
National composite policy index – 2006

Country: Belize

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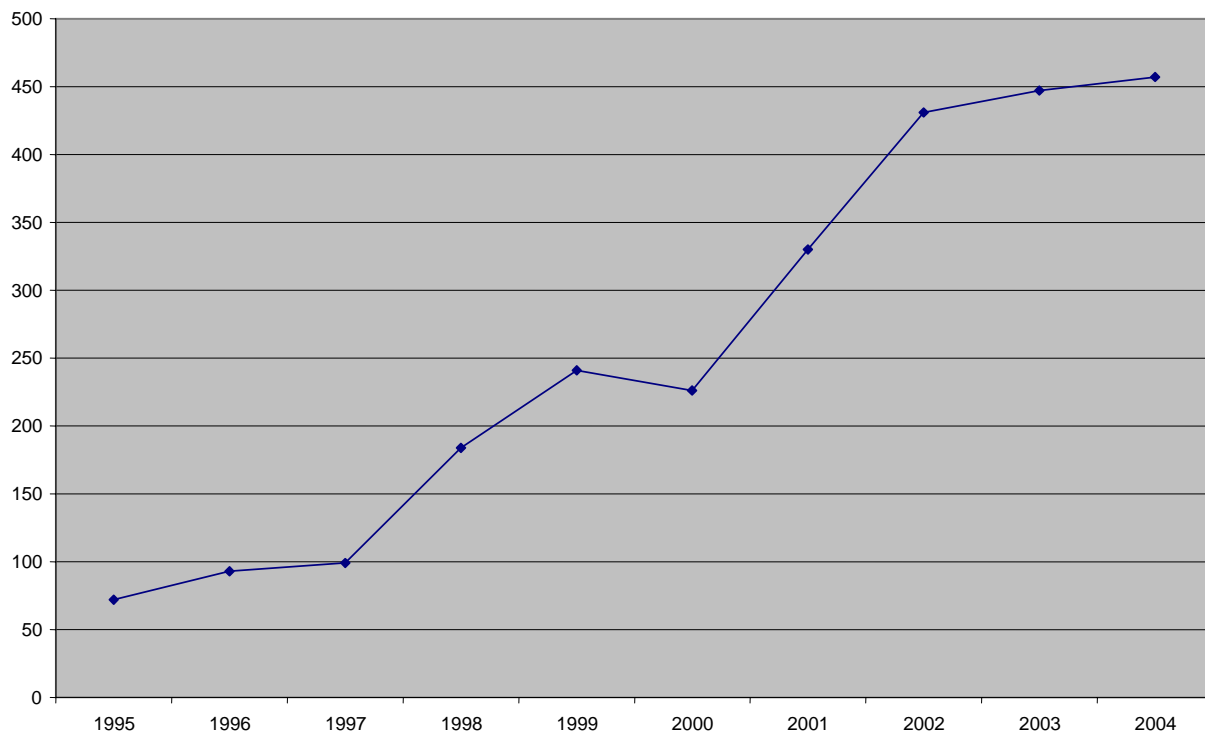
ANNEX 1: Consultation/preparation process for the national report on monitoring the follow-up to the *Declaration of Commitment on HIV/AIDS*

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I. Status at a glance

The first case of HIV was diagnosed in Belize in 1986. Since then there has been a steady and significant increase in the annual number of new reported HIV infections. This trend continued through the January, 2003 to December, 2005 reporting period, however data from this period indicate a slight reduction in the rate of increase during that time (*Fig 1.*)¹ In comparison to earlier estimates of 2.1% at the end of 2001, the most recent figures by UNAIDS estimate the adult prevalence of HIV in Belize at the end of 2003 to be 2.4%,². Belize is now the country with the highest adult HIV prevalence in Central America, and the third highest in the Caribbean, the second most affected region in the world.

Fig1. Number of HIV Infections Reported by the Central Medical Laboratory, 1995-2004



The primary reported mode of transmission in Belize is heterosexual, although available data suggest the possibility of a concentrated epidemic among Belize's MSM population in particular among those in the prison population. Data from the Ministry of Health Voluntary Counseling and Testing (VCT) program indicate transactional sex and having more than one sexual partner in the past 5 years as major risk factors promoting HIV transmission in Belize. Although information on the gender of sexual partners of VCT Center attendees was not collected, the ratio of HIV positive men to HIV positive women confirm a primarily heterosexual epidemic.

A multi-sectoral National Strategic Plan (NSP) to address HIV/AIDS in Belize has been developed by the National AIDS Commission and is scheduled for finalization by December, 2005. The NSP provides a framework for scaling up Belize's multi-sectoral national response, which includes VCT, condom promotion and distribution, STI prevention and treatment, prevention of mother-to-child transmission,

¹ National Health Information Surveillance Unit, Ministry of Health

² UNAIDS, Belize: Epidemiologic Fact Sheets On HIV/AIDS and Sexually Transmitted Infections, 2003

treatment and care, and PLWHA involvement. The NSP incorporates the health, education, labour and tourism sectors, and targets women, youth, and other vulnerable populations (e.g. MSM, CSW, mobile populations, uniformed services).

There has been some improvement in the political support given to the HIV/AIDS response. The National AIDS Commission (NAC), created in February 2000, was incorporated as a statutory body in 2004 when then National AIDS Commission ACT was passed and has been placed under the office of the Prime Minister. The ACT established the NAC as the body charged with inter-sectoral coordination of the implementation of a national strategic plan to address HIV/AIDS, adopting appropriate HIV& AIDS policies and legislation, mobilization of resources, advocacy and monitoring and evaluation. After a nation wide consultative process, both the National Policy on HIV/AIDS and Workplace Policy have also been passed by the government of Belize in 2005. Such policies will lead to the development of the legal framework in support of the same.

