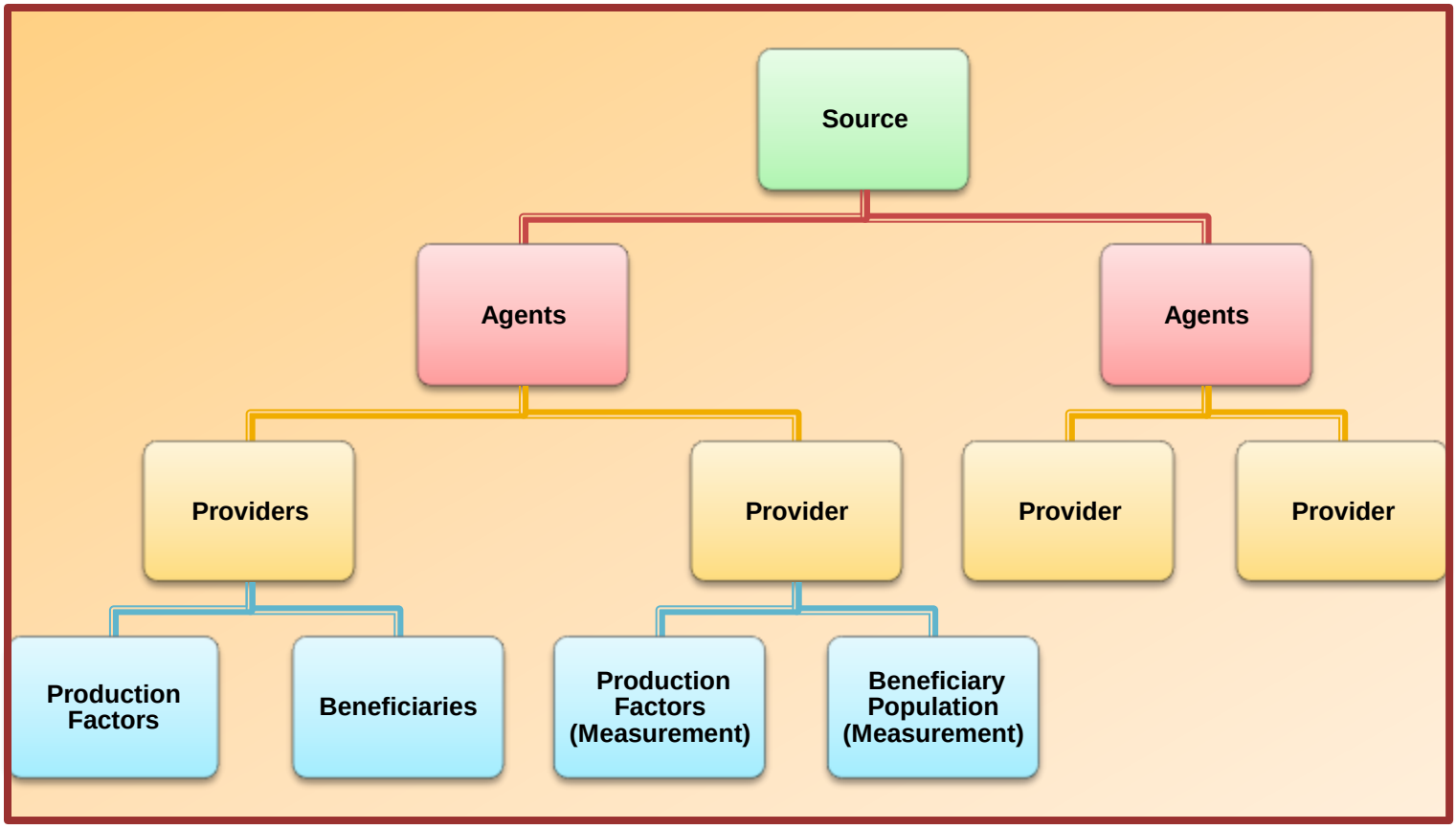

National AIDS Spending Assessment:

Belize 2012

EXECUTIVE REPORT

Table of Contents

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LIST OF ACRONYMS

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

LIST OF TABLES & GRAPHS

FOREWORD

The National AIDS Commission (NAC) Belize is the national multi-sectoral statutory body tasked by law to guide, coordinate and monitor the National Response to HIV/AIDS. Recognizing that manifestations of the HIV/AIDS epidemic are not only to be regarded as a public health issue, but are also highly influenced by social, cultural and economic factors, the NAC has promoted the involvement and stakeholdership of relevant and associated segments of the public sector, the private sector and civil society in the planning, implementation and monitoring of the National Response to the epidemic.

