National AIDS Spending Assessment (NASA) 2021/22 Financial Year

Financing Flows and Expenditure in the National HIV Response

FINAL REPORT

August 2024

National AIDS Spending Assessment – Belize

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FY 2021/22

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PRESENTED TO: Belize Country Team and National AIDS Commission (NAC)

By: Faith D.F. Cunningham - Consultant

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Acronyms

AIDS	-	Acquired Immuno Deficiency Syndrome
ART	-	Antiretroviral Treatment
ARV	-	Antiretroviral
ASC	-	AIDS Spending Categories
BCC	-	Behavior Change Communication
BP	-	Beneficiary Population
CCM	-	Country Coordinating Mechanism
CSOs	-	Civil Society Organizations
CML	-	Central Medical Laboratory
FAP	-	Financial Agent Purchaser
FE	-	Financial Entity
FS	-	Financial Source
FY	-	Financial Year
GFATM	-	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	-	Human Immunodeficiency Virus
HIVST	-	HIV Self -Testing
HMIS	-	Health Management and Information System
HSS	-	Health Systems Strengthening
HTC	-	HIV Testing and Counselling
HTS	-	HIV Testing Services
IBBS	-	Integrated Behavioral and Biological Surveillance Survey
IPs	-	Implementing Partners
KP	-	Key Populations
LGBT	-	Lesbian Gay Bisexual Transgender
MOECST	-	Ministry of Education, Culture, Science and Technology
MOF	-	Ministry of Finance
MOHW	-	Ministry of Health and Wellness
MSD	-	Medical Store Department
MSM	-	Men who have Sex with Men
NAC	-	National AIDS Commission
NASA	-	National AIDS Spending Assessment
NGOs	-	Non-Governmental Organizations
NCDs	-	Non-Communicable Diseases
NHI-PR	-	National Health Insurance – Principal Recipient
NSP	-	National Strategic Plan
PAHO	-	Pan American Health Organization
PF	-	Production Factor
PLHIV	-	People Living With HIV & AIDS
PMTCT	-	Prevention Mother to Child Transmission
PR	-	Primary Recipient
PrEP	-	Pre-exposure prophylaxis
PS	-	Provider of Services
PSE	-	Population Size Estimate
REV	-	Revenue
RTT	-	Resource Tracking Tool
SCH	-	Schemes
SDM	-	Service Delivery Modalities
SHA	-	System of Health Accounts
SRHR	-	Sexual and Reproductive Health and Rights
STI	-	Sexually Transmitted Infections
SW	-	Sex Worker
TG	-	Transgender
UNAIDS	-	Joint United Programme on HIV & AIDS
VLT	-	Viral Load Testing
VTC	-	Voluntary Testing and Counselling (for HIV)
WHO	-	World Health Organization

Acknowledgments

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14. Kylah Ciego – Belize Family Life Association
15. Katerina Sharapka – UNAIDS NASA Consultant
16. Faith Cunningham – Consultant

Fact Sheet

HIV and AIDS Spending by Financial Source	Financial Year									
	2017/18	%	2018/19	%	2019/20	%	2020/21	%	2021/22	%
Public	4,187,236	59.4%	3,831,054	44.2%	4,052,596	71.0%	9,092,792	76.0%	5,962,338	70.4%
Private	701,790	9.9%	316,872	3.7%	314,478	5.5%	-	0.0%	-	0.0%
International	2,164,150	30.7%	4,518,950	52.1%	1,342,000	23.5%	2,879,102	24.0%	2,506,149	29.6%
Total HIV Expenditure (BZD)	7,053,176	100%	8,666,876	100%	5,709,074	100%	11,971,894	100%	8,468,487	100%
HIV and AIDS Spending by Funding Agents	**Financial Year**									
	2017/18	**%**	**2018/19**	**%**	**2019/20**	**%**	**2020/21**	**%**	**2021/22**	**%**
Public	4,187,236	59.4%	3,831,054	44.2%	4,052,596	71.0%	9,092,792	76.0%	5,962,338	70.4%
Private	701,790	9.9%	316,872	3.7%	314,478	5.5%	-	0.0%	-	0.0%
Bilateral Agencies	6,116	0.1%	-	0.0%	-	0.0%	-	0.0%	-	0.0%
Multilateral Agencies	1,587,782	22.5%	3,939,378	45.5%	831,870	14.6%	2,576,405	21.5%	2,500,149	29.5%
International non profit making organizations and foundations	570,254	8.1%	579,574	6.7%	510,134	8.9%	302,697	2.5%	6,000	0.1%
Total HIV Expenditure (BZD)	7,053,178	100%	8,666,878	100%	5,709,078	100%	11,971,894	100%	8,468,487	100%

HIV and AIDS Spending by Activity Spending Category	Financial Year			
	2020/21	%	2021/22	%
ASC.01 Prevention	6,715,700	56.1%	697,661	8.2%
ASC.02 HIV testing and counselling (HTC)	1,157,667	9.7%	2,374,861	28.0%
ASC.03 HIV Care and Treatment Care	1,288,911	10.8%	2,889,624	34.1%
ASC.04 Social protection and economic support (for PLHIV, their families, for KPs and for Orphans and Vulnerable Children) (where HIV ear-marked funds are used)	148,675	1.2%	15,200	0.2%
ASC.05 Social Enablers (excluding the efforts for KPs above)	832,712	7.0%	31,342	0.4%
ASC.06 Programme enablers and systems strengthening	1,715,653	14.3%	2,170,722	25.6%
ASC.07 Development synergies	106,976	0.9%	289,077	3.4%
ASC.08 HIV-related research (paid by earmarked HIV funds)	5,600	0.05%	-	0.0%
Total HIV Expenditure (BZD)	11,971,894	100%	8,468,487	100%

HIV and AIDS Spending by Provider of Services	Financial Year			
	2020/21	%	2021/22	%
Public	9,996,709	83.5%	7,058,543	83.4%
Private	1,202,609	10.0%	862,410	10.2%
International	772,576	6.5%	547,534	6.5%
Total HIV Expenditure (BZD)	11,971,894	100%	8,468,487	100%

HIV and AIDS Spending by Provider of Services (2)	Financial Year			
	2020/21	%	2021/22	%
Government Organizations	9,996,709	83.5%	7,058,543	83.4%
Non Profit Providers	1,202,609	10.0%	800,686	9.5%
Profit Making Private Sector Providers	-	0.0%	61,724	0.7%
Multilateral Agencies	762,576	6.4%	541,534	6.4%
International non profit making organizations and foundations	10,000	0.1%	6,000	0.1%
Total HIV Expenditure (BZD)	11,971,894	100%	8,468,487	100%

HIV and AIDS Spending by Beneficiary Population	Financial Year			
	2020/21	%	2021/22	%
People Living with HIV	1,595,779	13.3%	2,903,476	34.3%
Key Population	1,143,681	9.6%	396,449	4.7%
Vulnerable, accessible and other target population	7,518,485	62.8%	836,072	9.9%
General Population	1,018,070	8.5%	1,841,349	21.7%
Non Targeted interventions	695,879	5.8%	2,491,141	29.4%
Total HIV Expenditure (BZD)	11,971,894	100%	8,468,487	100%

Table 1: HIV Fact Sheet

HIV Funding Landscape

Description	Financial Year							% change		
	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2020 vs. 2021	2021 vs. 2022	2022 vs. 2023
Total Estimated Population *	378,770	386,121	392,997	399,373	398,405	404,198	410,919	1.62%	-0.24%	1.45%
Exchange Rate	2.00	2.00	2.00	2.00	2.00	2.00	2.00	0.00%	0.00%	0.00%
Total Government Expenditure **	1,222,713,839	1,336,342,440	1,374,940,417	1,201,404,522	1,323,176,054	1,498,842,266	1,604,954,840	-12.62%	10.14%	13.28%
Total Government Health Expenditure **	135,639,806	144,234,047	147,287,577	165,025,595	140,029,421	157,787,583	194,609,212	12.04%	-15.15%	12.68%
Recurrent Government Health Expenditure	132,659,818	138,720,564	124,279,146	138,913,607	123,111,120	144,353,734	161,999,995			
Capital II Government Health Expenditure	2,329,118	4,861,369	17,981,376	20,727,027	11,889,847	10,410,489	16,038,595			
Capital III Government Health Expenditure	650,870	652,114	5,027,055	5,384,961	5,028,454	3,023,360	16,570,622			
Total HIV Expenditure	8,666,876	5,709,074	11,971,895	8,468,487	NA	NA	NA	-29.26%		
Per capita HIV Expenditure	22.88	14.79	30.46	21.20	NA	NA	NA	-30.39%		
HIV Expenditure as a % of Total Health Expenditure	6.39%	3.96%	8.13%	5.13%	NA	NA	NA	-36.87%		
Government Health Spending as a % of Total Government Expenditure	11.09%	10.79%	10.71%	13.74%	10.58%	10.53%	12.13%	28.23%	-22.96%	-0.52%

* 2018/19 to 2023/24 population data updated based on results of SIB 2022 Census

** 2018/19 to 2020/21 financial data updated based on Estimates of Revenue and Expenditure FY 2021/22 to 2023/24 - (2021/22 for 2018/19; 2022/23 for 2019/20; 2023/24 for 2020/21)

** 2021/22 to 2023/24 financial data updated based on Estimates of Revenue and Expenditure FY 2024-25 as of March 1 2024

Table 2: HIV Funding Landscape

Background

Belize is divided into six (6) administrative districts: Corozal, Orange Walk, Cayo, Belize, Stann Creek, and Toledo. The 2022 Census recorded the country's population at 397,483. By the mid-year population estimates for 2022 and 2024, the population size had grown to 398,405 and 410,919 respectively with an almost equal male-female ratio (49.2% males, and 50.8% females). According to the Statistical Institute of Belize (SIB), 58.2% of the population resides in rural areas, although, 15.9% of the population inhabits Belize City. The largest proportion of the population resides in the Belize District which has 28.5% (116,914) of the population, followed by the Cayo District with 25.2% (103,413), and the Orange Walk District with 13.5% (55,622). The Toledo District recorded the lowest population density with 9.3% (38,259) of the population residing in that district.

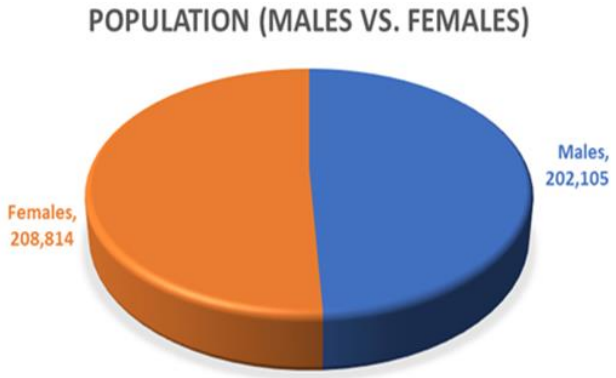

Figure 1: Population distribution (Male/Female)

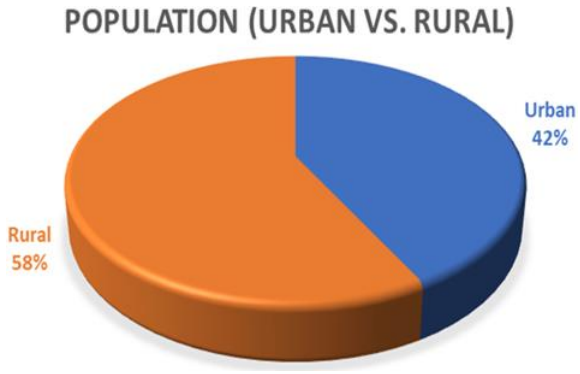

Figure 2: Population distribution (Urban/Rural)

Belize has a predominantly young population, with a nationwide average age of 25. 38.3% of Belize's population is under 20 years old, and 47.6% (195,647) are at least 24 years of age. 6.3% (25,906) of the total population are classified as elderly (65 years or older) as illustrated in the table below.