Prevention efforts in Belize include expansion of existing services such as improved STI diagnosis and treatment services, Voluntary Counseling and Testing program and increased access to antiretroviral therapy implemented by the Ministry of Health. In addition the MOH will expand its coverage of treatment of opportunistic infections, and will continue providing the necessary CD4 and viral load to monitor effectiveness of treatment free of cost. Fear of stigma and discrimination however, continues to be the main deterrent to accessing such services. As a result advocacy efforts will increase working with the media to promote accurate HIV and AIDS reporting, the “know your status campaign and universal access to antiretroviral therapy for individuals who meet the criteria for initiation of ARV treatment. A manual and guidelines for nutritional care has been developed. The challenge remains in establishing the nutritional programs to support those persons who need this service. This issue remains the main concern in terms of adherence to treatment.

The School Health and Physical Education Service (SHAPES) of the Ministry of Education continues to be operational, incorporating HIV&AIDS education into the curriculum at the primary and secondary school levels. A Draft Health and Family Education Policy is being finalized and should be adopted in 2006. The Ministry of Education also continues to annually provide training in HIV&AIDS education for teachers. However, there is still significant room for improvement, particularly in the area of home-based care, community-based care, nutrition and psychosocial support.

A national Monitoring and Evaluation (M&E) Sub-committee has been established under the NAC and a national M&E Unit and plan are currently being developed. When completed, the plan will include a data collection and analysis strategy, a well defined standardized set of indicators, guidelines on tools for data collection, and a strategy for data dissemination and use, as well as a budget for M&E implementation. Quarterly and annual HIV/AIDS reports are published regularly by the Ministry of Health National Health Information Surveillance Unit for the dissemination of information on the current status of the epidemic. However, there is a need to now expand this information base to include third generation surveillance. Overall, the focus of the response will extend to increasing access to critical services and strengthening support services to include long- term counseling, home base care and impact reduction programs.

Table 1. UNGASS Indicators and Indicator Scores, 2003-2005

Indicator	Indicator Description	Indicator Score (2003-2005)
GE Indicator 3	Percentage of schools with teachers who have been trained in life-skills-based HIV education and who taught it during the last academic year	N/A
GE Indicator 4	Percentage of large enterprises/companies which have HIV/AIDS workplace policies and programmes	N/A
GE Indicator 5	Percentage of women and men with sexually transmitted infections at health care facilities who are appropriately diagnosed, treated and counseled	N/A
GE Indicator 6	Percentage of HIV-positive pregnant women receiving a full course of anti-retroviral prophylaxis to reduce the risk of mother-to-child transmission	73.3%
GE Indicator 7	Percentage of women and men with advance HIV infection receiving antiretroviral combination therapy	N/A
GE Indicator 8	Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	N/A
GE Indicator 9	Percentage of transfused blood units screened for HIV	N/A
GE Indicator 10	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who rejected major misconceptions about HIV transmission	N/A
GE Indicator 11	Percentage of young women and men who have had sex before the age of 15	N/A
GE Indicator 12	Percentage of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	N/A
GE Indicator 13	Percentage of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner	N/A
GE Indicator 14	Ratio of current school attendance among orphans to that among non-orphans, aged 10-14	N/A
GE Indicator 15	Percentage of young women and men aged 15-24 who are HIV infected	3.4%
GE Indicator 16	Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy	N/A
GE Indicator 17	Percentage of infants born to HIV infected mothers who are infected	16.1%

*N/A=Data is currently not available to report the indicator as required. Where possible, the currently available data is reported in *Section II: Overview of the AIDS Epidemic*.