The National AIDS Spending Accounts (NASA) 2012 is timely as the National Response prepares for a new funding request to Global Fund to fight HIV/AIDS and TB. This report will be instrumental for the informed decisions and strategic, short- and long-term planning that will shortly take place. In conjunction with the National Strategic, Operational and M&E plans costing, NASA 2012 will guide the Response as it seeks to bridge funding, programmatic and monitoring and evaluation gaps for more robust, engaged, directed and efficient outcomes and outputs. Moreover, the NASA 2012 succinctly shows the Response's level of coordination and gains from this coordination in the country.

While NASA 2012 must be compared to the previous NASAs, it should not be juxtaposed for the surface picture it will yield but rather to frame an understanding, an appreciation of whether or not the efforts of the Response is met with proportionate gains on the street. Is the THREE ONES principle the guiding tenets of the Response? Have we definitively innovated ways to end new HIV infections; improve health and well-being and create an enabling environment? If not, why and when? The NASA 2012 calls us to evaluate, after seeing trends over past years, what can or cannot be continued any longer. We must now bear that charge and act.

Lastly, as the NASA 2012 teaches us how to rate our National Response to HIV/AIDS in Belize, it directs us to future implications and expectations of our role. We have, in our hands, the power to change the burden of HIV/AIDS in Belize. It is not a unilateral job but a singularly, concerted ground-swell of harmonized vision, use of resources and evidenced-based planning. The National AIDS Commission Belize is poised to accomplish this and more, and NASA 2012 is a step in that direction.

To borrow from one of NAC's stellar commissioners, TOGETHER IN THE STRUGGLE!

Allison Green
NAC Executive Director

EXECUTIVE SUMMARY

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

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

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

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

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

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

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

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

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

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

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

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

1.0 INTRODUCTION

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

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

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

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

2.0 KEY HIV INDICATORS

2.1 Epidemiological Profile at a Glance

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

Traditionally the group between 20-39 years has had the higher number of new cases but the 2012 data shows a particular spike in the 45-49 yr old group where the highest number of cases was reported for all age groups. The male to female ratio in this age range was 1.69:1 which is a little bit higher than the documented for the overall age groups. This trend is particularly more noticeable for the male groups but we are also seeing a tendency to have older females having a recent diagnosis of HIV; however, this doesn't necessarily reflect that these are new infections and the CD4 data actually suggests that the majority of patients are showing up in the later stages of the disease.[2]

The Belize district reported the highest number of new infections in 2012 with the second highest total number reported by the Cayo District. However, when the rates are calculated by district population size using the 2012 midyear estimates, the Belize District has the highest rate of 14.5/ 10,000 followed by the Stann Creek with 6.6/10,000.[3]

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

Table 1

Indicator	Male	Female	Total
HIV Rapid & Elisa Testing - 2012	9062	17533	26595
New HIV Cases - 2012	101	148	249
Positivity Rate	1.51%	.54%	0.89%
HIV Related Deaths	31	57	88
Source: Ministry of Health, Annual TB, HIV/AIDS, & Other STIs Programme Report, 2012			

[1] ***Annual TB, HIV/AIDS, & Other STIs Programme Report- 2012;"*** *Ministry of Health, National AIDS Programme*
[2] ***- IB ID -***
[3] ***- IBID -***

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

Table 2

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

2.2 MDG Indicators

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

However, data on young population with correct comprehensive knowledge of HIV/AIDS show a decline but this data was collected via sample surveys where non-sampling errors could skew the results.[4] See Table 3.

