National AIDS Commission

Responding to HIV/AIDS in Belize

Strategic Plan for a Multi-Sectoral National Response to HIVAIDS In Belize (2006 – 2011)

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Acronyms

AAA	Alliance Against AIDS
ARV	Antiretroviral
ART	Antiretroviral therapy
AZT	Azido-deoxy thymidine
BCC	Behaviour change communication
BEST	Belize Enterprise for Sustainable Technology
BFLA	Belize Family Life Association
BMDA	Belize Medical and Dental Association
BNA	Belize Nurses Association
BOWAND	Belize Organization of Women and Development
CAREC	Caribbean Epidemiology Centre
CARICOM	Caribbean Community
CBO	Community-based organization
CET	Centre for Employment Training
CCC	Caribbean Council of Churches
CCM	Country Coordinating Mechanism
CDB	Caribbean Development Bank
CDC	Centers for Disease Control and Prevention
CHART	Caribbean HIV / AIDS Resource Training Initiative
CML	Central Medical Laboratory
CRIS	Country Response Information System
CRN+	Caribbean Regional Network of Persons Living with HIV / AIDS
CSO	Central Statistical Office
CSW	Commercial Sex Worker
DAC	District AIDS Committee
FBO	Faith-based organization
GDP	Gross domestic product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPLA	Greater Involvement of Persons with AIDS
HBC	Home-based care
HCW	Health care workers
HECOPAB	Health Education and Community Participation Bureau
HFLE	Health and Family Life Education
HIV/AIDS	Human immunodeficiency virusacquired immune deficiency syndrome
HRM	Human resource management

Acronyms

IDB	Inter-American Development Bank
IEC	Information, education, and communication
ILO	International Labour Organization
KAPB	Knowledge, Attitudes, Perceptions, and Behaviour
KHMH	Karl Heusner Memorial Hospital
LACASO	Latin America and Caribbean Council of AIDS Service Organizations
M & E	Monitoring and evaluation
MCH	Maternal and child health
MEYS	Ministry of Education, Youth and Sports
MIS	Management Information System
MND	Ministry of National Development
MOH	Ministry of Health
MPS	Ministry of the Public Service
MSM	Men who have Sex with Men
NAC	National AIDS Commission
NAP	National AIDS Program
NATF	National AIDS Task Force
NCFC	National Committee for Families and Children
NGO	Non-governmental organization
NHI	National Health Insurance
NPESAP	National Poverty Elimination Strategy and Action Plan
NSF	National Strategic Framework
NSP	National Strategic Plan
OVC	Orphans and vulnerable children
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership against AIDS
PEP	Post-exposure Prophylaxis
PHLIS	Public Health Laboratory Information System
PLWHA	Persons living with HIV / AIDS
PMTCT	Prevention of mother-to-child transmission
SHAPES	School Health and Physical Education Services
SIC	Social Investment Fund
SICA	Central American Integration System
SIDALAC	Regional Initiative on AIDS for Latin America and the Caribbean
STI	Sexually Transmitted Infection
TB	Tuberculosis

Acronyms

TCC	Technical cooperation among countries
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
UNICEF	United Nations Children Fund
UNTG	United Nations Theme Group on HIV / AIDS
USAID	United States Agency for International Development
UWI	University of the West Indies
VCT	Voluntary counseling and testing
WHO	World Health Organization
YEA	Youth Enhancement Academy
YES	Youth Enhancement Service
YMCA	Young Men's Christian Association
YWCA	Young Women's Christian Association
YFF	Youth for the Future

Glossary

Input	Are the people training, equipment and resources that we put into a project in order to achieve the outputs.
Output	Are the activities or services we deliver, including the HIV/AIDS prevention, care and support services, in order to achieve the outcomes.
Outcome	Through the provision of good quality, economical, accessible, and widespread services, key outcomes should occur. Outcomes then, are the changes in behavior or skills, especially safer HIV prevention practices and increase ability to cope with AIDS.
Impact	The abovementioned outcomes are intended to lead to major measurable health impacts particularly reduced HIVSTI transmission and reduced AIDS impact.

(UNAIDS, 2002)

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Appendices

1. Introduction

This document is a broad national strategic plan designed to guide Belize's response to the HIVAIDS pandemic. It is not a plan specific to the health sector, but a statement of intent for the country as a whole, both within and outside the government. The plan recognizes that no single sector, ministry, department or organization is, by itself, responsible for addressing the HIVAIDS epidemic. It is envisaged that all government departments, organizations, and stakeholders will use this document as the basis for developing their own strategic and operational plans so that all the initiatives for the country as a whole can be harmonized to maximize efficiency and effectiveness.

HIV/AIDS is an infectious chronic disease with heavy social, economic, and developmental costs. The mortality structure of the disease is such that it strikes the most productive members of society— with over 50 % of new infections occurring in youths aged 15–24 years and about 70 % of all HIV/AIDS cases falling in the 15–44 year-old age group (ECLAC 2004). The impact of the disease lies in its ability to undermine economic growth through its effect on human, physical, and social capital. At the macroeconomic level, there is the immediate impact, which will be felt in terms of productivity losses due to decreases in labor supply.

At the end of 2005, there were estimated to be 300,000 persons living with HIV / AIDS in the Caribbean. HIV / AIDS, a long-term, fatal pandemic, has eroded the most economically active population of the region. A study conducted by the University of the West Indies predicted that by the year 2020, the direct and indirect costs of the HIV / AIDS pandemic to the region could reach US $20 million. However, the most recent evidence shows the Caribbean to be the only region in the world where the prevalence of HIV infection has not increased since 2003. Several countries in the Caribbean have also shown some recent evidence of a decline in HIV prevalence among pregnant women (although this is partly due to AIDS mortality), evidence of increased condom use among commercial sex workers, and evidence of expansion of voluntary counseling and testing services. Countries showing some signs of improvement in the epidemic in the Caribbean include Bahamas, Barbados, Bermuda, Dominican Republic, and Haiti. However, this is cause for only guarded optimism. In 2005, 30,000 persons were newly infected with HIV, and there were 24,000 deaths due to AIDS in the Caribbean. AIDS has become the leading cause of death in this region among the 15–44 age group, and the region remains the second most affected in the world.

In Central America as well, despite some signs of improvement, the epidemic shows little sign of slowing. In Panama and Costa Rica, improvements in access to antiretroviral treatment has increased considerably; with apparent improvements in AIDS mortality. However, in Central America in general, progress in this area has been slower than in the rest of the Latin American region. Also, the most recent publication on HIVAIDS in Central America produced by the World Bank reported that condom use in this region doubled from 1.8 million in 1999 to 18.1 million in 2001. However, there is continued need for improvement in condom distribution and use. The World Bank report showed four of the six countries in Latin America with the highest adult HIV prevalence at the end of 2001 to be Central American nations, of which Belize has the highest prevalence.

2. Strategic Plan

2.1 Purpose of the Strategic Plan

The National Strategic Plan for Belize will yield the following benefits:

- provide the structural framework to ensure cooperation and collaboration for action,
- supply guidelines and a framework for organizing and scheduling activities among the various agencies to avoid duplication of efforts,
- provide a frame of reference with agreed indicators and targets for measuring the country's achievements in its fight against the pandemic, and
- serve as the core coordinating mechanism for assisting with the resource mobilization and allocation for identified programmes and projects using a common basket approach.

This plan will guide Belize's scaled-up national response to HIV/AIDS. It sets out the fundamental principles and the broad approaches as well as the detailed actions needed to move the country from the current state (as documented in the situation and response analysis) to the achievement of the strategic objectives (as documented under the three priority areas in the strategic plan matrix).

2.2 Strategic Planning Process

The plan was developed using a participatory process at all levels. Applying the highly successful process of the joint application to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) which led to its subsequent approval, the National AIDS Commission conducted an updated situation and response analysis actively engaging various stakeholders in the discussions. These stakeholders included members of government and non-governmental agencies, community groups, labor and professional associations, private sector representatives, media representatives, members of civil society, donors, technical partners and persons living with HIV/AIDS.

Focus group discussions involving partners and representatives of district committees were carried out as well as site visits to voluntary counseling and testing (VCT) sites, care and treatment clinics during October 2004. A special consultation was convened with members of the Commission to obtain their input that guided the formulation of the proposed response.

In particular, the consultative team held extensive consultations with the Ministry Of Health officials, including a meeting with the minister held at the Secretariat of the NAC. Youth representatives were engaged as much as possible and a special meeting was held with student government representatives of the University of Belize. These consultations were essential to ensure the widest representation from all sectors of society and the inclusion of the views of as many stakeholders as possible in the formulation of priority areas and strategic objectives.

In addition to these discussions, it was necessary to meet directly with some key stakeholders to further define and bring to life concepts and visions that had emerged during the wider level consultations. Special emphasis was placed on discussions with

the Ministries of health, public service, education, human development, and tourism. A survey was administered electronically to these Ministries. In addition, a national stake holder's consultation was held in December 2004, at which time the draft strategic priorities were shared and defined. The Belize PAHOWHO country office supported this broad consultation.

The implementation of the strategic plan will adopt a multisectoral approach that demonstrates that an effective response to HIV/AIDS does not rely on individual ministries or agencies. The plan is built on a clear understanding of the comparative advantage of each entity and the opportunities for integration among the various entities to achieve a truly comprehensive, national expanded response where new partners are mobilized and where activities are well coordinated and prioritized.

Based on the gaps identified which include the absence or limited coverage of support services, quality and scope of existing care and treatment programmes and services, and the capacities to expand and replicate the response, priority areas were proposed to guide this phase of the response. The priorities identified also take into consideration the dynamic changes within the epidemic. Among those changes are the civil society response, the availability of new drugs and therapies, investigationdiagnostic tools and techniques of clinical management, and, very importantly, the needs of persons living with or affected by HIV/AIDS.

From this foundation, the lessons learned during the implementation of the previous strategic plan and the recent national consultations as well as the following principles emerge to guide the identified priorities and actions. The strategic plan for Belize is based on the following principles:

- **Inclusion and collaboration**: The articulated strategic response will reflect the needs and concerns of all sectors and target groups, in particular persons living with HIV/AIDS (PLWHA), their families, young people, and women.
- **Sustainability**: Resources required for financing the national response have been allocated in the national budget and estimates of expenditure. Further funding will continue to be accessed from partner agencies and the Global Fund.
- **Accountability**: There will be continuous implementation, monitoring, evaluation of programs and consistent reporting to stakeholders and the general public.
- The principle of **basic human rights** for all HIV–positive persons and their families will be promulgated in the appropriate legal and policy framework. The National Strategic Plan is informed by the considerations embodied in the National HIVAIDS Policy.
- **Unified leadership** involving partners from the communities, private sector, civil society, development agencies, and government institutions within the National AIDS Commission; will be provided.
- A **multisectoral approach** will be used in regards to planning, programming, implementing, monitoring and evaluating all stakeholders in support of the National Strategic Plan;
- The creation of an enabling environment **free from stigma and discrimination**;

- **Use gender equality** as a cross-cutting theme,
- Encourage active **involvement of communities and PLWHA** recognizing that PLWHA have equal rights (the majority of PLWHA do not know their HIV status);
- **The engagement and alignment** of international and local partners based on their comparative advantages to the national strategic priorities;

These principles create the opportunity for harmonization and strengthening of the critical coordination roles and functions of the National AIDS Commission.

3. Situational Analysis

3.1 Impact of HIVAIDS in Belize

Belize, with an estimated adult HIV prevalence of 2.4% at the end of 2005, has the unwanted distinction of having the third highest rate of infection in the Caribbean region and the highest in Central America.

According to Nicholls et al. (1997), by the year 2005, the gross national product of Belize will be at least 4.2%, lower than it would have been in the absence of HIV/AIDS, with a consequential fall in employment in such key sectors as agriculture and manufacturing by 20% if the disease is left unchecked. This study also estimated that in the absence of a national response, national savings stand to fall by as much as 10.3%. HIV/AIDS therefore harbors the real potential of crippling the level of national investment, which is a key variable in the determination of long-term economic growth.

3.2 Characteristics of the Epidemic

3.2.1 Prevalence

Data available since 1995 illustrates that, in the past several years, Belize has been experiencing a dramatic escalation in reported cases of HIV (Figure 1.), placing its prevalence at 2.4%—the highest in Central America and the third highest in the Caribbean.

Reports from 1986 through June 2005 indicate that 3,154 individuals in Belize have acquired HIV and 745 have developed AIDS. In addition, 576 deaths have been reported to be AIDS related.

A situation and response analysis was conducted in 2003. This was further elaborated and updated during 2004. The situation regarding HIVAIDS in Belize is highlighted by the following factors:

Population mobility, due to an open immigration policy, emigration, and immigration of seasonal agricultural workers;

60% of the population is under the age of 25 — the demographic sector with the highest infection rate;

A high fatality rate (85%) despite the availability of anti-retroviral (ARV) treatment;

Stigma and discrimination as a major factor inhibiting access to Voluntary Counseling and Testing (VCT), treatment, care, and support;

Feminization of the epidemic, particularly among young women aged 15–24;

A lack of strong central coordination in monitoring and evaluation standards and information dissemination;

High levels of poverty (33%);

The role and significance of the Catholic Church and others in education and in influencing attitudes and practice in the area of sexual and reproductive health; and

A limited capacity to coordinate and implement a national HIVAIDS strategy.

An examination of the demographic profile of HIV/AIDS reveals that there is no geographic district in Belize that is unaffected by the epidemic. The geographic distribution of infection during the period 1986–2004 is depicted in *Exhibit 3.1*. All districts in Belize have been progressively affected, with the majority of total new infections reported by the Central Medical Laboratory (CML) occurring in the Belize district (where over 45% of the population is located), and followed by Stann Creek and Cayo. *Table 1* also illustrates that the reported number of new HIV infections per 10,000 of the population increased notably in Toledo and Corozal in 2001-2003, indicating the epidemic in these districts may be worsening.

