xINICIATIVA MUNDIAL SOBRE TENDENCIAS DE LA LACTANCIA MATERNA

World Breastfeeding Trends Initiative (WBTi)

NATIONAL ASSESSMENT

BELIZE

2016

IBFAN
defending breastfeeding

bpni
putting child nutrition
at the forefront
of social change

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BEAM	Belize Education Advancement of Midwifery
MBFHI	Mother Baby Friendly Hospital Initiative
BPNI	Breastfeeding Promotion of India
CEDAW	Committee on the Elimination of Discrimination against Women
CEFEMINA	Feminist Centre for Information and Action
CHW	Community Health Workers
CML	Central Medical Laboratory
BHIS	Belize Health Information System
GBV	Gender based violence
HIV	Human Immunodeficiency virus
IBFAN	International Baby Food Action Network
INCAP	Institute of Nutrition of Central America and Panama
MOH	Ministry of Health
NAC	National AIDS Commission
NAP	National AIDS Program
MCH	Maternal and Child Health
PAHO	Pan American Health Organization
SSB	Belize Social Security Board
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme
UNIBAM	United Belize Advocacy Movement
UNICEF	The United National Children´s Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

I. INTRODUCTION

Belize was the site of several Mayan city-states until their decline at the end of the first millennium A.D. The British and Spanish disputed the region in the 17th and 18th centuries; it formally became the colony of British Honduras in 1854. Territorial disputes between the UK and Guatemala delayed the independence of Belize until 1981. Guatemala refused to recognize the new nation until 1992 and the two countries are involved in an on-going border dispute. Tourism has become the mainstay of the economy. Current concerns include the country's heavy foreign debt burden, high unemployment, growing involvement in the regional drug trade, high crime rates, and one of the highest HIV/AIDS prevalence rates in Central America.

Belize is a very small country with a population of 353,858 persons (July 2016 est.) Children 0-14 years are 34.41% of the total population (male 62,139/female 59,611).

The rate of births is: 24.3-births/1,000 population (2016 est.)

Belize´s population is composed by many different groups: mestizo, Creole, Maya, Garifuna, East Indian, Mennonite 3.6%, Caucasian, Asian, other.

The English is the official language, followed by Spanish, Creole, Maya, German, Garifuna, and others. It is the only English speaking country in Central America.

Migration continues to transform Belize's population. About 16% of Belizeans live abroad, while immigrants constitute approximately 15% of Belize's population. Belizeans seeking job and educational opportunities have preferred to emigrate to the United States rather than former colonizer Great Britain because of the United States' closer proximity and stronger trade ties with Belize. The emigration of a large share of Creoles (Afro-Belizeans) and the influx of Central American immigrants, mainly Guatemalans, Salvadorans, and Hondurans, has changed Belize's ethnic composition. Mestizos have become the largest ethnic group, and Belize now has more native

Spanish speakers than English or Creole speakers, despite English being the official language. In addition, Central American immigrants are establishing new communities in rural areas, which contrasts with the urbanization trend seen in neighbouring countries. The urban population is 44% of total population (2015.)

Immigration accounts for an increasing share of Belize's population growth rate, which is steadily falling due to fertility decline. Belize's declining birth rate and its increased life expectancy are creating an aging population. As the elderly population grows and nuclear families replace extended households, Belize's government will be challenged to balance a rising demand for pensions, social services, and healthcare for its senior citizens with the need to reduce poverty and social inequality and to improve sanitation.

Reducing poverty and improving sanitation pose major challenges for the country. Reducing the burden of communicable diseases remains as a priority for Belize, and the rise of chronic, non-communicable diseases poses a new challenge for the country's health system.
In 2003, the government introduced a non-contributory pension for women over the age of 65 as a tool for reducing poverty; in 2007, this benefit was extended to men over the age of 67.
The Government of Belize continues to put the primary focus of its strategies on the fight against poverty. Belize has identified several development priorities, namely, through key strategic documents such as Horizon 2030, including a focus on democratic governance through a transparent and accountable government machinery, capable of improving citizen security and access to justice; education for life and lifelong learning; building a resilient economy for healthy citizens, with care for the natural environment.

The economy of Belize is a small and essentially a private-enterprise economy, grounded primarily in tourism and petroleum. The long-term growth performance of Belize has been positive. However, inequality remains high. The population living below the poverty line has increased despite its positive trending gross domestic product. A crucial factor associated with backslides against the poverty is the country's high unemployment rate (women recorded twice the unemployment rate of men. The influence on food security is also worrisome as national figures indicate that the proportion of the population with less than minimum dietary consumption continues to increase. High levels of poverty and weak institutional capacity within the criminal justice system are also thought to be at the core of the country's deteriorating citizen security (PAHO).

Belize's Human Development Index value for 2014 is 0.715, positioning Belize at 101 out of 188 countries and territories. The effective integration of sustainable development principles across all sectors of the economy of Belize, however, is thought to be lagging. Belize is ranked 8th. among 167 countries as being most vulnerable to climate risk (World Bank).

With such a large part of the national economy dependent on the health of the natural resource base (tourism, agriculture, aquaculture, forestry, among others), vulnerabilities to natural disaster and climate change more broadly, have been moved to the centre of the national agenda. While climate change is predicted to increase the population's exposure to natural hazards, the presence of unsustainable management practices, such as unchecked land conversion, the expansion of agriculture onto inadequate terrains or marginalized soils and the concentration of people in highly exposed areas, increases both the risk and impact of climatic variation.

"Belize has a strong commitment to the normative human rights framework, but faces challenges in its full operationalization"; as well as supporting the establishment of development coordination mechanisms, confirmed by the early successes of the coordination groups on security and gender" (UNDP).

The Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination against Women are important guiding frameworks for rights-based development. Since ratifying the conventions, the Government of Belize has made several important legislative and policy developments/reforms to align national laws to international standards. A new social protection programme, BOOST, is being implemented to guarantee the rights of children to social protection, health and education. The standards and principles of the Convention on the Rights of the Child have been expressly enacted into law through the Families and Children's Act 2000, and a National Plan of Action (NPA) has been developed, including the establishment of a National Committee for Families and Children.

Despite these important gains, some gaps remain in protection, including the need for a fuller incorporation of the provisions of the Convention on the Rights of the Child into all domestic legislation.

Belize is one of the few countries in the region that has ratified the ILO Convention 183 - Maternity Protection Convention -2000, in November 2005.

Belize has not approved any law based on the International Code of Marketing of Breastmilk Substitutes, which creates big vulnerability of mothers and babies towards company's promotion and marketing. Luckily Belize is not a big market that interests companies thus the new trends of influencing public policies through sponsorship and public relations have not become a big problem yet for the country.

II: BACKGROUND

In 2015-2016, the Belize MICS5 – Belize Multiple Indicator Cluster Survey 2015 – Key Findings, August 2016 – Government of Belize, UN Belize, UNICEF, Statistical Institute of Belize (http://mics.unicef.org/ and http://data.unicef.org/) was carried out in 2015 by the Statistical Institute of Belize in collaboration with the Government of Belize and the United Nations Children's Fund (UNICEF), as part of the global MICS programme. UNICEF, UNDP and the Office of the UN Resident Coordinator provided technical support.

The survey was held to identify key indicators to formulate policies and programs and to set the baseline for the Sustainable Development Goals and other conventions Belize has ascribed to.

The result is a mix bag: there is a significant improvement in child mortality and challenges in respect of nutrition.

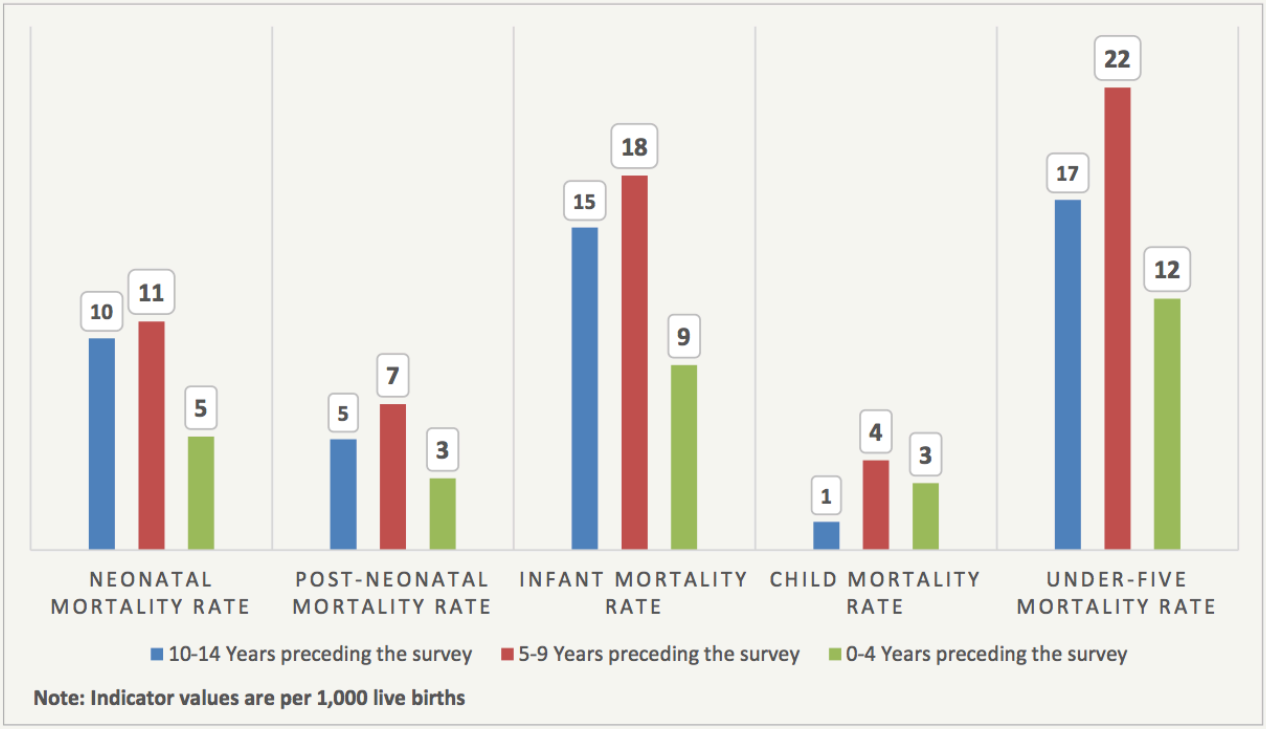
Another really significant measure of our development is the infant mortality rate and this went from fifteen deaths per one thousand fifteen years ago to nine deaths in the last five years. So that is an area where we have made improvement and where MICS has provided really valuable data for us to monitor our development – says Robyn Daly, Nutritionist, Ministry of Health.

