

HIVA

PLAN

A red ribbon symbol, commonly used to represent HIV/AIDS awareness, is positioned to the right of the word 'HIVA'. The ribbon is three-dimensional with a slight shadow and a highlight, giving it a realistic appearance.

2014 - 2019

.be

List of main abbreviations

<i>ART</i>	Antiretroviral therapy
<i>AIDS</i>	Acquired immunodeficiency syndrome
<i>CIT</i>	Client Initiated Testing
<i>ARC</i>	AIDS reference centres
<i>GMR</i>	General medical record
<i>SPR</i>	Shared pharmaceutical record
<i>WSW</i>	Women who have sex with women
<i>MSM</i>	Men who have sex with men
<i>STI</i>	Sexually transmitted infections
<i>LGBTQI</i>	Lesbian, Gay, Bisexual, Transgender, Queer and Intersex
<i>SAM</i>	Sub-Saharan African migrants
<i>NONOPEP</i>	Non-occupational post-exposure prophylaxis
<i>OPEP</i>	Occupational post-exposure prophylaxis
<i>PMTCT</i>	Prevention of mother-to-child transmission of HIV
<i>PrEP</i>	Pre-exposure prophylaxis
<i>PLHIV</i>	People/Persons living with HIV
<i>VCT</i>	Voluntary Counselling and Testing

Contents

I. Introduction	4
II. Current response against HIV/AIDS	7
III. Epidemiological Context	9
IV. Prevention	12
V. Screening and access to care	21
VI. Care of persons living with HIV	26
VII. Quality of life of persons living with HIV	30
VIII. Evaluation and monitoring of the Plan	31

I. Introduction

Since 30 September 2013, Belgium has had a HIV Plan providing a commonly agreed framework for action against HIV/AIDS and constituting the fundamental element of an effective response to HIV/AIDS.

Multi-year, the plan is the programming tool for the policy that the public authorities and their partners will use to respond to the HIV/AIDS epidemic.

Cross-cutting, it is supported not only by those involved in public health, but also other actors including those in education, justice, equal opportunities, social integration, culture, etc.

National, it involves all public authorities at all levels of power.

Production process

Produced in accordance with international recommendations, the Plan is the result of a process in which all the stakeholders concerned were instrumental.

*

Production phases:

Phase 1: study, data collection and experimentation phase

During this phase many studies and projects were conducted with a view to refining our knowledge of the epidemic and determining the most relevant processes for developing an effective response to the HIV epidemic.

Phase 2: consultation and conceptualisation phase (*April 2012 - September 2012*)

This phase included organising many meetings, site visits and consultations with those involved on the ground and persons living with HIV (PLHIV) and studying the scientific literature in order to identify the key issues and principal problems to which the Plan would need to respond. This phase ended with a symposium, during which all the medical and association personnel involved in this fight, including PLHIV were able to give recommendations, after workshops organised for this purpose.

Phase 3: introduction and development phase (*September 2012 - November 2012*)

The principal bodies responsible for producing the Plan were established. These bodies guaranteed the effectiveness of the process and the active involvement of everyone, including medical and association personnel, persons living with HIV (PLHIV), etc. Tools and support resources for the effective and transparent production of the Plan were made available. The production methodology, objectives, strategic pillars and Plan structure were defined.

Phase 4: production phase (*November 2012 - May 2013*)

During the production phase, working groups defined the Plan's strategic actions. These working groups brought together all those involved (associations and medical organisations, persons living with HIV, representatives from priority groups, personnel from public health, justice, equal opportunities, education, etc.).

Phase 5: validation phase (June 2013 - September 2013)

All political authorities that are signatories to the Plan validated the work of those involved in its production.

Phase 6: implementation phase (October 2013 - April 2014)

It should be noted that Plan's actions are implemented under the competence of various political authorities. Some actions come under the competence of the Ministers of Public Health for the Communities and Regions, some actions under that of the Federal Minister for Public Health and others under the responsibility of the Minister of Justice or Equal Opportunities, or Education, etc. The implementation phase will therefore aim to enable each political authority to develop an implementation and financial plan for those actions for which it is responsible, under the coordination of the Ministers of Public Health.

*

The production of the AIDS Plan has been transparent. Since September 2012, all the information regarding the process has been made public and freely available on the website of the Federal Public Service Health, Food Chain Safety and Environment. Suggestions and comments on the production process were welcomed from any citizen, group or association and all the suggestions received were sent to and processed by the working groups.

*

The production of the AIDS Plan has relied on the active involvement of persons living with HIV. Persons living with HIV have participated in all the Plan's production bodies. There were also workshops by persons living with HIV, starting with existing patient groups within associations or hospitals. All work by the groups was submitted to these workshops.

*

The UNAIDS Expert Committee was also involved in producing the Plan, both in defining its production process and validating its actions and objectives.

Purposes and objectives

Purposes

- To reduce new cases of HIV infections while promoting the conditions for healthy and responsible sexuality,
- To encourage access to specialised HIV services and programmes for prevention, screening, care and quality support, within the framework of universal access to healthcare,
- To reduce all forms of stigma and discrimination, particularly those based on serostatus or health.

Objectives

- To reduce the transmission risk of HIV and other STIs in the general population and among the most exposed groups in particular, by combining available prevention strategies and tools,
- To increase the proportion of people infected with HIV who find out their serostatus at an early stage,

- To increase the proportion of people infected with HIV who are undergoing treatment and have an undetectable viral load,
- To enhance the quality of life and living conditions for persons living with HIV, particularly by improving the quality and accessibility of care and medical and psychosocial support,
- To reduce stigma and discrimination, not only based on serostatus and health, but also based on gender, sexual orientation and identity, national origin and related to drug use, sex work, etc.

Four strategic pillars

1. Prevention

This pillar's objective is to reduce HIV transmission, notably through information, education, awareness, outreach programmes, work on the environment, institutional and policy work, etc. Prevention is considered in the broader context of promoting sexual health.

2. Testing and access to care

This pillar aims to screen those infected with HIV as soon as possible and guarantee immediate access to the necessary care and support. An early diagnosis is extremely important, since late diagnosis may limit the effectiveness of treatments and therapeutic choices, raise morbidity and mortality, delay immune reconstitution, increase the transmission risk, etc.

3. Care of persons living with HIV (PLHIV)

The objective of this pillar is to guarantee PLHIV the best care within the healthcare system.

4. Quality of life of persons living with HIV (PLHIV)

This pillar aims to improve the quality of life of PLHIV.

