Belize Stigma Index 2019

Stigma Index for Persons living with HIV

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MC Consultancy: Sexual Health and Development
BELIZE 2019
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PREAMBLE

“After 36 years of efforts to combat and contain HIV in Belize, our biggest challenge remains combating stigma and discrimination - the #1 barrier to accessing essential HIV services and the #1 cause of death for persons living with HIV.” - Anonymous, Belizean living with HIV

This Stigma Index 2019 Report is a documentation of the realities of stigma and discrimination experienced by persons living with HIV in Belize, a country reporting an HIV incidence rate of 1.9% among adults 15 to 49 years of age.\(^1\) The Ministry of Health has reported that at the end of 2017 there were 4,373 persons living with HIV in the Belize.\(^2\)

This project is being implemented in accordance with the goals and objectives of the global Stigma Index 2.0. The main aim of implementing the People Living with HIV Stigma Index 2.0 in Belize is to broaden understanding of the extent and forms of stigma and discrimination faced by people living with HIV in the country, so that it can be used as a local, national and global advocacy tool to advocate for improved rights for people living with HIV. In particular it seeks to describe the progress made since 2013 when the first Stigma Index was conducted in Belize by the Collaborative Network of Persons living with HIV.

The 2019 Stigma Index has been conducted by the Regional Network of Persons living with HIV in Central America in collaboration with the Collaborative Network of Persons living with HIV, the National AIDS Commission and the Ministry of Health with the technical support of MC Consultancy: Sexual Health and Development. As one of the 4 countries engaged in the regional initiative, the process in Belize engaged persons living with HIV in a significant manner. They served as members of the Study Steering Committee but also participated as interviewers recruiting and interviewing members of the community. The overall purpose was to build local capacity but also enhance ownership of the Stigma Index process in Belize.

The Stigma Index study in Belize was conducted from June to October, 2019 focusing on the 3 most affected districts in the country - Belize, Cayo and Stann Creek districts.

\(^1\) UNAIDS Global Report 2018  
\(^2\) Ministry of Health HIV and TB Surveillance Report 2018
ACKNOWLEDGEMENT

The Belize 2019 Stigma Index for Persons Living with HIV Report is the product of a successful collaborative effort both at the regional and national level. Bringing together key technical partners, stakeholders and community members, the study has resulted in the documentation of the realities of HIV-related stigma and discrimination in Belize.

The expectation is that these findings and recommendations will serve to inform program managers, policy makers and community organizations as they engage in important initiatives and decision-making to enhance the lives of persons living with HIV in Belize.

Special gratitude is extended to the persons living with HIV who were engaged in the process of data collection. Without their efforts to identify, recruit and interview the 495 persons that participated in this study, this report would not have been possible. Thanks for their endless, and selfless commitment to this important process.

Special mention is due to:

*REDCA+ Regional Team and National Focal Points*

*National Steering Committee*

*The Ministry of Health*

*The National AIDS Commission*

*Collaborative Network of Persons Living with HIV*

Lastly, we extend our gratitude to MC Consultancy: Sexual Health and Development consultants Kennedy Carrillo, Liz Aldana and Evelio Cocom for their technical contributions to this process.

May the fruits of their labour serve to enhance the lives of persons living with and affected by HIV in Belize.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CNET+</td>
<td>Collaborative Network of Persons living with HIV</td>
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<td>GNP+</td>
<td>Global Network of Persons Living with HIV</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
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<tr>
<td>NAC</td>
<td>National AIDS Commission</td>
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<tr>
<td>PLHIV</td>
<td>Persons living with HIV</td>
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<tr>
<td>REDCA+</td>
<td>Regional Network of Persons living with HIV in Central America</td>
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<tr>
<td>S&amp;D</td>
<td>Stigma and Discrimination</td>
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<tr>
<td>SI</td>
<td>Stigma Index</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations Joint Program on HIV</td>
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<td>UNDP</td>
<td>United Nations Development Program</td>
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</table>
EXECUTIVE SUMMARY

Many people are in a position of vulnerability, because of their sexual orientation or sexual practices, gender or activities that put them in a position of risk; this is why these findings are important because it reflects these features of stigma and discrimination internal or external; where by on the basis of evidence, allowing to make timely and accurate decisions to design strategies and interventions to reduce stigma and discrimination by a first point to epidemic response; this will also help to guarantee quality health services according to the needs of people with HIV and motivate to productive socio-economic participation of persons living with HIV.

In Belize, thirty-six years after the first-ever reported case of HIV in 1983, the epidemic continues to be of grave concern to local authorities and affected communities. According to UNAIDS, Belize has the highest overall HIV prevalence rate in Latin America and 4th in the Caribbean, with an estimated 1.9% prevalence rate among adults 15 to 49 years. The Ministry of Health reports that as of 2017 there are 4,373 persons living with HIV in Belize. There were a total of 223 new reported cases in 2017.

This project is being implemented in accordance with the goals and objectives of the Belize Stigma Index 2019. The main aim of implementing the People Living with HIV Stigma Index 2.0 in Belize was to broaden understanding of the extent and forms of stigma and discrimination faced by people living with HIV in the country. The specific objectives of the SI was:

- To document the various experiences of people living with HIV regarding HIV-related stigma and discrimination in Belize;
- To compare the situation of people living with HIV with respect to particular issues such as access to health services and stigma and discrimination for reasons other than HIV status such as sex work, diverse sexual behaviours and drug use, if applicable.
- To measure changes since the last Stigma Index in 2013 to answer questions like, “Has the situation with respect to stigma, discrimination and rights of people living with HIV worsened or improved over the last couple of years in Belize?”
- To provide an evidence base for policy change and programmatic interventions.

The findings and recommendations will be used as a local, national and global advocacy tool to advocate for improved rights for people living with HIV.

Utilizing the Stigma Index Version 2.0 questionnaire to collect data and GNP+ Portal to manage and analyse the data the Stigma Index study in Belize was conducted from June to October 2019. Of the original sample size of 500 persons living with HIV, 495 were identified and interviewed in 3 districts of the most affected districts of the country, Belize, Cayo and Stann Creek. The last Stigma Index was conducted in Belize in 2013 when 430 surveys were conducted in all 6 districts of the
country. Of the 430 respondents in 2013, 49.1% identified their gender as women, 48.8% as male and 1.63% as transgender. Of the 495 respondents in 2019, 289 (58.3%) identified their gender as female while 206 (41.7%) identified as male. When asked about their sex assigned at birth 286 (57.5%) identified their sex at birth as female, while 190 (38.3%) identified their sex at birth as male. There were 13 (2.6%) persons that identified as transgender, 3 (1.8%) that did not identify as female, male or transgender and 3 (1.8%) that preferred not to answer.

Overall findings and recommendations:

1. Respondents were unclear about the difference between their sex and their gender identity. There is need for greater education on the topic of sexuality and the differences between one’s gender and one’s sex at birth.

2. Most of the people interviewed stated that they were not excluded from any social, religious and family activities, but they preferred to exclude themselves from activities. There is need to give greater attention to the issue of perceived versus felt stigma and discrimination. Even though the majority of persons living with HIV do not experience actual exclusion, they choose to exclude themselves due to fear.

