a criminal act. This present law criminalizes sexual activities between men who have sex with men and legitimizes societal and institutional discrimination of this population. There is the need for more public discussion and support of stigma reduction as well as the reintroduction of comprehensive sexual health education in the current life skill curriculum of the Ministry of Education. The government continues to be influenced by evangelical and radical church leaders that oppose sex and sexuality education in schools including the topic of HIV.

1.1 Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable groups?

YES NO

Circle yes if the policy specifies any of the following key populations and vulnerable groups:

KEY POPULATIONS and VULNERABLE GROUPS

People living with HIV Yes No

Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No

Other specific vulnerable subpopulations *[write in]*: Yes No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on nondiscrimination?

Yes No

IF YES to Question 1.1. or 1.2. briefly describe the content of the/laws:

Even though there are no specific non-discrimination law protecting persons who are vulnerable to HIV, Section 16.2 of the Belize Constitution states that "no person shall be treated in a discriminatory manner by any person or authority". The revision of the Labour Act 2011 under section 42.1 which relates to unfair dismissal now includes protection from dismissal or the imposition of disciplinary action against workers based on their HIV status. This is the only law that specifically makes reference to non-discrimination in relation to HIV.

Briefly explain what mechanisms are in place to ensure these laws are implemented:

The Ministry of Labour represents the mechanism in place to monitor the enforcement of the Labour Act. The revision of the Labour Act is a most recent development and the Ministry of Labour is in the process of socializing this new information among employers and employees. The Women's Department has the responsibility to monitor the implementation of the Domestic Violence Act and to effectively advocate for its enforcement.

Briefly comment on the degree to which they are currently implemented:

Even though the Constitution includes a clause on non-discrimination, there is still the need to introduce laws to give this greater functionality. There have been cases in which the Constitution has been used to demonstrate discriminatory actions against persons for example in the case of Maria Roches vs. Wade in which the Catholic Church was found to have discriminated against Ms. Roches when she was dismissed due to her being pregnant out of wed-lock. Presently, the United Advocacy Movement of Belize, a gay rights organization has posed a challenge to the Attorney-General's Office on the unconstitutionality of Section 53 which includes consensual anal sex among adults as an unnatural crime. The basis of their argument is the unconstitutionality as it

relates to discrimination against persons. The ruling was supposed to be passed in July 2013. To date, it has still not been passed.

2. Does the country have laws, regulations or policies that present obstaclesto effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

Yes No

IF YES, for which key populations and vulnerable groups?

People living with HIV	Yes	No
Elderly persons	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgendered people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No

Other specific vulnerable populations [write in below]: Yes No

clients of sex workers, discordant couples

Briefly describe the content of these laws, regulations or policies:

The legislative review suggests specific modifications to existing national laws, including the Public Health Act, Labour Act, Social Security Act, Immigration Act, and Criminal Code. Additionally, the review proposes new legislation, such as an Allied Health Care Bill and a Pharmacy Bill, that would require confidential treatment of medical records, prohibit the disclosure of one's HIV status by Health Care Providers, and impose sanctions for breach of confidentiality. Belize's Criminal Code reinforces stigma and discrimination against marginalized groups, including men who have sex with men and commercial sex workers, making them more vulnerable to HIV/AIDS.

The Code criminalizes:

- "unnatural crimes", which is used to criminalize acts of sodomy
- Procurement of a female to be used as a sex worker
- the operation of a brothel
- the willful transmission of HIV/AIDS

Section 53 – Unnatural Act Law which criminalizes anal sex among consenting adults. This law criminalize same sex relationships,

Loitering law which affects sex workers who are "street-walkers"

Criminalization of HIV transmission and exposure poses penalties persons who willfully and knowingly infect others with HIV.

The law that prohibits provision of sexual and reproductive health information and services to young people to young persons below the age of 18 unless they are accompanied by a parent or guardian

The law which relates to consensual sex which states that persons that are 16 years old can consent to sex even though they are unable to access sexual and reproductive health services until the age of 18

The Human Trafficking Prohibition Act always places sex workers at risk for HIV as many times they are treated as criminals rather than as victims

The Immigration Act currently requires HIV/AIDS testing as a part of the nationality/permanent residency application process

There are specific faith-based schools which prohibit sexual and reproductive health education to young persons especially in regards to discussions on condoms and sexuality

There are existing regulations at the prison which prohibit the distribution of condoms among the prison population

Briefly comment on how they pose barriers:

The above mentioned laws and policies pose barriers to the effective implementation of Prevention and Treatment programmes with vulnerable populations such as MSM, sex workers, young persons, prisoners and migrants because they criminalize certain behaviours of these populations as well as infringes on their right to protection and education.

1.2 **Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?**

Yes No

IF YES to Question 1.1. or 1.2., briefly describe the content of the laws:

Briefly explain what mechanisms are in place to ensure these laws are implemented:

Briefly comment on the degree to which they are currently implemented:

2. Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations and vulnerable groups?

Yes No

***IF YES,* for which key populations and vulnerable groups?**

People living with HIV	Yes	No
Elderly persons	Yes	No
Men who have sex with men	Yes	No
Migrants/mobile populations	Yes	No
Orphans and other vulnerable children	Yes	No
People with disabilities	Yes	No
People who inject drugs	Yes	No
Prison inmates	Yes	No
Sex workers	Yes	No
Transgender people	Yes	No
Women and girls	Yes	No
Young women/young men	Yes	No

Other specific vulnerable populations7 [write in below]: Yes No

Briefly describe the content of these laws, regulations or policies:

These populations do not have access to comprehensive education, prevention and treatment and care services due to laws that pose barriers.

Briefly comment on how they pose barriers:

Laws that criminalize same sex relationships pose barriers for access to services for MSM and transgendereds

Laws that prevent young persons below the age of 18 from accessing sexual and reproductive health services without the consent of parents

Laws that criminalize HIV transmission as well as laws that criminalize soliciting and commercial sex

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

Yes No

IF YES, what key messages are explicitly promoted?

Delay sexual debut	Yes	No
Engage in safe(r) sex	Yes	No
Fight against violence against women	Yes	No
Greater acceptance and involvement of people living with HIV	Yes	No
Greater involvement of men in reproductive health programmes	Yes	No
Know your HIV status	Yes	No
Males to get circumcised under medical supervision	Yes	No
Prevent mother-to-child transmission of HIV	Yes	No
Promote greater equality between men and women	Yes	No
Reduce the number of sexual partners	Yes	No
Use clean needles and syringes	Yes	No
Use condoms consistently	Yes	No

Other [write in below]: Yes No

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

Yes No

2. Does the country have a policy or strategy to promote life-skills based HIV education for young people?

Yes No

2.1. Is HIV education part of the curriculum in:

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

Within the church state system the implementation of the Health and Family Life Education curriculum is dependent on the school administration. Many of these church-managed schools choose to not implement the sexual and reproductive health component. In addition some churches have strongly opposed the inclusion of a life skills manual which included sex and sexuality education for primary schools and this resulted in the manual being removed from the curriculum by the Ministry of Education.

