ANALYSIS OF THE SITUATION & RESPONSE TO HIV/AIDS IN BELIZE 2011

ADVANCES, CHALLENGES, & OPPORTUNITIES

John Hembling, MPH

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ACRONYMS & ABBREVIATIONS

AAA	Alliance Against AIDS
AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communication
BCCI	Belize Chamber of Commerce and Industry
BFLA	Belize Family Life Association
BHIS	Belize Health Information System
BRCS	Belize Red Cross Society
CAREC	Caribbean Epidemiology Center
CARISMA	Caribbean Social Marketing Association
CML	Central Medical Laboratory
CSW	Commercial Sex Worker
FSW	Female Sex Worker
GOB	Government of Belize
HFLE	Healthy Family and Life Education
HIV	Human Immunodeficiency Virus
HIVOS	Humanistish Instituut voor Ontwikkelingssamenwerking
IEC	Information Education Communication
KAP	Knowledge, Attitudes, Practices
MARP	Most-At-Risk-Population
MCH	Maternal and Child Health
MOE	Ministry of Education and Youth
MOH	Ministry of Health
MOL	Ministry of Labour
MSM	Men who have Sex with Men
NAC	National AIDS Commission
NASA	National AIDS Spending Assessment
NAWG	National Advocacy Working Group
NCPI	National Composite Policy Index
NGO	Non-Governmental Organization
NSP	National Strategic Plan
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership against HIV and AIDS
PASCA	Programa para Fortalecer Repuesta Céntroamericana al SIDA
PAMSO	Pan American Social Marking Organization
PCR	Polymerase Chain Reaction
PITC	Provider Initiated Testing and Counseling
PLWHA	People Living with HIV/AIDS

POWA	Productive Organization for Women in Action
SBS	Sexual Behavior Survey
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TWC	Together We Can
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNIBAM	United Belize Advocacy Movement
UNICEF	United Nations Child Education Fund
USAID	United States Agency for International Development
UVG	Universidad de Valle - Guatemala
VCT	Voluntary Testing and Counseling
WIN-Belize	Women's Issues Network Belize
YES	Youth Enhancement Services
YFF	Youth For the Future
YWCA	Young Women's Christian Association

1 INTRODUCTION

Aligned with the Central American Regional Partnership Framework, the US Agency for International Development's (USAID) Central American Regional HIV/AIDS Program strategically supports programs in Belize to:

1) Increase healthy behaviors among most-at-risk populations (MARPs)
2) Improve health systems to reach people living with HIV/AIDS (PLWHA) and MARPs
3) Increase the availability and use of strategic information for the response to HIV/AIDS
4) Improve the policy environment to reach universal access to HIV/AIDS services.

USAID provides HIV/AIDS assistance in Belize primarily through programs implemented by (a) Pan-American Social Marketing Organization (Population Services International), (b) USAID/PASCA (Futures Group) and (c) the Capacity Project (IntraHealth International).

Given the commitment of the Governments of Belize (GOB) and the United States (USG) to addressing HIV/AIDS in the Central American and Caribbean regions, as outlined in the respective PEPFAR Partnership Frameworks, this analysis to the situation and response to HIV/AIDS in Belize is critical to:

1) Describe the current state of the HIV/AIDS epidemic and the national response in Belize
2) Identify the key implementers of the response, the programmatic areas of intervention, geographic coverage, populations reached and sources of funding
3) Highlight key challenges, gaps, and opportunities to improve the national response.

The results of this analysis will be used by USAID's Central American Regional HIV/AIDS Program to refine and strategically support Belize's national response.

2 METHODOLOGY

This situation analysis was elaborated for USAID in coordination with Belize's National AIDS Commission and the invaluable input from several government institutions, national and international non-governmental organizations (NGO), and donors. The information was compiled through:

1. A review of over 35 documents, including epidemiologic reports, national policies and regulations, legislative reviews, program plans and evaluations, and sector assessments
2. Application of a questionnaire through 32 in-person interviews with representatives of government institutions, non-governmental organizations, and international agencies
3. A review and inventory of 20 national policies, laws, and regulations.

The resulting document is organized in three parts:

Part 1: Advances and Challenges to the Situation and Response of HIV/AIDS, which describes the current state of the HIV/AIDS epidemic and Belize's national response.

Part 2: Mapping of the National Response, which graphically represents the institutions and organizations participating in the response and the prioritized programmatic areas, populations, and geographic areas covered.

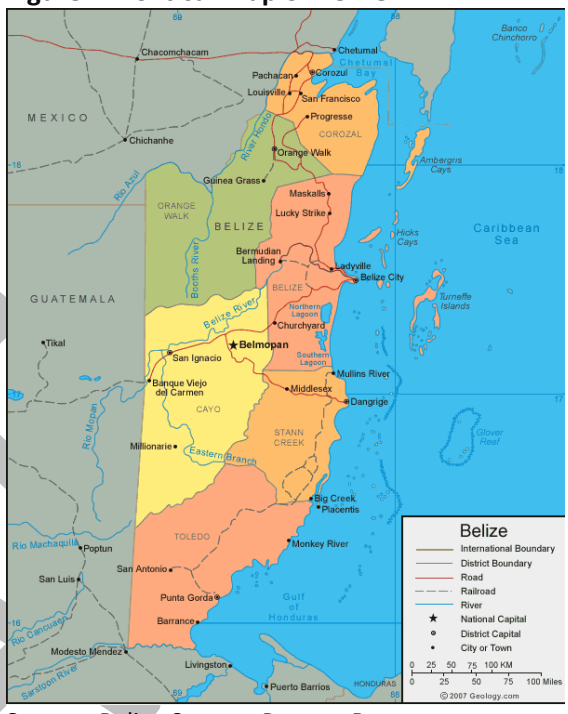
Part 3: HIV/AIDS Policy and Legislative Inventory, which compiles and analyzes laws and policies related to the national response to the HIV/AIDS epidemic.

3 DEMOGRAPHIC & SOCIO-ECONOMIC SITUATION

Geography

Situated on Central America's Caribbean coast, with Mexico to its North and Guatemala to its West and South, Belize spans nearly 23,000 square kilometers and has a total population of 333,200.(1) The Caribbean Sea and the Belize Barrier Reef lie to the East and consist of over 100 islands, or Cayes, and lagoons. While only few Cayes are inhabited, the Caribbean coast and the islands have become the center of the country's tourism industry. Belize has a diverse society, comprising many cultures and languages. Although Creole and Spanish are spoken among the population, Belize is the only country in Central America where English is the official language.

Figure 1: Political Map of Belize



Source: Belize Country Poverty Report

Belize consists of six administrative districts characterized by diverse racial/ethnic make ups, economies, and geographies. (See Figure 1.) Corozal and Orange Walk districts are located in northern Belize and are primarily Mestizo or Hispanic and Spanish speaking. Approximately 20% of the country's population is located in the Belize District, which is home to the former capital Belize City and the majority of the country's Creole population. The current administrative capital, Belmopan, sits in the Cayo District. The Stann Creek District sits to the south along the Caribbean coast and is home to a diverse Garifuna, Mestizo, and Creole population. The southernmost district, Toledo, is the primary home of Belize's Mayan population.

Government

Belize is a former British Colony and is a current member of the Commonwealth of Nations. It gained self-governance in 1964 and full independence in 1981. Belize's 1964 constitution established the country as a parliamentary democracy. Similar to the British system, Belize's Prime Minister is the head of the National Assembly, the body that makes laws.(2) A House of 31 elected representatives and 12 appointed Senators comprise the bicameral National Assembly. The House makes and debates laws that are in turn sent to the Senate, which can either approve or return them for further debate.

Demographics

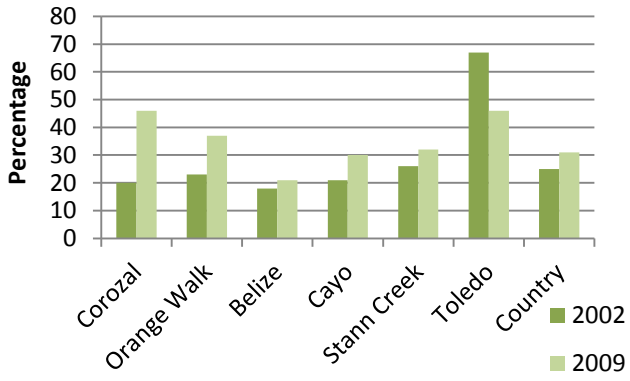
Belize has a current estimated population of 333,200, with nearly 50% women, 50% female and 63% under the age of 30. The population has increased gradually over the last three decades primarily in the Cayo and Belize districts. According to the 2009 population estimates there are roughly equal numbers of men and women in Belize.(1) Over the last 30 years Belize's population has been aging, with a 6% decrease in the number children under 15 years old (from 40% to 34% of the total population) since 2000.(2) The percentage of the elderly in the population has increased from less than 6% to 8% over the

last ten years. Steady urbanization since 2000 also characterizes Belize, with over 51% of the population living in urban areas.[1]

Poverty

The 2009 Belize Living Standard Measure Survey (LSMS) shows that approximately one third of Belize's households were in poverty, with 10% of all households classified as indigent[2].(2) The survey found that an additional 13% of all households were vulnerable to poverty. Nearly 30% of the population of urban areas and 55% of those residing in rural areas lived in poverty. As expected, the poorer populations were less likely to seek medical assistance, more likely to use public rather than private health facilities, and less likely to have health insurance.

Figure 2: Percentage of Poor Households by District and Year, Belize 2002 & 2009



Source: 2010 National Poverty Assessment

Since 2002 household poverty has increased by approximately 27%, with indigent households increasing by 40%. The largest increases in overall household poverty were in Corozal and Orange Walk districts. (See Figure 2.) The Caribbean Development Bank (CBD) asserts that the devastating effects of Hurricane Dean (2007) and the 2008 floods, low agricultural production, and negative economic impacts of the recent global recession contributed to the increase in overall household poverty. (2)

4 GENERAL HEALTH SITUATION

Belize's annual population growth is estimated at 3.3% (2005-2007). (2) Population indicators show that Belize is in the third phase of demographic transition, which is characterized by declining crude birth rates (21.9 X 1,000 population), a stable crude death rate (4.0 X 1,000 population), continued population growth, and an increased burden of non-communicable, communicable, and degenerative diseases on population mortality. (3)

Epidemiological data show that maternal, infant, and neonatal mortality rates have increased in recent years. Mortality from AIDS, malignant neoplasms of the lung and breast, and circulatory diseases has also shown a notable increase. The leading causes of death for all ages (2008) were primarily non-communicable.(4)

National Health System

Belize's MOH is responsible for leading the national health sector. The national public health system delivers services through a network of institutions at the primary, secondary, and tertiary levels,

[1] Belize is one of the least urbanized countries in Latin and Central America, suggesting that it will follow world-wide trends and continue to urbanize.

