UNGASS COUNTRY PROGRESS REPORT
BELIZE

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National AIDS Commission
Responding to HIV/AIDS in Belize

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

ACKNOWLEDGEMENTS

The National AIDS Commission of Belize would like to thank all members of the Commission as well as other partners and stakeholders who were involved in the process of elaborating this 2008 Report on the status of the national response to the Declaration of Commitment on HIV/AIDS adopted at the United Nations General Assembly Special Session in 2001.

We also acknowledge the important technical support received from the regional office of UNAIDS and Geneva.

The valuable participation and support on the part of these persons and agencies contributed to the successful completion of this national process.

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Acronyms and Abbreviations

AAA	Alliance Against AIDS
ARV	Antiretroviral
ART	Antiretroviral Therapy
BCC	Behavior Change Communication
BEST	Belize Enterprise for Sustainable Technology
BFLA	Belize Family Life Association
BMDA	Belize Medical and Dental Association
BNA	Belize Nurses Association
CAREC	Caribbean Epidemiological Center
CBO	Community-Based Organization
CBRC	Community-based Response Committee
CCC	Council of Churches
CCM	Country Coordinating Mechanism
CML	Central Medical Lab
CRIS	Country Response Information System
CSW	Commercial Sex Worker
FBO	Faith-based Organization
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
HECOPAB	Health Education and Community Participation Bureau
HFLE	Health and Family Life Education
IEC	Information, Education and Communication
KAPB	Knowledge, Attitudes, Perceptions and Behavior
LACASO	Latin America and Caribbean Council of AID Services
M&E	Monitoring and Evaluation
MCH	Maternal and Health Care
MHD	Ministry of Human Development
MOH	Ministry of Health
MOE	Ministry of Education
NAC	National AIDS Commission
NAP	National AIDS Program
NGO	Non-governmental Organization
NHI	National Health Insurance
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership against HIV/AIDS
PASMO	Pan American Social Marketing Organization
PMTCT	Prevention of Mother to Child Transmission
SIB	Statistical Institute of Belize
STI	Sexually Transmitted Infection
TCC	Technical cooperation among countries
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDAF	United Nations Development Action Framework
UNDP	United Nations Development Program
UNIBAM	United Belize Advocacy Movement
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counseling and Testing

Executive Summary

In June of 2001 Belize's Prime Minister, Honorable Said Musa, headed a delegation of governmental and non-governmental delegates to the 26th United Nations General Assembly Special Session (UNGASS) to present a status report on the situation of and response to HIV/AIDS in Belize. At the close of this historic occasion, Belize, along with 189 other member states, signed the Declaration of Commitment on HIV/AIDS. This commitment requires signatory countries to measure the extent of their commitment based on a standardized list of key indicators at the international, regional and national levels. These indicators measure impacts at the programmatic level with emphasis on Care and Support, Treatment and Prevention initiatives, which are aimed at mitigating the negative impacts of HIV/AIDS in the country.

This is Belize's third round of reporting. Building on the experience and lessons learned during the past two reporting periods (2003, 2005) Belize sought to ensure an even broader multi-sectoral participatory process for the elaboration of this 2008 report. The NAC Secretariat with support from UNAIDS, sought the services of a local consultant, to promote objectivity and transparency and ensure ownership by the contributing stakeholders.

The National Composite Policy Index (NCPI) questionnaire is an indicator of overall political commitment to the National Response which can be used to measure the level of advancement from one period of reporting to another. The NCPI focuses on a country's progress with the "Three ones"; One National Strategic Plan, One National Authority and one Monitoring and Evaluation Plan. These principles, promote harmonization, coordination, greater involvement of civil society and active participation of PWAs in guiding the national response. The NCPI at the programmatic level also seeks to monitor progress on prevention, treatment, care and support and the level of national investment in these areas. Compared to the previous reporting period in 2005, there has been a significant effort by the NAC to ensure more effective and active involvement of civil society and community-based groups especially those focusing on most at risk populations such as men who have sex with men, youth and women in difficult circumstances and orphans and children made vulnerable by HIV and AIDS. However, the challenge remains in securing the active contribution of PWAS at all levels of the response. Representation remains sporadic and is individually focused rather than representative of organized support groups.

In regards to the "Three Ones", Belize has an active and formalized, National Authority in the form the National AIDS Commission. The Commission's operational arm is the Secretariat whose role is to facilitate and report on progress regarding implementation of the National Strategic Plan. With Support of UNICEF, the NAC revised its 2006-2011 National Strategic Plan. This was developed through extensive consultations and sought feedback from all major stakeholders involved in the response. The NSP identifies as priority area 1: the need to strengthen Harmonization of the local response through effective coordination and monitoring and evaluation. The need for strengthening this priority area is supported in the findings of the NCPI survey, where it received low ratings.

Aside from harmonization, mitigation is also readily identified as another priority area. Since 2005, there has been a significant expansion of partners contributing to the mitigation of the epidemic in Belize. But

although these interventions address gaps in the area of care and prevention, these activities and programs need to be aligned with the NSP so that impact and implementation rate can be measured.

In the Programmatic areas of the response, there has been an increase in government funding in addition to support from the Global Fund and the Pan American Health Organization. This has enabled the Ministry of Health, a key stakeholder in the response, to strengthen its National AIDS Program. Coverage has since increased significantly, particularly in the areas of prevention of mother to child transmission (PMTCT), antiretroviral therapy (ART) and voluntary testing and counseling (VCT). This observation is readily evidenced in the NCPI, where these services were given higher ratings compared to 2005. The challenge that remains, however, is in offering appropriate interventions, which target most at risk populations. The specific needs of clients such as men who have sex with men and commercial sex workers have to be determined and assessed in order for the national response to be able to effectively provide access to critical services. This has posed a problem, particularly due to the fear of stigma and discrimination. Their clandestine lifestyle has made it exceedingly difficult to not only effectively integrate them into the national response, but also to engage them in dialogue from the onset.

The country is currently in the process of establishing the National AIDS Spending Accounts (NASA) to monitor domestic and international HIV/AIDS spending in support of the national HIV/AIDS response. The Government has committed to providing free access to HIV testing, provision of ARVs as well as diagnosis and treatment of STIs, some of the more common Opportunistic Infections and Tuberculosis. In addition, the Ministry of Health, Ministry of Labor and the National AIDS Commission have an earmarked HIV/AIDS budget received through national funds to support planning and coordination.

Although there is very minimal financial input from the national budget, many governmental agencies and civil society organizations have been able to continue implementation of their programs through the Global Fund, UN development partners and other funding sources such as the US Embassy and other regional and international NGO's for HIV. The expansion of HIV/AIDS treatment and care in Belize is complemented by a five-year grant from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) and support from the PAHO/WHO's 3 by 5 initiative in Belize. The GFATM has allocated US$2,403,678 for a 5 year project to strengthen the multisectoral response in Belize. This project culminates in 2009.

Although co-financing by the Government of Belize should amount to US$3,381,900 to be distributed among the implementing agencies, there is a need to advocate for specific and continual HIV line item allocations to be reflected within these agencies' budgets. For example, to date, the Ministry of Health's budget has shown fluctuations. In the first year of the implementation of ART, the Ministry had a budget of $US750.000. In the second year it was down to $US250, 000, and in year three it went up to $US400, 000. The majority of funds allocated by the Ministry of Health are used for procurement of ARV's and other STI's and OI's medications. ARV's and medications are procured through PAHO/WHO's Strategic Fund. These fluctuations in financial commitment pose a major challenge given the continued rise in new HIV infections identified each year. As a result, Belize remains highly dependent on externally generated funding. In spite of these challenges, however, there has been an overall increase in AIDS spending both at the national and international level since 2005.

Challenges to Belize's achievement of the UNGASS targets correlate with the expressed need to continue to enhance and promote the effective coordination of the multisectoral response. Improved sustainability planning, procurement and resource mobilization strategies are equally important in ensuring appropriate funding in the relevant areas of the response and support for community-based initiatives. Emphasis on promoting evidence-based planning supported by key baseline data, such as those relating to MARP and DHS, will guide the HIV/AIDS response. Finally, monitoring and evaluation of the National Strategic Plan and the National HIV/AIDS policy respectively, will inform on progress with implementation.

To address these challenges, Belize seeks the support of partners in developing a "costed" operational plan as a part of the National Strategic Plan that includes a resource mobilization component. Technical support and capacity-building is also needed to operationalize the current National Monitoring and Evaluation plan. The latter, surmises the list of prioritized national indicators and encompasses UNGASS, Millennium Develop Goals and Universal Access targets. There is also a need for support for the implementation of baseline and sentinel studies to aid in evidence-based planning; and for developing partners to continue to ensure harmonization of strategic plans.

After 27 years of struggling to contain and control HIV/AIDS, efforts must now be vested into mainstreaming prevention and mitigation initiatives into existing primary health care programs and other community based initiatives. In this manner development programs will seek to alleviate in a sustained way the factors that contribute to the vulnerability and susceptibility of the populations.

Status at a glance

In Belize HIV/AIDS continues to pose a major challenge. As a sparsely populated developing country of only 314,300[1] people, Belize is seriously vulnerable to the loss of human and financial capital resulting from the spread of HIV and AIDS. With an estimated HIV rate of infection of 2.1% at the end of 2007[2], Belize is ranked 1st in Central America and 4th in the Caribbean for rate of infection per capita. The National Health and Information Surveillance Unit of the Ministry of Health reports a total of 3,805 HIV infections at the end of 2006 and 4,131 up to the end of October 2007[3]. The overall epidemiological profile of the epidemic since the first reported case in 1986 demonstrates that Belize has experienced an escalation in reported cases of HIV, placing its prevalence rate of 2.1% per capita as the highest in Central America and the 4th highest in the Caribbean[4]. The country has embarked on a vigorous multi-sectoral response to the epidemic and HIV has been integrated into the National Poverty Elimination Strategy and Plan which also addresses related development issues such as gender inequities. Now, it is critical that the country response move away from traditional sectoral planning to an integrated macro-level planning to decrease ineffectiveness and capitalize on the utilization of limited resources.

[1] Statistical Institute of Belize, Labor Force Survey 2006
[2] UNAIDS Estimates-Belize, 2007
[3] NHISU Ministry of Health, Oct. 2007 Quarterly Report
[4] UNAIDS Report on the Global AIDS Epidemic, 2006

In June of 2001 Belize's Prime Minister along with 189 other member states, signed the UN Declaration of Commitment on HIV/AIDS. In 2003 and 2005 country progress reports were submitted for the years 2001/2003 and 2004/2005 respectively. Building on experiences and lessons learned during the past two reporting processes, Belize embarked on a multisectoral, participatory and comprehensive mission to elaborate the 2008 Country Progress Report.

Inclusiveness of Stakeholders in the Reporting Process

This reporting process was guided by the National AIDS Commission which is the country coordinating mechanism of the Global Fund and the body mandated by the Belize Government to facilitate the implementation of the National Strategic Plan. The NAC is a 23 member multisectoral body comprised of high level representatives of key governmental agencies such as the Ministry of Health, Ministry of Human Development, Ministry of Education, Ministry of Labor, Ministry of Tourism as well as representatives of key non-governmental agencies involved in the fight against HIV such as the Alliance Against AIDS, the Belize Family Life Association, the Belize Red Cross, the Pan American Social Marketing Organization (PASMO) and community-based response groups among other members of civil society. The NAC also includes representation from the faith-based and business sectors. Other key stakeholders who were integral to the process of the 2008 UNGASS Report are members of the UN Theme Group namely; PAHO, UNICEF and UNFPA; a representative of the support group of persons with HIV/AIDS and organizations representing most at risk populations such as men who have sex with men. During the past two years there has been an increase in the active involvement of civil society within the NAC. As members of this CCM they were actively engaged in the process of developing this report as well the strategic planning processes of 2006 and 2007.

With the technical support of an independent Consultant supported by UNAIDS, the Commission was engaged in the process of data collection, vetting and analysis. An initial consultation served to engage Commission members and other partners in an in-depth discussion regarding the revisions to the indicators as well as to discuss gaps identified in the previous report for 2005. Individually and then collectively they completed the NCPI questionnaire. Individual interviews were held with key members of the Commission who were unable to attend the initial consultation session to obtain their input on the NCPI, as well as to familiarize them with the reporting process and acquire vital updates from their organizations to input into the report. A team from the regional UNAIDS office conducted a 2 day working visit to familiarize Commission members with the Country Response Information System which would be utilized to submit data on the indicators as a part of the reporting format. Once the data indicators had been compiled a vetting session was held with the aim of reaching consensus on the correct value of each indicator. A technical consultant for UNAIDS arrived from Geneva to also assist the UNGASS working team with inputting the data into the CRIS software as well as to provide additional training to members of the National AIDS Commission's Monitoring and Evaluation Committee with the aim of sensitizing partners to the value of the CRIS as a part of the national monitoring and evaluation system. Upon completion of the report a team nominated by the National AIDS Commission members conducted the consistency check between the narrative and data entered into the CRIS. The final draft was then circulated for further endorsement by all members of the Commission including UN development partners and other stakeholders. An evaluation meeting will follow the submission of the

report with all members of the Commission and other partners to review the lessons learned, to identify gaps and to begin preparations for UNGASS 2010.