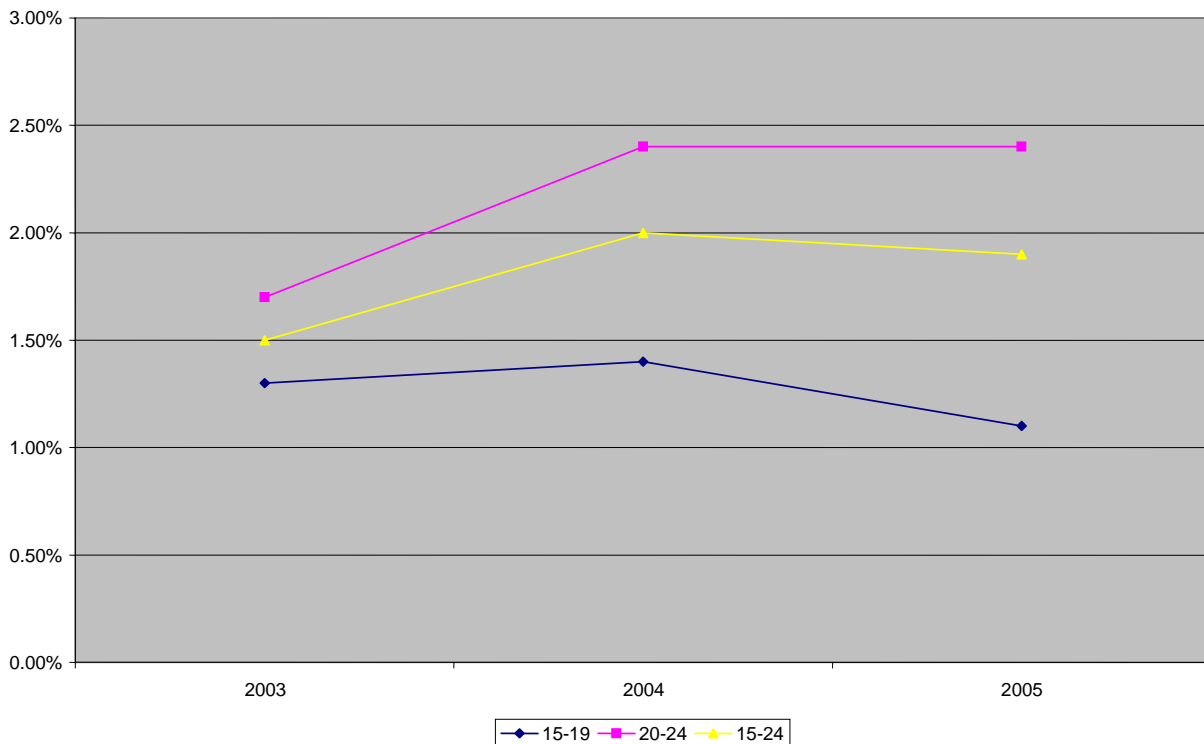
II. Overview of the AIDS epidemic

UNAIDS reported the adult prevalence of HIV to be 2.4% at the end of 2005, while the estimated adult prevalence at the end of 2001 was 2.1%. Data from the Central Medical Laboratory indicated the prevalence of HIV among those tested in Belize during the reporting period was 3.4%, ranging from 3.2% in 2003 - 4.5% at the end of June, 2005. These numbers show very little change in the prevalence of HIV in the total population of Belize compared to the previous three years (2000-2002), when the prevalence was 3.6% and ranged from 3.4% to 4.0% per year. The prevalence of HIV among youth 15-24 years of age who underwent testing increased from 1.5% in 2003 to 2.0% at the end of June, 2005. Within the 15-

24 year age group, the prevalence increased from 1.7% in 2003 to 2.4% at the end of June, 2005 among those 20-24 years of age. While among those 15-19 years of age the prevalence showed a slight increase from 1.3% to 1.4% from 2003 to 2004, but has decreased slightly in the first half of 2005 to 1.1%. (See Fig 2.)³

Changes in HIV prevalence in younger age groups are a good proxy indicator of recent trends in HIV incidence and risk behaviours due to the fact the changes in incidence that are due to behaviour change tend to be more detectable in the younger population. However, the slight decrease in prevalence in the 15-19 age group in the first half of 2005 should be interpreted with some caution until complete data for that year, and other complimentary behavioral surveillance data become available. In addition, these data on HIV prevalence exclude persons tested at private facilities, and are not based on a randomly selected sample. Thus the generalizability of these data may be limited.

HIV Prevalence Among Youth (15-24) Tested, 2003-2005



In terms of sex, the male to female ratio of new HIV infections has been gradually approaching an equal number of males and females, implying a feminization of the epidemic. In 1996, the male to female ratio was 2:1. For the period January, 2003 to December, 2005, the cumulative male to female ratio was 1.1:1.⁴ However, it is important to note that the existence of the Prevention of Mother to Child Transmission (PMTCT) Program, which specifically provides HIV testing for women, has likely contributed to increased case reporting from this population in more recent years.

³ National Health Information Surveillance Unit, Ministry of Health

⁴ National Health Information Surveillance Unit, Ministry of Health

In the period September, 2003 to September, 2005, 300 persons (166 men and 134 women) started antiretroviral therapy country-wide.⁵ As yet, the available information on persons infected with HIV exists in individual patient files and is not compiled in a manner that allows estimation of how many persons who need antiretroviral treatment are actually receiving treatment.

There were a total 186 cases of AIDS developing in 2003 to June, 2005, and there were 196 AIDS related deaths in that time period. The Belize district showed the highest number of AIDS cases developing (62.4%), as well as the highest number of AIDS related deaths (69.4%).⁶ AIDS related mortality rose from the 4th leading cause of death in Belize in 2003 to 3rd in 2004. The age group 15-49 years, which represents both the productive and reproductive population is the age group most affected. Within that age group, death related to AIDS ranked 3rd in those 20-29 years and was the leading cause of death due to preventable illness in that age group in both 2003 and 2004. In addition, AIDS also ranked as the 1st leading cause of death in those 30-39 and 40-49 respectively for both years.⁷ As yet, data on the survival of persons on antiretroviral therapy at 12 months after initiation of treatment is again available in individual patient files, but is not compiled in a form that facilitates the calculation of this estimation. However, in the period September, 2003 to September, 2005, 24 individuals receiving treatment died, 14 males and 10 females. However, as of September, 2005, the total number of deaths among individuals receiving treatment decreased from 15 in 2004 to 8.⁸

Currently there are no programs that specifically target children orphaned and made vulnerable due to HIV/AIDS. However, there are programs that target all orphaned and vulnerable children in Belize regardless of the reason for their status as an OVC. Thus HIV-related OVCs are targeted as a subset of orphaned and vulnerable children in Belize. Due to concerns about stigma and discrimination, no data on HIV status is collected in relation to OVCs in Belize, so data on the proportion currently being served is as yet unavailable.⁹ The Cornerstone Foundation, based in San Ignacio in the Cayo district, is in the process of establishing a program to provide case by case support to persons affected by HIV/AIDS, which is expected to generate some statistics on HIV-related OVCs.¹⁰

Teachers are trained every year in HIV&AIDS education; however there is currently no system in place to monitor the actual implementation of Life-skills-based HIV&AIDS education in schools. Based on the number of teachers participating in the annual training sessions, the number of primary schools with teachers trained in HIV/AIDS education increased from 25 urban public schools in 2003 to 60 urban public schools in 2005, and doubled from 20 rural public schools in 2003 to 40 rural public schools in 2005. Within the private institutions, the number of private schools with teachers trained in HIV/AIDS education remained the same at with only 5 urban schools having trained their teachers and none reported within the rural schools during that period. (*See Fig 3.*)¹¹

At the secondary school level, the number of public schools with teachers trained rose very little from 12 to 14 in urban areas, and from 6 to 7 in rural areas. The number of private schools with teachers trained in HIV/AIDS education remained the same at 2 urban and 1 rural. (*See Fig 4.*)¹² Through the Health and Family Education initiative, a database for better monitoring in this area should be operational by mid-2006. Also important to the interpretation of this information are the school enrollment rates in Belize. The most recent information for the 2003/04 academic year indicates a primary school net enrollment rate