[2] Indigent households have incomes "insufficient to enable them to maintain a healthy diet or spend money on essential non-food expenditures.

consisting of 56 health posts, 42 health centers, and seven hospitals. Currently, there is an emphasis is on primary and preventive care. (3)

The GOB embarked on the Health Sector Reform Project (HSRP) in 2001.(5) The Project focused on (a) sector restructuring, (b) services rationalization and improvement, and (c) development of a financing strategy. HSRP resulted in numerous infrastructural and managerial changes in the health care system, including:

- The reorganization of the health system into four decentralized Regional Health Authorities, which consist of a Regional Health Manager, Deputy Manager, Hospital Administrator, and Chief of Staff
- The introduction of National Health Insurance (NHI), designed to provide universal health care to the poorest sector in Belize, the Southern Health Regions and the southern part of Belize City
- A legislative review to provide the legal framework for the health reforms.

Since 1990 the GOB, through the MOH, has provided universal coverage for health services, including maternal, child, mental, and environmental health. The private sector is estimated to cover about 15% of the population. The NHI purchases services for 35% of the total population (residing in the south side of Belize City and Stann Creek and Toledo districts), and the remaining 65% is covered by the national public health system.(3)

Health services are generally provided free to the population through regional health facilities, which are funded through general revenues. The NHI purchases a set primary health care package from both public and private facilities with funding from general revenues, the Social Security Board, and a direct contribution from the MOH budget. A token co-payment is generally collected from patients but may be waived if it becomes a barrier to the access of care. Belize's total 2008 health expenditure was approximately 3.4% of GDP.(4)

Human Resources for Health

The 2009 PAHO Human Resources for Health (HRH) Assessment demonstrates a ratio of 18.9 health care providers per 10,000 population.(6) This figure falls well below the HRH targets (25 health professionals per 10,000 inhabitants) proposed by the Ministries of Health of the Americas (Toronto Call to Action). A 2009 Health System profile indicates that inadequate health staffing is a core weakness for Belize's health system.(3) Nursing attrition increased from 7.7% in 2001 to 9.6% in 2006. There exists an inequitable distribution of qualified health personnel, medical equipment, and supplies in urban versus rural areas.

National TB, HIV/AIDS and other STIs Program

While the HSRP has produced a decentralized health system, Belize's HIV program is administered primarily in a vertical manner by the National TB, HIV/AIDS, and other STIs Program. The goal of integrating HIV/AIDS services into the Regional Health Authorities, as described in the National Health Plan (2007-2011), has been limited due to insufficient financial and human resources.(5) The result is vertical programming of HIV services within a decentralized health system, causing reduced efficiency, a limited ability to reach vulnerable groups, and overburdened human resources.

The National TB, HIV/AIDS, and other STIs Program comprises a Director of Programs and an M&E Officer who are responsible for:

- Creating, updating, and monitoring STI and HIV standards, norms, and protocols
- Monitoring and evaluating the delivery of STI/HIV prevention and treatment programs

- Overall supervision of voluntary counseling and testing (VCT) stand-alone clinics situated in each of the administrative districts.

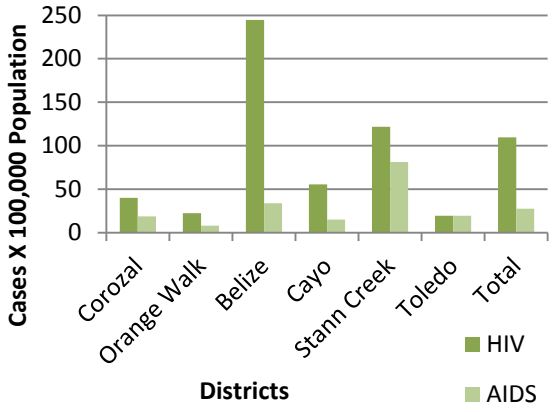
A recent review of public HIV services indicates that the day-to-day management and supervision of the VCT Centers consumes the Program staff's time and efforts. The Program is responsible for HIV testing and counseling, ARV distribution, and CD4 and other diagnostic testing in the four stand-alone VCT Clinics throughout Belize. The vertical programming of the HIV services limits the Program's ability to update and enforce standards, norms, and protocols, and to monitor the delivery of HIV services.

The MOH has made major strides towards integrating HIV services into the primary health care system. It is scaling up HIV testing and slowly promoting the use of provider initiated testing and counseling (PITC) in primary health care facilities. ARVs are being distributed through some of the national system's pharmacies. Treatment has expanded beyond the stand-alone VCT Center to seven additional governmental and non-governmental sites. Total integration of HIV services into the primary healthcare system, however, continues to be a slow process.

5 EPIDEMIOLOGIC PROFILE OF HIV/AIDS

The United Nations Program on HIV/AIDS (UNAIDS) estimates an HIV prevalence of 2.1% for Belize, the highest in Central America and the fourth highest in the Caribbean.(7) The estimated HIV prevalence among pregnant women (ages 15-24) was 0.77% for 2009.(8) Consequently, it is theorized that Belize has a generalized epidemic with higher HIV prevalence concentrated in pockets of the population, such as men-who-have-sex with men (MSM) and commercial sex workers (CSW)[3].(9)

Figure 3: New HIV Cases and New AIDS Cases per 100,000 Population by District, Belize 2009



From 1986 through 2009, Belize had registered 5,045 cases of HIV and 1,093 of AIDS. In 2009 the MOH reported 365 new HIV infections and 92 new AIDS cases.(8) There was a 14% decrease in newly reported HIV infections and a 21% increase in new AIDS cases between 2008 and 2009[4]. Ninety-two AIDS-related deaths were reported in 2009. Based on 2008 data, AIDS represented the seventh leading cause of death among Belize's total population and was the leading cause of death for Belizean men and women in the 40-49 year age group.(4)

The great majority of newly identified HIV cases have been residents of Belize District. In 2009 the rates of new HIV infections per 100,000 population were also much higher in Belize District than the other districts. (See Figure 3.) Similarly, 2009 data on newly reported AIDS infections indicated that most

[3] Currently no prevalence data for MSM and FSW are available for Belize.
[4] This may be a result of improved management of patient records due to implementation of the Belize Health Information System (BHIS).

cases resided in Belize (37%) and Stann Creek (30%) districts. AIDS cases per 100,000 population, however, were highest in Stann Creek followed by Belize District.(10)

Until 2008, more Belizean males received a positive HIV test result than females.(10) (See Table 1.) In recent years MOH data has indicated a reversal in this trend, with 224 females and 201 males testing positive in 2008 and 186 females and 177 males testing positive in 2009.(8) The 2009 rates of newly reported HIV infection also demonstrate this reversal, with 106.3 versus 111.6 new cases of HIV per 100,000 population in males and females respectively.[5]

Table 1: Number of new HIV cases by sex, Belize 2005 - 2009

Year	New HIV Cases			Sex Ratio
	Male	Female	Total	M:F
2005	224	210	434	1.1:1
2006	253	190	443	1.3:1
2007	254	196	450	1.3:1
2008	201	224	425	0.9:1
2009	177	186	365	1:1

Source: 2009 Gender Based Analysis of HIV

A 2009 Gender-based Analysis of HIV/AIDS in Belize demonstrates a younger distribution of newly reported HIV cases among females than among males.(10) Between 2003 and 2008, females aged 20-24 accounted for the largest number of reported HIV cases compared to other five-year age groups. This result may reflect a greater chance of case identification through the Prevention of Mother to Child Transmission (PMTCT) program. Men aged 45-49 years, however, were 2.5 times more likely to test positive than women of the same age group.

AIDS most often affected Belizean women and men aged 25 to 49 (2003-2008).(10) Belizean men were consistently more likely to receive an AIDS diagnosis than women were; the rate of AIDS averaged 30% higher in males than in females from 2003 to 2008. Higher rates of AIDS in males most likely reflected increased exposure of men to HIV earlier in the epidemic as compared to females. Such poorer outcomes for men may also have resulted from a lack of timely HIV testing, limited access to treatment or poorer self-care behaviors.

PMTCT

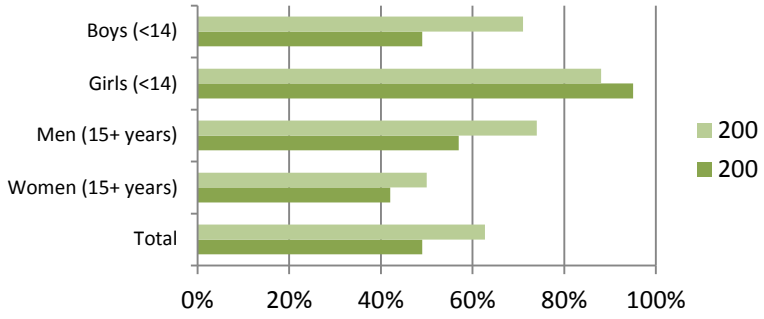
Belize's PMTCT Program data indicates that the HIV prevalence among all pregnant women was 0.98% in 2009.(9) Nearly 90% of pregnant women were screened for HIV in 2009, resulting in 62 HIV positive pregnant women, over 62% of which were newly identified cases. Almost 97% of the reported HIV positive pregnant women received anti-retrovirals (ARV) during pregnancy. Using Spectrum estimates, the MOH calculates that 87% of pregnant women needing ARVs actually received them in 2009. Fifty-four deliveries of HIV positive women took place in 2009, with 94.4% of the mothers receiving ARV at the time of delivery. Over 94% of the infants born to these mothers received ARVs at birth. For a second year in a row the MOH documented three cases of vertical transmission, or 5.5%

Treatment

The MOH reported that by the end of 2009, 855 PLWHA received free anti-retroviral therapy (ART), with slightly more males receiving treatment than females (52% to 48%).(8) Eighty patients, or 9.4%, were under 15 years of age. Spectrum estimates suggest that 61.3% of the people needing ARVs in 2009 received treatment.(10)

[5] Note that during this time period the number of women tested in the public health system decreased steadily, yet HIV rates increased. Data on the number of tests performed in private clinics and laboratories does not exist.