In terms of sex, the percentage of women infected has significantly increased. The male to female ratio has moved from 1.9:1 in 1996 to 1.1:1 in 2004. The epidemic is following the classic feminization trend apparent globally as the mode of transmission becomes increasingly heterosexual (see Exhibit 3.2, 3.3).
In the year 2000, the 9th leading cause of death in Belize was AIDS related. By 2003, HIVAIDS was the 4th leading cause of death and was the 3rd leading cause in 2004. The age group 15-49 years, which represents both the productive and reproductive population is the age group most affected. The majority of new HIV infections reported to the MOH in 2003 (79.6%) and 2004 (81.4%) occurred in this age group. More importantly, within that age group, death related to AIDS ranked 3rd in those 20-29 years and was the only leading cause of death due to preventable illness in that age group both in 2003 and 2004. In addition, AIDS also ranked as the 1st leading cause of death in those 30-39 and 40-49 in that time period (Table 2).

Exhibit 3.1 Distribution of New HIV infections by District, 1986-2004

DISTRICT	YEAR				
	1986-1997	2001	2002	2003	2004
Corozal	NA	1.2%	0.9%	2.0%	0.2%
Orange Walk	NA	2.7%	1.6%	2.7%	1.3%
Belize	63.2%	82.4%	84.4%	82.3%	88.2%
Cayo	10.7%	5.2%	4.9%	3.6%	4.1%
Stann Creek	16.5%	7.9%	6.7%	6.9%	5.7%
Toledo	NA	0.6%	1.4%	2.5%	0.4%

Source: Belize Health Information Surveillance Unit

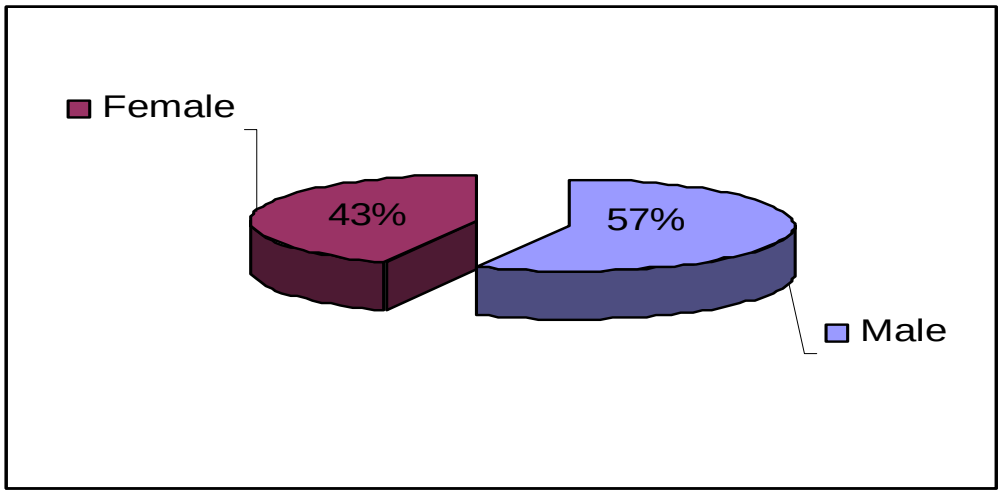
Exhibit 3.2 Cumulative Reported HIV Cases by Sex and Year

YEAR	MALE	FEMALE	TOTAL	M:F RATIO
1996	61	32	**93**	1.9:1
1997	61	38	**99**	1.6:1
1998	112	72	**184**	1.6:1
1999	143	98	**241**	1.5:1
2000	123	103	**226**	1.2:1
2001	192	138	**330**	1.4:1

2002	245	186	**431**	1.3:1
2003	241	206	**447**	1.2:1
2004	242	215	**457**	1.1:1

Source: Belize Health Information and Surveillance Unit

Exhibit 3.3 Total Reported HIV Infections by Sex, 1986-2004



3.2.2 Factors Influencing HIV/AIDS in Belize

Location

Belize's HIV/AIDS epidemic is influenced by its geopolitical location. The country is an excellent transit point to the United States due to its location, the bilingual characteristic of its population, and its diverse cultures.

Belize is divided into six administrative districts: Corozal, Orange Walk, Belize, Cayo, Stann Creek, and Toledo. Belize City remains the commercial centre, containing almost one fourth of the population. Belize is the only English-speaking country in Central America (although Spanish is also widely spoken) and has a great diversity of people due to the large influx of migrant populations from neighboring countries; Honduras, Guatemala, Salvador and Nicaragua that imbues it with challenges in terms of culture, tradition, communication, and literacy levels. These factors add complexity to the discourse on HIV/AIDS.

Transmission

Conclusions on the major mode of HIV transmission in Belize are difficult to make due to incomplete reporting of information. However, some information on mode of infection among persons with HIV who have developed AIDS is available. Existing information from these AIDS cases indicate the primary mode of infection between 1986 and 1994 to be heterosexual sex, with 71% of AIDS cases associated with heterosexual activity. While 22% of AIDS cases were among men who have sex with men, 6% were perinatal,

and 2% were associated with blood transfusions. In 1998-2000, the majority of AIDS cases were again associated with heterosexual transmission (47.5%), followed by homosexual activity (9.2%). The epidemic in Belize thus appears to be similar to the Caribbean and Central American regions, where transmission of the virus is largely heterosexual, with same sex activity also playing a significant, although largely unacknowledged role.

Although available information from AIDS cases is important in understanding the dynamics of HIV transmission in Belize, it is also incomplete. No data was available from 1995-1997, and in 42.6% of AIDS cases in 1998-2000 the mode of transmission was unknown. Thus, there are serious gaps in the data on the mode of transmission that need to be addressed. The critical role of surveillance in guiding the appropriate national response cannot be emphasized enough. In this regard, Belize will seek to strengthen this critical function.

Vulnerable Populations

Several groups in Belize have been identified as being particularly vulnerable to HIV infection, including persons living in poverty, mobile and migrant populations, commercial sex workers, persons living with Sexually Transmitted Infections (STIs), youth, men who have sex with men, members of the uniformed services and incarcerated populations.

The 1995 Poverty Assessment Report indicated 33 % of Belize's population to be living in poverty. Globally, persons of low socio-economic status are most affected by HIV, and Belize is no exception. Poverty limits the ability to make safe choices regarding HIV when unsafe lifestyles and behaviours (e.g. commercial sex work) become necessary for income generation. In addition, persons of low socio-economic status are those with least access to health services and information, and with lower educational levels, experience an increased level of vulnerability.

Commercial Sex Workers (CSWs) are a group particularly affected in the Central American region. The Central American HIVAIDS Prevention Project (PASCA) found CSWs in Central American cities and ports to be at high risk of acquiring and transmitting HIV, particularly "freelance" street-based workers. In Belize, data from clients of the Ministry of Health VCT program show transactional sex to be a major factor contributing to HIV infection in this country. However, the extent of HIV infection in Belize's CSW population is unknown. The PASCA survey is currently being completed in Belize to gather this information.

Youth are also at particular risk in Belize. Twenty-two percent of new HIV infections reported by the Central Medical Laboratory (CML) in 2004 occurred in Belize's 15-24 year age group, the population defined as youth. Poverty, child abuse, and early sexual initiation contribute to the vulnerability of this group, particularly Belize's young women. In a survey of 150 adolescent students conducted in six schools in Belize City in 2003, 35% of respondents reported being sexually active, of which 75% had sexual intercourse for the first time between ages 12 and 14 years, and 44% reported not always using condoms. Poverty among Belize's youth also creates a situation that encourages young women to engage in relationships with older men for financial support, where adult men are more likely HIV infected due to their older age and longer

period of sexual activity. Data from among VCT attendees in Belize indicate the prevalence of HIV among men 40 years of age and older to be as high as 12.5%.
Mobile and migrant populations are also at increased risk for infection largely due to long periods spent away from their wives and families, creating an environment that fosters infidelity. Studies in Africa indicate that mobile populations (usually men) are placed at increased risk through their own behaviours while away from home, as well as through the behaviours of the wives they leave behind for extended periods. Among migrants in Belize, language barriers and dependency on others for income generation limit their negation skills and increase their vulnerability to survival sex and sexual assault, particularly among women. Migrant populations are also made more vulnerable due to generally lower educational levels and limited access to health care and information.

Persons with sexually transmitted infections are at a particularly high risk of HIV infection as well. A direct correlation exists between sexually transmitted infections and an increased risk for HIV transmission during unprotected sexual intercourse, in particular among those STIs that cause genital ulcerations or lesions.

Incarcerated populations are another vulnerable group. They often represent a marginalized population not effectively reached with information, education and communication (IEC) and HIV prevention programs. Thus, incarcerated populations present a Public Health opportunity for IEC, prevention, diagnosis, and treatment in a marginalized population that may otherwise be less effectively reached. Since most inmates will eventually be released, the public health impact of such efforts will extend beyond the prison to the community. Finally, although very little information is available regarding HIV among men who have sex with men in Belize, anecdotal evidence from inmates at Belize's Central Prison suggest a hidden epidemic may be occurring in Belize's men who have sex with men (MSM) population. Information is currently being gathered on this population in the PASCA survey.

4. Strengths and Weaknesses

A complete strengths, weaknesses, opportunities and threats analysis was conducted, examining the unique characteristics of Belize's current national HIV/AIDS Response. The key findings are depicted below.

STRENGTHS	WEAKNESSES	THREATS
Belize's Economy shows potential expansion with the development of the Tourism Industry.	Weak surveillance data available that links the impact the epidemic is having on the work sector in Belize	Tourism growth without policy support for HIV/ AIDS prevention and support programs. Increased expansion of commercial sex work and trafficking of persons.
Countrywide network of public health facilities	Limited capacity and infrastructure, especially human resources to effectively	Extensive borders with constant cross-border traffic

	offer services to PLWAS	
Commitment of political leadership	Response has been concentrated primarily within the MOH with little involvement of other key ministries such as Public sector, Tourism, Finance etc.	Recent cuts in budgetary allocations in support of the National HIVAIDS program
Government commitment to universal access to treatment	Negative perceptions persist with users of the public service in respect to such issues as quality of health care and confidentiality	Heavy debt service burden that can limit expenditure on health
Strong health care infrastructure	Services highly centralized in Belize City, need for integration within the Primary Care Setting to include private providers.	Health Care Provider's negative attitudes and practices towards PLWAS.
Well-organized, active PLWHA support groups	Limited support programs exist to empower PLWAS to actively contribute to the response	Stigma and discrimination against positive persons and their families prevent continuous participation of PLWAS
Presence and support of international agencies	Lack of coordination among such agencies with the national counterpart for stronger collaboration	Weak joint planning in support of the "3 ones" principles endorsed by UNAIDS
Countrywide commitment to supporting the national efforts at mitigation	Lack of institutional capacity to support the operations of district committees	Activity driven actions due to limited access to necessary resources in support of programs
Strong spirit of volunteerism in community	Lack of sustained outreach mechanisms for the districts	Religious community reluctant to support social marketing and other non-abstinence prevention efforts
Commitment to home-based care with district AIDS committee support in some districts (e.g., Stann Creek)	Lack of expansion of such services in other districts and level of community involvement in delivering the same	Public's opinion that persons with AIDS should be cared for in institutions
Strong support from service clubs (e.g., Rotary)	Support if primarily activity	Donor fatigue,

	driven and not program driven (School programs, Nutrition programs etc)	with little evidence of impact of support

5. Need for National Response

Dramatic action is needed if the spread of HIV / AIDS in Belize is to be halted. Efforts toward putting a plan of action into effect must involve all sectors of the population of Belize.

Precisely because of these reasons, an appropriate response to HIV/AIDS that is both comprehensive and sustainable is required. Since what is faced is no longer a threat that is restricted to the nation's health but a threat that extends to the nation's developmental goals, this response has to draw on stakeholders in both the private and public sectors so that an all-embracing strategy to address this crisis may be effected. Some commitment to undertaking such a response has already been displayed by the Government of Belize, as is evidenced by its ratification of various regional and international agreements on HIV/AIDS. These include the Pan-Caribbean Partnership against HIV/AIDS and the United Nations General Assembly Special Session Declaration of Commitment on HIV/AIDS.

The Pan Caribbean Partnership was officially launched at the 12th CARICOM Intercessional Heads of Government meeting in Bridgetown, Barbados, on February 14, 2001. Its membership consists of all countries of the region and is coordinated by CARICOM with the objective of increasing the response to HIV/AIDS in the Caribbean. Regional and global targets set by the partnership include increased access to information, education, and services as well as a reduction of HIV prevalence in young people ages 15–24. A regional strategic framework that outlines priority areas for guiding the development of national strategic plans was also developed by CARICOM.

Belize is also a signatory to the "Declaration of Commitment on HIV/AIDS" issued during the United Nations General Assembly Special Session, June 25–27, 2001. This declaration, which describes the extent of the epidemic and strategies to reverse its effect, is essentially a statement of agreement by governments on what should be done to respond to the HIV/AIDS situation—independently, as well as with international and regional support. Additionally, targets and strategies were identified under prevention, care, support, and treatment, and HIV/AIDS and human rights. In addition, Belize subscribes to the Millennium Development Goals proposed by

6. Belize's Response and International Experience

A number of governments regionally and internationally have declared HIV/AIDS as a developmental issue (many also see it as a security issue) and therefore advocate for a comprehensive response with support and consideration at the highest political level.

Belize has embraced this level of commitment and is committed to the principle proposed and endorsed by UNAIDS entitled the "Three Ones". These principles are geared towards the alignment of national efforts in order to prevent parallel planning and funding of efforts that may hamper the implementation of key programs in a sustainable and effective manner.

The "Three Ones" is the approach emanating from the experiences of many countries, based on the following principles:

- One comprehensive HIV/AIDS national framework endorsed by all partners that provides the basis for coordinating the work of all partners involved in the national response;
- One national AIDS coordinating body, recognized in law and with broad-based multi-sectoral support and full technical capacity for coordination, monitoring and evaluation, resource mobilization, financial tracking and strategic information management;
- One agreed-to national monitoring and evaluation system.

Belize is committed to the adoption of some of the universally accepted best practices for managing the HIV/AIDS epidemic, which are outlined as follows:

·Multisectoral approach: There is expressed commitment by several Government agencies to develop their sector plans, to contribute using their comparative advantage in accessing the vulnerable groups, and to lead the development of their respective sector response. Sector plans for the main line ministries have been developed and areas for collaborative action towards a multisectoral approach are clearly articulated.

