IAS 2025 post-conference meeting in partnership with GOJoven Belize

Uniting science and community for an accelerated HIV response in Belize

Symposium and workshop, 29 – 30 April 2026

Report and recommendations[1]

[1] *This report was developed in collaboration with Dr. Minerva Pinelo & Loida Boiton - External consultants from Right Insights. The views expressed in the report do not necessarily reflect the views of IAS – the International AIDS Society*

Background

The IAS - International AIDS Society - convened a two-day meeting in partnership with Go Joven Belize and in collaboration with the Ministry of Health and Wellness (MOHW) and the National AIDS Commission (NAC) in Belize City, Belize on 29 and 30 April 2026. A total of 153 participants from various governmental, non-governmental and civil society organisations, physicians, students and community representatives attended the symposium and 76 attended the workshop.

This report summarizes discussions of this convening focused on uniting science and community for an accelerated HIV response in Belize with emphasis on UNAIDS 95-95-95 targets and reducing HIV-related mortality.

With an estimated 3,955 persons living with HIV, medical practitioners at the Ministry of Health and Wellness described the epidemic as concentrated, with the Belize District carrying the highest burden. The cascade gaps highlighted that while 78% of persons living with HIV know their status, 41% remain in active care and only 29% of patients have achieved viral suppression. Presenters underscored concerns such as treatment interruption for up to 23% of persons taking antiretroviral therapy (ART) and death statistics indicating continued HIV-related mortality; a total of 75 deaths were reported for 2025 and was concentrated among men ages 20 to 49 years. Medical professionals highlighted priority populations such as men having sex with men, trans people and youth.

During day 1 the four thematic areas discussed included: reducing missed opportunities and planning for self-testing, scaling up of differentiated service delivery (DSD) models, strengthening literacy and public messaging, integrating mental health as a core component of HIV response, and transitioning towards people-centred HIV care. Each session included presentations from key stakeholders, followed by a moderated panel discussion that explored different aspects and perspectives of the subject in question.

Opening Remarks

Key Points:

- An average of 200 new cases is confirmed per year with only one-third of these cases virally suppressed.
- One of the greatest achievements to date is the HIV self-testing policy approved by the Government of Belize.
- There has been an evolution of the HIV response over the past 40 years in Belize; yet the challenge of providing support services for young men and increasing risks among men having sex with men exists.
- There is value in promoting multiple differentiated models for PrEP (pre-exposure prophylaxis) such as TelePrEP, mobile PrEP, community and pharmacy PrEP.
- National interventions in support of expanded testing, treatment and prevention efforts reported a total of 49,615 tests conducted in 2025.
- With a rate of 16.1 death per 100,000 persons in Belize, HIV and AIDS-related deaths ranked the 8th highest cause in 2025; 70% of deaths were among men.

- Five recommendations were made for improving the HIV and AIDS response: (i) close treatment gap; (ii) scale retention (iii) expand viral load monitoring (iv) scale targeted prevention for target populations and (v) invest in youth (e.g. school programmes).

Session 1: Accelerating innovative interventions in prevention

The objective of this session was to share Belize's experience with self-testing, given its recent launch, discuss long-acting prevention options, alongside the need for provider and patient education and attention to adherence and resistance monitoring. There was a discussion on unlocking the potential of PrEP in Belize. It also highlighted community-led approaches and rights-based framing, particularly to reach men having sex with men, trans communities and youth.

Key Points:

- Three main long-acting treatments were referenced: Cabotegravir (CAB), Lenacapavir (LEN), Dapivirine (DPV).
- LEN is a capsid inhibitor; targets multiple stages of HIV replication cycle.
- Benefits of long-acting treatment include: improved adherence with less frequent dosing, greater privacy, and autonomy (in prevention decisions and care), reduced stigma, decreased anxiety (i.e. around HIV exposure risk), empowered individuals to take control of their sexual health and HIV prevention.
- There is abundant science behind U=U (undetectable equals untransmittable) and it is a solid prevention strategy; there is a measurable reduction in illnesses like renal, liver, and cardiovascular disease including new onset diabetes mellitus (DM) and reduction of non-AIDS malignancies.

Panel Discussion 1: Self-testing in Belize: A policy milestone for expanded testing

Panelists shared experiences of supporting people navigate the emotional stories when diagnosed with HIV. They underscored the importance of establishing a support system to assist clients with scheduling and adequate care, given the introduction of self-testing in Belize and possibility of introducing long-acting (LA) treatment options.