Figure 4: Percentage of Adults and Children Estimated to Receive ART, Belize 2008 and 2009



Source: 2009 Gender Analysis of HIV in Belize

According to 2008 and 2009 data, women represented the largest proportion of those needing ART.(9) An estimated 42% and 49% of women needing ART received it in 2008 and 2009 respectively. (See Figure 4.) Among men 15 years and older who needed ART, an estimated 57% and 74% received it in 2008 and 2009 respectively. Fewer boys than girls (aged 14 and younger) who needed ART received it in 2008 (49% of boys vs. 95% of girls) and 2009 (71% of boys vs. 88% of girls).

General Population

Belize conducted Sexual Behavior Survey (SBS) in 2009 to describe HIV/AIDS knowledge, attitudes and behaviors of the general population.(11) The SBS revealed that 36.5% of women and men (15-49 years old) reported taking an HIV test in the previous 12 months and knowing their results. More females (41.7%) than males (30.1%) reported having had an HIV test in the last 12 months and knowing their results. Respondents aged 25-49 (41.2%) were more likely to have had an HIV test in the last 12 months and know their results than those aged 14 -24 years (26.9%).

Approximately 9.0% of sexually active women and men aged 15-49 had more than one sexual partner in the 12 months preceding the survey. Men were three times more likely than women to have more than one sexual partner in the last 12 months (15.4% vs 4.9%). Males (65.8%, n=202)) who had multiple sexual partners in the past 12 months were significantly more likely than females (55.6%, n=81) to report condom use during their last sex act.

Table 2: Percentage of Men and Women aged 15-49 Reporting Select Risk Behaviors

Select Sexual Behaviors	Female (%)	Male (%)	Total (%)
Multiple sexual partners in last 12 months (n=2963)	4.9	15.4	9.4
Condom use in high-risk sex[6] (n=287)	55.5	65.8	63.1
Received HIV test in last year & know results (n=1111)	41.7	30.1	36.5

Source: 2009 Belize Sexual Behavior Survey

Most-At-Risk-Populations

HIV data among many most-at-risk populations (MARP), such as MSM, Female Sex Workers (FSW), clients of FSW, and migrant populations, are not available for Belize.(9) A 2010 serological and behavioral survey of HIV in the Belize Defense Force (BDF) revealed an HIV prevalence of 1.14% (95% CI 0.03%, 2.3%) among military personnel.(12) A 2005 study among inmates at the Belize Central Prison indicated a seroprevalence of 4.0% (95% CI 2.7%, 6.0%), almost twice the estimated prevalence of Belize's adult population.(13) Importantly, Belize is in the process of conducting a Behavioral

[6] High risk sex is assessed by condom use by men and women who reported more than one sex partner in the last 12 months.

Surveillance Survey in conjunction with the Universidad de Valle/Guatemala and the US Centers for Disease Control that will collect HIV and STI prevalence data on MSM, FSW and PLWHA.

Men who Have Sex with Men: Homosexuality is highly stigmatized in Belize, and limited information on HIV prevalence and high-risk behaviors exists. A 2007 survey[7] conducted by the Pan-American Social Marketing Organization (PASMO) revealed that condom use at last sex with any type of partner was over 85%.(14) Consistent condom use in the last thirty days with any male partner was lower, at 64%. Nearly 95% of respondents reported having more than one partner in the last 12months. Approximately 90% of MSM surveyed reported taking an HIV test in the last 12 months and receiving the results.

Female Sex Workers: No HIV prevalence data is available for FSWs in Belize. A 2009 rapid assessment of FSWs in Belize suggests that many sex workers are illegal migrants from Central and South America. PASMO's 2007 survey of FSW found that condom use at last sex with a client was high (96%).(15) Consistent condom use, however, was lower (81% among any client and 61% with regular partners). FSW had an average of 8.1 occasional clients and 7.6 regular clients in the 30 days prior to the survey. Over 95% of the FSWs had taken an HIV test in the last 12 months and received the results.

Incarcerated Populations

In 2005, the MOH conducted a behavioral and seroprevalence study of over 623 inmates of the Belize Central Prison.(13) Twenty-five of the inmates tested positive for HIV, or 4.0% (95% CI 2.7%, 6.0%). The analysis demonstrates that HIV serostatus was positively associated with male-to-male sexual activity outside prison, age, and district of residence before current incarceration. Currently, Belize Central Prison has about 1450 inmates and 85 known cases of HIV. HIV testing is not mandatory.

Uniformed Services: According to the 2010 HIV serological and behavioral assessment of the BDF, prevalence of HIV infection was 1.14% (95% CI 0.03%, 2.3%).(12) Over half (52%) of the respondents reported having sex with more than one sexual partner during the 12 months prior to the study. Fifty-five percent of the respondents reported ever having sex with a CSW, 19% of whom did not use a condom during their last sexual contact with a sex worker. Among males who reported more than one sexual partner during the 30 day period prior to the study, 80.9% and 76.9% reported inconsistent condom use with penetrative vaginal and anal sex respectively.

Violence Against Women: A 2010 Study of HIV and Violence against Women in Belize illustrated that this group is highly vulnerable for HIV/AIDS.(16) HIV risk perception among female users of sexual violence services was low. Knowledge and use of HIV services among this group was also found to be low. Importantly partners of the study respondents often refused to use condoms.

6 NATIONAL POLICY ENVIRONMENT

Belize's national response to the HIV epidemic follows the "Three Ones" principle[8] and is guided primarily by its National Strategic Plan for HIV/AIDS (2006-2011), the National HIV/AIDS Policy (2006)

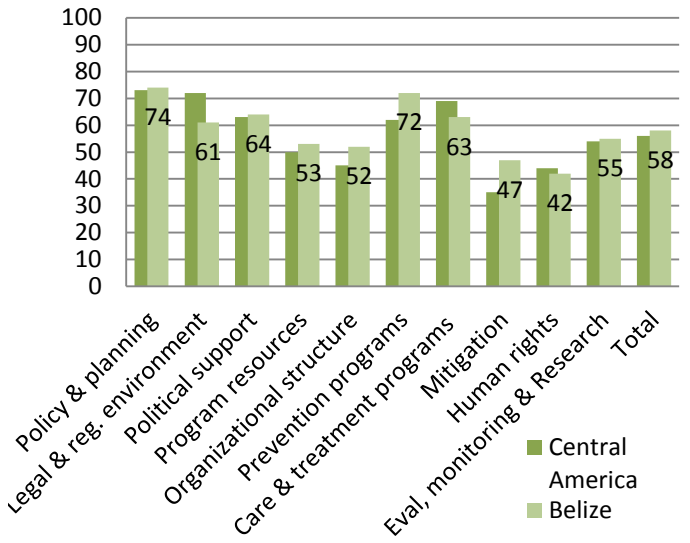
[7] PASMO reported difficultly in recruiting the total number of MSM required for the RDS study (225). Interviewers struggled to acquire the necessary sample size because the population had few in-group networks and no specific places where members congregated.

[8] The "Three Ones" is the approach proposed and endorsed by UNAIDS and calls for a) one comprehensive HIV/AIDS national framework that provides the basis for coordinating the work of all partners involved in the national response; b) One national

and National HIV/AIDS Workplace Policy (2006). The National AIDS Commission (NAC) leads and coordinates the overall multi-sectoral response and implementation of the NSP.

In 2009, with support from USAID/PASCA, Belize implemented the AIDS Program Effort Index (API) to measure systematically the extent to which the policy environment is supportive of an effective response to HIV/AIDS.(17) Belize received an overall score of 58 points (out of 100), which was comparable to the rest of Central America (57 points). (See Figure 5.) Belize's score was at or above the Central American average in policy and planning, political support, program resources, organizational structure, prevention programs, mitigation, and monitoring and evaluation.

Figure 5: API Score, Belize 2009



Strategic Planning and National Policies

National Strategic Plan for HIV/AIDS (NSP): The NSP describes the overall approach for Belize's national response to HIV/AIDS.(18) It is a product of extensive consultation with key stakeholders and partners and has a goal to reduce the spread and negative impact of HIV/AIDS on the social, economic, and cultural contexts in Belize. In order to achieve this goal, the NSP identifies three priority areas to guide the response: Harmonization, Prevention, and Mitigation. The 2009 API scored Belize just over the Central American regional average for HIV planning and policy (74 points versus 73 points respectively).

Belize has developed a singular monitoring and evaluation plan that describes the approach and system developed to assess progress and impact of the overall strategic objectives of the NSP. While Belize has not conducted an implementation assessment of the NSP, the NAC coordinated a participatory process in 2010 to develop an operational plan and begin updating the NSP and M&E Plan.

National HIV/AIDS Policies: Belize's 2010 National Composite Policy Index (NCPI)[9] indicates steady improvements in HIV policy efforts since 2003.(9) Although there is no national legislation governing HIV/AIDS, Belize's Cabinet approved the National HIV/AIDS Policy in 2006. The goal of the Policy is to provide a "framework, based on human rights, for the prevention of HIV and the reduction of its impacts at all levels of society".(19) It incorporates fundamental principles enshrined in Belize's Constitution, the National Poverty Reduction Strategy and Action Plan, and international human rights commitments to which Belize is a signatory.

While specific policy milestones have been reached, the 2009 API suggests that Belize's HIV/AIDS legal and regulatory framework has several gaps. Currently no national legislation exists to govern HIV/AIDS

AIDS coordinating body, recognized in law and with broad-based multi-sectoral support and technical capacity; c) One agreed-to national M&E system.

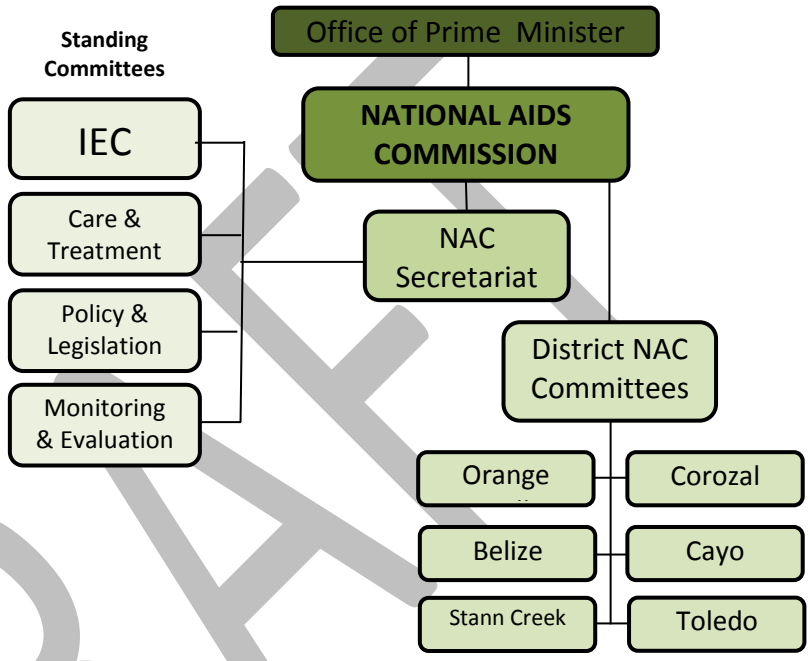
[9] The NCPI is a qualitative study that evaluates advances in the development and application of HIV/AIDS policies and strategies. It is conducted every two years for inclusion in a country's UNGASS report.

and enforce national policies. With support from the Global Fund Round 3 Project the NAC initiated a full legislative review in 2008 to identify legislative and regulatory gaps in Belize's national response to HIV/AIDS. This endeavor has resulted in the drafting of major legislative amendments and proposals for new laws. The NAC is planning nation-wide consultations on the draft legislation before forwarding them to Cabinet for approval and introduction as law.

