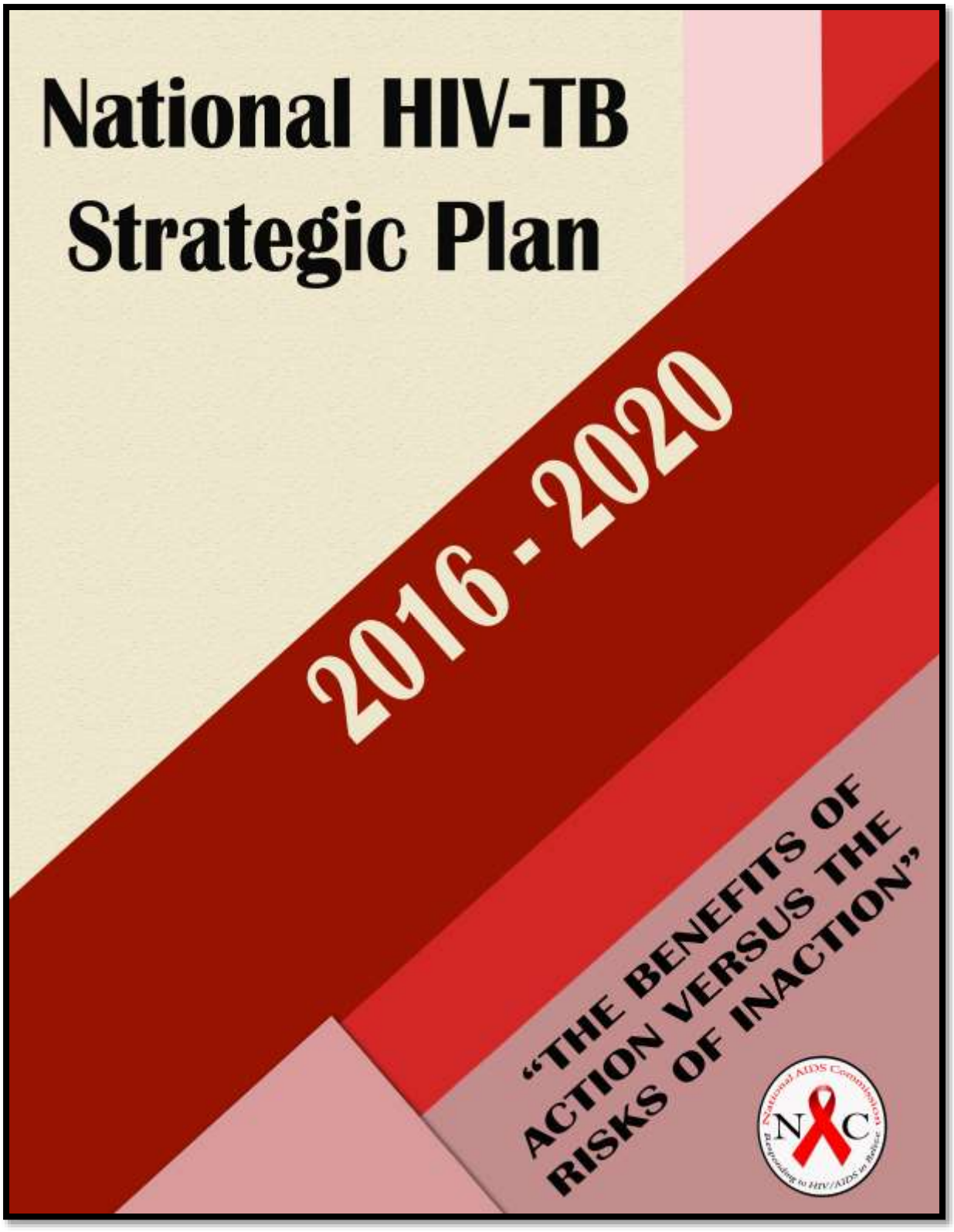

(Design: NAC)

National AIDS Commission
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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral (Drugs)
BCC	Behavior Change Communication
BDF	Belize Defense Force
BFLA	Belize Family Life Association
BFLA-YAM	BFLA-Youth Advocacy Movement
BHIS	Belize Health Information System
BSS	Belize Sero-prevalence Survey
BRC	Belize Red Cross
BNTU	Belize National Teachers Union
CNET+	Collaborative Network of persons living with HIV
COMISCA	Council of Ministers of Health of Central America (and Dominican Republic)
FSW	Female sex workers
GF(ATM)	Global Fund (to Fight AIDS, Tuberculosis and Malaria)
GOB	Government of Belize
HFLE	Health and Family Life Education
HIV	Human Immunodeficiency Virus
IEC	Information, Education, and Communication
LGBT	Lesbian, Gay, Bi-Sexual and Transgender
MCH	Maternal and Child Health
MHDST	Ministry of Human Development and Social Transformation
MICS	Multiple Indicator Cluster Survey
MOEYS	Ministry of Education, Youth and Sports
MOEYS-DYS	MOEYS- Department of Youth Services
MOH	Ministry of Health
MLLGRD	Ministry of Labor, Local Government and Rural Development
NAC	National AIDS Commission
NAC-IEC	NAC Information Education Communication committee
NASA	National AIDS Spending Assessment
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NOF	National Operational Frame
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PASMO	Pan American Social Marketing Organization
PITC	Provider-Initiated Testing and Counseling
PMTCT	Prevention of Mother-to-Child Transmission
PSM	Procurement and Supplies Management
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex workers
UNAIDS	United Nations Joint Program for HIV/AIDS

UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization
YES	Youth Enhancement Services

EXECUTIVE SUMMARY

Belize has formulated its third HIV National Strategic Plan (NSP), which spans the period 2016-2020 and which connects the HIV response to the national response to Tuberculosis (TB). The plan aims to be a user-friendly tool to guide the national response to HIV and TB, turning a number of core intervention targets into a blueprint for action. The NSP 2016-2020 confirms the need to narrow the intervention focus as the epidemic has evolved into one that is concentrated in the population of men who have sex with men. The NSP also reflects the conclusion that the current trend in the reduction of new HIV infections is neither sufficiently steep nor consistent to break the epidemic. It acknowledges a window of opportunity and is aware of the need to confront existing pressures and competition for financial resources. It also takes the position that lack of expansion or inaction will cause the epidemic to rebound with a more devastating consequence. Against this background, the plan has adopted a set of ambitious but realistic goals and targets.

The current situation of HIV and HIV-TB is defined by a few key factors that drive the direction of the response:

- While the overall HIV prevalence in adults has dropped from 2.1% to 1.4%, the population of men who have sex with men is now the group that records by far the highest HIV prevalence rate (13.9%) while it is expected to generate two-thirds of future new HIV infections. Health care seeking behavior of men who have sex with men is also being negatively impacted by legal and socio-cultural barriers to equitable treatment.
- Furthermore, 20% of new HIV infections are expected to result from casual unprotected heterosexual sex, which is a key attribute of sexual activity among many young Belizeans. The youth population reports furthermore a low level of condom use.
- Past investments in HIV testing have resulted in increased HIV testing of the general population, but testing levels need to be scaled up and to include key target populations to lead to meaningful changes.
- Serious gaps in the provision of HIV treatment and care services require to be filled. Although ARV coverage has moved in the right direction, coverage remains low while mechanisms to engage persons who test HIV-positive in care settings are fragile.
- The 12-months ART retention rate is dangerously low (<50%), rendering any required expansion of investments in HIV and HIV-TB treatment ineffective. Collaborative actions within the health system to detect and treat HIV-TB co-infections need to be boosted to fully reduce the burden of TB in persons living with HIV.
- Human rights infringements and wide-spread stigma and discrimination of persons vulnerable to or living with HIV negatively impacts choices for healthy living and health care seeking behavior.
- The current assessment provides sufficient indications to focus on the specific key affected populations of men who have sex with men, young persons and persons living with HIV and HIV-TB co-infections and to design for these groups a number of scaled-up, high-impact responses.

To move toward the ability to break the HIV epidemic, the NSP has adopted the following vision for the year 2020

The national response to HIV and TB in Belize is well poised to reach the 95/95/95 fast-track targets of 2030, while the burden of TB in persons living with HIV will have been eliminated.

The NSP 2016-2020 is underpinned by a number of normative, strategic and technical guiding principles, which has enhanced the formulation of a set of goals, targets and interventions strategies that will move the country to the overall goal of breaking the HIV epidemic by 2030.

The NSP builds on the success and structure of its predecessor NSP 2012-2016 and manages four Key Results Areas (KRA): Prevention; Testing; Treatment; and Removing Barriers. Within this landscape, the NSP defines three-layers of focus of intervention:

1. High-impact interventions and goals for specific key affected populations, forming the core of the NSP;
2. Peripheral interventions and goals for the general population, complementing the achievement of the core goals;
3. Consolidation and further mainstreaming of successful intervention strategies.

The NSP does not include a focus on the third layer as it is of the opinion that mainstreaming and further consolidation of successful approaches is an ongoing obligation of the state and its social partners;

The following matrix provides an overview of the response elements of the NSP:

Goal & Intervention Strategy	**Strategic Objective**
KRA Prevention	
Goal 1 (priority level) New HIV infections among persons, 15-24 years, account for a maximum of 8% of all new infections. **Intervention strategy** Intensified comprehensive HIV prevention services targeting all persons 15-24 years of age	A minimum of 80% of persons 15-24 years, in-school and out-of-school, partake in improved HIV prevention activities.
	A minimum of 90% of persons 15-24 years, in-school and out-of-school, are annually reached or actively involved in HIV prevention messages on social media channels
	The national condom and lubrication distribution plan is operational and has contributed to a minimum level of 80% in reported use of condom among young persons
	National social protection schemes offer effective support to girls and young women, highly at risk for transactional or forced sex.
Goal 2 (priority level) New HIV infections among men who have sex with men account for a maximum of 30% of all new infections. **Intervention Strategy**: scaled-up comprehensive HIV prevention services for men who have sex with men	Studies and surveillance data have generated an increased in-depth knowledge of the sub-population of men who have sex with men.
	A minimum of 80% of men who have sex with men are annually reached through HIV interventions that focus on increased HIV testing and subsequent engagement in care.
	The national HIV prevention plan, including condom and lubricant programming, is operational and has contributed to a minimum level of 80% in reported use of condom among men who have sex with men.
	Targeted HIV intervention strategies for men who have sex with men have secured the full involvement of that key population in their design and implementation.
KRA Testing	
Goal 3 (priority level) 70% of persons with HIV know their HIV status, including 80% of	Adoption of a National HIV Testing Plan, positioning HIV-testing as an integral component of overall health testing and containing projections and implementation schemes that are based on the 2020 and 2030 targets

men who have sex with men living with HIV. **Intervention strategy**: **i**ncreased targeted HIV testing opportunities for the general and specific key affected populations	The establishment of an adequate number of HIV testing facilities, which are friendly to men who have sex with men.
	All medical care providers, including NHI primary care providers, apply standard provider-initiated testing and counselling services.
KRA Treatment	
Goal 4 (priority level) 80% of persons living with HIV, who are on ART, remain on ART. **Intervention strategy**: intensified and improved comprehensive management of HIV and HIV-TB cases.	Belize's integration into the regional supply chain of HIV-related medical products, while improved Procurement and Supply Management has reduced ARV procurement costs and has contributed to multi-year zero ARV stock outs.
	The expansion of the continuum of care for children and adolescents living with HIV enhanced through new partnerships with NHI and the community-health system
	The clinical management of all cases of persons on ART includes consistent routine CD4 and Viral Load testing.
	The involvement of representatives of all operational organizations of persons living with HIV in the process flows for monitoring and reporting of the quality of care and treatment services.
	The expansion of existing social protection schemes from state and civil society actors, covering vital support needs of 90% of eligible persons living with HIV, including 100% of children living with HIV.
Goal 6 (peripheral level) 90% of persons living with HIV are connected to HIV care and treatment. **Intervention strategy**: improving ARV coverage	A minimum of 95% of persons testing positive for HIV are engaged in HIV care within 1 month after knowing their test result.
	The health system is using the Resource Needs Model to project the future cost and absorptive capacity of treatment of HIV
KRA Removing barriers	
Goal 5 (priority level) Reported discrimination in the provision of HIV-related health care services has moved toward "zero discrimination". **Intervention strategy***:* Intensified and well-monitored anti-stigma and discrimination programs in the health and allied health sector	The removal of legal barriers in the public domain that oppose the principle of universal access to treatment and services.
	The establishment of an independently managed complaints mechanism for the reporting of violations of medical confidentiality and/or denial or unavailability of health-care services.
	Sensitization and attitude changing programs on HIV & TB-related anti-stigma & discrimination provided to all health and law enforcement professionals as well as all policy- and opinion makers
Goal 7 (peripheral level) 50% of HIV and HIV-TB services are delivered via community-level health services.	The efficiency and effectiveness of services to persons living with HIV or a HIV-TB co-infection have improved dramatically
	All relevant professionals in the health sector are adequately equipped for the management of HIV and TB cases

The NSP contains a section that presents the NSP Operational Frame. This frame provides for the period 2016 –2018 for each strategic objective a blue print for action through specific objectives and related strategic activities.

The NSP contains the NSP Monitoring and Evaluation Framework, which presents all components of performance monitoring and evaluation. The frame serves as a guide for the construction of the subsequent Annual NSP M&E Plans

INTRODUCTION

This document contains Belize's third successive HIV National Strategic Plan (NSP) 2016-2020. It is in part the result an in-depth review and update of its predecessor NSP 2012-2016. The plan will be reviewed and adjusted periodically to stay aligned with changes that may occur, over time, in the epidemiological profile, the national enabling environment and technical insights and approaches.

The National AIDS Commission (NAC), which serves as the steward of the plan, regards the NSP as an instrument that will deepen engagement, collaboration and coordination among key stakeholders in the planning and implementation of the national response. The plan aims to be a user-friendly tool for guidance. It provides insight into the profile and key determinants of the epidemic, defines priority target groups and articulates a number of core intervention targets, enabling the periodic assessment of progress and success. It also turns the strategic outline of the response into an operational blueprint for action.

The NSP 2016-2020 confirms the need to further focus the intervention focus as the epidemic has evolved into one that is concentrated in the population of men who have sex with men. The NSP also signals that, 30 years after the first case of HIV/AID was reported in Belize, the current reduction in the number of new HIV infections is neither sufficiently steep nor consistent to break the epidemic within the foreseeable future. Evidence emerging from UNAIDS strongly suggests that, if efforts to move toward meeting the ambitious 90-90-90 target over this critical five-year window of opportunity are not intensified, the epidemic will rebound with an even more devastating and costly consequence.

While a substantial portion of the HIV response is dependent on unpredictable external financing streams, the national response to HIV and TB is increasingly competing with the rise in Non-Communicable Diseases for the allocation of domestic public resources. As a national plan for the scale-up of the HIV response currently does not exist, the NSP 2016-2020 reconfirms with a sense of urgency the need for the Belizean state and social partners to construct efficient intervention and financing mechanisms that enhance the sustainability of the HIV and TB response in the longer term. The NSP therefore advocates for immediate, narrow but high-impact targeted investments to break the epidemic as a means to realize the right to good personal and public health at an affordable cost to health services users and providers.

The elaboration process of the NSP occurred in two stages. In the second quarter of 2015, a desktop in-depth review of the implementation of the NSP 2012-2016 was performed to identify and deduct key successes, constraints and lessons learnt from the national response. The assessment was reviewed and validated by broad group of stakeholders, including men who have sex with men, transgender persons and young Belizeans and the final results were compiled in the "*Report of Proceedings and Results; Consultation for assessing the National HIV Strategic Plan 2011 – 2016 and the related gap analysis; June 2015).*

In the third quarter of 2015, updated epidemiological data were consulted and a final draft of the NSP was elaborated via a phased consultative process with the core stakeholders in the national response. The final version was adopted by the commissioners of the National AIDS Commission.

THE NATIONAL STRATEGIC PLAN 2016 - 2020

Chapter 1 Synopsis of 2015 Situation Assessment

This chapter provides a compressed overview of the context and salient characteristics of the HIV epidemic in Belize, which includes the epidemiological profile as of mid-2015, the determinants of the epidemic and the key affected population groups. A more detailed overview of the situation assessment is provided in Appendix 1 of this document. The assessment has provided the evidence-based inputs into the formulation of goals, strategies and objectives of the updated National Strategic Plan 2016 - 2020

Epidemiology

Belize has multiple ties with the Caribbean region and the Central American isthmus. Its estimated 2015 population is 368,310[1]and some 45% of that population resides in urban areas. Almost one quarter of the population lives in Belize City. Belize has a concentrated HIV epidemic with some residual load in the general population. The overall HIV prevalence rate is 1.4% of the adult population, but a higher rates has been recorded in specific groups such as men who have sex with men (13.9%; 2012) and incarcerated persons (4.9%; 20050). Other groups record lower rates, including young persons 15-24 (0.6%; 2014) and female sex workers (0.91%: 2012).

From 2010 to 2014, new HIV infections have fluctuated between 250 and 220 cases per year; in the age cohort 15-24 years, women are more infected than men, while in the 29-64 years old age group, there are consistently more cases in men. Peaks of reported new HIV infections have moved from women in the age cohort 20 – 29 (2010) to men in the age cohort 35 - 49 (2014).
The Belize District reports the highest rate of new HIV infections (10.8 / 10,000), followed by Cayo (5.4 / 10,000) and Stann Creek (5.2 / 10,000) districts while HIV continues to affect more men than women. Both features are also the case for TB and HIV/TB co-infections.

The number of reported annual AIDS-related deaths has decreased from 106 in 2010 to 79 in 2014. In 2014, 24 persons were diagnosed HIV+ and died the same year. Approximately 55% of all reported AIDS-related deaths in Belize occur in the 20-44 years age cohort while close to 90% of all reported AIDS-deaths occur on in the 20 - 60 years old. AIDS-related deaths occur most in men at a ratio of close to 2: 1.

Determinants and risk factors

Sexual Debut and Multiple Partners

- High adolescent birth rates (65.4%) reflect high levels of early and unprotected sexual activity among adolescents. The average age of sexual debut for males and females 15-19 years is 16.4 years.
- Studies point at the existence of a variety of sexual arrangements among young persons, leading to multiple opportunities for casual sex with multiple partners. 20% of survey respondents (15 to 24 years) reported having had multiple sex partners in the 12 months period prior to the survey; more than half of them were 15 to 19 years old.

[1] Statistical Institute of Belize; Population Estimate September 2014; http://www.sib.org.bz

- The general features of high risk behavior fuel the inconsistency between HIV prevention knowledge and actual behavior.

Condom use

- In 2013, 55.1% of men reported the use of a condom the last time they had anal sex with a male partner, down from 80.1% in 2010 and 56.4% of sex workers (female & male) reported the use of a condom with their most recent clients, down from 88.3% in 2010;
- Condom use among persons 15-24 years with multiple partners was 48% for females and 66% for males; a similar trend shows for condoms use with a non-regular partner.
- 42% of young women showed to have comprehensive knowledge about HIV transmission; for the age bracket 15-19 this was only 39.1% (MICS 2011).

Poverty

- Poverty (41.3%) and indigence (16%) call for the deployment of unconventional coping strategies, including transactional hetero, same-sex and inter-generational sex services.
- The risk is especially high for girls and women to become engaged in risky sexual activities, via consensual and non-consensual transactional sex as well as through human trafficking.

Legal and socio-cultural factors

- Comprehensive sexuality education is inconsistently delivered to young persons and has contributed to incomplete knowledge among youth on HIV, STIs and pregnancy.
- Under Belize's Criminal Code, anal sex is recognized as a criminal offence and therefore enhances criminalisation by exclusion in the various domains of public life. Meanwhile, hate-crime has not been legally defined.
- Gender norms and roles impact on sexual practices and risk behaviors of men and women as well as on health care seeking behavior of, especially, adult men.
- Victims of violent and forced sexual activity in public institutions, including prisons, and private domestic settings are particularly vulnerable to contracting HIV and other STIs along with profound impact on personal safety, self-esteem and psycho-social well-being.
- Stigma and Discrimination studies report of cases of discrimination and harassment towards men who have sex with men and transgender persons in community-settings, education and health services.

Key affected population groups.

Recent HIV prevalence data, results of the 2014 Modes of Transmission study and most recent sexual behavior and knowledge data provide a strong indication of the existence of a number of key populations who are highly vulnerable to and/or affected by HIV:

Men who have sex with men

- Close to two-thirds of the expected annual number of HIV cases will be in men who have sex with men. Although the group is likely an aggregation of a number of diverse sub-populations, it is by far the single most affected group, in terms of HIV prevention, HIV testing and HIV treatment, care and support:
- Men who have sex with men report having sex with multiple partners while the reported use of condoms is low, pointing at the inconsistency between HIV prevention knowledge and risk-reducing behavior.

- Men who have sex with men are impacted by external and/or internal factors. Legal provisions and stigma and discrimination by professionals (or the general public) create barriers to self-identification of the sexual preference and accessing health services. Internalization of perceived stigma and discrimination renders a similar net effect.