3. The number of key populations represented in this study was not significant, however, it can be concluded that they do experience discrimination that is not HIV related as well. This compounds the psychological challenges for members of the key populations. Thus, it’s important to put in place programs that cater specifically to the needs of key populations. It is also recommended that a study on stigma and discrimination be conducted with key populations to be able to identify a more significant number.

4. The majority of interviewees access their HIV care and treatment at public or government facilities. This means that more focus needs to be placed on ensuring that public or government facilities are sensitized and have the capacity to work with persons living with HIV and key populations. In particular there is need to continue focusing on the issue of confidentiality as this is a key challenge for persons living with HIV that refuse to access services or do so under much distress.

5. Even though the percentages are not very highly, interviewees still perceive that they are gossiped about, verbally abused and denied their rights due to their HIV status and their gender identity/sexual orientation. This means that stigma and discrimination are still very much issues that persons living with HIV need to contend with on a daily basis. There is need to continue the efforts to introduce non-discrimination laws that will protect persons living with HIV and key populations.

6. The majority of the interviewees indicated that they have disclosed to those that are closest to them such as their partners, children and family members but many still prefer
not to disclose when it is not necessary or to their employers or teachers who they fear may discriminate most against them and affect their employment or education. It’s essential to continue focusing education and advocacy at the workplace and in schools.

7. Interviewees stated that they experience feelings of shame, guilty and have a low self-esteem in relation to their HIV diagnosis which directly affects the acceptance of their diagnosis and the disclosure of the same. The majority of the respondents are struggling with these mental health issues which means that there is a need for more psychological support for persons living with HIV. This needs to be available throughout the entire process from testing to learning to cope with HIV especially as it relates to stigma and discrimination.

8. The majority of laws are unaware of laws that protect persons living with HIV in Belize. This may be due to the fact that there are not many laws that are specifically designed to protect persons living with HIV. However, there are general laws that can protect them such as the Labour Act which stipulates non-dismissal or refusal to employ someone due to their HIV status. There is need for continued education on legislation, human rights as well as building the capacity of persons living with HIV and key populations to advocate for themselves.
INTRODUCTION

I.) The Situation of HIV in Belize

Belize is located in Central America, and is the only English speaking country in the Latin American region apart from Guyana. It has a population of 385,766 inhabitants with a male to female ratio of 1:1. The population is made up of diverse ethnic groups with Mestizos 185,984 (49%) and Creoles 99,298 (24%) being the larger groups. Belize has a very young population with 128,177 (33.2%) below the age of 14 and 86,599 (22.4%) between the ages of 14-24. This means that 55% of the population is below the age of 24. The country is divided into six geographical districts including two major islands serve as the hubs for the tourism industry, the country’s greatest revenue source.

a.) Epidemiological Profile

According to the National AIDS Commission, overall there have been no major changes to the epidemiological contexts for HIV and TB since 2016. However, there continue to be political, programmatic and financial challenges that must be addressed urgently if the country is to successfully maintain its accomplishments and sustain its efforts in achieving universal health coverage including Fast Track targets, End TB targets, and Sustainable Development Goals. Moreover, recent analyses establish putative relationship of the main transmitted strains in the region. The UNAIDS prevention gap report of 2016 reported that estimations show an increase in the annual number of HIV infections in Belize from 2010 to 2015, together with other countries like Nicaragua and Guatemala.

Since 2014 the reported cases have consistently shown that males have been more affected than females. There were 252 new infections reported in 2018 with an estimated 4,915 persons living with HIV. A total of 35,192 HIV tests were conducted in 2018 with yielded a positivity rate of 0.72%. Over the 5 years, women tested for HIV twice as much as men. However, two of every 3 positive HIV results were male. There are a total of 1,455 HIV positive persons receiving anti-retroviral drugs as of 2018. There were 58 cases of HIV reported among pregnant women in 2017, 14 of these were newly detected. There were 16 babies born to HIV positive women in 2016 and babies were infected with HIV. In 2018 the majority of new cases were among the 20 - 44 year olds

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3 Labour Force Survey 2017, SIB
4 Belize Funding Request to the Global Fund, 2018
5 Epidemiological and Cost Modelling for Sustainable HIV/AIDS Finance Planning in Belize, 2017
representing a population within its optimum productive and reproductive age. According to the Ministry of Health, AIDS mortality rate is 2.8/10,000 population with men dying at twice the rate of women at 3.2/10,000. In total there were 108 HIV-related deaths reported in 2017 (39 females, 68 males). In 2017 a total of 57%, 125/220 of all new cases were reported in Belize District which continues to be the most affected region.

b.) Key Populations and HIV in Belize

HIV prevalence among MSM is high in Belize. A 2012 BSS and 2014 Modes of Transmission (MOT) Study indicate a high prevalence rate of 13.8% among MSM (2012 Ministry Of Health/CDC BSS Study, Belize and Modes of Transmission Study, Ministry of Health/PASCA 2014). The 2014 MOT study projected that by 2020, 68% of newly reported cases of HIV would be among MSM and based on trends at the time of the study. To date there has been no study conducted to corroborate this projection. However, the analysis of incoming data continues to provide strong evidence that MSM constitute the most affected key population. Even though there is no epidemiological data on transgender persons and HIV, regional patterns indicate high HIV prevalence among the transgender (TG) population in the region. UNAIDS 2017 estimates show that HIV prevalence for TG women in the LAC region range from 8% to 31% with countries like Mexico and Guatemala bordering with Belize reporting HIV prevalence of 17.4% and 22.2% respectively among transgender women. Key data collected on the TG in Belize population indicates a trend of higher risk and incidence due to socioeconomic factors that increase vulnerability. (Rapid Assessment of the Situation of Transgender Persons in Belize, 2016 TIA Belize/COC Netherlands. A Population Size Estimate Study among men who have sex with men and transgender persons is presently being finalized. The data indicated approximately 13,000 MSM and 900 transgender persons in the country.

2.) Rationale for the People Living with HIV Stigma Index

Stigma is recognized as one of the main obstacles to address prevention and effective response to the epidemic, thus limiting universal access to prevention, treatment, comprehensive care and support for people living with HIV. Discrimination prevents these people to have real access to decent employment, social security, to integrated services and sometimes to education, which contributes greatly to the reduction of quality of life and to the opportunity to improve socioeconomic conditions. Stigma and discrimination associated with HIV is manifested in almost every level of society: community, individual, family, legal, political and programmatic. Although discrimination is a violation of human rights and is expressly

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6 Ministry of Health Epidemiological Report, 2018
7 Ministry of Health Epidemiological Report, 2017
prohibited by international laws and by most national constitutions, discriminatory practices
can actually be institutionalized in laws, policies and practices that have a negative distinction for
persons living with HIV and other marginalized groups for their real or perceived association with
HIV. Discrimination by default, on the other hand, exists when the type, size and nature of the
responses to the epidemic are not in accordance with the level of the epidemic among certain
populations. (USAID/PASCA, 2011).