2.2. Does the strategy include age-appropriate,

a) age-appropriate sexual and reproductive health elements?	*Yes*	*No*
b) gender-sensitive sexual and reproductive health elements?	Yes	No

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

Yes No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions for key or other vulnerable subpopulations?

Yes No

Briefly describe the content of this policy or strategy:

The main focus of the Round 9 Global Fund Project being implemented in Belize is on key and vulnerable populations. This project includes a 5 year work plan that has been incorporated into the National Strategic Plan 2012 -2016. This strengthens the NSP's focus on these populations and provides specific goals and objectives for addressing their needs. In addition, the HIV Unit of the Youth for the Future has in place a specific strategy to address the needs of out-of-school and at risk youth. The YFF has developed a draft policy which incorporates an HIV component.

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

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

IDU
MSM
Sex workers
Customers of Sex Workers
Prison inmates

Other populations:
Young men and women at risk
Women in difficult circumstances
Transgendered
OVCs
Condom promotion
Drug substitution therapy
HIV testing and counseling
Needle & syringe exchange
Reproductive health, including sexually transmitted infections prevention and treatment
Stigma and discrimination reduction
Targeted information on risk reduction and HIV education
Vulnerability reduction (e.g. income generation)

3.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate policy efforts in support of HIV prevention in 2013?

Very Poor Excellent
0 1 2 3 4 5 6 7 8 9 10

Since 2011, what have been key achievements in this area:

One important initiative is 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 introduction of the revised 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. In addition the introduction of the updated Gender Policy by Cabinet as well as the Amendment to the Sexual Offences Act which now gender neutralizes sexual violence. Before this, men and boys were not considered victims of rape and other forms of sexual abuse.

What challenges remain in this area:

Even though the legislative review of 2008 was very comprehensive, during the past four years the recommendations have not translated into actual law. The legislative review identified a number of existing laws and policies which pose barriers to access to prevention and treatment and care services for vulnerable populations. These need to be addressed through a specific HIV law which will provide a legal framework for the provision of quality services and the protection of vulnerable groups from discrimination. The National HIV Policy, the HIV Policy of the Workplace and the HIV Policy of the Public Service as well as a number of workplace policies developed by different companies do not have a legal framework to make them truly effective. It is the opinion of many of the key informants that a lot more needs to be done at all levels to demonstrate a genuine concern for the protection of human rights as they related to HIV in Belize. The Ministry of Labour identifies commitment on the part of employers and companies as a challenge to the implementation of workplace policies. Even though some companies have been a part of the project they are hesitant to put in place policies that protect persons from screening for employment purposes. This creates a situation in which there is no successful completion of the project at the company level. In addition, respondents indicated that the Ministry of Education has not ratified the HIV Policy as well as the revised HFLE policy. The Council of Churches and the Evangelical Churches in particular continue to strongly oppose the movement to guarantee the rights of all humans including the LGBT population in Belize. The challenge remains one which calls on all key players in the response including decision-makers to make adjustments to the present response which seems to be stagnant.

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

Yes No

IF YES, **how were these specific needs determined?**

Through the process of developing the new strategic plan, the National AIDS Commission engaged in an analysis of the situation and response to HIV in Belize. Through the analysis of data from a number of recent studies and assessments, the NAC identified challenges, gaps and opportunities in the area of prevention. The analysis established that Belize has halted and started to reverse the spread of HIV, however pockets of continued new infections remain. The analysis identified

the successes in the prevention of mother-to-child transmission critical as well as key vulnerable groups that continue to play a crucial role in the determinants of the epidemic and whose sexual behavioral patterns show a continued high level of vulnerability to HIV. Response-frames therefore need to become more evidence-informed in targeting these groups and in designing high impact interventions that establish impact. This is certainly the case for behaviour change communication for young men and women, men who have sex with men, sex workers, incarcerated persons and mobile populations. In each area the analysis provided insight into the situation parameters, the on-going response actions, a deeper root cause analysis (including a Problem Tree) and a mapping of the extracted remaining gaps. Based on these findings the new strategic plan delineates three priority areas that speak to the response dimensions of ending new HIV infections, improving health and wellbeing, and creating an enabling environment for the response.

IF YES, what are these specific needs?

Targeted prevention education
Fostering an enabling environment
Integration of health services
Improved monitoring and evaluation
Evidence-based planning
Elimination of stigma and discrimination

4.1. To what extent has HIV prevention been implemented?

The majority of people in need have access to…

Strongly disagree   Disagree   Agree   Strongly agree   N/A

Blood safety	1	2	3	4	N/A
Condom promotion	1	2	3	4	N/A
Economic support e.g. cash transfer	1	2	3	4	N/A
Harm reduction for people who inject drugs	1	2	3	4	N/A
HIV prevention for out-of-school young people	1	2	3	4	N/A
HIV prevention in the workplace	1	2	3	4	N/A
HIV testing and counseling	1	2	3	4	N/A
IEC on risk reduction	1	2	3	4	N/A
IEC on stigma and discrimination reduction	1	2	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	N/A
Prevention for people living with HIV	1	2	3	4	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	2	3	4	N/A
Risk reduction for intimate partners of key populations	1	2	3	4	N/A
Risk reduction for men who have sex with men	1	2	3	4	N/A
Risk reduction for sex workers	1	2	3	4	N/A
Reduction of Gender based violence	1	2	3	4	N/A
School-based HIV education for young people	1	2	3	4	N/A
Universal precautions in health care settings	1	2	3	4	N/A
Other *[write in]*:	1	2	3	4	N/A

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in implementation of HIV prevention programmes in 2013?

Very Poor Excellent
0 1 2 3 4 5 6 7 8 9 10

V.TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes No

This has been done at the health care level and the psychosocial level.

If YES, Briefly identify the elements and what has been prioritized:

This includes the care and treatment manual, provision of second-line ARVs, introduction of viral load testing and compliance training as well as boost programme, counseling program and home-based care training through organizations such as network of persons living with HIV (CNET+) and the Ministry of Human Development, Social Transformation and Poverty Alleviation.

Briefly identify how HIV treatment, care and support services are being scaled-up?