CHILD MORTALITY

Early childhood mortality			
MICS Indicator	**Indicator**	**Description**	**Value[A]**
1.1	Neonatal mortality rate	Probability of dying within the first month of life	5
1.2	Infant mortality rate	Probability of dying between birth and the first birthday	9
1.3	Post-neonatal mortality rate	Difference between infant and neonatal mortality rates	3
1.4	Child mortality rate	Probability of dying between the first and the fifth birthdays	3
1.5	Under-five mortality rate	Probability of dying between birth and the fifth birthday	12

[A] Indicator values are per 1,000 live births and refer to the five-year period before the survey

Figure 1: Early childhood mortality rates, Belize MICS5, 2015

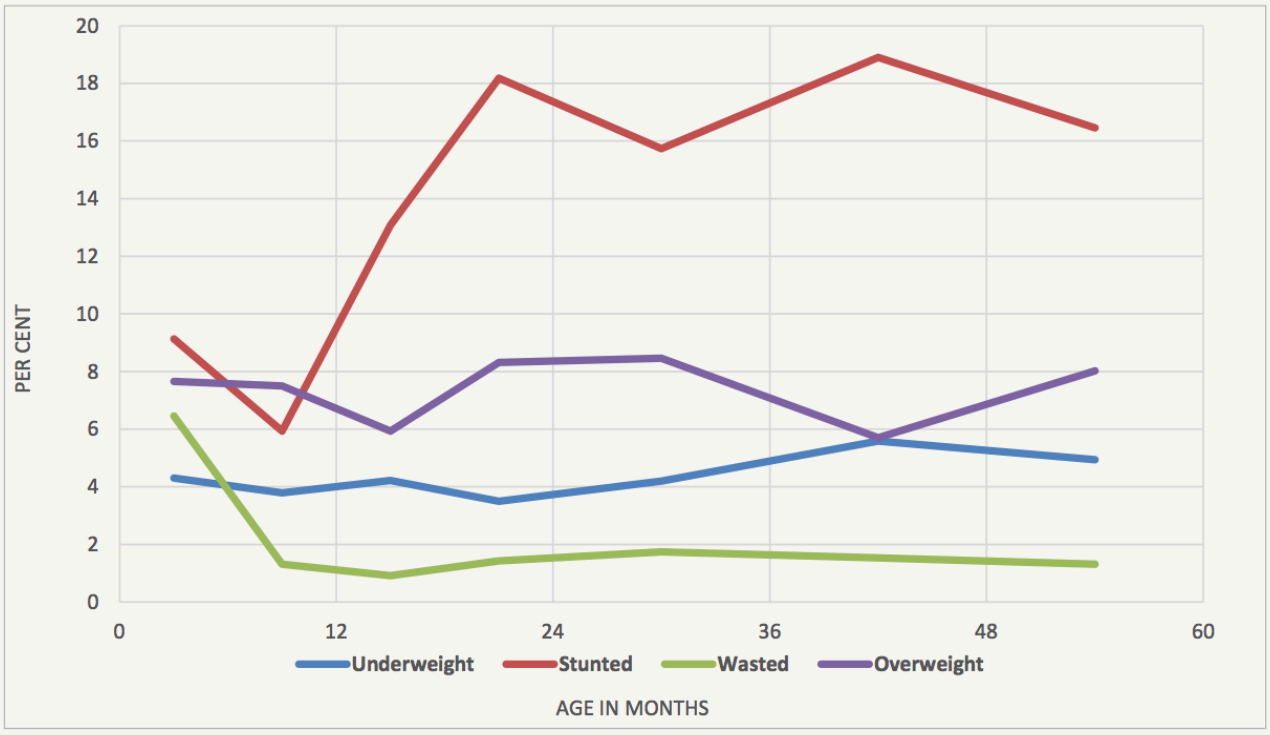


Note: Indicator values are per 1,000 live births

NUTRITION

Nutritional status[i]			
MICS Indicator	**Indicator**	**Description**	**Value**
	Underweight prevalence	Percentage of children under age 5 who fall below	
2.1a 2.1b	(a) Moderate and severe (b) Severe	(a) minus two standard deviations (moderate and severe) (b) minus three standard deviations (severe) of the median weight for age of the WHO standard	4.6 0.4
	Stunting prevalence	Percentage of children under age 5 who fall below	
2.2a 2.2b	(a) Moderate and severe (b) Severe	(a) minus two standard deviations (moderate and severe) (b) minus three standard deviations (severe) of the median height for age of the WHO standard	15.0 2.6
	Wasting prevalence	Percentage of children under age 5 who fall below	
2.3a 2.3b	(a) Moderate and severe (b) Severe	(a) minus two standard deviations (moderate and severe) (b) minus three standard deviations (severe) of the median weight for height of the WHO standard	1.8 0.5
2.4	Overweight prevalence	Percentage of children under age 5 who are above two standard deviations of the median weight for height of the WHO standard	7.3

Figure 2: Underweight, stunted, wasted and overweight children under age 5 (moderate and severe) Belize MICS5, 2015



Breastfeeding and infant feeding			
MICS Indicator	**Indicator** unted	**Description**	**Value**
2.5	Children ever breastfed	Percentage of women with a live birth in the last 2 years who breastfed their last live-born child at any time	92.7
2.6	Early initiation of breastfeeding	Percentage of women with a live birth in the last 2 years who put their last newborn to the breast within one hour of birth	68.3
2.7	Exclusive breastfeeding under 6 months	Percentage of infants under 6 months of age who are exclusively breastfed[ii]	33.2
2.8	Predominant breastfeeding under 6 months	Percentage of infants under 6 months of age who received breast milk as the predominant source of nourishment[iii] during the previous day	50.1
2.9	Continued breastfeeding at 1 year	Percentage of children age 12-15 months who received breast milk during the previous day	51.5
2.10	Continued breastfeeding at 2 years	Percentage of children age 20-23 months who received breast milk during the previous day	35.1
2.11	Median duration of breastfeeding	The age in months when 50 percent of children age 0-35 months did not receive breast milk during the previous day	17.2
2.12	Age-appropriate breastfeeding	Percentage of children age 0-23 months appropriately fed[iv] during the previous day	49.7
2.13	Introduction of solid, semi-solid or soft foods	Percentage of infants age 6-8 months who received solid, semi-solid or soft foods during the previous day	78.8
2.14	Milk feeding frequency for non-breastfed children	Percentage of non-breastfed children age 6-23 months who received at least 2 milk feedings during the previous day	83.2
2.15	Minimum meal frequency	Percentage of children age 6-23 months who received solid, semi-solid and soft foods (plus milk feeds for non-breastfed children) the minimum number of times[v] or more during the previous day	28.8
2.16	Minimum dietary diversity	Percentage of children age 6–23 months who received foods from 4 or more food groups[vi] during the previous day	66.3
2.17a	Minimum acceptable diet	(a) Percentage of breastfed children age 6–23 months who had at least the minimum dietary diversity and the minimum meal frequency during the previous day	4.8
2.17b		(b) Percentage of non-breastfed children age 6–23 months who received at least 2 milk feedings and had at least the minimum dietary diversity not including milk feeds and the minimum meal frequency during the previous day	39.3
2.18	Bottle feeding	Percentage of children age 0-23 months who were fed with a bottle during the previous day	61.2

Post-natal health checks			
MICS Indicator	**Indicator**	**Description**	**Value**
5.10	Post-partum stay in health facility	Percentage of women age 15-49 years who stayed in the health facility for 12 hours or more after the delivery of their most recent live birth in the last 2 years	94.3
5.11	Post-natal health check for the newborn	Percentage of last live births in the last 2 years who received a health check while in facility or at home following delivery, or a post-natal care visit within 2 days after delivery	96.4
5.12	Post-natal health check for the mother	Percentage of women age 15-49 years who received a health check while in facility or at home following delivery, or a post-natal care visit within 2 days after delivery of their most recent live birth in the last 2 years	96.4

"What we are looking at is to improve or scale up our case by case management of malnutrition... So what the ministry has done is that we have employed what we would call social advocates for nutrition and their responsibility is to literally work along with children and parents who have children, especially the women that have children under five years of age, to address malnutrition… They do growth monitoring, they are weighed, they are measured, the parents are educated about nutrition… we want to do a preventative strategy so we are going to look at having the same type of advocates, nutrition advocates… We do see there is a prevalence of obesity and this is alarming to us as well because remember this target group that the MICS covered is under five. So that is telling us that even though we have a large amount of malnutrition, we also have over nutrition as well which is obesity. And many times people like to see the chubby babies, it is so cute, but they do put them at health risk. So again the education and the monitoring goes both ways."

III. ABOUT WBT*i*

World Breastfeeding Trends Initiative (WBT*i*)

Background

The World Breastfeeding Trends Initiative (WBT*i*) is an innovative initiative, developed by IBFAN Asia, to assess the status and benchmark the progress of the implementation of the Global Strategy for Infant and Young Child Feeding at national level. The tool is based on two global initiatives, the first is WABA's (GLOPAR) and the second the WHO's "Infant and Young Child Feeding: A tool for assessing national practices, policies and programmes". The WBT*i* is designed to assist countries in assessing the strengths and weaknesses of their policies and programmes to protect, promote and support optimal infant and young child feeding practices. The WBT*i* has identified 15 indicators in two parts, each indicator having specific significance.

Part-I deals with policy and programmes (indicator 1-10)	Part –II deals with infant feeding practices (indicator 11-15)
1. National Policy, Programme and Coordination 2. Baby Friendly Hospital Initiative (Ten steps to successful breastfeeding) 3. Implementation of the International Code of Marketing of Breastmilk Substitutes 4. Maternity Protection 5. Health and Nutrition Care Systems (in support of breastfeeding & IYCF) 6. Mother Support and Community Outreach 7. Information Support 8. Infant Feeding and HIV 9. Infant Feeding during Emergencies 10. Mechanisms of Monitoring and Evaluation System	11. Early Initiation of Breastfeeding 12. Exclusive breastfeeding 13. Median duration of breastfeeding 14. Bottle feeding 15. Complementary feeding

Once assessment of gaps is carried out, the data on 15 indicators is fed into the questionnaire using the WBT*i* web based toolkit© which is specifically designed to meet this need. The toolkit objectively quantifies the data to provide a colour- coded rating in Red, Yellow, Blue or Green. The toolkit has the capacity to generate visual maps or graphic charts to assist in advocacy at all levels e.g. national, regional and international.

Each indicator used for assessment has following components;

- The key question that needs to be investigated.
- Background on why the practice, policy or programme component is important.
- A list of key criteria as subset of questions to be considered in identifying achievements and areas needing improvement, with guidelines for scoring, colour rating, and ranking how well the country is doing.

Part I: A set of criteria has been developed for each target, based on Global Strategy for Infant and Young Child Feeding (2002) and the Innocenti Declaration on Infant and Young Child Feeding (2005). For each indicator, there is a subset of questions. Answers to these can lead to identify achievements and gaps in policies and programmes to implement Global Strategy for Infant and Young Child Feeding. This shows how a country is doing in a particular area of action on Infant and Young Child Feeding.

Part II: Infant and Young Child Feeding Practices in Part II ask for specific numerical data on each practice based on data from random household survey that is national in scope.

Once the information about the indicators is gathered and analysed, it is then entered into the web-based toolkit through the ' WBT*i* Questionnaire'. Further, the toolkit scores and colour- rate each individual indicator as per **IBFAN Asia's Guidelines for WBT*i***

Assessment process of Belize was facilitated by the fact that by the fact that the country has current data to 2016 of the main indicators of infant feeding, the Belize – Multiple Indicator Cluster Survey 2015 – Key Findings; the Abstract of Statistics 2013; and the Annual Report 2015 – Statistical Institute of Belize. Annual reports of PAHO, UNICEF, UNDP, ILO and World Bank were consulted, as well as worldwide databases such as IndexMundi.