II. Current response against HIV / AIDS

Belgium already has a wide range of measures to respond to the HIV/AIDS epidemic, the main ones being:

- **9 aids reference centres**, where:
 - every PLHIV can receive multidisciplinary medical and psychosocial supervision
 - anyone can receive prophylactic antiretroviral treatment after accidental exposure to HIV
- **3 aids reference centres** where anyone can be screened anonymously and free of charge
- **7 AIDS reference laboratories** for diagnosis, the assessment and quality control of existing or new screening tests, data collection and monitoring
- **Specific action and research programmes** designed to prevent HIV and STIs, reduce the risks related to drug use, promote sexual health, etc.
- Financing for **research projects** within some screening centres with a view to characterising the specific health issues of sex workers. These centres focus specifically on sex workers and perform tests on those involved, not only for HIV/AIDS but also for other STDs, and provide guidance - where necessary - to the relevant bodies. The centres involved must draft an annual report that contains proposals.

However, in recent years, Belgium has also:

- adopted legislation to suppress racist and xenophobic-inspired acts
- allowed same-sex marriage
- created a national day against homophobia
- strengthened its action against discrimination by adopting a law that not only bans but also punishes any incitement to hatred or discrimination, based in particular on sexual orientation, national origin or current or future health
- launched a plan to combat homophobia and transphobia
- launched a plan to combat poverty, the objective of which is to lift 380,000 Belgians out of poverty by 2020, particularly by guaranteeing the population's social protection by combating poverty among children, improving access to the labour market and healthcare
- set up a powerful and independent Institute responsible for monitoring compliance with gender equality and the enforcing legislation

- set up an intergovernmental taskforce to improve access to healthcare for migrant populations
- improved accessibility to healthcare by introducing, for example, a 'maximum charge' which guarantees that anyone, whatever their health, will not pay more than a certain amount per year for treatment
- adopted a law on patient rights which guarantees everyone the right to quality services, the freedom to choose their healthcare provider, to be informed about their health, to give informed consent for any intervention, to view their medical file, to privacy and a private life
- adopted a law on medical examinations which bans any employer from performing HIV screening tests during medical examinations when hiring staff or to perform this test in the context of occupational medicine, even if the free and informed consent of the applicant/employee has been obtained
- adopted a regulation that gives migrants access to care in the context of emergency medical assistance
- etc.

III. Epidemiological context

Despite all the measures taken in Belgium by the country's public authorities, HIV remains a major public health issue. At least 20,000 people are living with HIV and between 1,000 and 1,200 new cases are diagnosed annually. Belgium is one of the European states with the highest number of diagnosed infections (10.7 cases per 100,000 inhabitants in Belgium, compared with 5.7 cases on average in Europe in 2011).

HIV

Breakdown by gender - With regards the breakdown by gender, the proportion of newly diagnosed HIV cases is increasing among men. After fluctuating between 51% and 60% during the 1994-2005 period, it was 66% in 2010 and 2011.

Breakdown by Belgians and non-Belgians - The proportion of newly diagnosed cases in people of Belgian nationality increased between 2002 and 2011, rising from 29.3% to 42.7% of patients where the nationality is known.

Mode of transmission - The number of infections diagnosed in men who have sex with men (MSM), mainly of Belgian nationality, has increased sharply, this mode of transmission was reported in 46.6% of infections diagnosed in 2011; it accounted for 23.5% of infections in 2002.

To date, heterosexual relationships remain the most frequently reported mode of transmission in Belgium, accounting for 49.6% of infections diagnosed in 2011. These are mainly people originating from high-prevalence countries that were probably for the most part infected in their country of origin.

Although other modes of transmission remain, these are falling. Injecting drug use was reported in less than 2% of recently diagnosed cases compared with around 8% at the beginning of the epidemic. Perinatal transmission was reported in approximately 1% of cases diagnosed in 2011. Two cases of transmission during a transfusion have been reported in Belgium in the last 26 years.

Belgian patients - Among PLHIV there were 8.9 times more men than women in PLHIV of Belgian nationality diagnosed in 2011. Of the, Belgian men diagnosed in 2011, 82.1% were MSM. In women, heterosexual transmission was reported in 92.1% of cases. Contamination through injecting drug use reduced proportionally in 2010.

Non-Belgian patients - Among the non-Belgian patients diagnosed between 2009 and 2011, 62.1% originated from Sub-Saharan Africa, 22.6% were Europeans, 12.8% were originally from America or Asia and 2.5% from North Africa. Patients originating from Sub-Saharan Africa accounted for 62% of infections through heterosexual contact diagnosed in 2011, the highest proportion observed in Europe. The number of infections diagnosed amongst MSM varied depending on their origin: it was 60.4% in nationals from European countries other than Belgium, 61.4% among those from America and Asia, 35% for those from North Africa and 3.9% in people originating from Sub-Saharan Africa. The male/female ratio among non-Belgians is much closer to unity than for Belgians.

It appears from the findings that we have just published that the HIV epidemic in Belgium is highly concentrated in two key populations: men who have sex with men (MSM), mainly of Belgian nationality and people who have contracted the virus through heterosexual sex and are mainly from Sub-Saharan Africa. Together, these two groups accounted for over two thirds of all new HIV cases recorded in 2011 (taking into account only those cases where the nationality is known, which is 75%).

Screening

During 2011, 679,655 HIV screening tests were performed in Belgium, excluding tests conducted on blood donations. Over the last 20 years, the number of tests has fluctuated between 50 and 60 tests/1000 inhabitants/year. A sustained increase in screening has been observed from 2007, with 56 tests/1000 inhabitants performed in 2007 and 64.2 in 2011.

The rate of new HIV cases diagnosed per 1000 tests rose by almost 50% between 1996 and 2000; it stood at 1.73 new infections diagnosed per 1000 tests in 2011.

The CD4+ cell count at the time of the HIV diagnosis is known for 7,995 patients diagnosed over the last 20 years (41.6%). This count can be considered as a biological marker of infection's progress, since it is lower when the infection is advanced. It generally stands at around 1000 CD4/mm³ in healthy people and lower at 200 CD4/mm³ in people infected with HIV developing into AIDS.

A diagnosis is considered as late when the number of CD4/mm³ is less than 350 when the HIV infection is diagnosed.

In 1998, 59% of HIV infections were diagnosed late, in 2011 this was 42%. The number of late diagnoses is therefore still high, even if a favourable trend has been observed over time.