⁵ Voluntary Counseling and Testing Center, Ministry of Health, 2005

⁶ National Health Information Surveillance Unit, Ministry of Health, 2005

⁷ National Health Information Surveillance Unit, Ministry of Health, 2005

⁸ Voluntary Counseling and Testing Center, Ministry of Health, 2005

⁹ Human Services Department, 2005

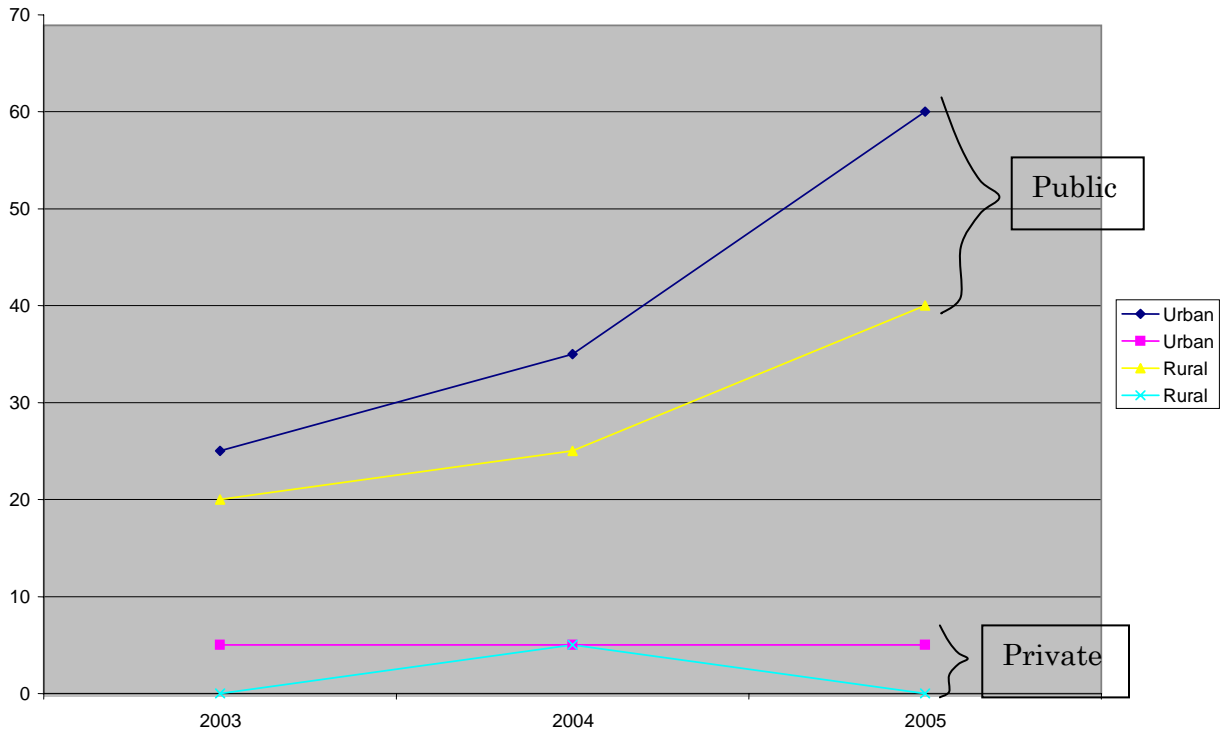
¹⁰ The Cornerstone Foundation, 2005

¹¹ Ministry of Education, 2005

¹² Ministry of Education, 2005

of 90.3%, and a secondary school net enrollment rate of 44.1%.¹³ Thus there are many out-of-school youth, particularly at the secondary school level that would be missed by in-school HIV education activities. Youth for the Future (YFF) is a non-governmental organization that provides services for out of school youth in Belize City. In 2005, YFF trained 35 youth as HIV/AIDS peer educators, and provided 250 youth with life skills and vocational training that included HIV/AIDS education.¹⁴

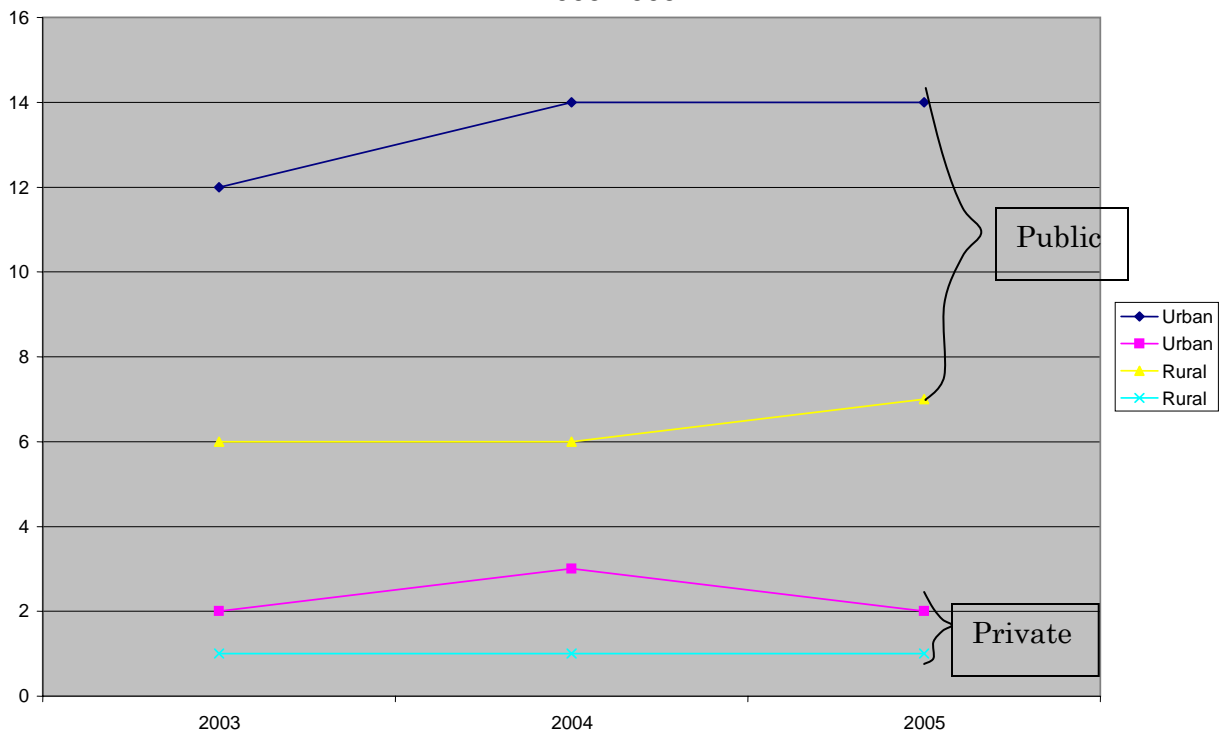
Fig 3. Number of Primary Schools With Teachers Trained in HIV/AIDS Education, 2003-2005