Young persons

- The MOT findings show that 20.3% of new HIV infections will occur as a result of casual heterosexual sex. Additionally, recent survey data show that there are multiple opportunities for casual sex with multiple partners among young persons 15-24 years. Of all survey respondents 15-24 years, 20% reported having had multiple sex partners, while more than half of them were 15 to 19 years old. Meanwhile, condom use among persons 15-24 years with multiple partners was 48% for females and 66% for males with similar trends for condom use with a non-regular partner.
- The overarching indication is that males are more affected by HIV than females, both in terms of new infections (HIV and HIV/TB), developing AIDS and dying of AIDS-related complications, including TB.
- Although males 40-49 years report peak number of new HIV cases, this NSP assigns a priority focus to preventing HV infections among young males 15 – 24 years as they face critical age- and gender-specific factors such as experimental multiple-partner sexual relations, market-driven consumption and communication patterns, peer pressure, crime and violence, low healthcare seeking behaviour, inadequate education, poverty and unemployment. The vulnerable situation of males 40-49 years, who are assumedly engaging more in transactional unsafe sexual relationships with either young women or young men, will be addressed by assigning a priority focus to scaled-up HIV testing in this sub-population.
- Aware of the multi-layered risks of young women to persistent violations of their right, this NSP advocates for continued investments in the protection, leadership skills enhancement and empowerment of adolescent girls and young women to strengthen their self-protection and determination when engaged in sexual relationships as well as facing threats of sexual intimidation or abuse

Persons living with HIV, including an HIV-TB co-infection

- The number of persons living with HIV is estimated to be between 3,000 (MOH; 2013) and 3,300 (UNAIDS) and there is no indication of the geographic distribution.
- The most recent ARV coverage figure is a 50.7% (2013). Aiming for the 90-90-90 targets, the current 2018 national target for ARV coverage is set at 75%.
- More than half of persons living with HIV who start ART are not on treatment after 12 months. As poor adherence creates a challenge to achieving the 90-90-90 targets, this situation also reflects the existence of barriers to using treatment as a prevention tool.
- The NSP makes a special case for ARV coverage, ART adherence and care and support for children 0-18 as paediatric HIV treatment, care and support are more extensive and costly and carry a high level of obligation to protect and fulfil the rights of the child as it goes through the life cycle stages.
- The combined HIV-TB disease burden is relatively high; approximately 1 in 5 persons diagnosed with TB is also HIV positive. The estimated HIV-TB co-infection incidence rate is 8.1 per 100,000 of population (2013) and TB, as opportunistic infection, plays a substantial role in HIV mortality in Belize.

There are a number of population groups that are not part of the high-impact focus of this NSP but whose situation and condition remains to be monitored and further investigated.

Commercial sex workers: The estimated HIV prevalence among this group is around 0.9% (BSS; 2012), lower than the overall prevalence rate and lower than previously estimated. Several aspects warrant continued attention to the dynamics and practices of commercial sex work, including the following:
A reported reduced use of condoms among female sex workers (from 88.3% in 2010 to 56.4% in 2013 according to PASMO's TRaC studies), increasing their risk, and that of their clients;
Anecdotal evidence suggest a widening spectrum of transactional/ commercial sex work going beyond the establishment-based commercial sex work and including men having commercial sex with men, ambulant women who offer sex to paying customers and young women who have sex with older men in return for economic benefits.

Persons with disabilities: Although persons with disabilities were identified in the NSP 2012 – 2016 as a sub-population most-in-need of HIV prevention services, no significant efforts have been undertaken in addressing the HIV-related situation of this group. The National AIDS Commission suggests that the widespread believe and perception that the life of persons with disabilities is devoid of sexuality and sexual activity, may in fact form the key barrier to changing the persistent in-action.

Transgender persons: There is a lack of HIV and/or TB epidemiological data and profiles of the transgender community and the inclusion of this sub-population as a population at-risk reflects the desire to generate an articulated epidemiological profile. Transgender persons, and especially transgender women, have reported to be subjected to serious levels of discrimination and harassment in community-settings, education and health services. In a similar fashion as with the community of men who have sex with men, this situation creates barriers to emotional intelligence, self-esteem and the uptake of HIV prevention and treatment services.

Foreign-born Workers and Incarcerated Populations: The majority of foreign-born workers is males and originates from Guatemala, which reports a high TB burden. Due to poverty, many may be latent TB cases when migrating to Belize, where they again face multiple challenges, including sub-standard living conditions, lack of legal documentation and fear of deportation. These factors combine to limit their access to social and health services, placing them at increased risk for adverse health outcomes.

According to a 2007 WHO Report, the prevalence of HIV, STIs, Hepatitis B and C, and TB in prison populations is estimated to be two to ten times higher than in the general population. A study in 2005 reported a HIV prevalence rate of 4.9% at the Belize Central Prison.

Uniformed Services: Studies have found that military personnel have a higher risk of HIV infection than civilians, in part because of their mobility, work environment and age. A study in 2010 on HIV Infection, Risky Sexual Behaviour and Condom Use in the Belize Defence Force reported a HIV prevalence rate of 1.1%. Many of the current –mostly male- recruits of the police and military forces are young people without previous extended exposure to formal or non-formal education.

Chapter 2 Guiding Principles

The normative frame

- The NSP 2016-2020 takes a human rights-based and child rights-based approach to responding to HIV. The NSP strives specifically to protect the right to good health and health services of vulnerable and most-at-risk girls, boys, women and men, and the right to universal access to affordable and proper health care and social security for persons infected with HIV, especially children.
- The principle of gender equity and equality, and non-discrimination requires a response that secures for all persons the right to freedom from discrimination on account of age, race, sex, gender roles, sexual orientation, socio-economic status, geographic location, disability and level of literacy.
- The NSP adopts the obligation to enhance the greater involvement of key affected populations. Persons infected and affected by the disease(s) understand their own situation better than anyone else and their personal experiences needs to help to shape the response to the disease(s).
- The delivery of the expected results envisioned in this NSP is embedded in the values of transparency of policy and accountability of implementation towards clients, service providers and domestic and foreign financiers of the HIV response.

The strategic frame

- The NSP is linked to a higher-level national development plan. The Horizon 2030 development framework suggests strategic investments in primary healthcare and preventive health strategies and envisions the expansion of the National Health Insurance scheme and the system of care points, especially in rural communities. Horizon 2030 also calls for sound health- related laws, codes and mechanisms that ensure greater transparency and accountability in the use of human and financial resources.
- The NSP is aligned with health sector objectives of the Health Sector Strategic Plan 2014-2024, which aims to halt new HIV and TB infections and to improve health and well-being through broader prevention and health care delivery.
- The NSP components that speak to the response to TB, MDRTB and HIV-TB co-infections are directly taken from the 2014 National TB Strategic Plan to ensure alignment of the response to the diseases.
- The implementation of the NSP 2016 – 2020 is driven by the acknowledgement of the need for enhanced cost-effectiveness and sustainability. The NSP will differentiate between higher and medium level response impact benefits.
- Management of the implementation of the NSP is rooted in the "Three Ones" approach one national action framework for coordinating the work of all partners; one national AIDS coordinating authority with a broad-based multi-sectoral mandate; and one agreed national monitoring and evaluation system..

Chapter 3 Technical guidance

The following key global or regional initiatives and technical guidelines have played a pivotal role in carving out the directions of the NSP intervention portfolio:

Fast-tracking the response to break the epidemic

Evolving from the globally agreed targets of the 2011 Political Declaration on HIV/AIDS, the global (UNAIDS) 90/90/90 targets for 2020, and more recently the expanded fast-track 95/95/95 targets for 2030, the HIV response must be gearing up to break the epidemic by 2030. This drive is a calculated response to the threat that national responses, if kept at current levels, will facilitate the epidemic to have rebounded by 2030. For Latin America and the Caribbean, UNAIDS projections show that a fast-tracking of the response will avert a high number of HIV infections among men who have sex with men, sex workers and children.

The fast-tracking of the response will require innovations in the delivery of services. HIV testing must be more focused to effectively reach those at greatest risk, and multiple testing modalities (community-based testing and provider-initiated testing) are required to reach the goal of ensuring that 90% of all people living with HIV know their HIV status. Much greater emphasis will be needed on community service delivery, shifting the delivery from facility-based to a minimum of 30% community-based, while improving service uptake in the process.

Implementing and monitoring the HIV Treatment Cascade / HIV Continuum of Care

The HIV Treatment Cascade approach, also termed as the HIV Continuum of Care, is closely linked to the above-mentioned targets. Rather than focusing on a single number in the HIV continuum of care (i.e. HIV treatment coverage), the 2020 and 2030 sets of targets recognize the need to focus on the ***quality and outcomes*** **of the spectrum of response services**. Measuring progress along the cascade of HIV care requires a sound projection of the estimated total number of persons infected by HIV, along with the narrowly monitoring of a) the number of persons who tested and were diagnosed; b) the number of persons with HIV who are engaged in HIV care; c) the number of persons with HIV who are on ART; and d) the number of persons with viral load testing results that show full viral suppression. The Continuum of Care provides a suitable approach to responding to HIV in settings of low available overall resources.

Treatment 2.0

Treatment 2.0 is a global WHO/UNAIDS initiative toward the next scale-up phase of HIV treatment, mainly through the promotion of innovation and efficiency gains. It aims to help countries to reach and sustain universal access to treatment and capitalize on the preventive benefit of antiretroviral therapy (ART). It aims to do this via a. the optimization of Drug Regimens (effectiveness; low-toxicity; affordability; broad suitability); b. the provision of point-of-care and other simplified diagnostic and monitoring tools; c. the reduction of treatment costs to the lowest possible levels without trading off quality; d. the move toward a decentralized and appropriately integrated service delivery with increased community engagement and improved retention in care; and e. the mobilization of communities, including people with HIV and key populations, to be fully involved in the demand creation, planning, delivery and evaluation of the services.

The Joint Approach for HIV/AIDS applications in Central America and the Dominican Republic before the Global Fund

The Council of the Health Ministers of Central America (COMISCA) agreed to a framework for the streamlining of requests from the region to the Global Fund (GF) for financing under GF's new funding model:

- A consensus agreement that men who have sex with men, transgender persons and female sex workers are deemed to be the main key affected populations, although differences between countries and regions within countries may exist;
- The establishment of minimum methodology and quality standards for HIV prevention interventions packages with proposed minimum coverage of 80% of the target population(s);
- A focus on the need for universal access for persons living with HIV to "routine care" with minimum standards for CD4 and Viral Load testing and the phased implementation of the Treatment 2.0 initiative;
- Other key interventions can be HIV-TB, Mother-to-Child Transmission and Congenital Syphilis, Human Rights protection and Community Strengthening.

The joint approach highlights the need to build in a move toward the sustainability of the financing parameters, including the development of a sustainability plan for continued domestic investments in HIV prevention interventions.

Chapter 4 Strategic choices

Almost 30 years after the first case of HIV was reported in Belize, this National Strategic Plan is underpinned by the desire to create a sense of urgency and opportunity to break the HIV epidemic before it gathers new and stronger momentum.

As the cover of this document shows, bends and dents have been made in the evolution of the epidemic: annual new infections fluctuate since 2010 between 220 and 250, after having been stagnant in the period 2002 – 2008 around the 440 level; vertical transmission of the virus has progressed toward a zero level; more persons of the general population are being tested for HIV; and more persons living with HIV have been receiving ARV medication at an earlier stage of the disease's progression while the bio-medical monitoring of treatment effectiveness has started to improve.

The recent reductions in new infections however are not providing convincing indications that Belize is on the road to eliminating the HIV epidemic. This conclusion is supported by indicative evidence that the epidemic has now roots in a specific community which is subjected to counter-productive, discriminatory practices in the public domain, while young Belizeans remain highly vulnerable due to far-reaching impacts of global and local socio-cultural and economic changing realities. Furthermore, these and other similar vulnerabilities are impacting negatively on HIV treatment effectiveness as retention and adherence rates are far too low to expect durable improvements in the quality of life of persons living with HIV and tangible preventive benefits of ART.

The ***fast-track targets and the approach of the HIV Continuum of Care*** are at the core of the intervention choices made in this NSP in order to break the HIV epidemic in Belize by 2030. The following considerations are at play:

a. This NSP focuses on a limited number of challenges and solutions that need urgent attention in order to forcefully push key HIV impact and outcome indicators in the right direction. This means

that other ongoing response efforts, which are not a point of focus in this document, are expected to continue as part of the collective, mainstreamed portfolio responsibility of the respective state and non-state service providers.

The main paradigm here is the consolidation of interventions that have proven to be successful in achieving their aim. We point here specifically at the continued reduction of cases of vertical transmission; the expansion of adequate sexual and reproductive health services; expanded screening for STIs, including the "2-in-1" testing for HIV and syphilis; continued implementation of the policy of HIV in the Work Place; and the accelerated expansion of the national responses to TB ,MDRTB, and HIV/TB.

b. The identification and selection of the goals and related interventions that are of concern to this NSP are driven by aggregating important attributes:
   - *Scaling-Up*, focusing on potentially successful interventions that need to be brought to scale in order to establish detectable and meaningful impact;
   - *Targeted*, focusing on a change in one or more specific groups that play a vital role in the mechanics of the epidemic;
   - *High-impact,* focusing on those changes in people and/or institutions that can move the value of one or more indicators in the HIV treatment cascade.
- *Priority versus Peripheral,* causing the portfolio to distinguish a priority set with goals that take precedent in the future programmatic attention and resource allocation and which reflect a portfolio, without which the adopted overall goal to "starve and break" the HIV epidemic cannot be timely met. It distinguishes a peripheral set of goals which are important but which "lead in second position". The achievement of the peripheral goals has a more durable impact when the priority goals are well on track to be met.

Priority goals

c. The sense of urgency and opportunity for action is reflected by the assumption made in this NSP that a sufficient reduction of new HIV infections cannot be achieved without a primary focus on a drastic reduction of the horizontal transmission of HIV for the following key affected populations:
   i) Men who have sex with men: this sub-population is the largest single contributor to the annual number of new HIV infections and the reduction of that share (65%; 2014) is a "must-achieve" and has been incorporated into this NSP by a separate dual goal. The key intervention approach contains a focus on HIV testing for men who have sex with men. It includes outreach and empowerment aspects for members and institutions of the community of men who have sex with men to promote personal decision-making for reduced risky behavior and for HIV testing as a standard practice. It will also ensure the uptake of HIV testing and care & treatment services.
   ii) Young persons: continuously, young persons' life-cycle development evolves from childhood into adolescents and later into young adulthood. The related changes in social ecology bring new elements, including debut sexuality, group sub-cultures and peer pressures and market-driven consumption patterns. When adequately accompanied and supported at an early stage, young people can get introduced and accustomed to life-based matters, including sexuality and sexual health, HIV, health and testing, and seeking health care services.

d. Simultaneously, lessons learnt show the limits to the envisioned impact and absorption capacity of HIV prevention activities with key affected populations. As HIV infections will continue to occur in spite of set of ambitious HIV prevention targets, those prevention programs need to be complemented *per definition* by a large increase in HIV testing. Persons living with HIV need to know they are infected in order to, as a minimum, have a fair and early chance to engage in care and treatment, and to avoid infecting other persons. This NSP assigns high importance to HIV testing in two ways:
   i. Envisioning a large increase in the uptake of HIV testing among the general population, with a primary focus on males who currently test at half the number of women;
   ii. Envisioning the consolidation of HIV testing as a mandatory bio-medical component of any standardized HIV-intervention package, especially for the identified key affected populations.

e. There is no doubt of the need for more persons to test for HIV in order to increase the chances to engage more persons living with HIV in care and treatment arrangements, providing them better options for a long and health life, and ultimately to minimize the potential for infecting others. This NSP however focuses on the response to a critically low ART retention and adherence rate. Consistent, continuous and comprehensive treatment is a "must-achieve" item without which additional investments in HIV testing and the provision of ARV (at either CD4 count > 500 or without any CD4 count threshold) only yield short-term gains and medium-term higher risks of virus mutations and drug resistance. The strategy of this NSP is foremost to ensure that persons living with HIV, who are in care, remain engaged in care and achieve maximum viral suppression. It places thereby a strong focus on making full adherence to ART a reality for children with HIV.

f. The design and offering of any of the HIV prevention, testing or care & treatment services only create impact if the services are ultimately utilized by the target populations. It is no new message to state that a spectrum of barriers to the uptake of health and other services exist in the wider legal, socio-cultural or psychological domains. The message in this NSP is that the struggle to remove those barriers needs to remain on the front burner and that key affected populations need to take, and be given, a greater involvement in the removal of those barriers. The NSP places a focus on moving counter-productive barriers in the health and law enforcement sector. Services in those sectors are often first-line services for persons in need to access services or for persons using their right to lodge a complaint about discriminatory behavior or practices. This does not mean that barriers don't exist in other sectors of the public domain.

Peripheral goals

g. It is envisioned that ongoing investments in HIV treatment will lead to a continued gradual increase of ARV coverage, but that the big leap ahead will need to incur once the capacity has been sufficiently strengthened to maintain persons living with HIV fully engaged in ART toward maximum viral suppression. In that process, health system investments will need to incur to ensure that people who test positive for HIV enter quickly and directly into the treatment and care components of the overall national health system. To enhance the achievement of this objective, the potential of the NHI scheme and the community health system has to be unlocked.

h. To ensure that the response capacity of the total health system is at maximum level and quality, a separate goal has been incorporated to ensure the continued strengthening of human resources in health in the key normative and technical dimensions of their professions along with a drive to accelerate the mobilization and strengthening of the community health resources and the institutional connectivity between the national and the community health system

Chapter 5 NSP in Summary: the Objectives & Results Matrix

The purpose of the NSP is to provide all actors and stakeholders in the national response to HIV and TB with overall guidance for breaking the HIV epidemic.
The NSP 2012-2016 scored unsatisfactory on being a user-friendly guidance tool and on its capacity to convince stakeholders to engage, collaborate and coordinate. The NSP 2016 – 2020 ambitions to provide more utility value by being more user-friendly, more concise and strategically focused while remaining inclusive and true to the principle of delivering results that are relevant to key populations and that improve the realization of their rights.

Vision (end 2020) ***The national response to HIV and TB in Belize is well poised to reach the 95/95/95 fast-track targets of 2030, while the burden of TB in persons with HIV will have been eliminated***
Priority Goals (end 2020)
PREVENTION **Goal 1** **New HIV infections among persons, 15-24 years, account for a maximum of 8% of all new infections.**
Strategic Objective 1.1 A minimum of 80% of persons 15-24 years, in-school and out-of-school, partake in improved HIV prevention activities.
Strategic Objective 1.2 A minimum of 90% of persons 15-24 years, in-school and out-of-school, are annually reached or actively involved in HIV prevention messages on social media channels
Strategic Objective 1.3 The national condom and lubrication distribution plan is operational and has contributed to a minimum level of 80% in reported use of condom among young persons.
Strategic Objective 1.4 National social protection schemes offer effective support to girls and young women, highly at risk for transactional or forced sex.
PREVENTION **Goal 2** **New HIV infections among men who have sex with men account for a maximum of 30% of all new infections.**
Strategic Objective 2.1 Studies and surveillance data have generated an increased in-depth knowledge of the sub-populations of men who have sex with men
Strategic Objective 2.2 A minimum of 80% of men who have sex with men are annually reached through HIV interventions that focus on increased HIV testing and subsequent engagement in care
Strategic Objective 2.3

The national HIV prevention plan, including condom and lubricant programming, is operational and has contributed to a minimum level of 80% in reported use of condom among men who have sex with men
Strategic Objective 2.4 Targeted HIV intervention strategies for men who have sex with men have secured the full involvement of that key population in their design and implementation
TESTING **Goal 3** **70% of persons with HIV know their HIV status. Including 80% of men who have sex with men living with HIV.**
Strategic Objective 3.1 Adoption of a National HIV Testing Plan, positioning HIV-testing as an integral component of overall health testing and containing projections and implementation schemes that are based on the 2020 and 2030 targets.
Strategic Objective 3.2 The establishment of an adequate number of HIV testing facilities that are friendly to men who have sex with men
Strategic Objective 3.3 All medical care providers, including NHI primary care providers, apply standard provider-initiated testing and counselling services
TREATMENT **Goal 4** **80% of persons living with HIV, who are on ART, remain on ART.**
Strategic Objective 4.1 Belize's integration into the regional supply chain of HIV-related medical products, while improved Procurement and Supply Management has reduced ARV procurement costs and has contributed to multi-year zero ARV stock outs
Strategic Objective 4.2 The expansion of the continuum of care for children and adolescents living with HIV enhanced through new partnerships with NHI and the community-health system
Strategic Objective 4.3 The clinical management of all cases of persons on ART includes consistent routine CD4 and Viral Load testing
Strategic Objective 4.4 The involvement of representatives of all operational organizations of persons living with HIV in the process flows for monitoring and reporting of the quality of care and treatment services
Strategic Objective 4.5 The expansion of existing social protection schemes from state and civil society actors, covering vital support needs of 90% of eligible persons living with HIV, including 100% of children living with HIV.
REMOVAL OF BARRIERS **Goal 5** **Reported discrimination in the provision of HIV-related health care services has moved toward "zero discrimination".**
Strategic Objective 5.1 The removal of legal barriers in the public domain that oppose the principle of universal access to treatment and services
Strategic Objective 5.2 The establishment of an independently managed complaints mechanism for the reporting of violations of medical confidentiality and/or denial or unavailability of health-care services
Strategic Objective 5.3

Sensitization and attitude changing programs on HIV & TB-related anti-stigma & discrimination provided to all health and law enforcement professionals as well as all policy- and opinion makers

Peripheral Goals (end 2020)
TREATMENT
Goal 6 **90% of persons living with HIV are connected to HIV care and treatment.**
Strategic Objective 6.1 A minimum of 95% of persons testing positive for HIV are engaged in HIV care within 1 month after knowing their test result
Strategic Objective 6.2 The health system is using the Resource Needs Model to project the future cost and absorptive capacity of treatment of HIV
REMOVAL OF BARRIERS
Goal 7 **50% of HIV and HIV-TB services are delivered via community-level health services**
Strategic Objective 7.1 The efficiency and effectiveness of services to persons living with HIV or a HIV-TB co-infection have improved dramatically.
Strategic Objective 7.2 All relevant professionals in the health sector are adequately equipped for the management of HIV and TB cases.

Chapter 6 NSP in Detail: Intervention Strategies

Informed by the body of global knowledge and experience, in combination with local lessons learnt, strategic priorities in the NSP 2016 – 2020 are based on the premise of "*first things first*" and allow for the distinction between **priority** and **peripheral** intervention strategies.

A. The priority intervention strategies

Area: Reducing HIV transmission and Increasing HIV testing

General Considerations

A number of national lessons learnt have been drawn in relation to HIV prevention services provided to the various target groups:

- Diversity between and among target groups is high and interventions must be tailored to the diverse realities and needs; service providers must document and exchange "what works and what does not";
- Interventions must go beyond the health perspective only and must speak to psychological and emotional factors of behavior and behavior change as well as other socio-economic interests;
- Prevention messages are to be marketed and sold in "sexy" manners, using sex, sexuality and risk reduction approaches rather than a non-imaginative social values or health paradigms;

Priority Intervention strategy 1 **Intensified comprehensive HIV prevention services targeting all persons 15-24 years of age**

Persons 15-24 years of age remain on the radar as a key affected population. This group is extremely diverse, exists in conduit environments for experimental learning, and harbours various sub-groups, including men who have sex with men, bisexual persons, transgender persons, and persons involved in various formats of transactional sex, who will all be the adults of tomorrow. Nested within the relatively large group is an overall adolescent birth rate of 65.4%; this age group reports a 15-20% share in the total annual number of new HIV infections.