The Stigma Community Based Response Baseline Assessment conducted by the Regional Stigma
and Discrimination Unit of PANCAP (Pan Caribbean Partnership on HIV) in 2011, indicated that
levels of stigma and discrimination in Belize was one of the highest in the Caribbean. In addition,
recent studies in Central America conducted by both USAID/PASCA (Proyecto Action SIDA de
Centro America) and USAID/PASMO (Pan American Social Marketing Organization) also report that
Belize has one of the highest rates of stigma in Latin America. The first Stigma Index exercise
conducted in Belize in 2013 found that even though efforts have been undertaken to address
stigma and discrimination within the context of HIV as well as key affected populations and there
has been a decrease in S&D in Belize, it is still very much present in the lives of some persons.
There are still those that expressed being discriminated due to their HIV status by their families,
religious and social communities. Persons were still reporting being dismissed from their jobs due
to their HIV status and the psychological impact of HIV was still weighing heavily on many persons
living with HIV causing them to live in isolation, fear and guilt.

Propelled by the existing evidence and the call for the urgent need to address stigma and
discrimination in Belize the Collaborative Network of Persons Living with HIV in Belize (C-NET+)
with the support of key national partners and the Regional Network of Persons living with HIV in
Central America REDCA through its Global Fund "Ensuring, through Political Advocacy Actions,
Universal Access to Health and Respect for Human Rights in the Response to HIV in Central
America, to Improve the Quality of Life of People with HIV." In addition, the Global Fund has
invested in the country to address stigma and discrimination through the National AIDS
Commission that serves as the country coordinating mechanism. Initiatives include raising
awareness on the rights of persons living with HIV and other key populations as well as building
capacity and establishing human rights observatories. Other Global Fund supported initiatives
include efforts to introduce an anti-discrimination law in the country.

The intent of this study is to obtain information that can be used as a national tool for evidence-
based data for the reduction of stigma and discrimination and the promotion of the rights of
people with HIV allowing open spaces where people with HIV can develop and excel in an
environment without stigma and discrimination.
METHODOLOGY

A.) Management

In Belize this quantitative research was consistent with the philosophy and methodology of the People Living with HIV Stigma Index 2.0. Executed by MC Consultancy: Sexual Health and Development, with the support of the REDCA+ Focal Points and a logistics coordinator, the study was managed locally by a Steering Committee comprised of the National AIDS Commission, the Ministry of Health, the Civil Society Organizations Hub and a REDCA+ representative. Regionally, the research was coordinated by a team of technical experts REDCA+. The Steering Committee with the technical support of the Country Technical Team was responsible for the overall successful execution of this project.

Country Technical Team:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Responsibilities</th>
</tr>
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<tbody>
<tr>
<td>Kennedy Carrillo</td>
<td>Lead Researcher</td>
<td>Supervised the overall project in addition to facilitated the training sessions, conducted the analysis of data and developed the report</td>
</tr>
<tr>
<td>Lizet Aldana</td>
<td>Research Assistant</td>
<td>Provide support for the supervision of the interviewees and coordination of the logistics of the training session</td>
</tr>
<tr>
<td>Castillo and Diego Grajalez, CNET+</td>
<td>Logistics Coordinator</td>
<td>Assisted in mobilization, recruitment and administrative matters related to the research in collaboration with the REDCA+ Focal Points</td>
</tr>
<tr>
<td>Names with held</td>
<td>Interviewers (7)</td>
<td>Identified the interviewees and conducted the interviews with the support of the logistics coordinator, the Focal Points and the Research Assistant</td>
</tr>
<tr>
<td>Evelio Cocom</td>
<td>Information Technology specialist</td>
<td>Inputted and compiled the data collected into the GNP+ Data Portal for quantitative analysis</td>
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</table>

The Ministry of Health’s Ethics Committee played an integral part in reviewing and approving the methodology and research design ensuring that it builds on the fundamental commitment to a process that is ethical and representative of the target population and the national context. Persons living with HIV played a critical role as interviewers and interviewees as well as drivers of how the information was collected, analysed and disseminated.
B.) Goal and Objectives

General Objective:

The main aim of implementing the People Living with HIV Stigma Index 2.0 in Belize was to broaden understanding of the extent and forms of stigma and discrimination faced by people living with HIV in the country, so that it can be used as a local, national and global advocacy tool to advocate for improved rights for people living with HIV.

Specific Objectives:

- To document the various experiences of people living with HIV regarding HIV-related stigma and discrimination in Belize;
- To compare the situation of people living with HIV with respect to particular issues such as access to health services and stigma and discrimination for reasons other than HIV status such as sex work, diverse sexual behaviours and drug use, if applicable.
- To measure changes since the last Stigma Index in 2013 to answer questions like, “Has the situation with respect to stigma, discrimination and rights of people living with HIV worsened or improved over the last couple of years in Belize?”
- To provide an evidence base for policy change and programmatic interventions.
- To Process, analyse, consolidate and present the information obtained for the study.
- To be able to conduct cross-analysis of data between countries, across themes or over time.

C. Study Design:

a.) Ethical Considerations:

The ethical endorsement was sought from the Ethics Committee of the Ministry of Health. The Ministry of Health is a member of the National AIDS Commission, the national coordinating mechanism that played an instrumental role in the oversight of this project.
Informed consent was obtained from all interviewees before the interviews were conducted. This entailed provision of standard information on the purpose and benefits of the study as well as what was expected of their participation. The form was in English and translated by the interviewer for those interviewees that do not read or nor understand English. Consideration was given to ensure that interviewers interviewing persons in Spanish were fluent in the language and familiar with the cultural context. Special support was provided to participants that could neither read nor write. Participants were asked to sign the informed consent form or mark an “X” if they were unable to write or sign their names. However, if they choose to participate but not to sign the informed consent form the interviewer signed the form recording that explicit verbal consent was given. If the interviewee did not give their full consent, the interviewer did not sign the informed consent form and the interview was terminated in accordance with the procedures of the User's Guide, 2018.

Confidentiality was one of the key principles of this exercise. Confidentiality was ensured by requiring all persons that came in contact with data at any time to sign a confidentiality agreement (annex 2) which stated that at no point would they share identifying information that they are privileged to during this process. When the investigation was conducted, all efforts were made to ensure that the appropriate measures were established, in such a way that it was absolutely certain that the information revealed by the interviewees, as well as their identity, would be kept confidential. This was accomplished through the use of a unique identifier code for each interviewee. Once the interviews were completed and submitted immediately to the main database, the interviewers did have access to the information. Every effort was made to ensure that the database was kept confidential and only the Information Technology specialist had access to the database. He compiled the data into a report that was submitted to the Logistics Support coordinator to review and then submitted to MC Consultancy for validation and approval. Importantly, the only people who may see the list containing the contact details and codes of all interviewees, the informed consent forms and the completed questionnaires are the interviewers who collected the data and the team leader. Those responsible for data entry, cleaning and analysis did not have access to the list that contains the personal details of the interviewees – or for that matter the informed consent forms.

