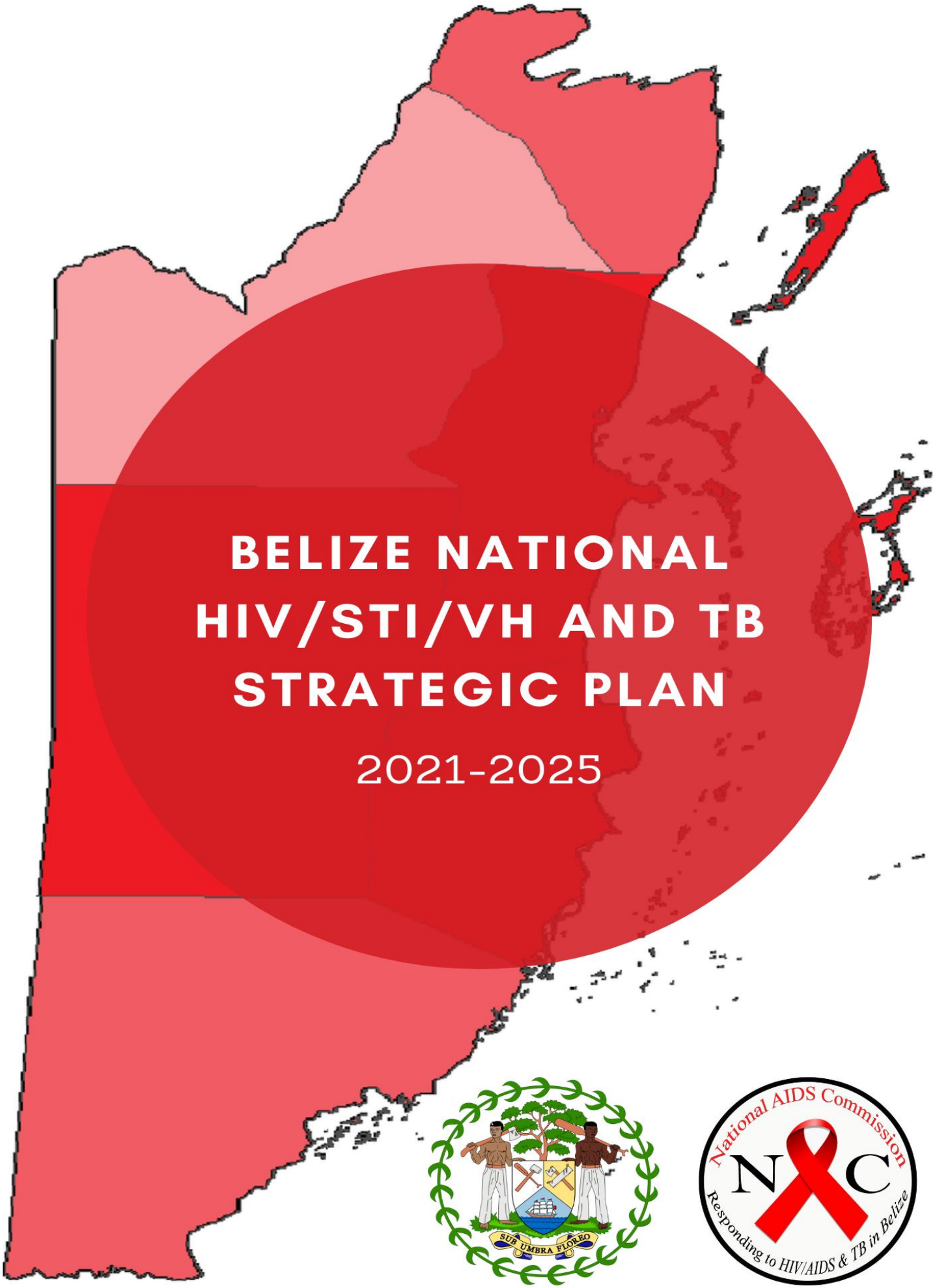

BELIZE NATIONAL HIV/STI/VH AND TB STRATEGIC PLAN

2021-2025

SUB UMBRA FLOREO

National AIDS Commission

NAC

Responding to HIV/AIDS & TB in Belize

Contents

Belize National Strategic Plan on HIV/STIs, Viral Hepatitis and TB 2021-2025

Towards ending AIDS/STIs/VH and TB

FOREWORD

The national response to HIV/AID & TB in Belize, spearheaded by the National AIDS Commission (NAC), is responsible for coordination of the multi-sectoral response and the development of the national strategic plan in collaboration with key stakeholders including the Ministry of Health & Wellness (MOHW), Civil Society, regional and global developmental partner.

In 2015 Belize formulated its third National Strategic Plan for the period 2016-2020. This plan focused its intervention activities using a human rights-based approach and confirmed the need to narrow the intervention's focus as the epidemic had evolved into one that is concentrated in the population of men who have sex with men. Evidence emerging from UNAIDS strongly suggests that, to meet the ambitious target of ending AIDS by 2030, countries must intensify their efforts or face a resurgence of the epidemic with adverse and costly consequences.

In heeding to UNAIDS advice, the Government of Belize has now formulated its new National Strategic Plan for HIV/STIs, Viral Hepatitis and Tuberculosis for the period 2021-2025 that seeks to scale-up and implement evidence-based interventions that have proven to be successful, to reduce HIV transmission, especially among Key Populations. The integration of viral hepatitis and other sexually transmitted diseases (STIs), along with TB, into the HIV response is expected to contribute to the reduction of new cases.

The National Strategic Plan will introduce the implementation of innovative interventions to reach Key Populations, expand coverage, optimise testing and linkage to care, retention and adherence to treatment for Persons Living with HIV and end HIV/STI, Viral Hepatitis and Tuberculosis as public health threats in Belize by 2030.

Dr Giovanni Solorzano
NAC CCM Chairperson

Acknowledgment (TBC)

The Belize National HIV/STI/VH and TB Strategic Plan 2021-2025 was developed as a collaborative and consultative process under the leadership of the Belize National AIDS Commission (NAC) and the Ministry of Health and Wellness (MoHW). The Belize NAC and MoHW would like to extend great appreciation to the Global Fund for financial resources and our technical partners who provided technical oversight in the planning and development process.

Thanks to all national stakeholders who contributed to the situational assessment of the previous Strategic Plan that served as a key pillar in understating the progress made, but more importantly in highlighting the gaps and challenges that served to focus this Strategic Plan.

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List of Acronyms and Abbreviations

AIDS	Acquired Immuno deficiency Syndrome
ANC	Antenatal Clinic
ARV	Antiretroviral
BHIS	Belize Health Information System
CCM	Country Coordinating Mechanism
CSO	Civil Society Organisation
CSW	Commercial Sex Workers
CTX	Co-Trimaxazole
DOTS	Direct Observed Therapy Short Course
DTG	Dolutegavir
EMTCT	Elimination of Mother to Child Transmission
GDP	Gross domestic Product
GoB	Government of Belize
HBV	Hepatitis B virus
HCV	Hepatitis C Virus
HIV	Human Immunio deficiency Syndrome
HIV	Human Immuno deficiency Virus
HPV	Human Papilloma Virus
INH	Izoniazid
KP	Key Population
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MoHW	Ministry of Health and Wellness
MSM	Men who have sex with men
MTB/RIF	Mycobacterium Tuberculosis/Rifampicin Resistance
NAC	National AIDS Commission
NCD	Non communicable Diseases
NSP	National Strategic Plan
OPM	Office of the Prime Minister
OPP	Out of pocket
PAHO	Pan American Health Organization
PANCAP	Pan Caribbean Partnership Against HIV and AIDS
PLHIV	People living with HIV
S&D	Stigma and Discrimination
SO	Strategic Objective
SPA	Strategic Priority Area
STI	Sexually Transmitted Infections
TB	Tuberculosis
TG	Transgender
UHC	Universal Health Coverage
VH	Viral Hepatitis
VIA	Visual Inspection with Acetic Acid

Concepts and Terminologies

People-centered health services is an **approach** to care that consciously adopts the perspectives of individuals, families, and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways.

Social Contracting is a mechanism by which governments can directly fund civil society organizations to implement aspects of their HIV response, helping maintain civil society's critical role and accelerate progress toward epidemic control. [1]

Human rights are rights inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status. Human rights include the right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, the right to work and education, and many more. Everyone is entitled to these rights, without discrimination.[2]

Differentiated models of care is service delivery that is tailored to the unique needs of client subgroups across the continuum of prevention, care, and treatment.[3]

Key populations are groups who, due to specific higher-risk behaviors, are at increased risk of HIV irrespective of the epidemic type or local context. They often have legal and social issues related to their behaviors that increase their vulnerability to HIV.[4]

Vulnerable populations are groups of people who are particularly vulnerable to HIV infection *in certain situations or contexts,* such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities, and migrant and mobile workers. [5]

MSM refers to all men who engage in sexual and/or romantic relations with other men.[6]

Transgender is an umbrella term for people whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth; it includes people who are transsexual, transgender or otherwise gender non-conforming.[7]

Children refer to every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier.[8]

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[1] https://pancap.org/pancap-documents/social-contracting-supporting-domestic-public-financing-for-civil-societys-role-in-the-hiv-response/
[2] https://www.un.org/en/sections/issues-depth/human-rights/
[3] https://www.fhi360.org/news/betterhivcare-differentiated-models-care-across-hiv-continuum#:~:text=One%20such%20strategy%20is%20known,of%20prevention%2C%20care%20and%20treatment.
[4] WHO Consolidated guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, Update 2016
[5] ibid
[6] WHO Consolidated guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, Update 2016
[7] ibid
[8] ibid

Adolescents refer to individuals between the ages of 10 and 19 years old.[9]

Youth refers to individuals between the ages of 15 and 24.[10]

Young people refer to those between the ages of 10 and 24.[11]

[9] ibid
[10] ibid
[11] ibid

Executive Summary

Belize has a generalized HIV epidemic with a concentrated epidemic among MSM (MSM). The HIV prevalence among the general population is 1.8%, with an estimated 4,900 persons living with HIV in 2018. New HIV infections among adults in Belize increased by about 7% between 2010 and 2018. In 2019 there 205 incident HIV cases compared to 254 and 223 in 2018 and 2017, respectively. HIV prevalence is higher for Men who have Sex with Men (MSM), 13.9%, and prisoners 5.8%. Prevalence data for Sex worker (SW) is 0.9% in 2016. The 2018 Modes of Transmission (MOT) study estimates that 2 of every three new infections occurred among MSM. More males are diagnosed HIV positive with a male to female distribution of 2:1. More than three-quarters (78.5%) of all cases diagnosed in 2019 are between the ages of 20-49 years, and the districts of Belize, Stann Creek, and Cayo continue to experience the highest HIV burden.

Belize is on the cusp of achieving elimination of mother to child transmission of HIV and Syphilis with high testing coverage of pregnant women, high ARVs uptake for the HIV positive woman and exposed women, and early infant diagnosis.

In 2019, 91 persons were diagnosed with TB disease, with 9 cases or 18% less than the estimated 100 cases. This was less compared to 2018, where 99 persons were diagnosed.[12] Like the HIV epidemic, most TB cases diagnosed in 2019 occurred among men and in the Belize and Cayo districts. In relation to age-groups, no children (0-14 years) were diagnosed with TB. One-third of all cases were persons 55 years and older, and more than one-fifth (21/91, 23%) were among those aged 25-34 years. [13] Like with HIV, Belize and Cayo districts account for most TB cases. Among the 91cases,16 persons were TB/ HIV coinfection. TB treatment success rate has declined from 2017 to 2018, and TB remains the fourth leading cause of death among all communicable, maternal, neonatal, and nutritional diseases. In 2019, 12 persons died of TB; nine persons were HIV negative and three HIV positive.[14]

In the five years of 2015-2019, there was an average of 1500 annual sexually transmitted infections (STI), with Pelvic Inflammatory Diseases account for the largest proportion of cases. Females report disproportionately more STIs diagnosed in 2018, possibly as a result of the Maternal and Child Health (MCH) program that integrates routine STI screening. The geospatial distribution of STIs is similar to HIV and TB. Belize has introduced Hepatitis B vaccination and Human Papilloma Virus (HPV) vaccination as part of the prevention efforts to reduce Hepatitis B and cervical cancer.

An analysis of the Belize programmatic response to HIV, STI, Viral Hepatitis, and TB showed that Belize had made progress in many areas of the response. The enabling environment was improved with successful strategic litigation to advance social justice and constitutional rights, with the 2016 Section 53 ruling decriminalizing consensual same-sex relationships and the development of the Equal Opportunities Bill. Comparison of the sigma index survey shows that stigma and discrimination (S&D) are still present but have reduced in the health care settings, in families, and communities. People living with HIV who are MSM and transgender (TG) face increased stigma and discrimination at all levels. There has been an increase in HIV/STI and TB community service delivery targeting key populations, primarily with support from the Global Fund and has resulted in enhanced access to services.

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[12] ibid

[13] http://www.stoptb.org/resources/cd/BLZ_Dashboard.html

[14] ibid

However, based on the population size estimates for MSM and TG persons, coverage remains low. A significant strength of the Belize response is the Belize Health Information System (BHIS) that presents real-time data for monitoring and program planning. The BHIS captures data related to patient management and risk factors critical to understanding the changing vulnerabilities for the transmission and acquisition of HIV/STI and VH. Expansion of BHIS to private sector and CSOs and addressing data quality focusing on completeness are two critical areas for improvement to generate more robust strategic information for policy and program planning and will be addressed in this strategic plan.

Belize has significant gaps along the 90-90-90 cascade with low treatment coverage. In 2019, of the estimated 5,100 persons living with HIV, 54.6% knew their status, and only 30% of all estimated PLHIVs were on treatment. Viral suppression is a significant issue. Among the 1530 persons on treatment, 607 or 39.7% of persons achieved viral suppression, which represented 11.9% of the estimated PLHIV. Belize will not achieve the 90-90-90 targets at the end of 2020. This Strategic Plan presents a tailored and targeted response that is data-driven to achieve the 90-90-90 by 2025 as an intermediary result to the end of AIDS by 2030 in Belize.

TB diagnosis has been scaled-up using point of care molecular technology, GeneXpert. TB treatment success rate is low. STIs are treated using the syndromic management approach.

The development of this National Strategic Plan on HIV/STI/VH and TB 2021-2025 was led by the Government of Belize (GoB) through the National AIDS Commission (NAC) and the Ministry of Health and Wellness (MoHW) and in consultation with national stakeholders, including development partners, civil society organizations and people living with and affected by HIV. The Strategic Plan addresses the gaps in the HIV/STI/VH and TB response to prevent new infections and to test and provide timely and high-quality treatment and care. To this end, an effective mix of evidence-based, high impact prevention, treatment, care, and support interventions are prioritized that will advance the progress where HIV/STI/VH and TB are no longer public health threats to Belize. The Strategic Plan articulates the Vision, Mission, Overall Goal, Specific Goals that will be achieved through strategies aligned to four Strategic Priority Areas (SPA): 1. Information for Tailored and Targeted Response, 2. Quality and Efficient Service Delivery for Impact, 3. Resilient and Sustainable Systems, an Enabling Environment and Human Rights for Equity, and 4. Responding for Sustainability.

The National Strategic Plan on HIV/STI/VH and TB 2021-2025 will be operationalized through a five-year implementation plan that defines priority actions, lead and supporting implementers and timeframes for implementation. The implementation plan will be reviewed annually to measure implementation progress, and, as appropriate, strategies will be redefined.

The monitoring and evaluation plan with indicators and annual targets for 2021-2025 will be used to measure progress towards achieving the expected results. An annual review will be conducted, and targets revisited as appropriate.

CHAPTER 1

Introduction

The Belize National HIV/STI/VH and TB 2021-2025 Strategic Plan builds on the achievements of previous national plans. The GoB under this Strategic Plan will continue to spearhead the national response through the MoHW and the NAC in collaboration with technical partners, civil society organizations (CSO), the private sector, and other national stakeholders. This Strategic Plan presents a multisectoral response with intersectoral collaboration that is critical in addressing the risk factors and vulnerabilities for HIV/STI/VH and TB, many of which are linked to the social determinants of health.

A lot has changed since the inception of Belize's HIV epidemic. This Strategic Plan presents new opportunities to accelerate its response towards ending HIV/STI/VH and TB as public health threats in Belize. This Strategic Plan takes into consideration Belize's commitments to global and regional targets. More importantly, it is grounded in Belize's National Health Strategic Plan 2014-2024 that envisions a healthy, empowered population supported by a network of quality services and effective partnerships for wellness. Central to this Strategic Plan is the achievement of universal health coverage (UHC) as the overarching strategy for achieving the Sustainable Development Goals health targets. This UHC framework will prioritize a people-centered approach grounded in access, human rights, and equity and ensuring a sustainable response.

This Strategic Plan will build on the well-established decentralized and integrated Belize HIV/STI/TB response to enhance access to services further. It will leverage the BHIS to provide comprehensive real-time data for policy, programmatic decision making, and individual patient care. This Strategic Plan will build on the gains made in preventing mother to child transmission of HIV, Syphilis, and Hepatitis B and will facilitate the achievement of elimination of mother to child transmission (EMTCT) status. The Strategic Plan will build on the successes in creating an enabling environment achieved through legislative reforms and strategic litigation. There will be continued empowerment and engagement of civil society organizations, key populations, and affected communities to advocate for policy and pro-health legislations and to participate in program design, planning, delivery and monitoring and evaluation. The engagement with CSOs and affected communities would be scaled-up to deliver the essential package for services to the key populations and those difficult to reach by the traditional health care system, including migrants.