	Age	Estimated Male Population			Estimated Female Population			Estimated Population	
		Total	% of Males	% of Population	Total	% of Females	% of Population	Total	% of Population
ECD Age Range	**Under 5**	17,710	8.8%	4.3%	17,044	8.2%	4.1%	34,754	8.5%
	5 - 9	20,472	10.1%	5.0%	19,231	9.2%	4.7%	39,703	9.7%
Adolescents	**10 - 19**	42,154	20.9%	10.3%	40,826	19.6%	9.9%	82,980	20.2%
	20 - 29	34,526	17.1%	8.4%	36,796	17.6%	9.0%	71,322	17.4%
	30 - 39	27,699	13.7%	6.7%	32,000	15.3%	7.8%	59,699	14.5%
	40 - 49	22,702	11.2%	5.5%	24,734	11.8%	6.0%	47,436	11.5%
	50 - 59	17,114	8.5%	4.2%	18,683	8.9%	4.5%	35,797	8.7%
Elderly (NCA)	**60 - 64**	6,737	3.3%	1.6%	6,585	3.2%	1.6%	13,322	3.2%
Elderly (UN)	**65+**	12,991	6.4%	3.2%	12,915	6.2%	3.1%	25,906	6.3%
	TOTAL	202,105	100.0%	49.2%	208,814	100.0%	50.8%	410,919	100.0%

Table 3: Population by Age and Sex (source: Statistical Institute of Belize, Mid-Year Estimates, 2024)

In 2022, the life expectancy of persons born in Belize was estimated at 67.1 years for males and 71.3 years for females. Reports from the Belize Health Information System (BHIS) highlight that six of the top ten leading causes of death for 2023 were Non-Communicable Diseases (NCDs). NCDs accounted for 44% of all deaths, while cardiovascular diseases accounted for 16%, cancers 14%, diabetes 7%, and chronic respiratory diseases accounted for 5% of all deaths. Based on the National Health Estimates, AIDS was ranked 8th among the leading causes of death in 2023 accounting for 3.4% of all deaths in that year. This is an improvement from 5.7 % in 2018, 4.8% in 2019, 4.4% in 2020, 5.8% in 2021, and 3.6% in 2022.

The foundation for the country's National HIV Response is laid in the National HIV, STI, VH, and TB Strategic Plan (NSP). The response addresses comorbidity, and STI transmission, seeking to leverage critical scientific advances in HIV prevention, diagnosis, treatment, and care to pursue the commitment to end the AIDS epidemic as a public health threat by 2030. The National Response seeks to:

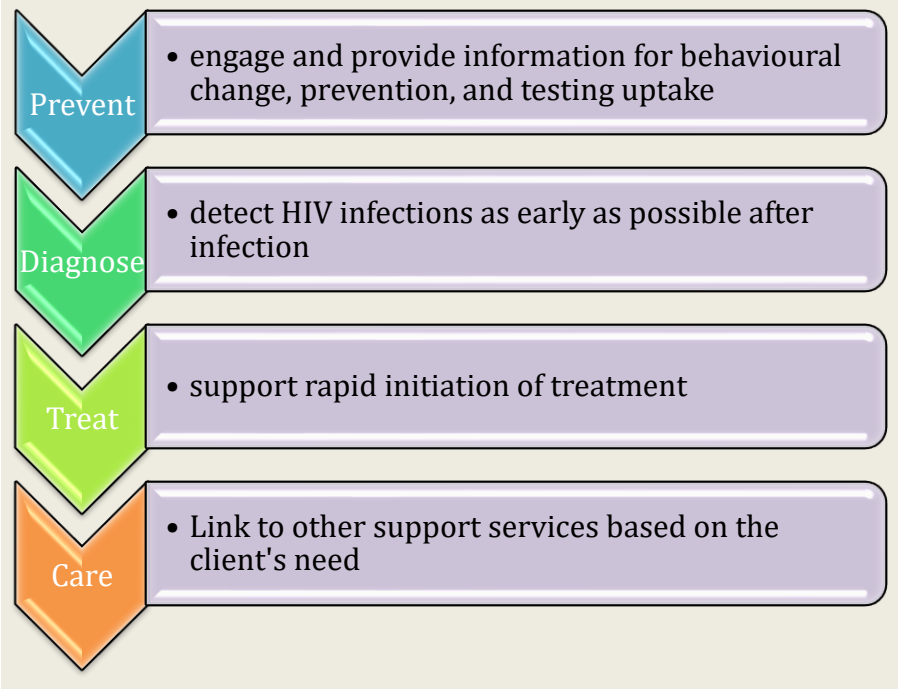

Figure 3: Objectives of the National Response for HIV, STIs, VH, and TB

Based on the Spectrum Estimate for 2021, there were an estimated 3,515 persons living with HIV in Belize. This estimate has increased to 3,781 for 2024 resulting in the country illustrating an HIV prevalence rate of 0.9%[1]. While Belize has made significant strides in the programmatic response to HIV, STI, Hepatitis, and TB, stronger action and extensive interventions that are aligned with global HIV strategies are required to combat and end the HIV/AIDS epidemic by 2030.

Belize continues the integration and decentralization of HIV, STI, and TB services into Primary Care Facilities, a process that commenced in 2009. The integration and decentralization of these services aim to support the

[1] Prevalence of 0.88% in 2021 and 0.92% from 2022 through to 2024.

wider availability and accessibility of HIV/AIDS services throughout the country. Through the integration of the prevention of mother-to-child transmission (PMTCT) program within the Ministry of Health's Maternal and Child Health (MCH) services, Belize has received certification for the Elimination of mother-to-child transmission (EMTCT) of HIV and Syphilis. Nonetheless, the work in this area must continue in order to maintain the reduction in HIV transmission within this population sector, and to ensure that the success is also replicated within other key population sectors.

During the 2021/22 period, Belize exhibited high testing coverage as the country strengthened the campaign for early HIV diagnosis and treatment. Additionally, Belize sought to increase the uptake of anti-retroviral (ARVs) among HIV-positive persons, and persons who may have been exposed to the virus and their partners. Investments were therefore primarily seen in areas relating to HIV testing and treatment. Despite this, significant challenges remain, and must be addressed. Many of the interventions implemented by the National Response during the 2021/22 cycle were non-targeted initiatives that were not accompanied by any robust behavior change communication or strategy. Particularly during the peak COVID-19 era, many population members were not aware of the services available or where and how to obtain them. Further, resources were reprioritized to address the concerns highlighted under the country's COVID-19 Response. While support from the Global Fund to Fight AIDS, Tuberculosis and Malaria addressed some gaps in service -*provision to key populations the country was unable to sustain the initiatives and the gap between pillars 2 and 3 continued to widen. That is, the gap between those persons who knew their HIV status and were on ART, and those who remained on ART and became virally suppressed continued to increase.

The country reported an estimated 5,504 persons living with HIV at the end of 2020. Of that number, 2828 (51%) were aware of their HIV status, 1490 (53%) were retained on treatment and 534 (36%) were virally suppressed as presented in the table below (MOHW Epidemiology Unit 2020).

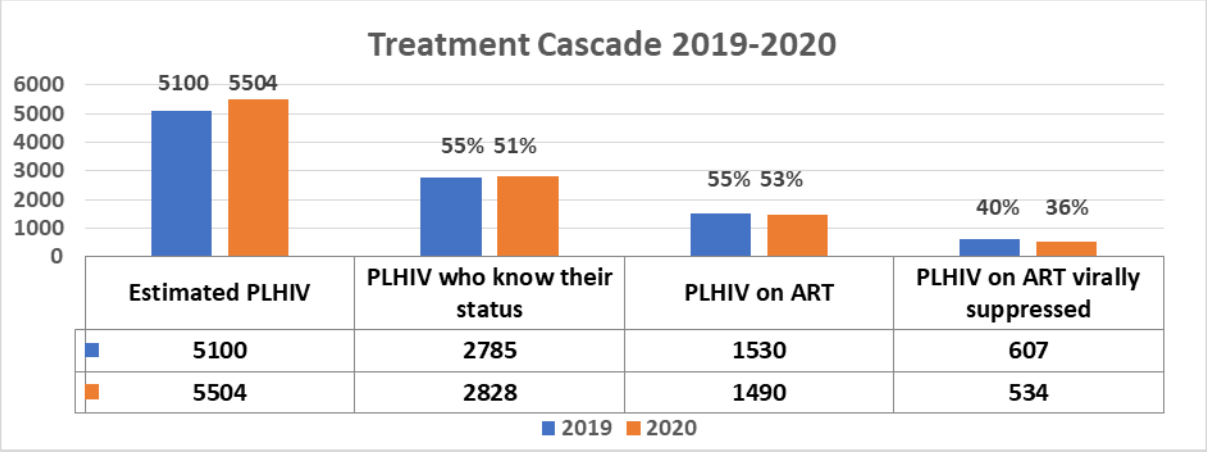

Figure 4: HIV Testing and Treatment Cascade 2019 vs. 2020 (source: Epidemiology Unit, 2020)

By December 2021, the country had undertaken an initiative to review and clean its data, prior to updating the 2021 Spectrum Estimates. At the end of 2021, Belize reported an estimated 3,515 persons living with HIV. As of

December 31, 2021, a total of 2,972 persons (84.6%) knew their status, and 46.8% of all estimated persons living with HIV/AIDs were on treatment (55.3% of those who knew their status). Only 956 or 58.1% of those on treatment, were virally suppressed (27.2% of all estimated people living with HIV/AIDS). The HIV Cascade highlights the importance of ensuring the complete rollout and incorporation of the Test and Treat (Treat All) Strategy since the gap between the pillars continues to widen into 2024.

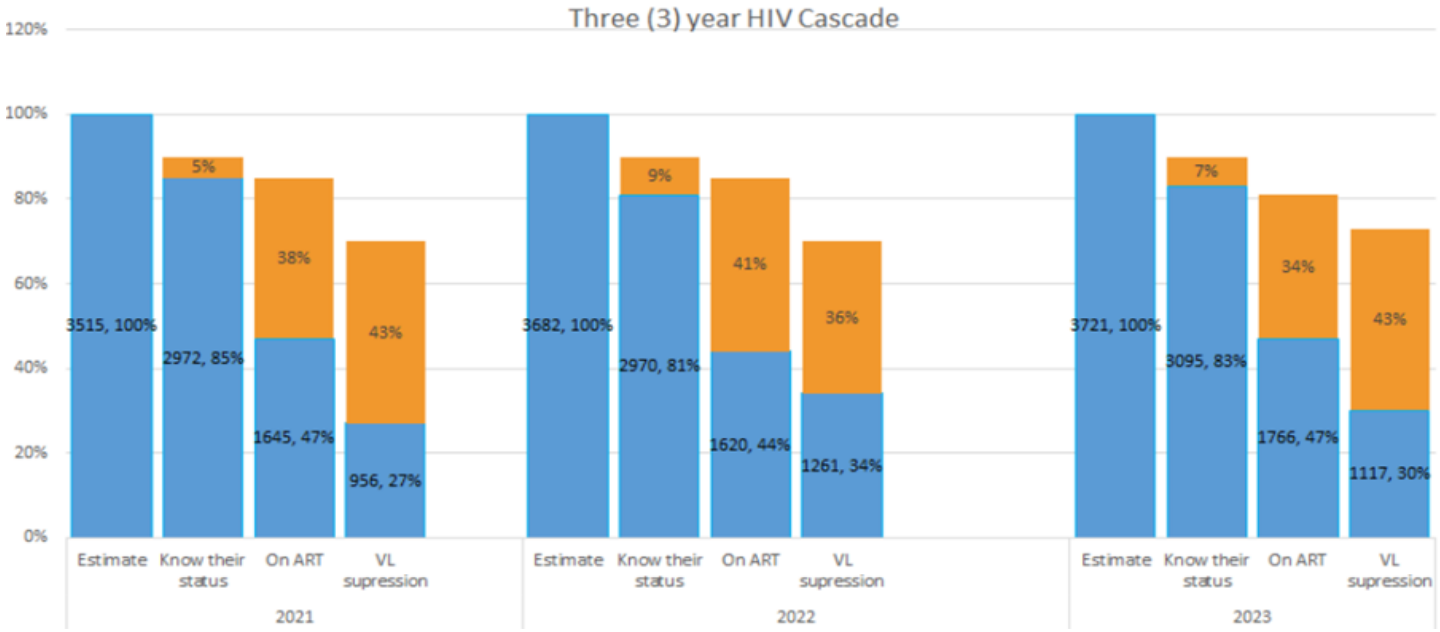

Figure 5: HIV Testing and Treatment Cascade 2021 to 2023(source: Epidemiology Unit, 2023)

The Spectrum Estimates for the 2021 period further approximated that in Belize, 67% of the persons living with HIV were between the ages of 30 – 54, although this group comprises only 30.1% of the entire population. A subset of this group - 35 to 49-year-olds accounted for 18.1% of the entire population in Belize but housed 45% of PLHIV. Over the years, Belize has reported a concentrated HIV epidemic among men who have sex with men (MSM) and transgender (TG) women who constitute the main key affected populations. The 2013 Behavioral Surveillance Survey (BSS) of HIV/STI Prevalence and Risk Behaviors in Most-at-Risk Populations in Belize: Female Sex Workers, MSM, and PLHIV presents an HIV prevalence of 13.85% in MSM. The Modes of Transmission (MOT) Study 2018 estimates that two of every three new infections occurred among MSM and TG women.