The informed consent forms are being kept in a safe and secure place, a locked filing cabinet that only the Lead Researcher has access to. The informed consent forms and the list of codes of interviewees are being kept separately. They will be destroyed within a week of approval of the report by all parties involved. (i.e. after all the information has been entered and verified in the database, the process of data cleaning and checking has been completed, and the report has been written up and accepted as a completed product).
b.) The Sample

Adapting Option 2 of the Stigma Index User Guide “Sampling without a list” a combination of sampling methods were adapted to ensure a representative group of people living with HIV. These were:

i.) Purposive sampling:

Participants in this study were recruited from networks and support groups for people living with HIV in three different districts. Permission was also requested from the Ministry of Health for the involvement of Adherence Counsellors in the 3 target districts who collaborate with the designated interviewers for the recruitment of interviewees.

ii.) Snowball sampling

This was based on peer-to-peer recruitment which sought to reach not only registered members of CNET+ but also persons registered with other organizations and support groups in the three target districts, accessing ART and not accessing ART. Individuals who are known members of key populations were identified to recruit people living with HIV who are marginalized for example: men who have sex with men, transgender persons and sex workers. Due to the existing fear of stigma and discrimination among persons living with HIV, this option was be more viable as peers were asked to invite eligible interviewees from among their peers. The interviewers were strategically selected from the 3 districts that have been identified by the National AIDS Commission as the most affected by HIV – Belize including the island of San Pedro, Cayo and Stann Creek Districts).

Based on the present data available from the Ministry of Health on the total number of persons living with HIV in Belize the sampling was calculated with the support of the REDCA+ Regional Index coordinator, using Open Epi - Open Source Epidemiologic Statistics for Public Health. It was determined that a total of 384 persons should be interviewed. However, considering a 30% sample of the population, it was concluded that the sample size should be 500 persons. To cluster by population (heterosexual, sex workers, MSM, Trans) it would have been necessary to have data on the total number of persons from this population that are living with HIV for 2017. Since this data was not available it was important to ensure that among the interviewers there is a proportionate number of persons from diverse populations. All PLHIV that are 16 years and older

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8 OpenEpi provides statistics for counts and measurements in descriptive and analytic studies, stratified analysis with exact confidence limits, matched pair and person-time analysis, sample size and power calculations, random numbers, sensitivity, specificity and other evaluation statistics, R x C tables, chi-square for dose-response, and links to other useful sites. OpenEpi is free and open source software for epidemiologic statistics.
were eligible to participate in the interviews. The sampling was based on the principles of gender equity and the greater involvement of persons most at risk.

c.) Data Collection

The Training of Interviewers was held on May 21st – 23rd, 2019 in Belize City at the ITVET/BTEC Conference Room in Belize City. The 3-day training was facilitated by: Kennedy Carrillo, Liz Aldana and Evelio Cocom (IT Specialist) of MC Consultancy with Logistical support from Diego Grajalez, C-NET+/REDCA Focal Point, and Derrick Castillo-Salazar, Logistics Support Assistant. The training was attended by the 8 interviewers recruited including 4 for Belize District, 2 for Cayo and 2 for Stann Creek. The training agenda and methodology was carried out in accordance with the User Guide indications, with minor adoptions. It was a very interactive 3 days, where knowledge and experiences were shared. During the course of the data collection, two of the trained persons left the study and had to be replaced by two other interviewers that received the training individually to prepare them to carry out their role as interviewers.

Looking at the rate of infection among districts, the Belize District had the highest rate of HIV infection for 2017 with almost twice as much as the Stann Creek District which has the second highest rate of infection followed by the Cayo District. Based on newly diagnosed cases (x 10,000 population) the following sample size was estimated per district:

- **Belize District:** 12.1% Females and 9.6% Males
- **Stann Creek:** 8.2% Males and 4.9% Females
- **Cayo District:** 5.1% Females and 3.9% Males

<table>
<thead>
<tr>
<th>DISTRICT</th>
<th># OF INTERVIEWEES</th>
<th># OF INTERVIEWERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belize District</td>
<td>285 (71)</td>
<td>4</td>
</tr>
<tr>
<td>Stann Creek</td>
<td>142 (71)</td>
<td>2</td>
</tr>
<tr>
<td>Cayo</td>
<td>73</td>
<td>2</td>
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*(Table 1: Number of interviewers and interviewees per district)*

Of the 495 respondents reached, 252 were from Belize district, 140 from Stann Creek district and from 103 Cayo District.
d.) Instruments:

The People Living with HIV Stigma Index 2.0 questionnaire was the main tool for data collection. The interviewers were thoroughly trained in the use of the questionnaire. Interviewers were trained in the application of every component of the questionnaire including how to address possible challenges that may have arisen during interviewing. The methodology of the training session also included basic training and practice in conducting interviews and dealing with difficult situations during the interview.

Electronic tablets were issued to the 8 interviewers. The tablets were specifically for the purpose of administering the questionnaire, entering the data and submitting to the database. The tablets issued served to also capture important information such as GPS locations for where the interviews were conducted as well as duration of the interviews.

The national team including the Lead Researcher, Assistant Researcher and the IT Specialist (all consultants of MC Consultancy) together with the REDCA+ Focal Points and the Logistics Assistant had the responsibility to ensure that the tools were implemented properly and that the required data was being obtained through continuous supervision, consultation of the interviewees and validation of the data before approval. Regular check-ins were carried out via a WhatsApp group that was set up just for the research Why regular check-ins via WhatsApp?

e. Setting up the Interviews

In the case of Belize, interviewers had the option to choose a private setting to conduct their interviews if they were not conducted at the care and treatment centres or clinics. Interviewees were assured privacy when meeting with the interviewer. Support was requested from the Ministry of Health which facilitated access to patients attending the clinic. This was done in coordination with the Adherence Counsellors at the clinics in the 3 districts as well as nurses in-charge of HIV care and treatment. The interviewers had logistical support in setting up their interviews when necessary. This was the responsibility of the REDCA+ Focal Points with support from a logistics coordinator that was contracted by REDCA+ specifically for this purpose.

f.) Important Information and Referrals

Interviewees were provided with an information sheet about the study and other information on resource organizations was provided by the interviewers verbally. In some instances, referrals calls were made to service providers.
g. Data Analysis

The management and analysis of the data was done using the GNP+ Portal computer software package. Following the example of partners that have developed and updated the index this software package was selected and proposed in the protocol. This is a cloud-based MySQL database, with analysis and reporting functions built in. It already includes data sets from over 40 countries that have implemented the index.

The GNP+ Data Portal allowed the country team to:

- Upload and securely store data from the index questionnaires individually and in bulk.
- Conduct quality checks and peer reviews of the integrity of the data.
- Carry out initial analysis of the data.
- Create simple tables and charts for use in reports.
- Have the data available in a ‘portable format’ for upload or export to other analysis packages, such as SPSS™ (which was the software used for the previous Stigma Index Study, 2003).
- Conduct cross-analysis of data between countries, across themes or over time.

Using the data portal allowed the national researcher to manage and analyse data without the need for expensive software packages, high levels of technical expertise or reliance on external sources.

Access to the portal was provided by the REDCA+ Stigma Index Regional Coordinator who has the user name and password which will be shared with the Lead Researcher.

Once the data for the index had been entered, the Lead Researcher identified recurring themes across the study sample and interpreted and analyse the data. Through this final analytical process the Lead Researcher was able to produce a report that documents the key results and findings from the People Living with HIV Stigma Index 2.0

The information was processed on a database called IBM SPSS are, performing crosstabs and getting the results presented below. Also charts and graphs were generated to illustrate the findings.
SECTION A: ABOUT YOU

This section of the report presents demographic data on the persons living with HIV who participated in the study.