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

Table 3: MDG-HIV Scorecard

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

Source: MDG Report & Post 2015 Agenda – Belize 2013

3.0 TOTAL HIV/AIDS SPENDING

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

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

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

Table 4

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

[5] *"Belize Labour Force Survey- Summary Findings, April 2012;" Statistical Institute of Belize – Estimated Total Population of 338,996.*
[6] *"Budget Speech Presentation, 2012/13" Projected GDP – BZ$3.04 billion*
[77] *"Health Policy Initiative – Costing Belize's National Strategic Plan for HIV/AIDS;" USAID-HPI, September 2008*

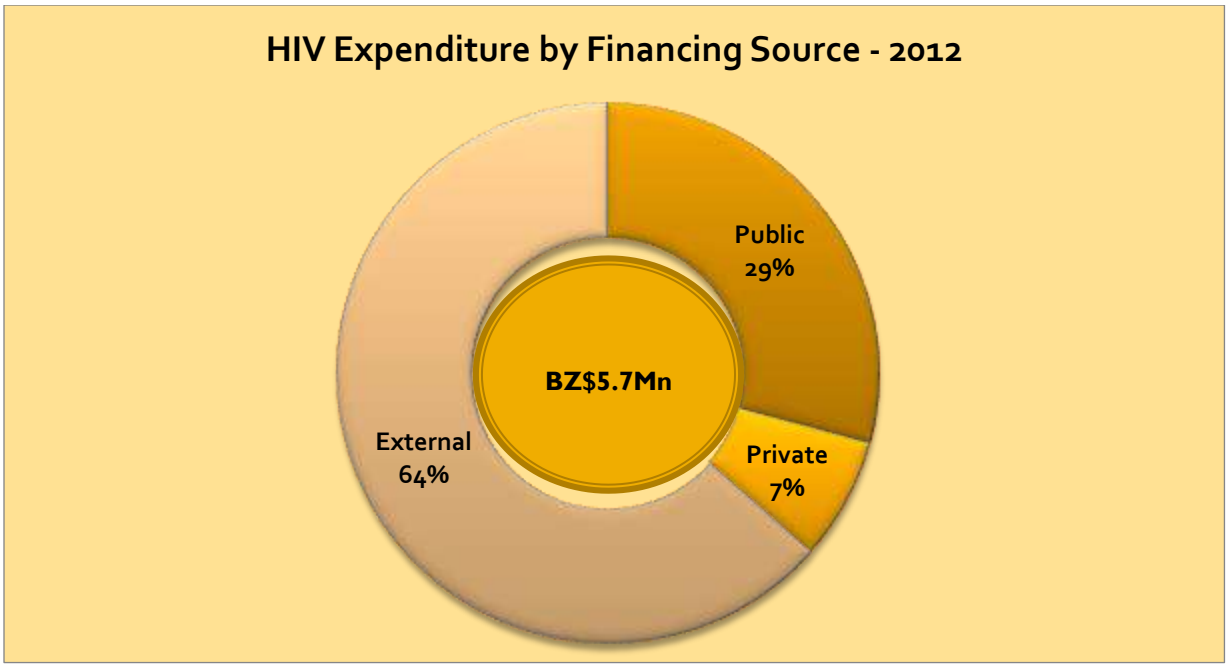
4.0 ORIGIN OF FUNDS – EXTERNAL DEPENDENCY