Institutionalization of the National Response to HIV/AIDS

National AIDS Commission: The National AIDS Commission Act of 2004 established and charged this body with the responsibility for coordinating and overseeing the national HIV/AIDS response in Belize. (See Figure 7.)(9) This legislation was amended in 2008 to redefine the composition of the NAC and provide for the position of the NAC Secretariat's Executive Director. The function of the NAC is to promote multi-sectoral collaboration and resource mobilization for the implementation of the NSP, to advocate for the establishment and strengthening of relevant programs and services that support PLWHAs, to develop relevant HIV/AIDS policies and legislation for the prevention of stigma and discrimination, and to monitor and evaluate of the overall response.

Figure 6: National AIDS Commission Organogram



The NAC, through its Chairperson, reports directly to the Office of the Prime Minister. Representatives from key stakeholder groups, including governmental ministries, UN agencies, national NGOs, community-based organizations (CBO), faith-based organizations (FBO), and PLWHA make up its membership.(18) District Committees report to the NAC and act as coordinating bodies at the community level. The Committees advocate for the provision of services within the districts, promote active community participation to support those infected and affected by HIV, and represent key local stakeholder groups.

The NAC Secretariat supports the work of the Commission and is responsible for facilitating the overall coordination of the Commission's work and M&E. The Secretariat comprises an Executive Director, M&E Officer, Communication and Programs Officer, Finance Officer, Secretary, and Driver. It supports and facilitates the four standing committees, the NAC's public relations efforts, resource mobilization, and the coordination of M&E. The Secretariat liaises with international organizations and plays an active role in regional planning efforts and the monitoring of regional standards. The Ministry of Human Development and Social Transformation is charged with the administrative management of the NAC Secretariat.

Political Support: According to the 2010 NCPI, political support for the national response to HIV/AIDS has improved since 2003.(9) While the head of government did not speak publically about HIV/AIDS issues, other high-level government functionaries spoke on the topic in major domestic and international fora in 2009. Importantly, several governmental ministries, including Education and Youth, Human Development and Social Transformation, Health, and Labour have earmarked budgets from national funds for HIV-related activities. The 2009 API rating for political support places Belize on par with the rest of Central America, with 64 and 63 out of 100 points respectively.

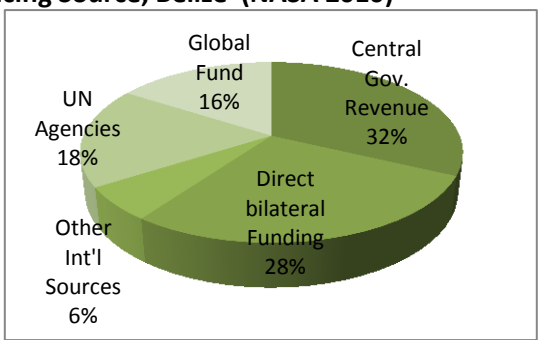
Participation of Civil Society

The 2010 NCPI indicates a steady improvement in civil society participation in the national response. The NAC standing committees include significant representation from many actors of civil society. Civil society played an important role in consultation and planning sessions for the development of the NSP, Global Fund Proposals, the National M&E Plan, and the Legislative Review. Participation by PLWHA is limited. The high-level of HIV-related stigma and discrimination may limit the number of PLWHA from stepping forward and openly playing a role in the response.

7 FINANCING OF THE NATIONAL RESPONSE

Belize conducted its first National AIDS Spending Assessment (NASA) in 2010.(21) This study documents the amount and distribution of spending on HIV/AIDS by spending category, financing source, and beneficiary population. For the 2008-2009 fiscal year, the total national AIDS expenditure was BZ$4,922,545, or 6.84% of Belize's national health budget.

Figure 7: Percentage of National AIDS Expenditures by Financing Source, Belize (NASA 2010)



The Government of Belize (GOB) contributed 31.8% (BZ$1,283,494) of the total cash spending on the HIV/AIDS response, with international donors providing BZ$2,757,312 or 68.2%. (See Figure 8.) Twenty-eight percent (28%) of the total HIV/AIDS financing was from direct bilateral contributions (primarily USAID/G-CAP). The United Nations agencies, through earmarked grants, provided 18% of the financing. Finally, the Global Fund to Fight AIDS, TB, and Malaria (Round 3) was the source for 16% of the HIV/AIDS expenditures.

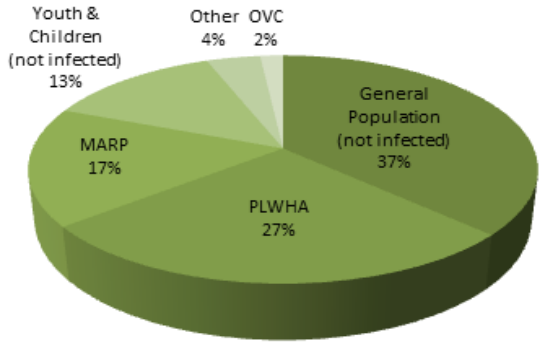
The highest HIV/AIDS expenditure category was Program Management and Administration (36.7%), followed by Prevention, Care and Treatment, and Enabling Environment (i.e. human rights based advocacy). (See Table 3.) The annual subvention paid to the NAC Secretariat amounted to 80% of the total program management expenditures.(9)

Table 3. Percentage of National HIV/AIDS Spending by Spending Category and Source, Belize 2008-2009.

AIDS Spending Category	Percentage (%)	National Contribution (BZ$)	International Contribution (BZ$)
Program Management & Admin.	36.7	381,552	1,100,109
Prevention	28.4	114,611	1,031,395
Care & Treatment	19.9	767,307	36,614
Enabling Environment	8.5	20,024	321,698
Orphans & Vulnerable Children (OVC)	2.1	-	86,550
Human Resources	2.0	-	80,619
Social Protection and Social Services (w/o OVC)	1.8	-	71,974
HIV/AIDS Related Research	.07	-	28,353
Total	100	1,283,494	2,757,312

Programs targeting the general population accounted for nearly 37% of the total cash spending. (See Figure 8.) This was followed by spending on programs targeting people living with HIV/AIDS (27%), Most-At-Risk Populations (MSM, CSWs, mobile populations and police) (17%), and non-infected Youth & Children (13%). Only 2% of the spending specifically targeted OVCs in 2008-2009.

Figure 8: Percentage of National AIDS Expenditures Targeting Beneficiary Groups, Belize 2008-2009



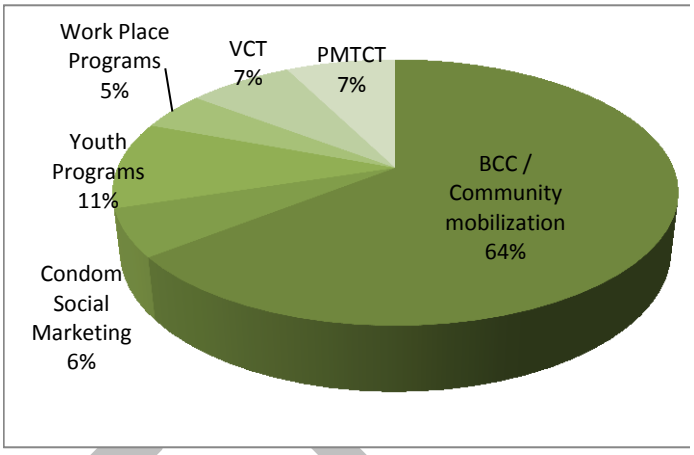
Source: 2010 NASA

8 PREVENTION

Belize's National Strategic Plan (2006-2011) identifies prevention of HIV/AIDS as a key priority to reduce the prevalence in Belize. To achieve this goal, the NSP aims to reduce transmission rates among (a) recipients of blood and children born to infected mothers, (b) the general population with emphasis on youth (15-24), and (c) most-at-risk populations (MSM, CSW, incarcerated population, uniformed services). Belize's HIV prevention programming received a score of 72 points out of 100 in the 2009 API, which was 10 points higher than the Central American regional average (62 points). The API respondents rated VCT, youth HIV prevention, PMTCT, safe blood banking, and the distribution and social marketing of condoms as the most successful areas. Mass media campaigns were rated lowest.

Nearly 28% of the Belize's national HIV/AIDS expenditures in 2008-2009 (BZ$1,146,006) was spent on prevention.(21) (See Figure 9.) The majority of the prevention expenditures focused on behavior change communications (BCC) programming and community mobilization (64%). Youth prevention programs made up 11% of the total prevention spending. The remaining expenditures were spread thinly among PMTCT (7%), VCT (7%), Condom distribution/social marketing (6%) and work place prevention programs (5%).

Figure 9: Percentage of National HIV/AIDS Prevention Expenditures by Program Area, Belize 2008-2009



Source: 2010 NASA

Behavior Change Communication-Information, Education, Communication Programs (BCC/IEC)

Data obtained from the "Mapping the National Response" activity demonstrates that most participating organizations implemented or supported BCC/IEC activities in Belize. The participating governmental institutions and NGOs reported covering a variety of methodological approaches, target populations, and geographic reach. Governmental institutions, including the Ministry of Health (MOH), Women's Department (Ministry of Human Development and Social Transformation), Ministry of Education (MOE), Ministry of Labor (MOL), Belize Defense Force (BDF), National AIDS Commission (NAC), National and Police reported implementing BCC/IEC activities with populations in all six districts.

The MOE implements the Health and Family Life Education (HFLE) program in all primary schools throughout Belize. The program aims to increase knowledge and skills on sexual and reproductive health and HIV; however, the MOE is not implementing the methodology fully in each school. Importantly, the MOE has assumed full budgetary responsibility for HFLE in primary schools and has employed six additional HFLE officers to support implementation in schools. The recently awarded Global Fund Round 9 Project will provide support to the MOE to train counselors and teachers to implement HFLE in 100% of the secondary schools, which has represented a serious gap in programming.