¹³ Abstract of Statistics, Central Statistical Office, 2004

¹⁴ Youth for the Future, 2005

Fig 4. Number of Secondary Schools With Teachers Trained in HIV/AIDS Education, 2003-2005



The total Labour Force Population in 2004 was 66,305 men and 36,132 women.¹⁵ The International Labor Organization has been working with the employment sector to develop HIV/AIDS workplace policies among 20 public and 18 private employers. One public sector employer to date has developed a workplace policy regarding HIV/AIDS; however this policy remains to be approved by the Board of Directors and finalized. Four private sector employers, the Belize Sugar Industries Ltd, the Belize Electricity Ltd., the Citrus Growers Association, and the Pelican Beach Resort also have policies completed that are awaiting final decisions before the policies can be adopted. All these policies in progress do, however, address anti-discrimination and prevention activities, including education, condom distribution, and referral information regarding VCT, STIs and medication.¹⁶

A few studies have been conducted targeting youth 15-24 years in Belize and addressing data collection needs on sexual practices in this population. One study conducted among youth at six schools in Belize City found 34.6% of respondents reporting that they were sexually active, of which close to half (48%) were 13 or 14 years old at their first intercourse.¹⁷ Another study, a baseline survey among in- and out-of-school youth aged 10-24 years conducted in Belize City, Dangriga and Orange Walk by the Belize Family Life Association (BFLA) in 2005 found that 41% of respondents were sexually experienced, of which 78.4% had their first sexual intercourse before the age of 15 years. Although there is no data available at this time on condom use in this population at last sexual intercourse with a non-regular, non-cohabiting partner, the BFLA survey also found 62% of respondents reporting condom use at their last intercourse.¹⁸

¹⁵ Abstract of Statistics, Central Statistics Office, 2004

¹⁶ Labour Department, 2005

¹⁷ Kinsler J, Sneed CD, Morisky DE. The Application of Psychosocial Factors to HIV Risk among Belizean Adolescents. *Journal of Adolescent Health* 2003; 32:3-4.

¹⁸ Baseline Study On Young People's Health And Development Needs For The "Youth Empowerment – Taking Change" Project, Belize Family Life Association, 2005

Although outside the 2003 to 2005 reporting period, another very comprehensive survey conducted countrywide in 1999 that is worth mention here is the Belize Family Health Survey. This survey found the mean age at first sexual intercourse among women 15-19 and 20-24 to be 15.6 years and 17.0 years respectively, while the mean age at first sexual intercourse among young men aged 15-19 and 20-24 was 14.8 years and 15.7 years respectively.¹⁹ These represent the most recent representative country-wide data on age at first sexual intercourse among youth 15-24 years in Belize.

A full-course of antiretroviral prophylaxis to reduce the risk of mother-to-child transmission is defined in Belize's PMTCT program as one 200 mg dose of Nevirapine to the mother 48 hours prior to delivery, and a 4mg per kilogram dosage of Nevirapine to the newborn within 72 hours post delivery. In the 2003-2004 reporting period, there were 109 HIV positive pregnant women who gave birth, of which 78 (71.6%) were provided a full-course of antiretroviral prophylaxis. The percent of women who received a full-course of prophylaxis increased slightly from 69.4% in 2003 to 73.3% in 2004.²⁰ The data currently available for 2005 may be incomplete at this time due to difficulties in data collection, so 2005 data will not be reported here.

Using the formula $\{T*(1-e) + (1-T)\} * v$, the rate of mother-to-child transmission in 2003 and 2004, excluding transmission through breast feeding and transmission prevented through other means (e.g. caesarean section) was 16.3% and 16.0% respectively. The rate for the 2003-2004 period was 16.1%. These data represent coverage predominantly in public sector health facilities, although some data from private facilities that provide antenatal care through the National Health Insurance Scheme (NHI) are included. However, the NHI was previously in a pilot stage and is now being expanded, but does not cover the entire country. Additionally, antenatal clinic usage, particularly among rural populations is limited, and the figures reported here were calculated based on the number of HIV positive pregnant mothers who delivered, not on an estimate of the total number of HIV pregnant mothers in the country to whom antiretroviral prophylaxis could have been given. Thus these data should be interpreted with some caution.

Currently data are available from the Blood Transfusion Services of Belize on the number of blood units screened for HIV in 2003 and 2004. Data from 2005 are not compiled as yet. However, there are no data on the number of blood units transfused in the time period, only on the total number of transfusions made, disaggregated by whole blood, packed cells and plasma. Since blood units are often times separated and used in more than one transfusion, using the total number of transfusions to calculate the indicator on blood safety would artificially decrease the measure of transfused units screened for HIV. However, correspondence with the Director of the Blood Transfusion Services in Belize has guaranteed that 100% of all blood units used in transfusions are screened for HIV according to the Caribbean Regional Standards for Blood Transfusion Services, which embodies elements of both the British and American Associations of Blood Banks, and is approved by the Pan American Health Organization/World Health Organization (PAHO/WHO) and the Caribbean Epidemiology Center (CAREC). A total 2883 units were screened in 2003 and 2978 in 2004, while the total number of transfusions made were 3132 and 3076 in 2003 and 2004 respectively.²¹ All blood transfusion services and blood units in Belize are managed and regulated by the Blood Transfusion Services, of the MOH. No private entities are allowed to independently collect, screen and store blood units.