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

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

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

Chart 1



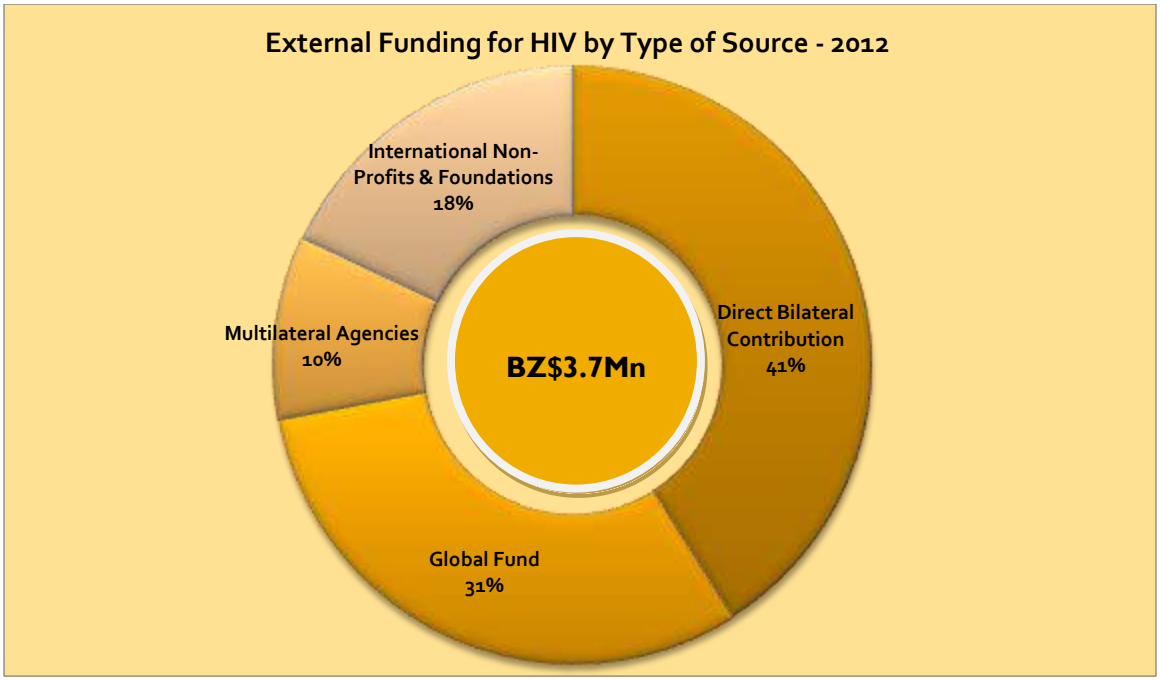
Origin of Funds	BZ$	US$
External	3,600,494	1,800,247
Private	414,837	207,418.5
Public	1,658,213	829,106.5
Total	5,673,544	2,836,772

5.0 FOREIGN SOURCES COMPOSITION

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

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

Chart 2



Direct Bilateral Agencies		
FS.03.01.08	Government of Germany	260,107.00
FS.03.01.22	Government of United States	1,110,965.00
Multilateral Agencies		
FS.03.02.08	UNAIDS Secretariat	10,722.00
FS.03.02.09	United Nations Children's Fund (UNICEF)	194,600.00
FS.03.02.17	United Nations Population Fund (UNFPA)	141,044.00
Global Fund		
UNDP/PR		
FS.03.02.07	The Global Fund to Fight AIDS, Tuberculosis and Malaria	**1034,713.00**
	Sub-total	**2,752,151.00**
International Non-Profit Organizations & Foundations		612243
		3,364,394.00