Policy and Programmatic Response

By applying the highly successful multisectoral process of joint application to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) which led to the approval of a 2.5 million dollar multisectoral 5 year project in 2003; the National AIDS Commission conducted a multidimensional and participatory Strategic Planning process in 2005. After extensive consultations and discussions with all stakeholders, the National AIDS Commission presented its 2006 – 2011 Strategic Plan for a Multisectoral National Response to HIV/AIDS in Belize. The NAC is presently in the process of developing an operational plan to guide the implementation of this new strategic plan which will include sub-plans, resource mobilization plan and a monitoring and evaluation plan. In April of 2006, on the initiative of the NAC, a National Communications Strategy for HIV/AIDS in Belize was developed to support the strategic priority areas of the National Strategic Plan. There has been minimal increase in the political support and commitment at the highest political levels in the country. After a nation wide consultative process, both the National Policy on HIV/AIDS and the National HIV/AIDS Workplace Policy were passed by the government of Belize in 2006.

These policies provide the legal framework needed to implement the National Strategic Plan in an efficient and effective manner. Even though the NAC was placed under the responsibility of the Prime Minister's Office, this strong statement of political will is yet to translate into concrete actions for change. The NAC was made a statutory body under the Office of the Prime Minister in 2004 with the passing of the National AIDS Commission ACT.[5]

In 2006 after sensitization on HIV in Belize and the region by PAHO and CAREC Cabinet endorsed the National Policy on HIV/AIDS as well as the National HIV/AIDS Workplace policy. As a result of this endorsement, specific HIV/AIDS workplace policies have been developed for the Public Service and other sectors. The Ministry of Education is in the process of formulating an HIV/AIDS policy for the education Sector. The National AIDS Commission's Policy and Legislation Committee is engaged in the process of formulating the specific legislation which will govern the implementation and enforcement of these policies.

[5] Belize National AIDS Commission, ACT 2004

Table 1: Overview of UNGASS Indicator data for 2008 Report

NATIONAL INDICATORS	2006-2007	COMMENTS
National Commitment and Action		
1. Domestic and international AIDS spending by categories and financing sources	Data not available	The National AIDS Commission is spearheading an initiative introduce NASA in collaboration with all key agencies involved in the HIV/AIDS national response.
2. National Composite Policy Index	See Annex 2	Members of the NAC and other partners completed NCPI individually at an initial consultation session on Nov. 21st 2007 and arrived at consensus at a special session Jan. 4th, 2008.
National Programs		
3. Percentage of donated blood units screened for HIV in a quality assured manner	100%	For 2007 3172 blood units were donated in Belize. Out of these, all were screened using the WHO Frame Tool standard operating procedures. As a part of an external scheme with the UK, Blood units not sent to external source but instead pre-conditioned samples sent to Belize for testing.
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	N/A	NHISU does not disaggregate data by advanced and non-advanced HIV infection. MOH utilizes the clinical staging by WHO as criteria for starting ART. Of 4131 persons living with HIV or AIDS, a total of 558 persons are on ART with 65 being less than 15 years of age while 493 are 15 years or above. Of the 65 who are below 15, 34 are male and 31 are female. Of the 493 who are 15 or above 229 are male and 264 are female. Measures are being taken by the NHISU to strengthen surveillance to be able to answer to this indicator.
5. Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission	2006 – 76% 2007 – 78%	For 2006 54 (numerator) HIV positive pregnant women received ART. There were 71 estimated positive pregnant women. Total number of pregnant women 7233 X 0.98 * (see comments on indicator 22) divided by 100. (denominator) Up to Oct. 2007 45 (numerator) positive pregnant women received ART. There were 57 estimated positive pregnant women. Total number of pregnant women 6886 X 0.83 divided by 100.

6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	2006: 83% 2007: 69.2%	The total number of persons screened for Tuberculosis was 420 while 67 were screened for TB and HIV. Of these 10 cases of co-infection were detected. All persons were treated according to the TB/HIV co-infection protocols of the Ministry of Health.
7. Percentage of women and men aged 15 -49 who received an HIV test in the last 12 months and who know their results	2006: 15 -24 = 15.05%	In 2006 a Sexual Behaviors Survey conducted by SIB[6] included 1900 (denominator) persons ages 15-24. It was not disaggregated by age groups as specified in the indicator. Of the 437 reporting having taken an HIV test, a total of 297 respondents reported taking an HIV test within the last 12 months. Of these, 286(numerator) also reported finding out the results
8. Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results.	Data not available	Small surveys have been conducted with Commercial Sex Workers and Men who have Sex with Men but these need to be expanded to included a representative sample. The MOH, BFLA, UNIBAM and PASMO have all embarked on separate but complementary initiatives focusing on most-at risk populations such as MSM, FSW and prisoners. This data should be available for the next reporting period.
9. Percentage of most-at –risk populations reached with HIV prevention programs	Data not available	- *Same as above* –
10. Percentage of orphaned and vulnerable children aged 0 -17 whose households received free basic external support in caring for the child	Not applicable	Belize Prevalence = 2.1%
11. Percentage of schools that provided life skills-based HIV education in the last academic year.	Data not available	Even though the Ministry of Education has introduced the Health and Family Life Education curriculum in all schools, it is not known how many of these schools have actually been implementing this curriculum. A new monitoring and evaluation system is being put in place by the MOE and this data should be available for the next report.
Knowledge and Behavior		
12. Current school attendance among orphans and among non-orphans aged 10 -14	Data not available	Data not available. Ministry of Human Development's Human Services Department and Ministry of Education are being encouraged to begin collecting and reporting this data.

[6] Statistical Institute of Belize commissioned a Labor Force Survey in 2006 which included a Sexual Behaviors component. The analysis was conducted in 2007.

13. Percentage of young women and men 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	2006: 26.1%	This is based on the KAP model of the Labor Force Survey, April 2006 which included a total of 1900 (denominator) young persons between the ages of 15 – 24. 496 (numerator) of the respondents both correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions. Data not disaggregated
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Data not available	Please see notes above for most-at-risk populations. Data will be available for next report.
15. Percentage of young women and men aged 15 -24 who have had sexual intercourse before the age of 15	2006: 8.73% total; 5.42% male and 3.31% female	This is based on the KAP model of the Labor Force Survey, April 2006 which included a total of 1900 (denominator) young persons between the ages of 15 – 24. Of a 166 (numerator), 103 were males and 63 were females. Data not disaggregated by age group as specified in indicator.
16. Percentage of women and men aged 15 – 49 who have had sexual intercourse with more than one partner in the last 12 months	8.31% total; 6.52 males and 1.78 females	This is based on the KAP model of the Labor Force Survey, April 2006 which included a total of 1900 (denominator) young persons between the ages of 15 – 24. 158 (numerator) of the 1900 stated that they have had multiple sex partners. Of the 158 persons, 124 were male and 34 were female
17. Percentage of women and men aged 15 – 49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse	Data not available	Data not available for this reporting period but will be available for next report through implementation of specific sexual behavior survey.
18. Percentage of female and male sex workers reporting the use of a condom with their most recent clients	Data not available	Small surveys have been conducted with Commercial Sex Workers but these need to be expanded to include a representative sample. The MOH, BFLA, UNIBAM and PASMO are all embarking on separate but complementary initiatives focusing on most-at risk populations which will include MSM and CSW.

19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Data not available	Studies with MSM population presently underway and reports will be available for next report.
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	Data not available	Data not available in Belize. Baseline study needed to confirm perception that IDU is not applicable to the Belize HIV/AIDS situation
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected.	Data not available	In collaboration with the National Drug Abuse Control Council the NAC will conduct baseline study to determine if perception of non- relevance is accurate.
Impact		
22. Percentage of young women and men aged 15 -24 who are HIV infected	2006: 0.98% 2007: 0.83%	In 2006, 3955 (denominator) women aged 15 -24 were booked at the antenatal clinic and took an HIV test, 39 (numerator) women tested positive. In 2007 up to October, 2766 women aged 15-24 were booked and tested, 23 (numerator) were positive. **Data not disaggregated by 5 year** groups
23. Percentage of most-at-risk populations who are HIV infected	Data not available	Information collected at VCT sites during pre-testing but not processed. MOH will strengthen report systems at VCT sites to address this and make data available for next reporting period
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	Data not available	This information is not available as there is no surveillance to provide this data at the moment. At the moment the MOH only keeps track of number of clients on ARV's for replenishing purposes but not the length of time on ARV's. The Ministry of Health is in the process of building database to strengthen surveillance system through patients' files to be able to monitor adherence.
25. Percentage of infants born to HIV-infected mothers who are infected.		Not to be reported at country level.

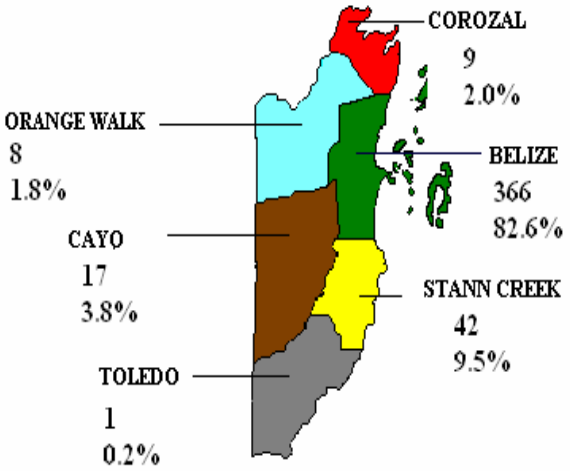
Overview of the AIDS Epidemic

As a sparsely populated developing country, Belize continues to be seriously vulnerable to the loss of human capital resulting from the spread of HIV and AIDS. Belize has the lowest absolute number of HIV cases in Central America but the total country population is only 314,300. The overall epidemiological profile of the epidemic since the first reported case in 1986 demonstrates that Belize has experienced an escalation in reported cases of HIV, placing its estimated prevalence rate of 2.1% per capita as the highest in Central America and the 4th highest in the Caribbean.[7] In 2006 and 2007 this upward trend continued but at a slower pace.

The 2006 Surveillance Report of the Ministry of Health indicated a total of 3,805 HIV infection cases up to the end of that year. The reported total number of HIV Infections from 1986 to end December 2005 was 3,362. In 2006 the total number of new HIV Infections was 443 which showed an increase from the previous year 2005 which was 434. The total number of new AIDS Cases for the year 2006 was 43. In the previous year 2005, it was 30.[8]

The total number of new AIDS Deaths for the year 2006 was 75 while in the previous year 2005 it was 76. The reported total number of AIDS Cases from 1986 to the end of December 2006 was 805. The reported total number of AIDS Cases from 1986 to end December 2005 was 762. The reported total number of AIDS deaths from 1986 to end December 2006 was 701. The reported total number of AIDS Deaths from 1986 to end December 2005 was 626.

Graph 1: NEW HIV INFECTIONS AND PERCENTAGE BY DISTRICT JANUARY TO DECEMBER 2006

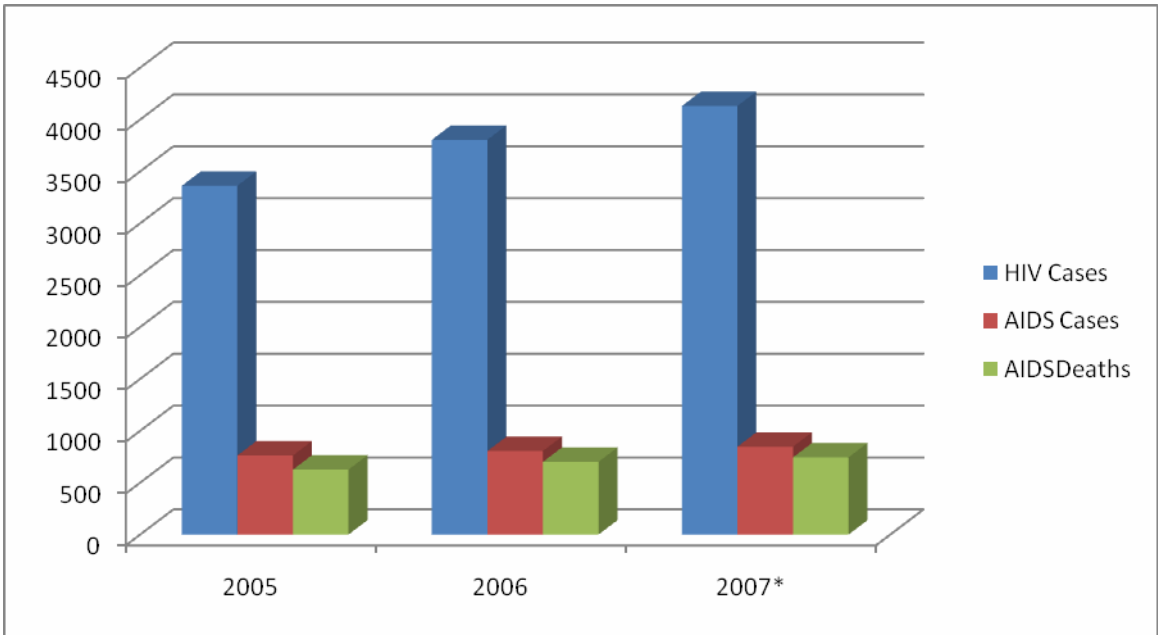


Ministry of Health, NHISU Annual Report, 2006

[7] UNAIDS Report on the Global Epidemic, 2006
[8] Ministry of Health , NHISU Annual Report 2006

The most recent NHISU report for the July-September 2007 quarter indicates a total of 4,131 HIV infections reported since 1986. In the same quarter of 2006 it was 3,805 and in the previous quarter 2007 it was 4,035. The total number of new HIV infections in the third quarter 2007 was 100, in the same quarter of 2006 it was 122 and in the previous quarter (April-June 2007) it was 137. The total number of new AIDS cases in this 3rd quarter of 2007 was 25, in the same quarter of 2006 it was 13 and in the previous quarter (April –June) 2007 it was 10. The total number of new AIDS deaths in the 3rd quarter 2007 was 20, in the same quarter of 2006 it was 21 and in the previous quarter 2007 it was 13.