Likewise, Belize has received broad support from international organizations for the development of its policies and programs, such as the National Gender Policy (Updated, January, 2010), which has facilitated systematization, analysis and study, including evaluations such as the EVALUATION OF THE COMMUNITY HEALTH WORKERS PROGRAMME Belize 2013 - Bridging the gap in the distribution of healthcare personnel through the provision basic primary healthcare to rural communities in Belize.

This documentation was carefully studied and corroborated by the coordinating team of the WBTi evaluation with the main national actors from the Ministry of Education, Culture, Youth and Sports; the Ministry of Human Development, Social Transformation and Poverty Alleviation; the Ministry of Health; health workers from various hospitals; women groups; breastfeeding groups and lactation consultants; PAHO/INCAP and UNICEF.

The development process of the national WBTi evaluation should be considered as a tool for on-going discussion, for tracking the gaps encountered and for follow up of recommendations.

IV. ASSESSMENT FINDINGS

Indicator 1: National Policy, Programme and Coordination

Key question: *Is there a national infant and young child feeding/breastfeeding policy that protects, promotes and supports optimal infant and young child feeding and the policy is supported by a government programme? Is there a mechanism to coordinate like National infant and young child feeding committee and a coordinator for the committee?*

Guidelines for scoring		
Criteria	**Scoring**	**Results** ✓ ***Check any one***
1.1) A national infant and young child feeding/breastfeeding policy has been officially adopted/approved by the government	1	✓
1.2) The policy recommended exclusive breastfeeding for the first six months, complementary feeding to be started after six months and continued breastfeeding up to 2 years and beyond.	1	
1.3) A national plan of action developed based on the policy	2	✓
1.4) The plan is adequately funded	2	
1.5) There is a National Breastfeeding Committee/ IYCF Committee	1	
1.6) The national breastfeeding (infant and young child feeding) committee meets, monitors and reviews on a regular basis	2	
1.7) The national breastfeeding (infant and young child feeding) committee links effectively with all other sectors like health, nutrition, information etc.	0.5	✓
1.8) Breastfeeding Committee is headed by a coordinator with clear terms of reference, regularly communicating national policy to regional, district and community level.	0.5	
Total Score	**3.5/10**	

Information Sources Used:

1. *National Breastfeeding Policy, 1997.*
2. *National Gender Policy, updated in January 2010.*
3. *Belize Country programme document 2013-2016, UNICEF.*

Conclusions:

Belize has a National Breastfeeding Policy issued in 1997. Breastfeeding and child nutrition programming are also integrated into the National Strategic Plan for Sexual and Reproductive Health Services. As of 2012, all seven hospitals hospitals have been certified as "Baby Friendly". These hospitals are supportive of breastfeeding practices but have not been recertified since then.

During the 1990´s decade and early 2000´s Belize received important support from UNICEF, AID and others to develop breastfeeding related policies and programmes. It is not the case after 2010-2012. Thus breastfeeding coordination has been weakened because also important breastfeeding NGOs are not a strong as before and well funded to support government´s policy development and implementation.

Breastfeeding is well integrated in other health programmes but has no specific well-funded and efficient coordination.

***Recommendations**:*

Conformation of a national breastfeeding committee, with legal structural support to coordinate breastfeeding programmes and to mainstream breastfeeding promotion, support and protection to governmental health, maternity and infant programmes. This breastfeeding national coordination should have clear working mechanisms, a coordinator with clear terms of reference, power to convene other related governmental institutions and ministries, ability to develop needed programmes and policies, and adequate and sufficient sustainable funding.

Indicator 2: Baby Friendly Care and Baby-Friendly Hospital Initiative (Ten Steps to Successful Breastfeeding[1])

Key questions:

- *What percentage of hospitals and maternity facilities that provide maternity services have been designated as "Baby Friendly" based on the global or national criteria?*
- *What is the quality of BFHI program implementation?*

Guidelines – Quantitative Criteria

*2.1) **2** out of 10 total hospitals (both public (7) & private (3) and maternity facilities offering maternity services have been designated or reassessed as "Baby Friendly" in the last 5 years: **20 %***

Guidelines for scoring		
Criteria	**Scoring**	**Results** √ **Check only one which is applicable**
0	**0**	
0.1 - 20%	1	✓
20.1 - 49%	2	
49.1 - 69%	3	

[1] **The Ten Steps To Successful Breastfeeding:** The BFHI promotes, protects, and supports breastfeeding through The Ten Steps to Successful Breastfeeding for Hospitals, as outlined by UNICEF/WHO. The steps for the United States are:

1. Maintain a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
6. Give infants no food or drink other than breastmilk, unless medically indicated.
7. Practice "rooming in"-- allow mothers and infants to remain together 24 hours a day.
8. Encourage unrestricted breastfeeding.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic

69.1-89 %	4	
89.1 - 100%	5	
Total rating	**1 / 5**	

Guidelines – Qualitative Criteria

Quality of BFHI programme implementation:

Guidelines for scoring		
Criteria	**Scoring**	**Results** **√ Check that apply**
2.2) BFHI programme relies on training of health workers using at least 20 hours training programme[2]	1.0	✓
2.3) A standard monitoring[3] system is in place	0.5	
2.4) An assessment system includes interviews of health care personnel in maternity and post natal facilities	0.5	✓
2.5) An assessment system relies on interviews of mothers.	0.5	✓
2.6) Reassessment[4] systems have been incorporated in national plans with a time bound implementation	1.0	
2.7) There is/was a time-bound program to increase the number of BFHI institutions in the country	0.5	
2.8) HIV is integrated to BFHI programme	0.5	✓
2.9) National criteria are fully implementing Global BFHI criteria (See Annex 2.1)	0.5	
Total Score	**2.5/5**	
Total Score	**3.5/10**	

[2] IYCF training programmes such as IBFAN Asia's '4 in1' IYCF counseling training programme, WHO's Breastfeeding counseling course etc. may be used.

[3] ***Monitoring*** is a dynamic system for data collection and review that can provide information on implementation of the *Ten Steps* to assist with on-going management of the *Initiative*. It can be organized by the hospitals themselves or at a higher level in the system. Data should be collected either on an on-going basis or periodically, for example on a semi-annual or yearly basis, to measure both breastfeeding support provided by the hospitals and mothers' feeding practices.

[4] ***Reassessment*** can be described as a "re-evaluation" of already designated baby-friendly hospitals to determine if they continue to adhere to the *Ten Steps* and other baby friendly criteria. It is usually planned and scheduled by the national authority responsible for BFHI for the purpose of evaluating on-going compliance with the *Global Criteria* and includes a reassessment visit by an outside team. Because of the human and financial resources required, in many countries it may be feasible to reassess hospitals only once every three years, but the final decision concerning how often reassessment is required should be left to the national authority.

Information Sources Used (please list):

1. *La Iniciativa hospital amigo del niño en América Latina y el Caribe: Estado actual, retos y oportunidades, PAHO 2016.*
2. *Midwifery Today, 2016 http://www.midwiferytoday.com/international/belize.asp*
3. *Medical Care in Belize, 2016.*
4. *Interviews with health workers from Karl Heusner Memorial Hospital, the Southern Regional Hospital in Dangriga, the Northern Regional Hospital in Orange Walk Town, San Ignacio Hospital and the Western Regional Hospital, La Loma Luz Hospital, Belize Medical Associates.*

Conclusions:

Belize did very well with the BFHI until 2012 when UNICEF support decayed. All public hospitals have been certified as baby friendly in Belize. The Karl Heusner Memorial Hospital, Corozal Community Hospital and Northern Regional Hospital were certified in 2008. Punta Gorda Community Hospital and Southern Regional Hospital were subsequently certified in the month of August and December 2010. Western Regional Hospital and the San Ignacio Community Hospital were the latest public hospitals to have met the necessary international requirements to be certified as Mother and Baby Friendly Hospitals in 2012.

The results of being BF gave as a result that early initiation of breastfeeding increased by 51 percent between 2006 and 2010, according to a UNICEF report.

No private hospital has been certified as baby friendly.

Belize has also a National Gender Policy, updated in January 2010, and declared zero tolerance for maternal mortality, encouraging prenatal control, information and support to mothers for breastfeeding, and to follow 10 Steps to Successful Breastfeeding. In 2011, Belize had zero maternal deaths since "every obstetric emergency was considered a national emergency". The country also provided mobile and community clinics to treat cause of maternal mortality, and trained community health promoters. The Baby Friendly Initiative became the Mother and Baby Friendly Initiative. The percentage of births attended by a skilled health professional rose to 94 % in 2010, up from 79 % in 1995, according to a report by the Ministry of Health. Early initiation of breastfeeding increased by 51 % between 2006 and 2010, according to a UNICEF report.

Exclusive breastfeeding rates (0-6 months) increased from 10 % to 18 % between 2006 and 2011, largely as a result of the baby-friendly certification of hospitals and clinics. In these safe and friendly environments, appropriate young child feeding practices were promoted. Additionally, mother-to- child transmission of HIV was reduced from 19 % in 2007 to 3.2 % in 2010, largely because of improvements in clinical protocols and practices, with strong emphasis on capacity building, monitoring and evaluation.

But as in most of the world, the BFHI declined as no follow up was given after and few re-certifications occurred.

Belize mothers reported overload of work of hospital staff and thus no proper support or counselling, and on the contrary many arguments to nurture the fears mothers already have, such as "not enough breastmilk, baby needs supplementation," etc.

Unnecessary C-section rates are growing in Belize as in most countries of the region and other delivery practices are influencing early attachment and skin to skin during the first hour of life.

Recommendations:

Rejuvenation of the Mother Baby Friendly Hospital Initiate, including all aspects of the 2016 revision of criteria and procedures for certification and recertification processes (training, monitoring, assessment systems, comprehensive integration of HIV, International Code and other crucial aspects, practical action to implement 10 steps, mothers support groups and community involvement for follow up, and others needed) in all public hospitals and maternity wards. This should also include respectful birthing practices.

Policy guidance to private hospitals to become Mother Baby Friendly, with clear deadlines to achieve results.

Systems in place for periodical auto evaluation, external evaluation, sharing of experiences and sufficient flexibility to incorporate without delay good practices.