6.0 RESOURCE TARGETING

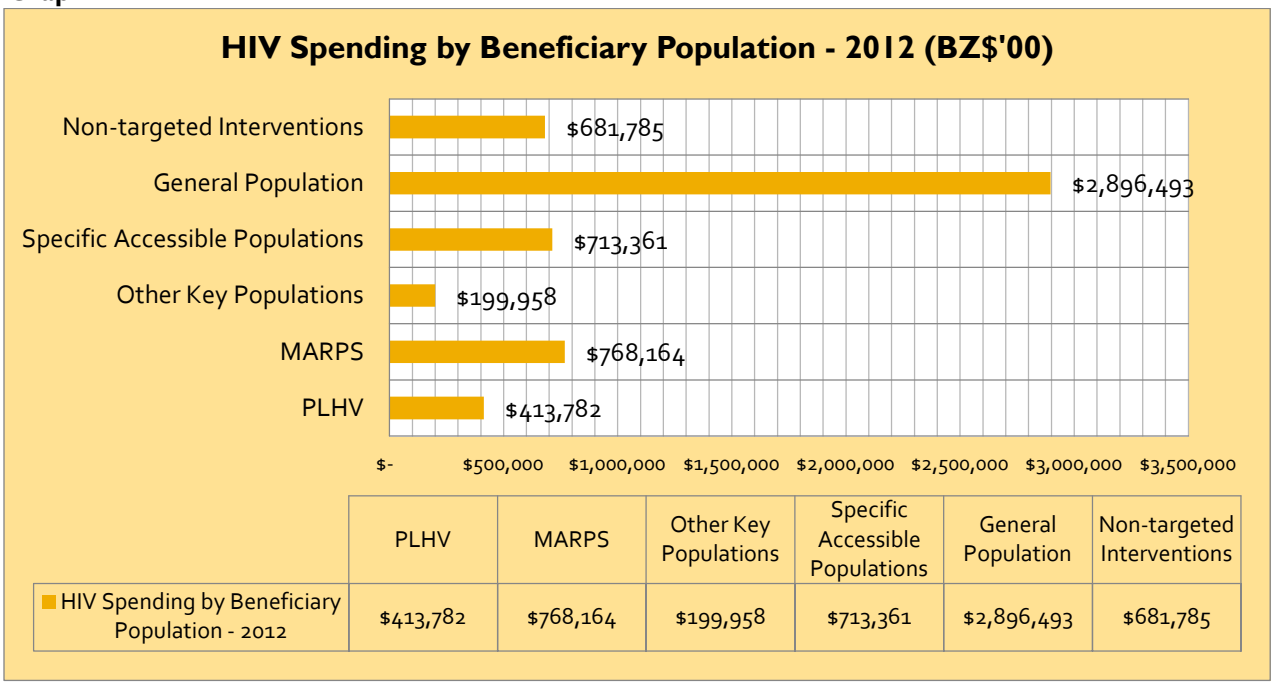
HIV spending shows a higher concentration within the 'General Population,' 'Non-targeted Interventions,' and 'Specific Accessible Populations' where 75% of total resources were deployed. However, and within the "Specific Accessible Populations," interventions were targeted at students, primarily and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

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

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

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

Graph 1



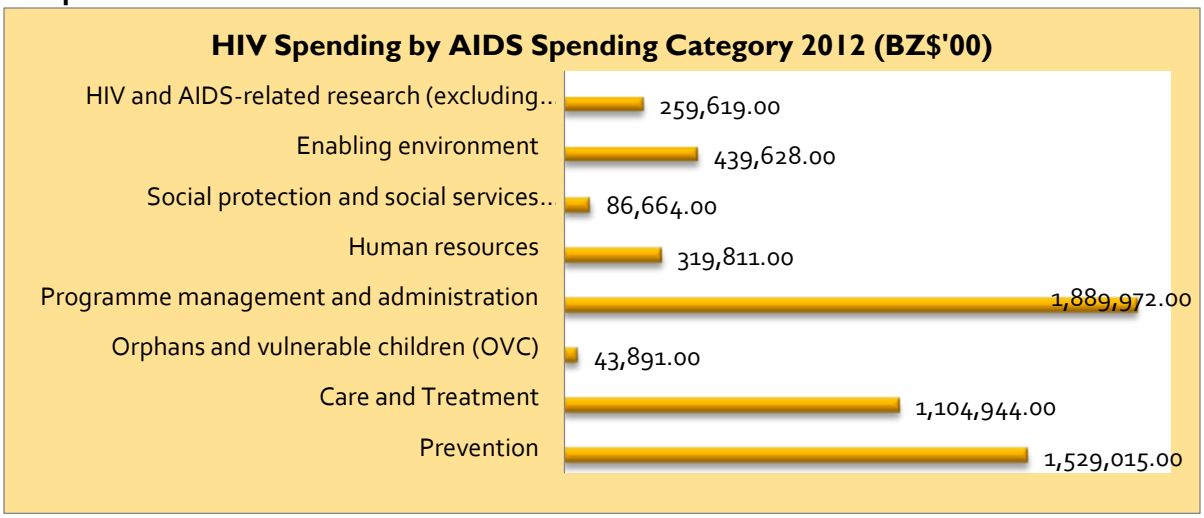
	PLHV	MARPS	Other Key Populations	Specific Accessible Populations	General Population	Non-targeted Interventions
HIV Spending by Beneficiary Population - 2012	$413,782	$768,164	$199,958	$713,361	$2,896,493	$681,785