Care of persons living with HIV (PLHIV)

Among those patients diagnosed in 2007, 91% were treated, including 83% in the three months following the HIV diagnosis. Of these same patients, only 60% were monitored regularly (at least one consultation every six months) in the two years after the first consultation. Access to treatment is also lower in SAM than in Belgian patients.

In 2011, 12,599 patients infected with HIV were monitored in Belgium and 81% were undergoing ART. Of the patients receiving ART in the ARCs, 83.1% had a viral load of less than 50 copies/mL at the end of 2010 and 9.7% had a viral load of between 50 and 500 copies.

An analysis of the patients monitored in the ARCs showed that 5.8% of patients were lost to follow up (LFU) between 2007 and 2008. This rate rose to 5.5% between 2008 and 2009. Of the patients lost to follow up in 2008, 25% were monitored again in 2009. There were more LFU among the most recently diagnosed patients and those from Sub-Saharan Africa. There is no national or international system for tracing patients lost to follow up.

AIDS

Of the 25,855 people whose HIV infection has been diagnosed since 1995, a cumulative total of 4,208 people were diagnosed with AIDS at 31 December 2011. Of these, 1,712 were alive and medically monitored at the end of 2011. In terms of the temporal trend in the number of new patients, a plateau was observed from 1991 to 1995, with an average of 255 cases diagnosed per year.

The incidence reduced sharply during 1996 and 1997 (-50%) due to the use of new antiretroviral combinations. However, this decrease halted in 1998, and the annual number of identified cases stabilised.

The halt in the reduction of the incidence of AIDS observed since 1997 seems to be connected, at least partially, to the number of patients discovering their seropositivity when AIDS is diagnosed. The proportion of patients discovering their seropositivity on diagnosis of the disease was 21% in 1995 and 1996 and 38% in 2010-2011 (41% in heterosexual patients and 37% in MSM).

The number of deaths related to the disease has fallen sharply. This fall is linked to the use of new antiviral combinations which began in 1996.

IV. Prevention

Introduction

HIV prevention requires an integrated strategy which combines primary prevention, screening and care including promoting the use of condoms and lubricant (and access to sterile syringes for injecting drug users), awareness of serostatus and where someone is seropositive, access to treatment that can achieve an undetectable viral load. Prevention, screening and treatment of other STIs are also very important, given the interactions between HIV and other STIs and particularly because the presence of an STI increases the risk of HIV transmission and vice-versa.

Primary prevention should be closely combined with the development of more effective screening strategies and both treatment and prevention.

This National Plan therefore aims to reduce the incidence of HIV and other STIs through these three strategic pillars. This section specifically covers primary prevention actions, but these should be implemented in an integrated way, in synergy with the other two pillars.

Primary prevention itself cannot be reduced to information strategies on the subject of HIV and other STIs. If this information is necessary, it must be part of a process to promote sexual health that acts on various individual, relationship and structural considerations in terms of physical, mental and social health.

The actions in this section are presented for two priority audiences, namely men who have sex with men and migrants. Other audiences are also taken into consideration, including people living with HIV, the general public, young people, sex workers, injecting drug users and prisoners.

Actions aimed at priority groups

1. *Men who have sex with men (MSM)*

ACTION 1: Inform and raise awareness about preventing HIV and other STIs and strengthen the capabilities of stakeholders

Whether through the organisation of specific campaigns or actions, the recommendation is to:

- ✓ pay particular attention to commercial LGBTQI venues, inclusive events, the internet and outdoor meeting places
- ✓ develop and conduct these campaigns and actions in close partnership with all those involved on the ground
- ✓ pay particular attention to STIs, given the target audience's lack of knowledge on this subject
- ✓ in addition to the information traditionally provided, supply information about preventative treatments and combined prevention issues (HIV and STI screening, post-exposure treatment, treatment as prevention, pre-exposure treatment, the effect of an undetectable viral load on the transmission risk)
- ✓ develop specific prevention information and tools for young MSM, for example using new technologies and social networks

- ✓ raise awareness, inform and train intermediaries and contacts in the association and commercial LGBTQI networks.

ACTION 2: In commercial gay venues, especially where sex is possible, guarantee easy and free access to condoms and water- and/or silicon-based lubricant

2. Migrants

ACTION 3: Inform and raise awareness about preventing HIV and other STIs and strengthen the capabilities of stakeholders

Whether through the organisation of specific campaigns or actions, the recommendation is to:

- ✓ promote local initiatives
- ✓ develop both individual and group counselling
- ✓ produce information focusing on:
 - HIV and STIs
 - contraception
 - the use of male and female condoms and lubricant
 - preventative treatments and combined prevention issues (post-exposure treatment, treatment as prevention, pre-exposure treatment, the effect of an undetectable viral load on the transmission risk)
 - healthcare or assistance organisations likely to provide better information to the target group
- ✓ work specifically so that talking about sexuality and sexual health is no longer taboo in this target group
- ✓ develop and conduct these campaigns and actions in close partnership with all community stakeholders, paying particular attention to the role of religious leaders and more generally, train contacts and intermediaries in the association networks
- ✓ take into account target group diversity and develop tools adapted to these specific characteristics

It is also recommended that a *health card* be produced for migrants with a view to providing this audience with information about the healthcare system and the organisations they can go to with a specific focus on issues related to sexual health.

ACTION 4: Guarantee, especially in areas with a high migrant population, easy and free access to condoms and water- and/or silicon-based lubricant.

3. Common actions aimed at MSM and migrants

Introductory comment: The actions common to MSM and migrants are actions that should be carried out for both MSM and migrants, taking into account, the specific characteristics of each of these groups.

ACTION 5: Develop a methodology for social-behavioural monitoring and research and research-actions to improve the identification of the behaviours of priority populations, monitor the development of these behaviours over time and identify the various determining factors within them.

ACTION 6: Implement campaigns, tools and policies that promote the development of a non-discriminatory and non-stigmatising environment within these target groups.

This environment should:

- enable PLHIV, if they so wish, to talk about their status in their social environment
- facilitate a dialogue about sexuality and the related risks within the target groups

Actions aimed at other population groups

1. Persons living with HIV (PLHIV) and their partners

ACTION 7: Ensure the distribution of comprehensive information on prevention strategies (wearing condoms, post-exposure treatment, treatment as prevention, pre-exposure treatment, the effect of an undetectable viral load on the transmission risk)

ACTION 8: Implement innovative strategies in terms of counselling

The recommendation is to:

- ✓ support online, group, peer and couple counselling outside hospital establishments
- ✓ pay particular attention to supporting the partners of PLHIV

ACTION 9: In stable serodiscordant relationships that express such a wish and where the PLHIV is undergoing treatment that has resulted in an undetectable status for over 6 months, the specialist may suggest not using condoms.