The people-centered approach grounded in human rights and equity will position Belize to achieve UHC for these diseases. It will contribute to a reduction in new infections and related deaths while improving health and wellbeing. It will guide efforts to prioritize the prevention and scale-up of highly efficacious treatment for these conditions. New strategies, approaches, and technologies such as Pre-exposure prophylaxis (PrEP), non-occupational and occupational post-exposure prophylaxis (PEP) and same-day or early initiation of optimized treatment will be implemented. Differentiated models of service delivery will be introduced for greater reach, impact, and efficiency for sustainability.

The integrated approach in responding to the HIV/STI/HIV and TB epidemics is critical in providing comprehensive and coordinated care, particularly for persons with multiple infections and co-morbidities. This will be strengthened for greater coordination and more effective use of systems, processes, and resources to achieve universal health coverage and sustainability.

Belize, unlike many other Caribbean countries, has reported an increase in new infections and AIDS-related deaths. Key populations –MSM and TG persons -and other vulnerable groups such as prisoners and migrants continue to be disproportionately affected by the HIV epidemic. More men in Belize are infected annually by TB and HIV and have greater mortality than their female counterparts. Yet, fewer men access testing and health care services. This Strategic Plan will focus on creating demand for the services targeting men. The dissonance between the age of access and the age of consent, discrimination in the health care setting, and the absence of adolescent and youth-friendly spaces continue to hinder access to sexual and reproductive (SRH) health services for adolescents and young people. Belize, Stann Creek, and Cayo districts continue to be disproportionately burdened by HIV/STI and TB cases and associated mortality.

Based on 2019 reporting, there are significant gaps in the HIV testing and treatment cascade. Achieving the 90-90-90 targets by the end of 2020 is beyond reach. Belize, therefore, will focus on achieving the 90-90-90 targets by the end of 2025 as interim targets to 95-95-95 and the end of AIDS by 2030. This Strategic Plan crafts a prioritized and tailored response that is data-driven, evidence-based, and impact results-oriented to achieving the 90-90-90 and ultimately towards ending HIV/STI/VH and TB as public health threats.

This Strategic Plan is developed at a time when the world is faced with the COVID-19 pandemic that has exposed the inadequacies of investments in public health, the persistence of profound economic and social inequalities, and the fragility of many key global systems and approaches.[15] The COVID -19 pandemic has challenged governments and health systems globally, regionally, and at country levels. Due to restrictive COVID-19 public health measures, global evidence suggests that key populations and PLHIV are particularly impacted. A regional assessment conducted by the Pan Caribbean Partnerships against HIV and AIDS (PANCAP) showed significant interruptions in HIV prevention, treatment, care, and support services and disruptions in the supply chain management systems. On the other hand, the challenges of COVID-19 have resulted in innovations for service delivery, including the use of technology for capacity building and for keeping communities connected. New approaches for coordination, prevention and treatment that are cost-saving were implemented, such as virtual planning sessions, self-testing and family pick up of ARVs, among many others. The full impact of COVID-19 in achieving the global and national targets is unknown but expected to be significant. This Strategic Plan, therefore, provides Belize the opportunity to embrace and scale-up the innovations and newer approaches to service delivery, especially in the immediate and short term as the pandemic continues. It presents an opportunity for Belize to evaluate their effectiveness as smart investments and institutionalize these as long-term strategies for impact and sustainability.

The impact of the COVID-19 pandemic on the economies of Caribbean countries is significant. Many countries will experience reductions in GDP, while some may experience negative growth.

[15] https://www.unaids.org/sites/default/files/media_asset/20200909_Lessons-HIV-COVID19.pdf

The fiscal space will become restrictive, and therefore prioritization across sectors will become crucial for governments[16]. In this Strategic Plan, Belize will focus on accruing financial and technical efficiencies through innovative financing models and partnerships such as social contracting for CSOs. The National Health Insurance (NHI) will be engaged to conduct cost-benefit analyses to expand the menu of services for expanded geographic coverage and greater involvement of the private sector in service delivery.

Bold leadership and political will are central to the implementation and success of this Strategic Plan. This Strategic Plan is a recommitment from the GoB to ending HIV/STI/VH and TB as public health threats in Belize.

The Strategic Plan outlines the Vision, Mission, Goals, Strategic Priority Areas, Priority Interventions, and Actions for the national response to HIV/STI/VH and TB. It includes a monitoring and evaluation plan and an implementation plan with clearly identified lead implementers and collaborating actors.

Guiding principles

This Strategic Plan is anchored in the three dimensions- access, coverage, and financial protection- of Universal Health Coverage and will be led by the GoB. The Strategic Plan applies a public health approach that considers the local epidemiology and context. It prioritizes high impact interventions for all persons in Belize. It pays specific attention to the key populations, those at increased risk and with the greatest need to prevent HIV/STI/VH and TB, promote health, and to prolong life. The Strategic Plan is people-centered and focuses on ensuring social justice in delivering services in collaboration with those infected and affected. It is designed to promote a long-term, sustainable response.

The following principles guide the strategy:

- Universal health coverage
- Effective, Bold, and Sustained Political Leadership and Accountability.
- National ownership
- People-centered service delivery
- Evidence-based high-impact interventions, services, and policies that are based on the epidemiology of the diseases and the local context.
- Social Justice- Equity, Human Rights and Participation
- Partnership, integration, and linkage with relevant sectors, programs, and strategies;
- Inclusiveness and Collaboration and Meaningful engagement and empowerment of people with HIV/STI/VH and TB.

[16] https://www.iadb.org/en/improvinglives/weathering-coronavirus-storm-caribbean

Methodology of Development of the NSP 2021-2025

The National HIV/STI/VH and TB Strategic Plan 2021-2025 was developed under the direction of the NAC and the MOHW, in collaboration with technical partners and national stakeholders, including but not limited to other Government Ministries, Professional Organizations, United Nations Agencies, the National Health Insurance, CSOs, the Private Sector, Key Populations, and PLHIV. The Global Fund, through UNDP, the principal recipient for the Belize Global Fund Grant, and the PAHO provided the resources for the development of this Strategic Plan.

The GoB established a technical steering committee to lead the development process. The steering committee comprises representatives of the NAC, MoHW, UNDP, and PAHO.

The development process started in the last quarter of 2019. The GoB commissioned, with support from PAHO, an assessment of the 2016-2020 NSP and situational analysis. The situational assessment and response analysis were conducted using both primary and secondary data collected between October and December 2019 and at a national stakeholder consultation held in Belize City in November 2019. The report from these processes outlined the strengths and challenges in responding to HIV/STI/VH and TB and made recommendations for this Strategic Plan. In the last quarter of 2020, the GoB, with support from the Global Fund through UNDP and PAHO, commenced developing this Strategic Plan. National stakeholders met in October 2020 and reviewed the progress, gaps, and challenges in the response to HIV/STI, VH and TB. They also identified opportunities, technical cooperation needs, and innovative strategies to scale-up prevention, care, and treatment services. The national consultation also formulated consensus-based recommendations that informed the development of this integrated multi-disease National Strategic Plan 2021-2025. The technical steering committee reviewed drafts of the Strategic Plan. In December 2020, at a national review meeting, national stakeholders provided feedback and comments, which were incorporated to produce the final Belize National HIV/STI/VH and TB Strategic Plan 2021-2025. A smaller technical group with M&E competencies from UNDP, PAHO, NAC, MoHW and CSO reviewed the draft M&E plan, indicators and targets and recommendations were incorporated to produce to the final plan.

CHAPTER 2

Country Context

Demographics

Belize is a small English-speaking country in Central America, bordered by Mexico on the north, Guatemala on the west and south, and the Caribbean Sea to the east. It is the only Commonwealth country in Central America with its government patterned on the Westminster system. The history, culture, politics, and health system of the country are aligned to that of the Caribbean. Given the country's unique geographical location in Central America and the Caribbean, the country is a full member of CARICOM, and also of the Central American Integration System (SICA) and the Council of Ministers of Health of Central America (COMISCA).

Over the past twenty years, the demographics of Belize have changed. There are four main ethnic groups: Mestizo (Hispanic, Latinos, reflecting the dominant ethnic grouping in Central America) now represent half the population; Creoles (mixed descents mostly residing in Belize City and Belize District) are currently 21% of the population; indigenous Maya (Mopan, Ketchi, Yucatec) make up 10% of the population; and the smallest ethnic group is the Garifuna at 6%. Other ethnicities account for 10% of the population and include Mennonites, East Indians, Middle Eastern, Chinese & Caucasian.[17]

Belize has a low population density, and the 2020 mid-year population estimates show that the population is 419,199.[18] The male-female distribution remains practically unchanged as reported in the post census estimates for 2020 (50 % males, 50 % females). Belize has a young population. In 2010, 35.6% of the population was under 15 years of age, while 53.7 % were 20 years of age or older. The elderly (60 years of age or older) accounted for 6.1 % of the total population. The 2020 mid-year population estimates remain the same.[19]

The country has six administrative districts and four health regions. The urban-rural distribution shifted from 48.6% urban and 51.4% rural in 2000, to 44.7 % % urban and 55.3% rural in 2020. The Belize District continues to have the largest portion, with 30.5% of the population (127,683), followed by the Cayo District with a 24.4% (102,115), Orange Walk with 12.7% (53,373), Corozal with 12 % (50,490), Stann Creek 11% (46,015) and the Toledo District maintained the lowest proportion of 9.4%(39,525), according to the mid-year estimates 2020.[20]

Economy

Although Belize has the third-highest per capita income in Central America, the average income figure masks a huge income disparity between rich and poor.
A key government objective remains to reduce poverty and inequality.[21] For poverty to decrease, there needs to be an improvement in the employment rate and an increase in wages at pace with inflation rates.[22]

Belize vulnerabilities are typical of Caribbean small island developing states (SIDS). These include:

- High dependence on a narrow range of resources in the agriculture and tourism sectors for economic growth;
- High levels of vulnerability to external shocks resulting from the lack of economic diversity;
- High levels of exposure to frequent, devastating hurricanes and flooding with long-lasting consequences;
- Vulnerability to climate change and sea-level rise is a critical factor in development and resilience;

[17] Ministry of Health Belize (2019): END TB Belize. Belize National Strategic Plan for TB Control and Prevention 20219-2022
[18] http://sib.org.bz/
[19] http://sib.org.bz/wp-content/uploads/2018_Abstract_of_Statistics.pdf
[20] ibid
[21] https://www.indexmundi.com/belize/economy_profile.html: Belize Economy Profile 2018
[22] Ministry of Health Belize. Health Sector Strategic Plan 2014-2024

- High rates of migration and population movement in the Central American region.[23]

Belize continues to recover from the 2014 global recession and hurricane Michael in 2016. The economy is expected to grow to a modest 2.3% in 2019, led by services and private consumption. Before COVID 19 pandemic, the Belize economy is forecasted to accelerate to around 2% annual growth, supported by tourism growth and the resulting impact on the retail and transport sectors. [24] The COVID -19 pandemic impact is still unknown; however, based on global predictions, it is likely that it could negatively impact economic growth, including in Belize.

Basic Health Indicators

Belize has a young population. In 2018, 35.59% of the population was under 15 years of age, while 53.67% were at least 20 years of age. The elderly (at least 60 years of age) accounted for 6.1% of the total population. Life expectancy at birth was estimated at 68.1 years for males and 73.8 years for females in 2018. Women of childbearing age (15–49 years) accounted for 52.67 % of the total female population. The total fertility rate for 2015 was 2.6 children per woman of childbearing age. Based on the PAHO Health Information Platform for the Americas, the reported maternal mortality ratio for Belize in 2017 was 138.1/100,000 live births, while the reported neonatal and infant mortality ratios were 9.9 and 14.5/1,000 live births, respectively.

Based on the WHO Noncommunicable Diseases (NCDs) Country Profile for Belize (2018), NCDs are estimated to account for 67% of all deaths, with more females dying from NCDs as compared to males. Cardiovascular diseases accounted for 26% of deaths, cancers 14%, diabetes 8%, chronic respiratory diseases 3% and other NCDs 17% of proportional mortality.

Since 2000, the probability of premature deaths from NCDs has steadily decreased for both males and females, however, both are higher than the global targets. Obesity as a risk factor for developing NCDs is in continual rise for both males and females, way above global targets. Elevated blood pressure as another risk factor, was on a slow downward trend since 2000 but still above global targets.[25]

Belize Health System

The Ministry of Health and Wellness is led by a Minister of Health and Minister of State in charge of Primary Care and the National Health Insurance (NHI). The Chief Executive Officer (CEO) reports to both Ministers according to their jurisdiction. The Director of Health Services (DHS) manages the technical program areas and Regional Health Authorities. The Belize Health Information System (BHIS)Technical Team reports to the CEO of Health along with Administrative Officers and support staff.

The Belize health services are a mix of private and public. However, the GoB remains the main provider of care. The Belize health system comprises of primary and secondary care level health facilities. There are four health regions organized as Northern, Central, Western, and Southern regions.

[23] PANCAP. Caribbean Regional Strategic Framework 2019-2025.
[24] Situational Analysis for the Belize National HIV/STI, Viral Hepatitis and Tuberculosis Response
[25] Situational Analysis for the Belize National HIV/STI, Viral Hepatitis and Tuberculosis Response

Health regions are headed by Regional Health Managers, who, with Deputy Regional Managers and regional teams, are responsible for ensuring individual and population-based services. The Central region has a single national referral hospital- Karl Heusner Memorial Hospital Authority (KHMHA). The KHMHA offers services in the areas of haemodialysis, neurosurgery, cardiology (including intervention cardiology), cardiovascular surgery, neurology, as well as the basic services of general surgery, internal medicine, obstetrics and gynecology, and pediatrics. The other regions have one community and one regional hospital each. Regional Hospitals provide surgical facilities and offer service in the general surgery, internal medicine, obstetrics and gynaecology and paediatrics. General practitioners run community hospitals. Polyclinics have a larger cadre of staff and provide laboratory, imaging and community-based services such as immunization, prenatal care, vector control, personal curative services, 24-hour emergency. Health clinics and health posts located at the community level are usually staffed with a Rural Health Nurse and, in some cases, a physician. There are 11 polyclinics, 36 health centers, 52 health posts, and one mental health facility. [26], [27]

Belize introduced its National Health Insurance (NHI) scheme focused on the delivery of Primary Health Care services through a network of Primary Health Care Providers based a pay-per-performance scheme.

In the past, health care was primarily financed by the government. Today, there exists a growing private health insurance and private investment in health.

Domestic health expenditure as a percentage of general government expenditure has declined from 13.1% in 2010 to 11.8% in 2015 and 11.0% in 2017. In 2017, domestic government health expenditure represented 68% of the current health expenditure and 3.8 % of GDP.

Out of pocket (OOP) expenditure as a percentage of current health expenditure has slowly and consistently decreased from 30.1% in 2005 but remains high at 24.2% in 2017.

OOP expenditure compares favorably with neighboring countries and other Caribbean countries but remains above the recommended threshold to protect against financial impoverishment.[28] Prioritization for financial efficiencies, therefore, will be central to this Strategic Plan to achieve universal health coverage.

In 2010, Belize had 251 doctors or 10.1/10,000 population for the entire health system. This increased in 2017 to 422 or 11.2/10,000. [29] The Human Resource Assessment conducted in 2016/2017 showed low specialist- population density that can significantly impact health outcomes. For example, there was four internal medicine specialists, however, 16 specialists are needed to achieve universal health coverage. Similar gaps are noted with other specialist[30]. Findings of this assessment were used to craft the Belize Human Resources for Universal Health Strategic Plan 2019-2024.

[26] EU project: The strengthening of critical maternal and neonatal services in Belize

[27] Belize Human Resources for Universal Health Strategic Plan 2019-2024

[28] https://apps.who.int/gho/data/node.main.HEALTHFINANCING?lang=en

[29] https://apps.who.int/gho/data/node.main.HWFGRP_0020?lang=en

[30] Belize Human Resources for Universal Health Strategic Plan 2019-2024

CHAPTER 3

STATE OF THE EPIDEMICS

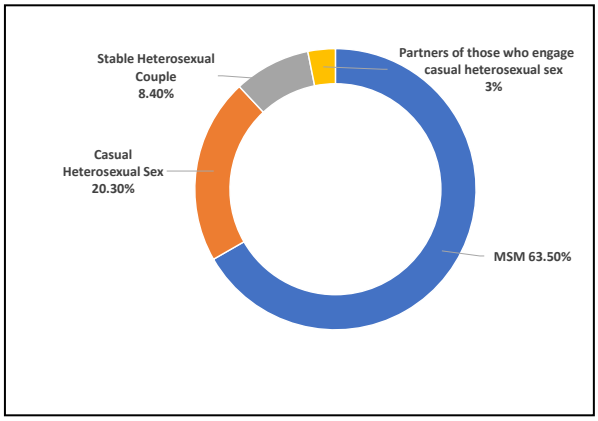
HIV

Belize reported an HIV prevalence of 1.8% in 2018 with an estimated 4900 [4,400-5,400] PLHIV. Of these, 4,700 [4,300-5,200] are adults, and 170 [160-190] are children 14 or under. New HIV infections among adults increased by about 7% between 2010 and 2018, while on average, new infections declined in the Caribbean region by 16 % for the same period. In 2019 there were 205 incident HIV cases compared to 254 and 223 in 2018 and 2017 respectively.