The country developed a differentiated service delivery approach for MSMs and TGs that was outlined in the 2021 Operational Plan. This is a critical component that must be developed across the cascade and should be applied to prevention, testing, linkage to care, ART initiation and follow-up, and the integration of HIV care and coinfections and comorbidities within the country. The country plans to extend the differentiated service delivery mechanism across population members living with, or susceptible to contracting HIV, taking into account their diverse needs. An effective HIV response requires a supportive social, legal, and policy environment that encourages persons at risk to access and use services.

The existence of strong systems for health is essential to making progress towards the ambitious targets of 95-95-95 by 2030 and ensuring that the country can address the varied health challenges it faces from natural disasters, pandemics, and global health security threats. Reaching diverse populations in many different settings requires strong, well-supported health and community systems, differentiated delivery of services, and an enabling environment that promotes health equity, gender equality, and human rights. Civil Society Organizations play a critical role in addressing the gaps in HIV prevention and delivery of community-based HIV services. They provide a comprehensive package of preventive services, behavior change interventions, counseling, testing, referrals for confirmatory testing and treatments as well as documenting and monitoring HIV services in the communities. However, efforts must be strengthened, supported, and adequately funded to ensure effectiveness.

Introduction to the NASA Exercise: Objectives, Design, and Methodology

The National AIDS Spending Assessment is a resource tracking tool that presents the annual flow of resources from the funding source to the point of expenditure and the delivery of services to the target beneficiary population. The NASA exercise supports transparency and strengthens monitoring to ensure that resources are spent in priority areas and among those most in need. The exercise informs the National HIV Response and supports planning and the creation of realistic and accurate HIV budgets.

The objective of the NASA Exercise is to better understand the spending patterns of the National AIDS Response and to analyze the HIV spending priorities in Belize. More specifically, the NASA Exercise seeks to:

1. Assess the allocation of HIV/AIDS funds from origin to the last point of service for different financial sources (public, external, and private to the extent possible), providers, beneficiaries or target groups, and production factors (any resource needed for the creation of a good or service);
2. Generate the necessary data to analyze the allocation of expenditures on HIV/AIDS in relation to the objectives and goals outlined in the National Strategic Plan for HIV, TB & STIs 2021 - 2025;
3. Synthesize the data into strategic information for decision-making and national strategic planning;
4. Facilitate actions to enhance the country's capabilities to effectively track financial flows on HIV/AIDS; and
5. Establish a continuous information system for the financing of the HIV/AIDS Response.

This assessment focused on the monitoring and analysis of national expenditure in response to HIV/AIDS during the 2021/22 Financial Year. Data collection covered domestic and external funds including those channeled through the government during the period being reviewed. The 2021/22 National AIDS Spending Assessment did not cover private contributions, nor out-of-pocket expenditure (OOPE) related to HIV and AIDS such as expenses to purchase condoms in pharmacies, to conduct HIV Tests at private facilities, or to purchase ARVs.

The NASA methodology is a standardized approach that utilizes a pre-existing tool with its unique coding and definitions to track the country's multi-sectoral response to HIV/AIDS. The National AIDS Spending Assessment is inherently retrospective by nature, and seeks to answer six key questions:

1. Who finances the AIDS response?
2. Who manages the funds?
3. Who provides the services?
4. Which intervention was provided?
5. Who benefits from the funds?
6. What was bought to facilitate the intervention?

To provide the answers, and to support the triangulation of the data, the NASA exercise reconstructs all the financial transactions related to the national response to HIV/AIDS by identifying three dimensions: financing, provision, and consumption. Each dimension incorporates two of the following vectors:

1. Financing Entities (FE) - entities that make the funds available to finance HIV and AIDS services.
2. Financing Agent-Purchasers (FAP) - entities that mobilize the resources to finance specific programmes. FAP makes the decisions on how the resources should be spent while acting as managers for funding sources.
3. Providers of Services (PS) - entities that engage in the delivery of HIV and AIDS services. They represent a mix of government, non-government, and private sector organizations.
4. Production Factors (PF) - resources bought to produce the interventions.
5. AIDS Spending Categories (ASC) - activities and services provided as the multi-sectoral response to HIV and AIDS.
6. Beneficiary Populations (BP) - the intended part of the population benefiting from a specific intervention.

NASA follows a system of expenditure tracking that involves the systematic capturing of the flow of resources by different financial sources to service providers, through diverse transaction mechanisms. A transaction is comprised of all the elements of the financial flow – that is, the transfer of resources from a financial source to a service provider, which spends the money on different production factors to produce functions (or interventions) in response to addressing HIV and AIDS to the benefit of specific target groups or to address the general population.

Figure 6: NASA Financial Flow

NASA uses both the top-down and bottom-up approaches for obtaining and consolidating information. The top-down approach tracks sources of funds from donor reports, commitment reports, and government budgets whilst the bottom-up tracks expenditures from service providers' expenditure records, facility-level records, and governmental department expenditure accounts. The feasibility of NASA relies on the:

- identification of key players and potential information sources;
- provision of complete and accurate information;
- understanding users' and informants' interests; as well as
- the development of an inter-institutional group responsible for
    - facilitating access to information,
    - participating in the data analysis, and
    - contributing to the data dissemination.

The National AIDS Commission commenced the 2021/22 NASA Exercise with an inception meeting in November 2023. Thereafter, a mapping exercise (Annex 1) was conducted to identify potential key partners and implementers in the HIV Response. These key partners are instrumental in providing the information required to implement a thorough NASA Exercise and to develop a comprehensive NASA Report. Thirty (30) organizations inclusive of GOB Ministries, Departments, and Commissions; Civil Service Organizations, and Non-Governmental Organizations; Technical Partners; and Donor Agencies were engaged and updated on the importance of the NASA Exercise as well as the role of each organization in the collection and reporting of data.

The Finance Officer and/or Programme Focal Point from each entity was contacted via email and telephone to arrange presentation dates to sensitize key personnel on

- the NASA exercise,
- the role of each entity,
- to ascertain the information being requested, and
- to outline a timeframe for the provision of the information.

The 30 entities who were engaged were provided with the Data Collection Form (DCF) – Annex 2. Twenty entities agreed to participate in the follow-up meetings. Of this number, fifteen entities confirmed that they had incurred HIV-related expenses during the period and that they would submit completed DCFs within the requested timeframe. Representatives from the Ministry of Finance; Ministry of Health and Wellness; Ministry of Human Development; Ministry of Education, Culture, Science and Technology; PAHO; UNDP; UNFPA; National Health Insurance; CSO – Hub; BFLA; CSOs; National Health Insurance; and the NAC were actively engaged via telephone and /or in person and supported the collecting, cleaning, and validating of the data from their respective organization.

During the data collection phase, some organizations noted that they were unable to provide expenditure data for various reasons, including:

- the absence of expenditure during the specified period;
- their systems' inability to easily identify relevant expenditures; and
- other competing interests.

At the end of an extended timeframe, twelve entities submitted data to be included in the 2021/22 NASA Exercise. The data received from the entities was organized, cleaned, and entered into the Data Consolidation Tool (DCT). Data were validated at several points by the participating Officers, and the National AIDS Commission, with support from UNAIDS. The NAC and UNAIDS provided oversight to ensure that queries were addressed and entries were accurately classified and coded in the DCT. Data was validated and inserted into the Resource Tracking Tool (RTT) for analysis and finalization. Based on the final data, charts and analysis were completed and the NASA Report was drafted.

Challenges / Limitations

1. Integration has complicated the disaggregation of data. Institutionalizing financial reporting and encouraging the frequent reporting of HIV expenditure, perhaps through quarterly updates to the Data Collection Forms which was developed during this exercise would assist in creating an environment where HIV/AIDS Expenditures are recorded, tracked, and shared frequently by key Ministries.
2. Weaknesses in the various information systems created bottlenecks in obtaining detailed information. Challenges included identifying the areas where interventions were provided; the beneficiary population the interventions were provided to; and the cost by production factors of each intervention. Some reported data were provided in aggregated figures, mixing different AIDS Spending Categories. At times, the costs could not be disaggregated by population targeted or served – whether MSM, TG, and other vulnerable populations despite further discussions with the various entities. Hence, these activities were classified as BP.03 Vulnerable, accessible, and other target populations.
3. CSOs were unable or unwilling to provide data on their HIV Expenditure despite the extended timeframe and the availability of support to complete the exercise. Key personnel believed that since they did not receive funds from, or through the NAC, they should not report there. This resulted in an underreporting of the contribution made by the CSOs to the HIV Response in Belize.
4. Competing priorities created difficulties in stakeholders' ability to submit data within a reasonable timeframe. This is further compounded when delays occur due to funding constraints. This challenge can be addressed by sustaining dialogue throughout the financial year to ensure that entities are aware of the NASA requirements and that HIV expenditures are recorded and readily available at the end of each period.
5. Out-of-pocket expenses and contributions by private entities (employers, private individuals, insurance companies and private clinics) were not provided during this exercise.
6. It was not possible to disaggregate the procurement of ARV between first- and second-line treatments, so most of the ARV expenditures were classified as ASC.02.01.03.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment.
7. The NASA methodology recommends using consumption data to reflect the actual cost of the implementation of the HIV Response programmes. However, the cost for medication and other supplies provided by the MOHW was estimated from procurement data rather than consumption since consumption data was not available at the time of the Exercise.

Estimations

MOHW – Medical Supplies	To account for the cost incurred for medical supplies and commodities utilized during testing for HIV and STIs, Viral Loads, and other costs that may remain uncaptured, 15% of the medical supplies line item in the Medical Supplies Cost Center is estimated to cover commodities, testing kits, ARVs and other supplements used to support treatment, and other related items that are purchased locally.