Indicator 3: Implementation of the International Code of Marketing of Breastmilk Substitutes

Key question: *Is the International Code of Marketing of Breastmilk Substitutes and subsequent WHA resolutions are in effect and implemented? Has any new action been taken to give effect to the provisions of the Code?*

Guidelines for scoring		
Criteria (*Legal Measures that are in Place in the Country*)	**Scoring**	**Results**
3a: Status of the International Code of Marketing		✓ (*Check those apply. If more than one is applicable, record the highest score.)*

3.1 No action taken	0	
3.2 The best approach is being considered	0.5	
3.3 National Measures awaiting approval (for not more than three years)	1	
3.4 Few Code provisions as voluntary measure	1.5	✓
3.5 All Code provisions as a voluntary measure	2	
3.6 Administrative directive/circular implementing the code in full or in part in health facilities with administrative sanctions	3	
3.7 Some articles of the Code as law	4	
3.8 All articles of the Code as law	5	
3.9 Relevant provisions of WHA resolutions subsequent to the Code are included in the national legislation[5] a) Provisions based on at least 2 of the WHA resolutions as listed below are included b) Provisions based on all 4 of the WHA resolutions as listed below are included	 5.5 6	
3b: Implementation of the Code/National legislation		✓ ***Check that apply***
3.10 The measure/law provides for a monitoring system	1	
3.11 The measure provides for penalties and fines to be imposed to violators	1	
3.12 The compliance with the measure is monitored and violations reported to concerned agencies	1	
3.13 Violators of the law have been sanctioned during the last three years	1	
Total Score (3a + 3b)	**1.5/10**	

Information Sources Used:

1. State of the Code by Country, A survey of measures taken by governments to implement the provisions of the International Code of Marketing of Breastmilk Substitutes & subsequent World Health Assembly resolutions**,** ICDC 2016.

[5] Following WHA resolutions should be included in the national legislation/enforced through legal orders to tick this score.
1. Donation of free or subsidized supplies of breastmilk substitutes are not allowed (WHA 47.5)
2. Labeling of complementary foods recommended, marketed or represented for use from 6 months onward (WHA 49.15)
3. Health and nutrition claims for products for infants and young children are prohibited (WHA 58.32) are prohibited
4. Labels of covered products have warnings on the risks of intrinsic contamination and reflect the FAO/WHO recommendations for safe preparation of powder infant formula (WHA 58.32, 61.20)

2. 2014 Nutrition Country Profile - www.globalnutritionreport.org Belize.
3. Ministry of Health officials.

Conclusions:
Even if Belize is not a big market for baby food companies, violations of the International Code occur in health acre facilities and in commercial settings such as pharmacies and supermarkets. Belize needs a law that includes the International Code.

Recommendations:
It is urgent for Belize to approve a law based on the International code of Marketing of Breastmilk Substitutes and all Relevant WHA Resolutions, including clear mechanisms for implementation, evaluation and monitoring and measures for company's accountability, including strong sanctions. The responsible organism for surveillance of this law should have the adequate human, legal and financial resources for rendering of accounts and efficient management and results.

Indicator 4: Maternity Protection

Key question: *Is there legislation and are there other measures (policies, regulations, practices) that meet or go beyond the International Labour Organization (ILO) standards for protecting and supporting breastfeeding for mothers, including those working mothers in the informal sector?*

Guidelines for scoring		
Criteria	**Scoring**	**Results Check ✓ that apply**
4.1) Women covered by the national legislation are allowed the following weeks of paid maternity leave		
a. Any leave less than 14 weeks	0.5	
b. 14 to 17 weeks	1	✓
c. 18 to 25 weeks	1.5	
d. 26 weeks or more	2	
4.2) Women covered by the national legislation are allowed at least one breastfeeding break or reduction of work hours daily.		
a. Unpaid break	0.5	
b. Paid break	1	✓
4.3) Legislation obliges private sector employers of women in the		

country to *(more than one may be applicable)* a. Give at least 14 weeks paid maternity leave b. Paid nursing breaks.	 0.5 0.5	 ✓
4.4) There is provision in national legislation that provides for work site accommodation for breastfeeding and/or childcare in work places in the formal sector. *(more than one may be applicable)* a. Space for Breastfeeding/Breastmilk expression b. Crèche	 1 0.5	 ✓
4.5) Women in informal/unorganized and agriculture sector are: a. accorded some protective measures b. accorded the same protection as women working in the formal sector	 0.5 1	 ✓
4.6) *(more than one may be applicable)* a. Information about maternity protection laws, regulations, or policies is made available to workers. b. There is a system for monitoring compliance and a way for workers to complain if their entitlements are not provided.	 0.5 0.5	 ✓ ✓
4.7) Paternity leave is granted in public sector for at least 3 days.	0.5	
4.8) Paternity leave is granted in the private sector for at least 3 days.	0.5	
4.9) There is legislation providing health protection for pregnant and breastfeeding workers: they are informed about hazardous conditions in the workplace and provided alternative work at the same wage until they are no longer pregnant or breastfeeding.	0.5	✓
4.10) There is legislation prohibiting employment discrimination and assuring job protection for women workers during breastfeeding period.	1	✓
Total Score:	**6/10**	

Information Sources Used (please list):

1. *National Gender Policy (Updated, January, 2010)*
2. *Belize Social Security Board (SSB) 2016 http://www.socialsecurity.org.bz/short-term-benefits-branch/*
3. *Ministry of Labour, Local Government and Rural Development 2016*
4. *http://www.worldpolicycenter.org/countries/belize/policies/family*
5. *World Bank 2016 - http://www.doingbusiness.org/data/exploreeconomies/belize/labor-market-regulation*

Conclusions:

Belize is one of the few countries in the region that has ratified the ILO Convention 183 in 2005. Women's length of maternity leave is 14 weeks. The Maternity Allowance is paid weekly for a maximum period of 14 weeks. The Maternity Grant is a lump sum payment (approximately $300.00) made upon confinement for women that qualify. For employed women, maternity leave benefits are dependent on the amount of social security contributions being paid. Therefore those with the lowest income levels also receive lower amounts in maternity benefits. Men qualify for a one-time maternity grant when their spouse or partners become confined for childbirth. Maternity Benefit is paid to Insured Women who are on Maternity leave from work because of their pregnancy and confinement.

It is a fact that social security legislation does not legally consider a household to be a place of employment. Consequently, neither the Labour Department nor the Belize Social Security Board (SSB) monitor homes for compliance with labour and social security legislation, thus limiting benefits to those employed therein. Less than 50% of women participate in the formal labour force. Furthermore, women's high unemployment rate and their tendency to be unemployed for longer periods than men place women at a disadvantage in qualifying for some social security benefits.

Belize has a National Gender Policy to protect women's rights. Because of women's reproductive roles, they have primary responsibility for child rearing. The related issues of absentee fathers and lack of resources for the effective enforcement of child maintenance legislation place single mothers at a distinct economic disadvantage. Additionally, the fact that pregnancy is biologically determined makes maternity-related employment discrimination a major gender issue.

The labour department reported an increasing number of complaints regarding employers firing pregnant women or refusing to pay the difference in maternity payment provided by the Social Security Board. Consequently, it is at the time when women are most in need of economic support that they fall victims to employment related discrimination.

A majority of women are employed in basic occupations. Approximately 60 % of working women are employed as service and shop sales workers and clerks, or in elementary occupations. Women also make up 18 to 20 % of the labour force that are professionals, legislators, senior officials and managers, half of all clerks, service workers and shop sales workers and less than one half or (40%) % of legislators, senior officials, and managers are women.
Even in sectors in which women comprise a majority of the work force, they still experience more unemployment than men. Women outnumber men in the health sector by more than two to one, but among unemployed health workers, women outnumber men by three to one.

A UNDP report used labour statistics to show that:
"The average earnings of males and females reflect inequality in earnings, and demonstrate that women are at a higher risk of poverty". This gender disparity in income levels was also been reported in other socio-economic studies (12 coastal communities in Belize.)

Recommendations *(List action recommended to bridge the gaps):*
Belize needs to strengthen its mechanisms for compliance with the maternity protection law and national gender policy. This needs adequate human, legal and financial resources to be prioritized.

The ILO Convention 183 ratified by Belize is a minimum standard that can be improved given the Belize efforts in achieving infant and young child health and development. Efforts to improve the rates of 6 months exclusive breastfeeding and continued breastfeeding for 2 years o more need to be accompanied by at least 6 months paid maternity leave post partum, guarantee of paid breastfeeding breaks at work for breastfeeding or extraction of breastmilk in adequate private spaces, and other motherbaby friendly policies and programmes, including the cultural changes needed for the creation of non discriminatory conditions and enabling environments for the respect of women workers rights and maternity rights.

Women workers in non-formal settings have rights that are not been protected and it is the responsibility of the state to grantee their fulfilment. This implies the need for policies and practices to protect these workers maternity rights, including those working at household, in migration status, agricultural and domestic workers, and other women working in vulnerable conditions.

Breastfeeding challenges include the need of human resources to advance breastfeeding at the district level, the need to generate greater fathers' (partners-family- community) support for breastfeeding mothers and the need to develop workplace strategies that support exclusive breastfeeding practices.

Indicator 5: Health and Nutrition Care Systems (in support of breastfeeding & IYCF)

Key question: *Do care providers in these systems undergo* skills training, *and do their pre-service education curriculum support optimal infant and young child feeding; do these services support mother and breastfeeding friendly birth practices, do the policies of health care services support mothers and children, and whether health workers responsibilities to Code are in place*?

Guidelines for scoring			
	Scoring √ *Check that apply*		
Criteria	**Adequate**	**Inadequate**	**No Reference**
5.1) A review of health provider schools and pre-service education programmes for health professionals, social	2	1	0

and community workers in the country[6] indicates that infant and young child feeding curricula or session plans are adequate/inadequate.		✓	
5.2) Standards and guidelines for mother-friendly childbirth procedures and support have been developed and disseminated to all facilities and personnel providing maternity care. *(See Annex 5b Example of criteria for mother-friendly care)*	2	1	0
		✓	
5.3) There are in-service training programmes providing knowledge and skills related to infant and young child feeding for relevant health/nutrition care providers.[7]	2	1	0
		✓	
5.4) Health workers are trained on their responsibility under the Code implementation / national regulation throughout the country.	1	0.5	0
			✓
5.5) Infant feeding and young feeding information and skills are integrated, as appropriate, into training programmes focusing on (diarrheal disease, acute respiratory infection, IMCI, well-child care, family planning, nutrition, the Code, HIV/AIDS, breast cancer, women's health, NCDs etc.)	1	0.5	0
		✓	
5.6) In-service training programmes referenced in 5.5 are being provided throughout the country.[8]	1	0.5	0
		✓	
5.7) Child health policies provide for mothers and babies to stay together when one of them is sick.	1	0.5	0
		✓	
Total Score:	**4.5/10**		

Information Sources Used:

1. University of Belize, Faculty of Nursing, Allied Health and Social Work, 2016
2. Bliss School of Nursing in Belize, 2016
3. Ministry of Health Belize

6 Types of schools and education programmes that should have curricula related to infant and young child feeding may vary from country to country. Which departments within various schools are responsible for teaching various topics may also vary. The assessment team should decide which schools and departments are most essential to include in the review, with guidance from educational experts on infant and young child feeding, as necessary.

7 The types of health providers that should receive training may vary from country to country, but should include providers that care for mothers and children in fields such as medicine, nursing, midwifery, nutrition and public health.

8 Training programmes can be considered to be provided "throughout the country" if there is at least one training programme in each region or province or similar jurisdiction.

4. Belize Medical School, 2016

Conclusions:
Belize is devoting efforts to improve the training and capacities of health professionals, social and community workers but face lack of adequate resources to maintain the quality and sustainability of the results. There are some areas that need more support such as the national coverage of the provision of health services and a better inclusion of issues such as adequate complementary feeding with home made nutritious foods and surveillance of the International Code.