·Emphasis on sexual and reproductive health and rights: Belize is well ahead with its sexual reproductive health (SRH) policy framework but requires improved coordination and joint programming of relevant activities.

·Universal access to ARV: The Government has acquired ARV for the treatment of 200 PLWHA; a stated goal is to make ARV universally accessible to all persons requiring treatment.

·Voluntary counseling and testing: A network of VCT sites across the country has been planned. One site is fully functioning in Belize City and seven others are planned to open during the current year. The logistics and roll-out plans are being led by the National AIDS Program Unit of the Ministry of Health.

·Elimination of stigma and discrimination: The NAC has established a policy and legislation committee, which has drafted a national HIV/AIDS policy and legislation document to address, inter alia, stigma and discrimination of the infected and those affected.

·Empowerment: Empower PLWHA and the targeting of vulnerable groups, including youth.

Belize is firmly committed to this approach with the creation of a legislated National AIDS Commission (NAC), the review of the National Strategic Plan, the establishment of a monitoring and evaluation (M & E) committee of the NAC, and the ongoing efforts to establish M & E capacity at the centre to provide national leadership in support of this goal.

6.1 HIV/AIDS Policy Development

In the early stages of the response, the Ministry of Health, consistent with most countries initially led the national response. In an effort however, to engage the wider community, the MOH held a special session in which concerned citizens led to the establishment of a National AIDS Task Force (NATF). This group was charged with

facilitating a situational analysis that would guide future planning. The NATF recognized from the onset the significance of promoting a multi-sectoral response and proposed that a formal body be established in this regard. By 1999, it was obvious from Belize's first strategic plan that a broader based approach would be required.

When the National AIDS Commission (NAC) replaced the NATF in 2000, it was located in the Ministry of Human Development, Women and Civil Society under the chairmanship of the Minister. Since its establishment, the NAC in 2004 has since been legislated as a statutory body in accordance with the Act and placed under the office of the Prime Minister. The NAC is mandated by Cabinet to facilitate, coordinate, and monitor the prevention and control of HIV/AIDS in Belize. In addition, the NAC has the responsibility to advocate for policies and programs in support of the response and to mobilize resources for the implementation of the activities proposed within the National Strategic Plan.

In 2002, the National AIDS Commission with support from the United Nations Development Program (UNDP) and The Global Fund Project embarked on a consultative process in view of proposing a draft National HIV/AIDS Policy document to be presented to Cabinet for consideration. This effort was guided by the Policy and Legislation subcommittee of the NAC led by Dolores Balderamos Garcia, Chairperson.

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 that same year, the NAC facilitated several national workshops to build support and consensus for the passage of the national policy. Over 200 persons and roughly 40 organizations including key businesses, religious and civil society sectors participated and pledged support for the policy. It is with this level of community support, that the policy was then presented and approved by Cabinet in December of 2005.

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 HIVAIDS, 2001 (UNGASS).

Rationale for Policy:

The rationale behind the National Policy is ultimately the protection of the rights of persons infected and affected by HIV/AIDS. It also lays the foundation for the development of the appropriate legal and ethical framework that will then guide the conduct of persons living with HIVAIDS (PLWHAS), service providers, the public and private sector and the general public. It also highlights the fundamental principles and guidelines required to create an enabling environment to reduce stigma and discrimination essential in the successful fight against HIV/AIDS. And finally, it gives

"teeth" to these fundamental principles, policy decisions and ethical guidelines so that necessary mechanisms are established to monitor compliance with the same.

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 address 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 HIVAIDS 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.

Along with the submission of the National Policy, Cabinet also approved the HIV/AIDS in the World of Work Policy developed by the Ministry of Labor with support from the International Labor OrganizationUnited States Department of Labour, Workplace Education Program (ILOUSDOL).

6.2 Health Sector

The Government of Belize is the main provider of health services in the country. The 2003–04 recurrent health budgets totaled BZ$41.9 million for 2003-2004; and BZ$47.5 million for 2004-2005 respectively. In 2003, a network of seven district hospitals, 42 health centres, and 49 health posts provided the basic structure for public health care delivery. These facilities are complemented by several private hospitals, clinics and diagnostic centres located throughout the country but centered primarily in Belize City.

There is a health sector reform program aimed at improving quality, efficiency, and equity in the delivery of health services. The reform is to be achieved through the execution of the restructuring of the health sector, service rationalization and improvement, support to the establishment of a national health insurance fund, and support in developing the private sector.

Like the more developed countries, Belize within the last five years has undergone an epidemiological transition with the predominance of non-communicable diseases cited as the 10 leading causes of hospitalization and death. Such non-communicable conditions include hypertensive diseases, acute respiratory infections, diseases of pulmonary circulation and other forms of heart disease, diabetes mellitus, and ischemic heart

disease. In addition - traffic accidents, homicides and injuries - purposefully inflicted on other persons, are on the rise. With Belize now demonstrating such a high prevalence of HIV/AIDS, the challenge for the Ministry of Health is ensuring that this issue is addressed and that the relevant services are integrated within the package of services to be offered.

On December 1st, 2004, the MOH announced Government's commitment to offering universal access to free antiretroviral medications and Voluntary Counseling and Testing services. To date significant strides have been taken to meet this commitment with the establishment of formal VCT centers and sites and the provision of ARVs for those who meet the clinical criteria for initiation of the same. However, such services remain highly centralized and concentrated in Belize District and offered primarily through the public system. Within the public system there are some challenges faced in expanding such services as described below:

The major constraints faced by the MOH are:

- a limited human resource base and capacity to deliver services, inadequate space and facilities to offer the same, and inadequate financial resources to fully implement its HIV/AIDS program;
- a lack of proper referral systems for ensuring continuum of care and proper case management;
- negative effects of stigma and discrimination on clients by both staff and the public, resulting in underutilization of services, especially ARV drug therapy;
- Concerns with confidentiality and quality of services

Although the private health sector offers services such as testing and treatment, this sector remains unregulated for the most part. As a result, there is an underreporting of HIV infections from the private sector, with the potential for the quality of the treatment to be compromised. In addition, the cost of these services often affects the client's ability to pay for such services in a continuous and sustainable fashion.

6.3 Private Sector and Trade Union Response

The tourism industry in Belize has experienced an unprecedented growth. The Government is mindful that among its challenges will be finding ways to minimize the risk associated with the accompanying commercial sex work, drug abuse, crime, and violence. Although the Tourism sector authorities accept the need for addressing the HIV/AIDS on a whole, they have not internalized the issue and developed the critical sector-specific policies, sectoral plans, and programs within that ministry. A starting point for the Ministry of Tourism can be the adoption of guidelines set forth in the HIV Workplace Policy in support of the establishment of relevant education, prevention and care programs for PLWHAs employed in this sector.

Labor unions have articulated that their membership bears the brunt of the HIV/AIDS epidemic. Moreover, they have expressed the view that enough was not being done to

reach workers both in terms of information and services. They advocate for the inclusion of HIV/AIDS education in the curriculum of schools for students and teachers; nondiscrimination on the basis of gender, health, and social status; and the removal of mandatory testing for employment purposes. These sectors in particular need to be targeted in order to effectively engage their response.

6.4 The National Surveillance System

It is well recognized that a comprehensive HIVAIDSSTI surveillance unit significantly contributes to a better understanding of the magnitude of the epidemic, the risk behaviours that are promoting further spread of this illness and the impact that services are having in improving the quality of life of those affected. The latter is collectively referred to as 1st, 2nd and 3rd Generation Surveillance respectively. The valuable information gained through the various surveillance methodologies will critically guide the planning process of the National Response. Currently, the surveillance unit conducts what is referred to as passive surveillance that only offers very basic data on the incidence of new HIVAIDS cases and reported deaths with very limited behavioural information as to what are some of the risk factors promoting transmission. Although this was the accepted practice in the past, it is critical for countries to now invest more resources and efforts in improving this level of reporting and incorporating the other more comprehensive forms of surveillance. The MOH health has limited technical capacity to conduct these additional functions and will need both additional human resources and technical support to strengthen such systems.

6.5 Regional and International Agencies and Partnerships

Belize is a member of the Pan Caribbean Partnership against HIVAIDS (PANCAP). Like other members, it has committed to a regional approach to addressing the problem, both as a contributor (especially to the knowledge base) and as a consumer of information, services, and technical assistance from regional institutions and programs. Some of the added benefits from this membership include:

- reduced prices for ARV;
- laboratory support through CAREC for HIV–related tests and surveillance systems, e.g., the Public Health Laboratory Information System (PHLIS);
- technical assistance, training, e.g., the Caribbean HIVAIDS Resource Training (CHART) Initiative, and funding from regional projects; and
- Access to the donor community through advocacy, attendance at critical regional meetings, and mediation.

The country is also a member of the Regional Initiative on HIVAIDS for Latin America and the Caribbean (SIDALAC) and should be in a position to receive technical assistance and share information in the field of HIVAIDS.

Belize has ongoing relations with a large number of donor agencies. In the field of HIVAIDS, it has significant relations with the United Nations agencies through the local United Nations Theme Group on HIVAIDS and in some instances, through bilateral projects, e.g., the OPECUNFPA project on HIV prevention and the special UNICEF

project for OVC, the Global Fund, the International Labour Organization, and the diplomatic corps.

There is a need for these agencies however to recognize Belize's national AIDS coordinating authority and establish closer links with this local counterpart. This would facilitate better joint planning and coordination of efforts. In this regard, the UN Theme Group has made a commitment to meet regularly with the National AIDS Commission and its Secretariat in order to strengthen this area of communication and support.

7. Structure for the National HIVAIDS Response

The following organizational structure has been proposed to provide a framework to facilitate the leadership and coordination functions of the NAC required to execute the expanded response, while promoting the effective delivery of services at the community level.

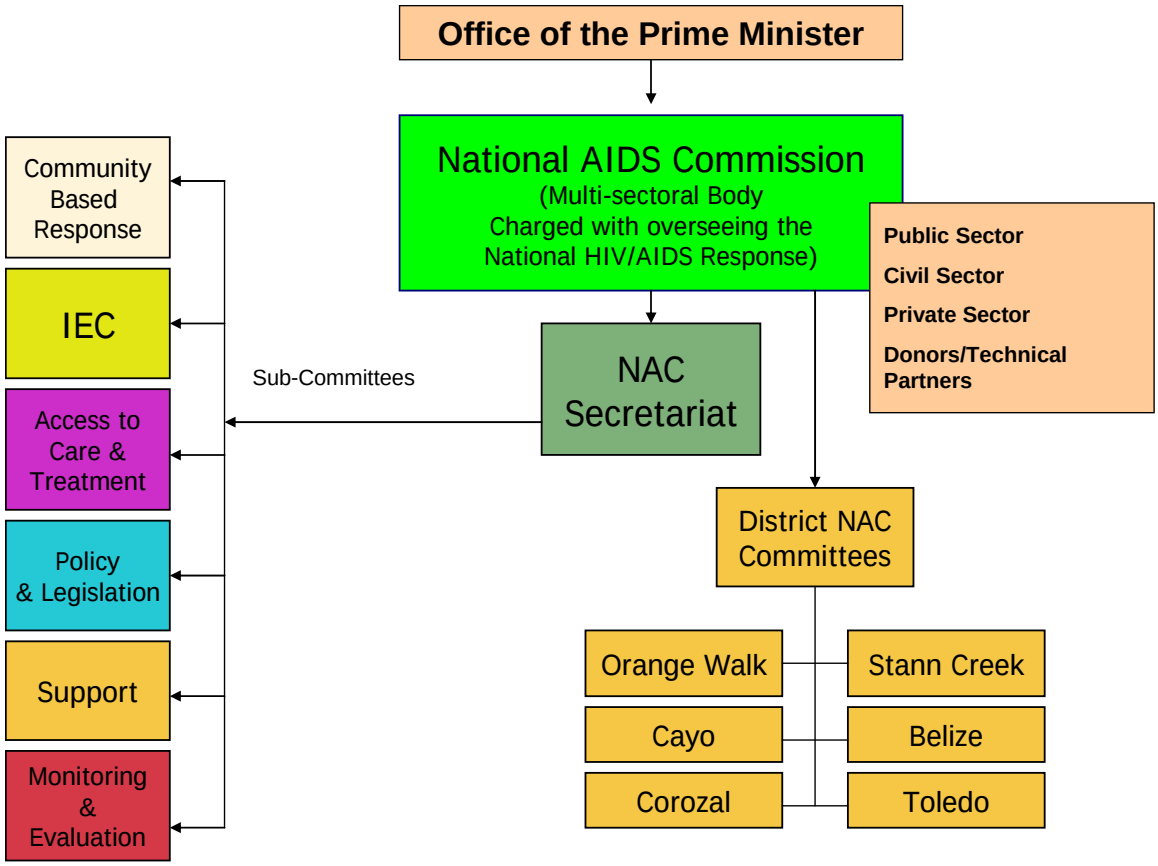


Exhibit 7.1 Structure of the National HIVAIDS Response

7.1 Office of the Prime Minister

Pivotal to the success of reducing the impact of HIV/AIDS in Belize is the level of commitment at the highest decision making and planning levels. Political will and leadership is essential to ensuring that HIVAIDS pandemic remains a priority and at the forefront of national development. The Office of the Prime Minister is the entity

responsible for promoting the expanded HIVAIDS response at the national and regional levels respectively. This office is expected to report progress on the aforementioned international agreements, and is therefore accountable to both its populace and international partners. This office should therefore facilitate the creation of linkages with regional and international organizations involved in the fight against the HIVAIDS pandemic and assist in formalizing the direct link of all such partners both locally and internationally with the NAC so that this body in turn, can effectively guide the National HIVAIDS response.

7.2 National AIDS Commission

The expanded response is led by the National AIDS Commission (NAC), the statutory body in Belize charged with the responsibility for coordinating and overseeing the national response. The NAC through its Chairperson, reports directly to the Office of the Prime Minister. The Act has granted this body the necessary authority to ensure a sustained and broad-based response where resource mobilization efforts should promote a common basket approach for the effective utilization of these resources.

The NAC is therefore expected to promote inter-sectoral collaboration and resource mobilization for the implementation of the national strategic plan, advocating for the establishment and strengthening of relevant programs and services in support of PLWHAs, development of relevant HIV/AIDS policies and legislation for the prevention of stigma and discrimination, and finally, creating the necessary mechanism for monitoring and evaluation of the overall response.