Community Health Workers (CHW)	An estimated 30% of the Community Health Workers' time per annum is assigned to HIV-related activities. CHW provides general HIV preventative information and interventions, and are the primary organizers/coordinators of all national health fairs (inclusive of HIV testing with other staff). These activities increases during women's month, men's health, world TB day, World AIDS Day, and Regional Testing Day.
Ministry of Education's SRH Interventions (Primary School)	At the Primary level, SRH; HIV; and topics addressing equality, gender, tolerance for others, and equity and justice for all are included in the Education Curriculum and are taught at all government schools. At the full government-funded primary schools, 1 hour per week of a 25-hour school week (**4%**) is assigned **to the areas** of Health and Social Studies where the SRH and HIV topic areas are covered (Study Area 3[2] and Study Area 4[3]). SRH and HIV-related topics cover approximately **75% of these areas** . 50% of the teachers' paid time is estimated to being assigned to the preparation and actual teaching of the lessons. This equates to 1.5% of primary school teachers' salaries being estimated as the HIV-related contribution for 9 teaching months - January to June and September to December[4].
Ministry of Education's SRH Interventions (Secondary School)	At government-funded secondary schools, 1.5 hours of a 30-hour school week (5%) is assigned to the areas that cover the SRH and HIV topic areas. 75% of the areas in their Life Skills / HFLE Programmes address HIV and SRH-related topics, and 40% of the teachers' paid time is assigned to the preparation and teaching of the lessons. It is therefore estimated that 1.5% of the teachers' salaries provided by GOB at the secondary level contribute to the provision of SRH and HIV education[4].

The following time estimations were utilized for relevant MOHW Staff time based on their role and contribution to the HIV Response during the 2021/2022 period:

Staff	Time % for HIV	Staff	Time % for HIV
RNs/ Phlebotomists	**20%**	2 Senior Medical Technologist	**10%**
Quality Improvement Officers	**15%**	2 Medical Technologist I	**10%**
Public Health Nurse	**20%**	16 Med. Tech II	**10%**
Advisor MCH	**50%**	2 Pathologists	**10%**
Community Health Workers	**30%**	Histology Technician	**10%**
Deputy DHS (HIV)	**45%**	Cytotechnologists	**10%**
M&E Officer	**30%**	Senior Biostatistician	**15%**
Surveillance Officer	**5%**	Software and Training Support Officer	**15%**
Epidemiologist	**10%**	Finance Officer (Support)	**15%**
Coordinator VCT	**80%**		

Table 4: Estimations of the 2021/22 NASA Exercise

[2] Study Area 3 focuses on Social Studies and Personal Development (aspects of personal development relating to social/cultural, spiritual, economics) – based on the National Syllabus (MOECST).

[3] Study Area 4 includes the Expressive Arts, Physical Education, and Health (including the physical aspect of personal development)

[4] During the disruption of classes due to COVID-19 and the provision of online teaching at various levels, and later, the implementation of a hybrid system, an 80% reduction was further applied to these estimations between the period from January 2021 to June 2022. A further 50% reduction is applied to denomination schools due to the challenges encountered with the adoption of the curriculum by some denominational schools.

Findings

A total of BZD 8,468,487 (USD 4,234,243.50) is estimated to have been spent on the HIV Response during the 2021/22 Financial Year. These expenditures were 29.3% less than the 2020/21 estimate and could be attributed to the economic challenges faced as a result of the COVID-19 pandemic, and the changes implemented within the country as a result of its prioritization of its COVID-19 Response.

Description	Financial Year					
	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
Total Estimated Population *	378,770	386,121	392,997	399,373	398,405	404,198
Exchange Rate	2.00	2.00	2.00	2.00	2.00	2.00
Total Government Expenditure **	1,222,713,839	1,336,342,440	1,374,940,417	1,201,404,522	1,323,176,054	1,498,842,266
Total Government Health Expenditure **	135,639,806	144,234,047	147,287,577	165,025,595	140,029,421	157,787,583
Recurrent Government Health Expenditure	132,659,818	138,720,564	124,279,146	138,913,607	123,111,120	144,353,734
Capital II Government Health Expenditure	2,329,118	4,861,369	17,981,376	20,727,027	11,889,847	10,410,489
Capital III Government Health Expenditure	650,870	652,114	5,027,055	5,384,961	5,028,454	3,023,360
Total HIV Expenditure	8,666,876	5,709,074	11,971,895	8,468,487	NA	NA
Per capita HIV Expenditure	22.88	14.79	30.46	21.20	NA	NA
HIV Expenditure as a % of Total Health Expenditure	6.39%	3.96%	8.13%	5.13%	NA	NA
Government Health Spending as a % of Total Government Expenditure	11.09%	10.79%	10.71%	13.74%	10.58%	10.53%

* 2018/19 to 2023/24 population data updated based on results of SIB 2022 Census

** 2018/19 to 2020/21 financial data updated based on Estimates of Revenue and Expenditure FY 2021/22 to 2023/24 - (2021/22 for 2018/19; 2022/23 for 2019/20; 2023/24 for 2020/21)

** 2021/22 to 2023/24 financial data updated based on Estimates of Revenue and Expenditure FY 2024-25 as of March 1 2024

Table 5: HIV Funding Landscape 2018/19 to 2023/24

During the period being reviewed, the Government's Total Expenditure decreased by 12.6% from 1.37 billion in 2020/21 to 1.2 billion in 2021/22. This may have been related to several cost cutting measures which were implemented as the Government experienced reductions in GOB's revenue streams such as the income from the tourism sector and other economic drivers which were significantly affected as a result of the COVID measures which were imposed during the period. These tactics included but were not limited to travel restrictions and nationwide curfews, salary cuts, and increment freezes. Simultaneously, donor funding was reprioritized to address the COVID-19 pandemic and other emergency needs. Despite this, the period saw increases across Recurrent, Capital II and Capital III Government Health Expenditures as Total Government Health Expenditures increased by 12% from 147.2 million in 2020/21 to 165 million in 2021/22. This increase in spending was related to the country's increased expenditure to combat the COVID-19 pandemic which demanded more of the government's resources during the period. The increased health burden resulted in a reprioritization of the

available human and financial resources, which resulted in a 29.3% decrease in Total HIV Expenditure for the 2021/22 period. During this period, HIV Expenditure equated to 5% of the Total Health Expenditure.

Expenditures by Scheme and Funding Source

Revenue Descriptions	SCH.01.01.01 Central government schemes	SCH.02.02.01 Not-for-profit organisation schemes (excluding SCH.02.02.02)	Grand Total
REV.01.01 Internal transfers and grants	5,850,313		5,850,313
REV.01.02 Transfers by government to social health insurance on behalf of specific groups	95,485		95,485
REV.01.04 Transfers from government domestic revenues to non-profit organization financing schemes	3,000	13,540	16,540
REV.07.01.02 Direct multilateral financial transfers	2,475,682	24,467	2,500,149
REV.07.01.99 Direct foreign financial transfers n.e.c.		6,000	6,000
Grand Total	**8,424,480**	**44,007**	**8,468,487**

Table 6: HIV Expenditure by Scheme and Funding Source 2021/22

During the 2021/22 period, the Government of Belize contributed BZD 5,962,338 (USD 2,981,169) to the HIV Response, covering 70.4% of overall expenditures, and remaining as the primary financing entity in the National Response. Internal transfers and grants from GoB, accounted for 69.1% (BZD 5,850,313) of overall expenditures in the 2021/22 HIV Response, and were the primary revenue source during the period. The Government further contributed 1.1% of overall expenditures through transfers by the government to social health insurance, and 0.2% through transfers to NGOs. 29.6% (BZD 2,506,149 or USD 1,253,075) of the total HIV spending for the period was provided by International Donors. This was primarily provided through direct multilateral financial transfers, with only BZD 6,000 being a direct foreign financial transfer which was provided by an International NGO.

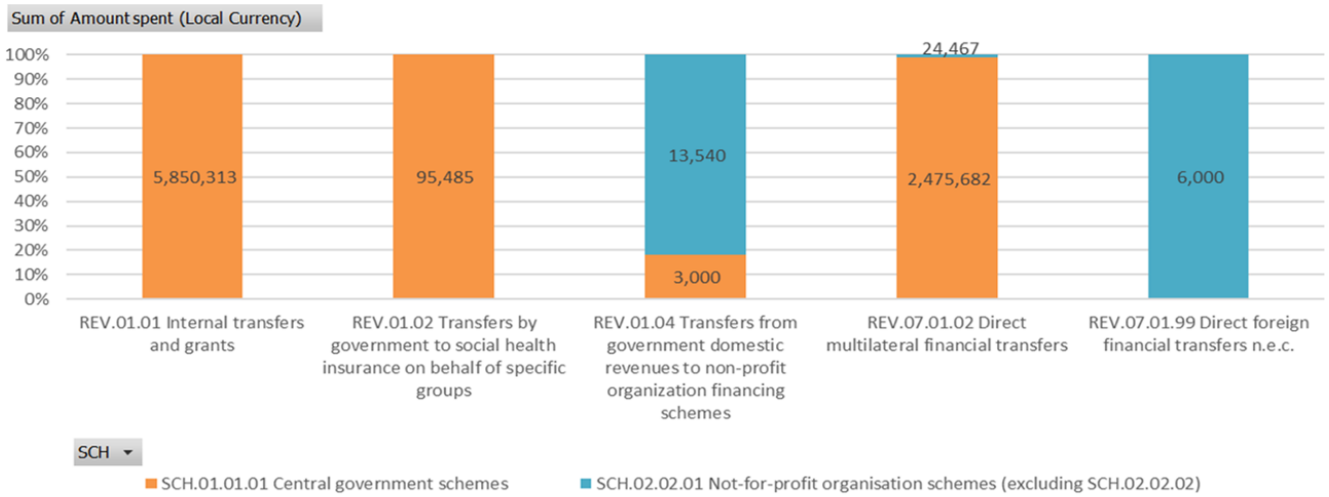

Figure 7: HIV Expenditure by Scheme and Revenue Source 2021/22

The majority of the funds (99.5%) flowed through the Central Government Schemes, and primarily to public financing agents and purchasers – the drivers of the response, who pooled resources and made programmatic

decisions. GoB has remained constant in its percentage coverage of the HIV Response during the past 3 years. The Government of Belize covered 71%, 76%, and 70.4% of total expenditure in the 2019/20, 2020/21, and 2021/22 periods respectively. GoB's Expenditures supporting the National HIV Response were obtained from spending reported by the Ministry of Health and Wellness; the Ministry of Education, Culture, Science and Technology; the Ministry of Human Development, Families and Indigenous People's Affairs; the National AIDS Commission and services provided through the National Health Insurance.

Financial Entities Descriptions	SCH.01.01.01 Central government schemes	SCH.02.02.01 Not-for-profit organisation schemes (excluding SCH.02.02.02)	Grand Total
FE.01.01.01 Central government	5,948,798	13,540	5,962,338
FE.03.02.07 The Global Fund to Fight AIDS, Tuberculosis and Malaria	2,260,566		2,260,566
FE.03.02.17 United Nations Population Fund (UNFPA)	162,250	24,467	186,717
FE.03.02.20 World Health Organization (WHO) / PAHO	52,866		52,866
FE.03.03.99 Other International not-for-profit organizations and foundations n.e.c.		6,000	6,000
Grand Total	**8,424,480**	**44,007**	**8,468,487**

Table 7: HIV Expenditure by Scheme and Financial Entity 2021/22

The Global Fund remained the country's largest international donor providing 90.4% of the spending reported by Multilateral Agencies, or 90.2% of funds reported by international donors, and financing 26.7% of the country's overall HIV expenditures.