The Women's Department implements the Gender Awareness Safe School Program, an initiative to provide a participatory tool for teaching youth in Belizean secondary schools about the importance of Gender and related issues.(22) The Program implements interactive sessions on HIV/AIDS, self-esteem, sexual harassment, gender sensitization, and domestic violence. The Women's Department reached 1,889 students in 2009.

NGOs, including the Belize Family Life Association (BFLA), Alliance Against AIDS (AAA), Cornerstone Foundation, POWA, Youth Enhancement Services (YES), Belize Red Cross, UNIBAM, and PASMO, play an important role in implementing BCC/IEC programs in Belize, especially among MARPs. While these activities take place in each of Belize's six administrative districts, nearly 100% of the organizations work in Belize City. Toledo represents the district with the most limited IEC/BCC presence.

Condom Distribution

According to the 2009 MAP Study conducted by PASMO/PSI, half of Hot Zones[11] met condom availability targets[12]. When considering high-risk[13] sites exclusively, only 25% of the hot zones had met the condom availability target. This level of coverage is down since 2007.(23) The MAP Study also indicates that only 25% of hot zones had at least one vendor selling water-based lubricants on the day of the survey.

Table 4: Percentage of Hot Zones with at least 75% condom coverage, by type of distributor, Belize 2007-2009

Type of Distributor	2007	2008	2009
High risk	40%	25%	25%
Any[10]	50%	40%	50%

Source: 2009 MAP Study

Facilitated by Belize's Round 3 Global Fund Project, both NGOs and governmental institutions have distributed free condoms as a part of prevention activities. With the end of Round 3 many NGOs reported condom stock outs and have discontinued this activity until more condoms become available. For Belize's Global Fund Round 9 Program, free condoms will be distributed (nearly 1,169,000) to MARPs through interventions linked with the project. UNFPA and MOH also have a cost sharing agreement (2009-2011) for the procurement of male and female condoms, which are procured at very low cost.

Population Services International/Caribbean (PSI/C) supports the sale of socially marketed male condoms in the form of Vive and COOL (in partnership with BFLA and CARISMA). Additionally they support the sale of branded condoms at Got-It Get It certified non-traditional outlets (GIGI).[14] Over the life of the project, PSI/C will support the sale 135,000 socially marketed IPPF condoms along with an additional sale of 110,000 branded condoms at GIGI outlets, including 2000 female condoms.

Voluntary Counseling and Testing (VCT)

In 2003, Belize introduced its first VCT Center, the Pro Care and Treatment Facility, in Belize City. Currently there are four stand-alone VCT Centers that are managed vertically by the National TB, HIV/AIDS, and other STIs Program.(24) The 2009 MOH HIV Surveillance Report indicates that 5,125 men and 4,099 women tested in Belize. Between 2008 and 2009 VCT accounted for 7% the national HIV prevention spending. (21)

According to a recent review of public-sector HIV services, Belize implements a mixture of VCT and Provider Initiated Testing and Counseling (PITC) services. As of 2009, 65 health care professionals from public and private agencies were trained in VCT. Through the Global Fund Round 9 Project, the MOH plans to scale up PITC throughout the public health system, in addition to maintaining the VCT Centers.

NGOs also provide VCT, including Kolbe Foundation (Belize Central Prison), Claret Care, and BFLA. Currently BFLA has 8 centers countrywide that provide sexual and reproductive health services and VCT.

[10] "Any" includes high-risk sites, non-traditional sites, and pharmacies.

[11] The MAP study defines Hot Zones as a Geographic spaces where target populations (MSM, FSW) concentrate for work or social reasons.

[12] The hot zone condom of availability target was 75% of all condom outlets having condoms available on day of the study visit.

[13] "High Risk" sites include places where target populations (MSM, FSW) meet for social or sexual reasons (night clubs, brothels, bars, motels, saunas, massage parlors, etc.)

[14] The Got It Get It outlets have been branded, indicating that the distributor is trained and ensuring higher quality of service.

Private, for-profit clinics and laboratories also provide testing services; however it is unclear how many HIV tests are performed by private providers.[15]

A 2010 Laboratory Assessment indicated major gaps in the quality of VCT services.(25) Government and NGO sites visited during the assessment had no process or procedure documents available. Multiple nurses working at public and NGO VCT sites reported having been trained in counseling but not on testing procedures. Also no processes or formats for periodic reporting and monitoring of testing were in use.

Workplace Prevention Program

Since 2003, Belize's Ministry of Labour, in coordination with the Belize Chamber of Commerce and Industry (BCCI) and labor unions, has implemented an HIV workplace education program utilizing a model created by the International Labour Organization (ILO).(9) The model involves a formative assessment of the business, which in turn is used to develop a workplace BCC program. Peer educators are trained to implement the BCC activities onsite. Since the program's inception, 40 companies, with over 6,000 employees, have participated in the BCC trainings. A total of 22 companies in agriculture, tourism, sanitation, and other sectors have implemented workplace HIV policies as part of the MOL's program.

Prevention with MARPs

MSM: With support from the GOB and international donors, eight non-governmental organization targeting MSM populations. BFLA, for example, has a presence in each district and reaches MSM with information, condoms, VCT, and STI diagnosis and treatment. PASMO and PSI/C also work throughout Belize and has provided information, peer counseling and condoms to MSM. The United Belize Advocacy Movement (UNIBAM) implements BCC, human rights and advocacy activities among MSM, transgender populations and others. The recently awarded Round 9 Global Fund Project aims to reach 3,000 MSM over the project period with information on HIV/AIDS and STIs and correct, consistent condom use. The Round 9 Project will also distribute condoms to MSM and provide referrals to STI screening and treatment at a subsidized cost.

FSW: AAA, BFLA, PASMO, POWA, UNIBAM, and PSI/C target prevention services to FSW, including IEC/BCC, condom distribution, VCT and STI diagnosis and treatment. While the majority of the activities take place in Belize City and Stann Creek, both PASMO, BFLA and UNIBAM work in all six districts. Through the Global Fund Round 9 project, approximately 1,500 FSW will be reached with BCC interventions and condom distribution and over 900 FSW will be referred to free STI screenings and treatment during the five years of the project.

Incarcerated Population: The Kolbe Foundation is a Canadian organization which manages Belize's Central Prison. In conjunction with the MOH, the Kolbe Foundation provides VCT services. In coordination with the Belize Red Cross, a small-scale peer education program was initiated. For all HIV positive inmates, the Kolbe Foundation provides ART and psychosocial support services.

Uniformed Personnel: The Belize Defense Force requires mandatory testing upon entering the armed services, and HIV positive applicants are not admitted into the BDF. With funding from PEPFAR/US

[15] Private clinics and laboratories only report preliminary positive test results to the national authorities to complete confirmatory testing through the CML.

Department of Defense, the BDF has partnered with Charles Drew University to implement HIV prevention activities, including BCC, condom distribution, and VCT promotion.

The Belize Community Policing Program reaches other uniformed personnel, including police officers and customs officials. The Community Policing Program has trained peer educators and provided HIV education sessions to these groups of uniformed personnel.

Youth: Nearly 11% of the 2008-2009 prevention expenditures were aimed at youth. Organizations and institutions such as the Belize Red Cross, PAMSO, YWCA, BFLA, WIN Belize, Youth Enhancement Services, Community Policing, Youth for the Future and the HFLE Program have focused their prevention efforts on this population, primarily through BCC/IEC and condom distribution activities.

Belize's Global Fund Round 9 Project has a specific emphasis on young people. The Project will provide for a BCC campaign targeting nearly 17,000 young people in secondary school. A mass media campaign in year two of the Project will promote partner reduction and consistent condom use among 50,000 out of school youth (15 to 24 years old). Additionally Round 9 funds will provide support to the MOE to introduce HFLE in 100% of the secondary schools. The funds will also scale up an existing peer education program implemented by the Belize Red Cross to at least 85% of the secondary schools, reaching at least 5,000 youth over five years.

Prevention of Mother-to-Child-Transmission (PMTCT)

The MOH's Maternal and Child Health Unit launched Belize's PMTCT program in 2001, with a pilot program in Stann Creek, Corozal, and Belize districts.(9) The program expanded nationwide in 2002 and has continued to implement a regularly updated protocol. PMTCT efforts reach beyond the MCH Unit to the private sector, with private physicians regularly sharing information regarding HIV positive pregnant women and accessing free ARVs, laboratory services, and replacement feeding for their clients. Given the program's high HIV screening and treatment rates, the 2010 UNGASS Report highlighted the Belize's PMTCT efforts as a best practice.

Pregnant women who access public MCH clinics are tested for HIV at the time of their first visit. The women either test onsite or are referred to a VCT center. Women testing negative are tested again at 32 weeks. The PMTCT program refers HIV positive women to the VCT Center to access treatment and care, including CD4 testing every three months. The current PMTCT protocol calls for treatment to be initiated in the 13th week of pregnancy. According to 2008 program records, however, only 22% of women access antenatal care (ANC) during the first trimester. The majority (66%) sought ANC services in the second trimester, and 12% in the third.

Infants exposed to HIV receive Zidovudine and Bactrimel for the first six weeks. Dried Blood Spots (DBS) specimens are prepared and sent to Honduras for PCR testing at 48-72 hours, 6 weeks and 12 weeks after birth. MOH provides free replacement feeding for the first 10 months for children born to HIV positive mothers. Pediatric HIV cases are seen at MCH clinics for the first 18 months, after which they are referred to pediatricians in the hospital for clinical management and to the VCT for ARVs. Currently Belize has no protocol for management of pediatric HIV cases.

Blood Banks

The Central Medical Lab (CML) provides blood banking services for Belize. The CML screens all blood for HIV-1 and HIV-2 strains, hepatitis B virus, syphilis, Chagas disease, and malaria. According to the 2010 UNGASS Report, 100% of donated blood units were screened for HIV in a quality assured manner.

Belize's CML utilizes a standard algorithm for HIV screening, and CAREC provides external quality assurance on donated blood supplies.

Sexually Transmitted Infection Diagnosis and Treatment

The National TB, HIV/AIDS, and other STIs Program is responsible for STI prevention, diagnosis and treatment. According to the Global Fund Round 9 proposal, Belize has not emphasized STI surveillance and limited resources have been dedicated to STI diagnosis, treatment and reporting. Syndromic management is used to treat STIs. Importantly, the current MOH protocols do not require patients testing positive for an STI to be offered an HIV test.