Expanded counseling, expanded boost programme, increased training in home care, expanded training and implementation of home visits, increased provider initiated treatment, incountry viral load, responding immediately providing treatment once they are tested positive

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

The majority of people in need have access to…

Strongly disagree Disagree Agree Strongly Agree N/A

Antiretroviral therapy 1 2 3 4 N/A
ART for TB patients 1 2 3 4 N/A
Cotrimoxazole prophylaxis in people living with HIV 1 2 3 4 N/A
Early infant diagnosis 1 2 3 4 N/A
HIV care and support in the workplace (including alternative working arrangements)
1 2 3 4 N/A
HIV testing and counselling for people with TB 1 2 3 4 N/A
HIV treatment services in the workplace or treatment referral systems through the workplace
1 2 3 4 N/A

Nutritional care 1 2 3 4 N/A
Paediatric AIDS treatment 1 2 3 4 N/A
Post-delivery ART provision to women 1 2 3 4 N/A
Post-exposure prophylaxis for non-occupational exposure (e.g., sexual assault) 1 2 3 4
N/A
Post-exposure prophylaxis for occupational exposures to HIV 1 2 3 4
N/A
Psychosocial support for people living with HIV and their families 1 2 3 4
N/A
Sexually transmitted infection management 1 2 3 4
N/A
TB infection control in HIV treatment and care facilities 1 2 3 4
N/A
TB preventive therapy for people living with HIV 1 2 3 4
N/A
TB screening for people living with HIV 1 2 3 4
N/A
Treatment of common HIV-related infections 1 2 3 4
N/A
Other *[write in]*: 1 2 3 4 N/A

*2. Does the government have a policy or strategy in place to provide social and economic support
to people infected/affected by HIV?*

Yes No

Please clarify which social and economic support is provided:

Through the Ministry of Human Development, Social Transformation and Poverty Alleviation a social welfare program known as the BOOST program makes special allowances for orphans and vulnerable children with support from the Global Fund Round 9 project. All other support provided to persons living with HIV are provided through the general program of the Human Services Department and there are no specific policies for the provision of these services to PLHIV.

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

Yes No N/A

Both generic and brand name medications are purchased.

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

Yes No N/A

IF YES, for which commodities?

Condoms distributed by the government are procured through UNFPA while condoms distributed by USAID/PASMO are procured through their main funder in Guatemala. Antiretroviral and testing agents are procured through PAHO and COMISCA, a Central American mechanism.

5. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care, and support programmes in 2013?

Very Poor Excellent
0 1 2 3 4 5 6 7 8 9 10

Since 2011, what have been key achievements in this area:

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 who fit the criteria. There is also increase in combination ARV and increased access to CD4 tests and viral load tests in Belize. The Ministry of Health has also started increased provider initiated counseling and testing to be able to reach more persons in the population. There are expanded counseling services provided through the Collaborative Network of Persons Living with HIV as well as the Counseling Center of the Ministry of Human Development and Social Transformation. 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. CNET+ has been very instrumental in advocating for better treatment and care services. Through its home-based care project, CNET+ has been able to reach a significant number of persons living with HIV (600). The NCPI 2012 reported that one of the major challenges was the lack of a comprehensive package of support. CNET+ successfully made some progress in addressing this gap in the provision of psychosocial support to PLHIV and their families during the past 2 years.

What challenges remain in this area:

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 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. 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

needing 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. Even though efforts have been made to fill the gap in the provision of treatment and psychosocial care to persons living with HIV, there is still the challenge to reach more persons living with HIV based on the overall number of reported cases in Belize. There is also a need for further strengthening of positive prevention initiatives.

6. Does the country have a policy or strategy to address the needs of orphans and other vulnerable children?

Yes No N/A

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

Yes No

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

Yes No

7. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2013?

Very Poor Excellent
0 1 2 3 4 5 6 7 8 9 10

Since 2011, what have been key achievements in this area:

According to the Ministry of Health and Hand in Hand Ministries (NGO providing support to pediatric HIV cases), the majority of orphans and vulnerable children in need of treatment are receiving it. The continued work of the Hand in Hand Ministries which provides treatment, care and support to OVCs is seen as a major accomplishment. The organization has been able to mobilize external funds to continue its work with OVCs and their families. There has also been coordination among other civil society organizations collaborating in addressing the needs of OVCs such as Claret Care and POWA in Dangriga and Cornerstone Foundation in San Ignacio. CNET+ is also collaborating with HHM to provide psychosocial and nutritional support to OVCs.

What challenges remain in this area:

There are still challenges in addressing the needs of children in poverty stricken areas and children in high risk situations. Studies show that children are exploited and serve as "hustlers" or "income earners" for their families. Another challenge is the identification of the needs of the OVS and

ensuring that this is prioritized at the national level. Even though OVCs are included in the new strategic plan, greater focus needs to be provided to this vulnerable group. Limited resources and funds continue to be a challenge in reaching OVCs in smaller communities. There is a need to incorporate social indicators with health indicators because positive children become vulnerable adolescents and a great social burden to society.

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

Yes In Progress No

Briefly describe any challenges in development or implementation:

In 2012 it was reported that the Monitoring and Evaluation plan for the past strategic plan was never implemented due to an absence of a Monitoring and Evaluation Officer at the NAC as well as the fact that the HIV strategic Plan needed to be updated. In 2014 it can be reported that these gaps have been addressed as there is a full time M&E Officer assigned to the NAC. Even though there is an updated M&E plan which is aligned with the NSP, there is still the challenge in the implementation of the M&E Plan that it has not yet been "costed". It was also felt by some partners that they are still not aware of the M&E strategy and are unaware of their role in the M&E system. Another challenge is the lack of understanding and knowledge on the part of implementing partners of the M&E plan and the M&E role of the National AIDS Commission.

1.1. IF YES, years covered *[write in]:*

2012-2016

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

Yes, all partners
Yes, some partners

Briefly describe what the issues are:

Some key informants were of the opinion that there is a lack of ownership of the plan among the key stakeholders. Not all partners in the response have a functioning M&E plan or personnel in charge of M&E in the organization

2. Does the national Monitoring and Evaluation plan include?

A data collection strategy Yes No
IF YES, does it address:

Behavioural surveys	Yes	No
Evaluation / research studies	Yes	No
HIV Drug resistance surveillance	Yes	No

HIV surveillance Yes No
Routine programme monitoring Yes No
A data analysis strategy Yes No
A data dissemination and use strategy Yes No
A well-defined standardised set of indicators that includes sex and age disaggregation (where appropriate)
Yes No
Guidelines on tools for data collection Yes No

3. Is there a budget for implementation of the M&E plan?
Yes In Progress No

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

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

Yes In Progress No

Briefly describe any obstacles

The unit presently comprises of only one full-time staff member. Additional funds need to be identified to be able to provide more staff to support the work of implementing the M&E plan of the National AIDS Commission. Another challenge has been the frequent over-turn of staff and the lack of a pool of trained experts in the area of monitoring and evaluation in the country to satisfactorily fill the post of Monitoring and Evaluation Officer.

4.1. Where is the national M&E Unit based?

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

4.2. How many and what type of professional staff are working in the national M&E Unit?

1 Monitoring and Evaluation Officer - fulltime

POSITION Monitoring and Evaluation Officer Fulltime Part time Since when: Nov. 2011

Permanent Staff Fulltime Part time Since when?