This recommendation should be followed in accordance with the conditions set out by the Belgian Superior Health Council (Conseil Supérieur de la Santé - CSS) in its opinion on the guidelines for the use of condoms by HIV-serodiscordant partners receiving antiretroviral treatment. The STIs which should appear on the list, based on this opinion, will be produced by a committee of medical experts.

2. General population

ACTION 10: Improve the capabilities of psycho-medical-social organisations

It is recommended that, via basic and/or further training, the capabilities of all organisations offering medical, paramedical, psychological or social support, working in the private sector or in medical centres, family planning centres, hospitals, clinics, maternity wards, mental health institutions, nursing homes, prisons, reception centres for asylum seekers, occupational healthcare, etc. are improved.

The recommendation is to educate them, particularly in the reception of MSM, migrants, injecting drug users, young people and sex workers and for them to have an approach that takes the cultural and social specifics of these groups into consideration.

The objective is to improve their role in terms of prevention, but also the support of PLHIV and the development of a non-discriminatory environment to accommodate the aforementioned groups and PLHIV.

ACTION 11: Implement campaigns, tools and policies that promote the development of a non-discriminatory and non-stigmatised environment within society for PLHIV, LGTBQI and migrants.

ACTION 12: Raise awareness about the use of condoms, break down barriers and develop arguments for this use.

ACTION 13: Study the barriers to and arguments for the use of condoms

It is recommended that the specific features of the aforementioned barriers and arguments are considered depending on the groups (migrants, women, young people, MSM, etc.)

3. Women who have sex with women (WSW)

ACTION 14: Implement campaigns, tools and awareness policies designed specifically for the sexual health of WSW.

4. Youth

ACTION 15: Implement campaigns, tools and awareness policies specifically designed for young people.

The objectives of these campaigns, tools and policies are to:

- ✓ educate and inform about STIs including HIV
- ✓ foster the development of an environment that facilitates a dialogue about sexuality and the related risks
- ✓ encourage a healthy sexuality in young people, without fear of discrimination
- ✓ facilitate access for young people to information and services about sexuality - including medical services - particularly through the use of technology and social networks

The recommendation is to work closely with the school network, organisations caring for young people, youth associations, etc. in both the development and implementation of campaigns, policies, etc.

ACTION 16: Train education and health professionals and parents on relationship and sex education.

ACTION 17: Facilitate access to vaccines that according to the international scientific community and based on 'EBM' criteria are highly likely to protect young people from sexuality-related risks.

5. Sex workers

ACTION 18: Implement campaigns, tools and awareness policies designed specifically for sex workers and their clients.

The objectives of these campaigns, tools and policies are to:

- ✓ Educate and inform about:
 - HIV and STIs
 - preventative treatments and combined prevention issues (post-exposure treatment, treatment as prevention, pre-exposure treatment, the effect of an undetectable viral load on the transmission risk)
 - healthcare or assistance organisations likely to provide better information
- ✓ Facilitate access for sex workers and their clients to information and services related to sexuality

ACTION 19: Raise awareness of the issue of sexual health among internet sex workers and specialist website managers.

ACTION 20: Organise local and accessible healthcare and social assistance for sex workers and establish a level of trust with sex workers in their environment.

6. Injecting drug users

ACTION 21: Develop peer-based prevention initiatives

ACTION 22: Improve access to syringes and equipment to prevent and reduce the risk and develop safer consumption sites for injecting drug users.

ACTION 23: Develop and provide specific tools for injecting drug users to promote prevention and sexual health.

This means improving the knowledge and abilities of injecting drugs users to enable them to reduce injection-related and sexual risks (cross-risks)

ACTION 24: Define a coherent legal framework for drug users with public health and risk reduction objectives.

ACTION 25: Develop a better understanding of the profile of users and their behaviours and evaluate risk reduction actions.

ACTION 26: Integrate risk reduction related to drug use into care and treatment consultations for injecting drug users.

7. Prisoners

ACTION 27: Improve the knowledge and abilities of prisoners in terms of preventing HIV and other STIs and reducing the risks related to drug use and the sharing of drug, tattooing and piercing equipment.

ACTION 28: Improve discrete access to condoms and water-based lubricants in prisons.

ACTION 29: Reduce the stigma associated with drug users in prison.

ACTION 30: Research and evaluate interventions in the prison environment in order to develop suitable health actions.

ACTION 31: Establish a context conducive to health promotion in the prison environment, particularly by training prisoners so that they become health workers within the prison and by raising the awareness of prison staff.

Pre- and post-exposure prophylaxis

There is increasing evidence supporting the key role of treatment in preventing the transmission of HIV.

1. *Non-occupational post-exposure prophylaxis (NONOPEP)*

Non-occupational post-exposure prophylaxis is defined as the use of a combination of two or three antiretroviral drugs in people who may have been exposed to the HIV virus, generally after sexual intercourse, including certain acts of sexual violence involving penetration.

In Belgium, non-occupational post-exposure prophylaxis is used and reimbursed. In recent years, the use of non-occupational post-exposure prophylaxis has increased annually. In 2011, 738 courses of non-occupational post-exposure prophylaxis treatment were recorded. Many different antiretroviral regimens were prescribed.

The majority of patients benefiting from non-occupational post-exposure prophylaxis were men of between 20 and 50 years of age. Of these men, most were MSM. For both MSM and heterosexuals, the prophylaxis was usually applied following unprotected sexual intercourse or after a condom broke with a HIV+ partner.

In terms of women, most received post-exposure prophylaxis following a rape or after a condom broke with a HIV+ partner.

Onder de heteroseksuele mannen werd de profylactische behandeling na niet-professionele blootstelling gebruikt ten gevolge van een onbeschermd seksueel contact of een gescheurd condoom van een sekswerkster, een seropositieve partner of een partner met een risico van HIV-besmetting.

From the failures observed in the current system, we note the lack of standardised treatment regimens, leading to significant cost differences compared with an amount allocated as a lump sum. Furthermore the data quality is sub-optimal or non-existent (no record of the adherence to prophylaxis, side effects, etc.) because there is no monitoring and evaluation system. There is also a significant lack of knowledge about post-exposure prophylaxis in the relevant priority groups, hence the probable under-use of this intervention.