MCH clinics in 2008 reported 119 cases of trichomonias, 127 cases of bacterial vaginosis, 63 cases of candidiasis and 58 cases of actinomycis spp (bacteria). Rapid tests for syphilis are available at times, however, there is no ability to regularly test for Chlamydia in Belize. Through the Round 9 Global Fund Project, the MOH will work with NGO clinics to provide subsidized STI diagnosis and treatment to 1,875 FSW and MSM (reached through BCC activities).

9 TREATMENT, CARE, & SUPPORT

Since 2003 the MOH has provided free ART to men, women, and children meeting medical criteria for treatment (clinical signs of AIDS and CD4 counts between 350 and 200). Nearly 20% of the total national HIV/AIDS expenditures is directed towards HIV treatment and care (BZ$803,921), with 48% of that spending covering first-line ART (adults) in 2008-2009.(21) The ARV procurement and distribution are managed by the National TB, HIV/AIDS, and other STIs Program. By the end of 2009 there were 11 treatment and care sites in Belize, with 855 people receiving ARVs.

Table 4 : HIV Treatment & Care Sites

Health Region	Treatment Sites
Southern	Punta Gorda Community Hospital
	Southern Regional Hospital
Western	San Ignacio Regional Hospital
	Western Regional Hospital
Central	Karl Heusner Memorial Hospital
	Hand in Hand Ministries (FBO)
	Kolbe Foundation (Belize Central Prison)
	Belize Defense Force Health Center
	San Pedro Polyclinic
Northern	Northern Regional Hospital
	Corozal Community Hospital

Belize scored 63 out of 100 points for HIV/AIDS treatment and care on the 2009 API, falling below the Central American regional average of 69 points. Although Belize received strong scores for the overall provision of ART, MOH data estimates that approximately 61% of adults and children in need of ART received it in 2009, an improvement from the 2008 estimates (49%). Importantly, women aged 15 years and older represented the group with greatest estimated need for ART; only 50% of women needing ARVs were on treatment compared to 74% of men.

In 2005 Belize adopted the Caribbean Guidelines (PAHO, CAREC, CDC, CHART) for the clinical management of adults and adolescents. Care and treatment are provided by one doctor in each district, generally internists. Most of the doctors attend to patients at the VCT Centers or hospitals; however if no doctors are available, as is the situation at the Southern Regional Hospital (Stann Creek District) the VCT nurse provides HIV care and treatment to patients.

In 2009, the MOH only provided first-line ARVs to adults. Limited second-line ARVs were available for pediatric cases. Belize procures ARVs directly through an arrangement with the PAHO Strategic Fund for

HIV and AIDS. With the Round 9 Project, the Global Fund is set to provide first or second line ARVs for 200 people for the first two years of the project, at which time the MOH will absorb the costs.

Adherence

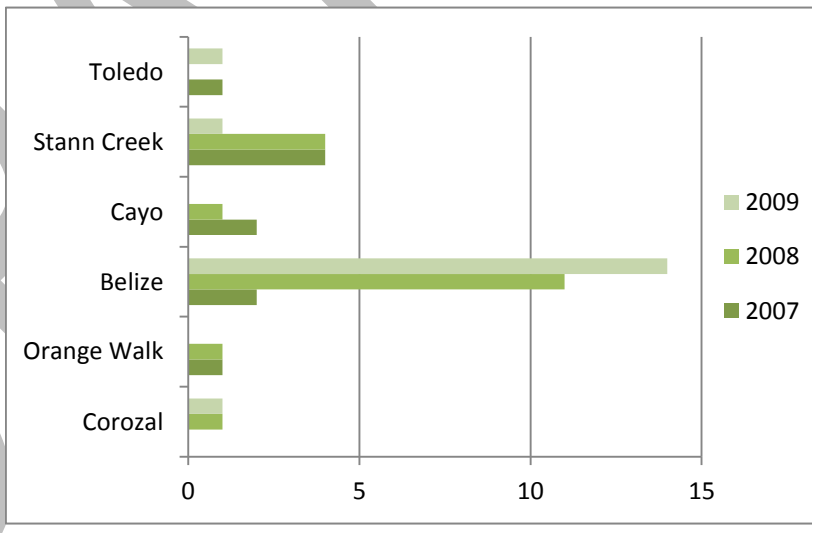
Although the MOH has improved and increased the provision of free ARVs to PLWHA, treatment adherence remains an impediment to the national response. In 2009, according to the Global Fund Round 10 proposal, the MOH did not have a system in place to conduct follow-up case management to support treatment adherence. VCT site data indicates that only 26.7% of adults and 47.37% of children were adhering to their ARV regimens. When adding mortality data, the national loss-to-follow-up was 22.96%. Low levels of adherence in Dangriga, Belize City, and Belmopan demonstrate a critical concern requiring immediate attention. The MOH currently uses four the 11 World Health Organization (WHO) Early Warning Indicators (EWI) to monitor resistance to ARV drugs in Belize.

HIV – Tuberculosis Co-Infection

By district, nearly 63% (49/78) of cumulative TB/HIV co-infections reported between 2007 and 2009 were found in the Belize district. (8) This was followed by Stann Creek with 20.5%, and Cayo with 6.4%. According a 2007 National HIV/AIDS Epidemiological Profile, spectrum estimates suggest under detection of TB in HIV patients.

Collaboration between Belize's National TB, HIV/AIDS, and other STIs Program and the National TB Program continues to improve; however, there are no mechanisms in place to coordinate HIV and TB services in most health facilities. Given the vertical nature of Belize's HIV/AIDS program, HIV services are often not provided in the same facility and most TB patients are referred to VCT Centers. While a new TB protocol was recently developed, a TB/HIV co-infection protocol does not yet exist. Importantly, all TB patients are referred to the VCT Centers to be tested for HIV, but not all HIV patients are tested for TB.

Figure 12: Number of Cases of TB/HIV Co-infection by District, Belize 2007-2009



Source: 2009 Gender Based Analysis of HIV

Central Medical Laboratory

The CML, located in Belize City, is the country's primary public health laboratory. It uses fourth-generation ELISA to conduct confirmatory HIV testing on all HIV positive samples received from VCT Centers and public and private health facilities. The CML is responsible for procuring and storing all reagents.

All CD4 testing in Belize District and the northern, central, and western health regions is performed at the CML.(9) The Southern Regional Hospital has a CD4 machine, processes samples from the southern medical region, and serves as a back up to the CML. CD4 testing is performed on specific days due to a lack of laboratory technicians. Belize does not have a viral load machine and samples are sent outside of the country for processing, when funding is available. The CML conducts tests for tuberculosis, pneumonia, and other opportunistic infections as well.

Critically, in 2006, the building housing the CML was destroyed by fire, damaging equipment and infrastructure. Since the fire the CML has been located in a small, temporary facility that creates risk for contamination of laboratory samples, worker safety, and patient confidentiality.(25) The current status of laboratory facilities combined with limited human resources have compelled the MOH to limit collection of samples for CD4 counts to once per week, with results available after 10 to 15days.

The GOB has earmarked US$750,000 to restore the CML to full functionality. Global Fund support was sought to:

- Procure/install diagnostic and safety equipment for the CML
- Procure/install serology equipment for the blood bank
- Provide computer equipment to interface with the BHIS, permitting electronic test orders and report generation
- Expand regional laboratories in Belmopan, Corozal, and Punta Gorda

Support Services

According to the 2009 Global Fund proposal, the provision of psychosocial and material support to PLWHA through the national government "remains weak and in many instances non-existent." The 2009 API also rated the psychosocial support for PLWHA and their families as "weak". Mitigation Programs, such as support for orphans and other vulnerable children (OVC) and public and community services to reduce the economic and social impacts of HIV, received a score of 47 out of 100 points on the 2009 API. Of the total 2009 HIV/AIDS expenditures, less than three percent was dedicated to psychosocial support, social protection, and social services to people infected and/or affected by HIV/AIDS.

Within the health system a psychiatric nurse in the VCT Centers or public health nurses at other sites provide some mental health services and psychosocial support for HIV patients. Few services are available at the community-level to support people on ARVs. Importantly, there is no formal structure or agreement that links CBOs/FBOs and NGOs with the health system for the provision of supportive services. Although a National Referral and Counter-referral system exists, it is not utilized effectively to support people with HIV.

Few CBOs and NGOs offer supportive services to individuals infected and affected by HIV/AIDS. Hand in Hand Ministries provides care and support (food and psychosocial support) to pediatric HIV cases and their families. The Alliance Against AIDS coordinates a support group, in Belize City. Claret Care and POWA offer supportive services in Stann Creek and Cornerstone Foundation offers limited nutritional support to people infected and affected by HIV in the Cayo. District-level PLWHA support groups have also formed throughout the country (except Corozal). A nascent network of PLWHA support groups, the Belize Network of Positive Persons, has also formed and may be strengthened through the REDCA+ Round 10 Global Fund proposal.

Belize's Ministry of Human Development and Social Transformation provides full scholarships to students to obtain master's degree level training in counseling through the University of the West Indies. The Ministry plans to train ten professional counselors in the next five years to work with PLWHA. The Round 9 Global Fund Project aims to train 180 social workers, nurses, faith leaders, and community members on basic counseling skills to provide psychosocial support to approximately 3,600 PLWHA and their families over 5 years. This initiative will focus on Belize and Stann Creek during the first 2 years of the project and scale up nationally.

10 HUMAN RIGHTS, STIGMA & DISCRIMINATION

National Response to Human Rights, Stigma and Discrimination

The 2006 National HIV/AIDS Policy adopts a human rights and responsibilities perspective and incorporates the fundamental rights freedoms found in the Constitution of Belize, the Universal Declaration of Human Rights, and other international agreements.(9) It provides a basis for the development of a legal and ethical framework to guide the conduct of PLWHA, service providers, public institutions, the private sector, and general public. Through the policy the national response aims to "respect the fundamental rights and freedoms of all persons regardless of their HIV status". (See Figure 13.)

Figure 13: National HIV Policy Guiding Principles

The Constitution of Belize and International Human Rights Conventions and agreements which have been signed and ratified by the Government provide the framework for the formulation of the HIV/AIDS Policy for Belize. The Policy is founded on the following principles:

1. Equity in Access to Goods and Services
2. Non-Discrimination
3. Individual and Collective Responsibility
4. Community Participation and Involvement
5. Partnership Building and Social Dialogue
6. Voluntary HIV Testing
7. Confidentiality
8. Professional Ethics
9. Committed Leadership
10. Stigma Reduction
11. Evidence-Based Planning
12. Integrated Planning
13. Best Interests of the Child
14. Gender Equity and Equality
15. Good Governance

While the National HIV Policy stipulates that the rights of all people shall be respected at all levels within the health and education system, it lacks a legal framework for enforcement. As reported in the 2010 NCPI, Belize does not have laws or regulations that protect PLWHA against discrimination.(9) Belize scored below the Central American average for human rights programs in the 2009 API, with a score of 42 out 100 points. The API highlighted the lack of mechanisms to record, document, and address cases of discrimination experienced by PLWHA, MARPs, and other vulnerable sub-populations. Additionally, the second evaluation of Belize's implementation of the San Salvador Declaration confirmed this conclusion.(26) Belize received low scores for stigma and discrimination due to a lack of laws protecting the rights of PLWHA and a lack of government IEC campaigns to combat stigma and discrimination.