The aim is that a minimum of 80% of persons 15-24 years, in-school and out-of-school, consistently and periodically partake in HIV prevention outreach activities, which meet the national quality standards for comprehensive outreach intervention, including HIV testing and sexuality education

The intervention strategy will have a number of attributes:

- Tailored and gender-specific programs for in-school and out-of-school adolescents and young adults, ensuring the delivery of effective sexuality education to the target groups;
- Intervention coverage is not below 80%
- When possible, interventions include a HIV testing component
- Prominent use of mass-media, social media and face-to-face interaction, encouraging sexual risk reduction;
- High levels of coverage of promotion of correct and consistent condom use, backed up by an effective national condom and lubrication distribution policy and plan;
- Arrangements for access to cash transfers for highly vulnerable girls at risk for transactional and/or forced sex;

Priority Intervention Strategy 2
Scaled-up comprehensive HIV prevention services for men who have sex with men

Data suggest that HIV epidemic is concentrated in the population of men who have sex with men, as it records the highest HIV prevalence of any sub-population and the biggest share in total annual new HIV infections. The NSP 2016 – 2020 regards this group a key population in terms of impact by and role in the HIV epidemic and has adopted a related a priority goal.

The intervention strategy will have a number of attributes:

- HIV interventions with men who have sex with men focus on increased HIV testing and subsequent engagement in care; although desired behavior change is not the immediate expected result, interventions will include HIV risk reduction aspects, which create a conduit to increase testing among men who have sex with men;
- Intervention coverage is not below 80% and interventions will tap into an effective national condom and lubrication distribution policy and plan;
- Access to additional and adequate testing opportunities for men who have sex with men must be created;
- Empowerment of leadership and institutional capacities within the community of men who have sex with men is a key component to enhance full ownership of the design, delivery and oversight of interventions for and with men who have sex with men, including those men that remain invisible.
- Interventions must be backed-up and reinforced by effective nation-wide anti- stigma and discrimination programs (see strategy 5).

Priority Intervention Strategy 3
Increased targeted HIV testing opportunities for the general and specific key affected populations

Adding to the acknowledgement that key affected and vulnerable populations require prioritized responses, there must be a parallel strategy for a general increase in HIV testing to levels that facilitate the achievement of the first segment of the 90/90/90 target cascade. There are three main considerations:

a. Data show that males lag behind in the uptake of health services, including STI diagnosis, initiation of HIV treatment, and HIV testing. For the latter, although yearly increasing in pace with the number of women testing for HIV, males account only for 34% of all HIV tests performed in 2014. This imbalance requires action;
b. In the age cohort 30-65, more males contract a HIV infection. These men test less and also show lower health care seeking behavior;
c. In the absence of a clear population size estimate for the group of men who have sex with men, and in combination with the indication that a substantial part of that group does not self-identify as such, a complementary HIV testing drive must be applied to achieve sufficient testing coverage among males.

The intervention strategy will have a number of attributes:

- Formalization of current and projected testing interventions in national HIV testing policy paper;
- Increased provider-initiated testing and counselling, including its standard incorporation into the health care package of the National Health Insurance scheme;
- Community-based testing campaigns;
- HIV-testing as an integral component of overall health testing, including for dominant NCDs;

Area: Improving ART treatment outcomes

Priority Intervention Strategy 4
Intensified and improved comprehensive management of HIV and HIV-TB cases.

Recently, Belize has made progress in its ability to engage persons living with HIV into care and subsequent ART. As part of that progress, Belize has moved the CD4 count threshold for ART initiation upward with the intention to move toward "treatment when tested HIV positive". However, treatment retention, and the related treatment adherence has deteriorated.
Additional investments in testing and engaging more persons into the required care and treatment will only deliver longer term benefits when people remained engaged and full suppression of the virus is achieved. The NSP therefore prioritizes the plight to successfully keep persons on ART engaged in the care and treatment.

The intervention strategy will have a number of attributes:

- Strengthened ARV Procurement and Supply Management (PSM) to avert stock outs and reduce costs of ART;
- Expanded continuum of care for children and adolescents living with HIV;
- Comprehensive case management of persons living with HIV and HIV-TB, including full routine testing (CD4; Viral Load);
- Forging new domestic partnerships for the management of HIV treatment, care and support

- Full involvement of persons living with HIV in the monitoring and reporting of the quality of care and treatment services;
- Scaling-up of the social and economic support safety net for persons living with HIV and HIV-TB, especially children and adolescents;
- Removal of socio-cultural barriers to achieving full and durable uptake of HIV and TB treatment services (see strategy 5).

Area: Removal of barriers to uptake of services

Priority Intervention Strategy 5
Intensified and well-monitored anti-stigma and discrimination programs in the health and allied health sector

Polls, surveys and studies over the past 5 years have reported fluctuating but high levels of stigma and discrimination, experienced predominantly by members of sexual minorities. Stigma and discrimination are pervasive and exist at a broad spectrum of settings in the private and public domain, including the social sectors.

Success in the various responses to HIV and HIV-TB is determined to a high degree by whether target populations, and especially males, are attracted to and confident enough to engage in the offered services, most prominently in the health sector. As health conditions and sexual behavior is often linked to the legal domain, there is a pressing argument to include the law enforcement sector.

The intervention strategy will have a number of attributes:

- The removal of legal or policy provisions in the public domain that contravene the right to freedom from discrimination on the account of age, race, sex, gender roles, sexual orientation, socio-economic status, geographic location, disability and level of literacy;
- Empowered and well-grounded civil society organizations for the monitoring, reporting and communicating of rights violations and discrimination, especially in the public domains of in health and law enforcement;
- Solid and resilient organizations of key affected and vulnerable populations, able to engage in the advocacy and implementation oversight of anti-stigma and discrimination policies and codes of conduct in the different public sectors;
- Sensitized health and law enforcement professionals, most relevant to key populations and their health-seeking behaviour, and public policy and opinion makers on anti-stigma and discrimination concepts and practices.

B. The peripheral intervention strategies

Area: Improving engagement in HIV care & treatment

Peripheral Intervention Strategy 6
Improving ARV coverage

Although ARV treatment data over the period 2008 – 2011 show a historic trend in the correct direction, there are no conclusive data on ARV coverage rate. However achievement of ambitious

targets appears to be within reach. Paediatric cases are successfully but predominantly managed by an NGO with a non-consolidated funding situation.
Efforts to provide nutritional support to persons living with HIV are growing and are being anchored in the nascent national social protection network, but an expanded and more structural approach is required.

There are number of constraints that obstruct a required well-planned expansion of ARV coverage:

- The demand-side for services is not sufficiently developed to engage all persons living with HIV in care, especially males; in 2014, some 24 persons who died of AIDS-related complications, tested positive for HIV in the same year, underscore the fact that 62% of ART starters did so with CD4 counts below 350 while 44% had a count below 200;
- Objective and/or perceived fear of stigma and discrimination among persons with HIV, including men who have sex with men;
- Data systems are not yet fully in place to facilitate sound projections of demand and associated multi-year costs.

The intervention strategy will have a number of attributes:

- Connected to increasing HIV testing coverage (see strategy 2 & 3)
- Bridging the gap in the continuum between HIV testing and engagement in formal care
- Strengthening technical modeling and projection to estimate required treatment absorption and financial capacity for expansion of threshold and coverage of persons living with HIV on ARV

Area: Removing barriers to uptake of services

Peripheral Intervention Strategy 7
Sector-wide program for technical capacity development at all levels of the health system

Community-based health care is formally well acknowledged within the national policy on primary health care, but the complementary partnership between the community and the national health system has not yet fully utilized the potential for improved integrated health outcomes for HIV and TB response efforts. The potential lies in the mobilization of the community health system that has nation-wide coverage of rural areas.

With additional up-front investments in the expansion of skills, knowledge and retention of Community Health Workers as well as facility-based health professionals, efficiency and effectiveness gains can be achieved in the community-level prevention, control and treatment of HIV and HIV-TB.
Efficiency gains are expected to occur in the following areas:

- Skills and response levels of staff: all staff will be able to manage both conditions, mitigating negative fall- out from unexpected human resource bottlenecks;
- Minimizing missed opportunities in applying the treatment guidelines;
- Improved health-seeking behavior among persons living with HIV and TB patients.

Key strategic attributes: community health system

- Articulated frame of work flow processes between community and national health system;
- Sensitized national and community-based health staff, committed to collaboration in HIV and TB response;

- Plan development for delivery and monitoring of community-based package of services for HIV and TB case management;
- Incentivation schedule for improving retention and performance of Community Health Workers.

Key strategic attributes: technical capacity building

- Articulated sector wide program for technical capacity building for targeted audiences of health staff;
- Improvement and familiarization training in national protocols and guidelines for HIV and TB case management and the use of the performance monitoring tools;
- Relevant focus on data systems and tools for HIV and TB case management;
- Improved undergraduate and post-graduate training curricula for medical doctors, nurses and laboratory technicians, inclusive of the issue of stigma and discrimination in the health care system.

THE FRAMEWORKS OF THE NSP

Chapter 7 NSP Institutional Implementation Framework

Coordination and Oversight

The National AIDS Commission (NAC) is responsible for the overall coordination and supervision of the national 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 and provide 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. It is noted that with the start of this NSP 2016 – 2020, a new Global-funded New-Funding-Model project will come on stream in January 2016. This project is expected to be active for 3 years and is managed by UNDP Belize as the Principal Recipient.

The NAC Secretariat is responsible for the day-to-day management of key tasks in the field of national coordination, mobilization, M&E and policy advocacy and guidance in the field of HIV and related TB maters. The Secretariat will work in close collaboration with other coordinating bodies, including the National Committee for Families and Children, the National Women's Commission and the National Drug Abuse Control Council.

The operations of all coordinating bodies are almost fully financed by domestic public funds.

Implementation

Implementing institutions include government ministries and institutions, and civil society organizations. The overall implementation scheme is driven by three separate funding streams:

- **The Global Fund New Funding Model project**

This project foresees a portfolio of interventions that focuses predominantly on a) halting the spread of HIV & HIV-TB co-infections among men who have sex with men and other males-at-risk with a focus on Belize, Stann Creek and Cayo Districts by increasing the percentage of men who have sex with men and other males-at-risk in these districts who live with HIV and know their HIV status; b) improving adherence and retention matters of persons living with HIV who are engaged in HIV treatment and care by effectively improving HIV and HIV-TB case management practices and support; c) effectively detecting and curing all cases of TB and HIV-TB by improving the quality of treatment and care services to persons with HIV, TB and HIV-TB; and d) to intensify efforts to remove legal and socio-cultural barriers to the uptake of health care services by the key HIV affected populations.

The implementation of this project, which will provide a solid contribution to achieving NSP priority goals 2, 3, 4 and 5, will occur along the governance, implementation and reporting mechanisms, which were introduced and have evolved since the start of the first Global Fund project in 2004.

The project's implementation arrangements with the implementing organizations (Sub-Recipients) will be crafted on the basis organizational profiles, which show –in general- the following landscape of expertise and experience:

- HIV outreach prevention for men who have sex with men (NSP priority goal 2) and anti-stigma & discrimination efforts (NSP priority goal 5) are the domain of Civil Society Organizations and where the agencies Belize Family Life Association, Pan-American Social Marketing Organization, United Belize Advocacy Movement and C-Net+ have developed track records;
- Improvement of treatment retention & adherence through HIV and TB case management (NSP priority goal 4) is the main domain of the Ministry of Health. Over the years, MOH developed a special partnership with the agency Hand-in-Hand Ministries for the provision of pediatric treatment and care services.
- HIV testing is an area of mixed implementation where MOH is takes the responsibility for the medical and testing products and processes while MOH and Civil Society take on the joint role of identify, attract and bringing clients to the testing facility or event,

- **Domestic Public Financing**

At the level of domestic funding, the financing stream from public resources is by far the most significant. Although this financing stream provides small levels of subvention funds to Civil Society, the main recipients are the relevant social sector Ministries and Departments and the Coordinating Bodies (Statutory Bodies). Most of the state institutions recipients are connected to the direct implementation of the NSP; in some cases, they are connected to mainstreamed HIV response activities

- The Ministry of Health is the most important recipient and implementer of HIV response activities. Apart from having critical resources and functions in the area of HIV testing (NSP priority goal 3) and HIV and TB care and treatment (NSP priory goal 4), MOH performs critical complementary functions in the area of ARV and ART (Peripheral goal 6), Maternal and Child Health / Prevention of Mother-to-Child-Transmission, overall TB and MDR-TB response, Health Information & Intelligence (Epi Unit and BHIS); and the development of human resources in health (NSP peripheral goal 7);
- The Ministry of Education, Youth and Sports utilizes public funding for the development and delivery of curriculum that aims to enhance the response in the education sector to HIV and other STIs. Through its Department of Youth Services, it expands its intervention reach also to out-of-school young Belizeans. The Ministry and its departments therefore constitute important and experienced players in the achievement of NSP priority goal 1;
- The Ministry of Human Development, Social Transformation and Poverty Alleviation is the key player in the provision of state support to vulnerable persons, including children and adults living with or affected by HIV. The Ministry's Department of Human Services and Community Rehabilitation Services have gained invaluable experience in the design, implementation and evolution of social safety, protection and support programs that contribute to the achievement of parameters for improved treatment adherence and retention (NSP priority goal 4). The Ministry is also a strong ally in that part of social transformation that speaks to the reduction of domestic and sexual violence and high levels of counterproductive stigma and discrimination practices at institutional and societal level (NSP priority goal 5).

- The Ministry of Labor applies public domestic funding to its mainstreamed operations for implementing and overseeing compliance with the national policy for HIV in the Work Place.

- **External Financing**

Although volatile in size and consistency, external funding predominantly focuses on interventions and capacities in the HIV prevention arena, which is the main domain for civil society organizations.

The achievement of the wider aims of NSP priority goals 1 and 2 is based on the assumption that a) efficiencies in HIV prevention strategies and interventions will be achieved and will lead to overall cost reductions; and b) that external financing will reduce but will continue at levels that provide continuity to the most experienced civil society organizations, including Belize Family Life Association, Pan-American Social Marketing Organization, United Belize Advocacy Movement, C-Net+, Go Belize/Go Joven, the Productive Organization for Women in Action, Youth Enhancement Services and Cornerstone Foundation, whose operations depend on foreign sources.

Chapter 8 NSP Operational Framework

The National Operational Framework 2016 – 2018 accompanies the National Strategic Plan 2016 –2020 and provides a roadmap for the achievement of the goals defined in the National Strategic Plan. The operational framework focuses at the level of strategic activities, which are delineated by goal, strategy and objective and which can be broken down into specific activities and tasks in annual work plans. Although only indicative, the matrix provides a suggested time line and the proposed lead agency or agencies.

Specific Objective	Strategic Activities	Time Frame			Lead Agency(ies)
		Y 1	Y 2	Y 3	
Goal 1 (priority level) New HIV infections among persons, 15-24 years, account for a maximum of 8% of all new infections. *Intervention Strategy*: intensifying comprehensive HIV prevention services targeting all persons 15-24 years of age.					
Strategic Objective 1.1 A minimum of 80% of persons 15-24 years, in-school and out-of-school, partake in improved HIV prevention activities.					
Develop a plan for compliance with the commitments of the Mexico Declaration	Strengthen technical collaboration between the MOEYS and MOH to undertake gap analysis and fulfil commitments to the Mexico City declaration	X			MOEYS; MOH
	Conduct national assessment of barriers to the adequate content and consistent delivery of comprehensive sexuality education curriculum.	X			MOEYS
	Conduct an advocacy campaign on comprehensive sexuality education (CSE) and sexual & reproductive health education with religious leaders and school managers	X			MOEYS
Improve the content and delivery of Comprehensive Sexuality Education curriculum at primary and secondary education levels	Establish renewed dialogue between key education actors and stakeholders to implement Sexuality Education Compliance Plan	X			MOEYS ; BNTU
	Develop an improved and expanded multi-level curriculum for CSE for use in upper primary and secondary education institutions	X	X		MOEYS
	Additional training for teachers and school counsellors in HIV-SRH -Sexuality topics and delivery of improved CSE curriculum	X	X		MOEYS; BNTU
	Training of HIV Peer Educators at secondary education school in complementary peer delivery of CSE curriculum	X	X	X	MOEYS: BRC

	Conduct parenting sessions to promote accurate and updated information sharing	X	X	X	MOEYS; MHDSTPA
	Monitoring of the implementation of the Sexuality Education Compliance Plan	X	X	X	MOEYS; NAC –IEC
Expand the delivery of HIV prevention interventions tailored for out of –school adolescents and young adults	Improve effectiveness of content and delivery methodology of HIV prevention and risk reduction interventions to better meet the realities of out of school adolescents and young adults.	X			MOEYS-DYS; Go Belize; BRC
	Innovate, intensify and expand age and culturally relevant behaviour change peer-education programs for out-of-school young adults	X	X	X	MOEYS-DYS; Go Belize; BRC
	Expand peer- education with specific emphasis on homosexual and bisexual youth	X	X	X	MOEYS-DYS; Go Belize; BRC;BYEC
	Consolidate the system of nationwide monitoring programs targeting out of school youth	X	X	X	MOEYS-DYS; Go Belize; BRC
	BCC-oriented edutainment program for youth 15 – 24 years	X	X	X	MOEYS-DYS; Go Belize; BFLA-YAM; BYEC
Strengthen the national network of skilled youth leaders	Intensify capacity building of young leaders, organizations and their networks to create positive change in Sexual and Reproductive Health issues among adolescents and young adults	X	X	X	MOEYS-DYS; BFLA –YAM; GO Belize; POWA
Increase the demand and access to SRH services for the prevention of HIV and other STIs for youth	Reinforce protocols, ensuring access of young persons to youth friendly health services	X			MOH; BFLA; YES
	Provide “youth friendly” sexual and reproductive health services	X	X	X	BFLA; POWA; YES
	Support programs for teenage parents.	X	X	X	BFLA; POWA; YES
	Adopt the physical environment of facilities that offer SRH services to youth to make them more comfortable.	X	X		MOH; NGOs
Systematize quality-control mechanisms for IEC-BCC activities	Conduct periodic quality control interventions to ensure that are consistent and clear.	X	X	X	NAC –IEC
Build the technical, social and communication capacities of professionals and primary care givers to adequately interact with adolescents and young adults on HIV issues	Expand and scale-up sensitization and training of professional health and social sector workers in HIV-prevention, sexuality, sexual and reproductive health, approaches and protocols for youth-friendliness, confidentiality, rights protection and anti-discrimination.	X	X	X	MOH; MHDSTPA MOEYS-DYS; NGOs
	Conduct parenting sessions to promote accurate and updated information sharing, targeting highly deprived areas of Belize	X	X	X	MOEYS/DYS; MHDSTPA

Strategic Objective 1.2 A minimum of 90% of persons 15-24 years, in-school and out-of-school, are annually reached or actively involved in HIV prevention messages on social media channels.					
Deliver multi-media information and education campaigns for HIV prevention, targeting specific key affected (sub-) populations	Continue the airing of pre-tested video messages, in more languages, on delaying sexual activity, partner reduction and sexual risk reduction	X	X	X	MOEYS-DYS; BFLA –YAM; Go Belize; NAC-IEC
	Innovative messages (multi-language) for mass-cultural events, marketed using sex, sexuality and risk reduction approaches.	X	X	X	MOEYS-DYS; BFLA –YAM; Go Belize
	Positive Prevention campaigns for persons living with HIV	X	X	X	MOEYS-DYS; C-Net+
Develop innovative, consistent and continuous use of social media for messages and dialogue	Persistent dissemination of compressed high impact HIV prevention information via cell phone text messaging	X	X	X	BFLA –YAM; Go Belize; POWA
	Recruit and train cyber-educators to target websites frequented by key affected populations	X			MOEYS-DYS; BFLA –YAM; Go Belize; NAC-IEC
	Develop social networks and blogs on the web for sharing and discussing key issues for HIV risk reduction	X	X		BFLA –YAM; Go Belize; K-CAT
	Continuous electronic dissemination of comprehensive IEC material and messages to the national community	X	X	X	BFLA –YAM; Go Belize; NAC-IEC
	Dissemination of interactive online education material	X	X	X	BFLA –YAM; Go Belize; NAC-IEC
Strategic Objective 1.3 The national condom and lubrication distribution plan is operational and has contributed to a minimum level of 80% in reported use of condom among young persons.					
Put in place a quality assurance process for procurement and distribution of condoms and lubricants	Develop and implement the National Condoms Strategy and Plan	X			MOH
	Create quality protocols for condom and lubricant storage as part of the National Condom Policy and Strategy	X			MOH
	Create an inspection process which will form part of regular health inspections	X			MOH