Based on prevalence data and risk factors, the key population groups include MSM and TG persons in Belize. Vulnerable populations include adolescent girls and young women, young adults, prisoners, men and migrants.[31] In many places, sex workers are considered key populations. However, in Belize, their HIV prevalence in 2016 is 0.9%

Key populations account for higher HIV prevalence compared to the general population. The HIV prevalence among MSM is 13.9%. Prevalence data for TG persons in unavailable. The 2018 Modes of Transmission study estimates that 2 of every 3 new infections occurred among MSM. The additional 20% of new infections occurred because of casual heterosexual sex; with the remaining 8% and 3 % accounted for by stable heterosexual couple and the partners of those who engage in casual heterosexual sex. The HIV prevalence for SW is 0.9% suggesting, contrary to other places, that this may not be key population group for Belize. However, an epidemiological and cost modelling for sustainable HIV/AIDS Finance Planning in 2017, concluded that MSM, female sex workers (FSW), and commercial FSW are contributing to over 85% of the new HIV infections annually[32].

There is no data on the burden of HIV on transgender persons, although there is an estimated 596 transwomen in Belize based on the 2018 size estimation process[33].



Ratio Male to female distribution ratio of 2:1 (170 males and 84 females) in 2018 continued similarly in 2019 with more men (119) compared to women (86) diagnosed HIV positive. Male diagnosis was higher than that of females in every age-group except in the 25-29 years age-group. More than three-quarters (78.5%) of all cases diagnosed in 2019 are between the ages of 20-49, while persons >50 years accounted for 24%, almost 1 in every four new infections.

[31] https://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf
[32] Belize HIV/TB Evaluation, Field Based Evaluation, September 2020.
[33] Estimation of Key Population Size of Men who have Sex with Men and Transgender Women in Belize, 2018

The districts of Belize, Stann Creek, and Cayo continue to experience the highest burden of the infection. Belize District, which has 30.3% of the population, accounted for more than half, 54.7%, and 55.1% of all cases in 2018 and 2019, respectively.

Table 1: HIV cases by District in 2019

District	Total population- 2018 mid-year estimates	Percentage of the population- 2018 mid-year estimates	Number of HIV cases 2019	Percentage of HIV cases 2019
Corozal	48429	12.2	12	5.9
Orange Walk	51749	13.0	13	6.3
Belize	120602	30.3	113	55.1
Cayo	96197	24.2	44	21.5
Stann Creek	43459	10.9	20	9.8
Toledo	37614	9.4	3	1.5
Total	398050	100.0	205	100

Social Determinants and Risk Factors

General knowledge of HIV and AIDS

The majority of the people living in Belize have heard about AIDS- 91.2% women and 92.5% men. Among women aged 15-49 years, only 69.2% knew that HIV could be prevented by having one uninfected partner and using a condom, 56% rejected at least two common misconceptions, and 45.8% had comprehensive knowledge of HIV and AIDS. For men, knowledge was slightly higher; 72.9% knew that HIV could be prevented by having one uninfected partner and using a condom, 55.4% rejected at least two common misconceptions, and 46.5% had comprehensive knowledge of HIV and AIDS. [34] Toledo district followed by Cayo had the lowest knowledge of HIV transmission and misconception. Women with no education had the lowest comprehensive knowledge of HIV transmission (18.7%) compared to 66.9% in women with higher education. Women in the poorest wealth quintile had the lowest knowledge (24.7%) compared to 61.6% in the richest wealth quintile. The Mayans (23.2%) had the lowest knowledge. The situation is similar for men.

Knowledge of all three (pregnancy, delivery, and breastfeeding) means of transmission of HIV from mother to child is 55.9% for women and 53.4% for men and was lowest among persons with no education, in the lowest wealth quintile and among the Mayans.

Knowledge of HIV testing

Among people aged 15-49, 83.8% of women and 79.3% of men knew where to get an HIV test, and 63% of women and 51% of men had an HIV test in the recent months and know their results.

[34] https://www.unicef.org/belize/media/936/file/Multiple%20indicator%20cluster%20survey.pdf

Sexual behavior
The man number of lifetime sexual partners among 15-49 years old is 7 for men and 2 for women.

Stigma and Discrimination
Accepting attitudes towards PLHIV is 16.3% in women and 18.2% in men for all five parameters* used to measure stigma and discrimination. Lowest accepting attitudes are among the Mayans, people with no education and in lowest wealth quintile. [35]
*__*Willingness to care for a family member with AIDS, would buy vegetables from a shopkeeper or vendor who is HIV positive, a female teacher who is HIV positive should not be allowed to teach in school, would not want to keep a secret that a family member is HIV positive, and an HIV positive child should not be allowed in school.*__

The Stigma Index Survey conducted in 2019 shows that there has been progress, but stigma and discrimination continue to impact health for PLHIV. PLHIV are still do not disclose their status, fearful of stigma and discrimination, particularly from family and loves ones. While there has been improvement from 2013 to 2019, PLHIV are still excluded from social and religious gatherings and from family activities and are denied employment based on their HIV status.
PLHIV (44.4%) delayed accessing treatment for fear that they will be treated badly or that a health care worker will disclose their status, and 12.2% delayed because of a prior bad experience with health care workers. More than two-thirds (68.9%) delayed accessing services because they were afraid that other persons will find out their status and a half (49.6%) delayed accessing services because they were not ready to deal with their HIV infection.

The 2019 Belize Stigma Index Survey showed that ***perceived fear*** of or a prior bad experience hinders access services. One-fifth of PLHIV reported that healthcare workers disclosed their status and have avoided physical contact or have taken extra precautions when attending to them. PLHIVs were forced to disclose their HIV status or to take an HIV test to obtain a travel visa, when applying for a job, to access educational institution or scholarship and for health care and medical insurance. Many were denied visas or permission to enter a country. PLHIV were unable to access redress for these human rights violations; almost one-third (32%) did not where to go or how to take action, 17% felt intimidated or scared to take action, and 9.4% had little confidence in the outcome of any action taken. Moreover, 66.1% of PLHIV did not know of laws that protect them from stigma and discrimination.

PLHIV experiences of stigma and discrimination also corresponded strongly to key population identity, with TG people most frequently reporting experiences of stigma (30.7%), followed by men who identify as gay/homosexual (25.0%) and thereafter by people identifying as MSM (13.6%) and bisexual (9.5%) - suggesting that stigmatization and discrimination may be more closely linked to sexual orientation and gender identity than to HIV status. 15% MSM have felt excluded from family activities and 20% have felt that family members made discriminatory remarks or gossiped about them and 25% avoided accessing health care services. [36]

[35] https://www.unicef.org/belize/media/936/file/Multiple%20indicator%20cluster%20survey.pdf
[36] Belize Stigma Index Survey 2019

Domestic Violence

Among all women aged 15-49 years, 6.7% believe that a husband is justified in beating his wife in various circumstances. This believe is slightly higher in rural (7.7%), than urban (5.6%) areas and in Stann Creek (11.7%) and Corozal (10.6%), among the poorest quintile (13.2%) and those with secondary education (9.1%). The belief was highest among girls 15-19 years (8.7%) Mayan (17.5%) and Garifuna (10.5%) women.

On the other hand, 7.3% of men believe that a husband is justified in beating his wife. This believe is slightly higher in rural (8.2%), than urban (6.0%) areas and in Toledo (20.4%) and Stann Creek (12.9%), among the poorest quintile (14.9%) and those with no education (8.8%).

Adolescent girls 15-19 years accounted for the largest proportion (8.7%) among all age-groups who believe that husband is justified in beating his wife in various circumstances. The believe was highest among boys 15-19 years (10.3%) Mayan (18.8%) and East Indian (14.5%) men.

Gender- based Violence (GBV) :

According to the Gender-Based Violence Report from the Ministry of National Security, in 2018, there were 2061 cases of domestic violence. 75% of the cases occurring among persons older than 25 years.[37] Three quarters (78%) of the domestic violence victims were females, and 43% of the cases occurred in the Belize District. There were 90 cases of sexual violence in 2018; all were females. Among these 35 cases were 10-14 years old and 18 cases 15-19 years old.

Key and Vulnerable Populations

Belize has determined that MSMs and Transgender persons are key populations that will be prioritized in this plan. Vulnerable populations will include adolescents, women and girls, migrants and prisoners

MSM

The average age of sexual debut for MSM 14.7 years. 6.9% of MSM had their first sexual act at ten years or younger. Early sexual debut-10 years and younger- is greatest in Belize District. Majority of the MSM had their first sexual encounter with someone older, who was a friend (43.5%), neighbor (14.1%), friend (13.8%) and family member (10.6%). Almost two-thirds of MSM have multiple concurrent relationships and used a condom the last time they had anal sex with a biological male. One third had unprotected anal sex with a biological male partner within the last three months. The reasons for not using condoms were primarily the unavailability of condoms and the perception that condoms were not needed[38]. Younger MSMs are more engaged in sex work.

About 70% of MSM having had an HIV test at some point in their lives; among these 17% had done so in the last year, two thirds within the previous two years (66.6%); and 16,5% three years or more ago. 98.2% of persons of MSM who tested received their results.

[37] https://bco.gov.bz/wp-content/uploads/2019/10/Belize-Crime-Observatory-Report-on-GBV-Published-June-2019.pdf

[38] Estimation of Key Population Size of Men Who Have Sex with Men and Transgender Women in Belize, 2018

MSM continue to face stigma and discrimination. They felt excluded from family gatherings because of their sexual orientation and experienced family members making discriminatory remarks or gossiping about them. 43.4% MSMs have disclosed to a family member that they were having sex with another man. MSMs also face sexual, physical, mental, and emotional abuse from their partners.[39]

Sex Workers

The HIV prevalence for SW is 0.9% suggesting, contrary to other places, that this may not be a priority group for Belize. This resulted in a de-emphasizing of the response to sex workers, particularly as most of donor funding prioritized MSM and TG persons. However, an epidemiological and cost modelling for sustainable HIV/AIDS Finance Planning in 2017, concluded that MSM, female sex workers (FSW), and commercial FSW are contributing to over 85% of the new HIV infections annually. Belize stakeholders agreed that the paucity of data on sex workers should be addressed in this strategic plan for a better understanding of their risk and vulnerabilities for HIV/STI/VH. Sex workers therefore will be treated as a vulnerable population to receive the essential package of services. Moreover, data collection will be strengthen- surveys and routine- to include data on sex workers.

Adolescents

One-fifth (40/205) of new HIV infections in 2019 occurred in the 15-24 age-group. Almost one in four (23.1%) adolescents between 13-15 years of age reported having sex with significantly higher rates among adolescent boys, 32.9% compared to girls, 13.5% [40].

Among young females aged 15-24, 60% reported ever having sex and among them 5.8% initiated sex before the age of 15 years. Similarly, 60% of young men reported ever having sex, 14.9% had sex before 15 years of age. About one in five young women and two in five young men reported having had sex with a non-marital, non-cohabiting partner in the last 12 months. Of these, 56 percent of women and 67 percent of men reported using a condom.

Twenty-two percent of young women and 36 percent of young men who have never married/in union report to have had sex with a non-marital, non-cohabiting partner in the last 12 months. Of which, 56 percent of women and 62 percent of men reported using a condom. [41] Among 15–19-year-olds who are sexually active in the last 12 months, less than half have ever been tested for HIV[42]

Among all women aged 15-49 years, 5.5% were married before the age of 15, the majority from the poorest quintile and with no educational background[43].

Two thirds or 61% of 15-19 years old who are married or in a union among all women aged 15-49 do not use any method of contraception. The non-use of any method of contraception among all women aged 15-49, was highest in the poorest quintile, and among those with no educational background.[44]

[39] Estimation of Key Population Size of Men Who Have Sex with Men and Transgender Women in Belize, 2018
[40] https://www.who.int/ncds/surveillance/gshs/2011_GSHS_FS_Belize.pdf?ua=1
[41] https://www.unicef.org/belize/media/936/file/Multiple%20indicator%20cluster%20survey.pdf
[42] ibid
[43] ibid
[44] ibid

While the total fertility rate for Belize of 2.6, adolescent birth rate is 74/1000 in 2015 increased from 60/1000 in 2011[45]. Among women aged 15-49 years, 1.8% had a live birth before the age of 15 years and 21.1% before the age of 18 among 20-49 years old.
Adolescents aged 15-19 years, the largest proportion among all women who believe that a husband is justified in beating his wife in various circumstances*.[46]
**If she goes out without telling him, If she neglects the children, If she argues with him, If she refuses sex with him, If she burns the food, If she wastes the money, If she is seen talking to another man who is not a relative, If she does not keep the house clean.*

AIDS-related death. Since 2010, AIDS-related deaths have increased by 90%. In 2018, there were 105 HIV related deaths, with 38 females and 67 males (1:1.7), a rate of 2.6/10,000 population. In 2019, this decreased to 80 deaths; however, mortality continued to be higher in men (44 deaths) than in women (36 deaths). Most of the deaths occurred in males of working age (35-50 years), the sub-population most affected by HIV. This is out of step with the regional and international trends of declining AIDS-related deaths: in the Caribbean, AIDS-related deaths fell by about a third over the period 2013-2018. In 2019, most AIDS-related deaths occur in the Belize District (53/80, 66%), which has the highest HIV incidence, followed by Cayo (12/80, 15%), and Stann Creek (9/80, 11%).

Tuberculosis:

TB incidence for 2019 is estimated at 100 cases or 27 per 100,000 and represents a 9% decrease from 2018. HIV positive TB incidence is estimated at 20 cases or 5.2 per 100,000 population.

MDR/ RR TB is estimated at zero. The estimated TB mortality among persons who are HIV negative is greater than those HIV positive (9 cases or 2.2 per 100,000 population vs 3 cases or 0.81 per 100,000 population).[47]

[45] https://mics-surveys prod.s3.amazonaws.com/MICS4/Latin%20America%20and%20Caribbean/Belize/2011/Final/Belize%202011%20MICS_English.pdf
[46] ibid
[47] https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&lan=%22EN%22&iso2=%22BZ%22

Table 2: Tuberculosis cases by age groups in 2018

	Females	Males	Total	Proportion by age-groups
0-4	0	0	0	0
5-14 years	0	0	0	0
15-24	3	6	9	10
25-34	10	11	21	23
35-44	4	13	17	19
45-54	5	9	14	15
55-64	6	14	20	22
>64	2	8	10	11
Total	**30**	**61**	**91**	**100**

The Belize Ministry of Health and Wellness, in 2019 reported 91 persons diagnosed with TB disease with is 9 cases or 18% less than the estimated 100 cases. This was less compared to 2018 where 99 persons were diagnosed. Among the 91 cases diagnosed, 89% had rapid diagnosis, 79% were bacteriologically confirmed and 98% were pulmonary TB. All bacteriologically confirmed cases were tested for RR. There were no cases of MDR/RR TB. [48]

Most TB cases diagnosed in 2019 occurred among men (61/91, 67%) compared to women (30/91, 33%). No children (0-14 years) were diagnosed with TB. One-third of all cases were persons 55 years and older and more than one-fifth (21/91, 23%) were among those aged 25-34 years. [49]

Belize, Cayo and Corozal districts accounted for 65% of all cases.

TB/HIV coinfection

In 2019, 16 persons were diagnosed with TB/ HIV coinfection. This represents 48% reduction compared to 2018. All persons diagnosed with TB/HIV coinfection in 2019 were placed on antiretroviral therapy.[50]

TB treatment success rate has declined in 2018 (66/99, 67%) compared to 2017 (83/117, 71%). The average treatment success rate for the period of 2015-2018, is 66%. Comparatively, TB/HIV treatment success rate is lower and declined from 64% in 2017 to 48% in 2018.

TB remains the fourth leading cause of death among all communicable, maternal, neonatal and nutritional diseases. In 2019, 12 persons died of TB, nine persons were HIV negative and three HIV positive. TB mortality is 2019 was reduced by 20% from2018. [51]

[48] ibid
[49] http://www.stoptb.org/resources/cd/BLZ_Dashboard.html
[50] http://www.stoptb.org/resources/cd/BLZ_Dashboard.html
[51] ibid

Sexually Transmitted Infections

The treatment for STIs is primarily through a syndromic approach, and all data available from the MOHW Surveillance Unit with an average of 1500 annual infections over the last five years. Pelvic Inflammatory Diseases account for the largest proportion, 47.1% of all cases, followed by trichomonas 21.8% and anogenital warts, 9.5%. Syphilis and genital herpes are also included among the more common forms of STIs.

Table 3. Cases of Sexually Transmitted Infections (STIs) reported on the BHIS 2015-2019

STI	2015	2016	2017	2018	2019	Total
Anogenital Warts	89	145	174	217	129	754
Chancroid	4	4	2	4	2	16
Chlamydia	8	6	13	5	3	35
Crab Louse	0	0	0	0	1	1
Genital Herpes	50	62	46	37	39	234
Gonorrhea	16	11	13	15	6	61
Pelvic Inflammatory Diseases	957	692	725	741	608	3723
Syphilis	77	98	75	132	127	509
Trichomonas	266	276	496	376	310	1724
Unspecified STIs	89	132	90	128	134	573
Urethral Discharge	38	59	68	55	52	272
Total	1594	1485	1702	1710	1411	7902

Overall, females report disproportionately more STIs diagnosed in 2018 (80.53% females vs. 19.47% males) and 2019 (80.73% females vs. 19.27% males). This could be explained, in part, by the ongoing efforts by the MCH program, which routinely includes STI testing as part of antenatal care. In addition, among the 81% men who participated in the modes of transmission study, 30% reported self- treating for STIs. Also, as evident across the Caribbean, men are generally less likely to seek health care and therefore cases among men are less likely to be picked up by the BHIS.