Graph 2: HIV, AIDS and AIDS Death Cases reported cases per year

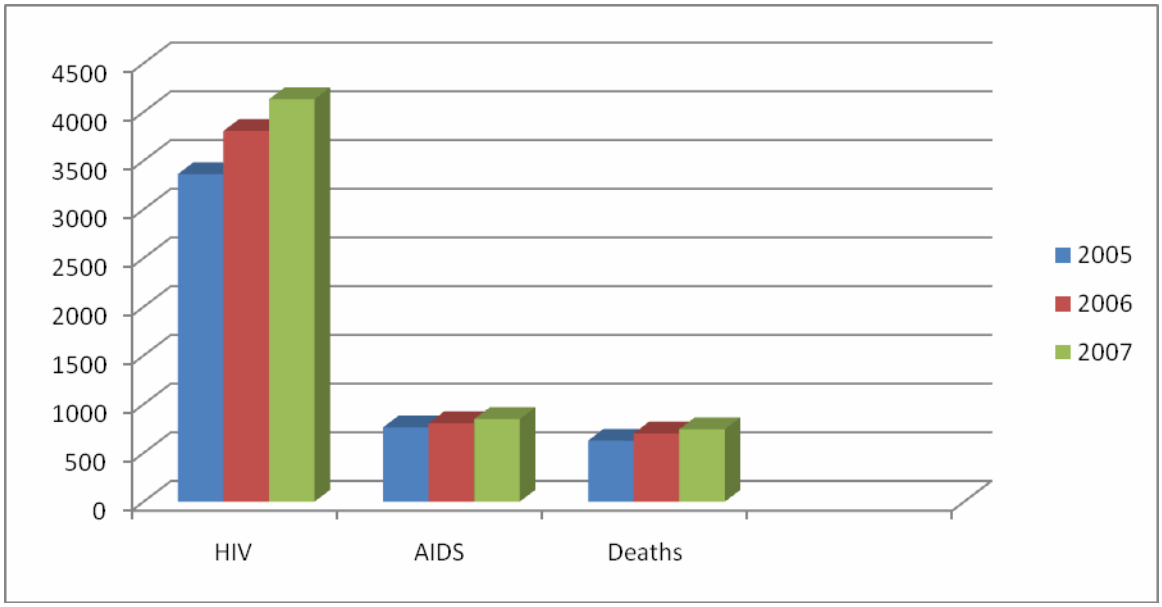


(**2007 includes Jan – Sept. only)*

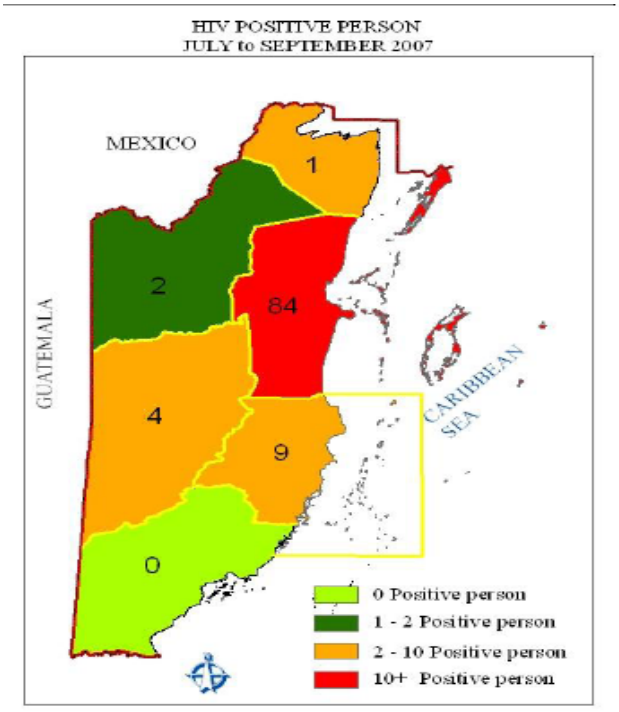
The total number of AIDS cases reported since 1986 up to the ending of the 3rd quarter 2007 was 847 in comparison to the cumulative total up to the 3rd quarter of 2006 which was 793. This demonstrates an upward trend in the number of reported cases. It is unclear at this time, whether this increase is due to increase access to testing versus a true incidence rise.

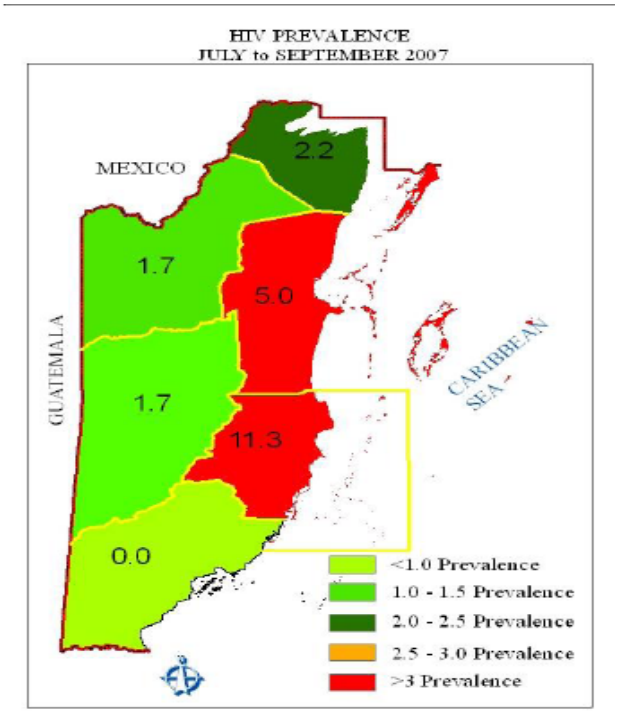
Conversely, the total number of AIDS deaths reported since 1986 up to the ending of the 3rd quarter 2007 was 744, in comparison to the cumulative total for the 3rd quarter of 2006 which was 679. Although this reflects an upward trend in deaths, again there is a need to analyze the data to determine the cause. This is important, because it impact directly on mitigation, and reflects on whether we are effectively ensuring access to critical services to prolong life.

Graph 3: Cumulative Total of HIV, AIDS and Death Cases Reported



Graph 4: Reported New HIV Infections and Prevalence, July – Sept. 2007





Ministry of Health, NHISU Annual Report 2006

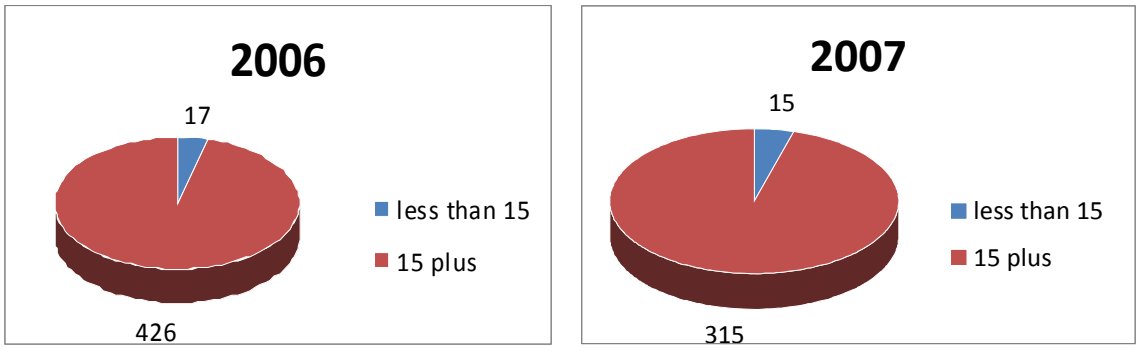
Table 1: Global Summary of the HIV/AIDS Epidemic in Belize 2006 - 2007

	Jan. – Dec. 2006	Jan. – Sept. 2007
Total number of new infections for the year	443	330
Total new AIDS cases reported for the year	43	42
Total new AIDS deaths for the year	75	43
Total reported HIV infections since 1986	3,805	4,131
Total reported AIDS cases since 1986	805	847
Total reported Deaths since 1986	701	744

(NHISU*, Ministry of Health 2006 Yearly Report and October 2007 quarterly report)*

In 2006 17 of those who tested positive for HIV were under the age of 15 while 426 were 15 years and plus. In the age group under 15, 4 were females (2.1%) while 13 (3.0%) were males. In the 15 and plus age group 186 (97.9%) were females while 240 (96.1%) were males. Up to the end of September in 2007 15 of those who tested positive for HIV were under the age of 15 while 315 were 15 years and plus. In the age group under 15, 8 were females while 7 were males. In the 15 and plus age group 137 were females while 178 were males. In 2006 the age group under 15 accounted for 2.1% cases among women while the 15 and plus group accounted for 97.9%. In 2007 the age group under 15 accounted for 5.5% of the cases among women while the age group 15 and above accounted for 94.4%. In 2006 3.9% of the new HIV infections among males was under the age of 15 while 96.1% of the cases was 15 years and plus. For the year 2007 up to September, 3.8% of the cases among males were under the age of 15 while 96.2% were 15 years and plus.[9]

Graph 5: Number of persons infected in 2006 and 2005 below 15 years and 15 years plus

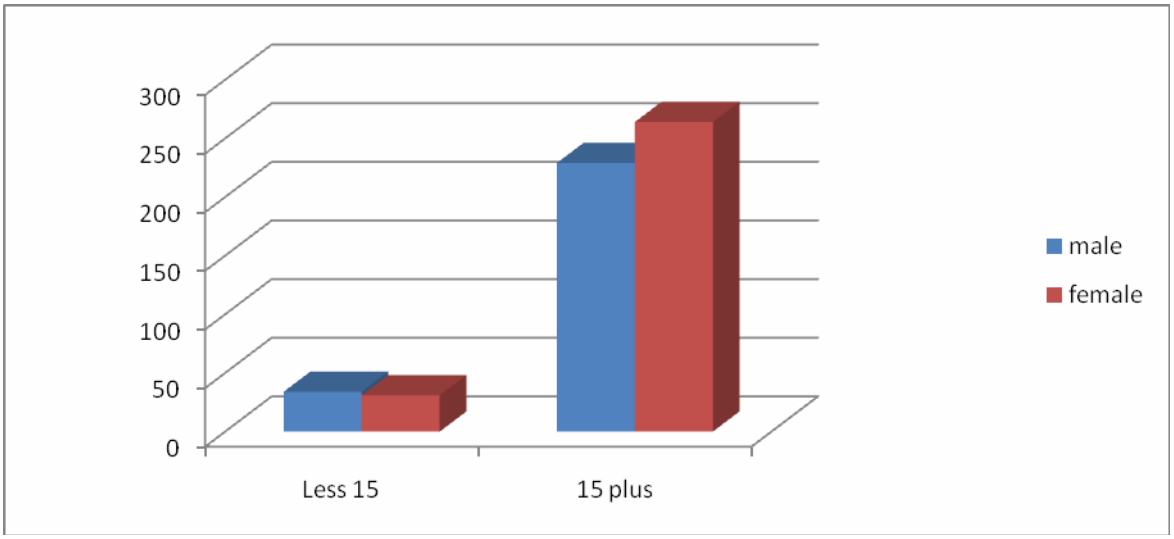


[9] Ministry of Health, NHISU Quarterly Report July-Sept. 2007

For the year 2006 within the age group <1 there was 1 (0.5%) female and 3 (1.2%) males. Within 15-24 years there were 70 (36.8%) females and 38 (15.0%) males resulting in 24.4% of all HIV Infections (443). In the age group 15-49 years there were 180 (94.7%) females and 192 (75.9%) males resulting in 84.0% of all HIV Infections (443) for this year. In 2005 within the age group <1 there were 4 (1.9%) females and 3 (1.3%) males. Within 15-24 years there were 62 (29.5%) females and 28 (12.5%) males resulting in 20.7% of all HIV Infections (434). In the age group 15-49 years there were 184 (87.6%) females and 187 (83.5%) males resulting in 85.5% of all HIV Infections (434) for this year.

A total of 558 persons are on ART with 65 being less than 15 years of age while 493 are 15 years or above. Of the 65 who are below 15, 34 are male and 31 are female. Of the 493 who are 15 or above 229 are male and 264 are female. The NHISU does not disaggregate data by advanced and non-advanced HIV infection. MOH utilizes the clinical staging by WHO as criteria for starting ART.