Recommendations:
Belize needs to create mechanisms to attend each one of the indicators for the implementation of the Global Strategy for Infant and Young Child Feeding and to guarantee qualified training to health professionals, social and community workers in order to create the base for nation wide inclusive and sustainable results.

Indicator 6: Mother Support and Community Outreach - Community-based support for the pregnant and breastfeeding mother

Key question: *Are there mother support and community outreach systems in place to protect, promote and support optimal infant and young child feeding.*

Guidelines for scoring			
Criteria	**Scoring** √ *Check that apply*		
	Yes	To some degree	No
6.1) All pregnant women have access to community-based ante-natal and post-natal support systems with counseling services on infant and young child feeding.	2	1	0
		✓	
6.2) All women receive support for infant and young child feeding at birth for breastfeeding initiation.	2	1	0
		✓	
6.3) All women have access to counseling support for Infant and young child feeding counseling and support services have national coverage.	2	1	0
		✓	
6.4) Community-based counseling through Mother Support Groups (MSG) and support services for the pregnant and	2	1	0

breastfeeding woman are integrated into an overall infant and young child health and development policy IYCF/Health/Nutrition Policy.		✓	
6.5) Community-based volunteers and health workers are trained in counseling skills for infant and young child feeding.	2	1	0
		✓	
Total Score:	**5/10**		

Information Sources Used:

1. *Ministry of Health*
2. *Belize MICS5 – Belize Multiple Indicator Cluster Survey 2015 – Key Findings, August 2016*
3. *EVALUATION OF THE COMMUNITY HEALTH WORKERS PROGRAMME Belize 2013 - Bridging the gap in the distribution of healthcare personnel through the provision basic primary healthcare to rural communities in Belize.*
4. *Community health workers and lactation consultants*

Conclusions:

Statistics show the following:

Post-natal health check for the newborn:

% of last live births in the last 2 years who received a health check while in facility or at home following delivery, or a post-natal care visit within 2 days after delivery: 96.4.

Post-natal health check for the mother:

% of women age 15-49 years who received a health check while in facility or at home following delivery, or a post-natal care visit within 2 days after delivery of their most recent live birth in the last 2 years: 96.4.

Average of family support:

Mother´s support: 68%

Father support: 24%

Skilled attendant at delivery:

% of women age 15-49 years with a live birth in the last 2 years who were attended by skilled health personnel during their most recent live birth: 96.8%.

Pre and post-test counseling are essential components for good clinical care of individuals at risk or infected with STI/HIV. Counseling is integrated with all HIV testing, screening and care. Anti-retroviral drugs are freely provided to all those infected with HIV and these drugs are now provided through pharmacies to enhance access to those needing them.

The Primary Health Care initiative was one of the first efforts implemented worldwide that sought to address the many social and health problems affecting countries. Belize, being one such country, adopted the Primary Health Care Strategy. As a part of the Ministry of Health's implementation plan in the utilization of this strategy there was the recruitment and training of Community Health Workers (CHWs) countrywide in Belize.

This saw the establishment of a vibrant CHWs Network of individuals who were willing to serve their communities as volunteers. The basic role of these CHWs was to identify the health needs of rural communities, and to develop, and implement programmes to address these needs.

Since the 1980's these CHWs have been operating in this capacity and became the main link between the formal health system and the community. Their level of training afforded them the capability to respond to the many health conditions affecting communities.

Over the years, the roles and responsibilities of CHWs were redefined and expanded, increasing their level of involvement and response. They were provided additional training and their roles and responsibilities were upgraded to meet the changes in country's health profile. This upgrade saw their involvement in the provision of basic medications and basic health care as well as the development of health promotion interventions in the schools and in communities.

To ensure that CHWs continue to function effectively and efficiently within their communities a programme of continuing education was established whereby in each district on monthly or bi-monthly basis refresher training on a wide cross section of health topics were provided

Fifty-two Community Health Workers (CHW) from municipalities of the all-Northern districts of Belize successfully graduated from the Community Health Worker program lead by the Ministry of Health and the Salud Mesoamérica 2015 Initiative in Belize. The graduated professionals have been through ninth months of preparation, attending over than twenty workshops to prepare themselves to support their communities with basic knowledge of community health. Currently there are almost three hundred Community Health Workers, representing all ethnic groups, in Belize.

Recommendations:

The national counselling structure that has given emphasis to prevention of HIV and early treatment of AIDS needs to be widen to provide all pregnant women with access to community-based ante-natal and post-natal support systems with counseling services on infant and young child feeding, support to initiate early breastfeeding, exclusive breastfeeding for 6 months and to maintain breastfeeding for 2 years or beyond, giving emphasis too to the introduction of nutritious home made complementary feeding.

The full implementation of the Global Strategy for Infant and Young Child Feeding needs to become an integral practice of the Primary Health Care System and needs to strengthen community participation and reinforcement of abilities of community and civil society support groups with important experience acquired in previous decades when Belize had important support donors to consolidate them. Health workers in health facilities need to coordinate with community support agents to provide integral support to mothers and their families.

Indicator 7: Information Support

Key question: *Are comprehensive Information, Education and Communication (IEC) strategies for improving infant and young child feeding (breastfeeding and complementary feeding) being*

implemented?

Guidelines for scoring			
Criteria	**Scoring** √ ***Check that apply***		
	Yes	To some degree	No
7.1) There is a national IEC strategy for improving infant and young child feeding that ensures all information and materials are free from commercial influence/ potential conflicts of interest are avoided.	2	0	0
			✓
7.2a) National health/nutrition systems include individual counseling on infant and young child feeding	1	.5	0
		✓	
7.2b) National health/nutrition systems include group education and counseling services on infant and young child feeding	1	.5	0
		✓	
7.3) IYCF IEC materials are objective, consistent and in line with national and/or international recommendations and include information on the risks of artificial feeding	2	1	0
		✓	
7.4. IEC programmes (e.g. World Breastfeeding Week) that include infant and young child feeding are being implemented at local level and are free from commercial influence	2	1	0
		✓	
7.5 IEC materials/messages to include information on the risks of artificial feeding in line with WHO/FAO Guidelines on preparation and handling of powdered infant formula (PIF).[9]	2	0	0
		✓	
Total Score:	**3/10**		

Information Sources Used (please list):

1. *Ministry of Health*
2. *Interviews to health workers and community promoters*
3. *Revision of IEC materials, various booklets and training manuals*

[9] to ensure that clinicians and other health-care personnel, community health workers and families, parents and other caregivers, particularly of infants at high risk, are provided with enough information and training by health-care providers, in a timely manner on the preparation, use and handling of powdered infant formula in order to minimize health hazards; are informed that powdered infant formula may contain pathogenic microorganisms and must be prepared and used appropriately; and, where applicable, that this information is conveyed through an explicit warning on packaging;

Conclusions:

There is an important gap in terms of an infant and young child feeding strategy that ensures all information and materials are free from commercial influence/ potential conflicts or interest are avoided and that provides adequate counselling to mothers.

Recommendations:

Belize needs a national IEC strategy for improving infant and young child feeding that ensures all information and materials are free from commercial influence/ potential conflicts of interest are avoided.

National health/nutrition systems are to include individual counseling on infant and young child feeding; infant feeding IEC actions need to be consistent with international recommendations and include information on the risks of artificial feeding.

Indicator 8: Infant Feeding and HIV

Key question: Are policies and programmes in place to ensure that HIV - positive mothers are supported to carry out the national recommended Infant feeding practice?

Guidelines for scoring			
Criteria	**Results** ✓ ***Check that apply***		
	Yes	To some degree	No
8.1) The country has a comprehensive updated policy in line with international Guidelines on infant and young child feeding that includes infant feeding and HIV	2	1	0
	✓		
8.2) The infant feeding and HIV policy gives effect to the International Code/ National Legislation	1	0.5	0
			✓
8.3) Health staff and community workers receive training on HIV and infant feeding policies, the risks associated with various feeding options for infants of HIV-positive mothers and how to provide counselling and support.	1	0.5	0
	✓		

8.4) HIV Testing and Counselling (HTC)/ Provide Initiated HIV Testing and Counselling (PIHTC)/ Voluntary and Confidential Counselling and Testing (VCCT) is available and offered routinely to couples who are considering pregnancy and to pregnant women and their partners.	1	0.5	0
	✓		
8.5) Infant feeding counselling in line with current international recommendations and appropriate to local circumstances is provided to HIV positive mothers.	1	0.5	0
	✓		
8.6) Mothers are supported in carrying out the recommended national infant feeding practices with further counselling and follow-up to make implementation of these practices feasible.	1	0.5	0
	✓		
8.7) HIV positive breastfeeding mothers, who are supported through provision of ARVs in line with the national recommendations, are followed up and supported to ensure their adherence to ARVs uptake.	1	0.5	0
	✓		
8.8) Special efforts are made to counter misinformation on HIV and infant feeding and to promote, protect and support 6 months of exclusive breastfeeding and continued breastfeeding in the general population.	1	0.5	0
		✓	
8.9) On-going monitoring is in place to determine the effects of interventions to prevent HIV transmission through breastfeeding on infant feeding practices and overall health outcomes for mothers and infants, including those who are HIV negative or of unknown status.	1	0.5	0
		✓	
Total Score:	**8/10**		

Information Sources Used:

1. *HIV AND AIDS IN THE CARIBBEAN – Avert (Averting HIV and Aids), 2016.*
2. *Children & Aids – 2015 Statistical update, UNICEF*
3. *GLOBAL AIDS COUNTRY PROGRESS REPORT 2014 BELIZE - Reporting period: January 2013–December 2013 Submission date: March 31, 2014.*
4. *Annual HIV Statistical Report, 2016*
5. *A Gender-Based Analysis of HIV/AIDS in Belize, Prairie Women's Health Center of Excellence, PAHO, 2010.*
6. *2015 - published annually by the National HIV/AIDS program, Epidemiology Unit, Ministry of Health, Belmopan*
7. *Prevention of Mother to Child Transmission of HIV (PMTCT). Summary of Prevention of Mother to Child Transmission of HIV (PMTCT), Belize 2015.*
8. *Belize Country programme document 2013-2016 (approved in 2012), UNDP*
9. *Belize Country programme, 2016 UNICEF*

10. *National Women's Commission National Gender Policy (Updated, January, 2010), Government of Belize*
11. *The State of the World's Children 2016.*
12. *Ministry of Health.*
13. *Belize HIV Strategic Plan 2012-2016.*

Conclusions:

The Caribbean is now considered one of the most HIV/AIDS affected region in the world after sub-Saharan Africa, with a high HIV prevalence rate. Among the Central American countries, Belize has the highest estimated prevalence rate of HIV among adults. From 2003 to 2007, HIV/AIDS was the leading cause of death for Belizean men and women in the 40-49 year age and 20-39 years.

The Caribbean has well-established prevention of mother-to-child transmission of HIV (PMTCT) programmes. The percentage of HIV-positive mothers on antiretroviral treatment increased from 72% in 2011 to more than 95% in 2013, with many more women and infants in the region now receiving the HIV-related services they need.