In 2009, the NAC initiated a legislative review funded by the Caribbean Development Bank to identify legislative gaps in the national response to HIV/AIDS.(27) The report highlighted the lack of specific legislation that:

- Protected PLWHA against discrimination (in the workplace, education system, medical system, etc.) on the basis of HIV status;
- Prohibited discrimination against members of vulnerable groups such as MSM, sex workers, and incarcerated populations
- Imposed a positive duty on health care professionals to protect the confidentiality of medical records and information obtained on PLWHA during the course of treatment
- Required employers to adopt and implement the National HIV/AIDS workplace policy
- Prohibited employers from requiring mandatory screening of employees of HIV/AIDS.

The legislative review suggests specific modifications to existing national laws, including the Public Health Act, the Labour Act, Social Security Act, Immigration Act, and the Penal Code. Additionally, the review proposes new legislation, such as an Allied Health Care Bill and a Pharmacy Bill, which would require confidential treatment of medical records, prohibit the disclosure of information on one's HIV status, and impose sanctions for breach of confidentiality.

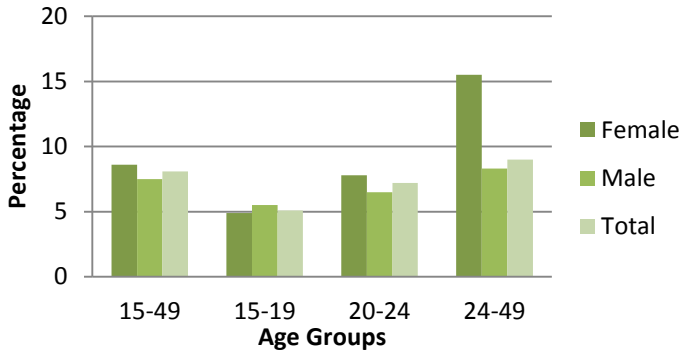
Non-governmental organizations, such as UNIBAM and the Alliance Against AIDS, work to reduce stigma and discrimination against PLWHA and vulnerable populations, such as MSM, FSWs and transgender women. UNIBAM, for example, implements the Legal Empowerment Project, which builds the capacity of people living with HIV and sexual minorities to become human rights defenders and provides legal advice to these groups who are suffering rights abuses in Belize. The project focuses on data collection, advocacy, and strengthening the capacity of these groups to participate in legal reform mechanisms. The Round 9 Global Fund Project indicates that several NGOs will work with PLWHA and sexual minorities to design a "Know Your Rights/Laws" media campaign to reach the general population. Additionally, over the next five years, the MOH will also provide ongoing stigma and discrimination for 1440 health care providers.

Attitudes Towards PLWHA among General Population

The 2009 Belize Sexual Behavior Survey (SBS) indicates high levels of unaccepting attitudes towards PLWHA, with only 8.1% (241 respondents) of men and women (15-49 years old) expressing accepting attitudes[16] towards PLWHA. Youth 15 to 19 years old expressed the least acceptance of PLWHA, at 5.1%. Nine percent of 24-49 year olds expressed accepting attitudes, led by 15.5% of women in this age group. Such low accepting attitudes towards PLWHA among the general population suggest a high level of HIV/AIDS stigma and discrimination and misconceptions about the disease.

[16] To determine "accepting attitudes" towards PLWHA, the 2009 SBS asked: (1) If a member of your family is sick with HIV, would you be willing to care for him/her in your household? (2) If a member of your family became infected with the HIV virus, would you want it to remain a secret? (3)Would you buy food from a vendor if you knew that person was HIV positive? (4) In your opinion, if a teacher is HIV positive but not sick, should that person be allowed to continue teaching?

Figure 14: Percentage of the General Population with Accepting Attitudes Towards PLWHA, Belize 2009



Source: 2009 Belize Sexual Behavior Survey

Stigma and Discrimination Towards PLHA and MARPs among Health Care Providers

Qualitative research among PLWHA and other vulnerable groups, including MSM and FSW, have consistently highlighted a perception of high levels of health care provider stigma and discrimination.(28-31) Consultations with MSM and FSW in 2008 concluded that experiences with stigma and discrimination and the fear which factors in with this experience, many times will discourage them from accessing much needed services.(32) Breaches of confidentiality were repeatedly mentioned as a concern of MSM and FSW seeking VCT and other services.

A 2007 population-based survey of doctors and nurses working in public hospitals in Belize characterized their stigmatizing attitudes and acts of discrimination against PLWHA.(33) The study concluded that the health care workers tended to be more stigmatizing toward those patients belonging to marginalized groups, including MSM and FSW, who are believed to have contracted the virus through "morally" sanctioned practices. Additionally, the results show that nearly 29% of health care workers reported differential treatment of patients based on HIV status. Twenty-two percent of health care workers surveyed indicated that they had disclosed a patient's HIV status to colleagues at least once. Nearly 10% of respondents indicated that they had let a colleague work with a patient because of his/her suspected HIV/AIDS status.

According to a UNIBAM study, the MSM population is "invisible to the national health system", limiting the MOH's ability to deliver health services to this high risk group.(34) Due to high levels of homophobia in Belize, there is a reluctance to disclose MSM status when taking HIV tests. Among a sample of 103 MSM who were tested for HIV, only 22.6% indicated that they honestly disclosed their sexual orientation to health workers.

11 MONITORING AND EVALUATION

The 2009 API ranked Belize on par with Central America in terms of research, monitoring, and evaluation (55 out 100 points and 54 out of 100 points respectively). Areas of strength include the presence of M&E technical resources in Belize, including full-time M&E staff in the NAC and National TB, HIV/AIDS, and other STIs Program, and the national HIV/AIDS surveillance system. Belize scored weakest on seroprevalence and behavioral surveillance of most-at-risk groups and the use of data for program planning and policy formation.

National Monitoring and Evaluation Plan

The 2010 NCPI demonstrates a steady improvement in M&E related to Belize's national response to HIV/AIDS. In accordance with the Three Ones Principle and other international commitments the National AIDS Commission produced the *National Monitoring and Evaluation Plan of the National Strategic Plan (2006-2011)* in 2008. The purpose of the plan is to guide the core M&E activities to be implemented within the framework of the NSP.

National AIDS Commission

As described in the NSP, the NAC plays a critical role in the monitoring and evaluation of the implementation of national response. An HIV/AIDS M&E Officer is located within the NAC Secretariat and is directly responsible for coordinating all M&E related activities, including:

- Supervision of the national M&E Plan
- Design and implementation of a strategic information communication, in collaboration with the Communications Officer
- Coordination with national and regional M&E partners
- Provision of M&E technical assistance to partners
- Oversee special studies and/or surveys

The M&E Officer provides technical support to the recently revitalized NAC M&E standing committee, which comprises seven members from both civil society and GOB. According to the Plan, the key objectives of the M&E standing committee include:

- To coordinate and facilitate the implementation of the national M&E Plan
- To safeguard the quality of M&E activities that are part of the national HIV and AIDS response reports
- To submit strategic information and recommendations for decision making to the NAC for policy making, planning, research and general use.

While the National M&E Plan and standing committee exist, at the time of this assessment, no mechanism was in place to ensure that all major implementing partners reported M&E data to the NAC M&E Officer for inclusion in the national M&E system.(9) The current M&E Plan does not include an implementation plan, resource mobilization strategy, clear research agenda, or data dissemination strategy. The data collected responds primarily to donor requests and international commitments and is not linked to user needs. The NAC has purchased and modified a national M&E tool, Development Information (DevInfo), for warehousing, management, and dissemination of HIV information from outside of the national public health facilities; however this system is currently not in use.(9)

Belize Health Information System

The Ministry of Health implements the Belize Health Information System (BHIS), which consists of multiple modules that capture data for each client of the public health system and provide important details on each of their encounters.(3) The HIV/AIDS module, which is based on the WHO staging criteria, has been installed at VCT Centers, BFLA clinics, Hand-In-Hand Ministries, Kolbe Foundation (Belize Central Prison), and the Belize Defense Force medical facility. It records data collected during pre-and post-voluntary testing and counseling and clinic visits, and records factors and case histories to assist in assessing risk and contact tracing. Each facility with BHIS access has a secure version of the database on its server that synchronizes continuously with master data store. Data are refreshed

instantaneously, enabling health-care providers to monitor patients in "real-time" and supporting treatment and care of PLWHA.

HIV Surveillance

The BHIS is also a primary source of surveillance data. The Epidemiology Unit of the MOH is responsible for collection, compilation, analysis and interpretation of health data, including HIV/AIDS, and the dissemination of health information to support decision making. Importantly, this is a passive surveillance system that relies entirely on positive cases reported by the VCT Centers, NGO clinics and the Central Medical Laboratory through the BHIS. Additionally, the National TB, HIV/AIDS and other STIs Program provides the Epidemiology Unit with Rapid Test and Adherence Report Forms on a monthly basis. The MCH Unit submits PMTCT data separately to the Epidemiology Unit.

The Epidemiology Unit is charged with producing a quarterly HIV/AIDS Surveillance Report. No quarterly reports had been produced or disseminated in 2010 because of human resource constraints in the Unit.

12 ADVANCES, CHALLENGES & OPPORTUNITIES

Since the first case of HIV/AIDS in Belize, nearly 25 years ago, it is clear that the national response to the epidemic has grown more comprehensive. It has developed to represent financial, material and human efforts at multiple levels and from various actors, including international donors, governmental institutions, civil society, PLWHA, faith-based organizations and other NGOs. Below, several advances in the national response to HIV/AIDS are described followed by challenges and opportunities.

Advances

- The Three Ones: Belize has been successful in strategically focusing its national response through (1) the legal establishment of the National AIDS Commission as the statutory coordinating body, (2) the development of a National Strategic Plan (2006-2011) to guide the response, and (3) the existence of a singular National M&E Plan to assess progress.