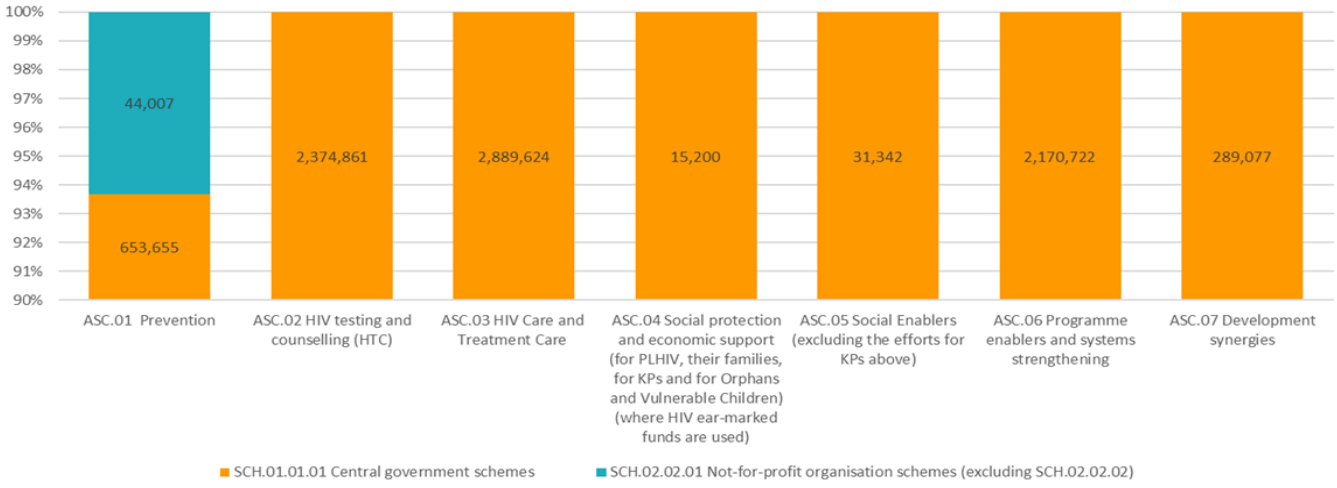

Figure 8: HIV Expenditure by Scheme and AIDS Spending Categories 2021/22

The funds expended through the Central Government Scheme from April 2021 to March 2022 were predominantly assigned to HIV Care and Treatment (43%) and HIV Testing and Counselling (HTC) (37.5%). The CSOs and NGOs who were the primary directors of the Not-for-Profit Organization Schemes in Belize, obtained funding support from GoB and other donors to address gaps identified in the National HIV Response. In 2021/22 all the funds received under this scheme (BZD 44,007) were sourced for activities related to the prevention of HIV. This accounted for 6.3% of the total funds expended for prevention-related activities. The Government provided 30.8% of these funds, while UNFPA contributed 55.6%, and 13.6% was provided by an International NGO.

AIDS Spending Categories Descriptions	FE.01.01 Governmental	FE.03.02 Multilateral Organizations	FE.03.03 International not-for-profit organizations and foundations	Grand Total
ASC.01 Prevention	363,295	328,366	6,000	697,662
ASC.02 HIV testing and counselling (HTC)	2,234,576	140,285		2,374,861
ASC.03 HIV Care and Treatment Care	2,563,764	325,860		2,889,624
ASC.04 Social protection and economic support (for PLHIV, their families, for KPs and for Orphans and Vulnerable Children) (where HIV ear-marked funds are used)		15,200		15,200
ASC.05 Social Enablers (excluding the efforts for KPs above)	10,000	21,342		31,342
ASC.06 Programme enablers and systems strengthening	734,192	1,436,530		2,170,722
ASC.07 Development synergies	56,510	232,566		289,077
Grand Total	**5,962,338**	**2,500,149**	**6,000**	**8,468,487**

Table 8: HIV Expenditure by AIDS Spending Categories and Financial Entity 2021/22

The NASA highlights that the Country assigned 34.1% of the total expenditures to activities related to HIV Care and Treatment Care. 28% of funds were assigned to HIV Testing and Counselling, and 25.6% were allocated to support Programme enablers and systems strengthening. Prevention activities utilized 8.2% of estimated resources, and the remaining 4% of the estimated expenditures were utilized for Development Synergies (3.4%), Social Enablers (excluding the efforts for KPs) 0.4%, and Social protection and economic support (for PLHIV, their families, for KPs and Orphans and Vulnerable Children) 0.2%.

Prevention interventions (52.1%), HIV Testing and Counselling (94.1%), and HIV Care and Treatment (88.7%) activities were primarily funded by GoB. BZD 5,161,636 or 86.6% of the total funds provided by GoB were assigned to these 3 categories. HIV Care and Treatment Care included access to ART and support to remain adherent and on ARVs. Prevention activities were comprised of interventions provided through the Prevention of Mother to Child Transmission (PMTCT) Programme, outreach and HIV-related information sessions with the general population and youth, and the inclusion of HIV/AIDS related topics in the Sexual and Reproductive Health and Life Skills Curriculum in schools.

Expenditures related to Prevention were shared almost equally between GOB (52.1%) and International Donors (47.9%). 47.1% of the spending category was funded by Multilateral Organizations, while .85% was supported by International Not for Profit Organizations and Foundations. Multilateral Organizations funded 66.2% of the programme enablers and system-strengthening component. This component of the HIV Response utilized 57.5% of the total funds provided by Multilateral Organizations. Activities under this category consisted of strategic planning, coordination, and policy development; strategic information (including M&E, science research, surveillance, and the NASA activities); public systems strengthening (including laboratory systems strengthening, institutional and organizational development, and financial and accounting systems strengthening); and community system strengthening.

Expenditure by AIDS Spending Categories

The dominant spending categories for the 2021/22 period were HIV Care and Treatment Care (2.89 million), HIV testing and counseling (2.37 million), and Programme enablers and systems strengthening (2.17 million). Activities under the spending categories for social protection and economic support, and social enablers, appears to be grossly underfunded during the 2021/22 period.

AIDS Spending Categories Descriptions	Grand Total
ASC.01 Prevention	697,662
ASC.02 HIV testing and counselling (HTC)	2,374,861
ASC.03 HIV Care and Treatment Care	2,889,624
ASC.04 Social protection and economic support (for PLHIV, their families, for KPs and for Orphans and Vulnerable	15,200
ASC.05 Social Enablers (excluding the efforts for KPs above)	31,342
ASC.06 Programme enablers and systems strengthening	2,170,722
ASC.07 Development synergies	289,077
Grand Total	**8,468,487**

Table 9: HIV Expenditure by AIDS Spending Categories 2021/22

AIDS Spending Categories Description	Grand Total
ASC.01 Prevention	697,662
ASC.01.01 Five Pillars of Prevention	242,331
ASC.01.02 Other prevention activities	455,331

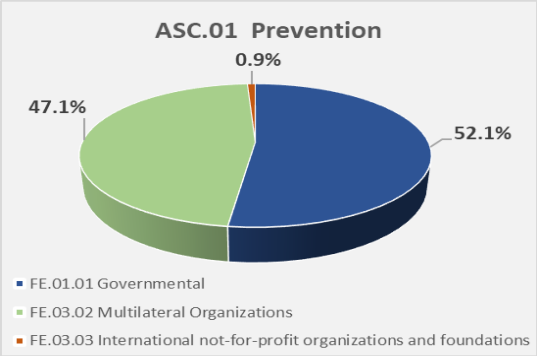

Figure 9: HIV Expenditure by AIDS Spending Category 1 and FE 2021/22

Risk reduction programmes form the base of the prevention initiatives. These include the implementation of PMTCT, community mobilization and condom and lubricant programmes, prevention activities implemented in schools, and social and behavioral communication for change campaigns. These expenses were shared almost equally between GOB and Multilateral Organizations, with GOB providing 52.1% of the expenditures.

During the 2021/22 period, the HIV Testing and Counselling services offered by the MOHW sought primarily to engage population members who were most at risk of contracting and/or spreading the disease. The Ministry utilized general engagement strategies such as media appearances, community outreach – community fairs, community workers, and the provision of general health services packaged to target the general population members but were steered with a specific focus on engaging persons who were considered particularly vulnerable. Still, more must be done to engage men and youth specifically, primarily those engaging in risky behaviors or exposed to persons who are likely to increase their risk factors.

70.5% of the reported expenditures under ASC 2 were utilized to provide Voluntary HIV testing and counseling for the general population. 17.2% was utilized for HIV Screening in blood banks, while 5.8% (BZD 138,919) was utilized to provide targeted HTC services for MSM and TG. 6.4% of the expenditures were utilized to support HTC for pregnant women as a part of the PMTCT Programme and the early infant diagnosis of HIV (2%), Provider

Initiated Testing and Counselling (0.6%), and to provide testing and counseling services to the vulnerable and accessible groups (3.9%).

AIDS Spending Categories Description	Grand Total
ASC.02 HIV testing and counselling (HTC)	**2,374,861**
ASC.02.02 HIV testing and counselling for MSM	136,199
ASC.02.03 HIV testing and counselling for TG	2,720
ASC.02.06 HIV testing and counselling for pregnant women (part of PMTCT programme)	37,126
ASC.02.07 Early infant diagnosis (EID) of HIV	8,840
ASC.02.08 HIV testing and counselling for vulnerable and accessible populations	92,282
ASC.02.09 Voluntary HIV testing and counselling for general population	1,675,018
ASC.02.10 Provider initiated testing and counselling (PITC)	14,114
ASC.02.11 HIV screening in blood banks	408,563

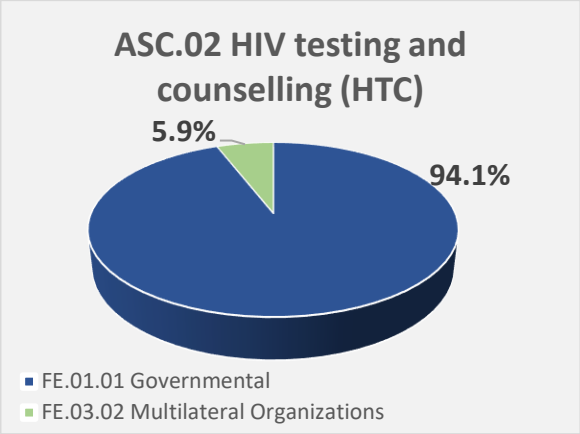

Figure 10: HIV Expenditure by AIDS Spending Category 2 and FE 2021/22

AIDS Spending Categories Description	Grand Total
ASC.03 HIV Care and Treatment Care	**2,889,624**
ASC.03.01 Anti-retroviral therapy	312,148
ASC.03.02 Adherence and retention on ART - support (including nutrition and transport) and monitoring	264,231
ASC.03.03 Specific ART-related laboratory monitoring	113,476
ASC.03.04 Co-infections and opportunistic infections: prevention and treatment for PLHIV and KPs	56,520
ASC.03.05 Psychological treatment and support services	8,600
ASC.03.98 Care and treatment services not disaggregated	2,134,001
ASC.03.99 Care and treatment services n.e.c.	648

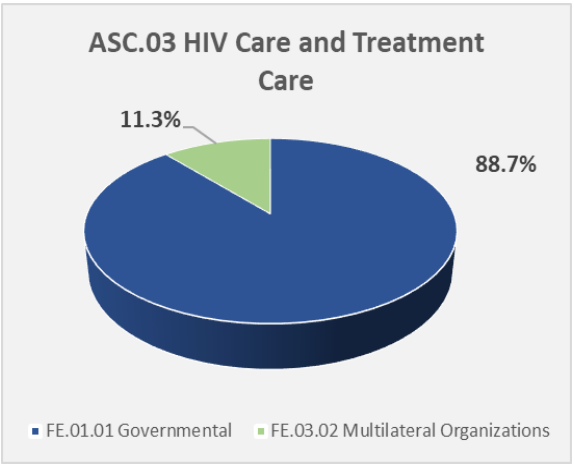

Figure 11: HIV Expenditure by AIDS Spending Category 3 and FE 2021/22

During the period being reviewed, 2.89 million was expended under spending category 3: HIV Care and Treatment Care. This is the ASC with the highest levels of expenditure for the period. GoB funds covered 88.7% of these expenditures. 73.9% of the category was not disaggregated by care and treatment services, such as between the reagents for ART related lab monitoring and the reagents to facilitate labs to monitor prevention and treatment interventions for coinfections and opportunistic infections and so forth. Similarly, the utilized production factors could not be disaggregated by interventions – whether ART or coinfections and opportunistic interventions; ART or DOT Treatment activities, and nutritional support or support for supplements. 10.8% of the expenditures could be specifically assigned to ART, 9.1% to Adherence and Retention on ART, and 3.9% to ART-related lab monitoring. Overall, the Spending Category funds various support services including the provision of nutritional support and supplements, monitoring of viral load and CD4s, and care through Adherence Counsellors to support adherence and retention on ART.