Some data on most-at-risk populations exist and more is being collected. A baseline study conducted among Belize's inmate population found an overall HIV prevalence of 4.9%, the prevalence among men and women being 4.0% and 50.0% respectively. Twenty-eight percent of inmates responded correctly to

¹⁹ Belize Family Health Survey, Central Statistics Office, 1999

²⁰ Maternal and Child Health Department, Ministry of Health, 2005

²¹ Blood Transfusion Services, Ministry of Health, 2005

all questions assessing correct knowledge on prevention of HIV and common myths and misconceptions, including protection through having sex with only one faithful, uninfected partner; condom use; whether a healthy-looking person can be HIV positive; and HIV transmission through mosquito bites or sharing a meal with an infected person.²² Similar baseline surveys are currently being completed country-wide among men who have sex with men and commercial sex workers, as a part of the Central American HIV/AIDS Prevention Project (PASCA). A Uniform Service Study has been completed and findings to be published. Other such studies have been conducted and findings need to be collated. However, in terms of the UNGASS indicators, significant efforts need to be invested to collect the appropriate baseline data and subsequent surveys in accordance to the specific indicators.

III. National Response to HIV&AIDS Epidemic

The National AIDS Commission, through its secretariat seeks to strengthen its coordination function and active participation of all key sectors. Within this period greater emphasis has been placed on improving the community response through its District AIDS Committees. The Dangriga AIDS Society is one such group in the southern part of the country whose efforts in prevention, reduction of stigma and discrimination have been well recognized. Other districts are now seeking to scale up the level of efforts and will work with the NAC in addressing the key priority areas identified within the National Strategic Plan. Another key response that has begun to be formalized is the Faith Based Response. This sector can be extremely instrumental in offering support to families and persons infected or affected by the epidemic. However, there has been a challenge to engage some denominations due to their concern with the promotion of condom use as a preventative method. However, the NAC with support of the Caribbean Council of Churches held a sensitization and planning session with representation of all key denominations countrywide. This resulted in a revitalized Faith Based Committee “COMFORTH” who are now in the process of developing a plan of action in support of the National Response.

National Commitment to programs and services:

During the period January 2003- December 2005, significant strides have been undertaken in response to the HIV&AIDS epidemic in Belize. As mentioned, the Government of Belize has committed to providing universal access to Antiretroviral medication for those who met the criteria as well as supporting diagnostic tests to monitor effectiveness of therapy to include CD4 and viral load testing and treatment of opportunistic infections such as Tuberculosis. The PMTCT program has also been adopted, and offered in all public primary health care centers countrywide. The voluntary counseling and testing program and relevant services have now been expanded to other areas in the country which will ease access to care and treatment. However access to treatment continues to be highly centralized with only a limited number of physicians trained to offer care and treatment services. The NAC is working closely with the National AIDS Program of the Ministry of health to promote better integration of these services at the primary care level as well as the upgrading of clinical management guidelines for both adult and pediatric populations as well as the PMTCT program.

In the area of prevention, initiatives addressing vulnerable groups continue with emphasis on the youth in and out of school. Through the support of the OPEC/ UNFPA project, behavioral change modules and tools have been developed and partnerships have been strengthened among key agencies such as Youth for the Future, Red Cross, Alliance Against AIDS and PASMO. Several initiatives appear to be effective

²² HIV Seroprevalence Among Inmates at the Kolbe Foundation, Belize Central Prison, Ministry of Health, 2005

in engaging the youth such as the “Together we can” Peer education program implemented by the Youth arm of the Belize Red Cross. Youth for the Future with support from PASMO have conducted “satellite tables” targeting the hard to reach populations which have allowed for the active participations of members of these communities. Outreach efforts targeting commercial sex workers specially those in cross border towns and areas as well as MSM have increased significantly. The MSM population still presents a significant challenge due to their clandestine lifestyle. Fear of stigma and discrimination prevent this particularly vulnerable group from openly participating in prevention efforts and accessing services. The Ministry of Education is now in the process of finalizing its Health and Family Life Education Policy to be presented for approval by cabinet. This policy promotes healthy life-styles education in schools of which HIV&AIDS is a component of the curricula.

Civil Society Response:

Since 2003, civil society response has greatly expanded in support of those persons living or affected by the epidemic. Alliance Against AIDS is one of the leading NGOs offering support to PLWAS. This agency has trained a cadre of volunteers in all districts of Belize and is now in process of establishing a hotline service to promote appropriate referrals to relevant services and crisis management. Cornerstone Foundation, has been very instrumental in training individuals in home-based care and supporting orphans and vulnerable children affected or infected by HIV&AIDS. Belize Family Life, offers numerous support services to include family planning, HIV&AIDS prevention and also have a youth arm that promotes peer education and youth friendly services. Hand in Hand Ministry, a faith based NGO, offers support for children living with HIV&AIDS with emphasis on educational development of children and parenting support. PASMO has focused on behavioral change and have had great success reaching CSW, MSM as well as hard to reach youth in both urban and rural areas. It is also the leading condom social marketing agency.

Positive Lives:

With support of AAA, individuals living with HIV&AIDS have formed a support group in the name of Positive Lives. 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.

National HIV&AIDS Policy Process:

The NAC has been actively engaged in promoting a National Policy on HIV&AIDS. Between 2002-2004 a review of HIV related legislation and a survey of perceptions were conducted. Country wide consultations with major stakeholders were also completed so that the views of many concerned sectors could be included. This broad consultation process culminated in January 2005, with the Draft National Policy on HIV/AIDS.

During this year, 2005, the NAC facilitated several national workshops to build support and consensus for the passage of our national policy. Over 200 persons and roughly 40 organizations including key business, religious, and civil society sectors participated and pledged support for the policy. Some funding from the Global Fund project has also been utilize to complete this process and therefore, it is with broad national consensus that the Draft National HIV/AIDS policy is now presented to Cabinet for approval.