A. Sex, gender and Age Representation

Of the targetted sample size of 500 persons living with HIV, 495 respondents were reached in this study. There were more female (58.3%) than male respondents (41%). Even though more females than males participated in this study, the ratio for HIV prevalence among men and women in 2017 shows more males than females infected. In 2013 49.3% women and 48.8% men participated in the Stigma Index study.

Since its important to differentiate between sex assigned at birth and gender identity, respondents were also asked to state their sex at birth. There were 16 persons that identified their sex at birth as different from their actual gender identity. There were 13 persons that identified as transgender and 3 as neither male, female nor transgender. These persons can be classified as gender-non-conforming. There were also 3 (1.8%) that chose not to respond to the question. From the responses, it was evident that some persons were not sure how to respond to this question as some persons were confused about the difference between their sex at birth, sexual orientation and their gender identity. It was important for the interviewers to explain these differences to the interviewees to get a response. Even though the data captured on gender non-conforming persons was low, the percentage was significant enough to be able to make some valid assessment about this group.

The majority of the respondents were between the ages of 25 – 44 years of age. The highest prevalence of HIV in the country is among persons 24 – 49 years of age. Thus, the majority of the respondents were within this age range. One important finding to highlight is that the participation of young persons from the age of 18 – 24 years of age was low. One common complaint across the 3 districts was that young persons were reluctant to participate and share their experiences. Even though efforts were made to ensure that the cadre of interviewers included diversity in sex, gender and ages, the 6 remaining interviewers were all women between the ages of 35 – 55 years, which may have influenced the profile of respondents who participated in the study.

9 Ministry of Health Epidemiological Report, 2017
Of the 495 respondents, 131 females and 121 were males from Belize District, 54 were females and 49 were males in the Cayo District and in the Stann Creek district 104 were females and 36 were males.

Graph 1: Age by Sex Belize Stigma Index version 2.0 (N=495)

The majority of the respondents were aware of their HIV status for more than 5 years. Overall, women had known their HIV status longer than men and the majority of respondents of all ages had known their status more than 5 years. Over the years, life expectancy for persons living with HIV has increased due to the availability of treatment and care. This is very different from the earlier years of HIV when persons would find out that they had HIV when they were already full-blown AIDS. The majority of women 191 (66%) are in intimate relationships while 63% of the male respondents are. Of those that are with an intimate partner or more, 46% indicated that their partner/s are living with HIV while 25% did not know. 25% is significantly high for partners do not know the HIV status of their intimate partners because of the risks of infection or co-infection.
The # of children that the respondents care for ranged from 0 – 15 children, of the respondents 38% (188) have 0 children in their household; Of these 74 (39%) were female and 114 (61%) male. There were a total of 104 (26%) that have 2 children while the most number of children, 15 and 12, are under the care of 1 male and 1 female respectively.

The highest level of formal education for the majority of the respondents was secondary/high school. The level of education is interesting when compared to the level of unemployment which may be due to lack of higher education or could be due to stigma and discrimination for those that have some level of education but are still unemployed.
48.6% (241) indicated that they are able to meet their basic needs some of the time. Of these 58% were females and 42% were males. 35.7% (177) indicated that they are never able to meet their basic needs. Of these 57% were females and 43% were males. 77 (15%) of the respondents indicated that are able to meet their basic needs most of the time. Of these 63% females and 37% male.

The majority of the respondents indicated that they are not members of minority racial/ethnic groups/indigenous, 49 indicated that they are. There were 60 (13%) of persons living with disabilities. Persons living with HIV who are also living with disabilities need to be given special attention as many times it is believe that persons with disabilities are not engaging in sex. In reality, they are risk because they are vulnerable to sexual abuse or they would be living normal sexual lives but may not have the capacity or ability to have safer sex e.g. no access to condoms.

There were 45 respondents that are either mobile, migrant, displaced, refugee or returned immigrants. 13% of the respondents have been incarcerated. Migration brings significant impacts on public health, including vulnerability to HIV/AIDS and sexually transmitted infections (STIs). Mechanisms that may explain the relationship between
migration and HIV vulnerability include social factors, such as the tendency for migrants (especially men) to seek new, concurrent, casual, and/or same-sex partners to ease the isolating experience of migration, as well as exposure to new (often more liberal) social norms for sexual behaviour and substance use. Similarly, the vulnerabilities are the same for mobile, displace and refugees. 13% of persons who have been incarcerated is also very interesting as the prevalence of HIV in prisons is also recognized to be high as prisoners are identified as a key population in Belize.

Graph 5: Percentage of persons that belong to a minority group Belize Stigma Index version 2.0 (N=495)

85.5% indicated that they do not belong to a support network of people living with HIV. 14.5% is a very low percentage for persons who have access to support via a network. The psychosocial support that is received through a support group is very important. However, many persons may choose not to be part of a network because they do not want to be visible or due to general mistrust even towards others that are HIV positive. Such groups serve the purpose of sharing experiences, encouraging disclosure, reducing stigma and discrimination, improving self-esteem, enhancing patients' coping skills and psychosocial functioning and supporting medication adherence and improved retention in HIV care.

11 National AIDS Commission, 2016
SECTION B: DISCLOSURE

Disclosure continues to be a challenge for persons living with HIV. The majority are not sure or disagree that disclosing to those closest to them is a positive experience. Many do it because they have not due to the closeness of the relationship and not necessarily because they want to. 55% of the partners know of their status, 38.9% of them have disclosed to their children; 76.5% of other family members know; 48.6% of them have disclosed to their friends; In 2013, 66.9% of persons had disclosed to their partners and 73.7% told adults in the home. Of those that answered that there status had been disclosed, 58% female and 42% males indicated that it was disclosed without their consent. In 2013, 5.5% indicated that their status had been disclosed without their consent. Persons who experience disclosure without their consent are many times more fearful of discrimination. They make a conscious decision not to disclose to those they feel may discriminate them most such as abusive partners or family or employers or schools that may take away their rights to employment or education. The majority of persons indicated that people that they are close to were somewhat supportive but overall, the experience is not a positive one for the person that has to disclose or has their status disclosed.

Graph 6: Percentage of persons who they have told about their HIV status  Belize Stigma Index version 2.0 (N=495)

SECTION C. Your Experience of Stigma and Discrimination

The different variables included in this section were used to evaluate different dimensions of stigma and discrimination experienced. However, it is possible important to assess the results against the background of disclosure or non-disclosure of persons’
HIV status. The findings show that persons living with HIV are hesitant to disclose their status, particularly to persons outside of their families.

Stigma and discrimination poses many barriers to access to services for persons living with HIV and key populations. It is seen as the most singular challenge for persons living with HIV. However, the percentage of discrimination experienced as shown in this study is not as high as it was in 2013.