7.2.1 Role and Responsibilities

The core responsibilities of the NAC therefore include:

- building partnerships at the local, regional and international levels;
- defining the national policy agenda;
- approving and guiding sectoral plans;
- approving budgets in support of the implementation of the NSP;
- establishing national standards; and
- evaluating and monitoring all programme targets at the national level.

The Commission also has the flexibility to appoint subcommittees. Such sub-committees include the Policy and Legislation, Monitoring and Evaluation, Care and Treatment and Information-Education and Communication (IEC), Community Based Care to strengthen the response of the Districts and Faith Based Response.

7.2.2 Composition of the NAC

The NAC is comprised of representatives from all key stakeholder groups, i.e., representatives of government departments that include the Ministries of Health, Education, Labor, Human Development and Tourism as well as PLWHAs, the business sector, youth, other non-governmental organizations (NGOs), faith-based organizations (FBOs), community-based organizations (CBOs), and representatives of district AIDS

committees. The UN agencies and other such entities serve as technical partners to the national counterparts.

7.3 District Committees

District Committees, like the wider NAC act as the coordinating bodies at the community level. These committees advocate for the provision of services within the districts to ensure access to critical prevention programs and services. The leaders of each committee are members of the Community- based response sub-committee. The latter provides the forum for networking and sharing of experiences for greater expansion of the response. Similarly, the District committees advocate for the active participation of community members in supporting those persons living with or affected by HIV/AIDS within an environment free of stigma and discrimination. As a result, the district committees report to the wider NAC on progress of such efforts.

7.3.1 Roles and Responsibilities

The core responsibilities of the district committees therefore include:

- building partnerships; and networking primarily at the community level;
- responding to the national policy agenda;
- guiding the implementation of local sectoral plans;
- advocating for the establishment and expansion of prevention and care services within their communities;
- mobilizing resources at the community response;
- monitoring all program targets at the local level.

The District Committee members may also identify representatives that can serve in any of the other sub-committees of the NAC as they see fit.

7.3.2 Composition of the District Committees

The district committees will comprise of members of all local key stakeholder groups, i.e., representatives of local government departments, PLWHAs, local businesses, youth agencies, other local non-governmental organizations (NGOs), representatives of FBOs and CBOs.

The Districts Committees will appoint among themselves a Chair and an alternate in the event that the Chair cannot attend important planning sessions. The respective chairs of all the District Committees are members of the Community Based Response sub-committee and should appoint a representative that will then meet with the executive committee at the Secretariat on a regular basis.

7.4 NAC Secretariat

7.4.1 Role of the NAC Secretariat

The Secretariat of the NAC has been established to support the work of the commission. The NAC Secretariat falls under the Office of the Prime Minister with its administrative functions overseen by the Ministry of Human Development. The Secretariat reports to the NAC. The NAC Secretariat will be responsible for facilitating the overall coordination, monitoring, and evaluation role of the commission and ensures the effective implementation of the National Strategic Plan.

The NAC Secretariat, while not an implementing agency, is the operational arm of the NAC and will be expected to have the following responsibilities:

- Have a lead role in guiding policy development, strategic planning, and management of the national response to the epidemic, ensuring that the response is effective and efficient and in keeping with national, regional, and international HIVAIDS and development goals andor indicators.
- Within the framework of the national HIVAIDS strategic plan, facilitate a coordinated and effective response to the epidemic across and within all sectors of society, from high-level government and administrative leadership to effective community organization and district-level involvement.
- Lead the efforts for the mobilization of financial and technical resources for the national HIVAIDS response.
- Monitor the allocation and use of all resources assigned to the HIVAIDS response and report to the NAC on status of the same.
- Monitor and evaluate the implementation of national HIVAIDS strategies and programs to assess the achieved results against targets set for reducing the impact of the epidemic on Belize in order to guide future planning.
- Keep the NAC abreast of current and relevant information to facilitate informed, evidenced-based decision-making and actions. Such strategic information will encompass but not necessarily be limited to:
    1. reporting on the status of national HIVAIDS planning and implementation of activities;
    2. reporting on the progress of the epidemic within the country and worldwide;
    3. informing the NAC and other relevant partners on the impact of the national response on the progress of the epidemic, with attention to its strengths and areas for program and service improvement, acceleration, and expansion of interventions; and documentation of best practices.

7.4.2 Composition of the NAC Secretariat

The Secretariat of the NAC will comprise of the Technical Director, a Monitoring and evaluation Officer, a Programs and Communications Officer, an Administrative Officer, and at least one other support staff. With the assistance of The Global Fund, the Secretariat was able to mobilize resources in support of the M & E and Programs and

Communication's Officer's positions respectively. The NAC will need to ensure that these key positions are absorbed and retained by the Government in order to support the work of the secretariat.

The major roles and responsibilities of these key positions are described as follows:

Responsibilities of the Technical Director:

- Serve as a Technical Advisor and Officer to the National AIDS Commission and its Secretariat in the development of programmatic areas of the HIVAIDS National Response to include policy and legislation, care and support, mitigation, advocacy, resource mobilization, inter-sectoral coordination and monitoring and evaluation.
- Oversee the strategic management and coordination of the national HIVAIDS response and its impact on the progress of the epidemic.
- Build the capacity of the National AIDS Commission as the authority responsible for coordinating the multi-sectoral response by putting in place an organizational framework that stimulates coordination between all partners and promotes mutual accountability.
- Facilitate the implementation of the National Strategic Plan which should be reflective of national priorities in order to combat HIVAIDS.
- Act as the focal contact point with lead national and international partners, ensuring that their input is well coordinated and falls within the parameters of the national HIVAIDS strategic framework and plan.
- Provide advocacy, including lobbying with all stakeholders to ensure that the response to HIV/AIDS in Belize is congruent with the national strategic planpolicies of Belize, including the reduction of stigma and discrimination.
- Conduct regular planning sessions and updates with partners to monitor the progress in implementation of the response while identifying possible gaps and or areas for collaboration and strengthening.
- Participate actively in the administrative work, including the development of proposals that attract the resources in support of the National AIDS Response.

Responsibilities of the Monitoring and Evaluation Officer:

- Assist in the establishing the Monitoring and Evaluation Unit of the National AIDS Commission in order to oversee the national response.
- Assist in establishing the monitoring and evaluation framework and system to ensure effective implementation of National Strategic Plan and key program initiatives such as the Global Fund.
- Produce and disseminate Monitoring and Evaluation reports that will guide decision making and program implementation.
- Gather and utilize epidemiological data and social indicators that assess strengths, weaknesses and gaps in existing programs and services.

- Facilitate capacity building for implementation partners to enable them to monitor and evaluate their own efforts, gather relevant data and produce required progress reports.
- Ensure that the NAC through the Technical Director has up-to-date information on implementation performance of the national HIVAIDS response.
- Perform other duties assigned by the NAC and the Technical Director regarding monitoring and evaluation as necessary.

Responsibilities of the Program and Communication Officer:

- Design and maintain a comprehensive national information and communication system for all programs and interventions in support of the national response to HIVAIDS to maximize cooperation among partners.
- Assist in building capacity of community groups and District Committees to be an effective part of the national response.
- Facilitate knowledge- sharing among implementing agencies in respect to key research findings, activities and documentation of best practices.
- Assist in the development and dissemination of information, education and communication materials to support national efforts.
- Ensure that sectoral plans and efforts are in line with the priority areas proposed within the National Strategic Plan.
- Assist the administrative manager in organizing special programs and sessions of the National AIDS Commission and produce the required reports.
- Perform other duties relating to program support, communication and outreach as directed by the NAC and Technical Director as necessary.
- Assist in the development and maintenance of a database of programs being undertaken by stakeholders with a view to maximizing the synergies among the various programs while avoiding duplication of efforts.

Responsibilities of the Administrative Manager:

The executive administrative officer will be required to provide overall support for the NAC and will be expected to have the following responsibilities:

- Execute all human resource matters with regard to administering staff entitlements.
- Supervise and monitor specifically the work of the support staff of the NAC.
- Oversee mail flow.
- Ensure that meetings of the NAC are properly organized and coordinated.
- Assist with the overall financial management of the office to include the following:

1. Devise and maintain a system that would facilitate up-to-date tracking of the allocation and use of all resources, including those generated by and through external agencies and partners.
2. Prepare quarterly reports for the technical director coordinator on the allocation and use of financial and technical resources.
3. Facilitate coordination and information sharing among all key national and international partners who provide technical and financial resources for the national HIVAIDS response.
4. In collaboration with the programs and communication officer, ensure that all information technology systems are properly maintained and functional.

- Assist with financial and other reporting required of the NAC to agencies, the Global Fund, UN and Donor agencies and the Government, respectively.

In order for the Secretariat to operate effectively, at the very minimum these key positions should be retained. The Global Fund project has provided the means for the establishment of two of these critical posts; the Monitoring and Evaluation Officer and the Programs and Communications Officer respectively. The Government through the subvention that the secretariat receives supports the positions of the Technical Director, Administrative Manager and Executive Secretary.

The NAC needs to ensure sustainability of this human resource base and must mobilize government's support to fully absorb the newly established positions and should begin to demonstrate this by the third year the implementation phase of the Global Fund has been introduced.

8. Priority Areas

The 2000 – 2003 National Strategic Plan identified the Vision and Mission of the National AIDS Commission as following:

Vision:

"Belize will have decreased the rate at which HIVAIDS is spreading and will be providing comprehensive social services which are affordable and accessible to all PWAS and their families, discrimination against persons with HIVAIDS will be decreased and public and private sector programs addressing the HIVAIDS situation will be well coordinated and resourced"

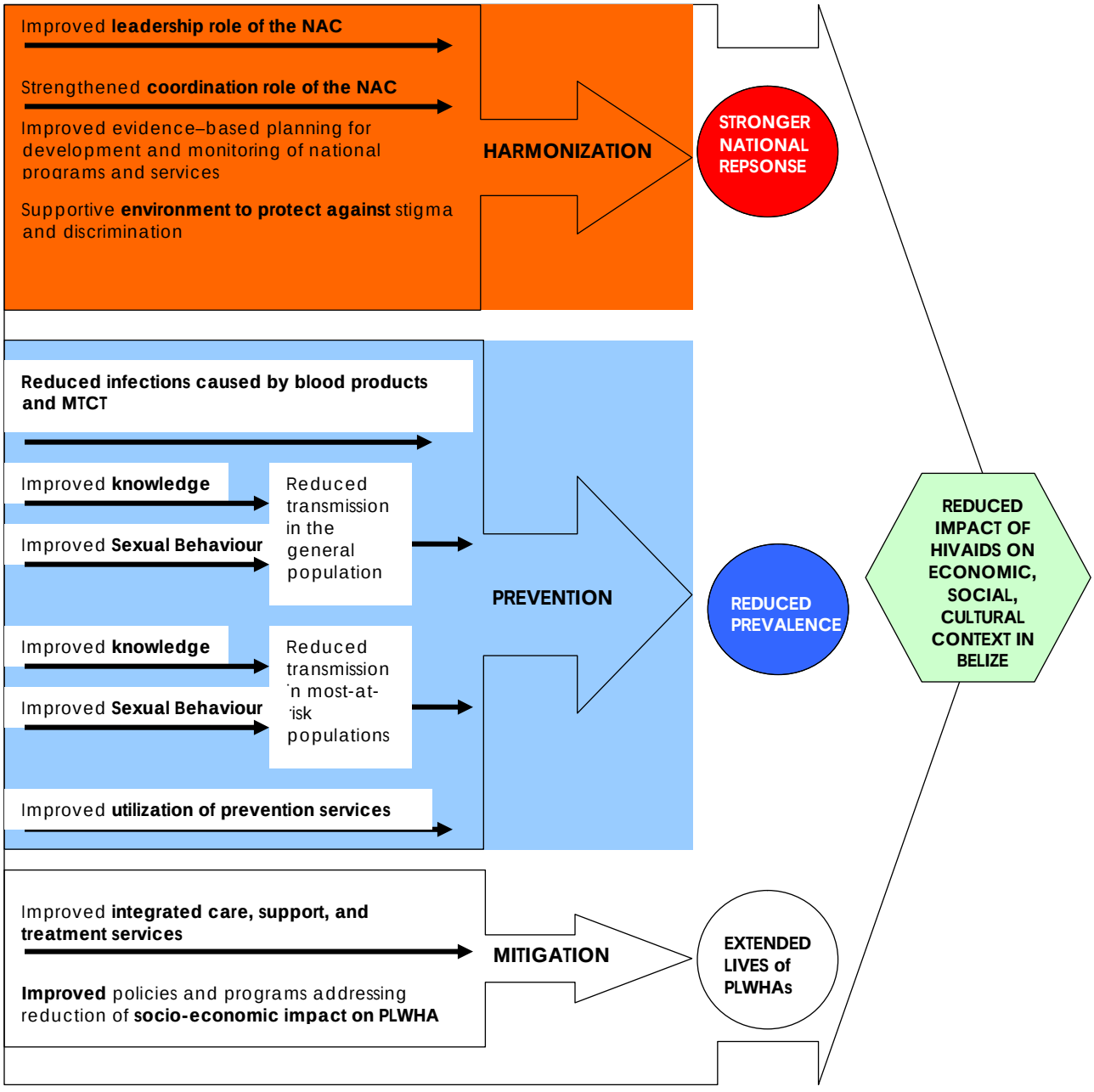
Mission:

"To effectively coordinate multi-sectoral programs which strategically address the prevention, and or intervention of HIV/AIDS in Belize in order to promote healthy sexual behavior, reduce discrimination, against PLWHAs and provide easily accessible services to those in need and reduce the incidence of the epidemic".

These statements are still relevant today. While significant strides have been undertaken in the response, the challenge now is to expand on those efforts in order to ensure more equitable access to these critical services and programs countrywide.

To this end, the overall goal of the national response to HIVAIDS is to reduce its impact on the economic, social, and cultural contexts in Belize.

In order to achieve this overarching goal, three priority areas were identified to guide the HIVAIDS response: Harmonization, Prevention and Mitigation. Each of these priorities in turn, further identifies the key target impact and outcome indicators that are to be achieved in order to address these priority areas.