The Policy adopts a HUMAN RIGHTS AND RESPONSIBILITIES perspective, which incorporates the fundamental rights enshrined in the Belize Constitution and the commitments set out in the National Poverty Reduction Strategy and Action Plan as well as our international commitments in the Millennium Development Goals, MDGS and the United Nation's Special Session on HIV/AIDS, 2001 (UNGASS).

Rationale for Policy:

The rationale behind the National Policy is the protection of the rights of persons infected and affected by HIV/AIDS. It also provides a legal and ethical framework to guide persons living with HIV/AIDS (PLWHAS), service providers, the public and private sector and the general public in understanding the fundamental principles and guidelines required to create an enabling environment to reduce stigma and discrimination which is essential in being successful in the fight against HIV/AIDS. And it finally gives "teeth" to these fundamental principles, policy decision and ethical guidelines so that necessary legislation can follow.

Specific Commitments:

In terms of specific commitments, this policy pledges to:

- Respect the fundamental rights and freedoms of all persons regardless of their HIV status.
- Ensure that the National Response addresses National and International Commitments.
- Ensure that the HIV/AIDS epidemic remains a high priority National Development issue.
- Pursue strategic actions to prevent the spread of HIV/AIDS in Belize.
- Reduce its impact on the individual and community and ensure equal access to treatment, care and support for those infected and affected.

Guiding Principles:

There are 16 guiding principles which broadly inform the entire policy. Key among which are individual and collective responsibility, voluntary counseling and testing, confidentiality, reduction of stigma and discrimination, equity in access to goods and services.

The policy then goes on to outline specific objectives and strategies for prevention; voluntary counseling and testing; treatment care and support; surveillance and research; legislation and legal issues; and finally coordination, implementation and monitoring.

Legal Implications:

A legal and policy framework is key to creating an enabling environment for the reduction of stigma and discrimination, and legal protection of the rights of persons living with HIV/AIDS, their families and other vulnerable population will provide a clear recourse for legal action in instances where such rights are being violated. It will also guide legislative action that will have an impact on preventing the spread and mitigating the effects of HIV/AIDS and Sexually Transmitted Infections (STIs).

Government would therefore be required to amend legislation and pass new legislation for these purposes. For example, to defend a person's right to keep his or her job.

Submitted along with the National Policy was the Draft Policy on HIV/AIDS in the World of Work prepared through the International Labor Organization/United States Department of Labor Workplace Education Programme (US- DL, ILO) which is now in progress and administered through the Ministry of Labor. This work-place policy is a vital component of the overall National Policy and is therefore submitted with it for approval. The Work Place Policy has also undergone an extensive process of consultation and consensus building. Amendments to existing laws and the development on new legislation will therefore be required to be consistent with the provision of this and the Work Place Policy.

In terms of work-place policies and HIV&AIDS education and support programs, the Ministry of Labor through the ILO project has been actively working with key employment sectors both public and private in order to promote the adaptation of the same. The response needs to be expanded and efforts placed on targeting other sectors that have been resistant to this process.

Communication Strategy:

Belize is now working closely with PANCAP and other partners such as UNICEF to develop a national communication strategy supporting the policy process as well as aiming to reduce stigma and discrimination. There is a need to take full inventory of all the communication tools already developed in country by individual agencies to then determine what efforts can be adopted and expanded nationwide. In this regard, the involvement of the media continues to present a challenge.

Although on a whole, the media houses have been very supportive of national efforts and have dedicated extensive air time to promoting prevention and other related issues, there is still a need to engage them in a more active and effective way. A strategy for engaging this sector is being developed to be implemented in 2006.

Resource Mobilization and Collaboration:

Belize was successful in mobilizing the support of the Global Fund to aid in enhancing the national response. The joint proposal demonstrates the strength of Belize's CCM in engaging its key partners in the planning process that led to the approval of the project. The Fund is supporting 4 major arms of the response to include, behavioral change, prevention, care and treatment and improved coordination. The Ministry of Health is the main sub-recipient of the fund which will support provision of ARVs, strengthening of laboratory services for the case management of HIV/AIDS cases and diagnosis of opportunistic infections, as well as the extension of voluntary counseling and testing centers.

The NAC secretariat also received support for key posts to enhance its coordination function. The fund is supporting the posts of a Monitoring and Evaluation Officer as well as a Programs and Communication Officer respectively. Other funding will assist the NAC in its advocacy function and resource mobilization efforts.

The challenge remains in accelerating the implementation of this project in accordance to the criteria set by the fund. In particular the procurement and monitoring and evaluation criteria remain a challenge for most countries including Belize. To date, Belize has been trying to gain the approval of its procurement plan for the MOH's component.

Advocacy:

With the support of CAREC and PAHO, the NAC conducted in 2005, a special sensitization session with key political leaders and decision makers. Cabinet members met with the team to discuss policy and economic implications related to the HIV&AIDS epidemic. The team also met with other

parliamentarians, city council members and well as civil society representatives to promote a more joint response by these sectors. This consultative process was very beneficial in gaining the government's support in adopting the National Policies mentioned above as well as committing to invest more human resources in support of the National HIV&AIDS program of the Ministry of Health.

The NAC armed with the National Strategic Plan, will now seek to improve its sectoral response and engage other critical sectors such as the Ministry of Tourism, the Public Sector and Uniformed Services that have not been effectively engaged to date. The intention is to avoid unnecessary duplication of initiatives and to maximize on the existing resources promoting more cross-sector planning and implementation.

UN Response:

The role of the UN partners in supporting national efforts must be mentioned. Our UN partners have been very instrumental in enhancing the coordinating function of the NAC by supporting the Strategic Planning initiative as well as strengthening our advocacy and policy activities. Implementing agencies have also gained valuable technical and financial support in behavioral change, Information, Education and communication projects as well as support of critical services such as home base care and social services. The level of continued commitment by our UN partners is evident and has been instrumental in promoting a collaborative environment with our local counterparts.