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What has been your experience in self-testing and empowering your clients? How has this early approach impacted linkage to care?

When clients receive positive results, it is important to encourage them to start treatment immediately as there can be great emotional confusion upon learning about their diagnosis. Therefore, there is a need to have a toll-free number or support via a messaging platform and it is important for providers to establish that emotional connection with the client and initiate conversations on treatment options.

Are clients aware of self-testing and how are they routed?

There is a need to increase awareness and education on self-testing. In addition, to ensure adequate care is provided clients who come to the clinic are sent to the nurse who then direct them to the specific unit. One of the challenges faced by client is that self-testing is done in an 8 a.m. to 5 p.m. setting and not available on weekends. It was recommended that the scheduling of self-testing be revisited to accommodate more flexible access and support.

How can long-acting treatment options overcome adherence challenges and what will it take to introduce them here?

It was reported that the process of accessing PrEP can be frustrating compounded with scheduling conflicts of persons living with HIV. In light of this, introducing long-acting treatment will require closing gaps on access. 3 recommendations were made to increase adherence – (i) strengthening clinic systems, (ii) increased training of providers and (iii) increased education.

Panel Discussion 2: Unlocking the Potential of PrEP in Belize

Panelists shared specific steps on expanding PrEP across Belize to overcome barriers and expand access. The need to move PrEP from a bio-medical intervention to a pathway for empowerment, equity and resilience for those most affected was tabled. In addition, panelists highlighted the need for integration of psychosocial support (PSS) into PrEP programs.

What steps can we take to expand PrEP across urban and rural areas?

There are 3 main factors to consider in order to increase access; these include geographic locations, perceived discrimination of institutions and limited education on PrEP. A key step to expand PrEP is to decentralize services; this will support increased access, address perception against actors, increase education via civil society organisations (CSO), amalgamate institutions and strengthen community-led initiatives.

How can we integrate psychosocial support into PrEP programs?

Mental health and psychosocial support discrimination are key factors in adherence. The aforementioned impacts efficacy and a person's ability to engage in risk reduction behaviours. One recommendation was to increase task sharing among mental health professionals. This will also allow professionals to start with tools for administering and supporting the referral process.

How can young leaders transform pills to a movement?

Youth panelists detailed their experiences with accessing treatment options and the frustrations arising from schedule conflicts or business operating hours (i.e. 8 a.m. to 5 p.m.). It was also noted that PrEP is often promoted as a pill for persons living with HIV. Therefore, it is important to analyse how medication is advertised; present public messaging adds stigma to adherence, building on misunderstanding and emotions such as embarrassment and shame. Youth panelists agreed that being healthy is a right for all – it should not be perceived as just prevention for HIV; they called for a unified message across all services; such movement must promote healthy sexual experiences for young people with services available to them.

Session 2: The role of mental health in the HIV response

The objective of this session was to discuss integration of mental health in the HIV response. Presenters shared techniques such as motivational interviewing, the intersection of substance abuse, mental health and sexual behaviour in the HIV response and internalised stigma as a barrier to care. A testimonial on best practices from service providers to reduce stigma for clients was also shared. The discussion on strengthening mental health services to improve access to HIV services and reduce self-stigma was also tabled.

Key Points

- Mental health is a core component of the HIV response;
- A study entitled *"Assessing mental health service needs and barriers to access for men having sex with men, Trans, sex workers and persons living with HIV* by social work students at Galen University, indicated that barriers are both structural (access, cost, availability) and relational (trust, stigma, confidence) and lead to compounded risks among key populations;
- Practical solutions include motivational interviewing and differentiated mental health care which are directive yet non-judgemental drawing from open-ended questions, affirmations, reflective listening and summaries;
- There is external (i.e. rejection, being treated differently, etc.) and internal (shame unworthy, self-blaming) stigma;
- Emotional distress but also economic situations of persons living with HIV impact choices (e.g. choosing food over bus fare to remain adherent);
- Substance abuse lowers inhibition and increases HIV vulnerability;
- There are 3 factors which are interconnected: syndemic: co-occurring, mutually reinforcing epidemics that interact to increase vulnerability and worsen health outcomes; the shame cycle: profound psychosocial challenge when internalized stigma creates significant barriers to health and well-being; and gaps: limited mental health integration, substance abuse (as a coping mechanism) and low barrier access;
- Higher stigma equals lower antiretroviral therapy and higher loss to follow-up;
- Recommendations include: screening for emotional distress and substance use, creating safe spaces and training frontline providers;
- Solutions to address stigma at the: individual level include – cognitive behaviour therapy, peer support and navigation, self-affirming; at the health system level

include - trauma informed communications, stigma-free communications, integrated mental health screening and redesigned clinical environments.