Temporary Staff [Add as many as needed]

4.3. Are there mechanisms in place to ensure that all key partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes No

Briefly describe the data-sharing mechanisms:

What are the major challenges in this area:

The major challenges are the lack of a functional M&E Unit and System at the national level. Even though the Belize Health Information Systems exists, the data is not readily available to inform decision-making. There are limited staff that have the expertise to utilize this information.

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

Yes No

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

Yes No -

IF YES, briefly describe the national database and who manages it.

6.1. IF YES, does it include information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations?

Yes, all of the above
Yes, but only some of the above
No, none of the above

IF YES, but only some of the above, which aspects does it include?

Only surveillance data is available via the Belize Health Information system

6.2. Is there a functional Health Information System?

At national level Yes No

At sub-national level Yes No

IF YES, at what level(s)? Both levels

7. 1 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of Current and Future Needs - Yes

Estimates of Current Needs Only - Yes

No

These estimates are acquired using the Spectrum Analysis.

7.2 Is HIV programme coverage being monitored? Yes No

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

Yes No

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

Yes No

IF YES, for which population groups? BY AGE, DISTRICT, SEX

Briefly explain how this information is used:

The Ministry of health has a data cohort and baseline data for M&E

(c) Is coverage monitored by geographical area?

Yes No

IF YES, at which geographical levels (provincial, district, other)?

National, district, regional and local

This is done at the district level through the Belize Health Information System. The BHIS is an interactive and dynamic system that gathers data on patients from public health care facilities. Information on these patients can be accessed by doctors wherever the patient seeks medical attention if they move from one district to another.

Briefly explain how this information is used:

The information is used for planning and evaluation of impact. Epidemiological updates are prepared and disseminated among key partners and stakeholders that utilize the data for reporting, planning and evaluating their programs. Several of the key informants were of the opinion that the information collected by the BHIS is not utilized to its full potential and much of the data is not analyzed and reported.

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

Yes No Surveillance data via the BHIS

9. How are M&E data used?

For programme improvement? Yes No
In developing / revising the national HIV response? Yes No
For resource allocation? Yes No
Other *[write in]*: Yes No

Briefly provide specific examples of how M&E data are used, and the main challenges, if any:

It is used for reporting on international commitments such as the Global Response Progress Report, the Millennium Development Goals Report and Universal Access Report. It has also provided important information for the assessment of the situation of HIV in Belize which has guided the development of the new strategic plan.

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

At national level? Yes No
IF YES, what was the number trained: 25

At subnational level? Yes No
IF YES, what was the number trained

At service delivery level including civil society? Yes No

IF YES, how many?

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

Yes No

IF YES, describe what types of activities

10. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the HIV-related monitoring and evaluation (M&E) in 2013?

Very Poor Excellent
0 1 2 3 4 5 6 7 8 9 10

Since 2011, what have been key achievements in this area:

In fulfillment 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 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. There is now a full-time Monitoring and Evaluation Officer at the NAC Secretariat. With the support of USAID/PASCA the country has been able to conduct a capacity-building session. The country has engaged in an exercise to develop the National AIDS Spending Accounts 2011-2012, the AIDS Efforts Policy Index tool 2014 and the National Composite Policy Index 2014. In addition the Ministry of Health has engaged in a process to develop Modes of Transmission Model to inform and guide decision making at the national and local level with the support of USAID/PASCA.
What challenges remain in this area:

Since the last reporting period 2011, Belize has made fair progress in the implementation of its Monitoring and Evaluation Plan and building capacity in the area of M&E. However, even in 2013, there is still is no functional monitoring and evaluation system and reports are not being submitted by partners to the NAC. During the past two years the post of Monitoring and Evaluation Officer has been filled by a full time staff there is the need for capacity building of the M&E Officer and other staff members in M&E as there still exists a lack of adequate expertise in M&E at the Secretariat level. 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. There is also need for the M&E plan to be costed as a part of this process

ANNEX 3: NCPI B Civil Society and International Partners Composite

2014 Global AIDS Response Progress Report

National Commitment and Policy Instrument

NCPI B–
Civil Society

Celia Lizet Aldana
Consultant
February, 2014

NCPI - PART B: Administer to Civil Society Organization, bilateral agencies and UN organizations

Respondents to Part B

#	NAME	Position/Organization	Section
1	Abel Vargas	Executive Director, Hand in Hand Ministries	All
2	Eric Castellanos	Executive Director Collaborative Network of Persons living with HIV	All
3	Carolyn Reynolds	Director, Women Issues Network of Belize	All
4	Carmen Silva	Political and Economic Assistant US Embassy	All
5	Caleb Orozco	Executive Director United Advocacy Movement of Belize	All
6	Lilly Bowman	Director General, Belize Red Cross	All
7	Dr. Pedro Arriaga	Internist, Karl Huesner Memorial Hospital	All
8	Erica Goldson	Deputy Country Representative UNFPA	All
9	Joan Burke	Executive Director Belize Family Life Association	All
10	Karen Cain	Executive Director YES	All
11	Sonia Linares	Director Young Woman's Christian Association	All
12	Eva Burgos	Director, Go Joven/Chairperson, Belmopan HIV Committee	All
13	Michelle Irving	President Productive Organization of Women in Action	All
14	Guadalupe Huitron/KeronCacho	Country Representative, PASMO	All
15	Martha Carrillo	Country Representative USAID/PASCA	All
16	Maisoon Ibrahim	HIV Project Coordinator, UNDP	All

I. CIVIL SOCIETY INVOLVEMENT

1. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") has civil society contributedto strengthening the political commitment of top leaders and national strategy/policyformulations?

LOW HIGH

0 1 2 345

Comments and examples:

Key Informants from civil society provided the following comments and examples:

Civil society has invested and contributed extensively, however, the support from government in facilitating the effort of civil society has not been encouraging according to some key civil society respondents. There seems to be a disconnection between the administrative leadership and the actual needs on the ground. They feel that there hasn't been any significant political commitment. The Office of the Prime Minister has been seen to give minimal to no visible support. They also felt that some civil society organizations are weak and non-assertive in the response to HIV. Civil society has been a fairly active partner in the response especially through advocacy to ensure that Belize has HIV issues and concern as a top priority and to ensure that there are policies and strategy planning focusing on all areas of the epidemic. There are a number of non-governmental and community-based organizations participating in the process but the persons that have the link with the grassroots lack the resources and technical expertise to contribute significantly. Legal and institutional barriers also prohibit these organizations from working with most at risk and vulnerable populations. With the focus being on vulnerable populations and community groups, civil society has had to play a greater role in the response and this has been recognized at the National AIDS Commission level. During the past two years the National AIDS Commission has not made any significant efforts to scale up civil society participation except for the countrywide consultations and formalization of the NAC HIV Committees.

2. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Planon HIV or for the most current activity plan (e.g. attending planning meetings and reviewingdrafts)?

LOW HIGH

0 1 2 345

Comments and examples:

In 2011 the NCPI reported that the NAC involved more people in the revision of the NSP and the development of the OP. Civil society was involved in the working group, in the validation and the consensus building sessions. Even though there was involvement from civil society in the strategic planning process the implementation of the strategic plan has not fully involved civil society. Civil society has been included in planning committees and sub-committees of the NAC but it is not felt that they are influential in the decision making process. It was felt by some respondents that some key representatives from civil society organizations have been involved in the process but only to a limited extent. It is felt that sometimes it has been more token than true involvement. There has been more civil society involvement through participation in the Country Coordinating Mechanism for the Global Fund.

3. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?
LOW HIGH
0 1 2 345

b. The national HIV budget?
LOW HIGH
0 12 34 5

c. The national HIV reports?
LOW HIGH
0 1 2 345

Comments and examples:

Strategy: Some informants stated that even though civil society is consulted and participates in the strategic planning process they feel that they are only invited when input is needed from the specific populations they access to for example, men who have sex with men and sex workers. A few of the key informants stated that their organizations are included in the national strategy especially in this past process, which was highly consultative and inclusive. They had an opportunity to submit their plans to be integrated into the operational plan. It is felt by some respondents that civil society is doing a lot to implement key strategies. However, it is uncertain how much it's aligned to the national budget or how much is used for national reports. There is still a lack of capacity among civil society organizations to conduct research and to utilize the data for decision-making.

Budget: The majority of key informants stated that they do not receive any funds from the national budget for the implementation of their programmes. The few that receive stated that the amount was minimal and insignificant. The district committees stated that there is no support from the national budget other than what is received through the National AIDS Commission. However, there is value to the technical support and guidance received through the NAC, which receives some funds from the government.

Reports: In regards to the national HIV reports, some key informants were of the opinion that the work of civil society is always highlighted. Others were of the opinion that the reporting formats do not truly capture the accomplishments or achievements of civil society. Due to the lack of a monitoring and evaluation system, civil society does not submit reports to the National AIDS Commission. The input from civil society for reports is done on an ad hoc basis when international reports are being prepared such as this report. Most of the information that is captured from civil society is through the Ministry of Health and the National AIDS Commission for international reports and not necessarily as a part of an established M&E system

4. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?
LOW HIGH
0 1 2 34 5

b. Participating in the national M&E committee / working group responsible for coordinationof M&E activities?
LOW HIGH
0 1 234 5

c. Participate in using data for decision-making?
LOW HIGH
0 12 34 5
Comments and examples:

a. Development of the M&E system: Some key informants indicated that the involvement of civil society representatives in the monitoring and evaluation was at the planning level but that civil society is not significantly consulted on the implementation of the M&E Plan.

b. Participation in M&E meetings: Civil society representatives are part of the Monitoring and Evaluation Committee. Some informants were of the opinion that there were no substantial benefits to civil society since the representatives do not report back to the larger civil society network. Some of the respondents indicated that they were encouraged by the recent efforts to build the capacity of key partners in M&E.

c. Use of data for decision-making: Civil society collects its own data and does not rely on the M&E system since this is not functional. Organizations working with vulnerable populations were of the opinion that to date the government has not successfully completed any research on key populations such as MSM and sex workers. Efforts have been undertaken to provide data but there is still need for further research.

5. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations andnetworks of people living with HIV, of sex workers, and faith-based organizations)?
LOW HIGH
0 1 2 345
Comments and examples:
Membership on the National AIDS Commission is limited for diverse organizations. In accordance with the NAC Act only persons living with HIV and faith-based organizations are official members of the commission. Other organizations and networks of vulnerable groups such as sex workers, men who have sex with men and transgendered are part of sub-committees but the decision-making power is at the Commission level according to some key informants. Some most at risk population representatives indicated that they did not feel that other members of the Commission or the NAC on a whole is supportive of them when they have had to challenge legislation that pose barriers to education prevention and treatment work with their networks
6. To what extent (on a scale of 0 to 5 where 0 is "Low" and 5 is "High") is civil society able to access?

a. Adequate financial support to implement its HIV activities?
LOW HIGH
0 1 2 3 4 5
b. Adequate technical support to implement its HIV activities?

LOW HIGH
0 1 2 3 4 5
Comments and examples:

a. Financial support: Civil Society depends primarily on international funders to carry out their projects. Some of them due not have a specific HIV budget and need to use funds from other areas of their budget. For the past two years funders have decreased their support to HIV globally and this has affected civil society globally. The same situation applies in the provision of technical support. Organizations such as UNAIDS are no longer providing the same support in some countries. UNAIDS has closed its office in Belize and key agencies such as USAID/PASCA are in the process of closing off their projects and there is uncertainty regarding continued support in Belize.

b. Technical support: In the area of technical support, most of the informants were of the opinion that this has been readily available to civil society organizations. This includes training and capacity-building opportunities in a number of areas such as advocacy, stigma and discrimination, empowerment and behavior change communication among others. There has been primary focus on building capacity of civil society in strategic planning and monitoring and evaluation.

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

Prevention for key-populations:

1. People living with HIV <25% 25-50% 51–75% >75%
2. Men who have sex with men <25% 25-50% 51–75% >75%
3. People who inject drugs <25% 25-50% 51–75% >75%
4. Sex workers <25% 25-50% 51–75% >75%
5. Transgendered people <25% 25-50% 51–75% >75%
6. Testing and Counseling <25% 25-50% 51–75% >75%
7. Reduction of Stigma and Discrimination <25% 25-50% 51–75% >75%

8. Clinical services (ART/OI)* <25% 25-50% 51–75% >75%
9. Home-based care <25% 25-50% 51–75% >75%
10. Programmes for OVC** <25% 25-50% 51–75% >75%

8. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts to increase civil society participation in 2013?

VeryPoorExcellent

0 1 2 3 4 5 6 78 9 10

Since 2011, what have been key achievements in this area?

One of the key achievements between 2012 – 2013 has been greater validation of the work of civil society in particular district committees and the networks of vulnerable populations such as the Collaborative Network of Persons Living with HIV (C-NET+) and the United Belize Advocacy Movement (UNIBAM). Key informants shared that they felt that coordination has improved and that there is more networking among civil society organizations as they collaborate on similar projects and capitalize on limited resources. There is greater representation at the NAC level as civil society organizations sit on key sub-committees while the district committees have been receiving more support from the NAC and other partners. There has been strengthening of district committees to coordinate activities at the community level. The Collaborative Network of Persons Living with HIV has been playing a major role in the provision of psychosocial support to persons living with HIV at the national level as well as conducting key research such as Risk Profile Assessments and the Stigma Index. They have been successful because they do not depend solely on the NAC but seek their own resources and conduct their own advocacy.