GRAPH 6: PERCENTAGE OF MALES AND FEMALES ON ART WHO ARE LESS THAN 15 AND 15 PLUS



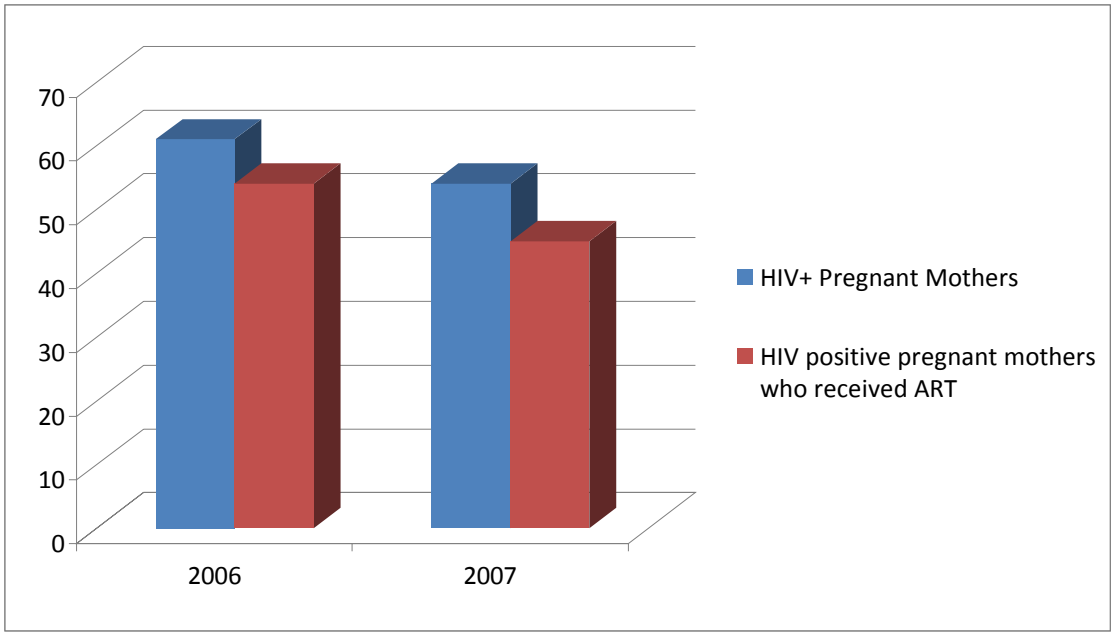
According to the Maternal and Child Health Unit's PMTCT indicators for 2006 and 2007 up to the end of October there had been 6721 antenatal clinic attendees between the ages of 15-24. In 2006 there were 3955 while in 2007 up to the end of October there had been 2766. Of the overall total number of pregnant women tested in 2006 61 were positive for HIV while 54 had tested positive in 2007. This is a total of 115 HIV positive pregnant women in the 2 years up to October 2007. Of these 115 HIV positive pregnant women 112 actually delivered.

Table 2: Antenatal attendees who test positive for HIV in 2006 and 2007

	2006	2007 (Jan – Oct.)	Total
ANC Attendees	3955	2766	6721
HIV+ Pregnant Women	61	54	115

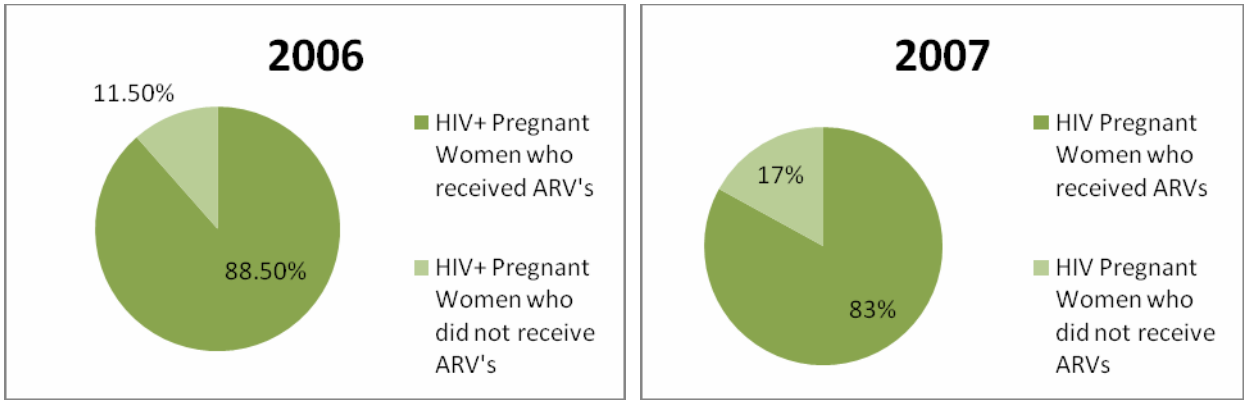
There were 61 infants born to HIV infected pregnant women in 2006 and 51 up to October of 2007. Of these 112 106 had received prenatal care. In 2006 the total number of HIV positive women who delivered and prenatal care was 58 while in 2007 it was 48. The total number of HIV infected infants born to mothers who received prenatal care was 11 with 5 for 2006 and 6 in 2007. The total number of HIV infected infants whose mother did not receive prenatal care because they were un-booked at the antenatal clinic and whose status was unknown were 5, 2 in 2006 and 3 in 2007. Thus, the total number of infants born HIV positive between 2006 and 2007 was 16 with 7 in 2006 and 9 in 2007. Ten (10) of the mothers who gave birth to HIV infected infants had received antiretrovirals, 4 in 2006 and 6 in 2007. Eleven (11) newborns had received ARV's with 5 in 2006 and 6 in 2007*. In 2006 57 (93.4%) new born infants were tested while 51 (100%) were tested in 2007. The total number of HIV infected mothers who received ANC and received ARV as per protocol up to delivery was 54 (93.1%) in 2006 and 45 (93.75%) in 2007. The total number of HIV exposed infants who received ARV at birth from mothers who were booked and tested at the antenatal clinic was 54 (91%) in 2006 and 45 (93.75%) in 2007* The percentage of infected pregnant women who received antiretroviral to reduce the risk of mother to child transmission was 88.5% in 2006 and 83.3% in 2007[10]

Graph 7: Infected pregnant women who received antiretroviral to reduce the risk of mother to child transmission



[10] Data for 2007 based on January to October only.

Graphs 8 & 9: HIV+ pregnant women who received ARV's in 2006 and 2007



In 2006, 3955 pregnant women between the ages of 15 -24 were booked at the antenatal clinic and took an HIV test, 39 tested positive. In 2007 up to October, 2766 women between the ages were booked and tested, 23 were positive. The percentage of young women and men aged 15 -24 who are HIV infected based on the MTCT surveillance was 0.98% in 2006 and 0.83% in 2007.[11]

In 2007 3,172 blood units were donated at the Belize Central Lab. Out of these, all were screened using the standard operating procedures. Blood units are not sent externally but rather participate in an external scheme in which pre-conditioned blood samples are sent from the United Kingdom (UK) to be screened in Belize. Thus, according to the report from the Central Medical Lab, the percentage of donated blood units screened for HIV in a quality assured manner using standard operating procedures was 100% for 2006 and 2007. The total number of persons screened for Tuberculosis was 420 while 67 were screened for TB and HIV. Of these 10 cases of co-infection were detected. All persons were treated according to the TB/HIV co-infection protocols of the Ministry of Health. Thus, the percentage of estimated HIV positive incident TB that received treatment for HIV and TB are 83% in 2006 and 69.2% in 2007.

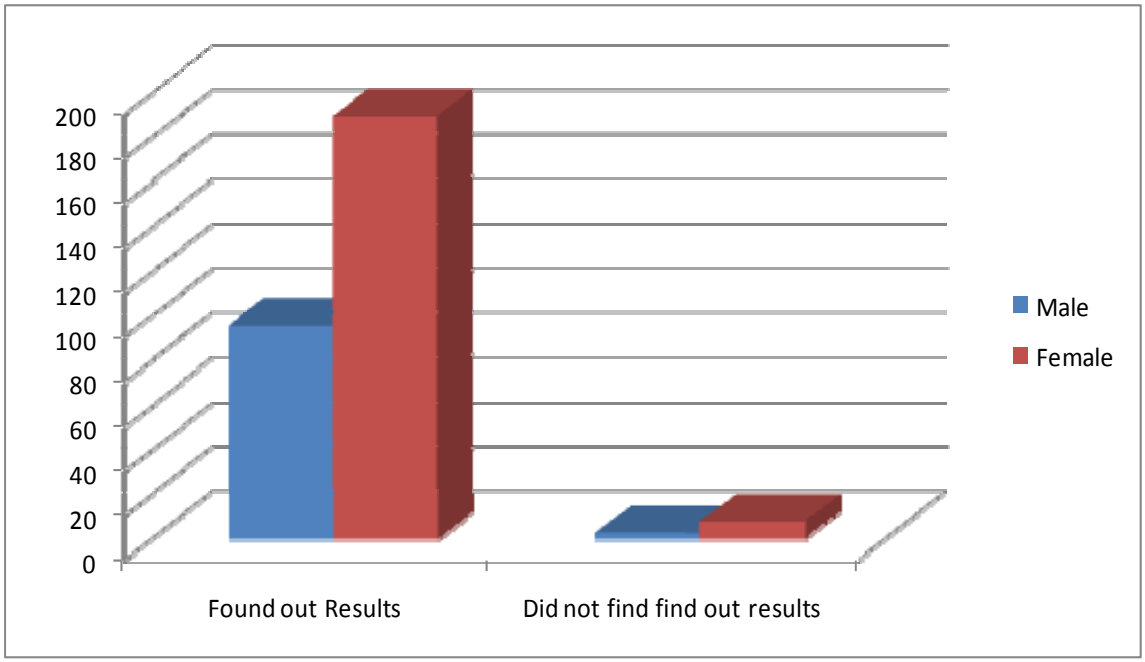
The National Health and Information Surveillance Unit presently does not disaggregate data by advanced and non-advanced HIV infection thus, data for this indicator is not available. Measures are being taken by the NHISU to strengthen surveillance to be able to answer to this indicator. Out of the total number of persons living with HIV up to the third quarter of 2007 there were 3.5% on antiretrovirals. Of 4131 persons living with HIV or AIDS, a total of 558 persons are on ART with 65 of them being less than 15 years of age while 493 are 15 years or above. Of the 65 who are below 15, 34 are male and 31 are female. Of the 493 who are 15 or above 229 are male and 264 are female. In 2006 75 persons started ARVT out of which 44 were male and 31 were female. In 2007 65 new persons were placed on ARV's, 34 of these were male and 31 were female. Up to the end of September 2007 there were a total of 558 persons on ARV's, 263 males and 295 females. The percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy is not known. This information is not available as there is no surveillance to provide this data at the moment. Presently the Ministry of Health only keeps track of number of clients on ARV's for replenishing

[11] Maternal and Child Health Unit, PMTCT Indicators 2006-2007 (2007 includes Jan. – Oct. only)

purposes. The Ministry of Health is in the process of building database to strengthen surveillance system and be able to monitor adherence.

A Sexual Behavior Survey[12] was conducted in 2006 with 1900 persons between the ages of 15- 24 years and was not disaggregated by age groups. This survey included five of the UNGASS Core Indicators for the 2007 Report. These included: HIV Testing and Results, MSM HIV testing, knowledge of HIV transmission, age of first sexual intercourse and multiple sex partners. Of these 1,900 respondents, 974 (51.3%) were females and 926 (48.7%) were males. The ages of the respondents were 15- 19 (60%) and 20-24 (40%). Of the 437 reporting having taken an HIV test, a total of 297 respondents reported taking an HIV test within the last 12 months. Of these, 286 (96.3%) also reported finding out the results of their HIV test while only 11 (3.7%) reported not finding out their HIV test result. Of the 286 who both reported taking an HIV test within the last 12 months and finding out their results, 96 (32.3%) were male and 190 (64%) were female. The percentage of women and men who received an HIV test in 2006 and knew their result was 15%.

GRAPH 10: Reported taking an HIV test within the last 12 months and know their results



Of the 1900 persons interviewed only four males reported having sex with a male partner. Two reported having taken an HIV test within the last 12 months and knowing their results. There is no baseline data available on MSM's in Belize as several attempts to conduct surveys and studies have failed. This is primarily due to the high level of fear related to the still existent stigma and discrimination against this population. Several agencies such as UNIBAM, MOH and PASMO are embarking on initiatives in HIV KAP

[12] A KAPS component of the Statistical Institute of Belize, Labor Force Survey 2006

studies and prevalence studies. This information should be available for the next round of UNGASS reporting in 2010.

Out of the 1,900 young persons who responded a total of 772 respondents correctly identified ways of preventing sexual transmission. Of these, 496 (64.2%) also rejected major misconceptions about HIV transmission while 276 (35.8%) correctly identified ways of preventing sexual transmission of HIV but did not reject major misconceptions about HIV transmission. Of the 496 who both correctly identified ways of preventing sexual transmission and rejected major misconceptions about HIV transmission, 240 (48.4%) were males and 256 (51.6%) were females. Thus, the percentage of young women and men 15-24 who both correctly identified ways of preventing the sexual transmission of HIV and who rejected major misconceptions about HIV was 26.1% .

Table 3: Knowledge of HIV Transmission and Rejection of Misconceptions

100% correct knowledge of HIV Transmission	Male	Female	Total
100% rejection of misconceptions	240	256	496
Less than 100% rejection Of misconceptions	140	136	276
			772

In this same study, one hundred and sixty six (18.4%) respondents reported having their first sexual intercourse at an age of less than 15. Of these, 103 (62%) were males and 63 (38%) were females. The reported age range of first sexual intercourse was 7 to 24 years. The data was not disaggregated by age group. Of the 1900 persons between the ages of 15 -24 interviewed, 158 stated that they have had multiple sex partners. Thus, the percentage of women and men aged 15 – 24 who have had sexual intercourse with more than one partner in the last 12 months is 8.31%.