	Make communication arrangements for inter-institutional information exchange on supplies and demand matters related to condoms and lubricants, including for free distribution by certified service providers among key affected populations	X			MOH; NAC-IEC
Implement national information campaign about special limited distribution of no-cost condoms and regular commercial distribution for general population	Advocate with private sector to distribute / place on sale condoms at businesses (barbershops), enterprises and all hotels/ motels and brothels	X	X	X	MOH; NGOs; NAC-IEC
	Collaborate with private sector distributors to regulate the prices of commercial condoms based on negotiated reduction of import taxes	X	X	X	MOH; NGOs; NAC-IEC
	Provide key vulnerable young persons with free condoms, when feasible	X	X	X	MOH; NGOs; NAC-IEC
Strategic Objective 1.4 National social protection schemes offer effective support to girls and young women, highly at risk for transactional or forced sex.					
Continue the further sensitization of media houses to abstain from airing audio-visual material that graphically degrades and offends women while promoting risky sexual behaviours	Advocate with event sponsors, Broadcasting Authority of Belize, media houses and cable TV stations for self-censoring and -regulation in relation to audio-visual material that promotes or idealizes risky sexual behavior	X	X	X	MHDSTPA; WIN Belize; UNIBAM; K-CAT
Provide comprehensive protection and support to all victims of transactional sex or sexual violence	Train all health care providers and other partners in the provision of comprehensive response to GBV and compliance with sexual violence protocols	X	X	X	MOH; MHDSTPA
	Strengthen medical diagnostics (post exposure and pregnancy prophylaxes; HIV/ STI testing; treatment) and psycho-social support for victims of transactional sex or sexual violence	X	X	X	MOH; MHDSTPA
Strengthen the capacity of girls and young women to be resilient to transactional sex	Encourage the development of skill-building programs to provide employment as an alternative to transactional sex for girls and young women	X	X	X	MHDSTPA; NGOs
	Expand and scale-up comprehensive empowerment and self-esteem building programs for girls and young women in high risk deprived areas.	X	X	X	MHDSTPA; NGOs
	Expand on-going (conditional) cash transfer schemes to include girls and young women, highly vulnerable to getting involved in transactional sex	X	X	X	MHDSTPA
Goal 2 (priority level) New HIV infections among men who have sex with men account for a maximum of 30% of all new infections**.** *Intervention Strategy*: scaled-up comprehensive HIV prevention services for men who have sex with men					
Strategic Objective 2.1					

Studies and surveillance data have generated an increased in-depth knowledge of the sub-population of men who have sex with men.					
Generate new knowledge about the population of men who have sex with men	Population size estimation study for men who have sex with men	X			NAC-CCM
	Profiling and mapping of sub-population of men who have sex with men in key geographic areas	X			NAC-CCM
	Sexual behavior survey data on men who have sex with men			X	NAC
	Behavioural Surveillance Survey/ Integrated Bio-Behavioural Survey			X	MOH
Generate new knowledge about the population of transgender persons	Conduct a Situation Analysis of the transgender population	X			NAC-CCM
Routine Reporting	Establishment of systems for HIV patient monitoring across the continuum of care, including cohort analysis and patient tracking	X			NAC-CCM
	Strengthen M& E and reporting capacities of TB and HIV (Epi) Program	X			NAC-CCM
	Design and operationalize the framework for monitoring of the HIV prevention strategy	X			NAC-CCM
Strategic Objective 2.2 A minimum of 80% of men who have sex with men are annually reached through HIV interventions that focus on increased HIV testing and subsequent engagement in care.					
Expand and improve IEC-BCC HIV prevention programs for men who have sex with men	Elaboration of social marketing & communication strategy, targeting key affected populations in priority areas for improved health seeking behavior	X			NAC-CCM
	Deliver social communication products to population of men who have sex with men	X			NAC-CCM
	Develop and deliver standardized package of risk reduction communication interventions to men who have sex with men for the promotion of risk reduction and the up-take of HIV testing and counseling	X	X	X	NAC-CCM
	Provide technical training to outreach persons/ educators and CHWs in the content and use of the standardized package	X	X	X	NAC-CCM
	Sensitize national response actors in order to introduce and promote the content and use of the standardized package	X			NAC-CCM
	Strengthen coordination capacity for the implementation of HIV Risk Reduction & Testing program	X	X	X	NAC-CCM
	Strengthen institutional capacity of providers of services to the community of men who have sex with men	X			NAC-CCM

	Expand the network of nurses and physicians who are MSM-friendly.	X	X	X	NAC-CCM
	Continue to provide referral services to men who have sex with men to professional health care for diagnosis and treatment of STIs	X	X	X	NAC-CCM
	Advocate for the provision of comprehensive sexual & reproductive health services to meet the needs of men who have sex with men	X	X		NAC-IEC
Systematize quality-control mechanisms for IEC-BCC activities	Conduct periodic quality control interventions to ensure that are consistent and clear.	X	X	X	NAC –IEC
Strategic Objective 2.3 The national HIV prevention plan, including condom and lubricant programming, is operational and has contributed to a minimum level of 80% in reported use of condom among men who have sex with men.					
Put in place a quality assurance process for procurement and distribution of condoms and lubricants	Develop and implement the National Condoms Strategy and Plan	X			MOH
	Create quality protocols for condom and lubricant storage as part of the National Condom Policy and Strategy	X			MOH
	Create an inspection process which will form part of regular health inspections	X			MOH
	Make communication arrangements for inter-institutional information exchange on supplies and demand matters related to condoms and lubricants, including for free distribution by certified service providers among key affected populations	X			MOH; NAC-IEC
Implement national information campaign about special limited distribution of no-cost condoms and regular commercial distribution for general population	Advocate with private sector to place condoms on sale at businesses, enterprises and all hotels/ motels and brothels	X	X	X	MOH; NGOs; NAC-IEC
	Collaborate with private sector distributors to regulate the prices of commercial condoms based on negotiated reduction of import taxes	X	X	X	MOH; NGOs; NAC-IEC
Strategic Objective 2.4 Targeted HIV intervention strategies for men who have sex with men have secured the full involvement of that key population in their design and implementation.					
Strengthen institutional capacity for engagement	Strengthen the institutional capacity of a selected entity for managing monitoring and reporting systems for quality of service compliance via client exit surveys	X	X	X	NAC-CCM
	Strengthen knowledge base and advocacy & communication skills of men who have sex with men	X			NAC-CCM

Provide a catalyst to self-empowerment men who have sex with men	Provide self-empowerment counselling sessions in emotional intelligence to build self-esteem, community pride and health seeking behavior among men who have sex with men	X	X	X	NAC-CCM
	Empower leadership within the community of men who have sex with men for claiming full ownership of the design, delivery and oversight of interventions.	X	X	X	NAC-CCM
Goal 3 (priority level) 70% of persons with HIV know their HIV status, including 80% of men who have sex with men living with HIV. *Intervention strategy*: **i**ncreased targeted HIV testing opportunities for the general and specific key affected populations					
Strategic Objective 3.1 Adoption of a National HIV Testing Plan, positioning HIV-testing as an integral component of overall health testing and containing projections and implementation schemes that are based on the 2020 and 2030 targets.					
Develop and implement National HIV Testing Plan	Undertake a review and analysis of best HIV testing practices in the region to define parameters of the national HIV testing plan	X			MOH
	Project resources needs and institutional capacity gaps on the basis 2020 and 2030 targets	X			MOH; NAC
	Undertake a study on the feasibility of nation-wide HIV self- testing	X			NAC-CCM
Expand, to the maximum capacity, the HIV testing opportunities	Expand the areas of mobile and facility-based HIV and STI testing opportunities in community settings	X	X		MOH; BFLA
	Identify key private sector clinics that will provide HIV and STI testing services to vulnerable populations	X	X		NAC; MOH
	Offer HIV testing to all STI patients	X	X	X	MOH
	Train interested civil society organizations in administering HIV testing				
Monitor the quality of PITC services provision	Conduct exit interviews to assess patient's perceptions of the quality of services and whether or not PITC protocol was implemented.	X	X	X	MOH; NGOs
Strategic Objective 3.2 The establishment of an adequate number of HIV testing facilities, which are friendly to men who have sex with men.					
Expand and improve services that are friendly to men who have sex with men	Increase referral of MSM to professional health care facilities for diagnosis and treatment of STIs	X	X	X	MOH; NGOs
	Add on to existing facilities specific and integrated HIV health and testing services friendly to men who have sex with men	X			NAC-CCM
	Expand the network of known MSM-friendly physicians and/or nurses	X	X	X	NAC-CCM

	Ensure that HIV-testing is an integral component of overall health testing	X	X	X	MOH; NGOs
Strategic Objective 3.3 All medical care providers, including NHI primary care providers, apply standard provider-initiated testing and counselling services.					
Expand the use and application of the provider-initiated HIV testing and counselling practice	Standardize training materials for provider-initiated testing and counseling	X			NAC-CCM
	Expand training of public and private sector health care providers on provider-initiated HIV testing and counselling as well as stigma and discrimination	X	X	X	MOH
	Increase the number of health care providers that apply and report on provider-initiated HIV testing and counseling	X	X	X	MOH
	Conduct exit interviews to assess patient's perceptions of the quality of services and whether or not PITC protocol was implemented.	X	X	X	MOH; NGOs
Goal 4 (priority level) 80% of persons living with HIV, who are on ART, remain on ART. *Intervention strategy*: intensified and improved comprehensive management of HIV and HIV-TB cases.					
Strategic Objective 4.1 Belize's integration into the regional supply chain of HIV-related medical products, while improved Procurement and Supply Management has reduced ARV procurement costs and has contributed to multi-year zero ARV stock outs.					
Increase consistent availability of ARVs at all treatment points for persons living with HIV and in need of ART	Revise national formulary and drug management protocols for inclusion of oversight body ensure timely procurement	X			MOH; NAC
	Continue the technical improvement of procurement and supplies management for service delivery at the Central Medical Stores, enhancing avoidance of stock-out situations	X	X	X	MOH
	Consolidate the comprehensive stock-out assessment and evaluation system to ensure timely forecasting and procurement of ARVs	X			MOH
Strategic Objective 4.2 **The expansion of the continuum of care for children and adolescents living with HIV enhanced through new partnerships with NHI and the community-health system**					
Create a National HIV Treatment Adherence Strategy for improved ART retention and adherence: *training program*	Develop and replicate adherence training models	X			MOH
	Expand and consolidate technical training on the MOH medication protocols	X			MOH
	Train health officials and district committees on HIV - TB collaborative interventions	X	X	X	MOH
	Standardize training materials for Cotrimoxazole Prevention Therapy (CPT) and ART	X			MOH

Create a National HIV Treatment Adherence Strategy for improved ART retention and adherence: *patient information and empowerment*	Put in pace a functional referral and counter referral system to provide support services to persons with HIV	X			MOH
	Update existing Referral Manual of available services for persons infected and affected by HIV	X			MOH
	Develop a HIV Support Database for persons living with HIV, complementing the existing referral manual, including service options, referral and counter referral forms and evaluation tools	X	X		MOH
	Educate persons living with HIV about more adequate medication and optimized prescription practices	X	X	X	MOH
	Conduct empowerment workshops for PHIV aimed at taking control of health issues	X	X	X	MOH
Create a National HIV Treatment Adherence Strategy for improved ART retention and adherence: *implementation*	Improve human resource allocation for coordination and delivery of HIV ART case management	X	X		MOH
	Expand knowledge and services of private medical practitioners for clinical management of HIV and opportunistic infections	X	X	X	MOH
Create a National HIV Treatment Adherence Strategy for improved ART retention and adherence: *new partnerships*	Forge new partnerships with NHI and the community-health system for enrolment and engagement of persons living with HIV in HIV treatment and care services	X	X		MOH; NAC
	Explore and mobilize NHI to include HIV and HIV-TB case management in insurance package	X	X		MOH
	Explore and mobilize community health system (CHWs) to include HIV and HIV-TB case management in task portfolio	X			MOH
Create a National HIV Treatment Adherence Strategy for improved ART retention and adherence: *monitoring and risk management*	Assess the adherence trends and practices of persons with HIV who use drugs or are drug addicted	X	X		NAC; NDACC
	Create monitoring tools and instruments to evaluate integration of TB with HIV (diagnosis, treatment and adherence)	X			MOH
	Enforce protocols for the treatment of HIV-TB co-infections	X			MOH
	Establish and apply mechanisms to hold practitioners accountable for adhering to treatment guidelines and protocols for HIV care	X	X	X	MOH
Create a National HIV Treatment Adherence Strategy for improved ART retention and adherence: i*ntegrated nutritional guidelines for HIV case management*	Conduct periodic national workshops, focusing on nutritional needs and standards for HIV clients	X	X	X	MOH
	Determine and distribute the appropriate protocols and guidelines for the provision of nutrition services to persons with HIV, followed by training session on the use of the new guidelines	X	X	X	MOH

Create a National HIV Treatment Adherence Strategy for improved ART retention and adherence: *management of pediatric HIV cases*	Conduct sessions with families of children living with HIV on case management and home care	X	X	X	MOH; Hand-in-Hand
	Conduct sensitization and education sessions for social workers	X	X	X	MHDSTPA; Hand-in-Hand
Strategic Objective 4.3 The clinical management of all cases of persons on ART includes consistent routine CD4 and Viral Load testing.					
Improved clinical management of HIV at all levels of the care system	Reinvigorate the standards for measurement and a tool to optimize performance and quality of clinical management	X			MOH
	Highlight that treatment protocols are human-rights based and include systems to provide adequate and sensitive client care via the selection of candidates for Viral Load and Genotype testing, second line ART and the most appropriate ARVs.	X	X	X	MOH
	Ensure routine testing of CD4 count and viral load testing for patients on ART	X	X	X	MOH
Improve laboratory operations for comprehensive diagnostic services for persons living with HIV or HIV-TB.	Increase technical capacity and capability of the Central Medical Laboratory	X	X		MOH
	Improve Infrastructure and equipment of medical labs for delivery of services at the Central and Regional Laboratories	X	X		MOH
	Rigorously implement drug resistance surveillance for HIV and TB	X	X	X	MOH
Strategic Objective 4.4 The involvement of representatives of all operational organizations of persons living with HIV in the process flows for monitoring and reporting of the quality of care and treatment services.					
Meaningful involvement of persons with HIV in planning, implementation and M&E of HIV response programs	Continue to ensure the active involvement of persons with HIV in all standing committees of the Commission	X	X	X	NAC
	Provide leadership training, technical and financial support to support organizations of and for persons living with HIV, encouraging their greater involvement and participation in project development, implementation and monitoring and evaluation	X	X	X	NAC-CCM; C-Net+
	Create and promote virtual self-help groups for persons living with HIV	X	X	X	
	Strengthen the institutional capacity of client and patient organizations for managing monitoring and reporting systems on quality of service compliance	X	X	X	NAC-CCM
	Improve complaints mechanism and respond to reports that are produced in the annual assessments.	X	X	X	MOH: NAC
Strategic Objective 4.5					

The expansion of existing social protection schemes from state and civil society actors, covering vital support needs of 90% of eligible persons living with HIV, including 100% of children living with HIV.					
Fully integrate HIV care and support initiatives into the social protection machineries	Assess the level , type and uptake of social protection services available to persons with HIV	X	X	X	NAC-C&T
	Expand the referral system between government agencies, NGOs and CBOs to provide required social and economic support services.	X	X	X	MHDSTPA; NAC-C&T
	Intensify capacity building programs for NGOs for home & community-based care.	X	X	X	NAC-C&T; NGOs
	Support to social protection programs for the provision of nutritional support packages to persons living with HIV	X	X	X	NAC-CCM
Goal 5 (priority level) Reported discrimination in the provision of HIV-related health care services has moved toward "zero discrimination". *Intervention strategy:* Intensified and well-monitored anti-stigma and discrimination programs in the health and allied health sector					
Strategic Objective 5.1 The removal of legal barriers in the public domain that oppose the principle of universal access to treatment and services.					
Remove legal barriers that obstruct an efficient HIV response	Undertake legal reviews of laws that penalize Sexual and Reproductive Health-care providers for working with young vulnerable populations	X			NAC
	Advocate for policies that ensure that S&RH rights for adolescents, youth and adults are protected and being exercised	X	X		NAC
	Enhance an international exchange visit on experiences with legal bottlenecks for key populations;		X	X	NAC-CCM
	Advocate for the passing of the Legal Review developed by the NAC Policy and Legislation Committee	X	X		NAC
	Advocate for the enactment of proposed laws, criminalizing willful unauthorized disclosure of confidential patient information	X	X		NAC
	Conduct public consultations to introduce and socialize the legislation and the importance of its enforcement	X	X		NAC
Strategic Objective 5.2 The establishment of an independently managed complaints mechanism for the reporting of violations of medical confidentiality and/or denial or unavailability of health-care services.					
Distribute national protocols and standards for widespread monitoring and evaluation	Collect all MOH rights-based standards of patient and client care, treatment and protocols	X	X		MOH; NAC

	Consolidate regular use by the Commission and Committees of the rights, standards and protocol documents for the evaluation of the HIV response	X	X		NAC
	Ensure that health care providers inform patients about their confidentiality rights	X	X		MOH
Establish a formal complaint and reporting mechanism	Develop and implement a post-care patient survey schedule	X	X		NAC; MOH
	Develop a complaint mechanism and forms based on the rights, standards and protocols provisions and make it accessible via the NAC website and other client-friendly avenues	X	X		NAC; MOH
	Establish a reward system to promote the adherence to rights, standards and protocols and a recourse system to minimize of any violations thereof	X	X		NAC; MOH
	Design and manage systems for monitoring of and reporting on discrimination cases for onward sharing with Ombudsman and relevant UN bodies.	X	X	X	NAC-CCM
Strategic Objective 5.3 Sensitization and attitude changing programs on HIV & TB-related anti-stigma & discrimination provided to all health and law enforcement professionals as well as all policy- and opinion makers.					
Decrease stigma and discrimination within the education sector against persons living with HIV	Establish mechanisms for redress for teachers, students and other staff who have been discriminated based on HIV status, gender or sexual orientation	X	X	X	MOEYS; NAC
Increase the number of professionals trained in human rights and anti S&D	Conduct training for media personnel on human rights and advocacy addressing stigma and discrimination	X	X	X	NAC
	Design and conduct training of health and social workers on reduction of stigma and discrimination, patient rights, human rights and emotional intelligence	X	X	X	MOH; MHDSTPA; NAC
	Develop complementary capacity building and technical support initiatives to reduce stigma and discrimination against sexual minorities	X	X	X	NAC; UNIBAM; TIA
	Deliver anti-S&D toolkits for target groups in various professional sectors of society	X	X	X	NAC
	Capacity building support to Trans In Action (TIA) to increase the knowledge about the fundamental rights of transgender population and public advocacy skills	X	X	X	NAC-CCM
	Provide sensitization and technical training to health workers and police on rights to institute and monitor anti-stigma & discrimination policies	X	X	X	NAC-CCM
	Development of a code of conduct to enhance the institution of anti-stigma & discrimination policies	X	X	X	NAC-CCM

	Conduct studies and surveys in the field of stigma and discrimination, which inform programs for enhancing the social acceptance of persons living with HIV and sexual minorities	X	X	X	NAC; UNIBAM; TIA
Goal 6 (peripheral level) 90% of persons living with HIV are connected to HIV care and treatment. *Intervention strategy*: improving ARV coverage					
Strategic Objective 6.1 A minimum of 95% of persons testing positive for HIV are engaged in HIV care within 1 month after knowing their test result.					
Ensure minimum "losses" to follow-up in relation to persons testing HIV positive	Link the results of increased coverage of HIV testing as input for the resulting increase in ARV coverage	X	X	X	MOH; NGOs
	Establish protocols for the confidential documenting institutional accompaniment and referral schedule for persons taking an HIV test and testing HIV positive	X	X	X	MOH; NGOs
	Define the time-bound evolution of protocol for the initiation of ART with persons living with HIV	X			MOH
Strategic Objective 6.2 The health system is using the Resource Needs Model to project the future cost and absorptive capacity of treatment of HIV.					
Improve the knowledge about absorption capacity of the HIV ART opportunities	Provide technical training to staff of the MOH-NAP and MOH-Epi in modeling scenarios for small, medium and large increases in the number of persons living with HIIV who engage in care and treatment.	X	X		MOH
	Put in place data projection systems that generate sound projections of demand and associated multi-year costs of projected or policy-driven increases in the number of persons living with HIV who are on ARV treatment		X	X	MOH
Goal 7 (peripheral level) 50% of HIV and HIV-TB services are delivered via community-level health services.					
Strategic Objective 7.1 The efficiency and effectiveness of services to persons living with HIV or a HIV-TB co-infection have improved dramatically					
Sensitize and enhance buy-in of relevant staff	All relevant national and community-based health staff have been sensitized on commitments to collaborate in HIV and TB response	X	X		MOH
Balance the tasks, roles and responsibility of the national and community health systems	Sustain the integrated HIV care at health facility and community level with adequate human resources	X	X	X	MOH

	Develop and operationalize a comprehensive service delivery plan, which provides diagrams for work flow processes between community and national health system for delivery and monitoring of HIV and TB case management services	X	X	X	MOH
	Provide a focus on data systems and tools for HIV and TB case management;	X	X	X	MOH
Strategic Objective 7.2 All relevant professionals in the health sector are adequately equipped for the management of HIV and TB cases					
Build the technical capacity of health facility and community health staff	Provide technical training program addressing concept, content and application of code of conduct, national protocols, guidelines, quality monitoring tools and data.	X		X	MOH
	Sector-wide professional development plan offers undergraduate and post-graduate training curricula for medical doctors, nurses and laboratory technicians	X	X	X	MOH
Monitor staff performance	Evaluate performance of all medical staff against provisions of the national treatment guidelines and protocols	X	X	X	MOH

Chapter 9 NSP Monitoring and Evaluation Framework

9.1 Introduction

This Monitoring and Evaluation (M&E) Framework constitutes a tool that guides and allows stakeholders in the national response to provide oversight and routine performance monitoring of that national response. In reference to the "Three Ones Principle, this framework –and its derivative M&E plan- constitutes the national monitoring tool in the processes for utilizing the pertinent monitoring and surveillance data for the generation of strategic information to stakeholders for further research, policy development and program planning.

The objectives of the National M&E Framework are:

- To facilitate the generation and use of accurate, timely and relevant data and intelligence on results and impact of the planned and implemented national response to HIV and HIV-TB;
- To guide the generation of strategic information that allows for the adequate provision of oversight and corrective actions to continuously improve the national response to the epidemic;
- To provide strategic guidance in the further capacity development of the national M&E system and its stakeholders

The key stakeholders in the management and implementation of the framework and its plan, and their respective roles and responsibilities are:

- The Commissioners of the National AIDS Commission

This body is responsible for promoting and facilitating effective coordination and adequate oversight of the national response. This includes the governance and operational management of the standing and ad-hoc committees and assures accountability of stakeholders for performance and progress. The oversight of the implementation of the NSP, and therefore the M&E framework, is ultimately a responsibility of the NAC.

The NAC has delegated specific tasks, including the oversight and implementation of the M&E framework, to one of its standing committees, the M&E Sub-Committee, along with the M&E officer within the NAC Secretariat.