As a country Belize does not recommended that HIV mothers breastfeed their infants. The Maternal and Child Health Program - MCH program offers breastmilk substitutes as an alternative feeding method for mothers who are HIV infected.

Prevention of Vertical Transmission

Over 90% of pregnant women in Belize utilize the antenatal care at the public facilities and more than 94.8 % of all births occur in hospitals, assisted by skilled attendants. The decision was taken at the inception of the programme to integrate PMTCT services into the Maternal and Child Health (MCH) Programme. In 2012 there were 38 positive pregnant women and 2 babies who were HIV positive; in 2013 there were 50 HIV positive pregnant women and 3 HIV positive babies. The HIV infected babies were born predominately to HIV infected mothers who did not access appropriate antenatal care. In 2013 the babies that were diagnosed with HIV all obtained then after delivery. The country does not promote the breastfeeding of HIV positive mothers to their children. The PMTCT program offers assistance to these mothers through nutritional packages and also milk for the infants. During 2012 AND 2013 100% of HIV pregnant mothers received antiretrovirals to reduce the risk of mother to child transmission.

Another major accomplishment for 2012 and 2013 is that 100% of babies born to HIV positive women received a virological test within 2 months of birth.

There has been a 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.

2015 Statistical update:

Annual number of births – 2015: 8.000.

Estimated number of pregnant women living with HIV, 2015: <100.

Reported number of pregnant women living with HIV who received ARVs for PMTCT, 2015: 54.

Estimated percentage of pregnant women living with HIV who received ARVs for PMTCT, 2015: 63%.

Estimated number of children (aged 0–14) newly infected with HIV, 2015: <100.

Estimated mother-to-child transmission rate (%), 2015: 9%.

% of infants born to HIV+ women started on ARVs, 2015: 62%.
Estimated HIV prevalence among adults: 1.5 %
Antenatal care coverage – at least one visit (2010-2015): 96%; at least 4 visits: 83%
Adult prevalence: People living with AIDS: 1.52% (2015 est.), more than double than any other Central American country.
Children living with HIV: <0.2
Percentage of people age 15-49 years who correctly identify all three means of mother-to-child transmission of HIV
(a) Women – 16.7
(b) Men – 18.7

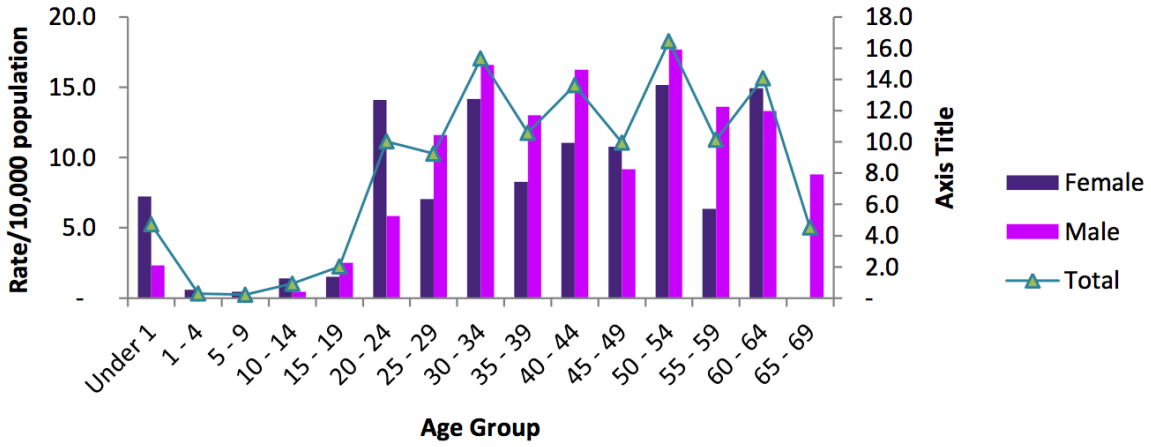
HIV counselling during antenatal care:

Percentage of women age 15-49 years who had a live birth in the last 2 years and received antenatal care during the pregnancy of their most recent birth, reporting that they received counselling on HIV during antenatal care: 56.5 %

HIV testing during antenatal care

Percentage of women age 15-49 years who had a live birth in the last 2 years and received antenatal care during the pregnancy of their most recent birth, reporting that they were offered and accepted an HIV test during antenatal care and received their results: 73.9 %
Sexually active youth people who have been tested for HIV and know the results: 37% women; 25% men

Rate of New HIV Cases by Age Group and Sex, Belize 2015



The majority of HIV positive young females are reached through the prenatal clinics, which is an indicator of unsafe sex resulting in pregnancy and HIV infection. Infants under the age of one year infected through mother to child transmission (PMTCT report) were high for 2015 after reaching an all-time low in 2014.

Prevention of Mother to Child Transmission of HIV (PMTCT). Summary of Prevention of Mother to Child Transmission of HIV (PMTCT), Belize 2015

	2013		2014		2015	
Total Pregnant Women Registered	6948		6893		6681	
	N	%	N	%	N	%
Pregnant Women Tested for HIV	6383	91.9	6328	91.8	6526	97.7
New HIV cases	11	0.2	17	0.3	14	0.2
Old HIV cases	39	0.6	34	0.5	40	0.6
HIV Positive Pregnant Women	50	0.8	51	0.8	56	0.9
HIV positive Pregnant Women on ARV	50	100.0	49	96.1	53	94.6
Deliveries to HIV Positive Women	46		45		57	
Infants received ARVs	46	100.0	45	100.0	53	93.0
HIV MTCT	3	6.5	1	2.2	4	7.0
1st PCR Coverage*	47/47	100.0	56/56	100.0	58/58	100.0
2nd PCR Coverage*	41/49	83.7	44/57	77.2	46/53	86.8
3rd PCR Coverage*	31/47	66.0	31/49	63.3	49/60	81.7

*Coverage=Total done/Total due for the respective year

There is an increase in HIV testing tendency in pregnant women since 2013. For 2015, there has been a decrease in the number of newly diagnosed HIV infections in women in comparison to 2014. At the end of 2015, there were a total of 56 HIV positive pregnant women, of these 95% (53) of all HIV positive women were receiving ARV´s. In this same year, 57 deliveries were to HIV positive women, and 93% (53) of these infants had received ARV´s. One of the women was diagnosed after delivery thus the reason for not receiving ARVs. For 2015, similarly to 2013 the number of HIV mother to child transmission was 7% of total of infants born to HIV positive women. Numbers of repeated PCR coverage in these HIV infected infants showed a slightly higher adherence to testing. There is 100% coverage in the first PCR reducing by almost 18% by the end of the third PCR.

There continues to be non-compliance to care and treatment among pregnant women. During 2015, three (3) of the positive pregnant women did not access and receive treatment even though they were aware of their HIV status.

Belize has a Gender-based approach to HIV/AIDS strategy:

Globally, sexual contact is the primary mode of HIV transmission. Because men and women who have sexual contact typically have different biological vulnerabilities, as well as gendered abilities to negotiate safe sex, the Joint United Nations Programme on HIV/AIDS (UNAIDS), states that "unequal relationships between men and women and societal norms of femininity and masculinity are important influences on HIV epidemics". UNAIDS also recognizes that gender relations are not only associated with the spread of HIV, but also with its consequences. For example, women and girls continue to bear the greater burden of caring for family members with HIV/AIDS, even when they become HIV infected themselves. Gender norms and expectations surrounding virility, male sexuality, and risk-taking can also make men and boys vulnerable to contracting HIV by reducing their likelihood of engaging in safe sexual practices or seeking medical care when they become ill.

A gender-based analysis of HIV/AIDS in Belize captures these gendered dimensions of the epidemic, thus increasing the sensitivity of our knowledge base, and the effectiveness of HIV/AIDS policies and programming. A gender-based analysis is an analytical process aimed at understanding how age, culture, ethnicity, sexual orientation, ability, geographical location, and other variables interact with

sex and gender in ways that affect the daily lives of women, men, girls, and boys. It assumes that sex—the biological and physiological aspects of the body— interacts with gender— the roles and responsibilities associated with the socially constructed concepts of "masculinity" and "femininity" to create health conditions and outcomes that are different for women and men.

A gender-based analysis of HIV/AIDS recognizes the importance of focusing on the biological as well as the social, cultural and economic realities of women, men, girls and boys, since all experience life differently. In this regard, economic, social and cultural realities in the family, community and society become important determinants for HIV vulnerability, and these social

HIV/AIDS-related stigma and discrimination tends to compound and reinforce existing prejudices and inequalities, as women and girls are often blamed for bringing the disease into the family, regardless of whether or how they may have contracted HIV

In Belize, men's reactions to women seeking care or divulging their HIV positive status to others may keep women away from voluntary HIV/AIDS counseling and testing. This reluctance has implications for HIV prevention in terms of controlling sexual transmission of the virus, and for efforts to reduce mother-to-child transmission.

As is the situation globally, women in Belize engage in the double or triple burden of family care and community service. This includes the physical and emotional burden of caring for HIV positive dependents and family members, regardless of whether the person is a man, woman, boy or girl. In this sense, women are affected by HIV/AIDS in a multitude of ways: as people infected with HIV, as mothers of children infected, and as support systems for partners, parents, or orphans living with HIV/AIDS. When women care for others, opportunities for financial remuneration are lost. This loss has a major impact on their own independence and wellbeing, in addition to that of the household.

The rate of HIV positive women's access to family planning and other sexual and reproductive services needs to be monitored so that services can be adjusted to increase their effectiveness. HIV positive women who decide to engage in family planning need support in choosing the most effective method for their individual circumstances. This may or may not include consistent condom use (male condoms) since this requires active participation by men. The Maternal and Child Health Program (MCH) in Belize understands these challenges and is working diligently to increase women's access to sexual and reproductive health services, including access to family planning commodities such as male and female condoms and injectables. The MCH program also offers substitute milk as an alternative feeding method for mothers who are HIV infected.

Recommendations:

The National AIDS Commission is engaged in an analysis of the situation and response to HIV in Belize. Through the analysis of data from a number of recent studies and assessments, the NAC identifies challenges, gaps and opportunities in the area of prevention. The analysis established that Belize has halted and started to reverse the spread of HIV, however pockets of continued new infections remain. Successes in the prevention of mother-to-child transmission critical have been identified, as well as key vulnerable groups that continue to play a crucial role in the determinants of the epidemic and whose sexual behavioural patterns show a continued high level of vulnerability to HIV.

HIV/AIDS national strategy needs response-frames therefore need to become more evidence-informed in targeting these groups and in designing high impact interventions that establish impact.

There should be analysis and provided insight into the situation parameters, the on-going response actions, a deeper root cause analysis and a mapping of the extracted remaining gaps in line with international Guidelines on infant and young child feeding that includes infant feeding and HIV. Based on these findings the new strategic plan should delineate the priority areas that speak to the response dimensions of ending new HIV infections, improving health and wellbeing, and creating an enabling environment for the response.

The Prevention of Mother to Child Transmission is prioritized and provides antiretroviral medication to pregnant women and their newborns. Pre and post□test counseling are essential components for good clinical care of mother at risk or infected with STI/HIV. Improved counseling should be integrated with all HIV testing, screening and care. Anti□retroviral drugs are freely provided to all those infected with HIV and these drugs are now provided through pharmacies to enhance access to those needing them.