After the presentations, a recorded testimonial was aired featuring a Belizean trans woman living with HIV for over 30 years and who now resides in the Netherlands. She is the Executive Director of Global Action for Trans Equality (GATE) and detailed best practices to reduce stigma for their clients, based on her experiences.

Panel Discussion 3: How can stronger mental health services improve access to HIV services and reduce self-stigma?

Panelists took a deep dive into mental health and the need for its integration into the national response efforts. The discussions underscored the need for policy-makers, medical providers and key stakeholders such as civil society organisations (CSOs) and faith-based organisations to ensure that mental health does not disrupt treatment but that its integration yields higher adherence.

Testimony: Best practices from service providers to reduce stigma for their clients

The speaker reinforced the importance of keeping clients connected to services and designing services so that safety is built into institutional practice (confidentiality from security officer to front desk to doctor). Best practices indicate that providers can reduce stigma for clients via discreet access, trusted community partners, and services that understands how to normalize care (this means asking clients what safety means to them). In addition, the speaker shared 5 key recommendations on reducing stigma. In essence, providers must:

- Develop core quality standards;
- Invest in peer and community-led support;
- Integrate mental health in the HIV response;
- Ensure confidentiality (i.e. confidentiality from security officer to front desk to doctor);
- Obtain client feedback to improve services (e.g. measure stigma)

How does mental health disrupt treatment and adherence?

Mental health exacerbates depression and anxiety, increases trauma-related stress (e.g. being raped) and often leads to decision-making under emotions (e.g. youths facing parents' divorce). The importance of integrating mental health during HIV response delivery, particularly for key populations facing layered stigma and structural barriers, was highlighted as a pivotal step in addressing challenges with treatment and adherence.

What concrete steps have been taken to integrate mental health into the national response?

As a part of the national response, the National AIDS Commission (NAC) facilitated training sessions on mental health for healthcare providers, magistrates, justice of the peace and national security forces. In addition, a collaboration among the Labour Department, the Belize Chamber of Commerce and Industry (BCCI) and other private sector entities led to training on HIV Workplace Policy and provision of safe spaces within the private sector in Belize. Another concrete step was increasing access via mobile clinics and outreach services to support the continuum of care.

What has been your experience and what message would you give to policymakers to support people living with HIV?

It is important that policy makers understand the challenges faced by people living with HIV. One persistent challenge is the lack of accessibility to services; persons living with HIV do not have access to mental health facilities in some parts of the country, and there is a cost for transportation to access services outside of their district. Policymakers can also integrate best practices learned, such as telehealth, which became very useful during the COVID-19 pandemic. Another key aspect discussed was the need to educate more medical practitioners on HIV and AIDS. This would reduce stigma, improve trust among clients and increase adherence rates.

What does an effective low-barrier referral look like in practice?

An effective low-barrier referral is one that offers simple, immediate and integrated care at all levels (i.e. brief mental health assessment at the clinics). It also would require seeing people living with HIV in short intervals to give support and counselling. These confidential services provide vital psychosocial support, treatment adherence counselling, and crisis intervention. Overall, these practices would establish stronger collaboration among health professionals (e.g. nurse and social worker). It was highlighted that when people living with HIV see unity among the professionals, they feel safe.

Session 3: Closing the gaps to reach the UNAIDS 95-95-95 targets

This session underscored the importance of people-centred approaches to reach key populations and strengthen the progress towards the 95-95-95 targets. It also examined differentiated HIV care and best practices on adherence to strengthen treatment as prevention. In addition, there was a discussion on transforming treatment, namely differentiated service delivery (DSD) in action for HIV programmes.