What challenges remain in this area?

Even though there have been key achievements during the past year there have also been some challenges. Some of the key informants also pointed out the low level of political support to some of the civil society organizations working with vulnerable populations such as MSM and sex workers. They stated that due to legal and political barriers the national response couldn't always take a visible stance in support of key populations such as MSM and transgendered persons. They were of the opinion that their support needs to be visible and that the participation needs to be significant. One major challenge continues to be the lack of support for salaries for those involved in work with vulnerable populations since most of the work is done at a voluntary level. Some of the informants also stated that civil society organizations lack training opportunities in areas such as strategic planning, research, policy analysis, monitoring and evaluation and human rights. Human and financial resources continue to be the greatest challenge for civil society organizations that do not receive any funds from the national budget to carry out their work in the country.

1. Has the Government, through political and financial support, involved people living withHIV, key populations and/or other vulnerable sub-populations in governmental HIV-policydesign and programme implementation?

Yes IF YES, describe some examples of when and how this has happened:

With the introduction of a national network of persons living with HIV, there is greater involvement of persons living with HIV in the national response. Even though PLHIV are involved more, there is still need for visible support from the government for the network. Key informants stated that there is no financial support especially to organizations that work with vulnerable populations such as men who have sex with men and sex workers. Due to the recent court case in which UNIBAM has challenged the Sodomy Law, the government has refused to discuss the topic of support to these organizations. Some of the key informants feel that government has been selective in its response. There are laws that prohibit organizations that work with sex workers from receiving funds for work on human rights and prevention. Recently, TikunOlam the network of sex workers in Belize was refused service by a banking institution in Belize for this reason.

1.1 Does the country have non-discrimination laws or regulations, which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifiesany of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	yes	No
Migrants/mobile populations	yes	No
Orphans and other vulnerable children	yes	No
People with disabilities	yes	No –
People who inject drugs	yes	No
Prison inmates	yes	No
Sex workers	yes	No
Transgendered people	Yes	No
Women and girls	yes	No
Young women/young men	yes	No
Other specific vulnerable subpopulations [write in]:	Yes	No

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

Yes No

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:

Briefly explain what mechanisms are in place to ensure that these laws are implemented:

Briefly comment on the degree to which they are currently implemented:

2. Does the country have laws, regulations or policies that present obstacles to effective HIVprevention, treatment, care and support for key populations and other vulnerable subpopulations?

Yes No

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	No
Men who have sex with men	yes	No
Migrants/mobile populations	yes	No
Orphans and other vulnerable children	yes	No
People with disabilities	yes	No
People who inject drugs	yes	No
Prison inmates	yes	No
Sex workers	yes	No

Transgendered people Yes No
Women and girls yes No
Young women/young men yes No
Other specific vulnerable populations [write in]: Yes No

Briefly describe the content of these laws, regulations or policies:

In regards to young persons accessing sexual and reproductive health services, the law still stipulates that a person 18 and under needs to be accompanied by an adult. Under the unnatural crimes act sodomy and buggery are still consider criminal acts even if it occurs between two consenting adults. With the legal challenge to Section 53, which includes the sodomy law, there has been even greater opposition by certain religious factors to put in place policies and legislations that protect the rights of these sexual minority groups. The court ruling should have been presented in July 2013. To date, it has still not been passed. These limitations continue to affect interventions with men who have sex with men, as this group remains inaccessible due to their fear of stigma and discrimination. Basic human rights legislation on sexual and reproductive health rights, sex work and sexual orientation has not been addressed beyond a national HIV/AIDS policy that is limited and is often not enforced. There is also the law that criminalizes the knowing and willful transmission of HIV and the Prohibition of Human Trafficking Act.

Briefly comment on how they pose barriers:

Sodomy is punishable and criminal in Belize so MSM and Trans will not go to get an HIV test if they have to disclose how they got infected as well as their sexual orientation. Care and treatment for PLHIV is only provided by the state which has the responsibility to uphold the law so MSM and Trans do not have any trust in the system. There is a high prevalence rate of HIV in the prisons yet there are regulations that do not allow for the distribution of condoms in prisons. Instances of rape as well as consensual non-protective sex occur on a regular basis. Denying that HIV transmission can happen through these means denies the prisoners protection from HIV. Persons refuse to be tested because they are afraid to be found HIV positive and for contact tracing to show that they may have infected others. For sex workers there is also the issue of their immigration status, which undermines their rights and confidence in accessing services. Some public health facilities require that sex workers present a social security card, which they may not have if they are in the country illegally. The present human trafficking laws also contribute to the victimization of sex workers. There needs to be some coordination with immigration to place the vulnerability of these women and their clients as priority. Immigration and police officers as well as bar owners and clients sometimes exploit sex workers. Due to their illegal immigration status they do not seek protection and justice. There is presently a discrepancy in the laws since the age of consent for sex is 16 years and they can get married at the age of 14 with parental consent. There is also a law, which states that young persons under 18 cannot access sexual and reproductive services without a parent or guardian. Young persons are a very vulnerable group to HIV infection in Belize.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?

Yes No

Briefly describe the content of the policy, law or regulation and the populations included.

There are a number of policies and laws that the Gender Policy, the revised Domestic Violence ACT, the Sexual Harassment Act and the Prohibition of Human Trafficking Law. The passing of the revised Gender Policy was very controversial but it has been introduced as national policy. The Policy addresses the vulnerability of women and girls to HIV. The present Domestic Violence ACT provides protection for men and women from different forms of domestic violence, which contributes to the vulnerability of women to HIV infection. The amendment to the criminal code in

relations to sexual offences has also been hailed as a positive change as now the gender of victims has been neutralized. Before, only women and girls could be considered victims under the old law. The Sexual Harassment law protects women and men from harassment in the workplace. In the past this law has not been effective due to the fear of being fired from their jobs if they reported these cases. However, the revised Labour Law of 2011 now states that no person can be dismissed on the basis of sexual harassment or his or her HIV status.

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

Yes No

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

The National HIV Policy provides the framework for the development of HIV policies in the country. The national policy is human rights based and is founded upon the principles of non-discrimination, respect and dignity of persons. Thus, all the policies that have been developed in Belize are human rights based. The HIV for the place of work is based on the ILO principles, which also highlight a human rights approach. The challenge in Belize is to convert policy to law and to move policies from drafts to official documents.

5. Is there a mechanism to record, document and address cases of discrimination-experienced bypeople living with HIV, key populations and other vulnerable populations?

Yes No

IF YES, briefly describe this mechanism:

6. Does the country have a policy or strategy of free services for the following? Indicate if theseservices are provided free-of-charge to all people, to some people or not at all (circle "yes" or"no" as applicable).