National response to the AIDS epidemic

POLICY ENVIRONMENT

As a direct result of the Declaration of Commitment on HIV/AIDS at the UNGASS in 2001, the Prime Minister placed the National AIDS Commission, the body responsible for coordinating the GF multisectoral response to HIV/AIDS in Belize, under the responsibility of his Office in 2002. This action not only solidified his position of leadership in the response to the epidemic in Belize as Prime Minister but also emphasized his confidence in the role of the National AIDS Commission to facilitate and coordinate the implementation of the country's national response to HIV/AIDS. In 2003, the Chairperson of the NAC was appointed as Special Envoy for HIV/AIDS in Belize. In 2004 the Belize National AIDS Commission Act was approved by Cabinet. The Act provides for the establishment of the Belize National AIDS Commission charged with the duty of multisectoral coordination and facilitation of the implementation of the National Strategic Plan, HIV/AIDS policies and related legislation, the mobilization of resources for the purposes of the National Strategic Plan, advocacy and development of mechanisms for monitoring and evaluation necessary for preventing and stopping the spread of HIV and AIDS in Belize.[13] Even though the National AIDS Commission had been in existence since February 2000 and had already been carrying out its mandate as set by Cabinet, its role, function, composition and operational framework were not confirmed until the National AIDS Commission Act was ratified,.

In fulfillment of its role and obligation to coordinating and facilitating the implementation of the National Strategic Plan, the NAC embarked on the process of revising existing strategies to combat and control HIV/AIDS in Belize. The 2006 – 2011 National Strategic Plan was the result of this significant process, in that it brought together all national stakeholders and their plans to produce one end product. Applying the lessons learned from the successful multisectoral process of the joint application and approval of the country's 5 year Global Fund Project, the Commission engaged all its members as well as other national and international partners in extensive consultations to obtain their input which would define for Belize the three priority areas to be addressed. Critical to this process was the input of the Ministry of Health, the main provider of care and treatment, and the main entity responsible for surveillance and the establishment of the National Guidelines for all related HIV/AIDS services. Special emphasis was also placed on discussions with the Ministries of the Public Service, Education, Human Development and tourism. Other partners involved in the process included governmental and non-governmental agencies, community groups, labor and professional associations, private sector representatives, technical partners, persons living with HIV/AIDS and other members of civil society. With the support of PAHO/WHO a national stake-holders consultation was held to present and validate the draft strategic priorities. These processes have served to ensure that the National Strategic Plan of Belize engenders a multisectoral approach, which is built on the strengths of those consulted whilst at the same time, ensures the creation of opportunities to integrate new partners with the aim of achieving continuity and longevity.

[13] The Belize National AIDS Commission ACT, 2004

In 2006 and 2007, the National AIDS Commission promoted the socialization of the NSP and continued to engage partners in the elaboration of sub-plans in aligned with the National Strategic Plan. The country now has a National Information, Education and Communication Strategy which was completed in October 2006. This strategy focuses on promoting behavioral change in the general populace. In addition, the Ministry of Health has developed a draft national plan which seeks to integrate, HIV/STIs/TB into the primary care system, as well as a draft 5 year plan which is aligned with the National Strategic Plan for HIV and AIDS in Belize and the PAHO/WHO strategy for Universal Access.

Over the years the capacity of the National AIDS Program has strengthened, and today there is a full-time Director and supporting staff which has allowed for the program to scale up prevention, care, and treatment services in keeping with the objectives outlined in the MDGs, and the UNAIDS Universal Access to prevention, care, treatment and support.

Despite the progress and commitment manifested up to this point, the NAC recognizes the need for the development of the operational plan and completion of the monitoring and evaluation plan. In addition, the need for a resource mobilization plan is critical if member agencies of the Commission and other partners are to be successfully integrated into the implementation of activities at various levels. Conversely, it is important to note that in order to enhance implementation it is critical for implementing partners and members of the NAC to recognize the role of their individual organization in improving harmonization and reporting progress. Agencies continue to work independently and this limits the ability to expand programs at the national level in addition to making it difficult to report on achievements and implementation rate. Furthermore, there is a need to look at sustainability strategies that allow for critical programs to be adopted within our national response so that the reliance on international funding and resulting constraints can be decreased. The NAC recognizes that agencies are implementing activities that respond directly to the three priority areas proposed in the 2006-2011 NSP. But there is no consistent reporting of these achievements, making it difficult to then report on progress with implementation of the NSP. Where there are resources available for program implementation, often the challenge is the absorptive capacity to meet the expected targets within the proposed timelines. In this instance, the agencies need to network on a wider scale to improve coverage.

The National AIDS Commission recognizing the challenges of harmonization described above, garnered the assistance of the International Development Bank to support a study which specifically reviewed the institutional structure of the NAC in order to identify challenges and opportunities for improvement especially regarding coordination, monitoring and evaluation and accounting systems; analyzed the capacity of the NAC to implement current and planned interventions under the National Response to HIV/AIDS in addition to the coverage of donor support to HIV/AIDS initiatives in Belize, especially in the context of harmonization around the GFATM Three Ones principles. Consequently, recommendations arising out of this process endorsed the need to clarify and realign roles and responsibilities of the NAC at all levels. For example, it was put forward that partner agencies be sensitized to the process of sectoral planning in order to encourage 'buy in' and ownership of their activities as a part of a wider strategy. The hope is that this process would foster cross sector collaboration and more effective mobilization of resources, especially at the community level.

This would also serve to promote the enactment of relevant legislation and programs that better respond to the priority areas which would encourage progress reporting.

In 2006, Cabinet approved the National HIV/AIDS Policy presented by the National AIDS Commission as well as the National HIV/AIDS Workplace policy, a joint venture between the Ministry of Labor and the National AIDS Commission with support from the International Labor Organization. As a result of their approval, several sectors have since completed and adopted sector specific HIV/AIDS Policies in their operational manuals and documents. This process has been strengthened by the launch of the Business Coalition on HIV/AIDS in December 2007, an initiative led by the Belize Chamber of Commerce and Industry. At its launch, twenty-two business establishments in Belize signed on as members of the Coalition which promotes the adoption of HIV/AIDS policies in the workplace as well as education programs in order to safeguard their employees who may or may not be HIV+, from issues such as stigma and discrimination. This approach will create the supportive environment for persons affected or infected with HIV/AIDS to continue to engage in productive lives. The Belize Business Coalition on HIV/AIDS is also a part of the Caribbean Business Coalition on HIV/AIDS, which provides a regional context for support, institutional building and capacity building.

The Office of Governance has also completed the HIV/AIDS for the Public Service Sector policy, which has been formally adopted. The Ministry of Education, although it falls under the Public Service Policy, is in the process of formulating its own policy for the Education Sector. The NAC is also encouraging the NGO and Civil Society agencies actively engaged in the response to adopt this policy as well. To date, the AAA and BEST have done so and are advocating for others to do the same. The NAC with support of the GF is also now conducting an assessment of the current laws to propose the way forward for the legal framework that will add give substance to the aforementioned policies. In the interim, the NAC continues to sensitize sectors on the policies to encourage partners to recognize the value of protecting the workforce and embracing the principles of the policies.

In 2005, Belize began the implementation of its 5-year project supported by the Global Fund entitled “Strengthening of the Multisectoral Response to HIV/AIDS in Belize”, for which the National AIDS Commission is the Country Coordinating Mechanism (CCM). During 2006 and 2007 of the Global fund project, seven (7) members of the CCM were selected as sub-recipients who have been involved in the implementation of activities included in the National Strategic Plan. These members include the Ministry of Health, the Ministry of Human Development (Women’s Department), the Ministry of Education – Quality Assurance and Development Services, Youth for the Future, the Alliance Against AIDS, the National AIDS Commission and the Belize Family Life Association.

As aforementioned, the Global Fund has contributed greatly to the national response to HIV/AIDS in Belize in 2006 and 2007 by complementing the National budget in providing the resources needed by key agencies involved in the implementation of HIV/AIDS activities. The National Budget in 2006 and 2007 continued to provide an HIV/AIDS budget for the Ministry of Health’s National AIDS Program ($400,000) and the National AIDS Commission Secretariat ($138,000 per annum) The budget for the NAC is expended primarily on operational functions, as most of the program budget is dependent on support from the Global Fund. In 2007, for the first time, the Ministry of Labour received an HIV budget from

national funds. This was as a direct result of sustainability-building for the ILO HIV/AIDS project activities which began in 2003. While other governmental agencies and departments involved in the response to HIV/AIDS in Belize receive funds from the Government of Belize, it is not definitive how much of it is spent of HIV/AIDS related activities, as they lack corresponding listings as line items in their budgets. In addition, these departments are well over tasked and lack the financial capacity to implement effectively, thus look toward alternative means of support like international sources such as the Global Fund, the UN development partners among others.

An though harmonization remains a challenge, working in collaboration with its partners and with the support of key institutions such as the Global Fund, member agencies of the National AIDS Commission have significantly increased implementation in the areas of prevention, behavior change, support, care and treatment.

PREVENTION

With the support of the Global Fund and other agencies such as the Pan American Health Organization the Ministry of Health, the country's largest implementing partner, has continued to strengthen major programmatic areas aimed at reducing the risk of HIV transmission. These interventions include the provision of care, treatment, diagnostic testing and syndromic management of STIs and Opportunistic infections for persons with HIV/AIDS. In addition, the MOH launched its annual "Know Your Status Campaign" further expanding voluntary HIV testing at the community level countrywide. Outreach programs promoting behavior change among vulnerable groups such as commercial sex workers, men who have sex with men, people living with HIV/AIDS, prisoners and uniformed services continue as well as those related to information, education and communication, access to VCT services and free condom distribution.

A significant turning point in the prevention efforts has been the enhancement of the PMTCT program aimed at reducing the vertical transmission of HIV from positive pregnant women to their newborns. With the adaptation of the revised PMTCT Plus Guidelines, that calls for triple antiretroviral therapy to be introduced at 14 weeks gestation instead of single dose Niverapine at the time of delivery, as well as the successful integration of the program within the Public Maternal Child Health Clinics, coverage has successfully expanded countrywide.

On September 2003, the Ministry of Health launched its first HIV Voluntary Counseling and Testing (VCT) center in Belize City, and later, established an additional 11 testing sites, in both the private and public sectors. The original target of four (4) VCT Centers supported by the Global Fund project was increased to seven (7) MOH sites. This initiative enabled 6,142 persons in 2006 and 7052 in 2007[14] to access testing while providing ARVs to 548 patients as well as the wider distribution of condoms. Accessibility is further enhanced since Antiretroviral Therapy is provided free of cost to persons infected. The latter forms part of Government's commitment and is also partially financed by the Global Fund Project.

[14] Data for 2007 is for January – September only.

Capacity building of Clinicians was a clear milestone for the Ministry of Health in 2006 and 2007. Trainings for 64 clinicians in the areas of HIV Clinical Management and VCT Pre and Post Test counseling were offered. NGOs have also benefited from these trainings with seventy-five percent of the clinic staff of Belize Family Life Association (BFLA), trained in Voluntary Counseling and Testing and 100% in the syndromic management of STI's. Since then, fifty percent of the association's clinics nationwide now offer both of these services. In 2006,there was not only an increase in access to these services by youth and women but also members of most at risk groups such as men who have sex with men and commercial sex workers. BFLA plans to include VCT services as part of their outreach mobile services shortly.[15] The MOH in an effort to provide effective treatment for STI's and with the support of PAHO developed and trained doctors and nurses country-wide on the syndromic detection and treatment of STI's. To date a total of 132 clinicians have been trained in this area.

The next area of action is to improve systems for reporting coverage of services and promoting the further integration of these key services. There is a need to implement more effective client monitoring systems which will identify adherence patterns, and referral pathways. Users of the services express concerns with issues of confidentiality and the need to facilitate entry to other support services. Alliance Against AIDS, an NGO offering support to persons infected and affected have now established a referral information system that they hope will provide valuable information in this regard.

In terms of meeting the reporting of these indicators, the lack of formal systems of data collection was the major contributing factor to not being able to effectively demonstrate coverage. Surveillance therefore needs strengthening and is an expressed need for continual collaboration with our technical partners. During these past two years special focus has been given to out- of- school and in school youth with support of the Global Fund. The Ministry of Education has increased its response to HIV in Belize especially in the area of prevention. With the approval of the Health and Family Life Education Policy by the Cabinet in June 2006, curriculum and resource guides for teachers were developed and disseminated. Fifty (50) national trainers and 1,000 teachers were trained on HFLE using the curriculum and guides. With technical assistance from UNICEF MOE has been able to implement the HFLE curriculum within Primary Schools. By September 2006, HFLE was installed in all Primary Schools. To date 100 national trainers have been trained in Health and Family Life Education (HFLE) and eight hundred new teachers were trained in 2007 reaching 22,000 children with Life Skills based HFLE.[16] The HFLE unit of the Ministry of Education has strengthened its human resource capacity through the employment of six HFLE Officers who were deployed to each of the districts. This significantly increased the support available to teachers at the district level and improved monitoring and evaluation of HFLE. All six HFLE officers have been trained in HFLE and Monitoring and Evaluation. With the support of the Global Fund in 2006 the Ministry of Education was able to conduct training of 1,300 teachers to properly incorporate the Health and Family Life Education program in 100 schools. This gives coverage to at least 9,000 students.[17] The Ministry of Education will now conduct monitoring visits to the various schools to

[15] Belize Family Life Association Annual Report 2007
[16] UNICEF HIV/AIDS, Violence and Adolescent Development Program Report, 2007
[17] Belize Enterprise for Sustainable Development, Global Fund Annual Report 2006

ensure that the HFLE is indeed being utilized by these trained teachers. As a part of its HFLE plan MOE is in the process of developing an HIV/AIDS policy for the education sector.

As an organization mandated to create and maintain youth friendly spaces and provide youth-friendly services, BFLA continued in 2006 and 2007 to participate in the implementation of various HIV/AIDS prevention projects with the Global Fund, OPEC/UNFPA project for Youth in Difficult Circumstances, FATE, Canadian International Development Agency's Youth Empowerment Project as well as SUMMIT International. BFLA's focus on out-of-school youth includes HIV/AIDS as a part of the overall education on sexual and reproductive health. Provision of counseling and condoms to young persons who are sexually active are also an important part of this program.