Key Points

- There must be a focus on quality of life;
- There are many factors to consider: historical trauma, stigma as a multi-layered issue, the burden of mental health, and integration of comorbidities;
- There are 3 pillars for person-centred HIV care: respect and dignity (this means use people-first language), shared decision-making (e.g. asking "Which regimen fits your schedule?"), holistic support – moving away from a siloed approach for care towards more trauma-informed (e.g. asking: "What happened to you?" instead of "What's wrong with you?")
- This will shift response from compliance to collaboration;
- There must be a decentralization of antiretroviral therapy from clinics to community-led groups;
- To improve adherence, scale up multi-month dispensation to more than 3 months, fast-track refills, scale up telemedicine and digital reminders (via SMS or WhatsApp™) to re-engage defaulters, integrate digital adherence tools and establish community ART groups;
- There must be increased testing, partner notification as a part of targeted follow-up (via peer groups and social workers) and development of tailored differentiated service delivery.
- Using Jamaica as a case study, Jamaica AIDS Support for Life (JASL), shared best practices on adherence including: conducting a detailed intake process (to find out who needs support), understanding barriers via focus group discussions and one-on-one (to find out what is getting in the way), developing individualised plans – case management (to find out what is the agreed plan), implementing interventions – service delivery (to find out which action fits best) and then review and adapt via monitoring and evaluation (M&E) (to find out if the plan is working);
- JASL's methodology draws from peer-navigators, an app developed as a treatment information system, conducting virtually direct observation therapy, provides pharmacy services on-site, offers socio-economic support, mental health integration and community service;
- Two approaches were offered as best practices – support groups and peer accountability advancement programme;
- Recommendations for closing the gap include: promoting adherence as a core prevention intervention, scaling of peer-led, community-based and digital support as standard practice, measuring interruption, re-engagement and suppression history (not only clinic attendance); understanding and responding to the full person (not just persons living with HIV treatment experience) and requiring a comprehensive mix of interventions working together to optimize client outcomes as part of adherence.

Panel Discussion 4 - Transforming treatment: Differentiated service delivery (DSD) in action for HIV programmes

Panelists explored the importance of differentiated service delivery and the key factors to support with increased access to treatment options as well as adherence and ultimately suppression. There must be a collective effort that combines economic support, psychosocial support and flexibility to secure client-centred services. In addition, community structures and public-private partnerships must be strengthened.

How can faith leaders be partners in reducing stigma and discrimination and encouraging mental health without comprising their values?

Faith-based leaders must guide, work with people living with HIV, cause no harm and lead with compassion. It is important that the church be seen as an institution that people living with HIV can approach. The church must also support education on HIV and AIDS in order to reduce stigma among its community or members.

Where do you see Belize's stand in implementing differentiated service delivery?

Barriers such as transportation costs or lack of confidentiality become deterrents to clients accessing services. In addition, communities may not be aware of differentiated service delivery, therefore there is a need for greater awareness and promotion of such model. Services such as community pick-up points must be established using peer-led soft landing (e.g. "Let us go get your meds today"). Also, community structures and partnerships such as those with community health workers, social workers and private sector must be strengthened. Another approach that can be established is a one-stop shop approach integrating services together (i.e. laboratory services, pharmacies, etc.).

Panelists also offered examples of impact statements that can increase the promotion of the overall national response. These ranged from medical providers advocating for colleagues to get to know their client to reminders of Belize's certification on the elimination of vertical transmission, to reminders that clients must be seen as a whole and treated with respect, dignity and empathy.

Annex 1: Recommendations during Day 2 (30 April 2026)

During day 2, participants engaged in group discussions and the development of concrete recommendations based on questions posed per group. Using SMART goals, participants tabled key recommendations, both short and medium-term, providing timelines and stakeholders responsible for each recommendation. Examples included but were not limited to: Group 1 recommended using appropriate messaging and establishing distribution centres to reach vulnerable populations. Group 2 recommended piloting long-acting treatment options by late 2027 and legislating sexual reproductive health (SRH) for adolescents. Group 3 recommended piloting integrated HIV and mental health services. Group 4 recommended the establishment of a mental health and stigma reduction network. Group 5 recommended establishing a commission to eliminate HIV/AIDS and rolling-out differentiated service delivery (DSD) models. Group 6 recommended increasing and expanding sexual reproductive health (SRH) that targets vulnerable and high-risk populations as well as expanding and improving support systems to complement continuum of care.

Question 1: How can we optimize the use of HIV testing, including self-testing, to expand reach among priority populations and normalize testing practices?

No.	Recommendations	Timeline	Focal Point (Who is the lead?)	Stakeholders (Which organisations should be involved?)	How? (first steps towards implementation)	Financing (funders/ implementing partners)
1	Distribute self-tests to sites other than health centers: Tertiary educational institutions and CSOs. This allows for subcontracting for outreach purposes to other groups that may not meet criteria for storing kits.	3 months to develop the program certification criteria 6 months – have MOU with interested CSOs or educational institutions	National AIDS Commission[2]	GO Belize Belize Family Life Association (BFLA)	Develop certification process, educational plan	No designated funding exists for procurement of self-tests outside of current stock or outside of distribution within Government of Belize (GOB) systems. Key populations citing interaction with healthcare facilities as main factor against accessing self-test kits; maximize the existing supply[3]

[2] commits to help develop a proposal to the Global Fund and local partners for financing for capacity building of new distributors
[3] via GoBelize and Belize Family Life Association (BFLA).