- National Policies: Belize's Cabinet approved two important national policies: National AIDS Policy and National HIV/AIDS in the World of Work Policy. The 2006 National HIV/AIDS Policy, for example, adopts a human rights and responsibilities perspective and incorporates the fundament freedoms protected in the Constitution of Belize, the Universal Declaration of Human Rights and other international agreements. The policies provide a basis for the development of a legal and ethical framework to guide the national response to HIV/AIDS.

- Multi-Sectoral Participation: Belize's national response to the HIV/AIDS epidemic has had active participation from multiple sectors, including various government ministries, civil society, non-governmental organizations, international donors, multilateral organizations, the private sector and other stakeholders. That National AIDS Commission and its standing committees, for example, includes representatives from the Ministry of Human Development and Social Transformation, Ministry of Tourism, Ministry of Education and Youth, Ministry of Labour, Belize Chamber of Commerce and Industry, PLWHA, NGOs, CBOs, FBOs.

- Political Support: The NAC sits within the Office of the Prime Minister, which is ultimately responsible for the national response. High-level government functionaries have spoken publically on HIV/AIDS in major domestic and international fora and have signed international agreements,

such as the Mexico City Ministerial Declaration (2008). Additionally, ministries, including Education and Youth, Human Development and Social Transformation, Health, and Labour have an earmarked budget from national funds for HIV-related activities.

- PMTCT Program: Belize's 2010 UNGASS Report hails the national PMTCT Program as a best practice. This well-established program is integrated in the public maternal and child health service delivery. It successfully coordinates with private healthcare providers to offer free ARVs, laboratory services, and replacement feeding for their HIV positive pregnant clients. Belize's antenatal care coverage is estimated to be over 95% and the coverage of antenatal HIV screening is well over 90% since 2006.

- HIV/AIDS Treatment: Since 2003 the MOH has provided first-line ARVs to PLWHA. There has been a steady improvement in reaching HIV positive patients in need of treatment. The percentage of adults and child with advanced HIV infection receiving ART increased from 49% in 2008 to over 61% in 2009. HIV treatment is provided at 11 sites throughout Belize, including the Belize Central Prison, the BDF medical facility, MOH VCT Centers, among others. According to the 2010 NCPI, since 2007 there have been no stock outs of ARVs.

- Belize Health Information System: The implementation of the BHIS improves Belize's ability to collect, analyze and disseminate surveillance data in a timely manner. The BHIS improves surveillance quality, linking patient records nationally and identifying duplicate records. The HIV/AIDS module records data collected during both pre- and post-testing and counseling and clinic visits and allows for the MOH to maintain case histories.

- Sexual Behavior Survey: Belize has collected comparable HIV knowledge, attitudes and behavior data of the general population in 2006 and 2009. This data is important to elucidate trends in the general population, particularly among youth.

Challenges

Prevention:

- Multiple qualitative studies of VCT services in Belize[i] indicate that stand alone VCT Centers may inhibit HIV testing. Respondents expressed concerns that the highly-visible stand-alone facilities fuel HIV-related stigma and discrimination. "The assumption is that anyone who goes there has AIDS and [people] don't want to be associated with it." Additionally, the studies highlight a strong perception that some VCT Center staff do not maintain patient confidentiality, offer poor or no pre- or post-test counseling, and express negative attitudes towards sexual minorities, PLWHA, and FSWs.

- There are major gaps in the quality of VCT services. A 2010 Laboratory Assessment demonstrated that untrained nurses were conducting HIV tests at public and NGO VCT sites. VCT guidelines and written procedures were not available at many sites.

- Belize lacks seroprevalence and behavioral data for MARPs, including MSM, CSW, PLWHA, and mobile and migrant populations.

- There is an incomplete integration of HIV/AIDS and other STIs. STI, reproductive health and family planning patients of the public system are not routinely offered HIV tests, resulting in missed opportunities to test potentially high-risk individuals.

- With the end of the Round 3 Global Fund Project, many NGOs reported condom stock-outs.

- The coverage of water-based lubricants in hot zones is low (25%).

- The Ministry of Education (MOE) has not fully implemented the Healthy Family and Lifestyles Education Program (HFLE) in primary and secondary schools. There is an uneven application of the school curriculum especially as it relates to dealing with sexual and reproductive health issues. The church-state system of education means that it is difficult to achieve a consistent approach in the implementation of the curriculum, since implementation is in the hands of different school managements. Additionally, some teaches have expressed discomfort and unwillingness to teach the curriculum. At the time of the situation analysis, HFLE was not being widely implemented in secondary schools.

- Prevention with Positives (PWP) services are extremely limited in Belize.

- Although the MCH Unit has been able to coordinate with private healthcare providers of HIV positive pregnant women, no formal accords exist between the two sectors. There are no official agreements for private providers to share information on HIV pregnant women with the MOH for provision of free ARVs or replacement feeding.

- Current legislation requires that youth under 18 years of age require parental consent for HIV testing or other STI diagnosis.

Treatment, Care and Support:

- Although Belize's Health Sector Reform Project has decentralized health services into four health regions, HIV/AIDS continues to be managed vertically by the National TB, HIV/AIDS, and other STIs Program. This structure inhibits the Program from focusing on policy development and the monitoring and evaluation of protocols and service delivery. An important result has been incomplete development and implementation of testing and treatment standards, norms, and protocols.

- The MOH does not provide second line ARVs for adults. Anecdotally, PLWHA in need of second or third line ARVs seek them from regional or international organizations.

- No formal linkages between MOH and private health care facilities exist for the provision of ARVs to patients who seek care and treatment from private providers. PLWHA must obtain free ARVs solely from the public health system.

- The Central Medical Lab was destroyed by a fire in 2006 and has been located in a small, crowded temporary facility since. The current space creates risk for contamination of laboratory samples, safety and patient confidentiality. The state of the laboratory facilities combined with limited human resources have required the MOH to limit collection of samples for CD4 testing, increasing turnaround times.

- Low ARV adherence is a major concern to the national response. PLWHA have limited or no access to adherence counseling. No national ARV adherence strategy is currently place.

- Only 20% of incarcerated people who receive ARVs from the Medical Center located at the Belize Central Prison report for follow up treatment upon release. All HIV positive inmates taking ARVs are referred to the VCT Centers upon release, however, no mechanisms are in place for follow-up treatment.

- Supportive services for PLWHA, including pyscho-social, nutritional, and economic support, are lacking in Belize. Of the limited community support services that are available, most are implemented by NGOs, CBOs and FBOs. Importantly, there are no formal agreements between MOH and non-governmental supportive service providers.

- The MOH's National Referral and Counter-referral System is underutilized and outdated, limiting the ability to connect PLWHA and those individuals vulnerable to HIV with comprehensive services provided by governmental institutions and NGOs.

- A 2009 Health System profile indicates that inadequate health staffing is a core weakness for Belize's health system.(3) There exists an inequitable distribution of qualified health personnel, medical equipment and supplies in urban versus rural areas. Nursing attrition increased from 7.7% in 2001 to 9.6% in 2006.

Policy and Legal Framework:

- Belize's National AIDS Policy lacks a legal framework for enforcement. Belize does not have specific laws or regulations that protect people infected and affected by HIV/AIDS against discrimination based on HIV status, including when seeking employment or in the workplace, leasing homes, attending school, accessing healthcare, and purchasing health insurance.

- Although the National Policy of HIV/AIDS in the World of Work prohibits employers from requiring mandatory screening of employees for HIV/AIDS, no national legislation exists to prohibit this employment practice.

- Laws do not impose a positive duty on healthcare providers to protect the confidentiality of medical records and information obtained on PLWHA during the course of treatment.

- Belize's criminal code classifies "unnatural acts", or anal sex, to be a criminal offence, increasing stigma and discrimination against MSM and marginalizing them from prevention, treatment, care, and supportive services.

- The Nationality Act requires all people seeking permanent residency/citizenship to obtain an HIV/AIDS as part of the application process.

Stigma and Discrimination:

- Among the actors of the national response (GOB, civil society, NGOs, etc.) there is limited and conflicting information and perceptions regarding formal mechanisms to report instances of stigma and discrimination within the public health system.

- In general, health care workers are in need of capacity building and skills development to provide quality, open, and friendly services to sexually diverse populations, such as MSM, transgender women, and lesbians.

- MSM continue to represent a highly marginalized and neglected group in Belize. Men who are identified as MSM often face general stigmatization in the community and rejection from family, friends, landlords, employers, and health care professionals. These factors may contribute to MSM invisibility and the difficulty in reaching them with condoms, lubricants and risk reduction.

Research, Monitoring and Evaluation:

- A major challenge to evidenced-based planning of the national response is the availability of timely and reliable research. Specifically, research to identify MARPs, the driving forces increasing their vulnerability, and their place in general epidemic is unknown.

- No mechanism exists to ensure that all major implementing partners submit M&E data or report to the NAC M&E Officer for inclusion in the national M&E system.

- The current M&E Plan does not include an implementation plan, a resource mobilization strategy, or a clear research agenda. Also, there is no data dissemination schedule.

- The data collected by the NAC and implementing partners responds primarily to donor requests and international commitments and is often not linked to user needs.

Opportunities

- In 2009, the NAC initiated a full legislative review to identify legislative and regulatory gaps in Belize's national response to HIV/AIDS. This endeavor has resulted in the drafting of major legislative amendments and proposals for new laws. The NAC is planning nation-wide consultations on the draft legislation before forwarding them to Cabinet for approval and introduction as law.

- In line with the integration of HIV/AIDS into the primary health care system, capacity is being built for implementation of provider-initiated testing and counseling (PITC). The model requires all health care professionals to recommend and provide HIV testing to patients, reducing missed opportunities to diagnose HIV infection. This strategy is considered key to achieve Universal Access targets and will be promoted by Belize's Global Fund Round 9 Project.

- The recently approved Global Fund Round 9 Project promises to increase funding for prevention, treatment, care, and support, concentrating efforts in the hard-hit districts of Belize and Stann Creek. There is strong emphasis on reaching youth (in and out of school) and MARPs. Critical support is also provided for ARVs and viral load testing. Additionally, several research studies will be conducted to support evidenced-based planning.

- The Universidad de Valle (Guatemala), with funding from the US Centers for Disease Control (CDC), has begun preliminary work on the implementation of a much-needed Behavioral Surveillance Survey of MSM, FSW, and PLWHA. The results of this survey are expected in 2011 will provide HIV seroprevalence, other STI, and behavioral data needed for an effective national response.

- The NAC, in conjunction with NGOs such as AAA, have been instrumental in reinvigorating district support groups for PLWHA. Supportive services represent a large gap in Belize's national response. Additionally, the NAC is supporting the development of a national network of PLWHA to act as an advocacy for positive people in Belize.

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