The infant feeding and HIV policy needs to give effect to the International Code and develop national related legislation. Health staff and community workers should receive training on the International Code, the HIV and infant feeding policies and the risks associated with bottle-feeding.

Special efforts are necessary to counter misinformation on HIV and infant feeding and to promote, protect and support 6 months of exclusive breastfeeding and continued breastfeeding in the general population, as well as to address the gender related vulnerability created by discriminatory and cultural patterns.

Indicator 9: Infant and Young Child Feeding during Emergencies

Key question: *Are appropriate policies and programmes in place to ensure that mothers, infants and young children will be provided adequate protection and support for appropriate feeding during emergencies?*

Guidelines for scoring			
Criteria	**Scoring √ Check that apply**		
	Yes	To some degree	No
9.1) The country has a comprehensive policy on infant and young child feeding that includes infant feeding in emergencies and contains all basic elements included in the IFE Operational Guidance	2	1	0
		✓	

9.2) Person(s) tasked with responsibility for national coordination with all relevant partners such as the UN, donors, military and NGOs regarding infant and young child feeding in emergency situations have been appointed	2	1	0
			✓
9.3) An emergency preparedness and response plan based on the practical steps listed in the Operational Guidance has been developed and put into effect in most recent emergency situations, and covers:	1	0.5	0
a) basic and technical interventions to create an enabling environment for breastfeeding, including counseling by appropriately trained counselors, support for relactation and wet-nursing, and protected spaces for breastfeeding			✓
b) measures to minimize the risks of artificial feeding, including an endorsed statement on avoidance of donations of breastmilk substitutes, bottles and teats, and standard procedures for handling unsolicited donations, and procurement management and use of any infant formula and BMS, in accordance with strict criteria, the IFE Operational Guidance, and the International Code and subsequent relevant WHA resolutions	1	0.5	0
			✓
9.4) Resources have been allocated for implementation of the emergency preparedness and response plan	2	1	0
		✓	
9.5) a) Appropriate orientation and training material on infant and young child feeding in emergencies has been integrated into pre-service and in-service training for emergency management and relevant health care personnel.	1	0.5	0
		✓	
b) Orientation and training is taking place as per the national emergency preparedness and response plan	1	0.5	0
			✓
Total Score:	**2.5/10**		

Information Sources Used:

1. *Ministry of Health*
2. *National Emergency Management Organization- NEMO of Belize*
3. *Strengthening of Disaster Preparedness and Emergency Response Capacity in Belize*
4. *National Transport and Evacuation Committee*

5. *National Emergency Management Organization (NEMO) Belize Hurricane Contingency Plan*

Conclusions:

The Caribbean is often hit by hurricanes and other natural phenomena that imply that Belize must be prepared to face them. PAHO and UNICEF have been very active in the region by promoting guidelines on infant feeding in emergencies, especially after the earthquake in Haiti in 2010. But the implementation of the guidelines is difficult and Belize needs to incorporate the issue of infant feeding in a proactive manner and taking into account the particular difficulties faced by mothers and their babies, including the need to facilitate mutual support.

Recommendations:

Belize needs a comprehensive policy on infant and young child feeding that includes infant feeding in emergencies and contains all basic elements included in the IFE Operational Guidance, with a responsible for national coordination with all relevant partners such as the UN, donors, military and NGOs and a response plan based that covers interventions to create an enabling environment for breastfeeding, including counseling by appropriately trained counselors, support for relactation and wet-nursing, and protected spaces for breastfeeding. It should include avoiding donations of breastmilk substitutes, bottles and teats, and standard procedures for handling un sollicited donations, and procurement management and use of any infant formula and BMS, in accordance with strict criteria, the IFE Operational Guidance, and the International Code and subsequent relevant WHA resolutions. This should also be integrated into pre-service and in-service training for emergency management and relevant health care personnel.

Indicator 10: Mechanisms of Monitoring and Evaluation System

Key question: *Are monitoring and evaluation systems in place that routinely collect, analyse and use data to improve infant and young child feeding practices?*

Guidelines for scoring			
Criteria	**Scoring** ✓ **Check that apply**		
	Yes	To some degree	No
10.1) Monitoring and evaluation components are built into major infant and young child feeding programme activities.	2	1	0
		✓	
10.2) Data/information on progress made in implementing the IYCF programme are used by	2	1	0

programme managers to guide planning and investments decisions.		✓	
10.3) Data on progress made in implementing IYCF programme activities routinely collected at the sub national and national levels.	2	1	0
			✓
10.4) Data/Information related to infant and young child feeding programme progress are reported to key decision-makers.	2	1	0
		✓	
10.5) Monitoring of key infant and young child feeding practices is integrated into the national nutritional surveillance system, and/or health information system or national health surveys.	2	1	0
		✓	
Total Score:	**4/10**		

Information Sources Used:

1. *National Gender Policy (Updated, January, 2010).*
2. *http://www.nationalwomenscommissionbz.org/wp-content/uploads/2015/10/Final_Sit-An.pdf*
3. *Ministry of Health*

Conclusions:

Experience has shown that on-going improvement of information systems, strengthened data collection and disaggregation exposes, and helps to reduce disparities. Using disaggregated evidence and building institutional capacity and networks through local institutions and universities promote transformative public governance practices that are integrated and collaborative, thus delivering better results for rights-holders.

More recently, with the support of international development partners, Belize has begun to move towards greater accountability of policies and action plans. The National Committee for Families and Children (NCFC) and the National AIDS Commission (NAC) are two agencies that have taken seriously their responsibility to monitor and evaluate specific plans of action. In the case of the NCFC, a monitoring framework was developed to monitor the National Plan of Action for Children and Adolescents. The NAC has also developed a Monitoring Plan to monitor the National Strategic Plan for a Multi-sectoral Response to HIV. Both action plans include gender related indicators. While these organizations are making breakthroughs in monitoring and evaluation, their individual efforts are constrained by the lack of a wider culture of accountability. Monitoring and evaluation systems do not exist within implementation bodies in the public or private sector and data is not collected in a manner that allows for easy retrieval and analysis. In fact, in some cases data, even when collected, is simply reported in tables or charts. No one, either within the Government or in the Civil Society Sector is charged with translating this data into useful information that is used to plan more effectively. This type of data analysis is not supported by national protocols, which may account for why this situation persists.

There is no national protocol that outlines the flow of data or the most effective system or mechanism for monitoring and evaluation. This creates a lack of formality regarding monitoring and evaluation and makes accountability very difficult. The absence of a technical body (such as the past Social Indicators Committee) to decide on the most useful indicators for Belize, define the metadata, decide on the level of disaggregation and on the process for data analysis, monitoring and evaluation results in a fragmented approach to planning and implementation. This also makes the establishment of baselines and the comparison of data over time a virtually impossible task as it creates challenges in monitoring progress in the achievement of international and local commitments. Monitoring and evaluation in Belize is therefore like "spitting in the wind". This situation results in an inability to effectively report on the impact of projects, programmes, plans of Action Plan.

The effectiveness in monitoring and evaluating the implementation of action plans related to the National Gender Policy will be impacted by this current monitoring and evaluation context in Belize. A more holistic approach will therefore need to be taken, with specific actions outlined for the legalization, formalization and institutionalization of M&E systems in Belize.

Recommendations:

Infant feeding programs need to target the critical periods of child development, when irreversible damage has not yet occurred. Focusing on monitoring and evaluation systems to understand the situation and needs of children under two years of age and pregnant mothers will bring the largest benefit in terms of human development as well as the largest return on investment to the country. To enhance the Belize´s human resource capacity therefore requires that inter-linkages between health and education programs be clearly articulated and that social sector programming becomes more truly integrated and child centred.

Monitoring and evaluation components should be built into a major infant and young child-feeding programme with data on progress made in implementing the IYCF programme to be used by programme managers to guide planning and investments decisions. This data should be routinely collected and reported to key decision-makers. It should also be integrated into the national nutritional surveillance system, and/or health information system or national health surveys.

Indicator 11: Early Initiation of Breastfeeding

Key question: *What is the percentage of babies breastfed within one hour of birth?*

Guideline:

Indicator 11	*Key to rating adapted from WHO tool* (see Annex 11.1)	IBFAN Asia Guideline for WBTi	
Initiation of Breastfeeding (within 1 hour)		***Scores***	***Colour-rating***
	0.1-29%	3	**Red**
	29.1-49%	6	**Yellow**
	49.1-89%	**9**	**68.3 - Blue**
	89.1-100%	10	**Green**

Data Source (including year):

Statistical Institute of Belize, Government of Belize, and UNICEF. 2016. Multiple Indicator Cluster Survey 2015: Key Findings. Belmopan, Belize.

Belize Multiple Indicator Cluster Survey 2015

Key Findings, August, 2016 - MoH, UNICEF, Statistical Institute of Belize, MICS Programme

https://mics-surveys prod.s3.amazonaws.com/MICS5/Latin%20America%20and%20Caribbean/Belize/2015-2016/Key%20findings/Belize%202015-16%20MICS%20KFR_English.pdf

Indicator 12: Exclusive Breastfeeding for the First Six Months

Key question: *What is the percentage of babies 0<6 months of age exclusively breastfed[10] in the last 24 hours?*

Guideline:

Indicator 12	*Key to rating adapted from WHO tool* (see Annex 11.1)	IBFAN Asia Guideline for WBT*i*	
Exclusive Breastfeeding (for first 6 months)		***Scores***	***Colour-rating***
	0.1-11%	3	**Red**
	11.1-49%	**6**	**33.2 % Yellow**
	49.1-89%	9	**Blue**
	89.1-100%	10	Green

Data Source (including year):

Statistical Institute of Belize, Government of Belize, and UNICEF. 2016. Multiple Indicator Cluster Survey 2015: Key Findings. Belmopan, Belize.

Belize Multiple Indicator Cluster Survey 2015

[10] Exclusive breastfeeding means the infant has received only breastmilk (from his/her mother or a wet nurse, or expressed breastmilk) and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines (2)

Key Findings, August 2016
MoH, UNICEF, Statistical Institute of Belize, MICS Programme
https://mics-surveys-prod.s3.amazonaws.com/MICS5/Latin%20America%20and%20Caribbean/Belize/2015-2016/Key%20findings/Belize%202015-16%20MICS%20KFR_English.pdf

Indicator 13: Median Duration of Breastfeeding

Key question: *Babies are breastfed for a median duration of how many months?*

Guideline:

Indicator 13	***Key to rating adapted from WHO tool* (see Annex 11.1)**	**IBFAN Asia Guideline for WBT*i***	
Median Duration of Breastfeeding		***Scores***	***Colour-rating***
	0.1-18 Months	**3**	**17.2 months- Red**
	18.1-20 ’’	6	Yellow
	20.1-22 ’’	9	**Blue**
	22.1- 24 or beyond ’’	10	Green

Data Source (including year):
Statistical Institute of Belize, Government of Belize, and UNICEF. 2016. Multiple Indicator Cluster Survey 2015: Key Findings. Belmopan, Belize.
Belize Multiple Indicator Cluster Survey 2015
Key Findings, August 2016
MoH, UNICEF, Statistical Institute of Belize, MICS Programme
https://mics-surveys-prod.s3.amazonaws.com/MICS5/Latin%20America%20and%20Caribbean/Belize/2015-2016/Key%20findings/Belize%202015-16%20MICS%20KFR_English.pdf

Indicator 14: Bottle feeding

Key question: *What percentage of breastfed babies 0-12 months of age, who are fed with any foods or drinks (even breastmilk) from bottles?*

Guideline:

Indicator 14	*Key to rating adapted from WHO tool* (see Annex 11.1)	IBFAN Asia Guideline for WBTi	
Bottle Feeding (0-12 months)		**Scores**	**Colour-rating**
	29.1-100%	**3**	**61.2% - Red**
	4.1-29%	6	**Yellow**
	2.1-4%	9	**Blue**
	0.1-2%	10	**Green**

Data Source (including year):

Statistical Institute of Belize, Government of Belize, and UNICEF. 2016. Multiple Indicator Cluster Survey 2015: Key Findings. Belmopan, Belize.