Table 4: Sex distribution of cases of STIs reported on the BHIS, 2018-2019

	2018		2018 Total	2019		2019 Total
STI	Female	Male		Female	Male	
Anogenital Warts	174	43	217	105	24	129
Chancroid	2	2	4	0	2	2
Chlamydia	1	4	5	1	2	3
Genital Herpes	15	22	37	23	16	39
Gonorrhea	0	15	15	0	6	6
Pelvic Inflammatory Diseases	741	0	741	608	0	608
Syphilis	66	66	132	58	69	127
Trichomonas	360	16	376	295	15	310
Unspecified STIs	18	110	128	48	86	134
Urethral Discharge	0	55	55	0	51	51
Grand Total	1377	333	1710	1139	272	1411

The trends for STIs by district follow the same patterns observed for HIV, TB and TB/HIV infection, consistent with the observation that Belize, Cayo and Stann Creek have the highest incidence of STIs reported in 2019.

Hepatitis

Current data on the epidemiology of Hepatitis in not available. Earlier data, in 1996, suggested high prevalence of Hepatitis B. In a study conducted in the Stann Creek district, 43.3% of students were positive for HBcAg suggesting that most children would have contracted Hepatitis B infection prior to starting school and therefore recommended the integration of HBV immunization into the routine infant immunization program.[52] Similarly, in 1995, of 330 workers tested, 94 (29%) were positive for antibody to HBV core antigen (anti-HBc). The presence of anti-HBc differed significantly among ethnic groups: Mestizo, 4%; Creole, 33% and Garifuna, 57%.[53]

In February 2019, the Hepatitis B birth dose was included in the national vaccination schedule. The Hepatitis B Birth dose vaccine coverage is 79% <24 hours (4995/6350x100) and 92% total 5868/6350x100). The Hepatitis B containing vaccine (DPT/Hep B, Hib or pentavalent) vaccination coverage (PENTA3) for 2019 is 96%, and is administered by public health staff or midwives, before discharge from hospital.

Hepatitis B coverage among 1 years old in 2018 in 98% [54]

Cervical Cancer

Cervical Human Papilloma Virus (HPV) is the most common sexually transmitted infection globally is the primary cause of precancerous and cancerous cervical lesions. HPV subset 16 and 18 are responsible for about 70% of cervical cancer globally.

[52] https://pubmed.ncbi.nlm.nih.gov/8916807/
[53] https://pubmed.ncbi.nlm.nih.gov/7677211/
[54] https://apps.who.int/gho/data/view.main.80400

Cervical cancer is the most common cancer among women living with HIV. Compared with women who are HIV-negative, women living with HIV have a risk several times higher of persistent HPV infection, are six times as likely to develop cervical cancer and are more likely to develop it at a younger age. [55]

Cervical cancer is the second leading cause of cancer mortality among women in Belize with an age-standardized rate (ASR) of 14.9 per 100,000. Cervical cancer incidence and mortality rates in Belize are 1.5 and 1.7 times higher (respectively) than the Latin American and Caribbean (LAC) region's average; and 4.9 and 5.7 times higher incidence and mortality rate respectively when compared to North America [56] In 2013 the Epidemiology Unit at the Ministry of Health and Wellness (MOHW) issued a report on cancer in Belize.[57] There were 266 cases of cancer in 2011-2012 and reported with a standardized cancer rate of 59/100,000 population. One out of every four cancer cases is cervical cancer [23% of total cases of cancer]. Sixty cases of cervical cancer were documented and reported; 68% of cases occurred in age group 15-49 years; Belize district had the highest and Corozal the lowest incidence rates with 25.98 and 4.75/100,000 respectively.

Response Analysis

An analysis of the status of the HIV/STI/ TB/VH responses, including the management and coordination of the response, was conducted to guide the development of this Strategic Plan. There has been substantial progress in the response, including the focus on reaching key populations, engagement of civil society organizations, enhancement of the enabling environment and advancing sustainability for the national response.

This summary highlights key areas for strengthening in this multi disease integrated plan.

1. The Coordination of the National Strategic Plan 2016-2020 was led by the NAC. This multi-disease integrated plan will require greater involvement of the MoHW in the overall planning and coordination, service delivery, and monitoring and reporting. The GoB continues to demonstrate political leadership to the response.
2. Belize continues to have a generalized HIV epidemic with concentrated epidemics among key populations, primarily among MSM and TG persons. Other populations with increased vulnerability are adolescents, young adults, men, SW, prisoners and migrants.
3. There is an increase in annual new HIV infections compared to the rest of the Caribbean region. More men are diagnosed HIV positive and with TB disease and have poorer treatment outcomes. AIDS-related deaths have also increased over the past three years, with mortality higher in men compared to women. Deaths continue from TB/HIV coinfection. Belize District, Cayo, and Stann Creek are the most affected health districts for HIV/STI and TB.
4. In relation to prevention of HIV/STI/VH and TB, the following is noted:
    - ✓ The age of sexual debut is low.
    - ✓ Comprehensive knowledge of HIV and AIDS continues to be low and corresponds with low education and income levels.
    - ✓ Condom use has improved among key populations but remains low.

[55] WHO Global Strategy to accelerate the elimination of cervical cancer as a public health problem
[56] Cervical Cancer, Prevention and Control Strategic Plan
[57] Report. Cancer data explorations and assessment exercise. 2013

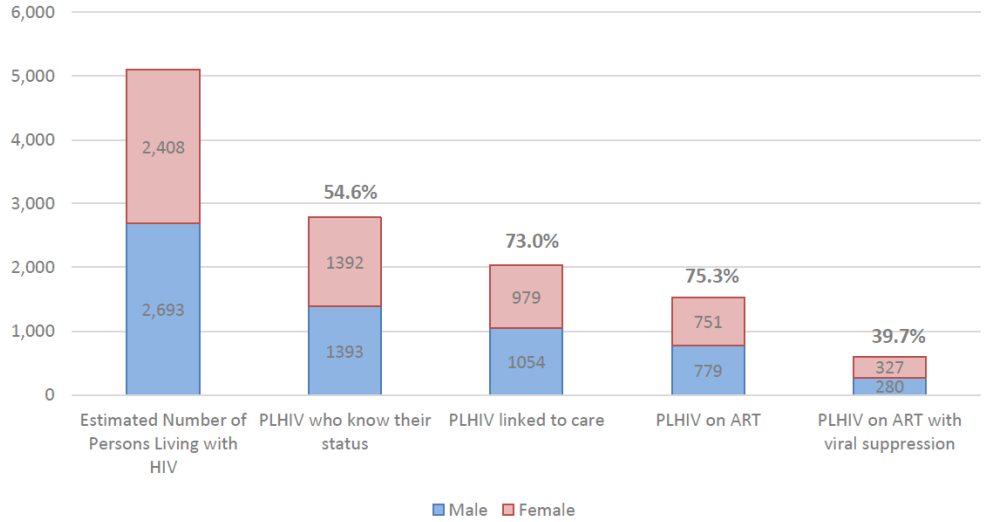
- ✓ Access to SRH services for adolescents has improved with the use of the Gillick Competency and Fraser Test. However, health care workers' inherent biases continue to manifest as stigma and discrimination hindering access to services.
- ✓ The Belize MoHW developed Cervical Cancer Prevention and Control Plan, Operational Plan and Monitoring and Evaluation Plan 2016-2020. The Ministry also developed clinical guidelines. HPV vaccines were introduced in 2016, initially targeting 10 year old girls in Standard IV and was later expanded to account for girls and boys aged 10-19. Coverage for the school year 2016/2017 was 58.8% and 2017/2018 was 62.4%.
- ✓ Domestic and GBV continue and correspond with specific sexuality and gender identities as well as educational status and income levels.
- ✓ HIV testing is lagging behind with approximately half of the estimated number of people living with HIV know their status. CSO through community tested continue to reach KPs, however, coverage remains low. HIV testing is done through provider-initiated testing and counselling. HIV self-testing is not implemented.
- ✓ STI testing is done only for Syphilis and Hepatitis B in ANC clinics and for Blood Safety.
- ✓ TB screening is done for all PLHIVs and point of care GeneExpert has been rolled out. The CSO hub has commenced TB screening using WHO symptomology questions with referral to the health care system.
- ✓ Pre- exposure prophylaxis (PrEP) is not available. Post-exposure prophylaxis (PEP) is available for health care workers but not for non-occupational exposure.
- ✓ There is greater collaboration with CSOs to deliver a prevention package of services.
- ✓ Belize is on the cusp of achieving EMTCT status. There is high uptake of HIV and Syphilis testing as well as early infant diagnosis and timely management of the HIV-infected mother and exposed infant. Hepatitis B testing has commenced but lagging due to resource constraints. These services are integrated in Maternal and Child Health (MCH) services.
- ✓ All blood and blood products are screening for HIV/STI/ VH and other infectious markers based on national protocols.

5. Treatment for HIV/STI and Tuberculosis is decentralized integrated in primary health care. Syndromic management continues for sexually transmitted infections. There is no treatment for Hepatitis C. The majority of TB cases are pulmonary TB. In the last year, there were no cases of TB in children or RR or MDR TB. Persons with HIV are screen for TB and persons with TB are screened for HIV.
6. The Treat All Policy was endorsed for HIV treatment; however treatment scale-up has been slow. Treatment guidelines have been drafted to include the use of Dolutegavir. The guidelines are not finalized, and DTG transitioning has not started.
7. Despite improvements, late entry into care persists. In 2019, the average CD4 at start of treatment was 308 which represents an improvement from 2018 and 2017 with 297 and 235 respectively. [58]
8. There remain significant gaps in the HIV treatment cascade with low treatment coverage. In 2019, of the estimated 5,100 persons living with HIV, 54.6% knew their status, and only 30% of all estimated PLHIVs were on treatment. Viral suppression is a significant issue.

[58] Focused Country Evaluation, Belize HIV/TB Evaluation, Field Based Evaluation, September 2020

9. Among the 1530 persons on treatment, 607 or 39.7% achieved viral suppression, which is 11.9% of the estimated PLHIV[59].

Graph 1: HIV treatment cascade



10. There is a shift from CD4 to viral load testing for monitoring of HIV treatment. National guidelines recommend viral load testing every six months. Viral load testing is conducted at the Central Medical Laboratory in Belize City and at Regional laboratories. In 2019, 1101 or 72% of persons on treatment accessed VL testing with an average of 1.8 viral load tests per person per year. [60]

11. Stigma and discrimination remain a major factor that hinders access to health care services, employment opportunities, and social support systems. The enabling environment was enhanced where strategic litigations to advance social justice and constitutional rights, with the 2016 Section 53 ruling decriminalizing consensual same-sex relationships. The Draft Equal Opportunity Bill that comprehensively addresses HIV and provides equal opportunity for all irrespective of sexuality or gender identity has not been passed in parliament. Stigma and discrimination continue in the health care setting from families and friends and the wider community. Self-stigma continues to a lesser degree, and improvements are attributed to the empowerment of PLHIV and the key population communities. The MoHW has a patient bill of rights but is unclear if this is being monitored.
12. The BHIS is well established in the health sector and has limited roll out to the private health and CSO sectors. The BHIS provides client, site and national level data. Systems however are lacking to generate prevalence data for populations and sub populations and to triangulate data from the BHIS, surveillance, special studies and other sources for a comprehensive understanding of the epidemics and responses.
13. HIV spending in 2018- 2019 is 4,333,438 USD of which Government's contribution is 1,915,527 USD (44.2%) and international donors, 2,259,475 (52.1%). Overall HIV expenditure for 2019-2020 decreased to 2,854,537 USD, due to the reduction in donor funding- 671,000 (23.5%).

[59] ibid

[60] Focused Country Evaluation, Belize HIV/TB Evaluation, Field Based Evaluation, September 2020

14. The increase from the GoB was minimal- 2,026,298 USD. Evidently, there was a significant shortfall in funding for the HIV response, cited as a key factor in the underachievement of the previous National HIV/STI Strategic Plan. [61] In 2017, most of the funds for the TB program was donor funded however, in 2019 with 64% of TB expenditure from public funds.

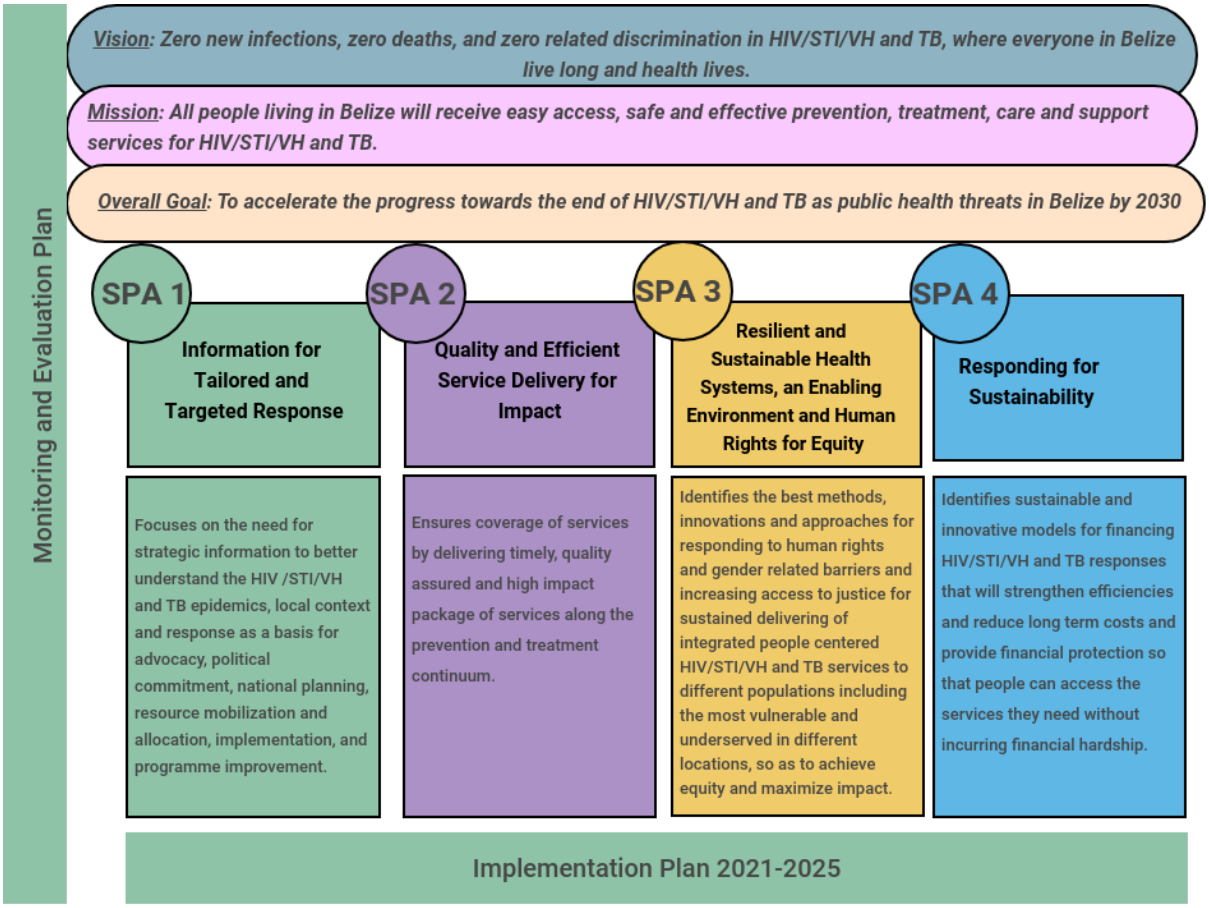
CHAPTER 4

Organization of the Strategic Plan

This document consists of three parts- the National HIV/STI/VH and TB Strategic Plan 2021-2025, a Five –Year Implementation Plan, and a National Monitoring and Evaluation Plan with five-year targets.

1. The National HIV/STI/VH and TB Strategic Plan 2021-2025 presents the current epidemiological status for HIV/STI/VH and TB, key highlights of the response analysis of the previous HIV/TB National Strategic Plan 2016-2020. It presents the vision, mission, goals, and strategic priority areas (SPA) to address HIV/STI/HIV and TB for the next five years in Belize. Each strategic priority area is detailed with specific goals, and strategic objectives (SO) used to define the five-year implementation plan.
2. The Five-Year Implementation Plan 2021-2025 details the activities based on the SO for each SPA. The implementation timelines and lead implementing and supporting agencies are identified for each activity.
3. The National Monitoring and Evaluation Plan outlines the goals and objectives of the plan, describes key M&E concepts, types of indicators and the M&E process including coordination, data collection, analysis, dissemination, and use. The M&E plan also presents the 52 indicators that will facilitate measurements along the results chain, from inputs to impact for HIV/STI/VH and TB for 2021-2025.

[61] An Assessment of HIV, AIDS and Tuberculosis Financing Flows and Expenditure FY 2018/19 and FY 2019/20



Strategic Framework

Vision

Zero new infections, zero deaths, and zero related discrimination in HIV/STI/VH and TB, where everyone in Belize live long and health lives.

Mission

All people living in Belize will receive easy access, safe and effective prevention, treatment, care and support services for HIV/STI/VH and TB.

Overall Goal

To accelerate the progress towards the end of HIV/STI/VH and TB as public health threats in Belize by 2030

Strategic Frame

This Strategic Plan is grounded in the Universal Health Coverage (UHC) framework to ensure that all people living in Belize receive the services they need, that the services are of sufficient quality to make a difference, and without financial hardship to anyone.