AIDS Spending Categories Description	Grand Total
ASC.04 Social protection and economic support (for PLHIV, their families, for KPs and for Orphans and Vulnerable Children) (where HIV ear-marked funds are used)	**15,200**
ASC.04.02 Other social protection and economic support (non-OVC)	15,200
ASC.05 Social Enablers (excluding the efforts for KPs above)	**31,342**
ASC.05.02 Human rights programmes	31,342

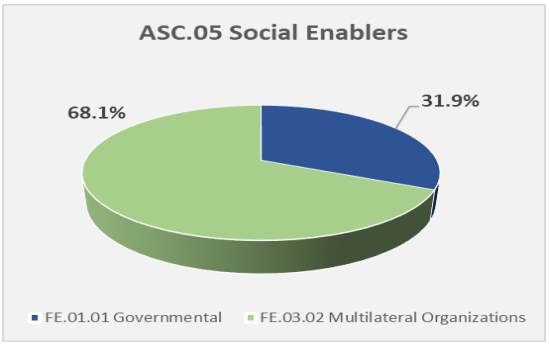

Figure 12: HIV Expenditure by AIDS Spending Category 4&5 and FE 2021/22

The social protection and economic support provided during the 2021/22 period was financed completely by Multilateral Organizations. The support allowed for the opportunities to obtain vaccinations and other support to ensure that the key population members remained healthy during the COVID-19 pandemic. AIDS Spending Category 05 – Social enablers consisted of activities that were financed primarily by Multilateral Organizations with BZD 21,342 (or 68.1%) of the funds provided. The category includes support for stigma and discrimination reduction, sensitization of lawmakers and law enforcement agents, and capacity building in human rights.

AIDS Spending Categories Description	Grand Total
ASC.06 Programme enablers and systems strengthening	**2,170,722**
ASC.06.01 Strategic planning, coordination and policy development	79,080
ASC.06.02 Building meaningful engagement for representation in key governance, policy reform and development processes	350
ASC.06.03 Programme administration and management costs (above service-delivery level)	1,250,084
ASC.06.04 Strategic information	276,920
ASC.06.05 Public Systems Strengthening	494,695
ASC.06.06 Community system strengthening	36,656
ASC.06.07 Human resources for health (above-site programmes)	32,937

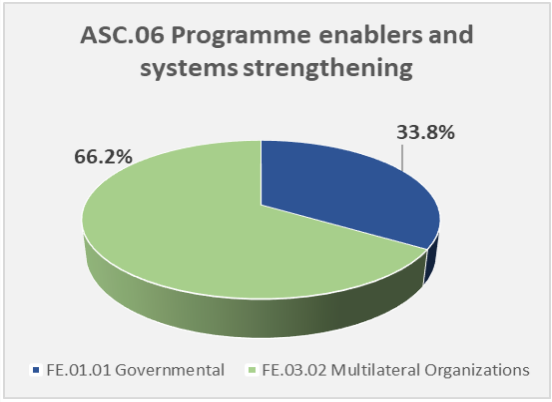

Figure 13: HIV Expenditure by AIDS Spending Category 6 and FE 2021/22

Programme enablers and systems strengthening activities were also primarily financed by Multilateral Organizations (66.2%). This category includes support for strategic planning, coordination, and policy development (ASC.06.01); building meaningful engagement for representation in key governance, policy reform, and development processes (ASC.06.02); programme administration and management costs (ASC.06.03); monitoring and evaluation, support to management information systems, NASA exercises (ASC.06.04); laboratory system strengthening, financial and accounting systems strengthening (ASC.06.05); civil society institutional and NGO development, community worker education, and training and support (ASC.06.06).

AIDS Spending Categories Description	Grand Total
ASC.07 Development synergies	**289,077**
ASC.07.01 Formative education to build-up an HIV workforce and other trainings not related to any specific activity (e.g. pre-service) using HIV earmarked resources	8,833
ASC.07.02 Reducing gender based violence	280,243

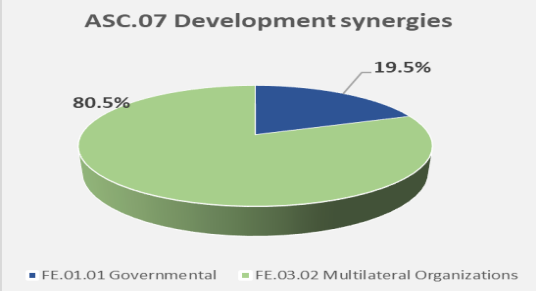

Figure 14: HIV Expenditure by AIDS Spending Category 7 and FE 2021/22

Support to develop synergies (ASC.07) is financed through funding predominantly from Multilateral Organizations and includes education to build up an HIV workforce, activities to reduce violence against women and young girls, and to reduce sexual diversity violence as well as promoting HIV-sensitive, cross-sectoral development.

Expenditures by Service Providers and Beneficiary Population

Governmental organizations (83%) were the primary service providers during the 2021/22 FY. During the same period, profit-making private sector providers delivered 1% of services supplied, and local nonprofit organizations provided 9% of the services being delivered. The services provided by local CSOs/NGOs were predominantly offered as community-based activities through the engagement of key and vulnerable population members. Due to competing interest primarily dominated by the COVID-19 experience, private stakeholders in the HIV Response were unable to contribute to the 2021/22 NASA exercise. It is expected that these entities would have contributed to spending related to the provision of HIV-related health services, such as HIV testing and counseling activities, the provision of condoms and lubricants, and the purchase of ART.

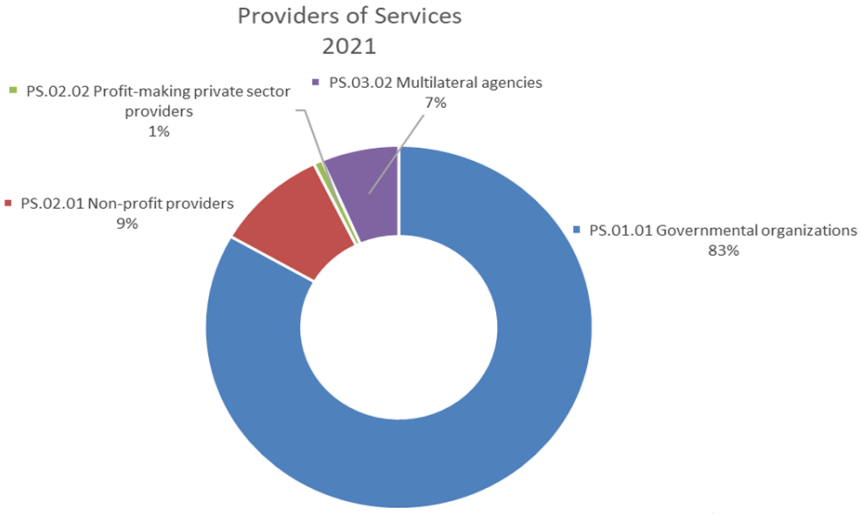

Figure 15: HIV Expenditure by Providers of Service 2021/22

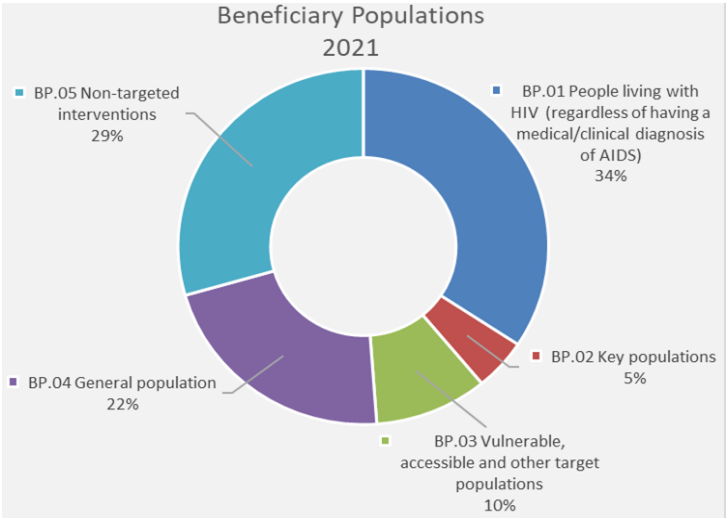

Figure 16: HIV Expenditure by Beneficiary Populations 2021/22

34% of the interventions reported were aimed at providing service to persons living with HIV, while 29% of the services provided were listed as non-targeted interventions. 10% of the activities' costs were assigned to support the vulnerable, accessible, and other target populations, and 5% for key populations. Key population members were primarily serviced by NGO organizations while the general population (22%), and vulnerable populations were serviced by GOB. While most service providers focused on providing service to the vulnerable population members, the non-targeted interventions such as the development of synergies, systems strengthening, and institutional and organizational capacity building were most often provided by Multilateral Agencies.

Global AIDS Monitoring

Category Description	Public Sources	International Sources				TOTAL
		Global Fund	All Other Multilateral	All Other International	Total International	
Treatment, care and support (sub-total)	**4,752,374.35**	**280,142.93**	**1,366.00**	**-**	**281,508.93**	**5,033,883.28**
HIV testing and counselling (HTC) for populations other than key populations	2,188,610.31	-	1,366.00	-	1,366.00	2,189,976.31
HIV tests (commodities)	115,901.56	-	-	-	-	115,901.56
Other direct and indirect costs	2,072,708.75	-	1,366.00	-	1,366.00	2,074,074.75
Not disaggregated by type of cost	-	-	-	-	-	-
Antiretroviral treatment (sub-total)	308,708.96	3,439.05	-	-	3,439.05	312,148.01
Adult antiretroviral treatment	308,708.96	3,439.05	-	-	3,439.05	312,148.01
ARVs	308,708.96	-	-	-	-	308,708.96
Other direct and indirect costs	-	3,439.05	-	-	3,439.05	3,439.05
Specific HIV-related laboratory monitoring (CD4, viral load), including:	-	113,476.24	-	-	113,476.24	113,476.24
Viral load tests (commodities)	-	113,476.24	-	-	113,476.24	113,476.24
Opportunistic infections (OI) prophylaxis and treatment, excluding Treatment and prevention of tuberculosis for people living with HIV	-	10,802.52	-	-	10,802.52	10,802.52
Support and retention	121,053.73	143,176.88	-	-	143,176.88	264,230.61
Programmatic activities for treatment, care and support not broken down by type	2,134,001.35	9,248.24	-	-	9,248.24	2,143,249.59
Prevention of vertical transmission of HIV (sub-total)	**51,625.77**	**31,978.56**	**-**	**-**	**31,978.56**	**83,604.33**
HIV testing and counselling (HTC) for pregnant women, including:	37,125.77	-	-	-	-	37,125.77
HIV tests (commodities)	28,031.70	-	-	-	-	28,031.70
Other direct and indirect costs	9,094.07	-	-	-	-	9,094.07
Early infant diagnosis, including:	8,840.00	-	-	-	-	8,840.00
HIV tests (commodities)	8,840.00	-	-	-	-	8,840.00
Antiretroviral treatment to reduce vertical transmission of HIV, including:	-	-	-	-	-	-
Non ARV related component of PMTCT	5,660.00	-	-	-	-	5,660.00
Programmatic activities for verticial transmission of HIV not disaggregated	-	31,978.56	-	-	31,978.56	31,978.56
Prevention (sub-total)	**102,892.30**	**410,839.35**	**-**	**6,000.00**	**416,839.35**	**519,731.65**
Prevention, promotion of testing and linkage to care programmes for gay men and other men who have sex with men (MSM) (sub-total)	-	364,529.23	-	-	364,529.23	364,529.23
Preventive activities for MSM (excluding HTC)	-	228,330.61	-	-	228,330.61	228,330.61
Condoms, lubricants (commodities)	-	17,775.52	-	-	17,775.52	17,775.52
Other commodities	-	-	-	-	-	-
Other direct and indirect costs	-	210,555.09	-	-	210,555.09	210,555.09
Not disaggregated by type of cost	-	-	-	-	-	-