2. Occupational post-exposure prophylaxis (OPEP)

Occupational post-exposure prophylaxis is defined as the use of a combination of two or three antiretroviral drugs in a healthcare provider who could have been exposed to the HIV virus, generally after a percutaneous injury, often a needle stick injury.

Several clinical studies have shown that HIV transmission could be significantly reduced by the post-exposure administration of antiretroviral agents. The early use of post-exposure prophylaxis is recommended for exposure to blood, blood fluids, or other potentially infectious agents.

The confidential HIV test (also for hepatitis B and C) for the exposed worker must take place at the time the occupational exposure is reported or within three days following the exposure.

In Belgium, there is an established use of occupational post-exposure prophylaxis. However, certain issues still need to be clarified, such as those about the legal framework for testing the source (issue of informed consent) and that of the optimal regimen.

No quality data regarding continuous evaluation and monitoring objectives is currently collected in Belgium. It would certainly be advisable to develop a feasible evaluation and monitoring system to continue to offer the current services.

3. Treatment as Prevention (TasP)

Treatment as prevention is defined as beginning antiretroviral treatment just after the diagnosis of the HIV infection with a view to reducing the viral load, which reduces HIV transmission. Treatment as prevention involves taking antiretroviral drugs during the early stages of the HIV infection, even if the criteria for beginning the antiretroviral treatment in accordance with the established directives have not yet been satisfied, with the aim of reducing HIV transmission.

Scientific evidence of the effectiveness of treatment as prevention should stem from randomised controlled trials. The fall in the number of people unaware of their HIV infection and long-term adherence to the treatment are important factors influencing the

reduction in transmission using antiretroviral drugs. There is no available data on adhesion for the Belgian population, but the number of patients achieving a persistent undetectable viral load is universally high.

4. Prevention of mother-to-child transmission

Post-exposure prophylaxis was the first, and probably most successful widespread application of combination antiretroviral therapy, reducing HIV transmission without intervention from up to 40% to less than 1%. This includes treatment as prevention of the mother and new-born and monitoring (including long-term) of children born to a HIV positive mother. This intervention has already been successfully applied for many years in Belgium.

Nevertheless, access to care (as well as free antiretroviral treatment) for pregnant women living with HIV is still an issue, although it is an imperative intervention in preventing mother-to-child transmission.

5. Pre-exposure prophylaxis (PrEP)

When used systematically, a combination of oral antiretroviral therapy for pre-exposure chemoprophylaxis against HIV has proved effective and safe in clinical trials with MSM and heterosexual men and women.

Among those MSM with detectable levels of medication in their blood, the risk of contracting HIV was reduced by over 90%. The prophylactic benefits were substantially reduced by non-adherence, indicating that effective pre-exposure chemoprophylaxis programmes must focus on this behavioural variable, in addition to advice on safe sexual practices. We must stress that the data currently available only concerns continuous pre-exposure prophylaxis, while intermittent pre-exposure prophylaxis as an alternative regimen is being evaluated.

6. Actions

ACTION 32: Form a permanent group of experts and stakeholders that will monitor, evaluate and provide guidance on the application and implementation of interventions using antiretroviral drugs.

Monitoring and evaluation (M&E) are vital management and learning tools for improving the planning of current and future programmes, their application and decision-making.

In order to monitor and evaluate the programme, a group of experts responsible for monitoring and providing guidance on the future use of antiretroviral drugs should be set up, gathering evaluation data from all partners and advising on future uses. The team of experts should be comprised of doctors specialising in HIV, scientists specialising in pharmaco-economic studies, public health specialists from different administrative levels, officials from drug regulatory bodies, officials from social security organisations, PLHIV and representatives from priority groups.

ACTION 33: Increase accessibility to non-occupational post-exposure prophylaxis in Belgium.

The recommendation is to revise and extend the directives on non-occupational post-exposure prophylaxis, then provide information on this subject and improve the understanding of post-exposure prophylaxis for HIV in Belgium with general practitioners, the emergency services and the most exposed groups.

ACTION 34: Develop a framework for pilot PrEP projects and operational research to assess the feasibility of PrEP.

ACTION 35: Ensure the existing directives for the prevention of mother-to-child transmission are widely available

It is recommended that the Belgian consensus of 2009 for the prevention of mother-to-child transmission of the HIV infection is updated and these recommendations be distributed to all professionals concerned.

ACTION 36: Improve and extend access to antiretroviral therapy without using CD4 criteria as a restriction

It is recommended that steps are taken with a view to a possible change in the reimbursement criteria for antiretroviral therapy (ART) so that all PLHIV can receive ART whatever their CD4 count. Indeed, the current criteria of the National Institute of Health and Disability Insurance (INAMI) for reimbursing HIV-related drugs allow the administration of ART only if the T CD4+ cell count of patients has fallen to 500 cells/mm³ or less. This measurement prevents doctors from prescribing drugs to patients in a serodiscordant relationship or patients who have recently contracted infections and whose CD4 count is greater than 500 cells/mm³. Patients with high viral loads may be the main drivers of HIV transmission, whatever their CD4 cell count.

V. Screening and access to care

ACTION 37: Develop a national screening strategy for HIV and STIs in accordance with existing regulations.

1. *Strategy principles*

- ✓ screening must be voluntary
- ✓ informed consent must be obtained prior to screening
- ✓ the screening results must remain confidential
- ✓ screening must be supported by appropriate pre-screening information and post-screening counselling (including effective information for the partner and strong links with a reference laboratory, healthcare, treatment and prevention services)
- ✓ access to treatment for HIV and STIs, healthcare and prevention services must be guaranteed regardless of the patient's legal or administrative status
- ✓ screening must be based on a patient risk assessment

2. *Combine different screening models*

- ✓ client-initiated testing (CIT) at healthcare infrastructures and specialist screening sites (VCT) after risk assessment
- ✓ provider-initiated testing (PIT)
- ✓ Testing within communities by healthcare personnel or other providers, with training

3. *Combine different screening entry points*

- ✓ specialist screening infrastructures
- ✓ day clinics specialising in primary care
- ✓ hospitals
- ✓ decentralised screening programmes
- ✓ general practitioners and specialists
- ✓ at home

The combination of different screening entry points should be implemented by balancing the effectiveness of the screening with its cost.