With technical support from UNICEF, the "Together We Can" Program, a Red Cross initiative was implemented by the Belize Red Cross and is in its third year. The program has been successful in promoting child and adolescent participation in activities aimed at reducing their vulnerability to HIV infection. Peer Education training is ongoing and has provided 29 newly certified National Trainers. The TWC methodology has since been integrated within other NGO's and partner agencies including the Belize Health and Family Life Education –HFLE program. In conjunction with the Ministry of Education, Belize Family Life Association and Go Joven, a total of 26 high school counselors have now been trained as TWC/HFLE National Trainers. These trainers are responsible for training and certifying young persons within their respective institutions.

As a result of multiple communication and social mobilization efforts such as the launching of the International Federation of Red Cross & Red Crescent initiative, the "FACES" Campaign; participation in Carnival; airing of Radio Show "The Real Deal"; launch of a school competition and the Youth Festival for the WAD "Youth and AIDS IN the XXI Century…Move On!, an estimated 70,000 children, adolescents and adults were reached with messages of prevention and stigma and discrimination reduction during 2006 & 2007.

Through partnership with the HFLE unit of the Ministry of Education, 50 per cent of secondary schools have been reached with peer education on HIV. In the absence of a structured curriculum for Sexual and Reproductive Health(S&RH) in secondary schools, the TWC program provides a structured, in-school methodology for reaching adolescents and young people with messages on HIV and AIDS. It is estimated that an additional 33,000 adolescents and young people have been reached with information on HIV, VCT and stigma and discrimination through social mobilization and public outreach. The Together We Can Peer Education Program (TWC) benefits from sustained donor support through the Summit Foundation and UNICEF. Additional donor support for the program has been available through the MOE, the IFRC, UNFPA, Global Fund and the United States Ambassadors HIV Prevention Fund.

Through its Gender Awareness Safe School Program the Women's Department of the Ministry of Human Development was able to reach 1656 students county-wide with interactive sessions on topics such as Domestic Violence, Gender Sensitization, Sexual Harassment, Self-Esteem and HIV/AIDS. A total of 1656 students countrywide benefited from this program. Personal development sessions were also held throughout the districts and impacted both women and men. Countrywide a total of 1721 persons

participated in Gender Sensitization sessions; 2258 participated in HIV/AIDS/STI's sessions; 3216 participated in Gender-based Violence sessions and 3962 persons participated in other sessions on such topics as Self-esteem, Child Abuse and Sexual Harassment. This program is unique because it focuses on the link between gender issues and HIV/AIDS.

The next link is to ensure that these valuable interventions are resulting in the desirable changes in prevention, and that the impact is noted for future planning.

KNOWLEDGE AND BEHAVIOUR CHANGE

With PAHO's technical Assistance and the collaboration of the Ministry of Health and the Belize Family Life Association, a National Condom Distribution Plan was developed. This plan sets forth a systematic program for the distribution, monitoring and delivery of condoms to all partners involved in the National Response.

In order to strengthen the capacity of National AIDS Program to develop, implement and evaluate behavioral and communication interventions targeting priority vulnerable populations (e.g. Youth, PWHA, MSM, women and female sex workers), the Ministry of Health that has been involved in the development and dissemination of information and communication information, as part of promoting sexual health. Over the years, IEC activities geared toward behavioral change have been developed and implemented. Since 2005, three (3) national "Know Your Status" campaigns have been launched, running through out the year and culminating on December 1st, World AIDS Day, on the given year with a national day of testing. This campaign has received tremendous support from other partners engaged in the national response, especially the media. In addition, throughout the year, the National AIDS Program conducts public screening in selected districts or towns or national activities where there are large gatherings. Public screening is also set up at major national festivities such as the National Agriculture and trade show, National Expos Fair, etc.

Even though no significant data is available on the MSM and CSW population in Belize several non-governmental organizations working with the MSM population have joined the national response and have already embarked on important studies to acquire baseline data which will inform their work. The United Belize Advocacy Movement (UNIBAM) became a part of the National Response in 2006 focusing on the elimination of stigma and discrimination towards men who have sex with men. In addition to advocacy work, such as the development of the first ever documentary on the experience of MSM's in Belize, the organization has also focused greatly on behavior change activities among MSM's sub-groups country-wide. For example, through its education, support and BCC programs, UNIBAM was able to reach 565 persons in 2006 and 925 in 2007. The organization which was comprised of a volunteer cadre distributed 2268 condoms in 2006 among the MSM population and 1,100 condoms and 221 lubricants in 2007. In spite of the challenges experienced in a country that still stigmatizes and discriminates against MSM's through its antiquated legislations against sodomy and buggery, UNIBAM has succeeded in establishing itself and mobilizing support from key partners at the highest level of the national response. The organization's plan of action for the next two years includes organizational strengthening, advocacy and increasing access to services for MSM's.

In Belize, PASMO, the Pan American Social Marketing Organization, a subsidiary of Population Services International, a Non Profit Organization out of Washington aimed at providing access to full health services at lower costs, has been training commercial sex workers on how to decrease the risk of sexual activity for the past five years using interactive, behavioral change methodologies with set targets for each year. In 2007, PASMO determined that there are over three hundred full-time commercial sex workers in Belize for which they have two full-time sex educators who use a series of interaction exercises to meet with and education this demographic. Over the past four years, they have met with over 90% of the commercial sex worker population in Belize, many of them on a regular basis, to provide information on safe sex, sexual health and in addition to condoms and lubricants.

As a part Global Fund sponsored project, the Women's Department of the Ministry of Human Development has adopted an integrated approach to HIV/AIDS education and behavior change by incorporating activities that address women's access to information, their skills in sexual negotiations, peer counseling and access to S&RH services. Vulnerability reduction is being achieved through the improvement of an empowerment program which addresses the situation of adolescents and women. Having identified gender relations as key in the feminization of HIV/AIDS in Belize, emphasis is being placed on training programs such as sexual negotiation skills for women and training of women and young girls in HIV/AIDS Peer Counseling through the Women's Department of the Ministry of Human Development. Various initiatives have also been undertaken by NGO's such as WIN Belize, the Youth Enhancement Services along with the Women's Department showing the link between Gender-based violence and HIV, for which Belize is in the process of finalizing a study. The Woman's Department, through funding from the Global Fund Project conducted twenty (20) workshops countrywide Participants of the workshops were mainly women living in both urban and rural areas as well as the female inmates of the Belize Central Prison; a few men participated as well. There were a total of six hundred and seventy-six (676) participants in the sessions held throughout the country.[18]

The Ministry of Labor has also been actively involved in the response to HIV/AIDS in Belize especially in the area of education and behavior change in workplace. Through the International Labor Organization project, the National Workplace Policy on HIV/AIDS was formulated and formally launched in August 2006 and has since been implemented country-wide. In 2006 and 2007, this project managed to socialize the policy for ten (10) organizations through educational programs. These programs promoted condom usage and HIV and AIDS awareness for the productive sector. This also contributed to the overall distribution of condoms to these organizations for its employees. This focus on the workplace has been critical to progress accomplished in the response since 2005. With the identification of national funds, the Ministry of Labor has an established HIV Unit that continues the work started in the workplace by the ILO Project.

[18] Ministry of Human Development, Women's Department, Annual Report 2007

Table 2: Program Objective 1

Main program objective 1: Reduce the Risk of HIV infection				
	Key indicators	Baseline (if applicable)	Intended results/ targets	Actual results
1	Number of persons who receive counseling and HIV testing (including the provision of test results) at VCT sites	1	5000	6,142
2	Number of voluntary counseling and testing (VCT) sites established	1 (Belize City)	4	7
3	Number of health service delivers trained	90	780	132
4	Number of condoms distributed (through public health clinics, VCT centers, prisons, BFLA and Alliance Against AIDS centers)	122,000	675,000	334,128
5	Number of non-traditional condom outlets established	0	15	15
6	Number and percentage of pregnant women receiving VCT services , including pre and post counseling and the provision of test results at maternal and child health (MCH) clinics (denominator = number of pregnant women who attend MCH clinics)	1,754	6,200	6,584

Table 3: Program Objective 2

Main program objective 2: Reduce the Vulnerability to HIV infection of women and youth, especially girls				
	Key indicators	Baseline (if applicable)	Intended results/ targets	Actual results
1	Number of people trained to deliver youth education	1,000	840	1,483
2	Number of young people reached with HIV/AIDS education in school setting	1000	22,000	9,000
3	Number of out-of-school youths reached by peer education programs	540	720	180
4	Number of youth friendly spaces equipped to provide HIV/AIDS information, condom distribution and counseling for in and out-of-school youths	1	2	2
5	Number of women and adolescent girls including Commercial Sex Workers trained in negotiation skills	7	732	814
6	Number and Percentage of HIV-positive pregnant women receiving ARV prophylaxis therapy during pregnancy	70%	80%	65%
7	Number of commercial sex workers trained as peer educators	0	50	0

Belize Enterprise for Sustainable Development, Principal Recipient Global Fund Yearly Report 2006)

These tables outline the Global Fund project results for 2006 in the areas of prevention and behavior change with the objectives of accomplishing reduction of risk to HIV infection and reduction of vulnerability.

CARE AND TREATMENT

Efforts to scale up prevention, care, treatment and support started in 2004 as part of the WHO "3 x 5 Initiative" and continued into 2006 and 2007. As a result, the Ministry of Health with the support of CAREC, PAHO/WHO, and the Global AIDS Program of CDC, conducted an evaluation of the care and treatment program, which assessed priority HIV programs and detailed recommendations for the improvement of services to people with the infection. This Rapid Assessment of HIV Treatment, Care and Prevention Services were conducted in accordance with WHO standards for monitoring ARV treatment programs. The purpose was to assess treatment facilities and capacities (including infrastructure, procurement systems and storage); program strengths, program gaps and areas for expansion; and to make recommendations for improving the provision of comprehensive, integrated services for people living with HIV/AIDS

This assessment resulted in a national consultation and the identification of services to be integrated into the primary heath care system was proposed. This process has resulted in the national plan for the integration and decentralization of HIV/STIs/TB services into the health system and is part of the National Five Year Plan for HIV/STIs developed. This plan is aligned to the PAHO regional plan for HIV/STI, which was launched on World AIDS Day 2005 in Belize, and the National Strategic Plan. . If HIV services are not integrated and decentralized the hope of achieving universal access to prevention, care, treatment and support will be compromised.[19]

In order to reach its mandate of providing quality care to people living with or affected by HIV infection, the National AIDS Program of the Ministry of Health has undertaken specific steps to meet its goals and objectives, especially those related to international commitments such as the MDGs, UNGASS, and Universal Access to prevention, care, treatment and support, the National Strategic Plan 2006-2011 and the National Health Agenda 2007 - 2011. As a result there is a stronger link between the National AIDS Program and the community, especially NGOs to ensure that proper referrals of patients are done and that there is a "scale up" of care for people living with the infection outside the health care system. This is not to say that challenges in these areas don't exist. For example, access to ARV by PWHA in Belize continues to face some challenges where the MOH has now placed in its plan a full review of those patients that are on ARVs, those that are still alive after receiving ART and those that are still on ART. Other challenges include inadequate patient tracking systems and information management as well as lack of adequate standards and norms remain a problem.

In 2005, the PAHO/WHO report on 3x5 initiatives in the Americas outlined that Belize is providing treatment to approximately 30% of those needing medications. While the Ministry of Health is providing treatment to people living with the infection who meet medical criteria, support services for this population, as well as people tested positive for the virus that are not on treatment relatively weak and requires urgent attention. CD4 level testing has been available in Belize since 2002 and the number of persons with HIV and AIDS who have had a CD4 test performed, as per protocol, is 2,000. An additional CD4 machine was acquired in 2007. Currently there are 584 patients receiving free medications along

[19] Achieving Universal Access Report 2007 - Belize

with medical and laboratory services for the ongoing management of the infection. A major challenge is to conduct CD4 level tests on all the persons who have been reported as HIV positive since 1986 and also to increase the total number of persons accessing HIV test. A major constraint in the provision of care and treatment is the access to a viral load machine. The Ministry of Health has been actively involved in securing this machine, and currently is awaiting a donation from PANCAP / EU to support this effort. The acquisition of the viral load machine will further assist in determining HIV resistance in patients.

In Belize, tuberculosis is the most common opportunistic infection affecting Persons with HIV and AIDS. In 2006-2007 the total number of persons screened for Tuberculosis was 420 while 67 were screened for TB and HIV. Of these 10 cases of co-infection were detected. All persons were treated according to the TB/HIV co-infection protocols of the Ministry of Health. The management of both STIs and TB will therefore be included in HIV prevention, care and treatment. This initiative will help strengthen and streamline services within the health system, and by extension will ensure better organization of care and treatment services, allowing the ministry to respond more effectively to the national epidemic.

With PAHO/WHO technical support the MOH acquired and currently utilizes specific software for the management of supplies management. This allows for the distribution and tracking of ARVs and other medical supplies for HIV. MOH has been successful in the area of care and treatment by training pharmacists on the rational use of ARVs and medications for opportunistic infections and training of personnel from the Central Medical Stores on pricing, forecasting, storage, etc of ARVs. However, many of these pharmacists are still not involved in the dispensing of ARV's. This is a major weakness in the treatment program. With the technical and financial support from PAHO/WHO the Ministry of Health acquired an HIV patient tracking system to improve the quality provided to clients, as well as monitoring of HIV drug resistance. Approximately 16 laboratory technologists were trained in the detection of opportunistic infections.