A more detailed description of these priority areas and targets will now be offered and strategies to achieve them proposed.

9. National Strategy Matrix

9.1 Priority Area I: Harmonization

The national strategic framework will serve as a guide for the development of programs to strengthen the national response and as a basis for resource mobilization and management. This priority area identified the following indicators to be achieved in order to enhance the coordination role of the NAC.

Impact: Improved effectiveness of the multi-sectoral coordination for implementation of the National HIV/AIDS Response.

The following outcomes have been established for this priority area:

Outcome 1.1: Improved leadership role of the NAC and District Committees to address HIV/AIDS issues in Belize.

Outcome 1.2: Strengthened coordination role of the NAC Secretariat

Outcome 1.3: Improved evidence–based planning for the development and monitoring of national HIV/AIDS programs and services

Outcome 1.4: Creation of a supportive environment to protect against stigma and discrimination of PLWHAs

9.1.1 Outcome 1.1: Strengthen leadership role of the National AIDS Commission and District Committees

The plan calls for supporting the leadership and capacity development of the National AIDS Commission and its membership and empowering and sustaining the leadership commitment to HIV/AIDS action at the national, regional, and global level.

Commissioners need to understand the role they play individually within the sectors they represent and collectively in impacting the overall national response, in order to be more active partners at the decision making and planning levels. Roles and responsibilities need to be clarified and mechanisms for communication and sharing of critical information formalized. Commissioners need to recognize the role the Secretariat plays in supporting the Commission's work. The Secretariat therefore should not be regarded as an entity acting on its own but rather as the catalyst for a more effective response.

This area is of top priority as it not only addresses issues of advocacy, policy and legislation development, and resource mobilization, but also decision making in planning, programming, monitoring and evaluation, information management, research, development, and standardization. These critical functions of the Commission can only be achieved through the active involvement of its members and other relevant partners who are to carry out this mandate with the support of the Secretariat.

A coherent national monitoring and evaluation framework to oversee the national response to HIV/AIDS needs to be promoted and put into operation. The capacity for HIV/AIDS information and knowledge sharing should be expanded to include those at

the local, district, and national levels. Program managers, political leaders, and change agents must be trained in the use and interpretation of this strategic information and be called upon as necessary to advocate for the adaptation of relevant policies and programs in support of the response.

The country needs to mobilize and manage the resources that are necessary for the national response to HIVAIDS. This may be accomplished by assessing the existing funding mechanisms and developing a strategy on how to channel and allocate financial resources as well as developing a system of accountability. The skills of stakeholders in financial resource mobilization and accountability need to be reinforced; the national resource tracking system should be put into operation. There must be an advocacy effort for increased resource allocation for HIVAIDS in the government budgeting process at all levels.

Key to enhancement of harmonization is the role of the District Committees. These bodies act as coordinating entities at the community level as already described. The challenge for some of these committees is the lack of leadership to sustain the level of participation and support of its members. One limiting factor is the lack of a formal structure and operational support to guide the efforts of these bodies. In spite of these limitations, some districts have been very successful in mobilizing a strong community response. The Community based sub-committee offers the forum for these district committees to network, share experiences and support the less formalized groups. This sub-committee will also identify areas of capacity building and resource mobilization that should then be presented to the NAC.

In addition, a plan needs to be developed for retaining HIVAIDS expertise in the NGO, private, and public sectors. Extensive resources have been invested in this area, but there is little evidence to demonstrate that these resources are being effectively utilized.

9.1.2 Outcome 1.2: Strengthen Coordination Role of the NAC Secretariat

The capacity of districts to coordinate and manage the response to HIVAIDS must be strengthened. In addition, the provision of support and inclusive participation of all the partners involved in the effort to eradicate HIVAIDS, including PLWHA must continue. In this regard there is a need to improve the dialog and inclusion of key sectors that have to date, not been active in the response but play a critical role, such as the Public Sector, Tourism, Uniformed Services, business sector and media respectively. Armed with the Strategic plan that clearly highlights the goals to be achieved, efforts will need to be harmonized and aligned in accordance to the national priorities, so as to ensure that the desired impact is achieved.

The Secretariat will play a significant role in this regard. To this end, there is a need to expand the human resource base of this office and necessary skills gained to carry out this coordination role.

With the support of Global Fund project, the secretariat now has a Monitoring and Evaluation Officer as well as a Programs and Communication Officer who will be contributing to the roles and responsibilities of the Secretariat.

The Secretariat will work closely with its UN technical partners in keeping with the “three ones” principle of establishing the following:”

1. One coordinating body
2. One Strategic Plan
3. One Monitoring and evaluation system

In this regard, the Secretariat has formalized the following sub-committees to aid in the planning and overseeing of relevant programs to include the following:

1. Policy and legislation sub-committee
2. Access to care and treatment sub-committee
3. Monitoring and Evaluation sub-committee
4. Support Services sub-committee
5. Information, Education and Communication sub-committee (IEC)
6. Community- based Response sub-committee (that includes the Faith based response)

These bodies have the broad representation of relevant partners and will need to be strengthened in order to continue their function in planning and implementation of key programs addressing the national response.

The coordination function of the NAC requires the commitment of all relevant partners to respect the process of communication and information sharing that guides planning and informs the progress of implementation. Partners for the most part, continue to plan vertical programs and also mobilize resources in support of these activities in the same fashion. The intention of the NAC is not to "police" such efforts but rather to facilitate networking, joint implementation and maximization of limited resources. The premise is that there are many opportunities for this type of collaboration when the information is being presented in time to effectively respond.

Commissioners also need to recognize that the response involves other partners who may not be members of the NAC. These partners themselves express a sense of being left out working in isolation when they can be more readily engaged in implementing key program areas. The coordination function therefore, offers this opportunity of inclusiveness, ownership and accountability.

For the most part, planning of the national response remains centralized, the District Committees and other sub-committees therefore offer the means for more decentralized management while bringing the issue down to the community level. It also allows other partners to be engaged.

9.1.3 Outcome 1.3 Improved evidence

Of key note in this strategic plan is the urgent need to conduct baseline surveys that will inform on the effectiveness of programs and services and the overall impact these are having on improving the lives of PLWHAS in Belize.

Though considered costly, it is critical that in an era of results-based funding, implementing agencies can demonstrate that programs are indeed addressing the needs of the target populations.

The strategic plan has highlighted areas that require such information. The NAC with the guidance of the M & E Unit of the NAC and its supporting subcommittee will need to then prioritize and commission the most significant studies required to guide the effective implementation of the NSP. Opportunities for collaboration among partners in this research field become even more significant.

9.1.4 Outcome 1.4: Creation of a supportive environment

Review of the legislation and ethics will also have to address concerns affecting the national response, including orphans and vulnerable children (eligibility for adoption), adolescents (sexual reproductive health [SRH] rights), men who have sex with men (MSM) and commercial sex workers, prisoners (SRH services), PLWHA (stigma and discrimination), and HIV–related drugs (registration) and clinical trials (approval mechanisms). The strategies adopted in Belize should be aligned with the Pan Caribbean Partnership against AIDS (PANCAP) Law, Ethics and Human Rights Regional Plan, which is further aligned to priorities in the Caribbean Regional Strategic Framework for HIVAIDS.

These efforts should be accompanied by the promotion of the protection of the legal, ethical, and social rights of people infected with and affected by HIVAIDS. The vulnerabilities of this population must be assessed and the nature and incidence of the violation and abuse of the rights of PLWHAs documented and effectively addressed. The process of adopting policies to ensure human rights and the fundamental freedoms of PLWHAs must be expedited. The Government of Belize has now adopted the National HIVAIDS Policy that will guide future processes. Advocacy efforts will now need to focus on the revision and or enactment of relevant laws in support of the National Policy. Capacity-building efforts need to be undertaken with key change agents and institutions on the rights, roles, and responsibilities of PLWHAs. Particular efforts must be made to publish and disseminate relevant policies, laws, and guidelines related to HIVAIDS in a manner accessible and of relevance to all parties.

Mechanisms for reporting, investigating, and addressing the violations and or abuse of the rights of PLWHAs must be established. Human rights, along with the legal and ethical needs of all vulnerable groups in relation to HIVAIDS, must be assessed and addressed. These groups include displaced persons, youth, women, and especially orphans and vulnerable children. Staffing levels at both public and non-public health facilities must be at adequate levels, and training must be provided in comprehensive care for relevant health workers. In addition, capacity-building efforts need to be undertaken to provide community-based HIVAIDS care at the local level.

In addition, there must be the promotion of increased awareness of the human rights and legal and ethical needs of PLWHAs among the country's media, health providers, schools, NGOs, law enforcement agents, and the community at large.

In order for Belize to effectively measure the impact of the combined efforts on reducing the prevalence of HIVAIDS in the country, there is an urgent need to assess the current situation by gathering the critical baseline data. As this strategic plan demonstrates, to date there is a significant gap in the relevant data that should be guiding the national response. Belize's response to HIVAIDS therefore needs to be evidence based. This may be accomplished by streamlining and strengthening the structures for conducting

HIVAIDS–related research. The development, implementation, and support of a national HIVAIDS research plan is therefore needed and should be a priority.

Those involved in research must be assured of protection, including the protection of legal and ethical rights of the participants in research studies as well as the intellectual property rights of researchers. In this regard, the Commission must advocate for the establishment of an Institutional Review Body that will address these issues. The Ministry of Health as the regulatory body must be actively engaged in this area as well as the Ministry of Education so that persons are protected and the relevant research is conducted to the benefit of Belize.

<table>
<tr><th colspan="3">PRIORITY 1: HARMONIZATION</th></tr>
<tr><td>OUTPUT 1.1.1 Strengthened understanding of roles and responsibilities of various players involved in the National Response: NAC, NAC District Committees, NAC Secretariat, Ministry of Health, etc.</td><td rowspan="5">Outcome 1.1

Improved leadership role of the NAC and District Committees to address HIVAIDS issues in Belize</td><td rowspan="11">Impact 1

Improved effectiveness of the multi-sectoral coordination for implementation of the National HIV/AIDS Response</td></tr>
<tr><td>OUTPUT 1.1.2 Improved involvement of NAC and District Committees for the effective implementation of the Strategic Plan</td></tr>
<tr><td>OUTPUT 1.1.3 Establishment of a system for Improved dissemination of information at the national, regional and international level to aid in future planning and implementation</td></tr>
<tr><td>OUTPUT 1.1.4 Improved collaboration between various stakeholders (ministries, faith based groups, district health offices, CBOs and NGOs, private sector, media, donors and technical partners) involved in the national response</td></tr>
<tr><td>OUTPUT 1.1.5 Increased number of cross-sectoral HIVAIDS programs offering comprehensive services to PLWHAs</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td>OUTPUT 1.2.1 Improved ability of the NAC Secretariat to coordinate and mobilize resources in support of the multi-sectoral response</td><td rowspan="2">Outcome 1.2

Strengthened coordination role of the NAC Secretariat</td></tr>
<tr><td>OUTPUT 1.2.2 Strengthen capacity of the NAC Secretariat and District Committees in planning, implementation, and monitoring of HIVAIDS programs at all levels</td></tr>
<tr><td>OUTPUT 1.3.1 Strengthened capacity of NAC Secretariat to establish and implement an M & E system to monitor the national response and guide future planning</td><td rowspan="2">Outcome 1.3

Improved evidence – based planning for the development and monitoring of national HIVAIDS programs and services</td></tr>
<tr><td>OUTPUT 1.3.2 Improved ability of the relevant agencies to conduct necessary research and surveillance to inform the policy process as well as program development and implementation</td></tr>
<tr><td colspan="2"></td></tr>
</table>

OUTPUT 1.4.1 Improved capacity of the NAC and partners to apply **gender and rights-based principles** for HIV/AIDS program and policy development	**Outcome 1.4** Creation of a supportive **environment to protect against** stigma and discrimination of PLWHAs	
OUTPUT 1.4.2 Strengthened capacity of the NAC Secretariat and District Committees to guide the **policy process and to address** HIVAIDS issues among NAC members and other key stakeholders, including the private and public sector, civil society, faith based organizations, and donors		
OUTPUT 1.4.3 Improved number of **sectoral policies** addressing HIVAIDS issues in various sectors, such as reproductive health and family life policy, youth policy, public health policy, etc.		
OUTPUT 1.4.4 Develop programs and establish legal framework in support of the National and Workplace HIVAIDS Policies.		
OUTPUT 1.4.5 Capacity building for various organizations and programs (media, uniformed services, health care providers, schools etc.) to present and address PLWHA without stigma and discrimination		

An assessment of the existing surveillance program is needed as well as a proposed plan to strengthen this unit developed and presented to Government and partners for future support. Surveillance should be expanded to ensure public and private sector participation. Baseline studies that determine the prevalence of HIVSTIs within identified groups and the key risk factors and behaviors promoting transmission of the same need to be commissioned.

Finally, a capacity building plan in these areas of coordination will guide future initiatives and should seek to enhance participation of all relevant partners.

9.2 Priority Area II: Prevention

In the absence of a cure or an available effective vaccine for HIV/AIDS, prevention will remain pivotal to the national response.

Under this Priority area the main impact is to reduce the prevalence of HIV in Belize.

Impact: Reduced prevalence of HIV in the adult population (15-49) of Belize

In order to achieve a reduced prevalence, three outcomes have been established:

Outcome 2.1: Reduced transmission rates among recipients of blood and children born to infected mothers;

Outcome 2.2: Reduced transmission rates in the general population with emphasis on youth (15-24);

Outcome 2.3: Reduced prevalence among most-at-risk populations (MSM, CSW, prison population, uniformed services);

HIV is transmitted through three most important modes of infection:

- Use of infected blood and blood products
- Transmission from infected mother
- Unsafe sex

Outcome 2.4: Improved utilization of other related prevention services.

9.2.1 Outcome 2.1: Reduced transmission rates – Emphasis on recipients of blood and children

A first objective in the prevention of HIV infection is the elimination of transmission by blood transfusion. This will be accomplished by strengthening quality control of blood products and transfusion services, improving the blood supply, and ensuring the implementation of universal precautions for infection control.