With regards home screening, accessible and reliable information must be communicated to those who will use it, including information in the event of a positive result as explained below. Where necessary, specific information tools must be available (via mobiles, the internet, etc.)

It is recommended that a legal framework is defined for these tests and pilot programmes are carried out to evaluate them and establish recommendations.

4. *Provide and, where necessary, repeat screening for the following groups*

- ✓ all individuals for whom screening gave a negative result, but with possible exposure in the seroconversion time
- ✓ all MSM - biannually or more frequently in the event of continued exposure to the risks
- ✓ all men and women from a country with a high HIV prevalence (>1%) - annually or more frequently in the event of exposure to high and continuous risks

- ✓ sex workers - biannually or more frequently in the event of exposure to high and continuous risks
 - ✓ injecting drug users - annually or more frequently in the event of exposure to high and continuous risks
 - ✓ prenatal care: pregnant women should be offered repeated screening, even if it is refused.
 - ✓ people presenting symptoms that may be associated with sentinel diseases (as listed in "HIV in Europe").
- Consequently, it is recommended that health professionals faced with these sentinel diseases in their specialities are given regular information.

Financial accessibility should be guaranteed for these groups and the obstacles to screening should be identified for each of them, in order to develop corrective actions based on this information.

5. Types of test

The use of a fourth-generation blood screening test with P24 antigen screening in all laboratories is recommended. In the event of a reaction, it should be sent to one of the 7 AIDS reference laboratories for confirmation and notification of a new infection.

Rapid HIV tests could provide a result from a finger prick or oral sample in a few minutes. Their advantage is that they are easy to use if venepuncture is impossible and if a delay in obtaining the results could be detrimental. However, the disadvantages of a test with reduced specificity and sensitivity compared with the sensitive fourth-generation laboratory tests should be kept in mind. Only POTC kits with an EC label should be used and an AIDS reference laboratory should be involved in the issues of governance and guaranteeing the quality of the screening process.

All new HIV cases should be diagnosed based on appropriate confirmation studies and screening must include a second sample. This stage must be combined with tests for the HIV base viral load, STIs and the CD4 count.

6. Provide appropriate information for people screening HIV positive.

It is recommended that, regardless of the screening entry point, the person screening HIV positive can immediately and easily take advantage of comprehensive information about all the structures, organisations and people likely to provide support in the region where they live, so that the PLHIV can follow the treatment correctly, avoid taking any risks and deal with the difficulties they may face, whether medical, social, economic, etc.

ACTION 38: Improve screening by general practitioners and specialists.

7. Incorporate HIV and all its related issues as a compulsory subject in medical training courses.

The following elements should be considered as part of the training:

- ✓ the epidemic of HIV and STIs in Belgium, including the issue of responsibility for collecting data for control purposes
- ✓ HIV/STI screening models
- ✓ HIV/STI screening conditions (informed consent, confidentiality, etc.)
- ✓ (national) regulations and directives regarding HIV/STI screening
- ✓ types of HIV/STI screening

- ✓ disease indicators for HIV or AIDS
- ✓ conditions where not identifying HIV could negatively affect clinical management
- ✓ symptoms of seroconversion
- ✓ evaluation and recognition of the risks
- ✓ communication skills, particularly with regards sexual health; information about previous sexual relations; providing screening results; partner information; counselling
- ✓ practical skills in terms of safe sexual behaviour
- ✓ recognition of the circumstances and symptoms that could be associated with seroconversion
- ✓ training in an approach that takes into account the specific features of the target groups regarding culture, traditions, etc.

HIV/STIs and their related issues should also be incorporated into continuing medical education (CME) for general practitioners and specialists:

- ✓ CME is used to increase awareness and confidence and to improve the skills of medical professionals in assessing the risks of HIV related to sexual behaviour and drug use, offering HIV screening and providing screening results and counselling
- ✓ CME aims to include HIV screening in the routine screening for other diseases, thereby reducing the stigma related to HIV
- ✓ CME raises awareness of disease indicators and symptoms of seroconversion
- ✓ CME uses various (existing) resources including training, symposia, e-learning

8. Provide general practitioners and specialists with technical guidance regarding:

- ✓ recognition of the circumstances and symptoms that could be associated with seroconversion
- ✓ indicative conditions for HIV/STIs or AIDS
- ✓ combined HIV/STI/AIDS screening
- ✓ repeated HIV/STI screening
- ✓ types of tests (ELISA, rapid tests, home tests)
- ✓ decision-making algorithms
- ✓ counselling
- ✓ partner information

9. Support decentralised and demedicalised screening

In accordance with existing regulations, decentralised and demedicalised screening should be developed with a view to targeting priority groups as well as situations presenting a high prevalence and where a high number of late diagnoses may be expected.

10. Establish a legal framework for decentralised and demedicalised screening.

It is recommended that this type of screening be carried out under the following conditions:

- ✓ with properly trained (non-medical) personnel
- ✓ with a quality assurance system
- ✓ with a referral system for counselling and care, i.e. practical pathways to care

It is recommended that national guidelines are drawn up which relate to situations where decentralised and demedicalised screening should be promoted.

11. Extend HIV/STI screening by recruiting a larger workforce, familiar with screening and with the skills to carry it out

12. Develop education and social mobilisation initiatives to encourage people belonging to priority groups to be screened with a view to treatment and promote a different image of screening in these populations under treatment as prevention

13. Identify available HIV/STI screening and assess its respective advantages depending on the context

The regular assessment of the choice of screening is also recommended.

14. Check all reactive screening using specific confirmation screening in one of the seven AIDS reference laboratories

15. Develop community-based screening services with the local ARC and guarantee fast and appropriate access to care, treatment and support services

16. Make an inventory of existing initiatives and standardise data collection tools

The reporting and data collection system for monitoring purposes should be organised nationally, by a single institution. A national inventory of HIV/STI screening sites should be drawn up and continually updated. Standard data collection tools and reporting formats should be designed and used to record information at site level. Data should be analysed nationally, with the return data flow enabling the sites to understand their performances, encourage the sharing of best practices and support the programme's improvement. Indicators should be selected by establishing a logic model for HIV/STI screening, describing the objectives and the logical sequence that connects inputs to activities and processes, leading to outputs, results and finally a targeted impact.