2	Normalize testing and reframe how we think and talk about sex. The approach is to develop video/messaging that starts the conversation. This would be for distribution to all public places (bus stops, clinics, banks, etc.): « Let's talk about sex » Incorporate testing, HIV services, U=U, PrEP and PEP.	1 month to develop messaging and criteria for competition or preparation for bid requests Submissions by 1/11/26 for release on 1/12/26	National AIDS Commission – Information, Education and Communications (IEC) committee	All members of the IEC committee	Develop messaging – conversation starters. Engage donors.	National AIDS Commission to help with raising funds for prize

Additional notes:

1. *By December 2026, increase distribution of self-test to low distribution areas identified via the 2025 HIV Belize report in collaboration with NAC, MOHW and in tandem with GoJoven and BFLA.*
2. *By December 2026, disseminate project titled "Let's talk about sex" to Belizean audiences in collaboration with NAC-IEC and in tandem with all stakeholders in the committee.*

Question 2 : How can we effectively expand PrEP in Belize, removing barriers and preparing health systems and communities for the introduction of long-acting PrEP by the end of 2027/early 2028?

Nº	Recommendations	Timeline (most specific timeline possible)	Who? Focal point (institutions responsible for implementation)	Stakeholders (which organization should be involved)	How? (first steps towards implementation)	Financing (funders/ implementing partners)
1	Pilot integration of long-acting PrEP within existing service delivery platforms	Third quarter of 2027	Ministry of Health and Wellness (MOHW) (HIV/TB/ STIs program director)	MOHW facilities, National Health Insurance (NHI), Private facilities, NAC, CSOs.	Establish national long-acting PrEP technical working group Adapt global guidelines to Belize context Train providers and define service flow (appointments, follow-up) Initiate phased procurement	Global Fund/ PAHO strategic fund, MOHW

2	Establish legislation that facilitates the delivery of sexual and reproductive health with emphasis on HIV and PrEP, to adolescent population (15-17) and 12-14 according to Gillick test[4].	Third Quarter of 2027	MOHW, Attorney General, Minister of Human Development, NAC (Chairperson), UNICEF, PAHO, Ministry of Education, NHI	Belize Medical Council, Nurse's Association, Belize Medical and Dental Association, CSOs	Stakeholder consultations and sensitization Draft and approve policy guidance for PrEP provision to adolescents	NAC, Global Fund
3	Improve communication packages on health prevention specifically sexual health with emphasis on HIV and PrEP, based on the client's profile through community outreach.	Fourth Quarter of 2026	MOHW, Health Education and Community Participation Bureau, Maternal Child Health Unit, NAC, PAHO, UNICEF, CSOs, Ministry of Education	Schools, churches, local media houses, village/ city councils	Review and update national HIV/PrEP communication strategy Develop tailored messaging for women, youth, and key populations Deploy through schools, communities, and trusted channels	MOHW
4	Improve accessibility and fast track PrEP in health facilities.	Oct 2026	MOHW, NHI, NAC, CSOs, private health facilities	Medical doctors, nurses, social workers	Telehealth (training and infrastructure) Implementation of rapid testing (POC) at Health facility No wait time when patient request PrEP PrEP Hotline	MOHW NHI

[4] Gillick competence is a UK legal principle determining if a child under 16 can consent to medical treatment without parental knowledge or permission. A child is "Gillick competent" if they possess sufficient understanding, intelligence, and maturity to fully appreciate the proposed treatment, including risks, benefits, and consequences

Question 3: How can providers effectively assess and identify clients' mental health needs, establish standardized referral processes, and integrate mental health services into HIV prevention, treatment and care, to improve overall outcomes?