*Graph 7: Experiences of discrimination in 2013 and 2019 Belize Stigma Index version 2.0 (N=495) and Stigma Index version 1.0 (N=430)*

<table>
<thead>
<tr>
<th>Discrimination</th>
<th>2013</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excluded from Social Gatherings</td>
<td>33.1% (165)</td>
<td>8.8% (44)</td>
</tr>
<tr>
<td>Excluded from religious gatherings</td>
<td>15.8% (78)</td>
<td>4.2% (21)</td>
</tr>
<tr>
<td>Excluded from family activities</td>
<td>34% (170)</td>
<td>14.7% (73)</td>
</tr>
</tbody>
</table>

The majority of those that have indicated that they experienced some form of discrimination, experienced it before 12 months ago. Most of the experiences were not as evident in the past 12 months. Of the total of 495 respondents 44 (8.8%) indicated that they have been excluded from social gatherings while in 2013, 33.1% (165) indicated the same. Of those that experienced discrimination, there was a higher percentage of women than men.

Of the 495 respondents, 21 (4.2%) persons indicated that they have been excluded from religious activities or places of worship because of their HIV status, while in 2013, 15.8% (78) indicated the same. Of the 495 respondents, 73 (14.7%) persons indicated that they have been excluded from family activities because of their HIV status, in 2013, 34% (170) experienced the same. Thus, in 2013 the interviewees reported higher levels of discrimination than in 2019.
Comparatively speaking, the discrimination experience by those that were affected, included more verbal discrimination than physical. In addition, persons that experienced discrimination once again had greater experiences of discrimination before 12 years ago. Of the 495 respondents, 230 (46.4%) persons indicated that they have been aware of other people other than their family members making discriminatory remarks of gossiping because of their HIV status, of these 76 (33%) experienced this within the past 12 months while 154 (66.9%) experienced it but not in the last 12 months. Of the 495 respondents, 130 persons (26.2%) indicated that their partner has experienced discrimination because of their HIV status, of these 130, 20 (15.3%) experienced this within the past 12 months while 110 (84.6%) experienced it but not in the last 12 months. It is important to note that more women than men experienced social exclusion.

Fear of being rejected, judged or being gossiped about by others including family members, discourages persons living with HIV from disclosing and from accessing essential HIV services. There were (26) 5% that indicated that they have been refused employment or lost a source of income or job because of their HIV status with the majority being before 12 months ago. In comparison, the respondents in 2013 experienced significantly more gossipping or discriminatory comments including physical aggression because of their HIV status than the respondents in 2019.
Thus, based on the results of this study it can be concluded that persons living with HIV both men and women do not disclose to their status to their neighbours, employers/colleagues, religious leaders or school mates or administration. Most are comfortable disclosing to close family members and friends and disclosure only happens out of necessity when support is needed from those that are close to the person. In addition, the level of discrimination experienced in 2019 is not as high as what was reported by the respondents in 2013. The survey did not probe the reasons for this, however, there are anecdotes that suggest that people who are living with HIV for very long periods become less affected by harassment and may not be as subjected to harassment, as people—and particularly their families—see them as “less of a problem.”

**SECTION D: Internal Stigma (the way you feel about yourself) and Resilience**

The majority of the interviewees indicated that their HIV status has not affected their self-awareness and worth. They also stated that their ability to respect others has not been affected by their status. However, the percentage of the persons that are affected ranges from 0 up to 20% which means that there are still factors that are causing these persons to be affected. For example, a total of 241 females and 148 males (80.6%) stated that their self-confidence has not been affected by their HIV status. Similarly, 257 females, 159 males and 9 transgender persons (86.8%) stated that their self-respect has not been affected by their HIV status. This could be due to lack of emotional support from family or friends as indicated in the results below. In addition, this could be due to
the fact that the majority of the respondents do not disclose their status thus, they are not affected by the attitude of others towards their undisclosed HIV status.

**Graph 10: How their HIV status has affected their abilities**  
Belize Stigma Index version 2.0  
(N=495)

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>I hide my condition from others</td>
<td>49.1%</td>
<td>33.5%</td>
</tr>
<tr>
<td>I feel worthless</td>
<td>17.8%</td>
<td>14.7%</td>
</tr>
<tr>
<td>I feel ashamed</td>
<td>15.6%</td>
<td>12.1%</td>
</tr>
<tr>
<td>I feel guilty</td>
<td>17.6%</td>
<td>15.8%</td>
</tr>
<tr>
<td>I feel dirty</td>
<td>11.3%</td>
<td>9.1%</td>
</tr>
<tr>
<td>Hard to tell someone my condition</td>
<td>48.5%</td>
<td>34.1%</td>
</tr>
</tbody>
</table>

When asked if their ability to cope with stress has been affected by their HIV status, 96 (19.3%) persons including 39 males, 48 females and 8 persons that identified as transgender indicated that their ability to cope with stress has been negatively affected. Some persons are still affected by stress due to their HIV status. A total of 364 (73.5%) persons stated that their ability to find love has not been affected by their HIV status, including 222 females, 136 males and 3 persons that identify as transgender. Although, that there is no direct correlation between stress and worsening HIV, research has shown that stress can weaken the immune system, making it less able to fight off infections. And the effects of stress don’t end there as stress and depression can trigger poor HIV self-care.

A total of 397 (80.2%) persons stated that their achievement of personal and professional goals has not been affected by their HIV status, including 233 females, 152 males and 7 persons that identify as transgender. A total of 401 persons (81%) stated that their ability to contribute to their community has not been affected by their HIV status, including 242 females, 144 males and 10 persons that identify as transgender. A total of 401 (81%) persons stated that their ability to practice a religion/faith as they want to has not been affected by their HIV status, including 245 females, 150 males and
2 persons that identify as transgender. 213 (43%) stated that their ability to need their needs due to their HIV status is about the same including 110 females, 88 males and 10 persons that identified as transgender; 239 (48%) stated that it was better including 156 females, 81 males, 8 and 1 transgender persons;

*Graph 11: Experiences with Gossiping or discriminatory comments because of their HIV status in 2013 and 2019  Belize Stigma Index version 2.0  (N=495)*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Positive Affect</th>
<th>Negative Affect</th>
</tr>
</thead>
<tbody>
<tr>
<td>My ability to practice a religion/faith as I want to</td>
<td>3.6%</td>
<td>11.1%</td>
</tr>
<tr>
<td>My ability to contribute to my community</td>
<td>2.6%</td>
<td>13.9%</td>
</tr>
<tr>
<td>My achievement of my personal or professional goals</td>
<td>4.2%</td>
<td>17.8%</td>
</tr>
<tr>
<td>My desire to have children</td>
<td>8.1%</td>
<td>18.6%</td>
</tr>
<tr>
<td>My ability to find love</td>
<td>3.6%</td>
<td>19.8%</td>
</tr>
<tr>
<td>My ability to have close and secure relationships with others</td>
<td>3.0%</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