ACTION 39: Increase awareness among and educate those people most exposed to the risk

It is recommended that they are informed about:

- ✓ different screening models
- ✓ the importance of early diagnosis
- ✓ possible symptoms of seroconversion and primary infection
- ✓ test entry points
- ✓ viral load
- ✓ treatment and its benefits
- ✓ access to treatment, care, tri-therapies tolerance, respecting confidentiality
- ✓ PMTCT (prevention of mother-to-child transmission)
- ✓ the existence of PET (PEP)
- ✓ ways of reducing the risks
- ✓ the importance of good sexual health
- ✓ PreP

The use of new technologies (applications, social networks, etc.) is recommended.

ACTION 40: Ensure access to HIV treatment, healthcare and prevention regardless of legal status or health insurance cover.

The development of a (single) national referral procedure for those who do not have access to healthcare in Belgium is recommended, so that they can benefit from screening

and subsequently HIV treatment, care and prevention services. The recommendation is to pay particular attention to people in a precarious socio-economic and/or legal (or administrative) situation. However, this must not lead to discrimination against other patients.

VI. Care of persons living with HIV (PLHIV)

Introduction

Since antiretroviral drugs have become widely available in Belgium and following the reduction in AIDS indicator diseases, life expectancy for PLHIV has steadily increased. HIV has become a chronic infection.

Consequently, PLHIV are faced primarily with a series of pathologies which are not directly related to the HIV infection. The medical care of PLHIV is complicated and requires poly-medication. Furthermore, the HIV infection is more than a purely medical issue. PLHIV must also deal with a complex set of social, psychological, sexual and other problems for which they are also looking for assistance and support. The care of PLHIV requires an overarching and multi-disciplinary approach that must be integrated into a care model.

Following improved survival chances due to ART and the low proportion of new infections, the number of patients monitored has increased by 74% in five years. This figure should be expected to increase again, with on average 1000 new cases of HIV diagnosed per year. A potential increase of around the same size in the number of patients treated should also be expected.

Actions

ACTION 41 : Develop care models

An integrated care model should be created which contains a complete list of all the needs of PLHIV based on international recommendations. All these elements are already included in the care activities of the ARCs. However, they should be structured in a consensus model that takes into account scientific evidence and the cost-effectiveness ratio. PLHIV must be involved in the care model once the diagnosis has been made. Every person diagnosed must be referred to an ARC as soon as possible to be cared for by a specialist experienced in this field.

*

Specific care models (or extensions of the basic model) must also be created for certain patient groups:

- ✓ HIV-positive women who are pregnant or want to become pregnant
- ✓ HIV-positive children
- ✓ HIV-negative children born to a HIV-positive mother
- ✓ [PLHIV without status or with a special status (prisoners, refugees, asylum seekers, etc.)]
- ✓ PLHIV living in nursing and/or care homes

The creation of a national register/cohort for this group of children is recommended.

A protocol should be established for children living with HIV in order to facilitate and optimise the child's transition from paediatrics to a recognised centre.

The care of children living with HIV should be concentrated in a limited number of recognised centres that have the required multi-disciplinary expertise. However, whether or not the number of children concerned is enough to justify this policy will need to be examined.

A national register should be established in order to consolidate data concerning pregnant HIV-positive women.

*

A significant number of PLHIV live in Belgium without status or with a special status (refugees, asylum seekers, prisoners, etc.). Their status can change quickly meaning they have to address different bodies for their healthcare (Public Social Welfare Centres, Federal Agency for the Reception of Asylum Seekers, etc.)

It is recommended that a clear, homogeneous and stable healthcare model be established by healthcare professionals for the groups of PLHIV without status or with a special status.

When returning to their country, PLHIV forced to leave Belgian should continue to have access to the care their condition necessitates.

*

ACTION 42: Adopt national recommendations for the treatment of PLHIV

Belgium should have a set of medical recommendations for the treatment of PLHIV. These recommendations should:

- ✓ be based on international recommendations and "evidence based"
- ✓ be adapted to the Belgian situation (availability, reimbursement and cost of antiretroviral drugs, local epidemiology, etc.)
- ✓ be used to organise a more standardised and consistent treatment for PLHIV
- ✓ be the subject of consensus within a group of Belgian experts
- ✓ be updated regularly

Peer-reviews should be organised with the aim of optimising the application of these national recommendations.

The reimbursement criteria for antiretroviral drugs should be adapted to the Belgian recommendations.

ACTION 43: Improve multidisciplinary support

Multidisciplinary support is needed for PLHIV.

A checklist of the difficulties that PLHIV may be confronted with, not only due to the treatment, but also in their social life should be developed and screening and monitoring instruments made available.

Every PLHIV should be given the opportunity to have access to specialist centres recognised for their expertise, so that they can take advantage of the appropriate support from professionals (psychologists, social workers, sexual and reproductive counselling experts, dieticians, etc.).

At any time, the PLHIV should be free to consult the various members of the multidisciplinary team, or conversely, to refuse the support offered by the recognised centre.

Collaboration between the recognised centres, general practitioners and associations and community partners should be strengthened and structured. This should aim to improve

access to care and appropriate support structures that promote overall health, well-being and the fitness of PLHIV, given the specific characteristics of certain groups such as vulnerable people, pregnant women or those wanting a child, etc.

ACTION 44: Structure the ARC-general practitioner relationship

The responsibility for the care of PLHIV should be shared between the general practitioner and the recognised specialist centres. Care that can be provided by the general practitioner should only be offered in the recognised centres to those who do not have access to a general practitioner. Conversely, care which requires a specific knowledge of the problem related to the HIV infection should be given by specialists at a recognised centre.

The exact and structured division of tasks between the general practitioner and the specialist working in a recognised centre is currently proving difficult for various reasons.

The division of tasks should remain flexible; all care falls under the joint responsibility of the general practitioner and the specialist. Depending on the health of the PLHIV, the focal point of the medical care may vary.

Each patient should be actively encouraged to register with a general practitioner of his choice. Preferably, this will be a general practitioner with an interest and expertise in the field of HIV infection.

A system should be developed that allows the bi- and multi-directional exchange of data (including drug therapy data) on the GMR between the general practitioner and the specialist(s).

The exchange of general information between the ARC and general practitioners should be improved, particularly with regards assistance, counselling and organisations that can be recommended to the patient to help deal with the different difficulties that may arise.

ACTION 45: Improve the management of antiretroviral drugs

National recommendations for antiretroviral treatment based on international recommendations and best clinical practices should be drawn up and adapted to the local situation.

The option to reserve the right for specialist doctors working in a recognised centre to introduce or change the antiretroviral treatment should be considered.