Nº	Recommendations	Timeline (most specific timeline possible)	Who? Focal point (institutions responsible for implementation)	How? (first steps towards implementation)	Financing (funders/ implementing partners)
1	Implement a standardized mental health screening protocol for post HIV diagnosis (e.g., PHQ-9, GAD-7) in at least 60% of HIV service delivery sites across Belize, ensuring that at least 80% of clients who have been newly diagnosed HIV services are screened for common mental health conditions at intake.	2029	MOHW	Access to Screening Questions	MOHW
2	Provide integrated mental health and HIV care training (including basic assessment, trauma-informed care for all staff, awareness for all staff, and referral processes clinical staff) to at least 75% of frontline HIV service providers (receptionist, security guards, nurses, doctors) in Belize, with pre- and post-training evaluations demonstrating a 30% increase in provider confidence and competency.	2027	MOHW	Proposal to Ministry Evidenced based training Continued professional training (population specific)	Grants and MOHW
3	By 2030, pilot an integrated HIV and mental health service model[5] in at least 3 HIV clinics in Belize (country	2030	MOHW	Proposal to Ministry Hiring (create post)	MOHW

[5] Belize integrates HIV and mental health care through a community-based, primary healthcare framework led by the Ministry of Health and Wellness (MoHW) and the National AIDS Commission. It shifts focus from institutionalized care to holistic, patient-centered services that address both medical

	wide), achieving a 10% increase in retention in HIV care and a 20% reduction in reported depressive and/or anxiety symptoms among participating clients within 12 months.				

Group 4 : How can the public system work with NGOs to implement community-led approaches to address mental health needs and reduce stigma in the HIV response?

Nº	Recommendations	Timeline (most specific timeline possible)	Who? (institutions responsible for implementation)	How? (first steps towards implementation)	Financing (funders/ implementing partners)
1	Ensure 50% of people with HIV in Belize will have their mental health needs met and the stigma index is reduced, though the establishment of mental health and stigma reduction network	December 2028	Lead: NAC	Stigma index study Assessment of mental health services for persons living with HIV Develop and implement a public education plan Strengthen patient monitoring.	MOHW

and psychosocial needs. It is supported via the Mental Health Unit within Ministry of Health and Wellness with direct support from Psychiatric Nurse Practicioners (PNPs) during mobile outreach clinics coordinated via Regional Hospitals.

2	Map stakeholders that have or can integrate mental health services and stigma reduction provided at the national and district level. This includes non-governmental organisations (NGOs), private services, and the resources currently available. Number of facilities, accessibility for patients, pricing, opening hours, what services are being provided.	December 2026	Lead: NAC Stakeholders: Go Belize, MOHW, Mental Health Association, Lavender Alliance, Hand in Hand Ministries, Red Cross, Council of Churches	Establish a working group Identify resources Establish timelines Conduct and analyse finding from the mapping	MOHW Mental Health Association of Belize
3	Develop, review and approve protocols and referral system between NGOs and public system for mental health services and stigma reduction.	March 2027	Lead: Established working group/task existing group comprised of different stakeholders	Establish a working group Identify resources Establish timelines	Review if mental health already falls under the scope of an existing NAC subcommittee. i.e. Testing and Counselling

Additional notes:

- *There is no hot line just non-governmental organisations (NGOs) work in silos; there is currently no formal structure for collaborations between Ministry of health and non-governmental organisations (NGOs). In Orange Walk there is currently some collaboration with GoBelize and Ministry of Health and Wellness (MOHW).*
- *We need to know what services are available. Look at the mental health association and what are agreements are there with the Government.*
- *Map geographic location of the mental health needs.*
- *There are referral pathways and tools to provide mental health support.*
- *There is no formal structure for referrals from non-governmental organisations (NGOs) to Ministry of Health and Wellness (MOHW).*
- *This is not only the responsibility of the Ministry to establish this network or referral process. It needs to be a collective effort.*
- *There should be monitoring of the progress of patients.*
- *This needs to be incorporated into the strategic plan.*

Group 5 : What differentiated service delivery DSD) interventions should be prioritized to close the remaining gaps across the HIV care cascade (testing, treatment, and viral suppression)?

Nº	Recommendations aligned with Belize National HIV/TB Strategic plan	Timeline (most specific timeline possible)	Lead	Who? (institutions responsible for implementation)	How? (first steps towards implementation)	Financing (funders/ implementing partners)
1	Scale community-led HIV self-testing (HIVST) and assisted partner-notification/index testing through trained peer navigators to identify estimated undiagnosed key populations (men having sex with men, transgender women, sex workers, migrants) in Belize City, Cayo, and Stann Creek districts — closing the 1st 95 gap.	Q3 2026: Adapt standard operating procedures (SOP) & train peers. Q1 2027: Pilot launch. Q4 2028: Full national scale-up.	MOHW NAC (Training Lead)	MOHW – National HIV/TB Unit NAC	(i) Adapt WHO HIVST guidance into a national standard operating procedures (SOP); (ii) procure OraQuick / Rapid test (iii) train ≥10 peer navigators /12 social workers/10 75 community health workers (CHW) (25 CY,25 BZ, 25 Stann Creek), on index testing and social-network strategies; (iv) integrate results into the national HIV monitoring and evaluation (M&E) dashboard (BHIS).	Government of Belize (GOB) Ministry of Economic Transformation (MET) NAC (Hon. Balderamos)
2	Centralize a one-stop hub for Holistic HIV/STI/TB and mental Health care Integrate blood withdrawal and spinning on-site at the Belize Family Life	Adopt a multi-disciplinary team protocol Q4 -2026	MOHW	MOHW/ HIV Programme	Formal mechanism between MOHW and CSOs to trace lost-to-follow-up	Social Contracting via Government of Belize