173 (34.9%) have indicated that they have chosen not to attend social gatherings. Of the 173 that have chosen not to attend social gatherings, 92 were female and 81 were male. 70 (14%) have indicated that they have chosen not to seek health care. Of the 70 that have chosen not to seek health care, 47 were female and 23 were male. 87 (17.5%) have indicated that they have chosen not to apply for a job(s). Of the 87 that have chosen not to apply for a job, 58 were female and 29 were male. (33.9%) have indicated that they have chosen not to seek social support. Of the 168 that have chosen not to seek social support, 92 were female and 76 were male. 183 have indicated that they have isolated themselves from family and friends. Of the 183 that have isolated themselves from family and friends, 99 were female and 84 were male. 107 (25%) have indicated that they have decided not to have sex due to their status. Of the 107 that have decided not to have sex, 64 were female and 43 were male.
When asked if it is difficult to tell people about their HIV infection, 409 (82.6%) persons stated that it is difficult, including 240 females and 169 males. When asked if being HIV positive makes them feel dirty, 101 (40%) persons stated that HIV positive makes them feel dirty, including 56 females and 45 males. When asked if they felt guilty that they have HIV, 165 (33.3%) persons stated that they feel guilty that they are HIV positive, including 87 females and 78 males. When asked if they ashamed that they have HIV, 137 (27.6%) persons stated that they feel ashamed that they are HIV positive, including 77 females and 60 males. When asked if they feel worthless because they are HIV positive have HIV, 161 (32.4%) persons stated that they sometimes feel worthless because they are HIV positive, including 88 females and 73 males. When asked if they hide their HIV positive, 409 (82.6%) persons stated that they hide their HIV status from others, including 243 females and 166 males. In 2013 similarly, interviewees expressed that they experienced negative feelings because of their HIV status. In 2013 56.2% reported feeling ashamed while 67% felt guilty. The psychological impact experienced by persons living with HIV many times is not as a result of their HIV status but because of their fear of stigma and discrimination.
Graph 13: Experiences with Gossiping or discriminatory comments because of their HIV status in 2013 and 2019 Belize Stigma Index version 2.0 (N=495)

The majority of the respondents indicated that their capacity to meet their needs is the same (45%) or has gotten better (45%) in the past year. Thus, it can be concluded that persons are better able to cope with HIV and the related stigma and discrimination or they are not disclosing as much and thus, are not affected by stigma and discrimination.

Graph 14: Percentage of persons whose capacity to meet their needs was better or worse in the past year Belize Stigma Index version 2.0 (N=495)
SECTION E. INTERACTIONS WITH HEALTHCARE SERVICES

HIV Testing, Care and Treatment

Among persons living with HIV, there is always concern about discrimination within the health sector as disclosure is necessary to be able to access the services needed by persons living with HIV. Higher levels of discrimination may be expected even though the expectation is that with high levels of trainings and sensitization, there should be less discrimination within this sector.

When the 495 respondents were asked if it was their choice to be tested, 223 (45%) females stated that it was their choice while 163 (26.2%) males indicated same, this was a total of 386 (77.9%) persons. This means that 23% of the interviewees stated that they were tested without it being their choice. This is a significant percentage since it is a violation of an individual’s right to be tested without their consent or to be pressured to be tested. In 2013, only 2.7% indicated that they were tested without their knowledge which shows a significant increase in 2019. According to their age, 75 persons that stated that it was their choice to be tested were between the ages of 35-39 years while 57 were between the ages of 40 – 44.

When asked what was the main reason for getting testing for HIV, 144 (32.1%) indicated that they felt sick. While in 2013, 16.5% tested because of illness. This means that more persons are deciding to get an HIV test when they are not feeling well which could mean that there is greater awareness about the need to get tested and to be placed on treatment now.

There were 137 (27%) persons that indicated that they believed that they were at HIV risk, including 82 females and 52 males in 2019 while in 2019 15.35% felt that they were at risk. There were 202 persons (45.1%), 115 females and 87 males indicated that they waited 6 months or less between the time they thought they should get an HIV and they took it. There were 153 (34.2%) persons who indicated that they waited more than 6 months to 2 years between the time they thought they should get an HIV test, and they actually got it this included 91 females and 62 males. Of the 495 respondents, 330 (66.6%) persons indicated that their fears about how other people would respond made them hesitate taking a test.

Of the persons that responded yes, 89%, 64 males and 103 females were worried that their partner, family or friends would find out their HIV status; 55%, 61 males and 74
females were worried that other people (not family or friends) would find out their status; 49%, 105 males and 74 females indicated that they were not ready to deal with their HIV infection; 35%, 180 males and 245 females indicated that they were afraid that health workers would treat them badly or disclose their status without their consent; and 28%, 107 males and 155 females had bad experiences with a health worker previously. Persons indicated that their fears about how people will respond to their HIV status prevents them from being tested or accessing services. Perceived fear is more prevalent than actual discrimination.

**Graph 16 : Percentage of persons who delayed accessing services due to fear of discrimination**

Belize Stigma Index version 2.0  (N=495)

Of the 495 respondents, when asked how long after being diagnosed did they begin their antiretroviral treatment, 131 (26%) indicated that they started immediately or the same they were diagnosed; 92, 19% indicated that they started from 1 day to 1 month after being diagnosed; 89 (18%) indicated that they started antiretroviral treatment from 1 month to 6 months after being diagnosed.

The majority of respondents who chose to start ARVs did so after they were counselled by someone. 235 (52%) including 141 females and 94 males indicated that they were told the benefits and they chose to start as soon as it was offered to them; 182 (41%) including 99 females and 83 males indicated that when treatment was offered to them, they took the decision to wait and start at a later time.

A significant percentage of persons that responded are currently on ARVs - 411 (83%) this includes 239 (58%) females and 172 (41.8%) males. However, when asked if in the last 12 months they had been told that they have an undetectable viral load or are virally suppressed, 237 (48%) person including 128 females and 109 males indicated that they
have been told that they are virally suppressed while the others are not or have taken a viral load test but have not received the results. In 2013 67% of the respondents indicated that they were on ARVs indicating an increase of 16% in 6 years.

Graph 17: Percentage of persons who have had a viral load
Belize Stigma Index version 2.0 (N=495)

Of the total of 495 respondents, 83.1% are on antiretroviral therapy while 47.9% are virally suppressed. This is indicative of the challenge that Belize continues to have with low viral suppression compared to the percentage of persons on ARVs. The 2017 cascade shows 56.8% on ARV and 37.4% virally suppressed at the national level.

Graph 18: Percentage of persons on antiretroviral treatment in 2013 and 2019
Belize Stigma Index version 2.0 and Belize Stigma Index 1.0 (N=430)
Overall, the majority of respondents have not contracted other diseases and infection but a significant percentage, 61 (12.3%), persons that contracted a sexually transmitted infection (herpes, gonorrhoea, chlamydia, syphilis). There were 46 persons that experienced some mental health issue (depression, anxiety, insomnia, post-traumatic stress). This very important as it shows the need for more emotional and psychological support for persons living with HIV. 46% indicated that they felt nervous, anxious or on edge; 51% indicated that they have not been able to stop or control worrying over the past 12 months and 36% have never been able to stop or control worrying over. Of the respondents that had experienced some of the problems mentioned in Q35, 362 indicated that they had not received any type of support in the past 12 months.

Graph 19: Percentage of persons who contracted other diseases and infections and were treated Belize Stigma Index version 2.0 (N=495)

Service Delivery Experiences

The majority (375 – 75.7%) of the 495 respondents indicated that they usually receive their regular HIV care and treatment at a government or public clinic or facility. The percentage of persons that have experienced overt discrimination is not significant. Most of the discrimination that is experienced seems to be covert such as gossiping behind their backs, people looking at them different or talking to them different. Most of the discrimination experienced has also been before 12 years ago. Of those that have accessed services over the past 12 months only 8 (2%) indicated that they had experienced denial of health services because of their HIV status. Of those that have accessed services over the past 12 months only 8 (2%) indicated that they had been advised not to have sex because of their HIV status. Of those that have accessed services
over the past 12 months only 71 (15%) indicated that they had been talked about or gossiped about because of their HIV status – 43 were female and 28 were male. Of those that have accessed services over the past 12 months only 28 (6%) indicated that they had experienced verbal abuse because of their HIV status – 21 were female and 7 were male.