There is a signed agreement with PAHO for the procurement of ARVs and other medications through the PAHO/WHO Strategic Fund. Utilization of the services which includes procurement of ARVs and OI's commenced in 2005 and continued through 2006 and 2007. With the support of PAHO/WHO and, Public health nurses and staff of the comprehensive clinic for STIs participated in a study tour in Jamaica to understudy the contact tracing program with an aim to replicate a similar program based on the Belizean reality. Through technical support from PAHO/WHO and CAREC developed a draft Partner Notification/Intervention Guidelines for HIV and other STIs.

The following table outlines the Global Fund project results for 2006 in the area of care and treatment change with the objectives of accomplishing alleviation of the impact of HIV infection.

Table 4: Program Objective 3

Main program objective 3: Alleviate the impact of HIV infection				
	Key indicators	Baseline (if applicable)	Intended results/ targets	Actual results
1	Number and percentage of patients diagnosed and treated for STIs according to norms	1,220	4,000	546
2	Number and percentage of PWHA diagnosed for opportunistic infections who receive treatment[2]	30	400	106
3	Number of people living with HIV (PWHA) receiving antiretroviral (ARV) combination therapy	100	500	406
4	Number of healthcare providers (doctors and nurses) trained in clinical management of HIV/AIDS	3 doctors, 6 nurses	10 doctors, 15 nurses	64
5	Number of people (PWHAs and their families) referred through the network	0	650	924

(Belize Enterprise for Sustainable Development, Principal Recipient Global Fund Yearly Report 2006)

SUPPORT

In 2006 and 2007, there was an increase in civil society involvement in the national response especially in expanded support of those persons living or affected by the epidemic. Alliance Against AIDS, established in 1997, is one of the leading NGOs offering support to PWAS and their families. AAA has increased its efforts in advocacy placing priority on programs seeking to eliminate stigma and discrimination and promoting human rights. Through a Prevention, Treatment and Advocacy Project with LACASSO, AAA has mobilized partners to develop a multisectoral Advocacy Plan which has included stigma and discrimination and advocacy public campaigns with the aim of reducing stigma and discrimination in the health care facilities and promoting education on sexual and reproductive health rights. The organization recently commemorated 10 years of providing service to persons infected and affected by HIV/AIDS by launching a Study on Stigma and Discrimination experienced by PWA's in accessing services. With support of AAA, the support group for individuals living with HIV/AIDS known as Positive Lives has continued to meet on a regular basis providing a safe space for all members to seek assistance, discuss issues and concerns. The group meets regularly providing peer to peer support and counseling. However, there is a need to strengthen this membership so that these persons can be more empowered to address their HIV status and cope with the challenges they face. There is a need to also promote leadership among this group so there is a more effective representation of this critical population in the national response.

Cornerstone Foundation has also been very instrumental in training individuals in home-based care and supporting orphans and vulnerable children affected or infected by HIV&AIDS. Created in 2005,

Cornerstone's focus is in empowering a community response for the protection of orphans and children made vulnerable by HIV or AIDS and ensuring their access to essential services. In collaboration with UNICEF 106 families and 206 children received direct emergency assistance for food, uniforms, books, school fees, sanitation supplies, vitamins, medicines, and other essentials through the efforts of Cornerstone Foundation National Network. Communication campaigns, ***"Caring for Children",*** were implemented in every district with posters, radio and TV ads produced and disseminated in five different languages. District Focal Points from the public and private sector, including Maya Alcaldes in Toledo District, were appointed and trained in the coordination of the network and the method of conducting a confidential assessment on the situation of children infected and affected by HIV/AIDS. The MOH also conducted education sessions with people living with HIV on issues of adherence to ARVs and nutrition. In collaboration with Hand in Hand Ministries conducted sessions for parents an guardians of children living with HIV on topics such as adherences, nutrition, etc. [20] Hand in Hand Ministry is a faith based NGO offering support to children living with HIV&AIDS with emphasis on educational development and parenting support.

UNICEF has actively collaborated with a number of community-based organizations to increased care and support for children infected and affected by HIV and AIDS during the past 2 year. Five hundred children infected and affected by HIV and AIDS received improved care and support through UNICEF's support to three CBOs in 2007; 100 per cent of known OVC (118) in Belize District, the district with the highest incidence of HIV infection , received direct assistance with food, medication, books, uniforms, hygiene and sanitation supplies and other essential items through Hand in Hand Ministries, 300 children nationally are benefiting from direct support through the Caring for Children Network and 75 children in Stann Creek District – the district with the second highest incidence of HIV infection – are benefiting from participation in a School First Remedial Program which includes homework help, life skills and an evening meal in a safe and protective environment. This sustained advocacy along with public education and awareness on OVC through the Caring for Children Campaign has reached 75,000 persons creating greater awareness and public commitment by national authorities. This has significantly impacted on the national response to OVC, which has been managed almost exclusively by CBOs. A commitment from government will ensure a sustained and structured national response.[21]

The Council of Churches has increased its involvement in the national response during 2006-2007. Fifty-five (55) individuals from six faith-based groups and three cultures were trained on pastoral counseling for HIV/AIDS. The trainings utilized a "Manual for a Faith-Based Response to HIV/AIDS" which was produced, published and disseminated by the Committee for the Faith-Based Response to HIV/AIDS (COMFORTH), with the support of UNICEF. The Committee created in 2004, under the auspices of the Belize Council of Churches and with the support from UNICEF has conducted training with the aim of extending care to HIV affected families in 5 Districts. In partnership with the BAHA'I Virtues Training Project, 20 Christian youths were also trained on "Virtues" as a part of COMFORTH's focus on the development of skills for youths to deal with PLWHA.

[20] National AIDS Program Accomplishments Report for 2007
[21] UNICEF 2007 Annual Report

Best Practices

Belize's approach to HIV/AIDS has been described as innovative and unique in the Central American and Caribbean Region. Unlike other CCM's that are under the Ministry of Health in other countries, the National AIDS Commission in Belize has been under the leadership of the Ministry of Human Development since its establishment in 2000. This approach has proven effective in addressing HIV/AIDS as more than just a health issue but as a multidimensional, human development one. This strategy has also been effective in fostering a strong multisectoral collaboration that has successful mobilized key sectors to become involved as well as proved effective in the elaboration of, subsequent approval of and implementation of the country's 5 year Multisectoral Project supported by the Global Fund.

Decentralization through the establishment of 6 district level commissions serves to heighten awareness and improve capacity and coordination of efforts at the local level and national levels. Acting as mini NAC's these multisectoral community based organizations are grass-root and comprised of volunteers representing key sectors of the community such as health, education, youth, business, churches among others. Each community-based group is distinct from the other as its focus, composition and priorities are determined by the specific cultural and geographical settings. All 6 CBRC's are in the process of developing or revising their plan of actions in alignment with the National Strategic Plan.

In 2007 the PMTCT Program of the Ministry of Health in Belize was highlighted as a best practice in Cuba. The program which was developed through a technical cooperation between Belize and the Bahamas resulted in the integration of HIV services into the Maternal and Child Health Clinics. Several clinicians, nurses and counselors participated in capacity-building and exchange site visits. This project was made possible through the support of the Pan American Health Organization in Belize.

Major challenges and remedial actions

In 2005 the following were identified as key challenges and this is the progress that has been evidenced during 2006 and 2007.

Human Resource Capacity:

The key challenge faced in Belize as presented in the 2005 was limited human resources in support of HIV&AIDS services and programs. In 2006 and 2007 with the support of the Global Fund and national funds this situation has been alleviated but still lack of human resource continues to be a challenge especially for governmental agencies which do not have HIV/AIDS budgets. The National AIDS program now has a full-time Director as well as a Programs Officer. It has secured funds to contract a full-time M&E Officer. This increase in human resources within the NAP strengthens its capacity to implement programs in prevention, care and treatment. Through the support of the Global Fund the National AIDS Commission was also able to contract a full-time M&E Officer.

Services:

In 2005 it was reported that care and treatment were highly centralized primarily in the Belize and Dangriga Districts making access for persons living in other parts of the country more challenging. By 2007 the Ministry of Health has successful decentralized VCT services by establishing 7 sites regionally. In addition, the Belize Family Life Association NGO was supported by MOH to establish VCT sites within 3 of its branch centers at district level in Belize District, Cayo and Toledo; provision of counseling, testing and ARV's have now been decentralized as a result. As a result of the reorganization of the delivery of services clients are now being provided with comprehensive health services at the primary care level. These services not only include HIV/AIDS but also STIs and TB prevention, treatment and care with an aim to provide universal access. It is hoped that by effectively implementing this model of care, the approach will enable the Ministry to achieve the targets for 2010 endorsed at the UN General Assembly in September 2005, the MDGs targets for HIV. In order to effectively plan for the integration and further decentralization of HIV/STIs/TB and services, the Ministry of Health in collaboration with PAHO and CAREC have developed a six-month plan which outlines immediate actions for comprehensive and integrated HIV/AIDS/STI/TB services into the existing primary health care system. It is anticipated that a phased approach will be utilized, after careful monitoring and evaluation of experiences at pilot sites, including different levels of care. The integration plan will address national outputs outlined in the National Strategic Plan and other international commitments. Referral systems have been introduced both by the Ministry of Health and the Alliance Against AIDS NGO. There is still need for these referral systems to be integrated into a comprehensive system of support for persons with HIV/AIDS and their families. Even though several CBO's have been building capacity in the area of home based care and support there is still a need to expand on other social services such as nutrition programs in support of adherence and home base care for terminal patients. The Living with Hope Foundation was instrumental in raising funds to provide "seed money" to persons living with HIV to establish income generating projects but more effective and sustained income generating programs need to be established. CBO's such as Hand in Hand Ministries have been providing for the needs of children and orphans infected and affected by HIV/AIDS through provision of school education, nutrition, referrals for treatment and training for parents and caregivers. The Department of Human Services is yet to put in place a comprehensive system of support for PWHA's and OVC's.

Surveillance:

In 2005 it was reported that there was a need to support the surveillance unit to expand its service to include second and third generation surveillance. This more comprehensive form of surveillance would encompass the behavioral data and quality of service provision information that will guide the overall national response. The MOH has dedicated significant efforts in re-structuring of the HIV Surveillance System in Belize. At the beginning of 2007, the format for the surveillance report changed, ensuring that key indicators which the country needs to monitor the HIV epidemic are included (the requirements of GF and other donors were also included). There has also been a standardization of the reporting format for VCT centers and sites. In February 2007, a team from the Dominican Republic assisted with the install and training of information technologists and health personnel in the use of a patient tracking system. The NHISU of the MOH has continued to prepare and disseminate quarterly and annual HIV

reports to the key stakeholders. In the area of research in 2006 studies were conducted on behavioral study among young people and behavioral and sero-prevalance study among MSM and CSW. Both reports are being finalized. Also, it is anticipated that the second generation surveillance will help to guide future planning for HIV as well as the ongoing monitoring of the national HIV response. By establishing a comprehensive M&E system, it is expected that surveillance which would be one of the key components of this system would be strengthened. Several NGO's have embarked on research initiatives focusing on most at risk groups. It is hoped that these will produce baseline and other key data needed to inform the national response and fulfill requirements with international commitments.

Involvement of PLWA in the national Response

The continuous and active engagement of persons living with HIV&AIDS in the national response was presented as a major challenge for Belize in 2005. In spite of efforts made by NGO's, CBO's and other agencies to involve PWHA's, this remains as much a challenge as in 2005. Even though the National AIDS Commission makes provisions for the membership of a PWHA's on the NAC, no one person has been able to assume this position in a permanent manner. There are still many factors that limit their involvement such as the fear of stigma and discrimination, and capacity. The supportive environment for persons who choose to disclose their status is lacking and therefore, very few individuals have taken that step forward. Organizations such as the Alliance Against AIDS and UNIBAM have been actively involved in advocacy work to eliminate stigma and discrimination but it is important to note that in some instances, PLWA face other social issues that affect their personal lives such as substance abuse and depression. These specialized services are very weak in Belize often affecting the ability for those persons to effectively participate in the response.

Coordination of the National Response:

In 2005 coordination of the national response was included as one of the challenges faced by Belize in its response to HIV/AIDS. This situation continues to be a challenge. Even though the NAC has been successful in completed its National Strategic Plan for 2006 – 2011, an operational plan which will guide the implementation of this plan is yet to be developed. Due to a lack of clearly defined roles and responsibilities within the national response, agencies are operating in an isolated manner in most of the cases. Participation within the NAC is sometimes seen as merely a formality to others. In terms of coordination, there is a need for NAC members and other development partners to work closer to ensure clearer lines of communication, collaboration and coordination. The NAC should act as the clearinghouse of information that should guide the national response. The NAC has tried to work more closely with the UN Theme Group to ensure more joint consultative planning efforts in order to more effectively maximize the use of their valuable technical and program support. This is in keeping with the UNAIDS "three ones" principle in support of one National Coordinating body, one Monitoring and Evaluation System and One Strategic Plan.

The integrated, multisectoral and decentralized approach requires strengthening the country's capacity to effectively coordinate, facilitate and monitor and evaluate activities. There is still need to increase the capacity of the NAC to mobilize resources both nationally and internally and to establish strong linkages

with regional and international initiatives. Also, to build its capacity to continue to develop necessary legislation and advocate for the enforcement of the National HIV Policy as well as to increase its capacity to complete and coordinate the new National Strategic Plan.