Category Description	Public Sources	International Sources				TOTAL
		Global Fund	All Other Multilateral	All Other International	Total International	
HIV testing and counselling (HTC) for MSM	-	136,198.62	-	-	136,198.62	136,198.62
HIV tests (commodities)	-	133,878.62	-	-	133,878.62	133,878.62
Other direct and indirect costs	-	2,320.00	-	-	2,320.00	2,320.00
Prevention, promotion of testing and linkage to care programmes for transgender persons (sub-total)	-	16,720.02	-	-	16,720.02	16,720.02
Preventive activities for transgender persons (excluding HTC)	-	14,000.02	-	-	14,000.02	14,000.02
Condoms, lubricants (commodities)	-	-	-	-	-	-
Other commodities	-	-	-	-	-	-
Other direct and indirect costs	-	14,000.02	-	-	14,000.02	14,000.02
Not disaggregated by type of cost	-	-	-	-	-	-
HIV testing and counselling (HTC) for TG	-	2,720.00	-	-	2,720.00	2,720.00
HIV tests (commodities)	-	-	-	-	-	-
Other direct and indirect costs	-	2,720.00	-	-	2,720.00	2,720.00
Prevention programmes for vulnerable and accessible populations (excluding HIV testing)	102,892.30	5,850.00	-	6,000.00	11,850.00	114,742.30
Post-exposure prophylaxis (PEP)	-	-	-	-	-	-
Workplace	-	23,740.10	-	-	23,740.10	23,740.10
Gender programmes	**56,510.24**	**61,483.00**	**162,250.00**	**-**	**223,733.00**	**280,243.24**
Programmes for children and adolescents	**254,743.18**	**-**	**24,467.10**	**-**	**24,467.10**	**279,210.28**
Social protection and economic support	**-**	**15,199.50**	**-**	**-**	**15,199.50**	**15,199.50**
Community mobilization and system strengthening	**-**	**-**	**-**	**-**	**-**	**-**
Governance and sustainability (sub-total)	**733,842.20**	**1,377,402.34**	**51,500.00**	**-**	**1,428,902.34**	**2,162,744.54**
Programme administration and management	498,851.53	751,232.36	-	-	751,232.36	1,250,083.89
Strategic information	138,886.13	138,034.20	-	-	138,034.20	276,920.33
Strategic planning and policy development	-	79,080.46	-	-	79,080.46	79,080.46
Procurement and logistics (Procurement and supply chain)	6,326.31	-	-	-	-	6,326.31
Health systems strengthening	72,015.04	348,392.32	51,500.00	-	399,892.32	471,907.36
Education	-	8,833.32	-	-	8,833.32	8,833.32
Governance and sustainability not disaggregated	17,763.19	51,829.68	-	-	51,829.68	69,592.87
Critical enablers (sub-total)	**10,350.00**	**37,803.43**	**-**	**-**	**37,803.43**	**48,153.43**
Policy dialogue	350.00	-	-	-	-	350.00
Key human rights programmes and advocacy activities	10,000.00	21,342.41	-	-	21,342.41	31,342.41
AIDS-specific institutional development	-	16,461.02	-	-	16,461.02	16,461.02
TB / HIV co-infection, diagnosis and treatment (sub-total)	**-**	**45,717.10**	**-**	**-**	**45,717.10**	**45,717.10**
TB screening and diagnosis in PLHIV	-	20,797.10	-	-	20,797.10	20,797.10
TB-HIV coinfection, diagnosis and treatment not disaggregated	-	24,920.00	-	-	24,920.00	24,920.00
Total (excluding other essential programs)	**5,962,338.04**	**2,260,566.21**	**239,583.10**	**6,000.00**	**2,506,149.31**	**8,468,487.35**

Table 10: GAM Sheet for the period 2021/22 as extracted from RTT Tool

The Global AIDS Monitoring Sheet re-emphasizes the government's investment in treatment, care, and support under the National HIV Response in 2021/22. The report also illustrates the challenge faced by the country to disaggregate expenditures by expenditure categories and by beneficiary populations. 25.9% of the expenditures recorded during the 2021/22 period were allocated to HIV Testing and Counselling for populations other than key populations, but not further defined. A further 25.3% were assigned to programmatic activities for treatment, care, and support not broken down by type, while only 4.5% were directly assigned to prevention, promotion of testing, and linkage to care programmes for gay men and other MSMs (4.3%) and Transgender (0.2%). It is noteworthy that the majority of the unassigned or generally assigned expenditures are primarily GOB Funds while the expenditures that were specifically assigned to MSM and TGs were all provided through the Global Fund resources. This suggests that while the country has reportedly been implementing a tailored HIV response through funds available from the Global Fund, the National Response has not yet fully adopted the tailored approach to HIV and has failed to ensure the existence of differentiated packages of services and reporting mechanisms to support the tracking of interventions and their results for further analysis and decision making. The expenditures therefore underscore that the country has continued to implement a primarily non-targeted approach in the National HIV Response.

This non-targeted approach may be a contributory factor to the widening gap between the pillars in the country's treatment cascade, and increasing incidence rate. Although considerable investments have been made, the country has failed to showcase the impact of the interventions. This suggests that the country must strengthen its HIV Response by adopting robust strategies to combat HIV/AIDS, address inefficiencies, improve access and adherence to treatment through behavioral change, and ensure the sustainability of the response over time.

Co-financing Realizations

At the start of the 2022-2024 HIV Grant, the country committed to continuing to finance the full costs associated with ensuring the availability of ARVs, CD4, and viral load testing, supporting PMTCT towards the Elimination of Mother to Child Transmission of HIV, and increasing the support for persons living with HIV and Orphaned and Vulnerable Children. The Country further committed to:

1. strengthening the integration and expansion of HIV and STI services (including MCH), sexual and reproductive health, and TB (including TB/HIV co-infection);
2. supporting evidence-based innovative interventions for HIV prevention, the testing and provision of treatment for HIV including the retention to care and monitoring of progress made in eliminating the disease;
3. strengthening the integration of HIV testing into primary care facilities, and supporting provider-initiated testing and counselling;
4. improving the country's supply chain management to ensure that there are no stockouts of ARVs, testing kits or other supplies;
5. supporting the complete rollout of the 2021 HIV Treatment Guidelines inclusive of the "treat all"/rapid initiation guidelines; and
6. absorbing the enumeration for the HIV/TB M&E Officer and 7 Adherence Counsellors.

The 2021/22 NASA shows a total government contribution of BZD 5,962,338 (USD 2,981,169). Of this amount, BZD 524,932.98 has been invested to strengthen the integration and expansion of HIV and STI services through initiatives around the Prevention of Mother to Child Transmission of HIV and to strengthen Sexual and Reproductive Health that were spearheaded by the Maternal and Child Health Unit – the Ministry of Health and Wellness, private NHI providers, the Ministry of Education, the Belize Family Life Association, and through the use of Community Health Workers. Belize drastically increased its cohort of Community Health Workers (CHWs) during the second half of the 2021/2022 cycle[5]. CHWs support the MOHW in providing health education and promoting and implementing health interventions throughout Belize. Community Health Workers are positioned to disseminate preventive health messages and provide basic curative services to their communities working in tandem with the Rural Health Nurses to ensure that rural populations have access to basic health services.

A further increase in GoB expenditure is expected during the upcoming 2022/23 and 2023/24 NASA periods as is being illuminated by preliminary data-gathering exercises. This is seen in an increase in PMTCT Training in both periods, which also resulted in an uptake in testing at the public and private service providers. Furthermore, the MOE estimations have shown an increase in the 2022/23 cycle with the resumption of regular classes during the period.

[5] 45 CHW deployed in 2021. This amount was increased to 184 in 2022, and 200 by December 2023

Additional GOB investments are expected with the recruitment of a GoB-paid TB/HIV Coordinator. While the Global Fund had supported Belize with funding for this TB/HIV Coordinator under both the 2019 and 2022 HIV Grants, the position is currently vacant. The government post to absorb the position (and funding) was created in 2024 and is currently being advertised by the Ministry of Health and Wellness. The position is expected to be filled by Q3 2024/25. Similarly, the country has recently completed the creation of posts for the absorption of 2 additional Adherence Counsellors, bringing the number of Counsellors being employed by GoB to 7 by 2025. The country estimates a total need for 14 Adherence Counsellors to implement adherence strategies aimed at reducing the gap being observed between pillars 2 and 3 of the treatment cascade. Belize plans to lobby GoB and its International Partners to acquire funds to onboard ACs within Q1 of the 2024/2025 cycle.

GOB has invested BZD 4,509,735 under the 2021/22 NASA to support HIV testing (BZD 1,753,224), treatment (BZD 2,467,379), treatment adherence and support through VCT Centers (BZD 139,526), and monitoring and related travel (BZD 149,606). During the 2021/2022 period, training and manual developments and updates were significantly reduced as the country sought to define its COVID Strategy, nonetheless, these were prioritized in the 2022/23 and 2023/24 cycles and will be showcased in the NASA Exercise for those periods. Similarly, the piloting of innovative interventions such as self-testing, the use of PrEP, and index testing were all delayed until late 2022 given the gathering restrictions in the country, during the initially planned 2022 period. Both PrEP and HIV Self Testing were piloted with support from PAHO and the Caribbean Med Labs Foundation respectively. The National AIDS Commission, the National Health Insurance, and the Ministry of Health and Wellness have been developing plans to support the use of HIV ST kits at MOHW facilities and a further nationwide scale-up before the option is rolled out for use in private homes. The uptake for PREP and Index Testing has been low, and the MOHW and NAC have been discussing strategies that could be adopted to increase PrEP uptake and improve Partner Initiated Testing and Index Testing countrywide.

Training opportunities offered during the 2021/2022 period dwindled with minimal training sessions primarily focused on PMTCT as the country sought to obtain its EMTCT Certification. However, trainings were increased in mid to late 2022/2023 focusing primarily on strengthening PITC and HIV Testing resulting in a visible increase being highlighted in the training areas during the period. Coupled with the training around PMTCT that was offered to private practitioners during the period, the country witnessed an increase in the demand for HIV testing and its accompanying HIV/STI Panel. As such, MOHW began to invest heavily in purchases for HIV Syphilis combo kits and expanded the HIV testing to further support rapid testing and Hepatitis B tests. Additional commodities for testing and prevention were also procured during the 2022/2023 and 2023/2024 periods.