The Strategic Plan embraces a public health approach that is concerned with preventing HIV/STI/ VH and TB, delivering the highest quality prevention, treatment, care and support with the widest coverage using strategies and interventions that are evidence- based and guided by local context and disease epidemiology. It aims to achieve health equity and leverages private and public sectors and civil society responses for a comprehensive, people-centered, and integrated response that leaves no one behind. It will leverage the competencies and comparative advantages of the affected communities in designing, implementing, and monitoring HIV programs and will facilitate their greater engagement in strengthening governance and accountability. This Strategic Plan will continue with the integration in the wider health care system and will fortify the linkages between the diseases – HIV/STI/VH/TB- for better services to improve impact and for greater efficiencies.

Innovations will be applied to reduce vulnerability and risk, prevent transmission, enable early and accurate diagnosis, and strengthen linkage to care, deliver quality treatment and provide chronic care. In the provision of chronic care, the plan will strengthen adherence to and retention on lifelong treatments in the case of HIV and Hepatitis B and the successful completion of treatment for STIs and Hepatitis C.

Public health approaches will be delivered that are people-centered and client-oriented such as differentiated models of care for key populations.

The strategic plan will focus on improving health systems, including strategic information, monitoring and evaluation, and supply chain systems. The public health approach will utilize the strategic information, including cost analysis, to understand and determine strategies for financial and technical efficiencies that will guide smart investments for the integrated response's long-term sustainability.

This Strategic Plan is also rooted in the health systems approach of the Belize Health Sector Strategic Plan 2014-2024. It is linked to the objectives of the Belize Health Sector Strategic Plan; to implement integrated health services based on primary health care, to achieve greater equity, cost-effectiveness and efficiencies in the allocation of health resources, to achieve universal health coverage, to strengthen human resource capacity for planning and service delivery, to develop quality improvement framework for stakeholder accountability and to strengthen strategic information through the investments in the Belize Health Information Systems.

The strategic plan is also aligned to key international and regional commitments described below.
The United Nations (UN) Sustainable Development Goals (SDGs) provide a mandate for integrated and holistic development efforts, including Target 3.3 among the health goals under SDG 3, “to end the AIDS epidemic by 2030, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases”.[62]

In this regard, this plan recognizes the need to address the multiple vulnerabilities and social determinants that are critical to achieving the SDGs, particularly goal 3, which is the overarching for health.

[62] Sustainable Development Goals, 2015

WHO End TB Strategy with the aim to achieve a 90% reduction in deaths, 80% reduction in TB incidence, and no TB-affected households facing catastrophic costs.[63]

The UNAIDS Fast Track Strategy provides guidance on far-reaching, people-centered goals and targets for achieving the 2030 ambition of ending the AIDS epidemic. The strategy recognizes the need for locally tailored responses that foster national leadership and accountability. The global Fast Track targets-95-95-95 by 2030, include:

- Diagnose 95% of people living with HIV by 2030
- Treat 95% of people diagnosed with HIV by 2030
- Achieve 95% viral suppression among people diagnosed with HIV and on antiretroviral therapy by 2030 [64]
- Achieve zero discrimination by 2030

The Global Health Sector Strategies 2016-2021: on HIV, STIs and Viral Hepatitis which outline goals, targets and priority action for ending these diseases as global public health threats.

The PAHO Plan of Action for the Prevention and Control of HIV and Sexually Transmitted Infections (2016-2021) sets out strategic interventions and actions to be implemented to strengthen and expand the prevention and control of HIV and STIs in order to eliminate these infections as public health threats by 2030.

PAHO Plan of Action for the prevention and control of Viral Hepatitis propose concrete actions to reduce morbidity, disability, and mortality, advance beyond immunization and to pave the way to eliminate viral hepatitis as a public health problem.

The Caribbean Cooperation in Health (CCH IV) recognizes that while the overall health situation has improved over the last two decades, the region faces complex health challenges: population ageing, urbanization, climate change, violence, and changing lifestyles. Economic challenges facing states include inadequate public health infrastructure and unsustainable costs of treating communicable diseases and the epidemic of non-communicable diseases.

Caribbean Regional Strategic Framework for HIV (CRSF) for the Pan Caribbean Partnership (PANCAP) for HIV (2019-2025) highlights policies and programs to accelerate progress for achieving the international and regional targets to end AIDS, sexually transmitted infections, viral hepatitis and TB/HIV by 2030.

The Call for Action of the Third Latin America and Caribbean Forum "Road to ending AIDS in LAC-Towards Sustainable Regional Fast Track Targets," endorsed by Belize and other Caribbean countries, reiterates the need for increasing public expenditure on health to sustain responses and achieve epidemic control. CARICOM Ministers of Finance, including Belize, committed at the 18th Meeting of the Council of Finance and Planning held on 4th July 2018 in Jamaica, to provide the budgetary support required to fill the financing gaps for HIV.

The Belize HIV/STI/VH/TB Strategic Plan sets out the goals, strategic priority areas, priority intervention and actions as well as indicators and targets and a five-year implementation that will move Belize towards the vision of the elimination of HIV/STI/VH and TB as public health threats.

[63] https://www.who.int

[64] https://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf

Strategic Priority Areas

The Strategic Plan comprises of Strategic Priority Areas. These are:

1. **Information for Tailored and Targeted Response:** Focuses on the need for strategic information to better understand the HIV /STI/VH and TB epidemics, local context, and response as a basis for advocacy, political commitment, national planning, resource mobilization and allocation, implementation, and program improvement.
2. **Quality and Efficient Service Delivery for Impact:** Ensures coverage of services by delivering timely, quality-assured, and high impact package of services along the prevention, treatment and care continuum.
3. **Resilient and Sustainable Systems, an Enabling Environment and Human Rights for Equity:** Identifies the best methods, innovations, and approaches for responding to human rights and gender-related barriers and increasing access to justice for sustained delivery of integrated people-centered HIV/STI/VH and TB services to different populations including the most vulnerable and underserved in different locations, to achieve equity and maximize impact.
4. **Responding for Sustainability:** Identifies sustainable and innovative models for financing HIV/STI/VH and TB responses that will strengthen efficiencies and reduce long term costs and provide financial protection for people to access the services they need without incurring financial hardship. This SPA will reinforce the concepts and approaches outlined in other SPAs that focus on accruing allocative and technical efficiencies through stronger partnerships with CSOs in delivering services to key populations, greater collaboration and coordination and enhanced governance and accountability with empowerment and engagement of PLHIV, key populations and communities affected by HIV/STI/VH and TB.

Strategic Priority Area 1: Information for Tailored, Targeted and People-Centered Response.

Strategic Information on HIV/STI/VH and TB will serve to understand the epidemics and the degree to which change has occurred as result of the response. Strategic Information will be the basis for advocacy, political commitment, program planning, and implementation, to set national targets and for monitoring and improvement in order improve quality and outcomes and ultimately contribute to ending HIV/STI/VH and TB as public health threats. It will serve to guide resource mobilization and allocation for maximum returns on investments and to address sustainability of the response. Focus will be placed on gathering strategic information that prioritizes people and their access to services along the care continuum.

SPA Goal 1: Increased data-driven policy, national programming, and response for focused action with the greatest impact.

Strategic Objectives:

1.1 Strengthen and Decentralize Belize Health Information System for comprehensive data to adequately monitor and respond to HIV/STI/VH and TB by 2025
1.2 Generate annual care cascades disaggregated by subpopulations, age-group, and geographic locations.
1.3 Increase the understanding of gonococcal antimicrobial resistance, HIV drug resistance, and Multidrug-Resistant TB and establish second-generation surveillance by the end of 2025
1.4 Strengthen data protection of data generated by routine data collection systems and special surveys for privacy, confidentiality, and safety.
1.5 Strengthen data quality through regular data reviews
1.6 Enable and Strengthen capacity to conduct research by the end of 2025
1.7 Strengthen Governance and Accountability for Strategic Information

Strategic Objective 1.1: Strengthen and Decentralize Belize Health Information System that generates data to adequately monitor and respond to HIV/STI/VH and TB

Strengthen Routine Data Collection by maximizing the use of the BHIS: In this Strategic Plan, Belize will maximize the potential of its BHIS, installed in 2004 at the Karl Heusner Memorial Hospital (KHMH), the main referral hospital in Belize has since been implemented in every public hospital, polyclinic and some health centers across the country. The BHIS is also available in some private health facilities and at some community sites. The BHIS will be deployed to other private health sector and CSOs, including those working with KPs and involved in the HIV/STI/VH and TB responses. Formal agreements with these implementers will include provisions for the use of the BHIS. The BHIS is currently undergoing a review to ensure more comprehensive routine reporting aligned to the integrated approach in responding to the four diseases and will serve as the primary tool for routine data generation at the client, facility, and national levels.

In addition to biomedical data that will be inputted into the BHIS, mechanisms will be established for CSOs working in areas of advocacy and human rights to address issues related to stigma and discrimination, violence, discrimination in employment practices and other issues, will report to the NAC. This data will be triangulated with data from the BHIS, vital statics, special survey and other sources.

Generate granular and high-quality data: The patient monitoring systems will be reviewed to ensure that BHIS generates high-quality granular data that is disaggregated by age, sex, gender identity, risk factors, geographic locations and hots spots as well as data at the client, service delivery and population levels for a more efficient, tailored, and sustained response to HIV/STI/VH and TB. Aggregate data from the BHIS will be used to determine major modes of transmission as well as risk behaviors and factors for HIV/STI/VH and TB acquisition and transmission. The data generated from the BHIS will also be used to **conduct size estimation of populations** at risk that will further guide policy and programming.

Client data, at the lowest level of service delivery, will be generated and used by CSOs and service providers. Capacity will be built on data generation, analysis, and use for decision making at the service delivery level. This will include the routine generation of care cascades for different populations and age-groups.

Testing data, data from service delivery sites, EMTCT and MCH programs, vital statistics, private practitioners and CSOs, laboratories and other sources will be triangulated for client entered monitoring. This will be used to provide people center care and enhance the continuum of care including linking persons to care, tracking persons loss to follow-up and for contact tracing that will focus on key populations, adolescent, men and migrant populations.

Understanding the burden of the diseases: Data will be generated to understand the burden of the diseases- HIV, STI, Hepatitis B and C and TB incidence and prevalence and mortality- on the community and health system. Data will be generated to also understand the prevalence and such as prevalence liver cancers, drug resistant TB, cervical cancer and others. The routine availability of these data will allow for monitoring over-time and understand the impact of the response. This data will also be used to guide screening and treatment protocols.

Understand the social, economic, cultural and other factors: Granular data from the BHIS will contribute to a better understanding of the social, economic, cultural and other factors that increase vulnerability to HIV/STI/VH and TB. This is important to facilitate policy development and to guide implementation across sectors and disciplines.

Monitoring the impact of PrEP: PrEP will be piloted and scaled up under this Strategic Plan. The parameters for monitoring of PrEP will be integrated into the BHIS and will be used to understand the degree to which PrEP prevents acquisition of HIV/STI/ VH for key populations.

Strategic Objective 1.2: Generate annual care cascades disaggregated by sub populations, age-group and geographic locations.

Routine data from the BHIS should be used to develop annual care cascades for HIV/STI/VH and TB. Cascades will be generated for different populations (MSM, transgender persons, migrant populations, adolescents, men, the general population) and disaggregated by gender, age-groups and health districts or geographic location. Capacity building with be conducted for CSOs and other service providers to generate and monitor site specific cascades. Cascade analyses will be conducted to understand the gaps in the response and to implement timely interventions to address these. Cascade analyses will identify gaps in reaching and retaining persons in care and will be used monitor treatment completion for TB, STIs and Hepatitis C. It will be used to monitor viral load suppression and support treatment adherence and retention in care for HIV and Hepatitis B.

Strategic Objective 1.3: Increase the understanding of gonococcal antimicrobial resistance, HIV drug resistance and Multidrug Resistant TB and establish second generation surveillance by the end of 2025

Special disease surveillance will be done to understand the burden of gonococcal antimicrobial resistance, HIV drug resistance and multidrug TB resistance. Initially a special HIV drug resistance surveillance study will be conducted. A systems review will be undertaken to determine the gaps to fully implement second generation surveillance for HIV/STI/VH and TB. Systems will be established to support second generation surveillance including the review of laboratory policies and menu of services to ensure quality laboratory testing for HIV/ STI/VH and TB and for the monitoring of drug resistance. The regular, routine generation of this information will facilitate data-driven revision of guidelines for optimal patient outcomes.

Laboratory policy will be reviewed and updated to adequately capture the needs for Gonococcal antimicrobial testing, HIVDR and MDR TB. Systems for quality assurance in supporting these testing will be strengthened, including training of key laboratory staff.

Strategic Objective 1.4: Strengthen data protection of data generated by routine data collection systems and special surveys for privacy, confidentiality and safety.

Data collection, storage, use and sharing will raise concerns about data privacy and confidentiality and the ethical uses and sharing of personally identifiable data. Data protection, client confidentiality and client and community safety will be prioritized with the development and implementation of a data protection policy and accompanying implementation plan that will include capacity building for data collectors, users and managers on the ethical standards in gathering and using data. Principal investigators and survey teams for special studies will be trained and systems established for data protection and confidentiality. Formal agreements with CSOs and the private sector engaged in the HIV/STI/VH and TB response will include agreement on protecting data and client confidentiality and safety. This will include, inter alia, staff roles and responsibilities for safeguarding data privacy and confidentiality, circumstances and processes under which personally identifiable data may be released, data storage and security requirements. Standard operating procedures will be established on how to handle inadvertent data breaches in data confidentiality.

Strategic Objective 1.5: Strengthen Data quality through regular data reviews

High-quality data is critical for sound decisions on policies, programs and allocation of scare resources. Data will be reviewed for based on the four dimensions of quality: completeness and timeliness, internal consistency, external consistency and comparison with national population data. Data managers and data collection staff will be trained in data quality using standardized protocols and such as the WHO three module Data Quality Review Manuals and tools such as the Data Quality Review Desk Review Excel Tool. Data quality review manuals will be developed specific to this strategic plan that will focus on establishing systems for routine data quality and well as for specific data quality review exercises at the facility, community and national levels for public as well as private and CSOs sectors.

Supportive supervision will be provided to facility staff to ensure quality data emanates from the local level. Supportive Supervision with active oversight of data collection systems and the transfer of the knowledge and skills to local level staff will lead to improvements in the system on an ongoing and timely basis.

Strategic Objective 1.6: Enable and strengthen the capacity to conduct research by the end of 2025

A research agenda will be developed to coordinate and guide special studies, national program based and community program-based operations research. Special studies initially may focus on prevalence and behavioral studies for key populations, follow up stigma index survey to monitor progress and others as defined by the national program. Research will also focus on understanding the key social determinants of health and their impact on HIV/STI/VH and TB. Research data will be triangulated with surveillance to guide a comprehensive multi sectoral response to HIV/STI/VH and TB.

Strategic collaborations will be formed with academic institutions to support research through practicum attachments and other mechanisms.

Collaboratively with the Ministry of Health and Wellness and NAC research with be defined to fill knowledge gaps and add to the knowledge repository. National and local IRBs will be supported to facilitate review and approval of research.

A cadre of principal investigators will be created, and capacity will be built to develop research protocols, on the ethics of research and on qualitative and qualitative data analysis.

Strategic Objective 1.7: Strengthen Governance and Accountability for Strategic Information.

At the national level a strategic information (SI) working group will be established and will serve as the national mechanism for governance and accountability for strategic information. The SI working group will utilize strategic information to advocate for policy development, for program planning and improvement and to build investment cases to advocate for increased domestic financing and resource mobilization for equity in services and sustainability of the response. The SI working group will bring together a diverse representation of persons with the relevant competencies for data-driven policy recommendations and programmatic revisions for improved outcomes and impact.

The SI working group will triangulate data from surveillance, vital statistics, the BHIS, estimation processes and quality assured sources to generate prevalence and incidence data, care cascades for MSM, transgender persons, migrant populations, adolescents, men and for the general population. The SI working group will meet with the prevention and treatment working groups to address program implementation for a client centered response.

Governance and accountability will be strengthened through multi-sectoral annual programmatic reviews that are data-driven and measure progress against targets of this Strategic Plan. Data sharing will be timely with dashboards providing data on prevalence, incidence and prevention and treatment coverage. An annual national multi-stakeholder multi-sectoral data sharing forum will be convened. Additionally, the SI working group will lead a mid-term and end of terms review of this strategic plan.

With the enhanced data collection, analysis and triangulation, Belize will fulfil its global reporting requirements. Estimation processes will be done collaboratively with UNAIDS and WHO and timely submissions of the Global AIDS Monitoring process and WHO universal access will be made.

Belize will conduct regular policy, governance and programmatic assessments applying the WHO multi sectoral accountability frameworks and the HIV National Policy and Commitment Index to ensure that the multi-sectoral integrated response is optimally functional and that progress in measure in relation to greater stakeholder engagement for accountability. These assessments will be conducted with diverse stakeholders inclusive of affected communities, civil society, the private sector and others.

Strategic Priority Area 2: Quality and Efficient Service Delivery for Impact

Grounded in Universal Health Coverage, this SPA that addresses the first dimension of UHC and that is delivering the full range of quality services. This SPA describes the essential package of high-impact interventions and services that need to be delivered along the continuum of care for HIV/STI/VH and TB, for all people in Belize. High impact interventions and services will be delivered along the continuum of care will focus on ***prevention, testing and diagnosis, linkage to care, treatment, and chronic care.***

SPA 2: Prevention Goals

1. Reduction in overall incident HIV cases to less than 100 cases and among all persons and to less than 20 cases among 15-24 years by the end of 2025
2. By the end of 2025, 90% of PLHIV know their HIV status and 90% MSM would have an HIV test in the last 12 months.
3. By 2025, the will be less than five cases of PLHIV who test positive for TB.
4. No baby will be born with HIV, Syphilis or Hepatitis B by the end of 2022.