The prevention of mother-to-child transmission (PMTCT) is another objective in the prevention of HIV infection. This will be accomplished by expanding this service countrywide, inclusive of private providers. The PMTCT guidelines will be updated, and more personnel will be trained in both private and public facilities to provide this service according to appropriate standards.

9.2.2 Outcome 2.2: Reduced transmission rates – Emphasis on youth (15-24)

At the core of the spread of HIV is the presence of the virus in an infected person and behaviour that allows transmission to an uninfected person. By adopting safer-sex practices, the rate of transmission can be greatly reduced. To achieve this outcome, the major objective is to ensure that the general population, in particular the population defined as youth (15-24 years), is provided with accurate STI and HIV prevention information through the expanded coverage of programs that provide such information and education. The provision of information should not be limited to facts alone, but should also include behavioural change communication to promote change in attitudes and practices.

In addition, improved and integrated services for STI diagnosis and treatment will directly reduce transmission rates by reducing the physiological vulnerability in the population that is associated with STI infection. This will be achieved by strengthening syndromic surveillance, diagnosis and clinical management of STIs, which will require the development of clinical guidelines for STI management, including counseling for HIV prevention; promoting the integration of STI prevention and treatment programs at the primary care level; improving drug procurement, delivery, and management systems at all levels; and increasing the capacity to conduct necessary contact tracing for the treatment of infected partners.

Therefore, the issues within this priority area are:

promoting knowledge of HIV transmission and prevention methods;

- designing appropriate interventions which will allow for the targeted use of health promotion and HIV prevention information, and provision of necessary care and support services;
- improved diagnosis and treatment of STIs;

9.2.3 Outcome 2.3: Reduced prevalence among most-at-risk populations

Meeting this outcome will result in a reduction of HIV infection rates among most-at-risk populations. Vulnerability may be defined in several terms:

- **Epidemiological:** through increased levels of exposure to HIV as seen in certain particularly vulnerable population groups, e.g., commercial sex workers and men who have sex with men.
- **Social and cultural:** social and cultural norms create vulnerabilities for specific population groups. Such norms include gender inequalities, sexual roles and practices among different ethnic groups, the ability of women to negotiate safer sexual practices, and attitudes along with peer pressure among youth.
- **Economic:** poverty (affecting a third of the Belize's population) has been identified as a factor in risk-taking behavior to include transactional sex. It also affects the ability to access medical and social services, and to maintain the healthy nutritional balance critical to the effectiveness of and adherence to treatment.
- **Coverage**: access is largely dependent on location and the necessary resources to bring services to the community.

The most-at-risk populations identified for targeted intervention in Belize are men who have sex with men, commercial sex workers, the prison population, and uniformed services. As in the general population, adoption of safer-sex practices among most-at-risk groups can greatly reduce transmission rates. This can be achieved through improved provision of accurate HIV and STI prevention information and the expanded coverage of programs to improve HIV/AIDS knowledge and to promote behavioural and attitudinal change among these population groups.

Emphasis must also be placed on reducing the vulnerability to HIV and STI infection among the prison population, while respecting and promoting human rights principles of this and other vulnerable groups. The Central Prison should be viewed as a Public Health opportunity for information, education and communication, prevention, diagnosis, and treatment in a marginalized population that may otherwise be less effectively reached. Since most inmates will eventually be released, and many are serving sentences of 3 years or less, the public health impact of such efforts will extend beyond the prison to the community.

9.2.4 Outcome 2.4: Improved utilization of other related prevention services

Other areas of prevention will include expansion of condom distribution for the prevention of HIV transmission, expansion of voluntary counseling and testing (VCT) services, and the provision of universal post-exposure prophylaxis for sexual assault clients and health care providers. Improvements in the provision and utilization of these services will also serve to reduce the rate of HIV transmission in Belize by providing additional means of protection for the individual as well as the population at large.

<table>
<tr><th colspan="4">PRIORITY AREA 2: PREVENTION</th></tr>
<tr><td colspan="2">OUTPUT 2.1.1 Improved quality and access to safe and high quality blood products</td><td colspan="1" rowspan="2">Outcome 2.1
Reduced transmission rates among recipients of blood, and children born to infected mothers</td><td rowspan="11">Impact 2
Reduced prevalence of HIV in the adult population (15-49) of Belize</td></tr>
<tr><td colspan="2">OUTPUT 2.1.2 Improved delivery of and access to PMTCT services country-wide involving both private and public service providers</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">OUTPUT 2.2.1 Improved and integrated services for STI diagnosis and treatment</td><td rowspan="4">Outcome 2.2
Reduced transmission rates in the general population with special emphasis on youth (15-24)</td></tr>
<tr><td rowspan="2">OUTPUT 2.2.2 Improved reach of programs addressing increased knowledge, attitudes and practices among men and women (15-24)</td><td>INTERMEDIATE OUTCOME 2.2.2.1
Improved knowledge about mode of transmission, self-protection, etc. among men and women (15-24)</td></tr>
<tr><td>INTERMEDIATE OUTCOME 2.2.2.2
Improved sexual behaviour among men and women (15-24)</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td rowspan="2">OUTPUT 2.3.1 Improved reach of programs addressing increased knowledge, attitudes and practices among most-at-risk populations (MSM, CSW, prison population, uniformed service)</td><td>INTERMEDIATE OUTCOME 2.3.1.1
Improved knowledge about mode of transmission, self-protection, etc. in most-at-risk populations (MSM, CSW, prison population, uniformed service)</td><td rowspan="2">OUTCOME 2.3
Reduced prevalence among most-at-risk populations (MSM, CSW, prison population, uniformed service)</td></tr>
<tr><td>INTERMEDIATE OUTCOME 2.3.1.2
Improved sexual practices among most-at-risk populations (MSM, CSW, prison population, uniformed service)</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="2">OUTPUT 2.4.1 Improved universal procurement, distribution and access to affordable condoms through private and public providers</td><td colspan="2" rowspan="2">OUTCOME 2.4 Improved utilization of other related prevention services</td></tr>
<tr><td colspan="2">OUTPUT 2.4.2 Expansion of and increased access to VCT services countrywide in both private and public health sectors</td></tr>
</table>

OUTPUT 2.4.3 Formalized and strengthened provision of the **PEP** to health care workers and sexual assault clients within private and public health service providers		

9.3 Priority Area III: Mitigation

Under this Priority the main impact is the improved quality of life of people affected and infected by HIV/AIDS

Until a cure or an effective vaccine for HIV/AIDS becomes available, the aim of managing HIV–positive persons should be to prolong their lives, allow them to maintain an acceptable quality of life through the diagnosis, management and treatment of opportunistic infections and provide social and economic support services, as well as the opportunity to be productive citizens.

Impact: Extended life of Persons Living with HIVAIDS

The two key outcomes to be achieved include:

Outcome 3.1: Improved effectiveness of integrated care, support and treatment services for people infected with and affected by HIV/AIDS;

Outcome 3.2: Improved policies and programs addressing reduction of the socio-economic impact of infection for Persons Living with HIV/AIDS.

9.3.1 Outcome 3.1: Improved effectiveness in integrated care, support and treatment

HIV infection requires life-long commitment to providing treatment and care to persons infected. Therefore, the integration and sustainability of such services is critical.

Given the disproportionate levels of poor who are vulnerable and infected in Belize, the government has committed to financing the treatment program from local resources supplemented by donor contributions. **Treatment** is most effective when the patient is in good health. Therefore, healthy lifestyles, good nutrition, safer-sex practices, and prophylactic medical care are advocated. ARV drugs are relatively new, can have toxic side effects, and can be rendered less effective as drug-resistant strains evolve. While drug combination therapy helps with the reduction of side effects and resistance, monitoring of the patients' clinical conditions and ARV blood levels, in addition to active counseling, are essential to proper treatment.

In general, minimizing the development of resistance to ARV drugs requires a strategy of:

- educational intervention;
- good infection control practice, including the prudent use of antimicrobials;
- an integrated surveillance and monitoring system;
- risk assessments and management strategies;
- a regulatory framework for ARV drug management.

In order to ensure that this outcome is achieved, there will be a need to expand on existing services and promote the **integration** of the same. To date, services remain highly centralized. There are plans underway for expansion of services to all regional health facilities of the public system. There is a need to promote such services within the primary care setting in both public and private sectors and to improve the system of referrals, including the provision of referrals and follow-up.

Primary care providers will need to be trained in the clinical management of persons living with HIVAIDS, and efforts to monitor adherence to treatment will need to be strengthened. Assessments of the quality of services provided to PLWHAs will need to be conducted to ensure the highest standards of care and support. Critical to the success and effectiveness of ARV treatment in prolonging life, is the access to nutritional support. This area remains a challenge for the continuous adherence to ARV medications. The NAC will advocate for the establishment of nutritional programs for persons who are economically challenged and need that immediate assistance.

The prevention, surveillance and monitoring of HIV drug resistance are essential if ART programs are to be effective. Early warning assessments need to be conducted as proposed by WHO to avoid the transmission of drug-resistant strains of HIV among the population. This will create an even bigger challenge for Belize. The National AIDS Program currently reports having 300 persons from September 2003-2005 on HIV medications. There is a need to further report on the progress of adherence among and possible signs of resistance among the same. One such early resistance warning indicator relates to the effectiveness of ARV procurement systems and delivery points, the frequency of stock outs and whether minimum quality criteria are met.

Another area that will be addressed is the improved diagnosis, treatment and management of opportunistic infections related to HIVAIDS such as oral candidiasis and co-infections such as tuberculosis.

ART and OI management and treatment programs are the key components of effective HIVAIDS care, however, equally important are the support and prevention services. Support services include psychological services (for emotional support) social (e.g. food, material or financial support) and legal support (e.g. legal advise related to employment). These areas are to be strengthened as part of the expanded response proposed within the plan. These services extend beyond health care and therefore require the involvement of partners from other key public sectors.

As part of this strategy, there will be an increased effort in enhancing the **community-based response.** The role of the community in offering PLWHAs a supportive environment that promotes confidentiality, dignity and greater family support is invaluable. Home-based care becomes more relevant as persons living with HIV often prefer to be treated in the privacy of their own homes and by their own family members. Fear is the key deterrent of family support resulting in stigma. As more persons begin to access critical services, the AIDS related mortality rate should decrease. Until then however, terminal care for those persons with AIDS still remains an issue that requires attention. The role of families and other support groups like the faith based response need to be explored.

Also critical to the objective of improving the quality of life of persons infected and affected by HIVAIDS is the provision of support services to orphaned and vulnerable

children. These services include medical support, school-related assistance, emotional, psychological and spiritual support and companionship, and socioeconomic support.

9.3.2 Outcome 3.2: Improved policies and programs addressing reduction of socio-economic impact and infection

The HIVAIDS epidemic undermines the supply side of the economy by reducing the number of able-bodied persons in the labor force. The resulting effect is a loss in income, loss in savings, and reduction in the investment potential of the country. It also acts on the demand side by increasing the consumption of resources, especially health services, thereby increasing health expenditure. To address this situation, managers need to be aware of the impact of HIVAIDS on human resources within their sector and the corresponding estimated loss of production.

To protect the human capital of the country, there needs to be a reduction in the economic impact of infection on persons living with HIVAIDS and their families. An assessment of the socioeconomic status of PLWHAs in the community needs to be conducted. Support must be given to PLWHAs through the design and implementation of feasible income-generating projects. There needs to be an effort to advocate for the integration of microfinance programs that support such income-generating projects. Support groups for PLWHAs need strengthening and capacity building to empower the same to be part of the planning process and implementation of relevant programs. There is need for mobilization among members of the private sector, developmental partner groups, local governments and communities to contribute substantial resources for the support of PLWHAs and affected families.

<table>
<tr><th colspan="3">PRIORITY AREA 3: MITIGATION</th></tr>
<tr><td>OUTPUT 3.1.1 Improved quality, coverage and access to clinical management services for opportunistic infections, palliative care etc. for persons infected with and affected by HIVAIDS provided at the primary and secondary levels</td><td rowspan="4">Outcome 3.1
Improved effectiveness of integrated care, support and treatment services for people infected with and affected by HIVAIDS</td><td rowspan="4">Impact 3
Extended and better quality of life of Persons living with HIVAIDS</td></tr>
<tr><td>OUTPUT 3.1.2 Improved delivery of support services (long term counselling, spiritual and psychological support, terminal care, home-based care) provided to persons infected and affected by HIVAIDS by the relevant agencies. (GOV, NGOs and other civil society groups)</td></tr>
<tr><td>OUTPUT 3.1.3 Strengthened capacity for procurement, distribution and management of ARVs countrywide among both private and public providers</td></tr>
<tr><td>OUTPUT 3.1.4 Improved quantity and quality of services provided to OVCs by government, community based organizations and families (counseling, nutrition, etc.)</td></tr>
</table>

OUTPUT 3.2.1 Improved access to **services** and programs targeting **PLWHAs** (income generating, microfinance, food support, housing, insurance, nutritional support, support groups for PLWHA and affected by the disease)	**Outcome 3.2** Improved policies and programs addressing reduction of the socio-economic impact of infection for Persons Living with HIV/AIDS	
OUTPUT 3.2.2 Improved **participation of PLWHAs** in development, planning, implementation and monitoring of programs		

10. Monitoring and Evaluation

Monitoring and Evaluation is part of effective program management at all levels: project - national and international. An effective M & E system seeks to collect vital information at program input, output, outcome and impact levels in order to guide the national response to the HIVAIDS epidemic, and to provide an overall understanding of the effectiveness of the response to improve program performance or affect policy change.

Together these activities answer the following questions:

1. What is being done? Scope.
2. How well is it being done? Quality.
3. Are we doing it on a large enough scale? Coverage.
4. Is it working? Are we making a difference? Success, effectiveness.

Ultimately when designing an M & E system, one must ensure that such a system is relevant and useful to the implementing partners while at the same time, is meeting the report demands at country level. Today, evaluation efforts extend beyond its function of guiding program design and implementation, but currently focus on ensuring transparency in the use of funding, as well as the equitable distribution of services. These are critical to securing additional support from both internal and external funding agencies. Based on compliance with performance indicators on which the effectiveness of HIVAIDS preventive and care efforts are measured, M & E becomes a core part of financial management, procurement and distribution of supplies, provision of high quality services, and sustainability of programs.