A further BZD 509,207 has been invested in the management and operations of the National HIV Response, while 408,563 has been utilized to support blood bank testing to reduce the risk of the accidental transfer of HIV. The

2021/22 NASA and preliminary data for 2022-2024 from a few key GOB contributors showcase that the Government of Belize has invested in the agreed areas as follows:

Investment Area	2019 - 2021	2021/22	2022/23	2023/24	2024/25
Strengthen the integration and expansion of HIV and STI services through:					
PMTCT Initiatives	197,390	114,750	173,147	119,208	34,191
SRH Initiatives (CHW and BFLA)	53,025	21,845	41,330	43,490	14,496
MOE Contribution	NA	125,872	536,176	536,176	TBD
Absorption of TB/HIV Coordinator and 7 Adherence Counsellors	51,356	51,356	74,180	79,357	27,544
Continue to support testing and treatment of HIV	TBD	2,128,709	2,235,493	2,932,222	2,240,037
Monitoring & HIV-related Travel	111,878	74,803	82,885	76,890	29,468
Roll out of innovative interventions including HIV Self testing, Pre-Exposure Prophylaxis, and Index Testing	-	-	-	-	-
Strengthen the integration of HIV testing into primary care facilities, and provider-initiated testing and counselling	11,703	4,950	30,285	6,845	-
Investment to improve the supply chain management to ensure that there are no stock-outs of ARVs, testing kits, or other supplies	-	-	-	TBD	-
Complete rollout of the 2021 HIV Treatment Guidelines, including training and reorientation of facility staff to "treat all"/rapid initiation guidelines	-	-	5,609	-	-
Support for the implementation of Social Contracting	-	-	-	-	-
Reagents for the blood bank testing	TBD	204,281	486,473	486,473	TBD
Management of the HIV Response	357,361	202,779	159,055	155,333	71,193
HIV Testing under NHI (PMTCT, PITC, and Voluntary)	-	18,394	38,749	TBD	TBD
GBV/HIV Initiative		33,430	TBD	TBD	TBD
TOTAL (USD)		**2,981,169**	**3,863,382**	**4,435,994**	**2,416,929**

Table 11: Summary of Co-financing Realization

Areas	2022-2024		2019 - 2021		Increase between Cycles	
	BZD	USD	BZD	USD	BZD	USD
Strengthening the integration and expansion of HIV and STI services	**2,996,428.47**	**1,498,214.24**	**500,830.57**	**250,415.29**	**350,895.10**	**175,447.55**
PMTCT Support (Salaries, GOB Testing & Treatment referrals, outreach, supplies and equipment)	470,784.46	235,392.23	312,640.49	156,320.25	158,143.97	79,071.99
Training in PMTCT	115,371.02	57,685.51	82,140.08	41,070.04	33,230.94	16,615.47
Testing as PMTCT (Private)	66,936.85	33,468.43	-	-	66,936.85	33,468.43
PMTCT Initiatives	**653,092.33**	**326,546.17**	**394,780.57**	**197,390.29**	**258,311.76**	**129,155.88**
HCW contribution (stipends)	167,040.00	83,520.00	65,430.00	32,715.00	101,610.00	50,805.00
BFLA	31,593.33	15,796.67	40,620.00	20,310.00	- 9,026.67	- 4,513.33
SRH Initiatives	**198,633.33**	**99,316.67**	**106,050.00**	**53,025.00**	**92,583.33**	**46,291.67**
MOE Contribution	2,144,702.81	1,072,351.40	TBD		TBD	
TB/HIV Coordinator	-	-	-	-	-	-
Other Integration Initiatives	**2,144,702.81**	**1,072,351.40**	**-**	**-**	**-**	**-**
Fully support evidence-based innovative interventions for HIV prevention, optimise testing and linkage to care, adherence, and retention	**15,556,154.67**	**7,778,077.33**	**326,467.15**	**163,233.58**	**414,184.27**	**207,092.13**
Adherence Counsellors	362,164.21	181,082.10	102,711.38	51,355.69	259,452.83	129,726.41
Continue to support testing and treatment of HIV	14,815,503.25	7,407,751.63	TBD		TBD	
Monitoring & HIV-related Travel	378,487.21	189,243.61	223,755.77	111,877.89	154,731.44	77,365.72
Roll out of innovative interventions including HIV Self testing, Pre-Exposure Prophylaxis, and Index Testing	-	-		-	-	-
Strengthen the integration of HIV testing into primary care facilities, and provider-initiated testing and counselling.	**74,259.19**	**37,129.60**	**11,702.88**	**5,851.44**	**62,556.31**	**31,278.16**
Training in PITC and HIV testing	74,259.19	37,129.60	11,702.88	5,851.44	62,556.31	31,278.16
Improve Supply Chain Management	**-**	**-**	**-**	**-**	**-**	**-**
Trainings and forecasting exercises	-	-		-	-	-
Ensure the complete rollout of the 2021 HIV Treatment Guidelines	**11,217.93**	**5,608.97**	**-**	**-**	**11,217.93**	**5,608.97**
Training in guidelines and Treat All Policy / Rapid Initiation Guidelines	11,217.93	5,608.97		-	11,217.93	5,608.97
Support the process for Social Contracting	**-**	**-**	**-**	**-**	**-**	**-**
Social Contracting	-	-		-	-	-
Other Cofinancing Areas	**2,794,550.65**	**1,397,275.32**	**818,369.21**	**409,184.61**	**- 8,458.24**	**- 4,229.12**
Reagents for the blood bank testing	1,945,890.31	972,945.15	TBD		TBD	
Management of the HIV Response	771,161.59	385,580.80	714,721.51	357,360.76	56,440.08	28,220.04
HIV Testing under NHI (non PMTCT - PITC, and Voluntary)	38,749.38	19,374.69	36,787.70	18,393.85	1,961.68	980.84
GBV/HIV Initiative	-	-	66,860.00	33,430.00	- 66,860.00	- 33,430.00
	21,432,610.91	**10,716,305.45**	**1,657,369.81**	**828,684.91**	**830,395.36**	**415,197.68**

Table 12: Comparison of HIV Expenditure by Cycles: 2019-2021 vs. 2022-2024

Conclusion and Recommendations

The National AIDS Spending Assessment illuminates a decrease in the total HIV spending being reported in Belize during the 2021/22 period. This decrease in reported expenditure may be attributed to several factors related to the COVID-19 pandemic. The country experienced significant decreases in both international and domestic resources as a result of the constraints resulting from COVID-19. During the 2021/22 period, Belize was experiencing its COVID-19 peak and therefore implemented several cost-saving measures, such as a reduction in salaries paid to public servants, and the implementation of curfews and travel restrictions. 2021/22 therefore saw a decrease in the overall government income and expenditure. Simultaneously, the government had to shift its spending priorities as the country battled against the COVID-19 pandemic which required the significant reallocation of financial resources. The COVID-19 pandemic contributed to an overburdening of the Health System and further reduction in HIV spending and allocated resources. Adherence Counsellors, Social Workers, and other Health Workers were required to contribute a portion of their time to support COVID-19 interventions. The situation highlighted the importance of ensuring that Belize can address the varied health challenges it faces from natural disasters, pandemics, and global health security threats, since the existence of strong systems for health is essential to making progress towards the ambitious HIV/AIDs targets of 95-95-95 by 2030.

To continue to ensure the sustainability of the Country's HIV Response, and to ensure the achievement of the fast-track targets to eliminate HIV by 2030, GOB must continue to increase and sustain its expenditure across multiple sectors. While this will continue to reduce the country's dependency on external aid, it will also increase the ownership of local partners within the HIV Response. **However**, investments must be efficient and vigorously targeted towards the population sectors requiring critical interventions. During the period being reviewed, 29% of the interventions could not be easily linked to a beneficiary population and appeared as non-targeted interventions, while 22% were prescribed as activities targeting the general public. This means that more than 50% of the country's interventions adopted a general approach to the strategy being implemented. 10% of the reported expenditures were assigned to support the vulnerable, accessible, and other target populations, and 5% to key populations. However, the country has posited that the epidemic is concentrated, primarily affecting MSMs. Further, 34% of the interventions reported were aimed at providing service to persons living with HIV, however, the impact of these interventions is not readily visible, suggesting that either severe inefficiencies exist, interventions were delayed, or the interventions were not sustained for a period that was sufficient enough to effect impactful change. In addition to the expanding gap between the number of persons who know their status and are on ARVs, and are virally suppressed, the annual number of HIV/AIDS-related deaths increased from 68 in 2022 to 78 in 2023, after a decline from 95 in 2021.

While production factors and the location of implemented activities were provided during the exercise, room exists for further improvement. The 2021/22 NASA Exercise accentuates that HIV-related research has not been

a key priority for the country as the Activity Spending Category remains underfunded for a fourth consecutive year. The country must assess its research needs and develop a resource mobilization plan to ensure that the information required to develop sound strategies is in place to support the decision-making process. It should be noted that the Ministry of Health and Wellness has commenced the establishment of a Research Unit in 2022/23 with the recruitment of a Health Planner. Additionally, in 2023/24 the country has embarked on the Integrated Biological and Behavioral Surveillance Study (IBBS). These expenditures and associated costs are expected to appear in the 2022/23 and 2023/24 NASA Report. It is vital that the country adopt strategies that have been proven effective in reducing the AIDS burden in other countries and adapt them to the realities of the country.

As we utilize data and research to ascertain new strategies that should be incorporated and interventions that should be scaled up to successfully ensure the availability of services to those who need them, we must note that more domestic investments are needed to strengthen and sustain the National Response to HIV, STIs, VH, and TB in Belize. Hence, the forecasting, tracking, and reporting of HIV activities must be normalized to strengthen the NASA process. Establishing the stature and relevance of the National AIDS Commission is critical as the upcoming NASA Exercises will seek to include information from the private corporate sector and regional service providers. The institutionalization of the National AIDS Spending Assessment will require the strengthening of national structures, willingness, and capacities as the NASA and other information-sharing activities seeks to ensure the availability of accurate and consistent data in the national databases. Further, the availability of data, both financial and programmatic, would support the generation of in-depth analysis and strategies for a robust, innovative, and sustained National Response across sectors.

Specific Recommendations

1. Belize must adopt stronger action and extensive interventions that are aligned with global HIV strategies to combat HIV/AIDS to achieve the goal of ending the HIV epidemic by 2030.
2. Interventions must be swift, innovative, and flexible to address the needs of the various population sectors that are being affected by the epidemic. This re-emphasizes the need for the development of differentiated packages of services for the various population sectors that are primarily affected by HIV/AIDS, and focusing on risk factors. However, the efficiency of the National Response must also be improved.
3. Community providers are essential actors in increasing access to services. The country must strengthen the support for community-led responses including monitoring, advocacy, and resource mobilization.
4. Interventions that are proven to reach key and vulnerable populations must be scaled up with a targeted focus on risk factors or risky behaviors.
5. As the National HIV Response continues to improve, PLHIV will live longer and age and may develop non-HIV-related chronic conditions similar to the rest of the population. Hence the country should continue

to strengthen the integration of HIV and NCD services into the national health system. NCD tests could be used as an entry point for HIV testing and linkage to care and treatment. The provision of Point of Care Testing services for HIV and STIs in health and community-based facilities is an important breakthrough that has been adopted.

6. The country must ensure that the knowledge obtained from training sessions is adopted and implemented ensuring and enforcing the Treat All Policy and other National HIV Testing and Treatment Strategies. Providers should be encouraged and motivated to communicate testing results promptly and to provide post-test counselling to maintain non-reactive status and support and immediate linkage to care for those who receive a reactive result.
7. During the course of the 2021/22 NASA Exercise CSOs were unable or unwilling to provide data on their HIV Expenditure despite the extended timeframe and the availability of support to complete the exercise. One CSO agreed to participate in the exercise, primarily because key personnel believed that since funds were not received from the NAC, there was no need to report there. This resulted in an underreporting of the contribution made by the CSOs to the HIV Response.
8. The country must emphasize the importance and relevance of the National AIDS Commission, and the Principal Recipient, and the multisectoral approach envisaged under the National HIV Response. All HIV/AIDS-related discussions, projects, reporting, results, planning, and interventions, should be shared with coordinators, implementers, and stakeholders. Information such as ongoing projects, projects in the pipeline, results of interventions, quantification exercises, and so forth should be available to determine the need in the country and to inform the country's strategy. The country should work to normalize collecting, analyzing, and disseminating data across the Response.
9. The National AIDS Commission must support the institutionalization of the NASA Exercise and other programmatic, and monitoring and evaluation reporting. This can be done by engaging stakeholders and data bearers to obtain frequent updates (unofficial – quarterly), with official semi-annual reports being shared, discussed, and analyzed for action. A strengthened M&E Committee along with the commitment from the Executive Director and M&E Specialist of the National AIDS Commission can support this process.
10. The country must strengthen its data collection, analysis, and reporting capacities. A more granular analysis of testing data, including yield of HIV+ tests by sex, age, type of HIV testing service, and level of care, for example, would be useful to inform programming. Decision-making **must** be data-informed and this should be a major priority for the country.