Strategic Objectives

2.1 Tailored combination prevention package of services that integrates HIV/STI/VH and TB is delivered to all persons and focused on adolescents, young adults, women and girls, and men.
2.2 Tailored combination prevention package of services that integrates HIV/STI/VH and TB is delivered to MSM, TGs, and their sex partners.
2.3 Increase uptake of new prevention modalities including Pre-Exposure prophylaxis – PrEP, PEP, Hepatitis B, Hepatitis C and TB screening for MSM, Transgender persons, sex workers, and migrants
2.4 Increased uptake of new testing modalities, such as HIV self-testing and community-based testing, for screening and diagnosis of HIV/STI/VH/TB.
2.5 All blood and blood products will be screened for HIV/STIs/VH and other infectious markers
2.6 The burden of TB among PLHIV is reduced with increased TB case findings and IPT prophylaxis and enhanced infection control practices.
2.7 EMTCT is scaled up with 100% coverage for HIV, Syphilis, and Hepatitis B testing and the management of infected mothers and exposed infants by the end of 2025.
2.8 Enhanced governance and accountability for integrated HIV/STI/VH and TB prevention

HIV/STI and VH share common risk-associated behaviors, and multiple infections can be acquired at the same time. Existing infections can also facilitate transmission and acquisition of other sexually transmitted infections and diagnosis of one infection is often an indicator of risk for others. The integrated multi-disease approach will enhance comprehensive care for persons with HIV/STI/VH and TB. Newer technology will allow for combination testing for the screening and diagnosis of co-infections such as HIV and Syphilis and HIV and Hepatitis B. The elements of the essential package of services will therefore significantly overlap across the four diseases. This will facilitate better integration of services and will maximize resources across key dimensions of the health systems such as financial and human resources and as well as supply chain, for greatest impact.

The essential package of high impact interventions for HIV/STI/VH and TB will include:

1. A combination prevention package of services that address strategies to reduce risk and vulnerability for HIV/STI/VH and TB transmission and acquisition through the implementation of structural, behavioral, and biomedical interventions to reduce risk and vulnerabilities.
2. This combination prevention will target primary prevention of HIV/ STI/VH and TB infections and, at the same time, ensure that people with these conditions are successfully treated to reduce transmission.

3. A comprehensive package of high impact interventions for treatment, care, and support for persons with HIV/STI/VH and TB for better health outcomes and reduced mortality.

This SPA focuses on services for impact and will prioritize the behavioral and biomedical components of combination prevention. SPA 3 on Equity will address the structural interventions that promote an enabling environment, reducing discrimination, and improving access to high-impact interventions described in this section.

Strategic Objective 2.1: Tailored combination prevention package of services that integrates HIV/STI/VH and TB is delivered to all persons and focused on adolescents, young adults, women and girls, and men

The combination prevention package of HIV/STI/VH and TB will be established for adolescents, young adults, women and girls and men based in local epidemiology and context. The package of services will include but not limited to behavior change communication interventions, access to male and female condoms, HIV, Syphilis, HBV, and TB testing. The combination package of prevention services will also include sexual and reproductive health services for adolescents and young adults including access to PAP smear and Visual inspection with acetic acid, HPV vaccines for girls and boys, and well as interventions to manage gender-based and sexual violence including post exposure prophylaxis for HIV, screening and treatment for Syphilis, HBV and other STIs. For adolescents, the prevention package of services will also in health and family life education and comprehensive sexuality education.

Behavior change communication for risk reduction.

A Behavior Change Communication plan will be developed to include specific messaging for specific audiences through the most effective channels. Education to increase awareness of HIV, STI, VH and TB will be intensified and for adolescents will focus on delayed sexual debut, the reduction in the number of sexual partners, increased uptake of testing for HIV/STI/VH and TB as well as the promotion of good health and sexual well-being. The messaging for adolescents, young adults, women and girls will be reviewed to ensure appropriateness of content and effectiveness of methodology of message delivery. The use of new media and instant messaging such as Instagram, what's app, online games, and short videos will be scaled up. The network of peer HIV educators linked to CSOs will be expanded for greater coverage and their capacity build to conduct culturally relevant risk reduction counselling for HIV/STI/VH and TB for different sub populations of adolescents and young adults including young MSM and young transgender persons. The capacity of peer educators will be further enhanced to effectively serve as cyber educators to interact and educate young MSM and transgender persons who visit targeted websites and to refer then for additional risk reduction counselling or for services such as HIV and STI testing. The network of peer educator will meet regularly to share knowledge and experiences.

Sexual and Reproductive Health Services

The menu of SRH services will be expanded to include STI screening and counselling, screening for HPV and prevention of cervical cancer. Access to PAP smear and Visual inspection with acetic acid as screening tools will be scaled up and demand will be created for increased access to HPV vaccines for boys and girls. The HPV vaccination policy will be reviewed and updated to include vaccination for boys.

Belize will align its response to achieve the 2030 global targets of 90% of girls fully vaccinated by the age 15 years, 70% of women screened by the age of 35 years and again by the age of 45 years using a high-performance test and 90% of women with cervical diseases will receive treatment (90% with precancer treated and 90% with invasive cancer managed).

There will be ongoing programmatic monitoring of the HPV vaccination program for improvement. All eligible unvaccinated adolescents and young adults will be vaccinated for Hepatitis B contributing to micro-elimination.

The national condom strategy will be reviewed and updated to align with the SRH strategy that offers SRH services to adolescents younger than 18 years of aged based on the Gillick Competency and Fraser test. The number of youth friendly health centers will increase with differentiated model of care of care adolescents allowing for adolescent peer support groups beyond the traditional working hours. CSOs will also create youth friendly spaces, environments and interventions particularly for MSM and transgender adolescents and young adults. Health care workers will be trained to administer the Gillick Competency and Fraser test and to deliver culturally sensitive and competent sexual and reproductive health services to all adolescents and young adults.

CSOs will continue to provide social and other support to teenage parents and will collaborate with relevant government agencies to provide counselling, education on parenting skills, and reintegration in to school for completion of secondary education.

HFLE and CSE

Dialogue with continue with key stakeholders involved in the delivery of HFLE and CSE including the Ministry of Education, Youth and Sports, Teachers Association, Parents and other stakeholders. A review of HFLE and CSE will be conducted to understand the reasons for limited success and to enhance implementation. A review of the curriculum will be done to ensure that content remains relevant and age appropriate. Training for teachers will continue at level of the teachers training college and regular refreshers training will be conducted for teachers and counsellors in school to adequately deliver HFLE and CSE content. Parents will be continually engaged and empowered through parenting conferences and other mechanisms to effectively support HFLE and CSE in their home settings. The implementation of HFLE and CSE will be closely monitored for improvement.

The network of HIV peer educators in school will be expanded for greater coverage and their capacity strengthened to educate and counsel on other sexually transmitted infections, delaying sexual debut, correct and consistent use of condoms as well bullying, violence and other factors that increases vulnerability to HIV and STIs.

School Health Clubs will be established to for additional knowledge, mentoring and peer support to prevent HIV/STI/VH and TB.

Gender Based and Sexual Violence

Gender Based Violence and Sexual Violence correspond with income level, gender identity and sexuality and increases the risk for HIV and other sexually transmitted infections.

Communication campaigns will be developed, implemented and monitored to prevent GBV and sexual violence. Health care workers will be trained to provide culturally sensitive services to victims of GBV and sexual violence as well as to refer for legal, social and psychosocial and other support.

Victims and perpetrators of GBV and sexual violence will receive ongoing interventions to prevent further abuse. Family member and other support persons will also be counselled to assist in preventing GBV and sexual violence.

Persons who were sexually abused and eligible based on guidelines will receive post exposure prophylaxis for HIV and STIs.

Strategic Objective 2.2: Tailored combination prevention package of services that integrates HIV/STI/VH and TB is delivered to MSM, TG persons and their sex partners.

A high impact combination prevention package of services will be developed and tailored to meet the needs of MSM and Transgender persons and their sex partners and well as other persons at higher risk for HIV/STI/ VH and TB such as prisoners, migrant populations and sex workers. The package of services will include but not limited to behavior change communication interventions, access to male and female condoms as well as HIV, Syphilis, HBV and TB testing. The package of services will include new prevention modalities such as the use ARVs in the prevention of new infections with Pre-exposure Prophylaxis and Post exposure Prophylaxis. The combination package will also include interventions to manage gender-based and sexual violence including post exposure prophylaxis for HIV, screening and treatment for Syphilis, HBV and other STIs.

CSOs working with MSM, TG and other key populations will be pivotal in the delivery of the high impact combination prevention package. CSOs and private health sector will be engaged through a memorandum of understanding with the GoB. For those with existing MoUs these will be reviewed and revised as appropriate to ensure that CSOs are supported and positioned to deliver the prevention package of services. CSOs will be provided with additional capacity building such as training on Hepatitis B and Hepatitis C and TB. There will be oversight, mentoring and supportive supervision to ensure that quality prevention services are delivered to MSM, TG persons and other key populations.

Behavior change communication initiatives will be implemented focused on risk reduction, including partner reduction, consistent and correct use of condoms, and to increase uptake of HIV/STI/VH and TB testing, PrEP, and generally to increase health seeking behaviors. A BCC strategy will be developed and implemented that will focus on reaching MSM, TG and Key population through relevant channels such as social media and targeted websites where MSM and TG communities frequently visit.

Access to condoms and Lubricants: the National Condom Strategy and Plan with continue to ensure access to condoms for all. Access to condoms for MSM, TG persons and other key populations with be increased with greater involvement of CSOs in the delivery of the prevention package of services and the implementation of a condom marketing strategy. Advocacy will continue with the private sector and other stakeholders for an increase in number of non-traditional outlets for greater access. The quality protocols for condoms and lubricants will implemented and monitored for quality condoms and lubricants.

Strategic Objective 2.3: Increase uptake of new prevention modalities including Pre-Exposure prophylaxis - PrEP, PEP, Hepatitis B, Hepatitis C and TB screening for MSM, Transgender persons, sex workers and migrants

The use of ARVs will be included in the prevention package of services in Pre-Exposure Prophylaxis for high-risk populations including MSM, transgender person and sero-discordant couples. A PrEP policy will be develop making PrEP accessible to high-risk populations. PrEP programming will also present the opportunity to screen, manage and refer for other sexually transmitted infections including Syphilis, other STIs, Hepatitis B and C. A costing analysis will be conducted to understand the cost implications for a PrEP program and the long-term efficiencies in averting new HIV infections. Guidelines, standard operating procedures and tool for the documentation, implementation and monitoring of PrEP will be developed and integrated into the BHIS. Health care workers will be trained in PrEP delivery based on guidelines.

PrEP will initially be piloted, the experience documented, and the lessons learned will be applied to for a scaled-up PrEP program. CSOs that have the reach to MSM and TG persons will be integral in the pilot. Lessons from the pilot experience will be applied to the scale-up of PrEP for national coverage.

The combination prevention package of services will also focus on the prevention of HIV transmission through post exposure prophylaxis for non-occupational (nPEP) and occupational exposures (PEP). PEP will be offered to health care workers with occupational exposure. PEP guidelines will be updated to include nPEP which will be offered to key populations and others who experience sexual abuse or sexual exposure. Tool for documenting, to support implementation and for monitoring and reporting will be developed and integrated into the BHIS. MSM, TG and other KPs accessing nPEP will be counselled on risk reduction to prevent future exposure. Health care workers will be trained on infection control and universal precautions. All supplies necessary for universal precaution and infection control will be available at all service delivery sites including CSOs and private sector.

Hepatitis B and C will be screening, and management will be prioritized in this plan. Hepatitis B and C screening will be integrated in PrEP and nPEP for MSM, TG and other key populations. All persons with Hepatitis B and Hepatitis C infections will be referred for management.

Hepatitis B vaccination including birth dose vaccination already integrated in MCH will be further strengthened to achieve universal coverage and to achieve EMTCT. A comprehensive Hepatitis B immunization program, beyond MCH, will be developed to cover unvaccinated children and adults at high-risk for acquiring the infection MSM and TG for micro-elimination Hepatitis C treatment for cure is more widely accessible and affordable. Belize will leverage the funding opportunity under the Global Fund to expand its response to Hepatitis C and to treat all persons diagnosed with Hepatitis C.

Strategic Objective 2.4: Increase uptake of new testing modalities, such as HIV self- testing and community-based testing, for screening and diagnosis of HIV/STI/VH/TB.

Testing is a key component in the combination prevention package of services and is the critical pillar that links the prevention and treatment cascades. In Belize, almost 50% or an estimated 2,400 persons living with HIV do not know their HIV status.

Among specific populations 62.2% of sex workers and 44.3% of men MSM knew their HIV status.[65] While more women are testing in Belize, attributed to testing in the MCH program, more men are diagnosed HIV positive compared to their female counterparts.

Early testing and diagnosis for HIV/STI and TB is important for the optimal management of infections as well as for the management of co infections and will facilitate early and timely treatment with favorable outcomes and reduced mortality. For HIV, this situation has improved over the last three years with average CD4 count at start of treatment as 308 in 2019 compared to 235 in 2017. While this is improvement, most patients initiate treatment with advance disease[66]. In the case of TB, early testing and diagnosis with adequate contact tracing will reduce community spread as an important public health initiative that will contribute to ending TB in Belize. Early testing for HIV/STI/VH with early diagnosis will significantly improve treatment outcomes and facilitate testing and diagnosis of sexual partners. Priority interventions for early testing and diagnosis will include the continuation of HIV rapid test and the integration of testing for Syphilis, other STIs, VH and TB in primary health care, MCH programs and community service delivery. Innovations on testing will be implemented to accelerate efforts to achieve the target of 90% of people with HIV knowing their HIV status by 2025.

Testing will focus on everyone knowing their status. MSM, TG persons, Sex workers, men in general and migrants will be prioritized for testing. The national testing strategy will be updated include a mix new testing modality such as HIV self-testing and index testing with assisted partner notification that will result in higher yield taking Belize closer to achieving the first 90. Integral to the Belize will adapt and apply the WHO six step approach in updating of the testing strategy to determine the differentiated HIV testing models. This will be used to guide HIV self- testing implementation as part of broader HIV testing services. HIV self- testing will be piloted with subsequent scale-up that will incorporate the lessons learned from the pilot phase. Facility based testing will continue and community-based testing will be scaled up in collaboration with CSOs to adequately capture the hard-to-reach groups that face barriers in accessing facility-based services such as MSM, transgender persons, Sex workers, migrants and men. The national HIV testing strategy will also be updated and implemented to include testing for VH, an integrated approach to testing using newer technology for combined testing with early results. The testing strategy will clearly define the role of CSOs in scaling up community testing that is focused on higher risk groups including MSM, PLHIVs, Prisoners and patients on hemodialysis patients for micro elimination. Lay testers will be engaged in community testing through CSO that result in increased coverage, and yield. Effective and ongoing testing strategies such as provider-initiated testing and couples testing for HIV/STI integrated in MCH will continue and will be scaled up for universal coverage. All testing will be delivered based on normative guidance and in line with the “5 Cs”: consent, confidentiality, counselling, correct result, and connection/ immediate linkage. Initiatives to maintain high HIV testing coverage for TB patients will continue.

To support the scale-up to for wider reach and better yield, guidelines and protocols will be revised, staff will be trained and retained including lay counsellors, ongoing supportive supervision will be conducted, and assurance protocols will be developed and implemented to ensure the delivery of correct results.

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[65] https://aidsinfo.unaids.org/

[66] Country Focused Evaluations, Belize HIV/TB Evaluation, Field Based Evaluation, September 2020

Strategic Objective 2.5: All blood and blood products will be screened for HIV/STIs/VH and other infectious markers

As a key biomedical prevention strategy, Belize will continue to screen all blood and blood products for HIV/STIs/ Syphilis, Hepatitis B and Hepatitis C and other infectious markers based on national protocols and guidelines. Quality assurance protocols and standard operating procedures will be adhered to for quality blood and blood products. Any persons testing positive for HIV/STI/Syphilis, Hepatitis B and C or any other infectious markers will be referred for management.

Annual Reports from Blood bank will be generated and use to monitor the prevalence of HIV/STI/Syphilis/ Hepatitis B and Hepatitis C.

Strategic Objective 2.6: The burden of TB among PLHIV is reduced with increased TB case findings and IPT prophylaxis and enhanced infection control practices.

TB screening will be integrated into package of high impact prevention services and will be delivered with greater engagement of CSOs.

The integrated patient centered care and prevention for will focus on early diagnosis of TB including the expansion of RR and MDR testing and drug susceptibility testing for early diagnosis of drug susceptible TB. All traditional methods to aid in screening and diagnosis including microscopy for acid-fast bacilli, culture for mycobacteria, and growth-based drug susceptibility testing, chest X-Ray will continue to add to TB diagnosis. Investments in newer molecular technologies such as Gene-Xpert will be expanded to ensure greater coverage and earlier diagnosis. There will be systematic screening of contacts of TB and high-risk groups such as PLHIV and the homeless. The community TB symptomatic screening using WHO guidelines started by the CSO hub for high-risk populations will be monitored closely to understand its effectiveness and potential for scale-up. Although, over the years Belize has not reported cases of MDR TB, the program will maintain diagnostic capacity to detect MDR TB.

All PLHIVs will be screened based on protocols. All persons with TB infection will be placed on prophylactic management based on national protocols and guidelines.

TB prevention will focus on strengthening infection control practices in health care facilities, households of persons with TB diagnosis, prisons and other congregate settings and well as early detection and treatment of TB infections. Health care workers will be trained on infection control practices and will be provided with the necessary tools to support infection control. An infection control committee will be established to monitor compliance with infection control across service delivery sites.