The NAC therefore is the body that receives or solicits strategic information about the progress, effectiveness and relevance of the national response and is mandated to transform this information into policy and/or implementation recommendations for corrective action, where and when deemed necessary.

- The NAC M&E Committee

The M&E committee is composed of representatives of the National AIDS Commission and technical experts from the wider community of stakeholders. It functions as the technical body of the NAC on all issues related to overseeing, monitoring and evaluating the national response. Its chief responsibility is oversight of the M&E framework, including key data collection and reporting functions.

The committee periodically informs and offers recommendations to the National AIDS Commission and its stakeholders –or is requested to do so by the Commission- on monitoring and evaluation issue. The recommendations may include requests for and guidance in the design and implementation of corrective actions to the implementation of the national response.

In consultation with the NAC Executive Director, the M&E Committee provides guidance to and oversight of the M&E staff at the NAC Secretariat.

- The M&E section at the NAC Secretariat

This operational unit within the NAC Secretariat is responsible for implementing the M&E Framework. This can consist of the direct implementation and/ or guiding and causing the implementation of the framework. A paramount deliverable for the M&E section is the periodic production and dissemination of specific reports, as indicated in the Reporting Section of the M&E Framework.

- The MOH National AIDS Program (NAP)

The MOH-NAP is responsible for the provision of HIV support services within the MOH. As one of the core implementers of the national response to HIV (and HIV-TB), it manages a vital package of clinical and biomedical treatment and care interventions. The NAP, therefore, carries chief responsibility for strategic information in these areas. This responsibility requires that the NAP ensures the adequate flow of quality data coming from the Belize Health Information System, which is critical for facilitating efficient data management, calculation and analysis of performance indicators.

9.2 The concepts of Monitoring and Evaluation and Results-Based Management

Monitoring is a continuous periodic function that uses the systematic collection of data on specified indicators to document the extent of progress towards the realization of intended program or project outcomes; it facilitates an assessment of progress made against the attaining goals. Monitoring consists of:

- Measuring current situation to assess progress towards the achievement of established objectives;
- Setting up systems to collect data;
- Documenting the contextual issues which impact on program implementation;
- Using real-time information to manage a project

Evaluation is the determination of the value of a project, program or policy and should be seen as a process of knowledge production which rests on the use of rigorous empirical inquiry. Evaluation can take place at any point in time during the programming cycle and not necessarily always at the end of the cycle.The evaluator must make a series of interrelated decisions in order to make a judgment of worth. Evaluations come in many types including:

- Formative evaluations, providing feedback to facilitate program improvement;
- Summative evaluations, providing feedback in view of adoption, expansion or continuation of a program; and
- Prospective evaluations, assessing the likely outcomes of proposed projects, programmes or policies.

Results-Based Management (RBM): a concept under which planning, monitoring and evaluation come together and which refers to a management strategy that aims at achieving improved performance and demonstrable results. Existing programs and projects are regularly modified based on the lessons learned through monitoring and evaluation, and future plans are developed based on these lessons.

9.3 The Indicator Performance Framework

Indicators

Indicators are quantitative or qualitative factors or variables that provide a simple and reliable means to measure achievement, reflect changes connected to an intervention, or help assess the performance of a development actor. There are five types of indicators:

a. Input indicators; these measure and state the resources in terms of availability or accessibility, required to achieve outputs: persons, equipment, training services, etc.;
b. Process indicators; these measure achievements of putting in place certain activities that will lead to outputs. Sometimes process indicators are referred to as through-puts;
c. Output indicators; these measure the actual services or tangible goods that were established and/or delivered. Outputs indicators measure the goods and services delivered for which the service provider/ project actor can be held accountable and responsible;
d. Outcome indicators; they measure the level of change of personal or group behavior as well as institutional processes and practices. Service providers cannot be fully held responsible for achieving the expected outcomes as more outputs may be required to effectuate such change;
e. Impact indicators; these measure the manifestations on the highest level of the results-chain. In the case of HIV or TB, these are the disease- and epidemiology-related manifestations and trends, such as mortality and morbidity.

Outcome and impact indicators are higher-level effect indicator, as achievements of outcomes and impact are detectable only after some time. Furthermore multiple different efforts and factors contribute to their achievement.

The indicator cascade below illustrates the indicators that will be used in the monitoring of the implementation of the NSP 2016 – 2020.

Coverage / Output →	Outcome →	Impact
% of young people age 15-24, reached with HIV IEC interventions % of young people age 15-24, reached with HIV information platforms on social media outlets	% of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	# of new HIV infections among persons, aged 15-24 , as a percentage of total number of new infections % of young people, aged 15 -24, who are living with HIV
	% of young women and men aged 15-24 who have had sexual intercourse before the age of 15	
	% of women and men aged 15-24 who have had sexual intercourse with >1 partner in the last 12 months	
# of male condoms provided to targeted end-users in last 12 months	% of women and men aged 15-24 who had more than one sexual partner in the last 12 months and who report the use of a condom during the last sexual intercourse	
# of eligible vulnerable girls & young women receiving benefits from social protection schemes		
% of men who have sex with men reached with HIV prevention programmes	% of men reporting the use of a condom the last time they had anal sex with a male partner	# of new HIV infections among men who have sex with men, as a percentage of total number of new infections % of men who have sex with men, who are living with HIV
# of male condoms provided to targeted end-users in last 12 months		
# of HIV testing and counselling services provided to women and men aged 15-49.	% of women and men aged, 15-49, who received an HIV test in the last 12 months and who know their results	
# of HIV testing and counselling services provided to men who have sex with men	% of men who have sex with men who have received an HIV test in the last 12 months and who know their results	
% of people living with HIV that initiated ART with CD4 count of <200 cells/mm³	% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	AIDS-related mortality per 100,000 population (by sex)
# of adults and children with advanced HIV infection currently receiving ART		
% of eligible adults and children currently receiving ART		
% of adults and children that initiated ART, with an undetectable viral load at 12 months (<1000 copies/ml)		
# of adults and children living with HIV who receive care and support services outside health facilities during the reporting period		

% of estimated HIV-positive incident TB cases that received treatment for both TB and HIV		TB/HIV mortality rate (per 100,000)
# of annual complaints filed and validated	% of women and men aged 15-49 expressing accepting attitudes towards people living with HIV	
	% of women and men aged 15-49 expressing accepting attitudes towards men who have sex with men	
# of key staff trained in drug quantification and use of SOP's	# of survey respondents expressing experiences of discrimination in health care settings	

Indicator Performance Framework

The purpose of this Indicator Framework is to outline a concise and manageable set of indicators that can serve as barometers of progress against targets set in the National Strategic Plan.

Some indicators have been developed globally for use in monitoring program results at all levels. The globally recommended set of indicators for comprehensive HIV/AIDS programs was used to develop the indicator framework of the M&E Plan. These indicators are part of the Global AIDS Response Progress (GARP) reporting mechanism and align well with the nationally or internationally agreed standards for measurement and quality assurance. There are also national-level indicators that have been developed to reflect progress at the national-level.

Indicator		Baseline		Targets					Source	Reporting
		Value	Year	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5		
Priority Goal 1 New HIV infections among persons, 15-24 years, account for a maximum of 8% of all new infections										
Priority Intervention Strategy 1 Intensified comprehensive HIV prevention services targeting all persons 15-24 years of age										
Impact										
# of new HIV infections among persons, aged 15-24 , as a percentage of total number of new infections		18	2014	14	12	10	9	8	BHIS	MOH
% of young people, aged 15 -24, who are living with HIV *(GAR 1.6)*		0.6	2014	0.6	0.5	0.4	0.3	0.3	BHIS	MOH
Outcome										
% of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission *(GAR 1.1)*		42 (women)	2011			70		95	Sexual Behavior Survey	NAC
% of young women and men aged 15-24 who have had sexual intercourse before the age of 15 *(GAR 1.2)*		7.8	2009			6		5	Sexual Behavior Survey	NAC
% of women and men aged 15-24 who have had sexual intercourse with >1 partner in the last 12 months *(GAR 1.3)*	15-19	30	2014			25		20	Sexual Behavior Survey	NAC
	20-24	15				12		10		
% of women and men aged 15-24 who had more than one sexual partner in the last 12 months and who report the use of a condom during the last sexual intercourse *(GAR 1.4)*		56	2014			70		80	Sexual Behavior Survey	NAC
Coverage / Output										
% of young people age 15-24, reached with HIV IEC interventions								80	Reports from program implementation	NAC
% of young people age 15-24, reached with HIV information platforms on social media outlets								90	Reports from program implementation	NAC

# of male condoms provided to targeted end-users in last 12 months								Reports from program implementation	NAC
# of eligible vulnerable girls & young women receiving benefits from social protection schemes								Reports from program implementation	NAC
Priority Goal 2 **New HIV infections among men who have sex with men account for a maximum of 30% of all new infections**									
Priority Intervention Strategy 2 **Scaled-up comprehensive HIV prevention services for men who have sex with men**									
Impact									
# of new HIV infections among men who have sex with men, as a percentage of total number of new infections	63.5	2014	55	45	40	35	30	BHIS	MOH
% of men who have sex with men, who are living with HIV *(GAR 1.14)*	13.9	2012			10		6	Bio-Behavioral Survey	MOH
Outcome									
% of men reporting the use of a condom the last time they had anal sex with a male partner *(GAR 1.12)*	55.1	2013	60	65	70	75	80	Sexual Behavior Survey	NAC
Coverage / Output									
% of men who have sex with men reached with HIV prevention programmes	66.5	2010					80	Reports from program implementation	NAC
# of male condoms provided to targeted end-users in last 12 months								Reports from program implementation	NAC
Priority Goal 3 **70% of persons with HIV know their HIV status. Including 80% of men who have sex with men.**									
Priority Intervention Strategy 3 **Increased targeted HIV testing opportunities for the general and specific key affected populations.**									
Outcome									

% of women and men aged, 15-49, who received an HIV test in the last 12 months and who know their results *(GAR 1.5)*		28.4 (women)	2011						Sexual Behavior Survey	NAC
% of men who have sex with men who have received an HIV test in the last 12 months and who know their results *(GAR 1.13)*		59.6	2012						Bio-Behavioral Survey	MOH
Coverage / Output										
# of HIV testing and counselling services provided to women and men aged 15-49.									Reports from program implementation	NAC
# of HIV testing and counselling services provided to men who have sex with men									Reports from program implementation	NAC
Priority Goal 4 **80% of persons living with HIV, who are on ART, remain on ART.** **Peripheral Goal 6** **90% of persons living with HIV are connected to HIV care and treatment.**										
Priority Intervention Strategy 4 **Intensified and improved comprehensive management of HIV and HIV-TB cases.** **Peripheral Intervention Strategy 6** **Improving ARV coverage**										
Impact										
AIDS-related mortality per 100,000 population (by sex)	M	30.3	2013	31.9	29.6	27.5	25	23	BHIS	MOH
	F	20.6		17.0	16.2	14.8	12	10		
TB/HIV mortality rate (per 100,000)		2.0	2013	1.1	0.8	0.5	0.3	0.3	BHIS	MOH
Outcome										
% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy		47.7	2014	55	60	70	75	80	BHIS	MOH
Coverage / Output										
% of people living with HIV that initiated ART with CD4 count of <200 cells/mm³		43.6	2014	35	25	15	10	5	BHIS	MOH
# of adults and children with advanced HIV infection currently receiving ART		1,433	2013						BHIS	MOH

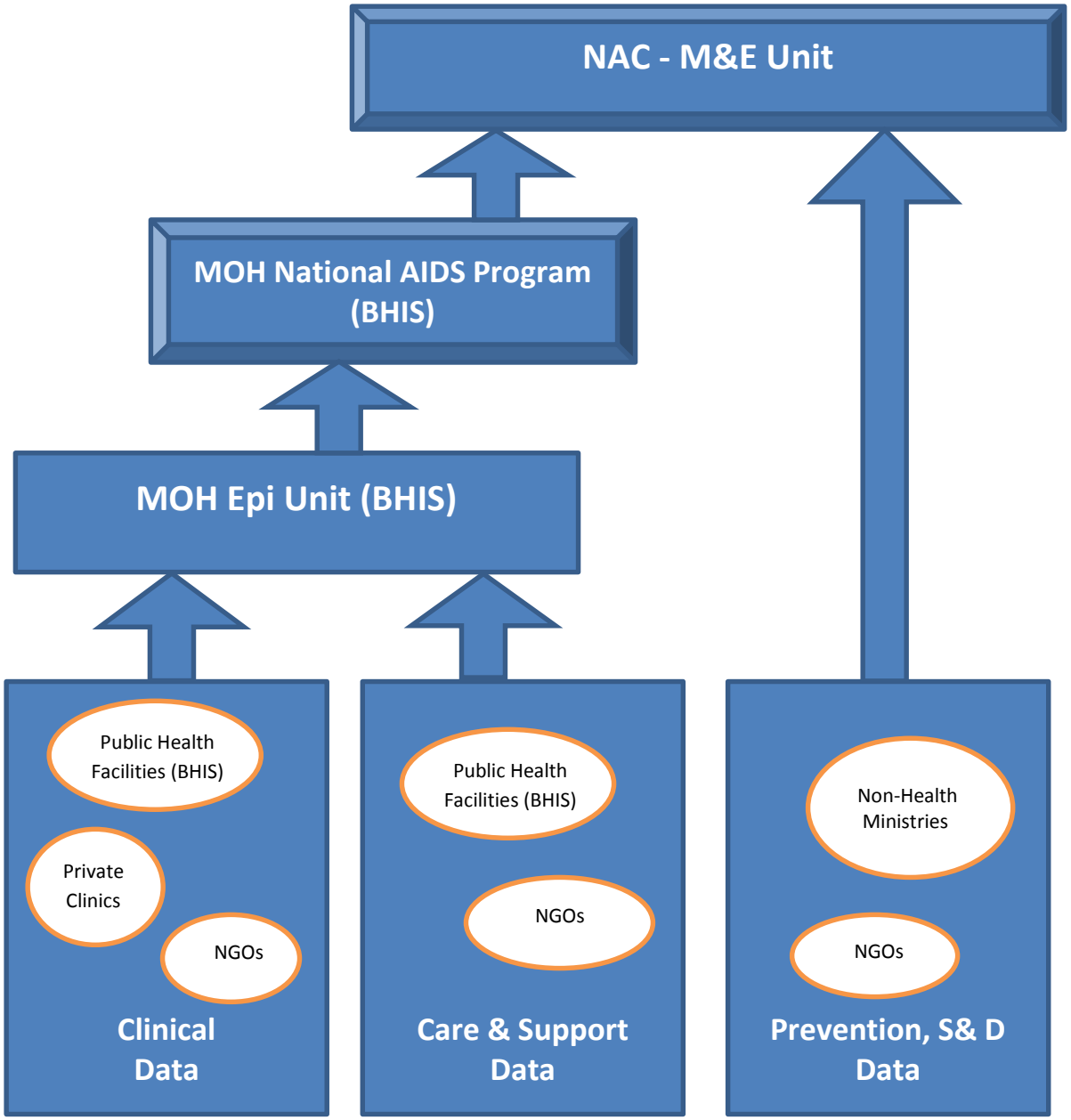
% of eligible adults and children currently receiving ART *(GAR 4.1)*	50	2014	60	70	80	85	90	BHIS	MOH
% of adults and children that initiated ART, with an undetectable viral load at 12 months (<1000 copies/ml)							80	BHIS	MOH
# of adults and children living with HIV who receive care and support services outside health facilities during the reporting period								Reports from program implementation	NAC
% of estimated HIV-positive incident TB cases that received treatment for both TB and HIV *(GAR 5.1)*	20.7 (25/121)	2013					75	BHIS	MOH
Priority Goal 5 **Reported discrimination in the provision of HIV-related health care services has moved toward "zero discrimination".** **Peripheral Goal 7** **50% of HIV and HIV-TB services are delivered via community-level health services.**									
Priority Intervention Strategy 5 **Intensified and well-monitored anti-stigma and discrimination programs in the health and allied health sector.** **Peripheral Intervention Strategy 7** **Sector-wide program for technical capacity development at all levels of the health system**									
Outcomes									
% of women and men aged 15-49 expressing accepting attitudes towards people living with HIV	8.1	2011						Population-based survey	NAC
% of women and men aged 15-49 expressing accepting attitudes towards men who have sex with men								Population-based survey	NAC
% of survey respondents expressing experiences of discrimination in health care settings								Population-based survey	NAC
Coverage / Output									
# of annual complaints filed and validated								Reports from program implementation	NAC
# of key staff trained in drug quantification and use of SOP's								Reports from program implementation	NAC

9.4 Data Collection, Analysis and Reporting

➢ Data Collection

General Flow

The diagram below outlines how routine HIV and TB data will reach the M&E Unit of the NAC Secretariat: clinical data from testing will be collected from the regular public health facilities (Polyclinics and Hospitals), private clinics and Non-Governmental Organizations (NGOs) and entered into the Belize Health Information System by the Epidemiology Unit of the Ministry of Health. In the case of polyclinics, public hospitals and some NGOs, data will be entered directly into the BHIS by the testing site staff and reviewed by the Epidemiology Unit.



Staff of the National AIDS Program will then review the data on a regular basis and produce periodic reports, which will be forwarded to the M&E Unit of the NAC for inclusion in national reports.

The same processes will be followed for care and support data for regular public health facilities (Polyclinics and Hospitals) and Non-Governmental Organizations (NGOs).

For prevention and stigma and discrimination issues, data will be forwarded directly to the M&E Unit of the NAC by the respective Non-Health Ministries (Education, Youth & Sports; Human Development; Labor) and NGOs.

The Belize Health Information System

Health information from the Ministry of Health is managed through the Belize Health Information System (BHIS), which is a web-based customized electronic health record system. It is accessed by health care providers at all levels of the Ministry of Health, inclusive of Laboratories, Pharmacies, the central prison and 3 military bases. As Primary Care Provider, the NGO BFLA is also connected to the BHIS.

BHIS consists of a set of mostly interdependent modules surrounding the central Electronic Health Record (EHR) and Admissions-Discharge-Transfer functions. For HIV and TB, there are key modules:

- *Electronic Health Record and Admission Discharge Transfer (HER-ADT),* capturing key details of each health service encounters;
- *Laboratory and Testing (LAB),* covering a broad range of typical laboratory tests, vitals and radiology;
- *HIV/AIDS,* recording data collected during pre/post testing counselling and HIV/AIDS clinic visits, contact tracing and utilizing WHO staging criteria for tracking the client's progress

HIV cases: as measure of quality control, any positive HIV test conducted is sent to the CML for confirmation; reports on the number of persons testing positive for HIV are routinely entered in the BHIS Lab Module and submitted quarterly to MOH Epidemiology Unit

AIDS cases: reports obtained from regional and community hospitals reports are submitted on a quarterly basis to the MOH Epidemiology Unit for further processing and analysis.

The MOH Epidemiology Unit is responsible for the collection, compilation, analysis, interpretation and dissemination of health data and information to support decision making.

Surveys

Population-based surveys are the basis for impact– and outcome evaluations about change and cause-effect relations. Through the measuring of performance indicators knowledge about changes in each desired target population is generated while evaluations will show whether the change is attributable to the intervention, de facto providing evidence for a causal relationship between the project's activities and the results achieved.

There are two types of population based surveys that are focused on the following aspects of the epidemic:

a. Surveys on Indicators for the prevention of HIV Infection, which will get results of behaviours, knowledge, attitudes, stigma and discrimination, with breakdown by sex, five-year age groups and geographical area.

b. Surveys of knowledge, behaviour and attitudes directed at specific key affected populations.

Population-based Sexual Behaviour Surveys (SBS) will be conducted with a national scope every two years to generate reliable and accurate information that can be used in further planning exercises.

Year of Survey	**Type of Survey**
Year 1 (2016)	Multiple Cluster Indicator Survey (MICS)
Year 3 (2018)	Sexual Behavioural Survey • correctly identify ways of preventing the sexual transmission of HIV • persons 15-24 who have had sexual intercourse before the age of 15 • persons 15-24 who have had sexual intercourse with >1 partner in the last 12 months • persons aged 15-24 who had more than one sexual partner in the last 12 months and who report the use of a condom during the last sexual intercourse • men reporting the use of a condom the last time they had anal sex with a male partner • persons 15-49 who received an HIV test in the last 12 months and who know their results • persons 15-49 expressing accepting attitudes towards people living with HIV • persons 15-49 expressing accepting attitudes towards men who have sex with men • persons 15-49 expressing experiences of discrimination in health care settings Behavioural Surveillance Survey/ Integrated Bio-Behavioural Survey • men who have sex with men, who are living with HIV • men who have sex with men who have received an HIV test in the last 12 months and who know their results
Year 5 (2020)	Multiple Cluster Indicator Survey (MICS) (repeat) Sexual Behavioural Survey (repeat) • correctly identify ways of preventing the sexual transmission of HIV • persons 15-24 who have had sexual intercourse before the age of 15 • persons 15-24 who have had sexual intercourse with >1 partner in the last 12 months • persons aged 15-24 who had more than one sexual partner in the last 12 months and who report the use of a condom during the last sexual intercourse • men reporting the use of a condom the last time they had anal sex with a male partner • persons 15-49 who received an HIV test in the last 12 months and who know their results • persons 15-49 expressing accepting attitudes towards people living with HIV • persons 15-49 expressing accepting attitudes towards men who have sex with men • persons 15-49 expressing experiences of discrimination in health care settings Behavioural Surveillance Survey/ Integrated Bio-Behavioural Survey (repeat) • men who have sex with men, who are living with HIV • men who have sex with men who have received an HIV test in the last 12 months and who know their results

Special Studies & Events

The NAC maintains an inventory of HIV related research conducted in Belize, which is partially accessible through the NAC website. As a routine practice, the indicator performance matrix is periodically reviewed in order to identify gaps where data can be collected through special studies and/or research.