IV. Major Challenges faced and actions taken to achieve the goals/targets

Human Resource Capacity:

The key challenges faced in Belize continue to be that of limited human resources in support of critical HIV&AIDS services and programs. The National AIDS program currently has a director who shares the responsibility of also managing the Epidemiology and Surveillance Unit of the Ministry of Health. In area of long term counselling and support services, there is a need for more personnel trained and offering these services, and more engagement and monitoring of the Private Sector in this regard. The need for integration of services at the Primary level is one that has not been fully adopted in Belize.

Services:

Care and treatment continues to be highly centralized primarily in the Belize and Dangriga Districts making access for persons living in other parts of the country more challenging. Referral systems to relevant services needs strengthening so there is more comprehensive case management of persons and families infected and affected by HIV&AIDS. Although care and treatment is available free of cost, there is a need to expand on other social services such as nutrition programs in support of adherence and home base care for persons who wish to remain anonymous for fear of stigma and discrimination. Terminal care for persons dying is a challenge as there are presently no such services available in country. More effective income generating programs need to be established so that persons affected can continue to be productive members of society and can meet their financial and family obligations. Stronger collaboration with the Ministry of Education and Human Services is essential in offering more concrete alleviation programs supporting continual education of children affected or infected as well as support to orphans of HIV&AIDS.

Surveillance:

The MOH has dedicated significant efforts in producing quarterly HIV&AIDS surveillance reports on the status of HIV&AIDS in Belize. The significance of this critical data in guiding service provision and

development of relevant programs cannot be emphasized enough. There is a need to therefore continue to support the surveillance unit to expand its service to now include second and third generation surveillance. This more comprehensive form of surveillance encompasses the behavioral data and quality of service provision information that will guide the overall national response.

The MOH has begun to conduct baseline studies among the high risk groups of Belize such as Imprisoned populations as well as MSM and CSW. Such population based studies need to continue so that impact of interventions can be measured. There is also an urgent need to report on the latest prevalence rate in Belize so that accurate information can be used to gain the level of commitment and response from our political leaders.

Involvement of PLWA in the national Response:

The continuous and active engagement of persons living with HIV&AIDS in the national response continues to present a big challenge for Belize. There are many factors that limit their involvement but at the forefront is the fear of stigma and discrimination. The supportive environment for persons who choose to disclose their status is lacking and therefore, very few individuals have taken that step forward. Also, 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 terms of Coordination, there is a need for partners to work in closer collaboration with the NAC and its Secretariat. The NAC should act as the clearinghouse of information and should guide the national response. More emphasis will need to be placed on cross sector collaboration moving towards more joint implementation of programs and less activity driven projects. The Secretariat will be instrumental in facilitating this process and partners have shown enthusiasm and commitment to this initiative.

In terms of its function, our regional technical and donor partners need to recognize that in Belize, the NAC is the body charged with overseeing the National Response and therefore need to strengthen the communication links with the same. This ensures more effective collaboration and inclusiveness of the relevant agencies involved in the response of which the Ministry of Health's AIDS Program is one of the key partners.

The NAC is now working 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 NAC embraces these principles although it presents some challenges in terms of clarification of roles and responsibilities as well as implementation functions of all partners involved.

V. Support required from country's development partners

Capacity building continues to be at the forefront in regards to the continued support by our development partners particularly in the areas of surveillance, training in care and treatment, counseling and home base care. The need to strengthen the Community based response is critical to this process of expansion of care and support services. The responsibility cannot continue to lie on the Government alone as the sole providers of care and support. Other civil society sectors need to be empowered to be more active.

One of the strongest criticisms that the NAC receives from its partners is the need to strengthen its coordination, communication and information functions. There is a need to build this culture of collaboration among all partners so that there is more harmonization of efforts and better monitoring of impact of the same.

Efforts need to be more focused on creating the necessary support programs to mitigate the impact of the epidemic on those persons affected and infected. Adherence is a challenge for persons living with HIV, due to the lack of nutritional support and financial resources. More concrete social programs addressing substance abuse, long term counselling and education must be promoted. Developmental partners can be very instrumental in advocating for such programs and supporting the establishment of the same.

Income generating programs are critical in alleviating the economic impact of HIV&AIDS and remain one of the weakest areas of the response to date. HIV&AIDS needs to be integrated into the poverty alleviation programs and should be considered one of the priority areas for Belize.

VI. 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.

To this end, the 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 National Strategic Plan which defines the key outcome and impact indicators selected to measure the effectiveness of the response.

Based on the NSP, the M&E plan will need to be developed and the M&E system formalized. Partners will then need to be trained on the reporting criteria and the M&E unit will need capacity building in gathering the data and reporting findings.

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.

Capacity building in M&E will need to be continuous and currently the NAC has been collaborating closely with the UN Theme Group and other partners in support of this process. This need for reporting on progress of the response needs urgent attention. The CRIS (Country Response Information System) is being contemplated as the possible data base system for collating this data. Belize will seek the support of UNAIDS and partners in training in the use of the system for facilitating future UNGASS reporting.

Consultation/preparation process for the National 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 (please specify)	YES	NO

2) With inputs from

Ministries		
Education	YES	NO
Health	YES	NO
Labour	YES	NO
Foreign Affairs	YES	NO
Others (please specify)	YES	NO
Civil Society	YES	NO
People Living with HIV/AIDS	YES	NO
Private Sector	YES	NO
United Nations organizations	YES	NO
Bilaterals	YES	NO
International NGOs	YES	NO
Others (please specify): <i>Local NGOs</i>	YES	NO

- | | | |
|--|-----|----|
| 3) Was the report discussed in a large forum? | YES | NO |
| 4) Are the survey results stored centrally? | YES | NO |
| 5) Are the data available for public consultation? | YES | NO |

Name/title: Ruth Jaramillo, Technical Director, NAC
Ethan Gough, Monitoring and Evaluation Officer, NAC

Date: December 31st, 2005.

Signature: Ruth Jaramillo.