Strategic Objective 2.7: EMTCT is scaled up with 100% coverage for HIV, Syphilis and Hepatitis B testing and the management of infected mothers and exposed infants by the end of 2025.

Belize has reported success in testing HIV exposed infants at birth and based on national protocols through to 18 months. On the cusp of achieving EMTCT status, high testing coverage for HIV, and Syphilis testing among pregnant women will be maintained and testing for Hepatitis B will be scaled up. Women testing positive for HIV, Hepatitis B and Syphilis will receive early treatment and the exposed infant will received prophylaxis for HIV, Hepatitis B and Syphilis according to national guidelines. High coverage for early infant diagnosis will continue so that exposed infants are optimally managed.

Ongoing capacity building will be conducted with health care workers to test, counsel and manage infected mothers and exposed infants and quality of care will be monitored. The GoB will submit its application for elimination status as short-term milestone and will continue to implement and strengthen its program to maintain EMTCT status.

Strategic Objective 2.8: Enhanced governance and accountability for integrated HIV/STI/VH and TB prevention

To provide leadership, oversight and monitoring of the quality of prevention services, a national prevention working group will be established that will include representatives of key populations, and CSOs. Prevention reviews will be conducted annually and will include revised target setting to strengthen programming. The national prevention working group will also liaise with the national treatment and strategic information and other working groups for the delivery of quality assured comprehensive HIV/STI/VH and TB services.

Treatment Goals

1. Reduction in AIDS related deaths to less than five deaths by 2025
2. Reduction in TB related deaths to less than 2 cases by 2025
3. Achieve 95% TB treatment success rate by the end of 2025
4. Achieve 95% treatment success rate for TB/HIV coinfection by the end 2025
5. Achieve 90% of PLHIV who know their status are on ARVS by 2025
6. Achieve 90% viral suppression among people living with HIV who are on treatment by 2025

Strategic Objectives:

2.9 Strengthen Linkage to Care for persons testing positive for HIV/STI/VH and TB through expanded community outreach and greater engagement of CSOs.

2.10 Expand treatment coverage for HIV/STI/VH and TB through the delivery of optimize, decentralized treatment using differentiated models of care.

2.11 Deliver innovative approaches to enhance adherence and retention in care for HIV/STIs/VH and TB including strengthening treatment literacy, multi months dispensing, treatment pick up and community follow- up.

2.12 Deliver the highest quality of treatment, care and support for HIV/STI/VH and TB that is based on national standards and guidelines.

2.13 Deliver an optimal menu of quality assured laboratory services for persons on treatment for HIV/STI/VH and TB

2.14 Enhanced governance and accountability for integrated HIV/STI/VH and TB treatment, care and support

The essential package of HIV/STI/VH and TB services will include high impact interventions for treatment, care and support services.

These interventions will be based on local epidemiology and context and will be defined by global, regional and local evidence to deliver integrated services linking persons testing positive for HIV/ST/VH and TB to care, initiate early and effective treatment and provide adequate treatment follow up and laboratory monitoring for a better quality of life and reduced mortality.

Strategic Objective 2.9: Strengthen Linkage to Care for persons testing positive for HIV/STI/VH and TB through expanded community outreach and greater engagement of CSOs.

Based on a 2017 HIV cohort analysis, 83.5% of persons diagnosed were linked to care. In an examination of the HIV treatment cascade for 2019, 73% of the 54.6% who knew their HIV status were linked to care. There are significant implications for persons not linked to care in the ongoing transmission of HIV and late entry into treatment with poor health outcomes and increased risk for early mortality.

Strategies to improve linkage to care will focus on capacity building for HIV counsellors to educate on the importance or early access to treatment and the value of viral suppression in reducing transmission and better health outcomes. Educational materials will be developed to support this initial counselling. A bidirectional referral system between implementing agencies and testing and treatment sites will be strengthened and implementation closely monitored. The peer navigation system established at the community level through CSOs will be strengthened with the development of a peer navigation manual, additional capacity building and closer monitoring on the outcomes of referrals. Linkages will be strengthened between testing and treatment sites to facilitate easy peer navigation for MSM, Transgender and vulnerable populations.

Strategic Objective 2.10: Expand treatment coverage for HIV/STI/VH and TB through the delivery of optimize, decentralized treatment using differentiated models of care.

Treatment for HIV/STI/VH and TB will be scaled up with early initiation for improved treatment outcomes. All persons with HIV/STI/VH and TB will receive early initiation or same day treatment of optimized, highly efficacious therapy based on national guidelines.

For an integrated treatment approach to HIV/STI/VH and TB treatment, Belize will develop and regularly update treatment plans that will support the continuity of treatment. Treatment plans will leverage the efficiencies of this integrated approach to develop and implement integrated strategies for treatment delivery. More effective models of service delivery will be implemented such as differentiated models that are based on timing of diagnosis and disease staging with different models for new patients, new patients with advanced disease and stable patients.

HIV treatment will be scaled up with the full roll out of Treat All policy. Treatment optimized for same day initiation or early treatment with highly efficacious ARVs based on national guidelines that will be reviewed and updated regularly to incorporate new evidence and recommended treatment approaches. The current guidelines will be finalized and implemented as an immediate priority. Also, as an immediate priority, a structured optimization and transition plan for Treat All and Dolutegavir (DTG) transition will be developed and implemented. There will be ongoing initiatives to optimize pediatric management and continued capacity building for health-care workers through training, clinical mentoring and supportive supervision.

Access to HIV/STI/VH and TB treatment will be scale-up in collaboration with CSO and will prioritize the delivery of treatment to key populations. Shared care protocols between the Ministry of Health and Wellness and CSOs will be established to provide medicines for treatments, technical support and monitoring.

Models of care will be revised to ensure that everyone is met with treatment for HIV/STI/VH and TB. Differentiated models where key populations can access treatment through CSOs and at public facilities on days dedicated for service to key populations will enhance their treatment coverage. This prioritization and delivery of differentiated models of care has significant benefits to quality of care and is instrumental for efficiency, equity and sustainability.

New innovations and approaches to the delivery of treatment for greater access and efficiencies such as multi month prescribing and pick up, treatment pick-up by relatives and CSO community workers will be included in the treatment plans, implemented and monitored. Protocols and standard operating procedures will be developed to support these new innovations and to ensure client confidentiality. Persons with HIV/STI/VH and TB will be sensitized to the new approaches.

Treatment guidelines that integrates the management of HIV/STI/VH and TB will be regularly updated to incorporate newer, optimized and more efficacious treatment and with the use of fixed dose combination treatments that will reduce pill burden and improve adherence for better treatment outcomes.

TB/HIV management will be strengthened to decrease the burden of TB in PLHIVs and HIV in people with TB disease. All HIV patients will be screened for TB and all TB patients will be tested for HIV. All PLHIV diagnosed with TB will be placed on early treatment for TB and HIV based on national guidelines to enhance treatment outcomes and reduce mortality. Newer medicines using fixed dose combinations and shorter course regimen particularly for second line and MDR TB management as well direct observed therapy short course (DOTS) will be scaled up with greater community engagement and in collaboration with private sector and CSOs. Isoniazid (INH) prophylaxis and co-trimaxazole (CTX) preventative treatment among PLHIV will be expanded to ensure full coverage to all those who need it and based on national guidelines. Specific focus will be placed on early diagnosis, treatment and follow up of men who have greater mortality rates for TB, HIV and TB/HIV in Belize. While there are no cases on MDR TB, guidelines will reflect the management of MDR TB to ensure safer, shorter course treatment and more effective medicines for improved treatment completed and outcomes.

BCG vaccinations will continue for all infants at birth as a TB prevention tool, except for HIV exposed infants as per national guidelines.

Belize will continue to provide syndromic management for STIs and overtime with the strengthening of surveillance will move towards etiologic management of STIs. Laboratory strengthening will focus on establishing systems for ongoing routine gonococcal antimicrobial resistance monitoring and with phased approach, the introduction of affordable point-of-care sexually transmitted infection diagnostics. With syndromic management, periodic etiologic assessments will be conducted to inform treatment recommendations and revise guidelines. Persons with STIs will receive single dose treatments, where applicable and this will be administered under direct observation at the service delivery site.

For Hepatitis B, guidelines will be updated, as part of the integrated guidelines for HIV/STI/VH and TB and will be implemented with use of antivirals for treatment. Belize will also prioritize accessing Hepatitis C treatment for cure.

All opportunistic infections, co morbid conditions and complication of HIV/STI/VH and TB will be managed according to national protocols.

Based on the continuum of care approach, a patient centered approach to support and chronic care will be implemented. All chronic conditions related to HIV/STI/VH and TB will be managed according to guidelines. Support groups and peer groups of people with and affected HIV/STI/VH/TB will serve to improve adherence, provide psychosocial, emotional and other support as well as to share experiences and information.

Strategic Objective 2.11: Deliver innovative approaches to enhance adherence and retention on care for HIV/STIs/VH and TB including strengthening treatment literacy, multi months dispensing, treatment pick up and community follow- up.

Good adherence prevents drug resistance, improves treatment outcomes and prevents new infections. Good adherence is equivalent to undetectable equals untransmissible- patients with good adherence to ARV treatment will be virally suppressed and that reduces the risk of transmission. In the 2017 HIV cohort analysis, only 10% of persons testing positive achieved viral suppression after one year. In 2019, 67% of persons who are treatment for HIV were virally suppressed, significantly lower than the Caribbean (80%). Strategies to improve adherence will be scaled up and strengthened in collaboration with CSO. Belize will review, update and implement its adherence strategy and work collaboratively with the private sector and CSO to retain people on treatment for HIV and Hepatitis B and for successful STI and TB treatment completion.

An integrated patient treatment literacy program will be developed and implemented using a client centered approach, and clients will be engaged as treatment advocates.

Peer support networks strengthened through continued empowerment of key population and people with HIV/STI/VH and TB. The peer support networks will serve to share experience and information on treatment to support peers to adhere to treatment.

The scope of DOTS implemented for TB treatment will be broadened, where applicable to include for more integrated and comprehensive outreach, community monitoring and treatment support for HIV/ STI and VH. For efficiencies, health staff involved in DOTs will also be trained to support other initiatives such as contact tracing and tracking loss to follow up. Outreach work will take on a more wholesome approach and outreach workers will receive more comprehensive multidisciplinary training. The DOTS program and community outreach will be supported by CSOs especially in reaching key populations. The Integrated DOTS program will be piloted and evaluated and scaled up with greater engagement of private health care and civil society organization.

Strategic objective 2.12: Deliver the highest quality of treatment, care and support for HIV/STI/VH and TB that is based on national standards and guidelines.

A quality-of-care program will be developed to monitor the delivery of care for persons with HIV/STI/VH and TB.

Quality improvement committees will be established at service delivery sites and Health Care workers will be trained on continuous quality improvement. A client satisfaction survey will be conducted, and regular collection and monitoring of early warning indicators would be conducted to ensure adherence to treatment guidelines and reduce the risk of stock out that has implications for HIV drug resistance and poor treatment outcomes. A network of treatment advocates will be developed and trained to support treatment literacy and adherence. The Global Fund ARV spot check will also be used to collect and analyze data on site performance.

Strategic Objective 2.13: Deliver an optimal menu of quality assured laboratory services to support diagnosis and treatment monitoring for HIV/STI/VH and TB

There will be laboratory strengthening for diagnosis of HIV/STI/VH and TB. Laboratory strengthening will focus on earlier diagnosis using newer technology such as point of care molecular technology, GeneXpert for TB diagnosis and Rifampicin resistance (Xpert MTB/RIF) and viral load testing. GeneXpert delivers rapid results and needs minimal technical training[67],[68]. Rapid diagnostics will be introduced for point of care testing for STIs. Ongoing laboratory initiatives for the diagnosis of opportunistic infections and monitor co-morbid conditions will continues. Laboratory policies will be reviewed and updated to reflect the expansion rapid diagnostics. Laboratory quality protocols will be updated, and capacity built to deliver quality laboratory services. Laboratory strengthening will also support special studies including an HIV drug resistance survey will be conducted to understand resistance patterns and trends and determine the most appropriate antiretroviral regimens in cases of treatment failure. In a phased approach to implementation, laboratory strengthening will support second generation surveillance with adequate routine monitor resistance to HIV, Gonococcal Infection and TB.

Strategic Objective 2.14: Enhanced governance and accountability for integrated HIV/STI/VH and TB treatment, care and support

To provide leadership, oversight and monitoring of the quality of treatment, support and chronic care services, a national multi-sectoral and multidisciplinary treatment working group will be established and will include among government and technical partners, representatives of people living with and affected by the HIV/STI/VH and TB key populations, and CSOs. As part of its strategic planning and review process, the national treatment working group will regularly review the interventions and package of essential treatment, support and chronic care services to ensure that they reflect any changes in the disease epidemiology and local context as well as new scientific evidence, technologies and innovations.

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[67] https://www.cdc.gov/tb/publications/factsheets/pdf/xpertmtb-rifassayfactsheet_final.pdf)
[68] https://www.cepheid.com/en/tests/Virology/Xpert-HIV-1-Viral-Load

Comprehensive treatment reviews will be conducted annually and will include a revised target setting process to strengthen programming. The national treatment working group will also liaise with the national prevention and strategic information and other working groups for the delivery of quality assured comprehensive HIV/STI/VH and TB services.

Strategic Priority Area 3: Resilient and sustainable health systems, an enabling environment and human rights for Equity.

All people living in Belize will receive services of high-quality for impact. The HIV/STI/VH and TB integrated response will focus on maximum impact, leaving no one behind.

The HIV/STI/VH and TB response under this plan is multidisciplinary and multi-sectoral with a whole-of-health-systems and whole-of-society-approaches with clear roles and responsibilities of key stakeholders within and outside of the health system who will contribute to the achievement of outcome the NSP. Further, the integrated and decentralized response to HIV/STI/VH and TB will greater engagement and empowerment of affected communities and CSOs, differentiated models of care, enhanced community service delivery to key populations will be strengthened to effectively deliver along the care continuum for key and vulnerable populations. These initiatives and others detailed in delivery of services along the continuum of care with engagement and empowerment of the affected communities will contribute to equity in services.

Equity Goals

1. Zero discrimination in the health care setting by 2025
2. Zero stock out of supplies of medicines and commodities of HIV/STI/ VH and TB by 2025
3. 95% of human rights violations reported to the Human Rights Observatory are successfully addressed by 2025

Str**ategic Objectives**

3.1 Strengthen advocacy for pro health legislations and initiatives to remove legal, institutional and service delivery barriers.
3.2 Strengthen capacity and protect human resources to adequately address HIV/STI/VH and TB responses.
3.3 Achieve Robust and Effective Supply Chain Management for uninterrupted supplies of quality assured of medicines and commodities.

Strategic Objective 3.1: Strengthen advocacy for pro health legislations and initiatives to remove legal, institutional and service delivery barriers

Equity can be compromised when there are legal, institutional, service delivery and other barriers that impede access to effective interventions and services.

It is therefore a critical function of the Belize National AIDS Commission and Ministry of Health and Wellness in collaboration with CSO and affected communities to advocate with relevant government agencies including the Office of the Attorney General to ensure that laws, policies and regulations are pro health, promote gender equality and protect and promote the human and health rights of populations that are at increased risk for diseases, as well as to protect adolescents and their needs for sexual and reproductive health services.

An enabling environment where laws and policies are properly enforced, will reduce gender inequality and protect and promote human rights and will result in reduced risk and vulnerability for HIV/STI/VH and TB and greater access to health services in relation to reach, quality and effectiveness, especially for key populations.

In Belize, like in many other Caribbean countries, the dissonance exists between the age of consent (16 years) and the age of access (18 years). This issue is frontally addressed in the Belize Draft Equal Opportunities Bill where any child who is over the age of sixteen years may undergo HIV testing with the child's voluntary informed consent with specific exception. Further, the consent of the child's parent or legal guardian is not required, bridging the dissonance between the age of consent and the age of access. Belize also has an SRH policy to ensure universal access to SRH and information as a basic component to health care, to be integrated throughout the healthcare system and in all aspects of health and well-being. The policy addresses SRH services throughout the life course, including for vulnerable populations. The national response has made progress in adapting the Gillick competency and Fraser guidelines that healthcare workers are applying to deliver SRH service to key populations.

Increasing access to SRH services for adolescents and young adults is pivotal in reducing HIV infections. Intervention and strategies to increase access including the enhancement of HFLE and CSE are detailed in SPA 2.

The Draft Belize Equality Opportunity Bill also addressed HIV prevention and care, to as far as possible eliminate practices which hamper an effective HIV response, recognizing the vulnerability of key populations at risk. The Bill enforces voluntary, anonymous and testing and care services, the need for trained staff to conduct testing and the confidential storing, handling information and disclosure of HIV status. Moreover, the Equal Opportunities Bill gives power to and protects the Ministry of Health and Wellness and National AIDS Commission from any liability with the implementation or use of any strategy and tool for reducing the risk of HIV transmission.[69] The legislation aims to remove barriers so that all persons living in Belize can enjoy the same opportunities regardless of circumstances and it seeks to protect from discrimination, harassment and victimization.

Belize has a national gender policy that promotes human rights, gender equality and gender equity while addressing the access and provision of services to the population.

In this Strategic Plan, the National AIDS Commission in collaboration with national stakeholders will continue to lead the high-level advocacy for parliamentary passing of the Equal Opportunities Bill.

[69] https://www.policytracker.bz/wp-content/uploads/2020/01/Equal-Opportunities-Bill-Belize-Draft-dated-10.1.20-1-1.pdf)

CSOs and affected communities will be sensitizing on the draft bill and capacity will be built to conduct advocacy for policy change.