It is important to manage a calendar that incorporates a mid-term and end-term evaluation of the NSP and the Operational Framework. Similarly, the M&E component of the NSP 2016 – 2020 is scheduled to be evaluated at mid-term (2018) and the evaluation results will be combined with the periodic M&E System Strengthening (MESS) efforts to enhance improvements in the quality of program implementation

The following initial agenda for research and special studies has been put in place:

Topic	Commissioner	Year
Cost-benefit Analysis of treatment as prevention strategy	NAC - CCM	2016
Evaluation of TB and TB/HIV surveillance system	NAC - CCM	2017
National study on the feasibility of HIV self-testing in Belize	NAC - CCM	2016
Profiling and mapping exercise of key target populations in the districts of Belize, Stann Creek and Cayo	NAC - CCM	2016
Situation Analysis of prevalence of HIV among community of transgender persons	NAC - CCM	2016
Mid-Term Review of NSP	NAC	2018
Final Evaluation of NSP	NAC	2020
Mid-Term Review of NSP M&E framework	NAC	2018

The specific studies have been included in the NSP Operational Framework.

Surveillance System

The source for reporting on some impact indicators is the Epidemiological Surveillance System from the MOH Epidemiology Unit. The BHIS system captures the following information related to the impact indicators:

• The prevalence, incidence, morbidity and mortality related to HIV/AIDS, according to computerized registry report on HIV/AIDS in the country, using the BHIS.

• Percentage of adults and children with HIV known to be on treatment 12 and 24 months after initiation of antiretroviral therapy.

Data Quality, Quality Assurance & Control, Auditing

The quality of data has several dimensions: accuracy; completeness; reliability; timeliness; confidentiality; precision; and integrity. Improvement of the data quality includes a number of actions: data profiling, to understand the quality challenges; data standardization; geo-coding if applicable; and matching or linking to align slightly different data.

Data quality assurance is the process of profiling the data to discover inconsistencies and other anomalies in the data (incompleteness; inaccuracies; precision; missing parts), as well as performing data cleaning activities (e.g. removing outliers, missing data interpolation). Data quality assurance processes provide vital information to the data quality control where decisions are made about the protection of usage of data and the use and dissemination of "safe" information.

As the MOH NAP/ Epi Unit is a core producer of confidential and vital bio-medical HIV-TB related data, the NAC M&E Unit will ensure full technical collaboration with MOH's NAP in the management of the overall data quality control mechanisms of the M&E System.
Other reporting agencies will internally identify key persons to conduct internal checks to ensure the completeness, validity, consistency, timeliness and accuracy of all data prior to submission to the NAC. On sight data verification and follow-up with reporting agencies will be conducted periodically with the full consent of the reporting agencies, and with due notice.

This M&E framework advocates for the introduction of data auditing, which is a higher and external process of ensuring data quality from the beginning of the end of the "HIV intelligence" process in a repeatable and measured way. Data auditing is a process that validates data against a set of data rules to determine which records comply and which do not, thereby ensuring that data comply with the adopted data rules.

Data analysis

The analysis of data is a critical process in increasing the understanding of the HIV/AIDS epidemic and in provision of information needed for the development of evidence-based strategies to combat the disease. The analysis of both quantitative and qualitative data will be conducted at the level of MOH's Epidemiology Unit and National AIDS Program, and at the NAC M&E Unit on a continuous basis to ensure the availability of pertinent and accurate to inform decision making.

The MOH Epidemiology Unit is responsible for the collection, compilation, analysis, and interpretation of health data, and the dissemination of health information to support decision making on current and emerging health situations at the local, regional and national levels. The BHIS is a dynamic and comprehensive tool used to collect data from various sectors of the Ministry of Health and acts as a repository for critical information that flows in and out of the Ministry of Health. The Epidemiology Unit is also responsible for disease surveillance, outbreak investigation and control of communicable and non-communicable diseases. Services provided by the Epidemiology Unit include but are not limited to, periodic reports on the status of communicable and non-communicable diseases and making data on morbidity and mortality available to health personnel and to the general public.

The NAC M&E Unit has the responsibility of transforming the compiled data into usable knowledge products with the aim of providing strategic information for decision making. The analysis of HIV/AIDS data will be conducted on an annual basis to explore trends by indicator, facilitate reporting and to

assess the programmatic performance to determine the level of target achievement. DevInfo di Monitoring software will be used for the monitoring, and analysis of national data, actual versus planned activities, trend analysis and measuring the performance against the state goals of the NSP 2016 – 2020. The NAC M&E Officer is responsible for administering the database and overseeing data entry and analysis activities.

Communication and reporting of M&E data, information and knowledge

Communication of general and specific information on the national response to HIV and TB in Belize is a key function of the NAC platform. Communication activities will be implemented predominantly by the NAC Secretariat on behalf of the Commission.
There are several types of communication contents, audiences, formats and channels through which the NAC will report, communicate and disseminate information.

- Dissemination of aggregated information reports on the progress made in achieving the core outputs and targets of the NSP and the wider national response to HIV and HIV-TB; in collaboration with data producing stakeholders, the NAC Secretariat is to facilitate consistent, periodic reporting and communication on program indicators for activities conducted in the NSP service delivery areas;
- Quantitative and qualitative information on technical or normative developments in the global or national response to HIV and HIV-TB. This involves the processing, re-compilation and dissemination of information on related HIV developments that take place outside of the direct parameters of the NSP and M&E frame;
- Information related to the resource needs and financing of the national response to HIV and HIV-TB. Reporting here follows the schedule of the budget cycle of the Government of Belize which provides financial information about the estimates of revenue and expenditure. Additional information will be disseminated via reports of National AIDS Spending Assessments (NASA);
- Specific knowledge or knowledge events that generate new insights in the characteristics of the national epidemic and/or design and implementation of innovative approaches to fight the epidemic. Apart from the dissemination of original or aggregated results from special studies and operational) research, this component can include arrangements for national research conferences.

Dissemination of M&E information in quarterly and annual national reports, HIV and AIDS fact sheets, brochures, periodic stakeholder workshops and other related methods is the responsibility of the NAC Secretariat. To facilitate information sharing, the NAC will utilize its website which will serve as a clearinghouse for official HIV/AIDS-related reports and documents. Dissemination of M&E results to policy makers at the Ministry of Health will serve to inform planning of HIV interventions, provide feedback on the resource requirements for HIV and AIDS, and increase public commitment to reducing HIV and AIDS. The data dissemination table below summarizes the recommended dissemination of information for the points of generation to points of utilization.

Below is a lay out of the type of information and knowledge products envisioned to be disseminated during the implementation of the NSP 2016 -2020.

Type of product	Audience	Responsible	Frequency	Due dates
Format: bulletin / webpage /social media				
HIV Facts & Figures	General public; Care providers Ministries NGOs / CBOs NAC committees	NAC / MOH-NAP	Quarterly	End of quarter
HIV Public Domestic Expenditure Overview	General public; Care providers Ministries NGOs / CBOs NAC committees	NAC	Annually	End April
Format: print / webpage / social media				
Global AIDS Response Progress (GARP) report	UNAIDS - UN Ministries; NGOs / CBOs	NAC	Annually	End March
NAP Annual Report	General public; Care providers Ministries NGOs / CBOs NAC	MOH-NAP	Annually	End April
NAC Annual Report	General public; Care providers Ministries NGOs / CBOs NAC committees	NAC	Annually	End Feb.
NSP M&E Report	NAC stakeholders Care providers NGOs / CBOs	NAC	Annually	End May
STI Report	General public; Care providers Ministries NGOs / CBOs NAC committees	MOH-NAP	Quarterly	End of quarter
NSP Mid-Term Review Report	NAC stakeholders Care providers NGOs / CBOs	NAC		Aug. 2018
NSP Evaluation Report	NAC stakeholders Care providers NGOs / CBOs	NAC		Nov. 2020
NSP M&E Mid-Term Review Report	NAC stakeholders Care providers NGOs / CBOs	NAC		Aug. 2018
Format: Special Events with launches & report dissemination				
NASA Report	General public; Care providers Ministries NGOs / CBOs NAC committees	NAC		Aug 2017 Aug 2019
Presentation Sexual Behavior Study	General public; Care providers	NAC		Aug 2018

	Ministries NGOs / CBOs NAC committees			Aug 2020
Presentation Bio-Behavioral /Seroprevalence Survey	General public; Care providers Ministries NGOs / CBOs NAC committees	MOH		Aug 2018 Aug 2020
HIV Research Conference	Academia NAC stakeholders Ministries NGOs / CBOs	NAC		Spring 2018

9.5 Strengthening of the M&E practice

Several functional components of data and information management systems require to be grounded in solid practices to ensure that standards for data quality are met:

- M&E capabilities;
- Training;
- Data reporting requirements;
- Indicator definitions;
- Data collection and reporting tools;
- Data management processes;
- Data quality mechanisms & controls;
- Links with the national M&E and reporting system

This paragraph focuses on the aspects related to the human capacity factor and provides direction to move toward continued capacity development in the HIV M&E practice.

Several reviews of the bottlenecks to the further professionalization of the current HIV M&E practice, including an assessment in April 2015 of progress made toward the recommendations of the 2011 MESS Action Plan for human capacity development, have given the following landscape:

- Progress has been made in: the ability of organizations to attract staff with a defined M&E skills set; in the ability to identify and mobilize local or regional M&E training opportunities;
- Some level of progress has been made in: staff accessing M&E training from national training organizations; building M&E human capacity through routine supervision, on-the-job training (OJT) or mentorships;
- Lack of progress occurs in: institutionalized opportunities for M&E career paths; putting in place a mechanism for routine comprehensive management of the national M&E system and structures; the management of an articulated M&E human capacity development plan; the establishment of a standard curriculum for technical capacity building.

This M&E framework suggests putting in place the following strategic responses to make the practice of HIV M&E more efficient, effective and sector –integrated and mainstreamed:

1. Full alignment of the HIV M&E-oriented components of job descriptions at data producing and/or data consuming organizations. Alignment is to occur with a strong reference to data flow and data quality, ensuring that all M&E partners operate and function in a coordinated and compatible manner;
2. Re-configuration, through the NAC M&E Committee, of the community of practice for monitoring and evaluation in the social sector as a means to i) build a platform for exchange of professional information about successes and failures of M&E practices; ii) build a platform for learning in M&E data collection and manipulation practices and techniques; and iii) create an institutional stepping stone to a further integration of monitoring and evaluation agendas in the sub-domains of the social sector;
3. Continue and expand opportunities for short-term formal training, nationally or internationally, in M&E, complemented by expanded opportunities for on-the-job M&E training and related mentorships facilities.

Appendix 1 SITUATION ASSESSMENT

Context and Characteristics of the HIV epidemic

1. Country Information and Profile

Geography and Demographics

Fig. 1- Map of Belize

Belize is the only English-speaking Caribbean country in Central America and harbors a multi-ethnic society comprised of many cultures and languages.

The 2015 Mid-Year Population Estimate is 368,310[2]and the gender ratio is close to 1:1. Some 45% of the total population lives in urban areas while 20% of the total population lives in Belize City. Approximately 42% of the total population is younger than 18 years, while 56% is under 25 years. The population's median age is 21.5 years (males 21.4 and females 21.7), pointing at a high youth dependency ratio. Women of childbearing age (15–49 years) accounted for 52.67 % of the total female population. Belize records a population growth of 1.92% (estimate 2014)[3]. Belize's declining birth rate and its increased life expectancy result in a slowly increasing aging population.

The national multi-ethnic landscape looks as follows: Mestizo (53.5%); Creole (25.6%); Maya (10.0%); Garifuna (4.7%); and other (6.0%) ; 78.9% of Garifuna, 59.1% of Creole 59.1%, 41.1% of Mestizo, 13.8% of Maya and 44.6% of Other live in urban centers (estimates of the Labor Force Survey 2014; Statistical Institute of Belize).

Migration patterns continue to transform Belize's population as some 16% of Belizeans live abroad, while immigrants constitute approximately 15% of Belize's population. Around 41% of the foreign-born population originates from Guatemala[4]. Immigration accounts for an increasing share of Belize's population growth rate. Many of the immigration flows have occurred in Belize and Cayo districts and are visible in the agro-industry belt in the Stann Creek District.

[2] Statistical Institute of Belize; Population Estimate September 2014; http://www.sib.org.bz

[3] Belize Demographic Profile 2014 (August 23, 2014). Retrieved from http://www.indexmundi.com/belize/demographics_profile.html

[4] Population and Housing Census Report 2010. Statistical Institute of Belize http://www.sib.org.bz/Portals/0/docs/publications/census/2010_Census_Report.pdf

Economy, Income Poverty and Unemployment

In July 2013, Belize was classified by the World Bank as an Upper Middle-Income Country. The country's GDP growth rates (around 4%) were set back by the global downturn in 2008. By 2012, GDP had grown again to 4%. During the first quarter of 2015, Belize's economy grew by 7.0% in comparison to the same period in 2014[5], due to a strong growth in the primary sector.

The most recent measurement of wealth distribution (Living Standards Measurement Survey 2009) reported a poverty level of 41.3% (28% of the urban population and 55% of the rural population), while 15.8% of the population is indigent. Belize reports a relatively high unemployment rate which is 20.4% for women, more than three times the 6.7% recorded for men. Although overall unemployment is declining (14.2% in Sept 2013 to 12.1% Sept 2014), it rose 15.1% to 18.3% in Stann Creek district.

Early child bearing

The national adolescent birth rate is 64 per 1,000 adolescents (MDG Report 2013) but for Stann Creek and Toledo Districts, this figure increases to 84 and 81 respectively. Some 16% of women 18-24 years gave birth by age 15 and over 43% by age 18.

Of all young women 15-19 years, 64% does not use any method of contraception. Only 42% of young women 15-24 reported to have comprehensive knowledge about HIV transmission; for the age bracket 15-19 this was only 39.1%[6].

Other Health Indicators

- The life expectancy at birth is estimated at 72 years for men and 74 years for women.
- The average total fertility rate (2002–2006) is 3.3 children per woman of childbearing age. The last reported total fertility rate in Belize is 2.79 in 2010 (World Bank; 2012).
- There is an increase in the prevalence of Non-Communicable Diseases such as Diabetes Mellitus Type 2, heart disease, cardiovascular disease and cancers; since 2007 the leading cause of mortality are heart disease and Diabetes and its complications[7].
- Women have a higher mortality rate than males from diabetes, while the leading causes of mortality for males are homicide, HIV and road traffic accidents[8].
- Health care provided to men has mostly been associated with and in relation to issues of violence[9]. Noteworthy is Belize's recent homicide rates which rank in the global top five.
- Government remains the main provider of health services, though efforts have been made for a public-private mix through the National Health Insurance (NHI), whose general practitioners are the gatekeepers and referral agents to specialists or tertiary care. This system represents the future key anchors for HIV and TB responses in the primary care setting. The share of Private Health Expenditure (PHE) in Total Health Expenditure (THE) was 32%, up from 28% in 2007[10].

[5] Statistical Institute of Belize Statistics, GDP Releases, 2015, 1st quarter release. Retrieved from http://www.sib.org.bz/statistics/gross-domestic-product

[6] Multiple Indicator Cluster Survey 2011; SIB 2012

[7] Health Sector Strategic Plan 2014-2024; MOH; April 2014; Figure 2.1

[8] Idem, page 16

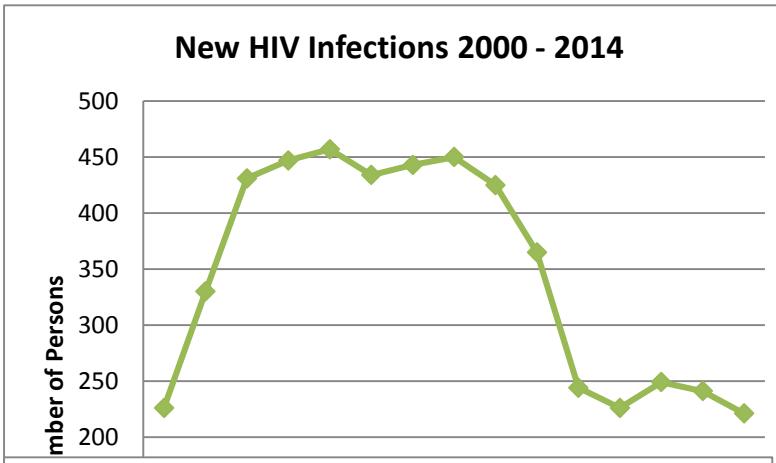
[9] Idem, page 29

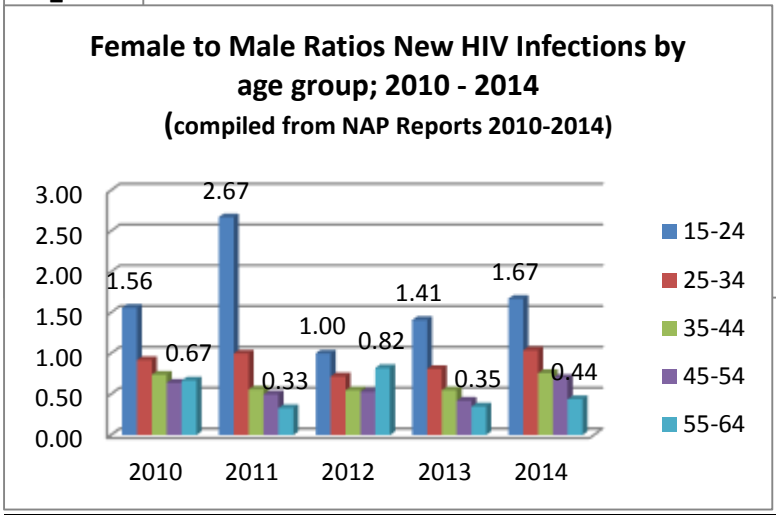
[10] Health Sector Strategic Plan 2014-2024, page 40; MOH; April 2014

- The Health Sector Strategic Plan 2014-2024 (HSSP) stresses the importance of the transition from a vertical program system to an integrated health care system.
- Community-based health care is well acknowledged within the primary health care approach and the Belize Health Sector Strategy aims to tap into the potential of the complementary partnership between the community and the national health system in order to improve health care coverage and impact.

2. Epidemiological Profile HIV, TB and TB-HIV

HIV SPECIFIC





New cases. Since 2007 there has been a continuous trend of decreasing new HIV infections. There were 221 reported new cases in 2014, the lowest number reported since 1998. This trend occurred against a backdrop of a continuous but modest increase in the number HIV tests performed.

Data for 2010-2014 show that men have been more affected by new infections than women. The proportion of new infections among men increased precipitously from 32% in 2010 and 2011 to 60% in 2012 and 2013. In 2014, this percentage was reportedly 54%.

The 2010-2014 data on new HIV cases, disaggregated by age, show

HIV Infection Peak Distribution 2010-2014 (*Figures from NAP reports 2010-2014)										
	2010		2011		2012		2013		2014	
Total new HIV infections	244		226		249		241		221	
Age cohort most affected	25 - 29		20 – 24		45-49		40-44		35- 39	
Peak number in cohort	47		40		42		39		34	
Distribution M / F	M	F	M	F	M	F	M	F	M	F
	23	24	13	27	25	17	27	12	18	16

that in the 15-24 year age cohort women are consistently more infected than men, while in the 29-64 years old age group, there are consistently more cases in men. This consistent difference may reflect that women are more likely to test during routine prenatal care while men may only start testing once

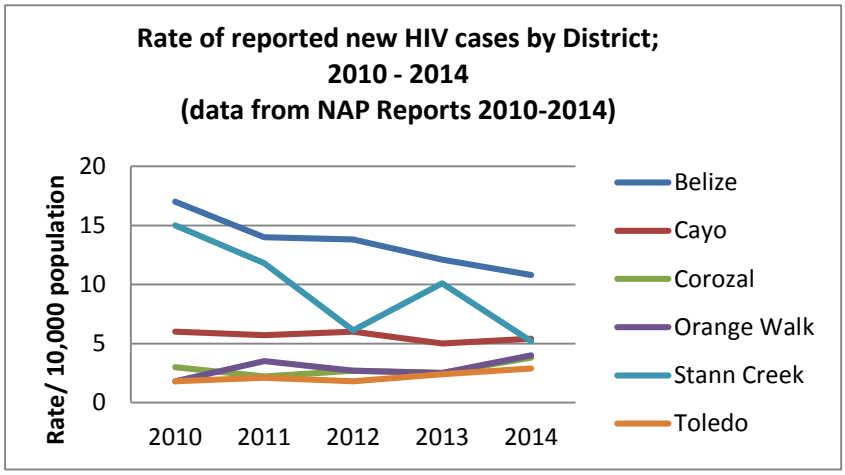
health problems surface. It may also indicate a practice of older men maintaining a sexual relationship with young women

Peaks of reported new HIV infections appear to have moved from a younger age cohort 20 – 29 (in 2010 and 2011) where females had a higher number of new infections, to an older age cohort 35 - 49 (in 2012-2015), where higher numbers of new infections were reported in males.

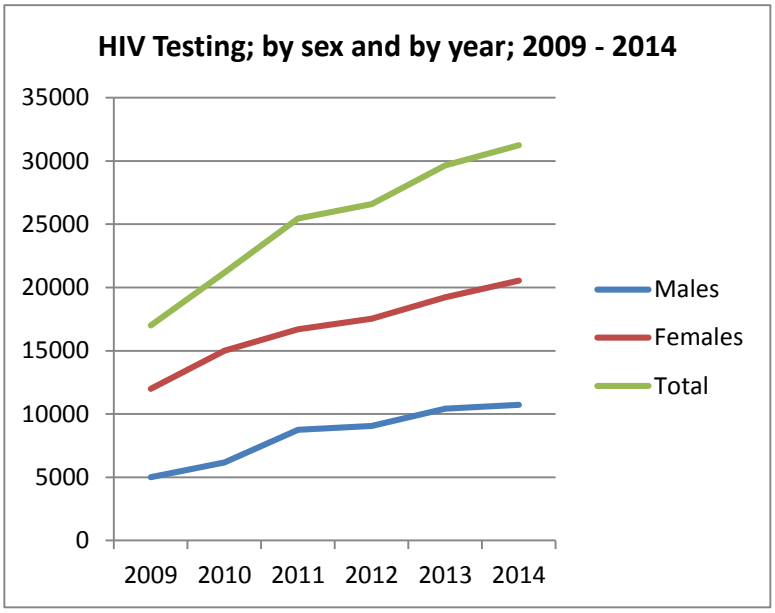
New HIV infections among adolescents and youth 15-24 years ; 2011-2014				
	2011	2012	2013	2014
Total number of new HIV infections	226	249	241	221
# of persons 15-24 testing positive	55	34	41	40
% of persons 15-24 testing positive	24	14	17	18

Findings from the KAP 2014 Study and MOH data indicate that adolescents and youth are vulnerable to HIV infection. High national adolescent birth rates (65.4% in 2013) 84% in Stann Creek; 85% in rural areas) point at high levels of early and unprotected sexual activity among adolescents. In 2013, the adolescent birth rate for Stann Creek district was 84%, while rural areas in Belize reported 85%

Spatial distribution: According to 2014 HIV surveillance data, Belize District distinctively continues to record the highest HIV incidence rate (10.8) per 10,000 district population. Cayo District (5.4) is the second most affected district followed by the Stann Creek district (5.2), which reports the highest adolescent pregnancy rate in the country. With regard to HIV incidence rates, Corozal, Orange Walk and Toledo Districts have remained fairly consistent over the past 5 years.