Challenges:

Challenges reported in 2005 continue to exist in 2007 even though partners have made significant strides in addressing these challenges. One other challenge that has been identified during 2006 and 2007 is the lack of a comprehensive M&E System. Even though this has been a part of the NSP and placed as top priority within the national response this system is still not in place. The M&E Committee of the NAC has had an opportunity to be familiarized in the use of the Country Response Information System (CRIS) and it is planned that this system will be customized to include other national indicators in addition to those of UNGASS. Another challenge during 2006 and 2007 has been the lack of resources to provide adequate support to the country's 6 community-based groups which act as branches of the NAC. These entities have remained operational based on minimal financial and technical support from the NAC and this has resulted in limited results in their implementation of activities at the community level. With the support of the Social Investment Fund (SIF) the NAC has just recently received support for its community-based groups and has started a process of providing capacity-building training in the areas of strategic planning and resource mobilization. These groups need financial support to establish centers and hire at least one full-time coordinator to ensure continuity of an effective coordination response at the districts level. There is also need for sustained national financing of the HIV/AIDS response in Belize. Too much reliance on external donors will result in lack of sustainability of critical programs and services which are now in place as a result of projects such as the Global Fund.

Challenges in Achieving Universal Access

The Universal Access Report 2007 prepared by PAHO/WHO and the Ministry of Health describe the following challenges in achieving universal access in care and treatment: ART is provided in only 7% of the health facilities; small proportion of doctors to patients; unable to determine the number of patients who are still on treatment 12 months later; information on medication given to patients are not easily available; only 7% of clinics are offering PEP services and only 29% of testing and counselling is received

Challenges in the prevention of mother to child include: access to ante-natal services in 1st trimester remains low – just over 20% (MOH, 2006); increase in number of HIV positive infants born to HIV positive mothers (at least 9% of all new infections in 2007) ; monitoring and Follow up care before and after delivery; and, testing for fathers.[22] Challenges in pediatric treatment include lack of data on the number of HIV positive children to inform planning and procurement. Critical gaps exist in follow up care after delivery (monitoring, clinical support, support to families with adherence issues etc.) The cost and procurement of pediatric treatment – especially 2nd line ARV medication continues to be a challenge.

[22] Towards Universal Access 2007 " What Does this Mean for Belize's Children and Adolescents Presentation, UNICEF

Another challenge is the lack of data on OVC's and the lack of a comprehensive package of essential services for those most in need which includes health care, education, social welfare and social protection is still lacking.

The major obstacles to achieving universal access to prevention, care and treatment and the recommendations to address these issues are outlined in the table below. These recommendations are drawn from the Country Consultation on Scaling up Universal Access as well as from the Rapid Assessment on HIV Treatment, Care and Prevention Services spearheaded by the Ministry of Health.

	Obstacles	Recommended Actions
Advocacy, Public Policy and Legal Framework	• The level of commitment by the Government of Belize is insufficient. • The cultural diversity of Belize affects advocacy efforts (advocacy efforts need to be culturally sensitive). • Human resources in support of advocacy and the development of policies and supporting legal frameworks are insufficient.	• Facilitate increased involvement of the relevant Government Ministries (health, education, tourism, human development, etc.) at the highest level (CEOs) • Facilitate more involvement in the decision making process at the Cabinet level of the government • Increase involvement and input from economists in policy development • Develop an advocacy plan that addresses cultural diversity • Develop policies related to the voluntary HIV counseling and testing of youth below the age of consent* • Develop policies related to HIV partner notification* • Develop Anti-discrimination policies and legislation to prevent stigma and discrimination in the health care setting and the wider community*
Strategic Planning, alignment and harmonization	• Planning among implementing partners and stakeholders is not harmonized and coordinated • Clear understanding of the national HIV/AIDS priorities (harmonization, prevention, and mitigation) is lacking among implementing partners and stakeholders.	• Sectoral plans, action plans and individual agency work plans need to be aligned with the National Strategic Plan. • Establish and make functional one national M&E system providing relevant periodic reports to all partners. • Establish a system for greater transparency with HIV/AIDS budgets and spending, in particular from the NAC • Establish national reporting on HIV/AIDS health account that will reflect spending in both public and private sectors • Perform periodic costing analyses of program and services to guide planning
Sustainable Financing	• No national HIV/AIDS budget exists outside the Ministry of Health and the NAC, and some limited support	• Establish financial and resource commitment by the Government of Belize through a national HIV/AIDS

	to NGOs • Too much reliance on international donor aid.	budget, particularly for those areas that require long-term commitment • Access to reduced cost antiretrovirals
Human Resources	• There is no sustainable Human Resource Management plan. • No Succession Plan exists for key provider positions • Epidemiological, data processing and analysis expertise is lacking among existing personnel • Training is lacking among personnel involved in the community-based • No system for monitoring human resources exists	• Conduct a training needs assessment for the various categories of health care personnel, PLWHA and NGO personnel to identify training needs* • Develop a training plan and guidelines defining function, duties and relationships of persons in the health sector with direct responsibility for HIV and AIDS * • Long term training needs should also be identified (e.g. training of specialist in infectious diseases and laboratory methods, and continuing medical training for physicians)* • Develop programs and provide more professional training in counseling (degree or certificate programs at university level) • Establish training guidelines and follow-up for counselors • Develop a more comprehensive Human Resource Plan. • Build capacity in PLWHAs as counselors, patient advocates, adherence buddies and in outreach. Capacity building should include attendance at regional and international meetings* • New positions to provide dedicated full-time staff are required*
Organization and Systems	• A national coordinating body exists and is functional, but participation at district level is lacking • M&E needs to be part of core budget • Funding is fragmented between the government and international donor agencies	• Establish a central financial disbursement system for better coordination of funding • Establish a functional M&E unit • Identify and equip spaces on the medical compounds in the districts for use by the District committees
Infrastructure	• Health facilities (both public and private) are not adequately distributed country-wide • Lab services are too centralized • The infrastructure to ensure confidentiality of HIV services is insufficient	• Decentralize service and integrate services with primary care facilities for better distribution of service delivery points • Establish system for sanctioning breaches of confidentiality (at all levels) • Share findings of country consultation

		with key decision makers • Decentralize lab services • Establish and enforce functional regulatory bodies for both private and public providers to ensure quality of services • Establish a team to conduct on-going needs assessments, develop operational work plans, gather data and information for planning, perform monitoring and evaluation, and conduct quality of care assessments* • Establish a mechanism for updating guidelines and protocols on an annual or biannual basis, to include a system for obtaining user feed back* • An efficient procurement and distribution system must be maintained* • Pharmacists must be included to contribute to the maintenance of the inventory systems* • Access to a referral laboratory is desirable, for CD4 counts and viral load estimations*
Partnerships	• Civil society involvement and networking among implementing agencies is lacking. • Better monitoring of the national response is needed. • Horizontal planning among partners and stakeholders is lacking	• More involvement of civil society organizations as "partners" is required from the initial stages • Better networking and horizontal planning among implementing agencies is required • Establish the M&E system for more effective monitoring of the national response and reporting to partners

* A Rapid Assessment of HIV Care, Treatment and Prevention in Belize, Ministry of Health, 2005

The National AIDS Commission and its partners in Belize have succeeded in accomplishing major strides in addressing challenges reported in 2005. In spite of this progress there is still need for further efforts to be vested in not only addressing these issues but eliminating them as challenges all together. With the genuine collaboration of partners and the sustained financial support from government and other international partners these challenges should be minimal if not completed non-existent in the next report.

Support from the Country's Development Partners

The UN Theme Group in Belize is presently comprised of 3 key development partners namely; UNICEF, PAHO/WHO, and UNFPA. In accordance with its function of providing support to the national response in Belize the UN Theme Group implements key activities within the UN Development Assistance Framework (UNDAF) for 2007 - 2011. Program 2 of UNDAF is directly related to the following MDGs: Goal 6 / Target 7 (Halt HIV/AIDS): Support to HIV/AIDS IEC and Social Mobilization programs that will contribute to a change in behavioral patterns and reduced HIV infection rates; Goal 8 / Target 16 (Productive Work for Youth): Adolescent Development and Participation aimed to enable adolescents to develop towards being productive citizens.

In 2006 – 2007 UNICEF chaired the UN Theme Group on HIV/AIDS which continued to coordinate and monitor agencies support to the national response. In 2006 the UN Theme Group provided technical support to enhance implementation of the Global Fund project among sub-recipients. In February 2006, the UN Theme Group conducted a Rapid Assessment of the seven sub-recipients working on Belize's Multi-Sectoral Response to HIV and AIDS funded by the Global Fund. This assessment led to the formation of an Oversight Committee in March 2006, which was charged, through the CCM, with overseeing the performance and targets achieved by the project.

UNICEF's Enabling Environments for Adolescent project in 2007 aimed to promote opportunities for adolescent development and participation in matters affecting their well-being, especially in the areas of adolescent health & HIV/AIDS. It sought to promote participation and positive attitudes among adolescents and adults on healthy lifestyles, improved life-skills with special focus on girls, HIV/AIDS prevention, protection from sexual abuse and exploitation and implementation of policies and legislation. In 2006-2007 UNICEF focused on "protection" as the central axis to links all its projects and sub-projects concentrating actions around HIV/AIDS incorporating the themes of OVCs, violence, protection, adolescent development, participation, and social investment. Generally, these interventions have created greater community awareness and support on the - impact of HIV and AIDS, especially on children and their families, the need for community-led actions, and empowered community actors through capacity building efforts with special focus on girls, and young people.

UNFPA's focus has been in the area of data information systems, policy development, monitoring and evaluation and human rights. UNFPA's mandate includes SRH, Gender and Population, HIV/AIDS being integrated into all three. In all cases UNFPA's focus on prevention has been through policy and planning, advocacy, education and capacity building. Under SRH the focus is on expanding and improving the quality of services and ensuring that these services are delivered in a human right, gender and culturally sensitive manner. We emphasize the vulnerable populations which the other UN Agencies do not work with closely such as out-school-youth. n the areas of Gender UNFPA has worked closely with the Women's Department and NGOs that work on Gender Issues with a focus on HIV and Gender Based Violence.

In 2006 and 2007 PAHO provided support to the Ministry of Health's component of the Global Fund. The PAHO/WHO Biennium for 2006-2007 outlined 2 specific indicators in building national capacity in the management and prevention of HIV/AIDS/STI/TB strengthening. Namely, to **s**upport the scaling up of

services so that 80% of persons with HIV/AIDS who require treatment are managed according to established protocols by December 2006 and Implementation of norms and protocols for clinical management of STIs supported throughout the country during the biennium. The Ministry of Health continued to maintain a collaborative partnership in 2006 and 2007 with the Pan American Health Organization/World Health Organization (PAHO/WHO).

Monitoring and evaluation environment

In an era of results- based management, the need to demonstrate the effectiveness of programs in addressing a critical problem is imperative for continuous support and funding of such initiatives. The NAC is mandated to monitor the overall national response.

While significant progress has been made in Belize to monitor and evaluate specific projects, such efforts continue to be done in a vertical, isolated fashion. Valuable information that guides planning at the national level is being lost because there is no coherent National M&E System in place to capture this critical data and report on overall findings at the national level.[23] M&E systems require significant resource investments in order to bring them to fruition. Most of the implementing agencies report having little resources available to make significant investments in M&E systems. The National Strategic Plan requires that at least 10% of the total funds mobilized for national programs are utilized for this purpose. In addition to the initial capital investment required to set up the national M&E system, a costing exercise needs to be conducted to determine the budget necessary to operationalize the M&E plan. Critical components that require support include overall system, surveillance, research, financial management, project implementation, referral and client management tracking systems.

The preliminary monitoring framework for the M&E plan has been completed as a part of the Strategic Planning process. It constitutes the basis for development of a detailed M&E plan for measuring progress in implementation of the strategic plan 2006-2011 and in output, outcome and impact target achievements. The M&E plan needs to be developed to further clarify indicators and baseline established for each. These indicators will enable the country to answer reporting requirements of international donors as established under the UNGASS Declaration and Global Fund, as well as to address selected national needs to guide the response to HIV/AIDS in Belize.

The NAC Secretariat has formalized an M&E subcommittee of the NAC that has cross representation from the key sectors involved in data gathering and surveillance. The intention is to establish within the NAC an M&E Unit that will formalize the data gathering process and reporting in accordance to both national needs and international donor reporting commitments. The Global Fund has supported the hiring of a full time Monitoring and Evaluation Officer to guide the establishment of the one National M&E system and will now seek to strengthen this function. Currently the M&E subcommittee is in the process of finalizing the M&E Plan and capacity-building in the use of the Country Response Information System which will be customized to respond to the M&E needs of the country.

[23] Strategic Plan for a Multisectoral National Response to HIV/AIDS in Belize 2006-2011

Through this analysis it has become evident, that significant efforts will need to be made on gathering the critical baseline data that will then inform the level of impact measured over time. This lack of data impeded the ability of the NAC to effectively respond to the UNGASS and MDGs indicators within this report. Significant resources will need to be mobilized in support of such baseline and subsequent studies if Belize is to effectively monitor its response.

ANNEXES

Annex 1: Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

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

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

2) With inputs from Ministries:

Education	Yes	No
Health	Yes	No
Labor	Yes	No
Foreign Affairs	Yes	No
Others	Yes	No
(Please specify)		
Civil society organizations	Yes	No
People living with HIV	Yes	No
Private sector	Yes	No
United Nations organizations	Yes	No
Bi-laterals	Yes	No
International NGOs	Yes	No
Others	Yes	No
(Please specify)		

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

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

Name / title: **Martha Carrillo, Consultant** Date: **January 31st, 2008**

Signature:

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