	Association (BFLA) clinic sites and send it to the lab for testing. Pilot strategy at 3 treatment sites.	Q4-2027	Belize Family Life Association (BFLA)	NAC Committee	clients and reintegrate them into the system for continuous services.	
3	Operationalize a national "Test-and-Start" differentiated service delivery (DSD) model with same-day antiretroviral therapy (ART) initiation (≤7 days) at 100% of public antiretroviral therapy (ART) sites and 3- and 6-month multi-month dispensing (MMD) (3MMD/6MMD) for stable clients (VL <200 c/mL ≥12 months), reaching coverage among eligible adults — strengthening the 2nd 95. Standardized the system in practice	Q4 2026: Update guidelines & site readiness. Q2 2027: Same-day antiretroviral therapy (ART) at all 8 ART sites. Q4 2027: 6MMD rollout complete	MOHW/ NAC	MOHW / NAC; Karl Heusner Memorial Hospital (KHMH); regional hospitals (Western, Northern, Southern); Belize Family Life Association (BFLA) – Belize City San Ignacio Dangriga	(i) Revise national antiretroviral therapy (ART) guidelines to align with WHO 2026 recommendations; (ii) Monitor the ARV supply chain to monitor MMD without stock-outs. Throughout (iii) train clinicians and pharmacists; (iv) introduce electronic appointment-spacing in Belize Health Information System(BHIS). Review of the 2012 same-day initiation lessons learnt	Government of Belize recurrent budget MOHW; Global Fund
4	Implement a standardized, nationwide health system quality assessment to strengthen HIV service delivery and client outcome	2026 Q2027	MOHW/PAHO	NAC	This will include conducting assessments across all priority service points to evaluate service flow efficiency, client satisfaction, clinical outcomes (including linkage to care, retention, and viral suppression), and supply chain performance (e.g., test kits, antiretroviral therapy (ART), and pre-exposure prophylaxis (PrEP) availability). Findings will be used	PAHO

					to provide targeted technical support, optimize differentiated service delivery (DSD) models, and inform continuous quality improvement plans, contributing to improved HIV response outcomes and progress toward the National Strategic Plan (NSP) and UNAIDS 95-95-95 targets.	
5	Interventions include virtual HIV risk assessments, tele-prescription/medicine for pre-exposure prophylaxis (PrEP) and PEP, tele-supported HIV self-testing (HIVST), and remote adherence counselling for antiretroviral therapy (ART clients). A centralized digital platform integrating mobile applications, WhatsApp™, and a toll-free hotline will facilitate service delivery, supported by Pan American Health Organisation (PAHO); Clinton Health Access Initiative (CHAI) (commodity pricing support)	YR 2:2027	MOHW/NHI/ Private Physicians		Incorporate digital prescription to be used by assigned pharmacies incorporated into the BHIS. YR 2 2007	NAC
6	Establish at least 4 youth- and key population (KP)-friendly "one-stop" differentiated service delivery (DSD) hubs (one per health region) offering integrated HIV testing, antiretroviral therapy (ART), pre-exposure prophylaxis (PrEP), sexually transmitted infections (STI)/viral hepatitis (VH) screening, mental-health and SRH services with extended hours (evenings & Saturdays), reducing loss-to-follow-up among 15–24-year-olds and key populations by ≥30% by 2028.	Q1 2027: Site selection & MOUs Q3 2027: 1st hub operational (Belize City). Q4 2028: All 4 hubs fully operational		MoHW – NAC; Go Joven Belize/GoBelize Alumni Association; Ministry of Human Development (Youth Services); private-sector partners. (Call	(i) Conduct a youth/KP needs assessment; Yr. 2 Q1 (ii) co-design service packages with affected communities; (iii) recruit and train peer-navigator teams; (iv) integrate hubs into the national referral system and BHIS.Yr.2Q1	Global Fund Government of Belize (GOB) Department of Youth Services (DYS) Adolescent Investment Case; UNICEF; UNFPA