Testing. The annual number of voluntary counseling and testing (VCT) services for HIV has increased from around 17,000 in 2009 to 31,263 in 2014. Data show that the number of HIV tests in women consistently doubles the number of tests in men. The national MCH program plays a role in this situation as 92-93% of pregnant women take an HIV test, offered as part of MCH's guidelines and successful contributing to the reduction of the vertical transmission of the virus. The overall fact that more men test HIV positive provides an indication that men are more affected by HIV.



Anti-Retroviral Treatment: Data for ARV treatment coverage over the period 2008 – 2011 show a trend in the correct direction, improving coverage of persons living with HIV, eligible for ART from 49% in 2008 to 90% in 2011. Partly as a result of changes in data processing methods as well as in the lowering of the initiation threshold CD4 count that level has dropped to 50% (1,433/2,828) in 2013. Pediatric cases (0 – 14 years) form around 7% of persons living with HIV on ART. For this group, ARVs are provided by MOH but are administered to the children, along with other complementary care and support, by the NGO "Hand in Hand Ministries".

The ART retention rate at 12 months after initiating ART has dropped, partly as a result of revised data, from 91% in 2011 to 53% in 2013 (males 51% and females 55%) to 48% in 2014 (males 49% and females 46%). In 2014, 24 months ART retention stood at 48% (males 48% and females 49%).

Other Key HIV Epidemiological Data

HIV Prevalence (%)			
Target Group	***Value***	***Year***	***Source***
Incarcerated persons	4.9	2005	Study Central Prison
Military (BDF)	1.1	2010	Study BDF Clinic
Female sex workers	0.9	2012	Seroprevalence Survey
Men who have sex w men	13.9	2012	Seroprevalence Survey
General adult population	1.4 – 1.5	2013	SPECTRUM
General youth (15-24)	0.3 – 0.6	2010-2014	EPI-MOH
Other			
men who have sex with men identifying as:	bisexual or heterosexual transgender	32.3% 2.9%	Seroprevalence Survey
Percentage of new HIV cases expected in specific populations	Men who have sex with men Casual hetero sex Stable hetero couples Partners casual hetero sex Clients of FSW	63.5% 20.3% 8.4% 2.7% 1.3%	Modes of Transmission study; 2014

Population size estimate for men who have sex with men (est. % of male adults)	Low: 1,800 (2% of all adult males) High: 4,500 (5% of all adult males)	2014	MOT

	2012	2013	2014
Percentage of first-time CD4 < 350	63.2		62.2
Annual number of HIV-related deaths	88	89	79*
Number of syndromically diagnosed STI cases	4,951	4,802	6,845

Source: MOH-NAP

** 24 persons were diagnosed HIV+ in 2014 and died the sane year in 2014*

Key Sexual Behavior Data

- Percentage of men reporting the use of a condom the last time they had anal sex with a male partner dropped from 80.1% in 2010 to 55.1% in 2013 (TRaC Studies)
- Percentage of sex workers (female & male) reporting the use of a condom with their most recent clients dropped from 88.3% in 2010 to 56.4% in 2013 (TRaC Studies)
- Percentage of women and men aged 15-49 who had more than one sexual partner in the last 12 months and who report the use of a condom during the last sexual intercourse was 63.1% in 2010 (males and females) and 28.6 in 2011 (only data for females available; MICS 2011)
- Around 64% of all young women 15-19 years do not use any method of contraception (only data for females available; MICS 2011)
- Only 42% of young women 15-24 reported to have comprehensive knowledge about HIV transmission; for the age bracket 15-19 this was only 39.1% only data for females available; MICS 2011).

TB SPECIFIC

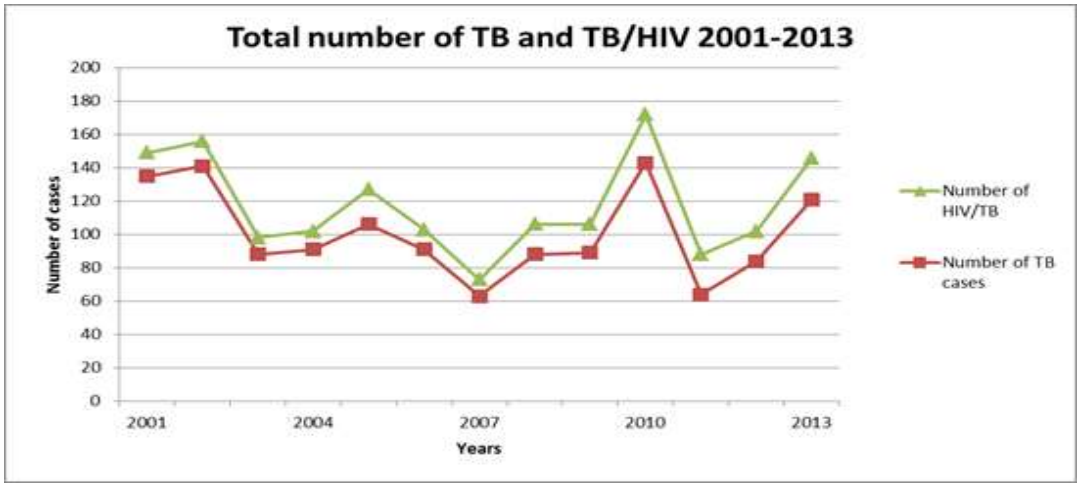
Key Indicators	***Value***	***Year***	***Source***
TB Incidence Estimated annual cases	40/ 100,000 133	2013	WHO estimates
Number of newly diagnosed TB in all forms	64	2011	EPI-MOH
	88	2012	
	121	2013	
	72	2014	
TB patients diagnosed	65% are males 48% in Belize district 20% are foreign-born 20% are HIV positive	2013	EPI-MOH
TB Prevalence	39/ 100,000	2013	WHO estimates
Peak ages of TB transmission	20 – 65 yrs.	2013	EPI-MOH
Detection rate	92%	2014	MOH- TB SitAn
Death as Treatment outcome	9-18%	2013	EPI-MOH
TB treatment success	< 60%	2013	EPI-MOH
TB treatment default	20-25%	2013	EPI-MOH

- The epidemiological drivers of TB incidence and mortality in Belize include poverty, HIV/AIDS, chronic non-communicable diseases and poor treatment outcomes with low success rates.
- Inconsistent and ineffective screening with low case detection has negatively impacted TB control.
- There remains a high degree of unknown and negative smears which may be attributed to poor diagnostic capacity, extra-pulmonary TB, and TB/HIV co-infections.
- WHO estimates that 2 percent of new cases and 14% of retreatment cases have Multi-Drug Resistant TB (5 such cases in the last 10 years with 3 cases in 2013)

TB-HIV SPECIFIC

Key Indicators	***Value***	***Year***	***Source***
Incidence TB-HIV	8.6/ 100,000	2013	WHO
TB patients with known HIV status	98%	2013	EPI-MOH
TB patients tested for HIV with positive result	21%	2013	EPI-MOH
HIV-positive TB patients on co-trimoxazole preventive therapy (CPT)	84%	2013	EPI-MOH
HIV-positive TB patients on ARV	100%	2013	EPI-MOH
Mortality rate TB-HIV co-infection)	28%	2013	EPI-MOH
TB cases offered HIV testing	56%	2014	MOH- TB SitAn
HIV-tested TB cases that are HIV+	28%	2014	MOH- TB SitAn
Death as a TB treatment outcome	50% of all HIV/TB patients	2013	EPI-MOH

- TB infections can exist as Latent Tuberculosis Infections (LTBI), Extra-Pulmonary Tuberculosis (EPTB) or active TB disease in a segment of the HIV-positive population that is larger than reported.
- Historical analysis of TB/HIV co-infection data reveals a continued upward trend. Since 2008 data indicate that co-infection rates have been above 20% with an average of 23.25% for the period 2008 to 2013. This may point at the possibility that HIV-positive persons are increasingly serving as both reservoirs and active carriers of the disease
- Calculations reveal that a person with TB in Belize is 87% more likely to also be HIV positive compared to their non-TB positive counterparts.
- The number of HIV/TB co-infections among males is significantly higher than among females with a ratio of 1.9 to 1 respectively.
- Consequently, almost 90% of HIV/TB co-infection deaths occurred in males, reflective of higher death rates for men in almost all categories of health.



Ministry of Health: Epidemiology Unit, 2014

3. Determinants of the HIV epidemic

Unprotected sexual intercourse, whether forced or voluntary, has remained the core cause of new HIV infections in Belize and at its roots is a complex of economic, sociologic, psychologic, cultural and emotional factors that sustain the gap between knowledge and behavior:

Socio-economic factors

Poverty and indigence, which were reported in 2009 at 41.3% of the population and 16.0% of the population respectively, are important determinants of the HIV epidemic as they promote the deployment of unconventional coping strategies, including transactional hetero, same-sex and inter-generational sex services. The risk is especially high for girls and women to become engaged in risky sexual activities, via consensual and non-consensual transactional sex as well as through human trafficking.

Poverty obstructs access to and enjoyment of education and learning, depriving already vulnerable young persons of gaining vital HIV, STI and sexual and reproductive health information. The high level of male drop-outs from secondary education causes vulnerable young males to disappear from the response radar.

Poverty is a factor at play in the level of success of clinical management of the HIV disease as it causes barriers to consistently following a strict drug-therapeutic schedule and to lead a healthy life style.

Socio-cultural factors

Gender norms and roles in Belize are influenced by dominant cultural patterns in the Caribbean and Central America and they impact on sexual practices and risk behaviors of men and women. They also impact on health care seeking behavior of, especially, adult men.

Sexual Abuse

Power issues often form the basis of violent and forced sexual activity in public institutions, including prisons, and private domestic settings. Girls and young women are particularly vulnerable to

contracting HIV and other STIs along with profound impact on personal safety, self-esteem and psycho-social well-being.

Human rights infringements

Studies about respect for human rights, related to persons infected or affected by HIV, show mixed results. 70% of respondents in the Stigma and Discrimination Gallup Poll (USAID/PASCA; 2013) expressed that persons living with HIV have a right to full access to public places, but also 70% denied women with HIV the right to become pregnant. Only 28% of respondents would share their home with a homosexual while 59% rejected the idea that HIV is a divine punishment for men who have sex with men or sex workers. Only 16% agreed that transgender persons have the right to legally identify as being of the other sex and 78% opposed aggression towards this group.

Furthermore, domestic legislation continues to contain provisions that infringe on the rights to equal access to health care and treatment services for young persons as well as provisions that criminalize homosexual activity.

Stigmatization and discrimination

The Stigma Index conducted through CNet+ and the Stigma and Discrimination Gallup Poll Results through USAID-PASCA are highlighting the need for increased advocacy and awareness for health care personnel working with infected and affected persons in Belize and more widely the general population[11]. The 2013 Stigma and Discrimination Gallup Poll reported of cases of discrimination and harassment towards men who have sex with men and transgender persons in community-settings, education and health services.

Health care providers do not usually recognize the act of stigmatization and discrimination nor the effects these have on healthy choices and health services. Incomplete knowledge about sexual health issues specific to key affected populations, for example anal sexual intercourse practices and anal hygiene, aggravates this situation.

Policy and legal aspects

For adolescents, the current policy with regard to HIV testing presents a barrier as parental consent is needed to take such test at the age of 16 or younger. This limits the number of youth who may feel comfortable accessing these services[12]. Furthermore, although available since 2014 in all primary and secondary schools, comprehensive sexuality education is inconsistently delivered to young persons, due to opposition from some churches and a lack of trained teachers, both in and out of schools. This situation has contributed to youth having only limited knowledge on HIV, STIs and pregnancy, on what adolescent sexual and reproductive health is, and on what the benefit of those services can be.

The act of having anal sex is recognized as a criminal offence under Belize's Criminal Code. According to UNIBAM, the corresponding section is deemed to enhance criminalisation by exclusion in the various domains of public life, including pension and social security benefits or making life-or-death health decisions in cases where a person is HIV positive or terminally ill[13]. Furthermore, national immigration

[11] Global AIDS Country Progress Report 2014; UNAIDS; page 35

[12] Beyond Barriers :recommendations for Adolescent Sexual and Reproductive Health Policies and Programs in Belize, Guatemala, and Honduras; International Planned Parenthood Federation; 2014

[13] Note on Human Rights Barriers and Gender Equality that affect Access to Services; Caleb Orozco, UNIBAM; 30 July 2014

legislation contains discriminatory provisions for entry and stay, inter alia for homosexuals, and is non-compliant with international obligations.

The regulatory environment for hate-speech in the media falls under the Belize Broadcasting Authority. To date, hate-crime has not been legally defined. State-led and data-based investigations of violence and discrimination against sexual minorities lack an operational mechanism for reporting of rights violations. .

Sexual behavior aspects: multiple partners and low condom use

Sexual debut and Multiple Partners

High adolescent birth rates (65.4% national: 84% in Stann Creek; 85% in all rural areas; all figures for 2013) reflect high levels of early and unprotected sexual activity among adolescents. The average age of sexual debut for males and females 15-19 years is 16.4 years and data suggest that most young people delay debut sexual activity toward the age of consent (16 years).

Studies on the number of sexual partners among young Garifuna persons in Stann Creek, Cayo and Belize districts point at the existence of a variety of sexual arrangements among young persons, leading to multiple opportunities for casual sex with multiple partners, without establishing conventional relationships. The 2014 KAP study indicated that 20% of the respondents, 15 to 24 years, reported having had multiple sex partners in the 12 months period prior to the survey; more than half of them were 15 to 19 years old.

Condom use

Despite widespread high-risk sexual behaviors, condom use remains low. The 2014 KAP study shows that condom use among persons 15-24 years with multiple partners was 48% for females, significantly less than 66% for males, and pointing at an overall trend of decreased condom use by females during sexual activities with multiple partners. A similar trend shows for condoms use with a non-regular partner.

UNDP has consistently reported through its Project Updates /Disbursement Requests, that condom use among key affected population, especially the group of men who have sex with men, has been below the targets set, providing an indicative reflection that condom use HIV prevention strategies appear not to be very effective in changing behavior[14]. This feature was confirmed by the Behavioral Surveillance Study of 2012, which showed that 55% of the men who have sex with men who participated in the study reported the use of a condom during their last anal sex with a male partner.

Low condom use is also influenced by constraints in the availability of adequate and attractive condoms as well as adequate and safe lubricants. This points also at a possible effect of the absence of a sound national condom distribution strategy national. This strategy will also provide a tool for the projection and planning of the sustainable procurement and free and commercial distribution of condoms.

Use of mind-affecting drugs and unsafe sex

[14] PU/DR June 2014; UNDP

The use of alcohol, marijuana and/or cocaine is reportedly high among high school students in the urban areas. Although formally no direct correlation has been established between drug (ab)use and increased risky sexual behaviour, there is a need to consider the use of drugs when addressing risk factors among young people. This is also a valid concern for interventions with men who have sex with men, as social life style issues may enhance the consumption of drugs and risky sexual activity.

4. Key affected population groups

Recent HIV prevalence data, the results of the 2014 Modes of Transmission study and the most recent sexual behavior and knowledge data provide a strong indication of the existence of a number of key populations who are highly vulnerable to and/or affected by HIV. Their right to adequate access to quality and affordable health care requires a highly prioritized response.

Men who have sex with men

The Belize Behavioral Surveillance Study (BSS) and Modes of Transmission (MOT) study suggest that the HIV epidemic has some residual general load but is now concentrated in the population of men who have sex with men. HIV prevalence among this group is as high as 13.9%, followed, at a distance, by the group of incarcerated persons (4.9% in 2005).

Close to two-thirds of the expected annual number of HIV cases will be in men who have sex with men. The population is by far the single most affected group, in terms of HIV prevention, HIV testing and HIV treatment, care and support.

- The group of men who have sex with men is not a homogenous community and displays, on the one hand, diversity in sexual preferences and behavior patterns (64.7% self-identified as gay or homosexual, 32.3% as bisexual or heterosexual, and 2.9% as transgender; BSS 2012), while on the other hand, many do not self-identify and remain invisible and out of reach of any prevention interventions or health care services.

- Men who have sex with men report having sex with multiple partners while the reported use of condoms is as low as 55%. This suggests little to no change in the reduction of risky sexual behavior pattern and points at the inconsistency between HIV prevention knowledge and risk-reducing behavior.

- Men who have sex with men are seriously confronted by unfavourable conditions that create additional barriers to their already limited health seeking behaviour. They are impacted by external and/or internal factors: legal provisions and stigma and discrimination by professionals (or the general public) create barriers to adequate self-identification and self-empowerment as well as accessing health services. Internalization of perceived stigma and discrimination renders a similar net effect.

Considering the high disease (HIV and TB) burden in the Belize, Stann Creek and Cayo Districts, men who have sex with men residing in these areas are of special concern.

Young persons

The MOT findings show that 20.3% of new HIV infections will occur as a result of casual heterosexual sex. Additionally, recent survey data show that there are multiple opportunities for casual sex with

multiple partners among young persons 15-24 years. Of all survey respondents 15-24 years, 20% reported having had multiple sex partners, while more than half of them were 15 to 19 years old. Meanwhile, condom use among persons 15-24 years with multiple partners was 48% for females and 66% for males with similar trends for condom use with a non-regular partner.

***Males*:** HIV and TB epidemiological data confirm that men are more affected by HIV and TB: most new HIV infections occur in males, with a peak in middle-aged men who assumedly engage more in transactional unsafe sexual relationships with either young women or young men; HIV-related deaths occur mostly among men; 50% more men than women are diagnosed with TB. The data also reflect that males display lower levels of health seeking behavior than women do: male participation in HIV testing is at half that of female participation; most of the persons living with HIV who initiate ART with a CD4 count below 250 are men.

Although males 40-49 years report peak number of new HIV cases, this NSP gives focus to preventing HV infections among young males 15 – 24 years as they face critical age- and gender-specific factors such as experimental multiple-partner sexual relations, market-driven consumption and communication patterns, peer pressure, crime and violence, low healthcare seeking behaviour, inadequate education, poverty and unemployment.
The vulnerable situation of males 40-49 years, who are assumedly engaging more in transactional unsafe sexual relationships with either young women or young men, will be addressed by including for this group an assigned priority focus to scaled-up HIV testing in this sub-population. This strategy is built on the conviction that sexual behavior of older men is more difficult to change and that a focus on disease detection and subsequent treatment and care may prove to be more cost effective.

Females: Aware of the multi-layered risks of young women to persistent violations of their right, this NSP advocates for continued investments in the protection, leadership skills enhancement and empowerment of adolescent girls and young women to strengthen their self-protection and determination when engaged in sexual relationships as well as facing threats of sexual intimidation or abuse

<u>Persons living with HIV, including an HIV-TB co-infection</u>

The number of persons living with HIV is estimated to be between 3,000 (MOH; 2013) and 3,300 (UNAIDS) and there is no indication of the geographic distribution. The most recent ARV coverage figure is a challenging 50.7% (2013) while MOH aims to move toward the UNAIDS 90-90-90 target of 90% of eligible persons living with HIV on ART. The current national target is set at 75% around 2018

More than half of persons living with HIV who start ART are not on treatment after 12 months; at 36 months, only 4 out of 10 persons living with HIV who started ART remain on treatment. As poor adherence creates a challenge to achieving the 90-90-90 targets, this situation also reflects the existence of barriers to using treatment as a prevention tool.

A special case has to be made for ARV coverage, ART adherence and care and support for children 0-18 as paediatric HIV treatment, care and support are more extensive and costly and carry a high level of obligation to protect and fulfil the rights of the child. Comprehensive treatment and care become vital aspects in the life of HIV-positive minors when they reach adolescence and go through puberty.

In Belize, the combined HIV-TB disease burden is relatively high; approximately 1 in 5 persons diagnosed with TB is also HIV positive. In 2013, Belize reported and estimated HIV-TB co-infection incidence rate of 8.1 per 100,000 of population, and TB, as opportunistic infection, plays a substantial role in HIV mortality in Belize. If HIV treatment and care is to be acknowledged a crucial matter in the fight against HIV and the protection of the human rights of persons living with HIV, then the treatment and care of HIV-TB co-infections is a prerequisite action for any further success.

There are a number of population groups that are not part of the high-impact focus of this NSP but whose situation and condition remains to be monitored and further investigated.

Commercial sex workers: The estimated HIV prevalence among this group is around 0.9% (BSS; 2012), lower than the overall prevalence rate and lower than previously estimated. Several aspects warrant continued attention to the dynamics and practices of commercial sex work, including the following:
A reported reduced use of condoms among female sex workers (from 88.3% in 2010 to 56.4% in 2013 according to PASMO's TRaC studies), increasing their risk, and that of their clients;
Anecdotal evidence suggest a widening spectrum of transactional/ commercial sex work going beyond the establishment-based commercial sex work and including men having commercial sex with men, ambulant women who offer sex to paying customers and young women who have sex with older men in return for economic benefits.

Persons with disabilities: Although persons with disabilities were identified in the NSP 2012 – 2016 as a sub-population most-in-need of HIV prevention services, no significant efforts have been undertaken in addressing the HIV-related situation of this group. The National AIDS Commission suggests that the widespread believe and perception that the life of persons with disabilities is devoid of sexuality and sexual activity, may in fact form the key barrier to changing the persistent in-action.