7.0 SPENDING CATEGORIES

7.1 Overall Spending by Categories

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

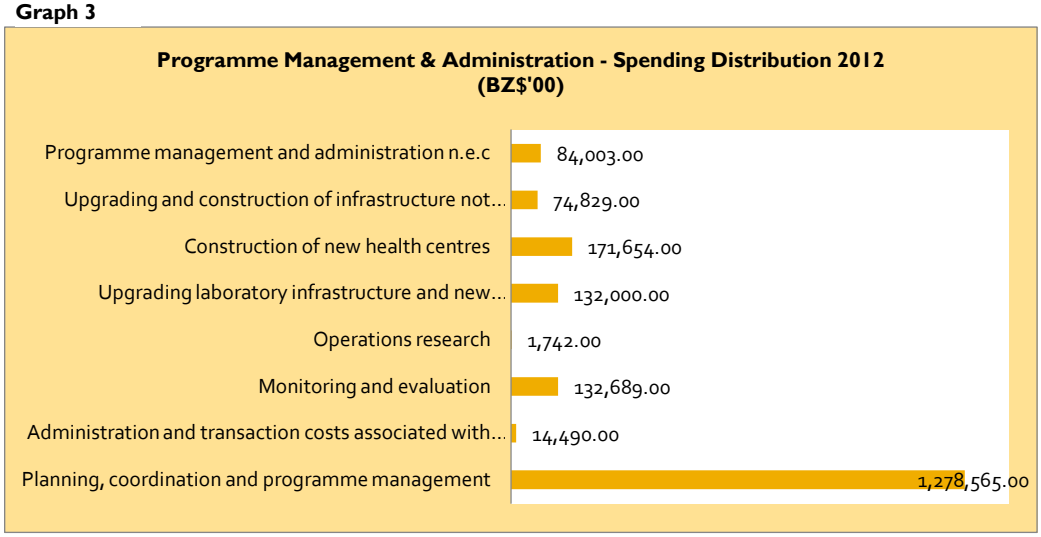
Graph 2



7.2 Programme Management & Administration

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

Graph 3



7.3 Prevention

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

Table 5

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

7.4 Care and Treatment

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

Table 6

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

8.0 CRITICAL INPUTS

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

Table 7

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

9.0 CONCLUSION

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

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

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

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

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

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

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

10.0 CONSTRAINTS & RECOMMENDATIONS

10.1 Information Quality - Data

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

10.2 Recommendations

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

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

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

11.0 LIST OF REPORTING ORGANIZATIONS

Belize Defence Force
Belize Family Life Association
Belize Red Cross
Central Medical Lab
Claret Care
Community Policing Unit
Cornerstone Foundation
GO BELIZE
Hand in Hand Ministries - Belize
Intra Health International - Capacity Project
MHDST - Women's Department
Ministry of Education - HFLE
Ministry of Education, Youth, & Sports
Ministry of Health - National AIDS Programme
Ministry of Human Development
National AIDS Commission
National Women's Commission
Private Sector Importers, Distributors, & Agents
Productive Organization for Women in Action
PSI PASMO - Belize
UNICEF-Belize Office
United Advocacy Belize Advocacy Movement - UNIBAM
USAID -PASCA
Women Issues Network Belize
Young Women's Christian Association
Youth Enhancement Services
Young Women's Christian Association (Belize)

12.0 ANNEXES

Annex 1: Beneficiary Population Matrix

Annex 2: Production Factor Matrix

Annex 3: UNGASS Matrix

Annex 4: NASA Outputs – Frequency Tables