While significant progress has been made in Belize to monitor and evaluate specific HIVAIDS care and prevention projects, such efforts continue to be done in a vertical, isolated fashion. In short, valuable information that guides planning at the national level is being lost because there is no coherent National M & E system in place to capture this critical data and report on overall findings at the national level.

M & E systems require significant resource investment in order to bring them to fruition. Yet, most of the implementing agencies report having little resources available for this purpose. The failure to account for the operational cost should be addressed by ensuring that at least 10% of the total funds mobilized for national programs are utilized for this purpose. In addition to the initial capital investment required to set up the national M & E system, a costing exercise will need to be conducted to determine the budget necessary to operationalize the M & E Plan.

When adopting a national M & E system, all stakeholders should recognize that there are critical M & E components that are part of this comprehensive system and must be fully functional to be effective. The components are as follows:

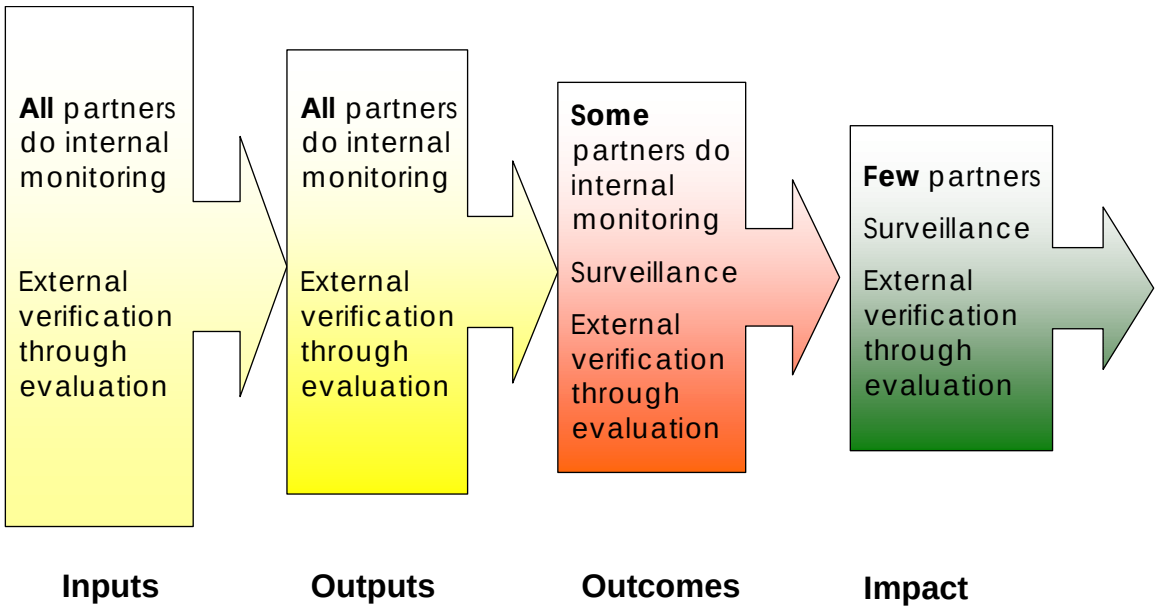
- **Overall System:** comprising of the overall strategy describing precisely how and when data is to be collected - the flow of data at each step in collection, management and reporting.

- **Surveillance:** comprising of the ongoing collection and reporting of data relevant to HIV/AIDS epidemic and care and support programs to prevent further transmission and provide care for those persons affected. More

emphasis is also now being placed on initiating second-generation surveillance for the ongoing tracking of sexually risky behaviours. In the Caribbean, there is an initiative to introduce third-generation surveillance as well which aims to track the level and quality of services rendered to those affected and to determine whether these interventions have increased the quality of life of persons living with HIVAIDS. The National AIDS Program of the MOH in Belize is the agency responsible for conducting this type of surveillance and is making significant strides in the same.

- **Research:** Surveillance should be complemented by essential research including epidemiological, evaluation and social impact research. The NAC has a strategic role in advocating for more planned research activities as well as collating, interpreting and disseminating research information. Critical partners including the Ministry of Health, Central Statistical Office (CSO), NCFC, academic research institutions, and local consultancies need to participate in guiding the research process. Where local capacity does not exist, then external support will need to be mobilized to complement this function.
- **Financial Management M & E:** A component of a comprehensive M & E system is a finance system that tracks all resources and can account for funds in a transparent and consistent manner. The NAC is a key recipient of donor resources earmarked for specific projects to be implemented within the commission itself or by other implementing partners. This system is critical, since it helps the Commission in identifying resource need gaps that will then guide resource mobilization efforts while avoiding duplication. The NAC does not have an established finance system within the secretariat or the necessary personnel to manage the same. HIVAIDS accounts offer detailed information as to the level of both national and donor investment committed to the fight against the epidemic. Although significant efforts to increase the local capacity to conduct such assessments in Belize have been undertaken in the past, much of the technical expertise has not been transferred or utilized. Agencies that do not have access to such financing tools will need assistance in their establishment.
- **Project Implementation M & E:** Reports on progress made in program implementation offer updates to both donors and the NAC on the level of response by service providers and point to areas of additional technical support or planning. NAC, public sector and civil society program activity, monitoring and evaluation represents the greatest challenge facing not only the NAC but also key implementing agencies.

- **Referral and Client Management Tracking Systems**: comprising of a system to track the continuum of care of clients to other critical services and to measure the effectiveness of coverage and quality of services provided.



The preliminary monitoring framework is presented in the tables below. It constitutes the basis for development of a detailed M & E Plan for measuring progress in implementation of the strategic plan and in output, outcome and impact target achievement. The M & E Plan will be developed to further clarify indicators, sources of data, agencies responsible for data collection, frequency of data collection, and data analysis and reporting. A baseline will be established for each indicator.

Input (including resources, activities and processes) as well as output data will be collected by all implementing partners. Each will define indicators. The data will be collected and analyzed to provide a comprehensive picture of the degree to which outputs are being achieved by each organization as well as cumulatively among all partners. In addition, data for national output indicators outlined in the tables below will be collected by the responsible agencies (to be identified in the M & E Plan). The data will be analyzed at the national level by the Monitoring and Evaluation Unit of the National AIDS Commission.

At the outcome and impact levels, data will also be collected at the national level by the responsible agencies and analyzed by the Monitoring and Evaluation Unit of the NAC. Relevant reports on national indicators will be prepared and disseminated to local implementing partners and international partners such as UNGASS and Global Fund.

The monitoring framework presented below is a summary of available baselines, indicators and targets. In some cases the baseline does not exist and additional research will be necessary to establish the baseline and relevant targets.

The indicators outlined were selected to meet Belize's reporting needs at the local, national and international levels. These indicators will enable Belize to answer to the reporting requirements of international donors as established under the UNGASS Declaration and Global Fund, as well as to address selected national level needs to guide the national response to HIV/AIDS.

PRIORITY AREA 1: HARMONIZATION			
Impact 1	**Performance Indicators**	**Baseline**	**Target**
Improved **effectiveness of the multi-sectoral coordination** for implementation of the National HIV/AIDS Response	**National Composite Policy Index (UNGASS)**	TBD (year 1, review of available data)	25% increase in average indicator score by 2010
	Amount of national funds disbursed by government (UNGASS)	TBD (year 1)	25% increase by 2010
Outcome	**Performance Indicators**	**Baseline**	**Target**
1.1 Improved **leadership role of the NAC** and District Committees to address HIVAIDS issues in Belize	Three Ones Index (to be developed) – relevant parts	TBD (year 2)	60% increase in average indicator score by 2010
Outputs	**Performance Indicators**	**Baseline**	**Target**
1.1.1 Strengthened understanding of roles and responsibilities of various players involved in the National Response: NAC, NAC District Committees, NAC Secretariat, Ministry of Health, etc.	Three Ones Indicators	TBD (year 1)	95% congruence with planned activities by 2010
1.1.2 Improved **involvement** of NAC and District Committees for the effective implementation of the Strategic Plan	Three Ones Indicators	TBD (year 1)	95% congruence with planned activities by 2010
1.1.3 Establishment of a system for Improved **dissemination of information** at the national, regional and international level to help in future planning and implementation	Three Ones Indicators	TBD (year 1)	95% congruence with planned activities by 2010
1.1.4 Improved **collaboration** between various stakeholders (ministries, faith based groups, district health offices, CBOs and NGOs, private sector, media, donors and technical partners) involved in the national response	Three Ones Indicators	TBD (year 1)	80% congruence with planned activities by 2010

PRIORITY AREA 1: HARMONIZATION			
1.1.5 Increased number of cross-sectoral **HIVAIDS programs** offering comprehensive services to PLWHAs	Three Ones Indicators	TBD (year 1)	85% congruence with planned activities by 2010
Outcome	**Performance Indicators**	**Baseline**	**Target**
1.2 Strengthen the **coordination role of the NAC Secretariat**	Three Ones Index (to be developed) - relevant parts	TBD (year 2)	50% increase in average indicator score by 2010
Outputs	**Performance Indicators**	**Baseline**	**Target**
1.2.1 Improved ability of the NAC Secretariat to **coordinate and mobilize resources** in support of the multi-sectoral response	percentage of the requested budget support supplied by donors on request from the NAC Three Ones Indicators	TBD (year 1) TBD (year 1)	95% congruence with planned activities by 2010 90% congruence with planned activities by 2010
1.2.2 Strengthen capacity of the NAC Secretariat and District Committees in planning, implementation, and monitoring of HIVAIDS programs at all levels	Three Ones Indicators	TBD (year 1)	90% congruence with planned activities by 2010
Outcome	**Performance Indicators**	**Baseline**	**Target**
1.3 Improved evidence – based planning for the development and monitoring of national HIVAIDS programs and services	Three Ones Index (to be developed) - relevant parts	TBD (year 2)	50% increase in average indicator score by 2010
Outputs	**Performance Indicators**	**Baseline**	**Target**
1.3.1 Strengthened capacity of NAC Secretariat to establish and implement an **M & E system** to monitor the national response and guide future planning	Three Ones Indicators number of M & E system requirements met by various stakeholders as outlined in M & E strategyframework	TBD (year 1) TBD (year 1)	100% congruence with planned activities by 2010 85% congruence with planned activities by 2010
1.3.2 Improved ability of the relevant agencies to conduct necessary **research and surveillance** to inform the policy process as well as program development and implementation	number of social or operational research projects underway or completed Evidence of research findings and M & E findings that are used for advocacy and program development	TBD (year 1) TBD (year 1)	100% congruence with planned activities by 2010 85% congruence with planned activities by 2010
Outcome	**Performance Indicators**	**Baseline**	**Target**
1.4 Creation of a supportive **environment to protect against** stigma and discrimination of PLWHAs	percentage of the general population with accepting attitudes towards those living with HIVAIDS percentage of PLWHAs and their families who perceive a change in respect for their rights by society	TBD (year 1) TBD (year 1)	30% by 2010 50% increase by 2010
Outputs	**Performance Indicators**	**Baseline**	**Target**

PRIORITY AREA 1: HARMONIZATION			
1.4.1 Improved capacity of the NAC and partners to apply **gender and rights-based principles** for HIV/AIDS program and policy development	number of relevant policies written or revised from a human rights and gender perspective in support of the National HIVAIDS policy.	TBD (year 1)	95% congruence with planned activities by 2010
1.4.2 Strengthened capacity of the NAC Secretariat and District Committees to guide the **policy process and to address** HIVAIDS issues among NAC members and other key stakeholders, including the private and public sector, civil society, faith based organizations, and donors	number of policy dialogue initiatives planned and undertaken by NAC Secretariat or with NAC Secretariat technical support Change in participation level of various groups in policy dialogue and advocacy for HIVAIDS issues	TBD (year 1) TBD (year 1)	95% congruence with planned activities by 2010 95% congruence with planned activities by 2010
1.4.3 Improved number of **sectoral policies** addressing HIVAIDS issues in various sectors, such as reproductive health and family life policy, youth policy, public health policy, etc.	number of policies developed by various sectors that address HIVAIDS issues number of cross-sectoral or multi-sectoral initiatives undertaken at national and district levels	TBD (year 1) TBD (year 1)	90% congruence with planned activities by 2010 95% congruence with planned activities by 2010
1.4.4 Develop programs and establish a legal framework in support of the National and Workplace HIVAIDS Policies.	percentage of large companiesdepartments that have HIVAIDS workplace policies and programs addressing discrimination and workplace prevention activities (UNGASS)	TBD (year 1)	80% by 2010
1.4.5 Capacity building for various organizations and programs (media, uniformed services, health care providers, schools etc.) to present and address PLWHA without stigma and discrimination	percentage of policies or guidelines for non-discrimination at national level or within various sectors andor agencies National Communication strategy addressing HIVAIDS and its issueschallenges in education system, media, health sector, uniformed services etc. Developed and implemented	TBD (year 1) TBD (year 1)	95% congruence with planned activities by 2010 95% congruence with planned activities by 2010

Priority Area 2 – PREVENTION			
Impact 2	**Performance Indicators**	**Baseline**	**Target**
Reduced **prevalence** of HIV in the adult population (15-49) of Belize	**percentage of the adult (15-49) population that is HIV infected**	2.4% (end 2003)	Containment of the epidemic by 2010
Outcome	**Performance Indicators**	**Baseline**	**Target**