Belize Multiple Indicator Cluster Survey 2015
Key Findings, August 2016
MoH, UNICEF, Statistical Institute of Belize, MICS Programme
https://mics-surveys-prod.s3.amazonaws.com/MICS5/Latin%20America%20and%20Caribbean/Belize/2015-2016/Key%20findings/Belize%202015-16%20MICS%20KFR_English.pdf

Indicator 15: Complementary feeding --- Introduction of solid, semi-solid or soft foods

Key question: *Percentage of breastfed babies receiving complementary foods at 6-8 months of age?*

Guideline

Indicator 15	WHO's	IBFAN Asia Guideline for WBTi	
Complementary Feeding (6-8 months)	***Key to rating***	***Scores***	***Colour-rating***
	0.1-59%	3	**Red**
	59.1-79%	**6**	**78.8 Yellow**
	79.1-94%	9	**Blue**
	94.1-100%	10	Green

Data Source (including year):

Statistical Institute of Belize, Government of Belize, and UNICEF. 2016. Multiple Indicator Cluster Survey 2015: Key Findings. Belmopan, Belize.

Belize Multiple Indicator Cluster Survey 2015
Key Findings, August 2016
MoH, UNICEF, Statistical Institute of Belize, MICS Programme
https://mics-surveys-

prod.s3.amazonaws.com/MICS5/Latin%20America%20and%20Caribbean/Belize/2015-2016/Key%20findings/Belize%202015-16%20MICS%20KFR_English.pdf

Summary Part I: IYCF Policies and Programmes

Targets:	Score **(Out of 10)**
1. National Policy, Programme and Coordination	**3.5**
2. Baby Friendly Hospital Initiative	**3.5**
3. Implementation of the International Code	**1.5**
4. Maternity Protection	**6**
5. Health and Nutrition Care Systems	**4.5**
6. Mother Support and Community Outreach	**5**
7. Information Support	**3**
8. Infant Feeding and HIV	**8**
9. Infant Feeding during Emergencies	**2.5**
10. Monitoring and Evaluation	**4**
Score Part I (Total)	**41.5**

IBFAN Asia Guidelines for WBT*i*

Total score of infant and young child feeding policies and programmes (indicators 1-10) are calculated out of 100.

Scores	**Colour- rating**
0 – 30.9	**Red**
31 – 60.9	**41.5 Yellow**
61 – 90.9	**Blue**
91 – 100	**Green**

Summary Part II: Infant and young child feeding (IYCF) practices

IYCF Practice	Result	Score
Indicator 11 Starting Breastfeeding (Initiation)	**68.3%**	**9**
Indicator 12 Exclusive Breastfeeding for first 6 months	**33.2 %**	**6**
Indicator 13 Median duration of Breastfeeding	**17.2 months**	**3**
Indicator 14 Bottle-feeding	**61.2 %**	**3**
Indicator 15 Complementary Feeding	**78.8 %**	**6**
Score Part II (Total)		**27**

IBFAN Asia Guidelines for WBT*i*

Total score of infant and young child feeding Practice (indicators 11-15) are calculated out of 50.

Scores	Colour-rating
0 – 15	**Red**
16 – 30	**27 Yellow**
31 – 45	**Blue**
46 – 50	**Green**

Total of Part I and Part II (indicator 1-15): IYCF Practices and Policies and Programmes

Total score of infant and young child feeding **practices and policies and programmes (indicators 1-15)** are calculated out of 150. Countries are then rated as:

Scores	Colour- rating
0 – 45.5	Red
46 – 90.5	**68.5 Yellow**
91 – 135.5	Blue
136 – 150	Green

Summary of Recommendations

-Conformation of a national breastfeeding committee, with legal structural support to coordinate breastfeeding programmes and to mainstream breastfeeding promotion, support and protection to governmental health, maternity and infant programmes. This breastfeeding national coordination

should have clear working mechanisms, a coordinator with clear terms of reference, power to convene other related governmental institutions and ministries, ability to develop needed programmes and policies, and adequate and sufficient sustainable funding.

-Rejuvenation of the Mother Baby Friendly Hospital Initiate, including all aspects of the 2016 revision of criteria and procedures for certification and recertification processes (training, monitoring, assessment systems, comprehensive integration of HIV, International Code and other crucial aspects, practical action to implement 10 steps, mothers support groups and community involvement for follow up, and others needed) in all public hospitals and maternity wards. This should also include respectful birthing practices.

-Policy guidance to private hospitals to become Mother Baby Friendly, with clear deadlines to achieve results.

-Systems in place for periodical auto evaluation, external evaluation, sharing of experiences and sufficient flexibility to incorporate without delay good practices.

It is urgent for Belize to approve a law based on the International code of Marketing of Breastmilk Substitutes and all Relevant WHA Resolutions, including clear mechanisms for implementation, evaluation and monitoring and measures for company's accountability, including strong sanctions. The responsible organism for surveillance of this law should have the adequate human, legal and financial resources for rendering of accounts and efficient management and results.

-Belize needs to strengthen its mechanisms for compliance with the maternity protection law and national gender policy. This needs adequate human, legal and financial resources to be prioritized.

-The ILO Convention 183 ratified by Belize is a minimum standard that can be improved given the Belize efforts in achieving infant and young child health and development. Efforts to improve the rates of 6 months exclusive breastfeeding and continued breastfeeding for 2 years o more need to be accompanied by at least 6 months paid maternity leave post partum, guarantee of paid breastfeeding breaks at work for breastfeeding or extraction of breastmilk in adequate private spaces, and other motherbaby friendly policies and programmes, including the cultural changes needed for the creation of non discriminatory conditions and enabling environments for the respect of women workers rights and maternity rights.

-Women workers in non-formal settings have rights that are not been protected and it is the responsibility of the state to grantee their fulfilment. This implies the need for policies and practices to protect these workers maternity rights, including those working at house hold, in migration status, agricultural and domestic workers, and other women working in vulnerable conditions.

-Breastfeeding challenges include the need of human resources to advance breastfeeding at the

district level, the need to generate greater fathers' (partners-family- community) support for breastfeeding mothers and the need to develop workplace strategies that support exclusive breastfeeding practices.

-Belize needs to create mechanisms to attend each one of the indicators for the implementation of the Global Strategy for Infant and Young Child Feeding and to guarantee qualified training to health professionals, social and community workers in order to create the base for nation wide inclusive and sustainable results.

-The national counselling structure that has given emphasis to prevention of HIV and early treatment of AIDS needs to be widen to provide all pregnant women with access to community-based ante-natal and post-natal support systems with counseling services on infant and young child feeding, support to initiate early breastfeeding, exclusive breastfeeding for 6 months and to maintain breastfeeding for 2 years or beyond, giving emphasis too to the introduction of nutritious home made complementary feeding.

-The full implementation of the Global Strategy for Infant and Young Child Feeding needs to become an integral practice of the Primary Health Care System and needs to strengthen community participation and reinforcement of abilities of community and civil society support groups with important experience acquired in previous decades when Belize had important support donors to consolidate them. Health workers in health facilities need to coordinate with community support agents to provide integral support to mothers and their families.

-Belize needs a national IEC strategy for improving infant and young child feeding that ensures all information and materials are free from commercial influence/ potential conflicts of interest are avoided.

-National health/nutrition systems are to include individual counseling on infant and young child feeding; infant feeding IEC actions need to be consistent with international recommendations and include information on the risks of artificial feeding.

-The National AIDS Commission is engaged in an analysis of the situation and response to HIV in Belize. Through the analysis of data from a number of recent studies and assessments, the NAC identifies challenges, gaps and opportunities in the area of prevention. The analysis established that Belize has halted and started to reverse the spread of HIV, however pockets of continued new infections remain. Successes in the prevention of mother-to-child transmission critical have been identified, as well as key vulnerable groups that continue to play a crucial role in the determinants of the epidemic and whose sexual behavioural patterns show a continued high level of vulnerability to HIV.

HIV/AIDS national strategy needs response-frames therefore need to become more evidence-

informed in targeting these groups and in designing high impact interventions that establish impact.

-There should be analysis and provided insight into the situation parameters, the on-going response actions, a deeper root cause analysis and a mapping of the extracted remaining gaps in line with international Guidelines on infant and young child feeding that includes infant feeding and HIV. Based on these findings the new strategic plan should delineate the priority areas that speak to the response dimensions of ending new HIV infections, improving health and wellbeing, and creating an enabling environment for the response.

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-Special efforts are necessary to counter misinformation on HIV and infant feeding and to promote, protect and support 6 months of exclusive breastfeeding and continued breastfeeding in the general population, as well as to address the gender related vulnerability created by discriminatory and cultural patterns.

-Belize needs a comprehensive policy on infant and young child feeding that includes infant feeding in emergencies and contains all basic elements included in the IFE Operational Guidance, with a responsible for national coordination with all relevant partners such as the UN, donors, military and NGOs and a response plan based that covers interventions to create an enabling environment for breastfeeding, including counseling by appropriately trained counselors, support for relactation and wet-nursing, and protected spaces for breastfeeding. It should include avoiding donations of breastmilk substitutes, bottles and teats, and standard procedures for handling un-sollicited donations, and procurement management and use of any infant formula and BMS, in accordance with strict criteria, the IFE Operational Guidance, and the International Code and subsequent relevant WHA resolutions. This should also be integrated into pre-service and in-service training for emergency management and relevant health care personnel.

-Infant feeding programs need to target the critical periods of child development, when irreversible damage has not yet occurred. Focusing on monitoring and evaluation systems to understand the situation and needs of children under two years of age and pregnant mothers will bring the largest

benefit in terms of human development as well as the largest return on investment to the country. To enhance the Belize´s human resource capacity therefore requires that inter-linkages between health and education programs be clearly articulated and that social sector programming becomes more truly integrated and child centred.

-Monitoring and evaluation components should be built into a major infant and young child-feeding programme with data on progress made in implementing the IYCF programme to be used by programme managers to guide planning and investments decisions. This data should be routinely collected and reported to key decision-makers. It should also be integrated into the national nutritional surveillance system, and/or health information system or national health surveys.