				Center Wellness Centers		
7	Achieve ≥95% routine annual viral load (VL) coverage and ≥95% viral suppression among people on ART by Dec 2028 by deploying point-of-care VL testing in 2 high-volume sites, short messaging system (SMS)-based viral load result return, and a structured Enhanced Adherence Counselling (EAC) package for clients with viral load ≥200 c/mL — closing the 3rd 95 gap	Q4 2026: POC-VL site validation Q2 2027: SMS result-return pilot Q3 2027: EAC SOP rollout. Q4 2028: Full national coverage	Ministry of Health and Wellness (MOHW)	MoHW –NAC & Central Medical Lab; KHMH Laboratory; Belize Telemedia Ltd. (short messaging system (SMS) partner); for peer adherence support	(i) Procure and validate point of care (POC) – viral load (VL) platforms GeneXpert HIV-1 viral load); (ii) build a closed-loop short messaging system (SMS) results pipeline within Belize Health Information System (BHIS); (iii) train 60 nurses/peer counsellors in Enhanced Adherence Counselling (EAC); (iv) review viral load cascade dashboards quarterly with the National AIDS Commission (NAC)	Global Fund (lab & M&E budget lines); President's Emergency Plan for AIDS Relief (PEPFAR) Lab Strengthening; Pan-American Health Organisation (PAHO); Clinton Health Access Initiative (CHAI) (commodity pricing support)
8	Reduce loss-to-follow-up by ≥50% by 2028 through a national "Welcome-Back" tracing protocol combining Belize Health Information System (BHIS) -generated missed-appointment lists, peer-led tracing within 14 days, and decentralized community antiretroviral therapy (ART) refill points, non-governmental	Q1 2027: Tracing SOP & data-sharing memorandum of understanding (MOU)	MOHW)/ NAC	MoHW NAC; District Health Teams; Go Joven Belize; Belize Family Life Association (BFLA).	(i) Update Belize Health Information System (BHIS) to flag clients >28 days late; (ii) train 30 peer tracers on confidential, stigma-free outreach; (iii) sign data-protection memorandums	Global Fund; Community-Led Monitoring; Pan-American Health Organisation (PAHO) technical assistance;

	organisation (NGO) drop-in centres, and mobile units in rural Toledo, Stann-Creek and Cayo	Q4 2027: 5 community refill points operational Q4 2028: Nationwide implementation			of understanding (MOUs); (iv) pilot mobile antiretroviral therapy (ART) delivery in Toledo and evaluate at 6 months.	private-sector customer service representative (CSR) (telecom & pharmacy chains)

Group 6: What changes does the community-led response need to make now to stay effective despite funding challenges?

Nº	Recommendations	Timeline (most specific timeline possible)	Who? (institutions responsible for implementation)	How? (first steps towards implementation)	Financing (funders/ implementing partners)
1	Increase and expand sexual reproductive health education that target vulnerable and high risk population and addressing stigma and discrimination via: - Empowering individual (Champions) - Education about services and in-depth HIV 101 - Customize the messages (simplify) & Different language - Multiple platforms (Facebook, WhatsApp, Instagram, TikTok) - Incorporation of artificial intelligence (AI) to keep persons anonymous	6 months	Ministry of Education National AIDS Commission Ministry of Health Global Fund Principle Recipient	Design and delivery workshops to stakeholders in education (Teachers, Public Servants) Schedule public consultations with community leaders, community members, grassroot organisations and policy makers	Proposals / Grant Global Fund Local Funding
2	Develop a national Anonymous Hotline/ Chat Service or mobile friendly tele-health while ensuring data privacy and confidentiality & making referrals Research on past hotlines (successes and failure)	3 years	MOHW National AIDS Commission monitoring and evaluation (M&E)	Training (Personnel)	Proposals/Grant Global Fund Local Funding

3	Expand and improve support system for people living with HIV (PLHIV) to compliment the continuum of care - Mental health services - Structured Support Group	6 months	MOHW NAC	Establishing a communication strategy for outreach	Proposals / Grant Global Fund Local Funding
4	Amalgamate services without cutting services - Combine services in exisiting healthcare - Training of integrated services - Access of services	1 year	MOHW CSOs NAC	Extend memorandum of understanding with civil society groups	Proposals / Grant Global Fund Local Funding