Transgender persons: There is a lack of HIV and/or TB epidemiological data and profiles of the transgender community and the inclusion of this sub-population as a population at-risk reflects the desire to generate an articulated epidemiological profile. Transgender persons, and especially transgender women, have reported to be subjected to serious levels of discrimination and harassment in community-settings, education and health services. In a similar fashion as with the community of men who have sex with men, this situation creates barriers to emotional intelligence, self-esteem and the uptake of HIV prevention and treatment services.

Foreign-born Workers and Incarcerated Populations: The majority of foreign-born workers is males and originates from Guatemala, which reports a high TB burden. Due to poverty, many may be latent TB cases when migrating to Belize, where they again face multiple challenges, including sub-standard living conditions, lack of legal documentation and fear of deportation. These factors combine to limit their access to social and health services, placing them at increased risk for adverse health outcomes.

According to a 2007 WHO Report, the prevalence of HIV, STIs, Hepatitis B and C, and TB in prison populations is estimated to be two to ten times higher than in the general population. A study in 2005 reported a HIV prevalence rate of 4.9% at the Belize Central Prison.

Uniformed Services: Studies have found that military personnel have a higher risk of HIV infection than civilians, in part because of their mobility, work environment and age. A study in 2010 on HIV Infection, Risky Sexual Behaviour and Condom Use in the Belize Defence Force reported a HIV prevalence rate of 1.1%. Many of the current –mostly male- recruits of the police and military forces are young people without previous extended exposure to formal or non-formal education.

The National Response to HIV, TB and HIV/TB

1. The Finances

Financial data produced by three subsequent assessments (National AIDS Spending Assessment; NASA; 2008/2009, 2012 and 2013/2014) reflect current trends in the various components of the national HIV response. Such comparison cannot yet be made in relation to HIV – TB portfolio as budgets for the TB response are fully submerged into the national MOH budget lines.

It is important to mention that the National Strategic Plans 2006-2011 and 2012-2016 have put limited attention to HIV-TB co-infections. In May 2014, the National AIDS Commission called for a greater level of attention to and alignment between HIV and TB. This resulted in the successful submission in January 2015 of a joint HIV-TB proposal to the Global Fund.

As percentage of the total national health expenditures, the level of HIV spending has dropped from 6.8% in 2008-2009, to 6.0% in 2012, and to 5.2% in 2013-2014. This trend signals that the response to HIV is slowly losing its share in the national health response. It reflects increased competition for resources between HIV and other emerging diseases and highlights the need for greater sustainability of the response, especially when new investments for scaling up the response to reach the 90-90-90 targets have become unavoidable.

The conscientious shift of focus of the NSP 2012-2016 on HIV prevention for most-at-risk populations (MARPs) has led to a shift in expenditure patterns. NASA 2012 classified 50% of the HIV prevention expenditures as targeting MARPs and in 2013-2014 this proportion had risen to 75%. The increase is a direct result of the implementation of the phase 2 of the Global Fund Round 9 Project as some 35% of the total HIV prevention expenditures in 2013-2014 originated from this project, which has an exclusive focus on MARPs.

Overall, shifts in HIV financing patterns have been relatively small over the past years. Since 2008, between 64 to 68% of the HIV response financing consistently originated from abroad. Zooming in on HIV prevention, the picture shows that almost 90% of the costs in 2013-2014 were financed from abroad. This signals a volatile HIV prevention funding basis, with a dependency on foreign money that is likely to continue since expected new domestic investments in HIV (and TB) is expected to occur mostly in HIV treatment aspects. The need to plan for higher levels of sustainability of HIV prevention interventions in Belize is also reflected in the 2014 Joint Approach of the Council of Ministers of Health in Central America and the Dominican Republic (COMISCA), which puts the development of a roadmap to sustainable domestically-funded HIV prevention high on the agenda.

While the share of overall management costs in the total HIV response showed a decrease from 33% to 28%, expenditures in social support and protection (including for orphans and vulnerable children) showed a 100% increase from 2% (2012) to 4% (2013-2014). Although relatively small in size, consistent progress has been made through efforts to strengthen the social safety net around persons affected by HIV, including children, while financing is mostly from domestic public resources. This increases the likelihood of higher levels of longer-term sustainability.

Funding opportunities for HIV-related research appear to be variable. NASA 2008-2009 reported HIV research-related expenditures at a level of 0.7% of the total expenditures. In 2012, this proportion had risen to 5% of the total expenditures and it subsequently dropped back to 1% in 2013-2014. These fluctuations provide an indication that HIV research is foreign-financed and not solidly anchored in domestic financial flows from a domestic research agenda. It further underscores core challenges in the establishment of sound and comprehensive monitoring and evaluation routines.

2. The Institutions

The national response to HIV – TB is the result of individual and collective planning and implementation efforts by a broad spectrum of state and non-state actors.

Prevention services

- Outreach Information, Education and Communication interventions, including behavior change communication, is predominantly the domain of civil society actors, whereby there is differentiation in target groups:
  - The Belize Family Life Association (BFLA) and the Pan-American Social Marketing Organization (PASMO) are lead agencies in IEC-BCC outreach with key affected populations, including men who have sex with men, female sex workers and youth-at-risk, whereby the former also offers bio-medical interventions (STI screening) and S&RH services;
  - The Productive Organization for Women in Action (POWA) is the key Community-Based Organization in Stann Creek District that collaborates with other actors to respond to the escalating incidence of HIV through education and advocacy campaigns on HIV and STI prevention, Sexual and Reproductive Health (S&RH), human rights protection and stigma and discrimination.
  - Youth Enhancement Services contributes to HIV prevention by focusing on S&RH services for young women and men.
  - Go-Belize is focused on developing the capacity of young leaders and organizations to create positive change in Adolescent Sexual and Reproductive Health (ASRH) and HIV prevention programs. It collaborates with government's Department of Youth Services.
- The Ministry of Health, along with support from civil society organizations, has traditionally managed IEC HIV prevention interventions through mass-media & campaign channels, but has increasingly narrowed its focus to the treatment aspects of the HIV and TB response;
- The Ministry of Education, Youth and Sports has mainstreamed HIV information and education intervention in the education system via the incorporation of the Health and Family Life Education and recently the Positive Youth Development concepts.

Testing services

The HIV testing domain represents a true mix between state and non-state actors. As regulator and manager of certified health workers, the Ministry of Health is the main provider of this bio-medical service. It provides the required testing tools and materials, the human resources and the follow-up laboratory testing in case of initial positive indications to HIV. Non-facility-based HIV testing however is often organized by civil society organizations that contribute outreach HIV prevention educators, transportation and other materials, supplementing the MOH human and testing resources. BFLA is the only civil society organization that is authorized to perform HIV tests, but results can only be communicated to tested clients via MOH health care staff.

Treatment and care interventions

This area is fully the domain of two actors:

- The Ministry of Health is through its national health system and the community health system the core actor in the treatment, care and clinical management of HIV, TB and HIV-TB cases. It procures ARVs and provides services to persons living with HIV via facility-based care and mobile clinics;
- The NGO Hand-in-Hand Ministries (HiHM) is the key actor for the comprehensive care, clinical management and comprehensive support of children living with HIV. In most cases, the Ministry of Health requests the engagement of HiHM when cases of HIV infections in children are detected. The Ministry is responsible for the procurement of pediatric ARVs.

Social and psycho-social support to persons living with HIV

This area is the domain of a mix of actors:

- The Ministry of Human Development, Social Transformation and Poverty Alleviation governs and manages the national social protection schemes. Under this umbrella, with includes a conditional cash transfer scheme, it provides social support to persons infected and affected by HIV, including children.
- Hand-in-Hand Ministries provides comprehensive support to children with HIV and their families.
- The organization of persons living with HIV, C-Net+ provides social and psycho-social assistance to persons living with HIV.

Creating Enabling Environments

- The National AIDS Commission is the body, mandated by law, to coordinate, facilitate and oversee the planning and implementation of the national response to HIV. Its prime intervention strategy is to create legal, policy and collaboration environments that enable maximum efficiency and effectiveness of the selected response efforts.
- The United Belize Advocacy Movement (UNIBAM) is the key civil society organization that focuses on the protection and realization of human rights for all sexual minorities. As HIV has evolved to an epidemic that is concentrated in the men who have sex with men community, UNIBAM's work is closely linked to the removal of barriers in areas where human rights of sexual minorities and HIV intersect.

3. The Interventions

a. Ongoing Efforts

There is a consolidated national response portfolio that aims to address gaps in various program areas:

- *HIV prevention interventions:* some state-supported HIV prevention interventions have evolved from project-based to mainstreamed program components. HFLE-driven HIV education programs of MOE continue to be integrated into the education curriculum at various levels. The implementation of the HIV Policy in the Work Place has been mainstreamed in the efforts of the Ministry of Labor, while the Department of Youth Services delivers Positive Youth Development-HIV prevention programs in collaboration with local NGOs.
- *Increased HIV testing:* MOH projects to increase, in collaboration with civil society partner agencies, HIV-testing numbers among the general population, with an intentional focus on males, including men who have sex with men, to counter-balance low health-seeking behavior patterns.
- *Removal of barriers:* HIV response interventions have been adopted for the establishment and capacity building of organizations of key affected populations, strengthening outreach practices and proactive engagement in the design and implementation of tailored interventions.
- *Expanded ARV treatment as prevention*: MOH has adopted a road map to reach the 90/90/90 targets and has acknowledged that improvement of ART adherence is vital to ensure a proper return on existing and additional investments.
- *Human Resources in Health*: MOH acknowledges the pivotal importance of compliance with the quality standards of health care and has adopted a strategic objective to strengthen capacity for Human Resources for Health planning. It strives for greater equity, cost effectiveness and efficiency in the allocation and use of health resources, including NHI.
- *Investment case*: Aware that the country now needs to move toward long-term sustainability of the national HIV response, preparations have been made to undertake a HIV Investment Case Study with the subsequent construction of a Sustainability Plan.
- *Acceleration of impact of TB response:* In 2014 MOH and its partners crafted the TB National Strategic Plan, which defined a set of actions to improve the national response and impact to TB, Multi-Drug Resistant TB (MDRTB) and HIV-TB co-infections. The plan focuses on the development of additional capacities for the detection, diagnosis and treatment of all forms of TB and to intensify the framework for HIV-TB collaborative response activities.

b. Remaining gaps requiring renewed action

The paragraphs below are the results of an overall assessment of the current status of the national response to HIV and HIV-TB.

The overall assessment benefits from an assessment of the implementation of the NSP 2012 – 2016, conducted by national stakeholders in June 2015. During this assessment, participants identified and documented the achievements, constraints/gaps and missed opportunities. The outcome of this assessment has been enriched with the relevant evaluative sections in the new Global Fund HIV-TB Concept Note 2016 – 2018. The final results are listed below and have informed the portfolio of strategic interventions of the updated National HIV-TB Strategic Plan 2016- 2020, shown in section II of this document.

b.1 Ending new HIV infections

Effective HIV prevention efforts for the general and specific population groups

- The delivery of sexuality issues in primary and secondary education curriculum requires an assessment to identify required improvements in the content of the curriculum and the didactics for an adequate and effective delivery of the curriculum to teenage boys and girls.
- Stakeholders need to arrive at a national consensus on the strategic weight and advantage of behavior change interventions over other strategies to reduce HIV infections. Consensus building is to be guided by collaborative mechanisms for the mapping, systematization, and shared analysis of existing intervention methodologies. Consensus will be a vital ingredient to improving programmatic effectiveness and financial sustainability.
- The Belize system of health care services is challenged in its efforts to attract and engage the male populations. Removing technical obstacles to an increase in the uptake of services is a crucial element to the community of men who have sex with men, which judges the traditional response to be mechanistic and lacking understanding of the intrinsic sexual and psycho-emotional aspects.

Condoms and Lubricants

- Efforts focussing on access to and availability of adequate condoms and lubricants need to be re-invigorated via a sound and implementable national condom distribution strategy for distribution of free, commercial and social-marketed condoms and lubricants.

STI screening and treatment

- The gender imbalance in the number of persons screening and receiving STI treatment for the needs to be addressed by incentivizing males, especially young men, to seek those services.
- Responses to the incidence of STIs among men who have sex with men need to include innovative dialogues with pharmacists, departing from the fact that men who have sex with men reportedly acquire antibiotic medication via regular over-the counter purchases.

Increased HIV testing and counseling

- A scaling-up of the HIV response requires the adoption of a national HIV testing policy & plan that projects the overall strategic effectiveness and that functions as a tool for expanded financing arrangements in the current constrained fiscal environment to move towards the 90/90/90 targets by 2020 (and 95/95/95 targets by 2030). The plan also needs to articulate procurement and supplies management to guarantee a consistent availability of testing kits and materials;
- In-depth studies on existing barriers to HIV testing among key populations, as well as the benefits of controlled HIV self-testing in Belize need to inform such policy. The implementation of this policy can include the capacity development of key affected populations for professional peer testing and counselling.

Post & Pre-Exposure Prophylaxis

- Policy-based improvements are required for the wide-spread (private and public health facilities) access to and available of PEP treatment for key affected populations (men who have sex with men, transgender persons and sex workers) due to the acknowledged heightened vulnerability of these populations to gender-based violence.
- Studies need to be designed to explore the feasibility of providing Pre-Exposure Prophylaxis (PrEP) to sero-discordant partners/ couples and other identified persons, highly vulnerable to HIV infection.

Consolidation of PMTCT

- Efforts are required to attract the 5 – 8% of pregnant women who do not visit pre-natal care services. This may go hand-in-hand with the enhancement of the uptake of SRH services for young persons.
- To complement this strategy, the delivery of anti-stigma and discrimination interventions is required to remove barriers to the uptake of pre-natal care services for the most-vulnerable women.

b.2 Improving Health and Well-being

HIV Treatment and Treatment Adherence

- Rates for ART retention (12 months period) are as low as 50% and form serious barriers to the fulfillment of human rights, the quality of life of persons living with HIV and the effectiveness and sustainability of HIV treatment itself. Guided by the 90/90/90 targets, the improvement of ART retention and adherence links to improved treatment outcomes and gives feedback to the improvement of HIV prevention efforts.
- ARV coverage data need to become more pronounced to get an idea about the current level of coverage and the trends that may be deducted. This data become a vital tool to monitor the country's progress toward the 90/90/90 targets and will also provide input to the forecasting, procurement and storage arrangements required to avoid any ARV stock-out.

Children living with HIV

- A special case has to be made for the national response to HIV among children. This extremely vulnerable population is entitled to the comprehensive fulfilment of their children's rights and requires no less than a solid continuum of care, with a focus on the group of children that enters adolescence and puberty.

Clinical Disease Management (HIV, TB, STIs, OIs)

- Adequate clinical management of HIV requires consistent and systematized testing of CD4 and viral load. This needs to occur in combination with diagnostic testing for STIs and clearly-defined OIs.

HIV Care and Support

- Engagement in ART points at a broad-spectrum of aspects of the life of persons living with HIV. To reduce the risk of persons living with HIV dropping out of ART, increased policy development efforts are required to scale up comprehensive support services by social safety and protection schemes, which act as regulators and purchasing agents of the professional social and psycho-social support services.

Empowerment of affected populations for Personal Management of HIV and HIV/TB

- Periodic formal consultations with key affected populations are preferred tools to review and validate period general or specific situation assessments. This will require new communication avenues that will reach out and engage additional "non-traditional" representatives from the key affected population groups.
- Empowerment and engagement also requires expanded community-led / self-led activities to engage key affected populations in the self-management and co-management of their health situation.

HIV-TB Co-infections: detection and treatment

- Recent epidemiological data indicate that the average TB patient, compared to the general population, is 87% more likely to also be HIV positive. However, management of HIV-TB co-infections is only slightly referred to in the HIV NSP 2012 – 2016, and has not been a national priority.The burden of HIV in TB patients and the burden of TB in persons living with HIV need to be reduced drastically to improve quality and longevity of life and to contain the risk of (multi-)drug resistance. This requires investments in the integration of HIV testing and TB screening practices.
- Opportunities need to be explored for the involvement of NHI as well as the community-based primary health care system in the adequate management of HIV and TB cases.

TB and MDRTB detection and treatment

- The HIV response is directly linked to the national response to TB and MDRTB, which needs to be accelerated to be able to close the circle of the HIV prevention and treatment.
- The accelerated improvements are most critical in the technical capacities for the detection and treatment of MDRTB, which is still of a sufficiently small size to allow containment.

b.3 Creating an enabling environment

The legal domain

- There is a lack of policies that are directed at the integration of key populations, including men who have sex with men, female sex workers, transgender persons and adolescents, into the provision of appropriate health services. Strategies need to include the empowerment of affected populations to become the main protagonists in the dialogue and debate for change as well as enhance the voice and visibility of champions in the health work force.
- The reporting **and** follow-up practices to identified rights violations are weak and often non-existent, obstructing the actual protection and fulfilment of human rights and, therefore, the strengthening of a culture of human rights in Belize.

Persistent stigma and discrimination

- Pervasive inappropriate behavior and actions of professional health care workers and law enforcement officers, coupled with their incomplete knowledge about population-specific sexual health issues needs to be addressed through profession-tailored anti-stigma & discrimination sensitization and information.
- To address persistent stigma and discrimination among the general public, efforts with a broad-based scope will need to be deployed, creating appropriate normative reference guides, and mobilizing key actors and policy- and opinion-makers at all levels of the public domain.

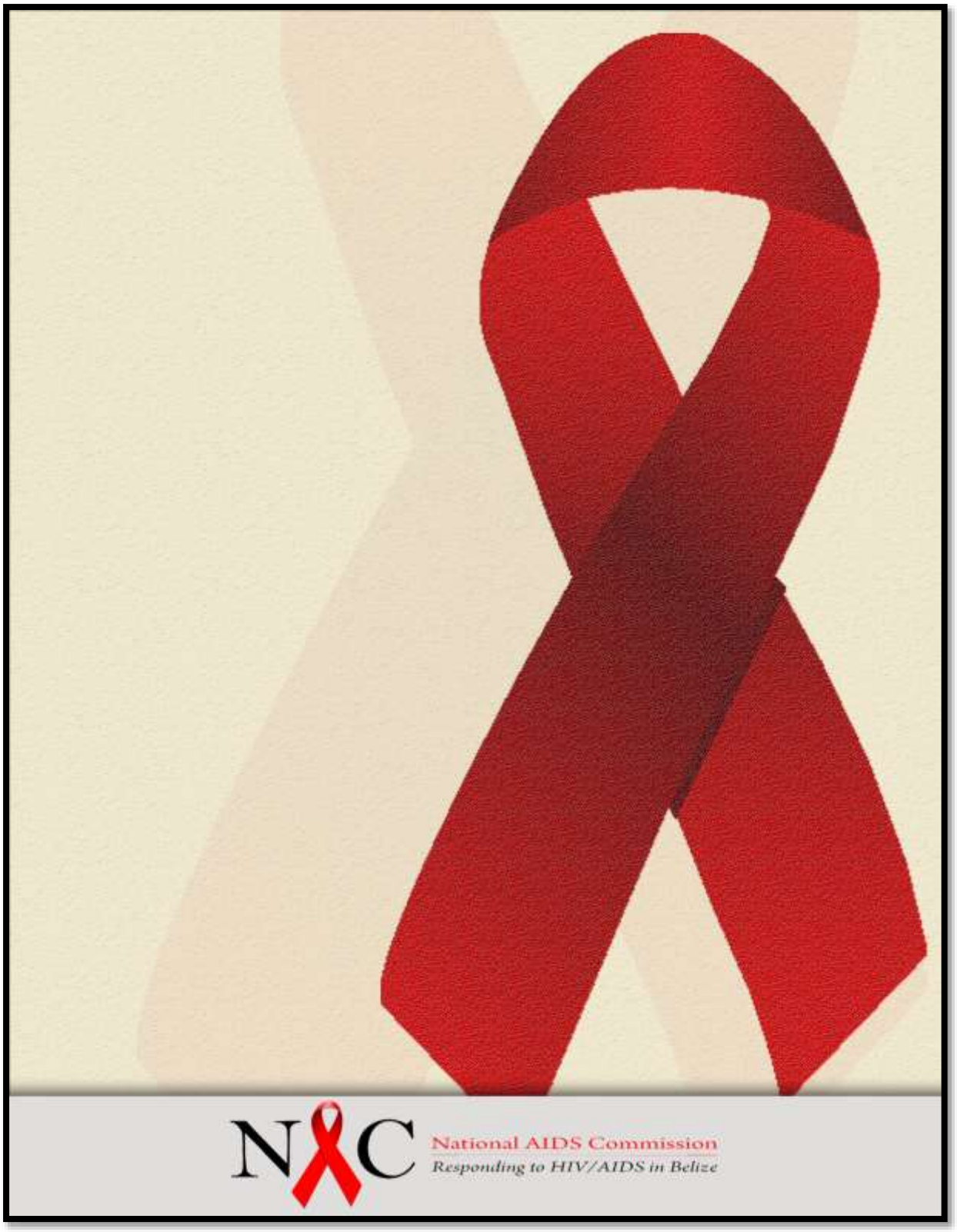
Health information and intelligence

- The Belize Health Information System (BHIS) remains with residual challenges to generating detailed health intelligence on HIV and TB. This situation is compounded by the fact that a) not all facilities are connected to the BHIS platform, rendering that data are not comprehensive or incorrect; b) not all health staff is fully competent in the use of the BHIS, increasing the risk of inaccuracies or errors; c) collection of data does not occur on a systematic basis along with a lack of standardized input of data on persons diagnosed with HIV; and d) data quality control mechanisms remain weak.

- Mirroring constraints other social sector public domains, there is a lack of a persistent and consistent schedule and practice of strategic and operational research. This limits the projection and planning of disease–specific responses.

Communication Management

- The national HIV and TB response platform needs to explore options for a more efficient organizational structure to deliver its M&E activities to enhance the participation of the relevant stakeholders in crucial aspects of HIV data and data systems.
- The utility value of the updated NSP needs to increase by ensuring that the corresponding M&E plan clearly articulates matters related to the management of data generation, processing and dissemination, skills enhancement in HIV M&E capacities, protocols for data auditing, and schedules for strategic reviews, research and other knowledge-oriented efforts.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