All the data on antiretroviral and others drugs should be included on the GMR of the PLHIV.

Given the importance of the PLHIV's adherence to the prescribed treatment, this adherence must be systematically checked and investigated during every visit by the patient to the treating doctor(s).

For various reasons, (financial, patient accountability, more direct monitoring and checking of adherence by the treating doctor, etc.), consideration should be given to the possibility that the hospital pharmacy could legally distribute antiretroviral drugs.

Subject to the patient's wishes, the possibility that all the data concerning the patient's medication (antiretroviral and other) may, for as long as the patient wishes, be included in a

complete pharmaceutical record held by a city pharmacist chosen by the PLHIV should be examined and supported.

ACTION 46: Improve the geographical coverage of care

The ARCs handle the treatment of most known PLHIV (+/- 85%), but only those patients monitored in a recognised centre can benefit from the agreement signed between the ARCs and INAMI.

It is recommended that the care offer is increased by allowing centres that have already acquired sufficient expertise in the overarching and multidisciplinary care of PLHIV to affiliate themselves with a recognised ARC. Whatever the centre, patients should be able to take advantage of any care currently dispensed to patients in the recognised centres.

ACTION 47: Develop self-management

Since HIV has become a chronic disease, care models encouraging self-management (in terms of adherence, sexual risk management, etc.) must be promoted, because these allow PLHIV to make informed healthcare decisions and be in better control of their own life and health.

PLHIV must easily be able to take advantage of comprehensive information on all the structures, organisations and people likely to support them in the region where they live..

ACTION 48: Develop a protocol to reduce the number of patients lost to follow up

A specific protocol that helps to maximise the reduction in the number of PLHIV lost to follow up should be developed.

ACTION 49: Develop the national cohort

The national cohort should in particular supply information about the following elements:

- ✓ the mode of transmission,
- ✓ whether screening has been delayed or not,
- ✓ the time between diagnosis and the start of treatment,
- ✓ the change in the viral load of patients and measures taken in order to prevent transmission to other people,
- ✓ the quality of life of patients living with the virus (from a social and psychological perspective),
- ✓ the interruption of treatment by some patients and the reasons for this,
- ✓ etc.

This should be used to develop corrective actions based on the data collected.

VII. Quality of life of persons living with HIV (PLHIV)

Actions

Introductory comment: The 'prevention', 'screening and access to care', 'care for PLHIV' sections already contain several actions for improving the quality of life of PLHIV. However, it would also be advisable to:

ACTION 50: Provide better information to PLHIV about their rights (in terms of access to healthcare and against discrimination) and strengthen their abilities to assert these rights effectively

ACTION 51: Combat discrimination against PLHIV in housing, accommodation and reception, work and training and for children living with HIV, in the school environment

ACTION 52: Support a dialogue between social partners, public authorities and insurance companies regarding the issue of uninsurance and/or extra premiums for people living with HIV in order to provide people living with HIV with the same rights to insurance as the general population

ACTION 53: Lobby for the lifting of travel restrictions for PLHIV

VIII. Evaluation and monitoring of the Plan

Introduction

The Plan must have a lasting impact and be implemented appropriately.

To do so, it must rely on permanent and organised bodies, the participation of priority groups, the decisive involvement of PLHIV and be based on scientific evidence.

Both PLHIV and the priority groups should play a decisive role, not only in developing policies but also their implementation. PLHIV cannot be reduced to their condition as patients. Their rights must be guaranteed, including the right to be involved in the decision-making processes where these processes affect their own life or form part of a policy where their experience is a benefit to the public authorities.

A continuous evaluation of the policies based on suitable indicators or tools is vital so that these policies can be adapted where necessary to make them more effective and efficient.

Those involved should be able to consult, communicate, collaborate and discuss regularly within the framework of the Plan's implementation. This applies to both those in the field and those involved at policy level.

Finally, producing the Plan has highlighted that additional data is needed to gauge the policies, whether in terms of prevention, screening or care of PLHIV.

Actions

<p>ACTION 54: Support the establishment of a permanent body for consultation, monitoring and advice</p>
--

In particular, this body's missions should include:

- ✓ supporting the public authorities in implementing the HIV Plan
- ✓ identifying bad practices and proposing corrective actions
- ✓ supplying the public authorities with an annual report on the HIV Plan's implementation
- ✓ at the request of the public authorities or on its own initiative providing recommendations in terms of HIV policy
- ✓ ensuring a regular dialogue between all stakeholders
- ✓ centralising all information, data, studies and research relating to HIV
- ✓ supporting the training and providing continual information to stakeholders
- ✓ exchanging experiences with other countries
- ✓ promoting and supporting scientific research
- ✓ guaranteeing improved consultation between all medical, association, community and commercial stakeholders, PLHIV and public authorities so that they can conduct a joint and concerted action, agreed by all in a given area

This body requires the decisive involvement of:

- ✓ Healthcare professionals
- ✓ Associations working to combat HIV/AIDS
- ✓ Community stakeholders

- ✓ PLHIV
- ✓ The Scientific Institute for Public Health (ISP)
- ✓ Representatives of the authorities in question

ACTION 55: Establish a Council of persons living with HIV (PLHIV)

It is recommended that a Council of PLHIV is set up in order to ensure the decisive involvement of PLHIV in the Plan's implementation regarding prevention, screening, care and improving the quality of life of PLHIV.

ACTION 56: Improve existing data collection measures and support research/surveys with a view to complementing existing data and the evaluation of actions in terms of impact and/or expected results together with quality management to gauge and provide a better assessment of the policies for prevention, screening, care and improving the quality of life of PLHIV.

ACTION 57: Consolidate the role of the AIDS reference laboratories (ARL)

Currently, the 7 ARLs are working more than satisfactorily and in close collaboration (through the Board of Heads of the ARLs). The objective must be to consolidate their current role and improve the way in which they work and the quality of their work even further.

ACTION 58: Guarantee regular policy and administrative consultation

It is recommended that there is regular consultation between the various policy and administrative authorities concerned for the entire duration of the Plan's implementation.

Generally, new structures should not be created where existing ones can be used to take on the tasks listed above.

The status reports on 'prevention', 'screening and access to care', 'care for PLHIV', 'the quality of life of PLHIV' and all other information relating to the HIV Plan are available at:

[www.aidsplan](http://www.aidsplan.be)
[www.plansida](http://www.plansida.be)
[www.hivplan](http://www.hivplan.be)
[www.planvih](http://www.planvih.be) 