Priority Area 2 – PREVENTION			
2.1 Reduced transmission rates among recipients of blood, and children born to infected mothers	**percentage of infants born to HIV infected mothers that are infected (UNGASS)**	16.1% (2003-2005)	50% reduction by 2010)
Outputs	**Performance Indicators**	**Baseline**	**Target**
2.1.1 Improved quality and access to safe and high quality **blood products**	**percentage of transfused blood units screened for HIV (UNGASS)**	TBD (year 1)	100% by 2010
2.1.2 Improved delivery of and access to **PMTCT** services countrywide involving both private and public service providers	**percentage of HIV-positive pregnant women** receiving a complete course of antiretroviral **prophylaxis to reduce the risk of mother-to-child transmission (UNGASS)**	73.3% public sector (2003-2005) TBD private sector (year 1)	99 % by 2010 95% by 2010
	percentage of all pregnant women attending at least one ANC visit who received an HIV test result and post-test counseling	TBD (year 1)	90% by 2010
	percentage of public and private health facilities offering PMTCT according to current guidelines (Global Fund)	TBD (year 1)	80% by 2010
Outcome	**Performance Indicators**	**Baseline**	**Target**
2.2 Reduced transmission rates in the general population with special emphasis on youth (15-24)	**percentage of young women and men aged 15-24 who are HIV infected (UNGASS)**	3.4% NHISU Data (2003-2005)	25% reduction by 2010
Intermediate Outcome	**Performance Indicators**	**Baseline**	**Target**
2.2.2.1 Improved **knowledge** about mode of transmission, self-protection, etc. among men and women (15-24)	**percentage of population (15-24) who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (UNGASS)**	TBD (year 1)	95% by 2010
Intermediate Outcome	**Performance Indicators**	**Baseline**	**Target**
2.2.2.2 Improved sexual behaviour among men and women (15-24)	**percentage of young women and men who have had sex before the age of 15 (UNGASS) (Global Fund)** **percentage of women and men (15-24) who have had sex with a non-marital, non-cohabiting partner in the last 12 months (UNGASS) (MDG)** **percentage of people (15-24) reporting the use of condom during sexual intercourse with a non-regular sex partner (UNGASS)**	TBD (year 1) TBD (year 1) TBD (year 1)	20% reduction by 2010 20% reduction by 2010 90% by 2010
Outputs	**Performance Indicators**	**Baseline**	**Target**

Priority Area 2 – PREVENTION			
2.2.1 Improved and integrated services for **STI diagnosis and treatment**	**percentage of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counseled (UNGASS)**	TBD (year 1)	90% by 2010
2.2.2 Improved reach of programs addressing increased **knowledge, attitudes and practices** among men and women (15-24)	**percentage of men and women (15-24) reached by HIVAIDS prevention programs (UNGASS)**	TBD (year 1)	40% by 2010
	percentage of schools with teachers who have been trained in life-skills based HIV education and who taught it during the last academic year (UNGASS)	TBD (year 1)	60% by 2010
Outcome	**Performance Indicators**	**Baseline**	**Target**
2.3 Reduced prevalence among most-at-risk populations (MSM, CSW, prison population, uniformed services)	**percentage of most-at-risk population(s) who are HIV infected (UNGASS)**	TBD MSM (in process of completion)	25% reduction by 2010
		TBD CSW (in process of completion)	25% reduction by 2010
		4.9% Prison Population (2005)	25% reduction by 2010
		TBD Uniformed Services (year 2)	25% reduction by 2010
Intermediate Outcome	**Performance Indicators**	**Baseline**	**Target**
2.3.1.1 Improved **knowledge** about mode of transmission, self-protection, etc. in most-at-risk populations (MSM, CSW, prison population, uniformed services)	**percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (UNGASS)**	TBD MSM (in process of completion)	20% increase by 2010
		TBD CSW (in process of completion)	20% increase by 2010
		28.0% Prison Population (2005)	20% increase by 2010
		TBD Uniformed Service (year 1, review of available data)	20% increase by 2010
2.3.1.2 Improved sexual **practices** among most-at-risk populations (MSM, CSW, prison population, uniformed services)	**percentage of men reporting use of condom the last time they had sex with a male partner (UNGASS)**	TBD (in process of completion)	20% increase by 2010
	percentage sex workers reporting the use of condom with their most recent client (UNGASS)	TBD (in process of completion)	20% increase by 2010
	percentage of uniformed services population reporting at least one major mode of HIV prevention (condom use, partner reduction)	TBD (year 1, review of available data)	20% increase by 2010
	percentage of prison population reporting at least one major mode of HIV prevention (condom use, partner reduction)	TBD (year 1, review of available data)	20% increase by 2010

Priority Area 2 – PREVENTION			
Outputs	**Performance Indicators**	**Baseline**	**Target**
2.3.1 Improved reach of programs addressing increased **knowledge, attitudes and practices** among most-at-risk populations (MSM, CSW, prison population, uniformed service)	**percentage of the most-at-risk populations reached by HIVAIDS prevention programs (UNGASS)**	TBD (year 2)	40% by 2010
Outcome	**Performance Indicators**	**Baseline**	**Target**
2.4 Improved utilization of other related prevention services	percentage of general population utilizing various specified services	TBD (year 1)	50% by 2010
Output	**Performance Indicators**	**Baseline**	**Target**
2.4.1 Improved universal procurement, distribution and **access to** affordable **condoms** through private and public providers	Condoms available for nation-wide distribution (CHRC)	TBD (year 1)	20% increase by 2010
2.4.2 Expansion of and increased access to **VCT services** countrywide in both private and public health sectors	percentage of general population aged 15-49 years receiving HIV test results and post-test counselling in the past 12 months (UNAIDS Care and Support)	TBD (year 1)	50% increase by 2010
2.4.3 Formalized and strengthened provision of the **PEP** to health care workers and sexual assault clients within private and public health service providers	percentage of facilities in which post-exposure prophylaxis is provided and all items to support the service are available (UNAIDS Care and Support)	TBD (year 2)	20% increase by 2010

PRIORITY AREA 3: MITIGATION			
Impact 3	**Performance Indicators**	**Baseline**	**Target**
Extended life **of Persons living with HIVAIDS**	**percentage of adults and children with HIV still alive and known to be on treatment 12 months after initiation of antiretroviral treatment (UNGASS)**	TBD (year 2)	25% increase by 2010
	Reduced morbidity of persons infected with HIV (Global Fund)	TBD (year 2)	25% reduction by 2010
Outcome	**Performance Indicators**	**Baseline**	**Target**
3.1 Improved effectiveness of integrated **care, support and treatment** services for people infected with and affected by HIVAIDS	percentage of facilities that provide comprehensive care referrals for HIVAIDS care and support services when these services are not available on site (UNAIDS Care and Support)	TBD (year 2)	100% by 2010

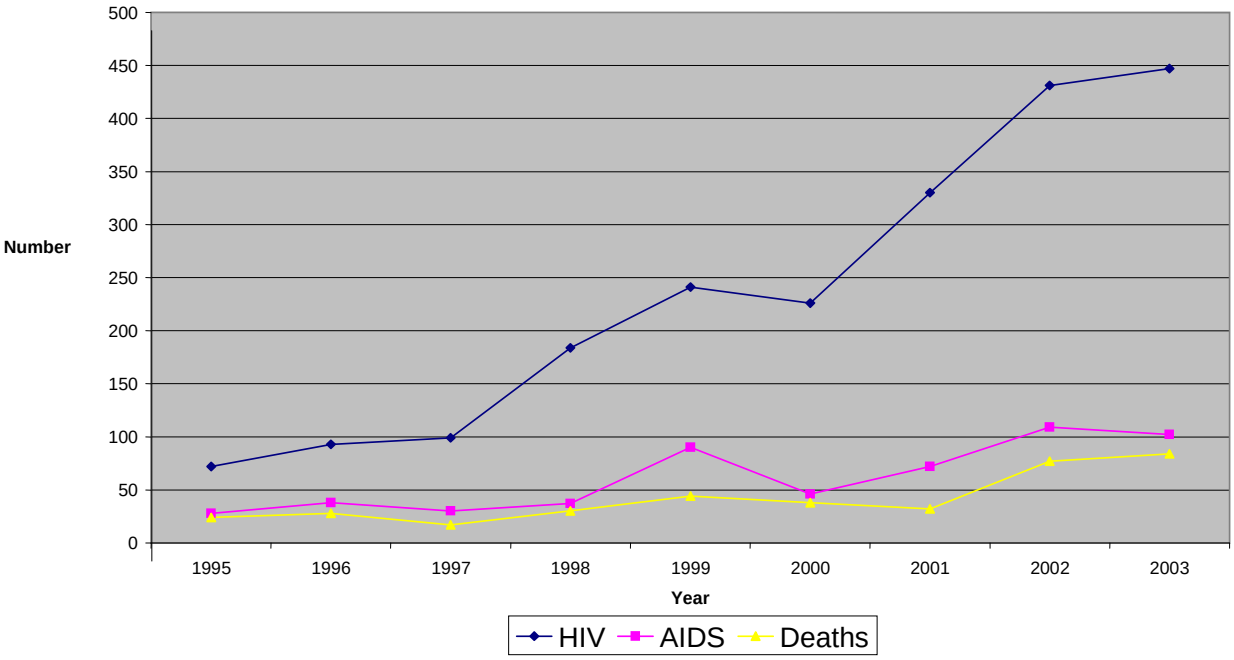
PRIORITY AREA 3: MITIGATION			
Outputs	**Performance Indicators**	**Baseline**	**Target**
3.1.1 Improved quality, coverage and access to **clinical management services** for opportunistic infections, palliative care etc. for persons infected with and affected by HIVAIDS provided both at the primary and secondary level	percentage of health care facilities that have the capacity and conditions to provide advanced-level HIVAIDS care and support services, including provision of ART (CHRC) (UNAIDS Care and Support) – secondary level indicator percentage of facilities that have the capacity and conditions to provide basic-level HIV testing and HIVAIDS clinical management (CHRC) (UNAIDS Care and Support) – primary level indicator	TBD (year 2) TBD (year 2)	25% increase by 2010 25% increase by 2010
3.1.2 Improved delivery of support services (long term counselling, spiritual and psychological support, terminal care, home-based care) provided to persons infected and affected by HIVAIDS by the relevant agencies. (GOV, NGOs and other civil society groups)	Adults aged 18-59 who have been Chronically ill for 3 months or more in the past 12 months whose households received free external support in caring for the ill person (number and percentage) (UNAIDS Care and Support) (Global Fund)	TBD (year 2)	30% increase by 2010
3.1.3 Strengthened capacity for procurement, distribution and management of **ARVs** countrywide among both private and public providers	**percentage of women and men with advanced HIV infection receiving antiretroviral therapy (UNGASS-National Programs)**	TBD (year 2)	90% by 2010
3.1.4 Improved quantity and quality of services provided to **OVCs** by government, community based organizations and families (counseling, nutrition, etc.)	percentage of orphans and vulnerable children whose households receive free basic external support in care for the child (New-UNGASS - National programs) Ratio of current school attendance among orphans to that among non-orphans aged 10-14 (UNGASS)	TBD (year 2) TBD (year 2)	30% increase by 2010 30% increase by 2010
Outcome	**Performance Indicators**	**Baseline**	**Target**
3.2 Improved policies and programs addressing reduction of **socio-economic impact of HIVAIDS infection for** persons living with HIVAIDS	Analysis of the social-economic profile of PLWHAs	TBD (year 2)	25% improvement in social-economic profile by 2010
Outputs	**Performance Indicators**	**Baseline**	**Target**

PRIORITY AREA 3: MITIGATION			
3.2.1 Improved **access** to **services** and programs targeting **PLWHA**s	number or percentage of PLWHAs participating in existing economic or social support programs (income generating, microfinance, food support, housing, insurance, nutritional support)	TBD (year 2)	25% increase by 2010
	percentage of NGOs and other agencies providing economic and social support programs	TBD (year 2)	25% increase by 2010
3.2.1 Improved participation of PLWHA in development, planning, implementation and monitoring of programs	number of PLWHA organizations represented on NAC and on other key government or multi-sectoral bodies	TBD (year 1)	100% congruence with planned activities by 2010
	number of PLWHA organizations registered at national level andor implementing socio-economic support programs	TBD (year 1)	80% congruence with planned activities by 2010

Appendix I

Selected Baseline

Figure 1 - Number of HIV Infections, AIDS Cases and Deaths related to AIDS
Belize, 1995 - 2003



Source: Epidemiologic Profile of HIVAIDS in Belize, MOH 2003.

Table 1. HIV Positive Infections by District per 10,000 Inhabitants Belize, 2001–2003

Year	Corozal	Orange Walk	Belize	Cayo	Stann Creek	Toledo
2001	1.19	2.21	35.62	3.04	10.00	0.82
2002	1.17	1.68	46.19	3.60	10.74	2.38
2003	2.60	2.80	45.21	2.62	11.11	4.23

Source: Epidemiologic Profile of HIVAIDS in Belize, MOH 2003.

Table 2. Impact of AIDS as a Cause of Mortality Belize, 2000 – 2003

	2000	2001	2002	2003	2004
All Age Groups	9th	*	7th	4th	3rd
20 to 29 years	3rd	5th	3rd	3rd	3rd
30 to 39 years	2nd	2nd	1st	1st	1st
40 to 49 years	4th	*	1st	1st	1st

Source: Belize Health Information Surveillance Unit
*Not ranked within the 10 leading causes of death

Appendix II

Interviewees

Name	Affiliation
Claudia Dominguez	MOHDCAC(Cayo AIDS Committee)
Nurse Lilia Middleton	MOHCAC
Ana Silva	Cornerstone FoundationCAC
Nurse Carmen Dacak	MOHCAC
Nurse Carol Tennyson	MOHCAC
Dylan Vernon	UNDP
John Flowers	NCFC
Margaret Ventura	MOPS
Armeid Thompson	MIAP Project
Adelfino Vasquez	MLLG
Adele Catzim	Independent Consultant
Lt. Lewis	BDF
Nurse Margaret Bradley	MOHVCT
Nurse Guillermina Heredia	MOHCorAC(Corozal AIDS Committee)
Romeo Magana	MOHHECOPAB
Erika Mc-Gregor Goldson	MOHHECOPAB
Jewel Quallo Rosberg	UNFPA
Michael Rosberg	Independent Consultant
Jay Coombs	UNTG
Rodel Beltran Perera	AAA
Dr. Paul Edwards	MOH
Yvonne Codd	MOE
Sheila Middleton	MLLG
Sandra Jones	PAHO
Dr. Pedro Noya	PAHO
Jay Coombs	UNICEF
Ruth Jaramillo	NAC
Dennis Jones	BEST
Adele Catzim	Independent Consultant
Joan Burke	BFLA

Erika Goldson-McGregor	HECOPABMOH
Marylee Ellis	Belize Red Cross
Mervin Lambey	YFF
Errol Fairweather	Kolbe Foundation
Tracy Rudne	PASMO
Dr. Ninfa Ken	Southern Regional
Anita Zetina	Women's Department
Austin Arzu	Peace Corps

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