This Strategic Plan has also prioritized interventions to prevent and manage gender-based violence and sexual violence experienced by women and girls, adolescents and key populations. The interventions are detailed in SPA 2.

At the institutional and service levels clients continue to face stigma and discrimination that hinders access to services along the prevention and treatment continuum.

To address these existing initiatives such as the Human Rights Observatory, documentation of human rights violations through the Shared Incident Data based and the redress system implemented through the Caribbean Vulnerable Communities Coalition and with support from the Global Fund will be strengthened to provide redress in cases of human rights violations. Other mechanisms for redress will be explored such as the Human Rights Commission of Belize and the Belize Ombudsman. The redress system will be supported by a network of lawyers and para-legals to handle human rights breaches. A rights-based legal literacy training will be conducted for PLHIV and KPs so that there is an improved understanding of their human rights and when these are violated. An awareness campaign will be implemented to sensitize PLHIV and KP of mechanisms for redress and how to access these. A regular review of cases will be conducted, and strategic litigation initiated as appropriate. Linkages will be made, and referrals systems will be strengthened with relevant government agencies such as the Ministry of Labor to address employment discrimination, the Police Force in relation to violence towards key population, social protection agencies and gender affairs bureau in relation to gender-based violence and others.

At the institutional level policies and protocols will be reviewed aimed at removing stigma and discrimination in the health care setting and follow up stigma index survey will be conducted to monitor progress and recommendation will be implemented to reduce stigma and discrimination.

At the service delivery level health care workers and patients will be sensitized and re-sensitized on the patient charter. Patients will be empowered to report discrimination from health care workers and health care workers will be trained on understanding Human Rights principles and practices when working with key populations and to deliver non-judgmental, non-discriminatory services in a respectful manner.

The Belize Network of PLHIV and people will be strengthened based on a comprehensive organizational assessment and capacity building plan. People with and affected by HIV/STIs/VH and TB will be empowered to bolster advocacy efforts, policy coherence and program coordination, strengthen accountability and address factors that affect access, uptake, performance and outcome of the response.

Strategic Objective 3.2: Strengthen capacity and protect human resources to adequately address HIV/STI/VH and TB responses.

The Strategic Plan presents an opportunity to address the gaps identified in the Ministry of Health and Wellness Human Resource Assessment conducted by the Ministry of Health and Wellness and to align with the strategic directions of the Ministry of Health and Wellness Human Resource Strategic Plan 2019-2024 to invest in the health workforce, to implement innovations such as task shifting and task sharing and moreover to incorporate lay workers in the CSO sector for service delivery. Further the integrated approach to responding to HIV/STI/VH and TB has the distinct advantage of accruing efficiencies around existing human resources.

For the implementation of this integrated HIV/STI/VH and TB plan and to deliver to services everyone, human resources in sufficient quantity and with the right skill sets must be in place to address coordination, program planning and implementation. To be more strategic, an assessment will be done to define the current human resource availability, estimate the needs and competence to effectively deliver the HIV/STI/VH and TB interventions for equity and to recommend innovation to bride the human resources gap such as cross training, task shifting and task sharing between the four disease areas. The assessment will also consider the CSOs care providers including lay testers, outreach workers and others who are not in the traditional health sector.

The role of lay providers in the public and CSO sectors involved in the HIV response, will be expanded to deliver integrated services particularly in community outreach, and testing for HIV/STI/VH and TB, care and support initiatives such as integrated DOTS. Innovations such as task shifting and task sharing as described in the expanded role of DOTS TB workers to cover outreach work for HIV/STI and VH such as contact tracing and tracking of loss to follow up will be implemented and closely monitored to ensure quality of services.

There will be substantial capacity building for all levels of health care providers including those with CSOs and engaged in community service delivery. Training will be conducted in required areas of expertise and will include cross training to adequately respond to the integrated approach for HIV/STI/VH and TB.

Coordination and implementation of this integrated approach to HIV/STI/VH and TB will require leadership at the nation level- Ministry of Health and Wellness and National AIDS Commission. The Human resource needs assessment will prioritize the HR needs at the leadership level of Ministry of Health and Wellness and NAC and recommendations will be implemented as priority for effective coordination, implementation and monitoring and reporting of this strategic plan.

Investing in human resources for equity also means protecting the human resource. A comprehensive occupation and safety occupational health and safety programs, which promote universal precautions, access to prevention commodities such as condoms, post-exposure prophylaxis for exposure to HIV, confidential HIV/STI/VH/TB testing, and treatment and care for health workers.

Strategic Objective 3.3: Achieve Robust and Effective Supply Chain Management for uninterrupted supplies of quality assured of medicines and commodities.

The scale-up necessary to achieve the vision and goals will require an expansion in coverage of services along the continuum of care- prevention, diagnosis, and treatment- for HIV/STI/VH and TB. To ensure long term sustainability of procurement and supply chain management, Belize will continue to procure and supply for HIV/STI /VH and TB within the broader health sector procurement mechanisms as this has significant efficiencies in terms of economies of scale with bulk procurement and consistency of supply. The integrated approach to procuring HIV/STI/VH and TB commodities also allows for scheduling of deliveries for a consistent uninterrupted supply as well as reducing wastage through expiration of commodities. Belize will explore cost saving and more efficient mechanism of procurement such as the PAHO Strategic Fund.

Capacity will be built in morbidity-based forecasting and a quantification super-group will be established to lead the quantification process, monitor use of commodities and medicines, identify potential issues such as stock out and expiration of pharmaceutical and examine mechanisms for greater efficiencies and improvement in supply chain management. All steps of the supply chain cycle will be closely monitored to ensure delivery of medicines and commodities to every person who needs.

Strategic Priority Area 4: Responding for Sustainability

Sustainability is key and cross cutting pillar in this strategic plan. Partnership with CSOs, the private health sector and key populations, enhanced governance and accountability at the political and technical levels, the empowerment and engagement of PLHIV, key populations and communities affected by HIV/STI/VH and TB, focusing interventions on the key populations, addressing human rights and efficiencies in supply chain will all contribute to technical and allocative efficiencies and overall sustainability of the response. This SPA will focus on financial sustainability.

Goals for Responding for Sustainability

1. Dependency on external donor financing is reduced to less than 10% by the end of 2025
2. Innovative financing mechanism with CSO for HIV/STI/VH and TB service delivery fully develop and implemented by 2022

Strategic Objectives

4.1 Estimate resource needs for the HIV/STI/VH and TB response and implement measures to address financial gaps
4.2 Engage the Belize NHI for financial protection and reduce financial risk in expanding scope and scale of services
4.3 Secure reduce prices and increase competitiveness for medicines, commodities and supplies for HIV/STI/VH and TB

4.4 Implement Innovative Financing mechanisms to engage CSOs for Key Populations response.
4.5 Strengthen resource mobilization

HIV spending in 2018- 2019 is 4,333,438 USD of which Governments contribution is 1,915,527 USD (44.2%) and international donors, 2,259,475 (52.1%). Overall HIV expenditure for 2019-2020 decreased to 2,854,537 USD, due to the reduction in donor funding- 671,000 (23.5%). The increase from the GoB was minimal- 2,026,298 USD. The minimal increase in the GoB funding did not match the decrease in donor funding and evidently, presented as a significant shortfall in funding for the HIV response and cited as a key factor in the underachievement of the previous National HIV/STI strategic Plan. [70]

In 2017, most of the funds for the TB programming was donor funded however, in 2019 with 64% of TB expenditure from public funds. [71] Additionally, the impact of the COVID-19 pandemic on the economies of Caribbean countries is significant. Many countries will experience reduction in GDP, while some may experience negative growth. The fiscal space will become restrictive and therefore prioritization across sector will become crucial for governments[72].

In this strategic plan, HIV/STI/VH and TB financing will focus on reducing costs and increase efficiency in the allocation and use of resources and will enhance financial protection, so that those who need them can access the health services without incurring financial hardship.

Strategic Objective 4.1: Estimate resource needs for the HIV/STI/VH and TB response and implement measures to address financial gaps

Belize will seek to better understand its financing landscape, resource needs and gaps. As an immediate and priority action, this strategic plan will be costed to understand the resource needs to fully deliver a comprehensive response. Many of the recommendations stemming from the 2018 transition readiness assessments are incorporated as part of the essential package of services and as strategic interventions for equity and sustainable financing.[73]Despite this, a financial transition plan will be developed to guide the incremental increase in domestic allocations and reduce donor dependency while ensuring that comprehensive HIV/STI/VH and TB services are delivered.

In collaboration with UNAIDS, Belize will develop an investment case for HIV/STI/VH and TB that outlines smart investment with best value for money.
The investment case will provide guidance on effective, rights-based responses that should be scaled up for enhanced equity and inclusiveness and to overcome barriers for the populations most in need of services. The investment case will also provide information on the mix and coverage of the interventions and investments in the high- burden districts and key populations for impact. It will also provide strategic directions of investments and approaches to reduce commodity costs, alter delivery systems, integrate services and decrease overhead expenses, all key elements for financial efficiencies and sustainability and will explore new funding mechanisms to bolster domestic contributions, critical considering the current financing landscape.

[70] An Assessment of HIV, AIDS and Tuberculosis Financing Flows and Expenditure FY 2018/19 and FY 2019/20
[71] https://worldhealthorg.shinyapps.io/tb_profiles/?_inputs_&lan=%22EN%22&iso2=%22BZ%22
[72] https://www.iadb.org/en/improvinglives/weathering-coronavirus-storm-caribbean
[73] Belize Transition Readiness Assessment Report, May 2018

The investment case will be a key resource mobilization tool in guiding the application for the upcoming Global Fund funding cycle and other funding opportunities.

Expenditure monitoring and cost and cost analysis will be conducted regularly to guide resource allocation, identify opportunities for cost reduction and redistribution of funding across diseases and their technical areas. National Health Accounts and National AIDS Spending assessments will be conducted on a scheduled basis to understand allocations and expenditure to ensure robust and fair financing. Costing and cost analysis will also be done for PrEP, and other initiatives and will be used to guide decision making on implementation and scale-up, value for money, and sustainability. The costing of these packages will be integrated in the overall costing of this strategic plan.
Local capacity will be built to conduct costing and cost efficiency analysis which itself is a sustainable approach for gathering strategic information to guide health financing.

Strategic Objective 4.2: Engage the Belize NHI for financial protection and reduce financial risk in expanding scope and scale of services

The Ministry of Health and Wellness will continue to work with the National Health Insurance to increase financial risk protection and pooling. In 2001, Belize introduced a National Health Insurance (NHI) Scheme which was established not "primarily about how to raise money for health care, but change the way that health funding is spent (value for money/equity) through the principle of an informed purchaser from a choice of providers". Under this scheme, primary care services are offered through a network of primary care providers (private and not-for-profit such as BFLA) to offer quality low-cost health services in defined geographical areas. Essential health services offered in the package of care covered by NHI are provided either free or for a small co-payment.[74]
The NHI established to support the achievement of UHC, has provided coverage only 30% of the total population. The NHI recognizes the need for an urgent policy decision on the Financing aspect of the Scheme so that 100% of the population has access to a Primary Care package of services that is of excellent quality, is efficient and effective, and sustainable. The NHI guided by its strategic objective for expanded coverage and financial sustainability, will undertake several studies to expand coverage and ensure sustainability, including a fiscal space study, costing analyses and payment mechanism study. The

The MoHW will coordinate with the NHI to include in these studies cost benefit analyses for new services and the expansion of ongoing HIV/STI/VH and TB services. The cost benefit analyses will focus on understanding the cost for the essential package of services including high impact interventions and innovations such as PrEP, treatment of Hepatitis C and the mechanisms in which these can be included in the menu of services covered by the NHI.

[74] https://health.gov.bz/www/health-projects/national-health-insurance, https://health.gov.bz/www/health-projects/national-health-insurance)

Strategic Objective 4.3: Secure reduce prices and increase competitiveness for medicines, commodities and supplies for HIV/STI/VH and TB

Initiatives will be implemented to address policies that will lead to reduced prices such as the use of high-quality generic medicine, understand the dynamics and shifts in supply chain and identify opportunities for reduced prices on the global market and understand the mechanisms for accessing these. A high level working group will lead the discussion on sustainability.

Belize will leverage the efficiency of an integrated, sector wide procurement system to accrue cost reduction and efficient use of resources to procure HIV/STI/VH and TB commodities. Additionally, Belize will use other regional and sub-regional mechanisms that allow for price negotiation and procurement, including the PAHO Pooled Procurement through the Strategic Fund.

Strategic Objective 4.4: Implement Innovative Financing mechanisms to engage CSOs for Key Populations response.

The coordination and implementation of this strategic plan that is integrated into health systems approach will require increased and optimized financing, with equity and efficiency taken into consideration and priority given to the first level of care and to the most vulnerable and at risk populations. To achieve this, sustainable and efficient funding models, including social contracting for CSOs response to key populations, will be explored and implemented. A review will be conducted to ensure that the legal and regulatory frameworks facilitate social contracting with CSOs. Recommendations, as necessary will be implemented to advance the social contracting engagement with CSOs. To prepare CSOs for social contracting, an organizational and management assessment will be conducted to ensure that the capacity for programmatic delivery, financial management and monitoring and reporting are adequate. A capacity building plan will be developed to assist CSOs to address any weaknesses identified in the organizational and management assessment. In addition, the GoB define and implement a transparent and accountable process for selection of CSOs for social contracting and will define avenues for predictable funding for social contracting. In addition to social contracting, CSOs will coordinate through the CSO hub or other mechanisms on strategic planning, to reduce duplication also contributing to sustainability. Capacity building with CSOs will also focus on proposal development and mobilizing external funding as well as advocacy and political engagement for sustainability.

Strategic Objective 4.5: Strengthen resource mobilization

The donor coordination group will work with the MoHW to provide technical guidance in relation of sustainability of the response and support the MoHW for high level political advocacy for increased domestic resources for the HIV/STI/VH and TB responses.

A resource mobilization plan will be developed and focused on different mechanisms for financing the response including leveraging non-traditional donors and the local private sector. Capacity will be built with CSOs to prepare proposals and apply for funding in addition to social contracting engagements with the GoB.

CHAPTER 5

NSP Implementation Framework

Coordination and Oversight

The Coordination for this strategic plan will be done collaboratively between the Belize National AIDS Commission and the Ministry of Health and Wellness. This will be a shared responsibility between the NAC and MOHW with clear delineation of roles and responsibilities. The integrated approach presented in this plan will significantly scale up the biomedical intervention will be optimally coordinated, implemented and monitored by the MoHW.

Specifically, the MoHW will lead the national planning and implementation of the medical response including for prevention, treatment, care and support, monitoring and evaluation for HIV/STI/VH and TB. Regular coordination meetings will be convened with the NAC and MOHW.

The Belize National AIDS Commission (NAC) was established in February 2000 as a multi-sectoral committee under the Office of the Prime Minister (OPM). The legislatively mandated function of the NAC is to coordinate, facilitate, and monitor the national response to HIV, including the National Strategic Plan (NSP). In collaboration with the Ministry of Health and Wellness (MOHW), the NAC shares responsibility for advocacy, resource mobilization, development of policy and legislation, and overall implementation monitoring and evaluation of the response.

The NAC membership comprises key ministries and departments, statutory bodies, civil society organizations and the private sector. The NAC, which falls under the governance portfolio of the Office of the Prime Minister, oversees the implementation of the NSP for HIV and provides overall policy guidance to all partners. In this role, the NAC also serves also as the umbrella agency for the GFATM Country Coordinating Mechanism (CCM), which oversees in collaboration with the GF Principal Recipient, the implementation of any ongoing GF-funded project.

The NAC will be continue to be responsible for advocacy, resource mobilization and development of policy and legislation, and will share responsibility with the Ministry of Health and Wellness for monitoring and evaluation of the response.

Thematic technical working groups will be established for SPAs – Strategic Information working group, Prevention working group and Treatment working group- and provide technical leadership for program planning, implementation and monitoring. The technical working groups will liaise with each other for a coordinated response.

The National Multi-Sectoral Forum will continue to provide overall leadership and coordination of the national response.

Implementation

Implementation of the Plan will be based on the five- year operational plan which clearly identifies the lead implementing agency and supporting agencies and will be implemented in a phased approach.

Implementing institutions include government ministries and institutions, private health sector and civil society. CSOs will take the lead in delivery services in the communities and to the key populations. UN and other technical partners will provide technical support to implementation, monitoring and evaluation and reporting.

The implementation plan will be reviewed and updated at annual national planning meetings.

Resourcing of the Strategic Plan

The Strategic Plan will be costed, and the resource needs established. The Strategic Plan will be financed by the GoB and with support from donors, at this time, mainly the Global Fund Against AIDS, Tuberculosis and Malaria. The GoB will continue to allocate finances in its national budget.

The Global Fund has invited the GoB to submit a funding proposal for 2,991, 251 USD for HIV and building resilient and sustainable health systems.[75] UN partners- PAHO, and others will provide technical resources and expertise. The donor group will support the MoHW for high level political advocacy for increased domestic resources.

A resource mobilization plan will be developed and strategies for bridging resource gaps will be defined and could include leveraging funds from non-traditional donors and local private sector.

Monitoring and Evaluation

A monitoring and evaluation framework is developed outlining the M&E systems, processes, and reporting requirements. The plan also includes indicators and targets to monitor and measure progress and impact. The NAC and MoHW will provide overall oversight for the M&E plan, through strategic information working group.

[75] Global Fund Belize 2020-2022 allocation letter