Antiretroviral treatment

Provided free-of charge to all people in the country Yes No
Provided free-of-charge to some people in the country Yes No
Provided, but only at a cost yes No

HIV prevention services

Provided free-of charge to all people in the country Yes No
Provided free-of-charge to some people in the country Yes No
Provided, but only at a cost yes No

HIV-related care andsupport interventions

Provided free-of charge to all people in the country Yes No
Provided free-of-charge to some people in the country Yes No
Provided, but only at a cost yes No

If applicable, which populations have been identified as priority, and for which services?

There are no strategies to target specific populations with treatment and care, however, the Prevention of Mother to Child Transmission is prioritized and provides antiretroviral medication to

pregnant women and their newborns. The Global Fund Round 9 project also has a specific focus on most-at-risk populations.

7. Does the country have a policy or strategy to ensure equal access for women and men to HIVprevention, treatment, care and support?

Yes No

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

Yes No

8. Does the country have a policy or strategy to ensure equal access for key populations and/orother vulnerable sub-populations to HIV prevention, treatment, care and support?

Yes No

IF YES, Briefly describe the content of this policy/strategy and the populations included:

The National HIV Policy and the National HIV/AIDS Strategy include the right to access for these populations but there is no legal framework in the country to enforce it.

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal accessfor different key populations and/or other vulnerable sub-populations?

Yes No

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

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

Yes No

IF YES briefly describe the content of the policy or law:

This is through the National HIV Policy and the HIV Policy for the Workplace, which has provided the framework for the development of workplace policies within different companies. The policy states that screening should not be done for employment purposes. However, there is still no legal framework to enforce these policies.

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

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

Yes No

b. Performance indicators or benchmarks for compliance with human rights standards in thecontext of HIV efforts

Yes No

IF YES on any of the above questions, describe some examples:

The HIV National Strategic plan incorporates a human rights performance indicator. There is an Office of the Ombudsman as well as a recently revived Human Rights Commission of Belize. In regards to benchmarks these are through international monitoring tools such as the NCPI, MDGs, Universal Access and the CEDAW. These are all international benchmarks and there are no national benchmarks except for the one included in the National HIV Strategy.

11.In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key populationsconcerning their rights (in the context of HIV)?

Yes No

b. Programmes for members of the judiciary and law enforcement on HIV and human rightsissues that may come up in the context of their work?

Yes No

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

a. Legal aid systems for HIV casework

Yes No

b. Private sector law firms or university-based centres to provide free or reduced-cost legalservices to people living with HIV

Yes No

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

Yes No

IF YES, what types of programmes?

Programmes for health care workers	yes	No
Programmes for the media	yes	No
Programmes in the work place	Yes	No
Other [write in]:	Yes	No

14. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would yourate the policies, laws and regulations in place to promote and protect human rights inrelation to HIV in 2013?

VeryPoor Good Excellent

0 1 2 3 456 7 8 9 10

Since 2011, what have been key achievements in this area?

Key civil society informants were of the opinion that the legal review was one step forward but it has not translated into an HIV law due to bureaucracy and "red tape". However some informants are not of the opinion that there has been no investment done in promoting nor implementing human rights related policies, laws and regulation because there is still no legislation.

Key informants were of the opinion that most of the advocacy work that has taken place on human rights has been done at the civil society level. The approval of the revised Gender Policy by government and the amendments to the Criminal Code, which neutralizes gender of victims of rape, has also been hailed as accomplishments in the past two years.

What challenges remain 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 yet there is still no legal framework to make these effective and provide the protection necessary for vulnerable groups. 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.

15. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2013?

VeryPoorExcellent

0 12 3 4 5 678 9 10

Since 2011, what have been key achievements in this area?

Key civil society informants were of the opinion that the legal review was one step forward but it has not translated into an HIV law due to bureaucracy and "red tape". However some informants are of the opinion that there has been no investment done in promoting nor implementing human rights related policies, laws and regulation because there is still no legislation. Most of the advocacy work that has taken place on human rights has been done at the civil society level. The approval of the revised Gender Policy by government and the amendments to the Criminal Code, which neutralizes gender of victims of rape, has also been hailed as accomplishments in the past two years. Even though a ruling has not been passed on the Orozco vs the Attorney General's Office in the challenge to Section 53, which includes the Sodomy Law, the case provided an opportunity for open discourse on the topic of the rights of the LGBT community in Belize. The topic has been discussed widely in the media, social media, educational institutions and the community at large. Even though, many of the discussions have been in opposition to the rights of the LGBT population, it has also provided the opportunity for human rights activists and others to express their support.

What challenges remain in this area?

The key informants identified more challenges than achievements in this area. Some informants were of the opinion that the Government is still not ready to discuss human rights in a sincere manner and to commit to ensuring that legislation that are discriminatory against certain populations are addressed for example the Unnatural Acts Law which makes reference to the Sodomy law. UNIBAM, the United Belize Advocacy Movement posed a legal challenge to the Attorney General's Office seeking the repeal of Section 53 as it relates to consensual sex between adults on the basis of its unconstitutionality in relation to discrimination. Even though the case has been heard there has been no ruling. The majority of civil society informants were of the opinion that both civil society and government have an important role to place in ensuring that policies, laws and regulations are put in place to promote and protect human rights.

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

Yes No

IF YES, how were these specific needs determined?

This has been through the process of developing the new NSP, which provided an opportunity to assess the present situation and response to HIV and identify challenges and gaps.

IF YES, what are these specific needs?

- Prioritizing targeted interventions with most at risk populations
- Continued intervention through primary prevention initiatives
- Scaling up of testing and counseling
- Continued strengthening of PMTCT program
- Advocating for sexual health and sexuality education for in-school and out of school youth

1.1 To what extent has HIV prevention been implemented?

HIV prevention component: The majority of people in need have access to…

	Stronglydisagree	Disagree	Agree	Stronglyagree	N/A
Blood safety	1	2	3	**4**	N/A
Condom promotion	1	2	**3**	4	N/A
Harm reduction for people who injectdrugs	1	2	3	4	**N/A**
HIV prevention for out-of-school youngpeople	1	2	**3**	4	N/A
HIV prevention in the workplace	1	2	**3**	4	N/A
HIV testing and counseling	1	2	**3**	4	N/A
IEC on risk reduction	1	2	**3**	4	N/A
IEC on stigma and discriminationreduction	1	2	**3**	4	N/A
Prevention of mother-to-childtransmission of HIV	1	2	3	**4**	N/A
Prevention for people living with HIV	1	2	3	**4**	N/A
Reproductive health services includingsexually transmitted infectionsprevention and treatment	1	2	**3**	4	N/A
Risk reduction for intimate partners of key populations	1	**2**	3	4	N/A
Risk reduction for men who have sexwith men	1	**2**	3	4	N/A
Risk reduction for sex workers	1	2	**3**	4	N/A
School-based HIV education for youngpeople	1	**2**	3	4	N/A
Universal precautions in health caresettings	1	2	**3**	4	N/A
Other [write in]:	1	2	3	4	N/A

2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would yourate the efforts in the implementation of HIV prevention programmes in 2013?

VeryPoorExcellent

0 1 2 3 4 5 **6** 7 8 9 10

Since 2011, what have been key achievements in this area?

During the past two years there has been continued 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. The 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 introduction of a Youth Policy and a revised Gender Policy are also key achievements. 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.

What challenges remain in this area?

Key civil society informants identified a number of challenges that were encountered during the past two years in the area of prevention. They are of the opinion that there is still a need for targeted interventions with key populations. Another major challenge is the situation of church managed schools, which do not allow the Health and Family Life Education curriculum to be taught in its entirety. There is still need for increased secondary prevention for PLHIV, which impacts the

percentage of new infections directly. Some of the informants stated that strategies remain monotonous and lacking innovation and there is not enough data and a lack of policies to truly make prevention strategies effective. 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. There is also the challenge of lack of human and financial resources to sustain prevention programs.

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes No

IF YES, Briefly identify the elements and what has been prioritized:

As part of the process of developing the new National Strategic Plan the essential elements of a comprehensive package of HIV treatment, care and support were identified. However, the focus continues to be on the provision of treatment and care while the prioritization of social support continues to be lacking. The Ministry of Health has also conducted its needs assessment process.

Briefly identify how HIV treatment, care and support services are being scaled-up?

There has been an increase in the types of ARVs available to persons who need them. There are more second-line medication for adults and children. There are more CD4 tests available in country and some viral load testing is being provided. Treatment of opportunistic infections has been expanded while the Ministry of Health has developed treatment guidelines.

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

HIV treatment, care and support service

The majority of people in need have access to…

Strongly disagree (1) Disagree (2) Agree (3) Stronglyagree (4) N/A

Antiretroviral therapy 1 2 3 4 N/A

ART for TB patients 1 2 3 4 N/A

Cotrimoxazole prophylaxis in peopleliving with HIV 1 2 3 4
N/A

Early infant diagnosis 1 2 3 4 N/A

HIV care and support in the workplace (including alternative workingarrangements)
1 2 3 4 N/A

HIV testing and counselling for peoplewith TB 1 2 3 4 N/A

HIV treatment services in the workplaceor treatment referral systems throughthe workplace
1 2 3 4 N/A

Nutritional care 1 2 3 4 N/A

Paediatric AIDS treatment 1 2 3 4
N/A

Post-delivery ART provision to women 1 2 3 4 N/A

Post-exposure prophylaxis fornon-occupational exposure
(E.g., sexualassault) 1 2 3 4 N/A

Post-exposure prophylaxis foroccupational exposures to HIV 1 2 3 4
N/A

Psychosocial support for people livingwith HIV and their families1 2 3 4 N/A

Sexually transmitted infectionmanagement 1 2 3 4
N/A

TB infection control in HIV treatmentand care facilities 1 2 3 4 N/A

TB preventive therapy for people livingwith HIV 1 2 3 4 N/A

TB screening for people living with HIV	1	2	3	4	N/A
Treatment of common HIV-relatedinfections	1	2	3	4	N/A
Other [write in]:	1	2	3	4	N/A

1.2. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?

VeryPoorExcellent

0 1 2 3 4 5 6 78 9 10

Since 2011, what have been key achievements in this area?

There have been some achievements accomplished in the area of treatment, care and support over the past two years. The Ministry of Health has continued to provide antiretroviral therapy free of cost to all persons that fit the criteria and there has been the introduction of new ARVs, pediatric treatment and more availability of CD4 tests. Distribution of ARVs has been scaled-up at the district level and in some districts pharmacies are open at night, which makes it convenient for persons that can't access their medications during the day or are reluctant due to fear of stigma and discrimination. Another achievement has been that there is a greater focus on addressing issues of stigma and discrimination in the health care system. Initiatives such as the USAID/Capacity Project have been focused on improving performance indicators as well as the infrastructure in regards to quality of service being offered. There has been increased training of staff and monitoring of performance at the different health facilities. Another achievement has been the revision of the treatment guidelines and the updating of the national TB guidelines to reflect HIV as a component. The post-exposure protocols now include non-occupational exposure such as sexual assault and the MOH has also started increased provider initiated counseling and testing.

What challenges remain in this area?

Even though there have been many achievements in the area of treatment, care and support there are still challenges which remain and need to be addressed. These include challenges in the area of testing since specialized diagnostic testing like viral loads and genotype resistance test are still not available in country. In regards to ARVs second and third line medication are still not available to all those persons that need it and second-line medication that is available is considered first-line in other countries. Most of the key informants indicated that one of the greatest challenges is the lack of psychosocial support and nutritional care. Adherence to medications and monitoring of cases continues to be a challenge for the Ministry of Health. The key informants interviewed stated that government needs to work closer with civil society to address these gaps. Civil society organizations providing services in the area of treatment, care and support have also encountered funding challenges as a number of key agencies have been forced to close their centers or downscale their services. Persons interviewed also felt that services are too centralized in Belize City and there is the need to expand to the districts where some persons are unable to cover expenses for travel or are uncomfortable seeking services in the city. Another challenge identified is the implementation of protocols and policies, which have been developed. For example, some key informants were of the opinion that even though there is a protocol for occupational and non-occupational exposure to HIV, the prophylaxis is not readily available to persons that need it.

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

Yes ***No***

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

Yes No

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

Yes ***No***

3. Overall, on a scale of 0 to 10 (where 0 is "Very Poor" and 10 is "Excellent"), how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2013?

Very Poor Excellent

0 1 2 3 *4* 5 6 7 8 9 10

Since 2011, what have been key achievements in this area:

One of the major achievements during the past two years continues to be the work of Hand in Hand Ministries. During the past two years HHM has continued to provide support to OVCs in the country. In spite of funding challenges, hey have continued to offer their services which include: ARV delivery at their center for persons who are unable or unwilling to access their medications at the public Pro-Care and Treatment Center. Another achievement is the continued collaboration between the Ministry of Health, the Ministry of Human Development, CNET+, Claret Care and POWA in Dangriga. 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 Global Fund Project HHM also collaborates with CNET+ for the provision of nutritional packages to OVCs and their families. Through the Boost Program low-income families receive a monthly allowance from the government. Second-line ARVs have been made available to made more pediatric cases and CD4 and Viral Load Tests are now more readily available as well.

What challenges remain in this area:

There continue to be challenges in this area. These included: adherence to medications, the lack of comprehensive laboratory services in Belize for example, viral loads, lack of professional counselors and the need for a hospice and palliative care center for persons living with HIV. 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. Stigma and discrimination still exists and the lack of legislation to change S&D continue to pose barriers to access to services.