Graph 20: Percentage of persons who experienced some form of discrimination in the health care setting Belize Stigma Index version 2.0 (N=495)

Of the 495 respondents, 210 (42.3%) indicated that when they go outside the clinic for general health care services, they do disclose their HIV status. Of the 495 respondents, 266 (53.7%) persons including 152 females and 114 males indicated that they don’t know if their medical records are confidential; 7 (11.5%), 43 females and 14 males indicated that it is clear to them that their medical records are not being kept confidential. Fear that their status will be disclosed without their permission by health care workers continues to be a concern similar as it was in 2013 when 54.8% indicated that they were not sure that their records were being kept confidential.

Sexual and Reproductive Health

Regarding their sexual and reproductive health, the majority of interviews indicated that they did not feel coerced or pressured by health professionals to make decisions. Of the 495 respondents, 400 (80.8%) -35% males and 45% females) indicated that a healthcare professional did not advise them to mother/father child; Of the 495 respondents, 419
(84.6%) persons including 238 females and 181 males indicated that a healthcare professional did not pressure or incentivize them to get sterilized; 65 (13.1%) persons indicated that the question was not applicable to them and 2 persons preferred not to answer. Of the 495 respondents, 425 (85.8%) persons including 244 females (49%) and 181 males (37%) indicated that a healthcare professional did sterilize them without their knowledge; 60 persons indicated that the question was not applicable to them and 3 persons preferred not to answer. Of the 495 respondents, 393 (79.1%) persons including 238 females and 151 males indicated that a healthcare professional denied them contraception’s/family planning services. Of the 495 respondents, 394 (79.5%) persons including 240 females and 154 males indicated that a healthcare professional did not tell them that in order to their antiretrovirals they had to use contraception, or a specific method of contraception; 92 (18.5%) persons indicated that the question was not applicable to them.

Of the total number of female respondents, 8 did indicate that they were advised by a healthcare worker to terminate a pregnancy, 2 were pressured to use a particular method of giving birth and 4 were pressured to take anti-retroviral during pregnancy without counselling them on this option.

Graph 21: Percentage of persons who were advised by health professionals to take some medical action due to their HIV status. Belize Stigma Index version 2.0 (N=495)
SECTION F. HUMAN RIGHTS AND EFFECTING CHANGE

Even though the following percentages may not seem significant they are still indicative of human rights violations against some persons living with HIV. This was similar for before 12 months as well as within the past 12 months. Within the past 12 months 8 (1.6%) persons were forced to have sex when they did not want to; 7 (1.4%) persons were forced to get tested for HIV or disclose their HIV status in order to apply for a job or get a pension job; 5 (1.0%) to obtain a visa or to apply for residency/citizenship in a country; there were 4 persons who were denied residency or permission to stay in another country because of their HIV status and 4 (.8%) were denied a visa or permission to enter another country because of their HIV status.

Persons that responded yes but not within the last 12 months indicated the following: 21 (4.2%) were forced to have sex when they did not want to; 9 (1.8%) were forced to disclose their HIV status publicly or their status was disclosed without their consent; 8 (1.6%) were forced to disclose for insurance purposes; 8 (1.6%) for medical insurance; 6 (1.2%) were denied a visa or permission to enter another country while 5 were required to get tested for HIV to attend an education institution or get a scholarship. Three (3 - .6%) persons indicated that they were arrested or taken to court on a charge related to their HIV status but not in the past 12 months.

Graph 22: Percentage of persons who were forced to test or disclose status Belize Stigma Index version 2.0 (N=495)

<table>
<thead>
<tr>
<th>I was forced to get tested for HIV or disclose my status in order to</th>
<th>Yes, but NOT within the last 12 months</th>
<th>Yes, within the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>obtain a visa or to apply for residency/citizenship in a country</td>
<td>54.5%</td>
<td>45.5%</td>
</tr>
<tr>
<td>apply for a job or get a pension plan</td>
<td>53.6%</td>
<td>46.7%</td>
</tr>
<tr>
<td>attend an educational institution or get a scholarship</td>
<td>71.4%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Event</td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td>Get health care</td>
<td>70.0%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Get medical insurance</td>
<td>80.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>I was arrested or taken to court on a charge related to my HIV status</td>
<td>75.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>I was detained or quarantined because of my HIV status</td>
<td>72.7%</td>
<td>27.3%</td>
</tr>
<tr>
<td>I was denied a visa or permission to enter another country because of my HIV status</td>
<td>60.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>I was denied residency or permission to stay in another country because of my HIV status</td>
<td>50.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>I was forced to disclose my HIV status publicly or my status was publicly disclosed without my consent</td>
<td>75.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>I was forced to have sex when I did not want to. “Forced” means physically forced or coerced</td>
<td>72.4%</td>
<td>27.6%</td>
</tr>
</tbody>
</table>

Even though there were some persons that tried to access some form of redress for the violation of their rights, many chose not to do so or those that did report having received little to no redress. Of the 66 respondents that had experienced any of the rights abuses listed in question 44, 13 (19.6%) of them stated that they did try to do something about it while 53 (80.3%) indicated that they did not. Of the 66 that tried to do something, 33 were female, 17 were male and 2 identified as a transgender person. Of the 13 respondents that did try to do something about the rights abuses, 6 (46%) stated that nothing happened/the matter was never dealt with; 4 (30%) stated that the matter was still in process of being dealt with and 3 (23%) persons stated that the matter was resolved.

**Graph 23**: Percentage of persons and reasons for not trying to do something about the human rights violation Belize Stigma Index version 2.0 (N=495)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Females</th>
<th>Males</th>
<th>Prefer not to answer</th>
<th>Trans</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advised against taking action by someone else</td>
<td>1.9%</td>
<td>3.8%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Did not know where to go/how to take action</td>
<td>22.6%</td>
<td>7.5%</td>
<td>0.0%</td>
<td>1.9%</td>
<td>32.1%</td>
</tr>
<tr>
<td>Feeling</td>
<td>13.2%</td>
<td>1.9%</td>
<td>0.0%</td>
<td>1.9%</td>
<td>17.0%</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------</td>
<td>------</td>
<td>------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>Felt intimidated or scared to take action</td>
<td>0.0%</td>
<td>7.5%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Insufficient financial resources to take action</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.9%</td>
<td>0.0%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Lack of evidence for the abuse</td>
<td>7.5%</td>
<td>1.9%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>9.4%</td>
</tr>
<tr>
<td>No/little confidence that the outcome would be successful</td>
<td>3.8%</td>
<td>1.9%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>5.7%</td>
</tr>
<tr>
<td>Other, specify:</td>
<td>1.9%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Process of addressing the problem appeared too complicated</td>
<td>11.3%</td>
<td>7.5%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>18.8%</td>
</tr>
</tbody>
</table>

Of the 53 respondents that chose not to take action, 17 (32%) which included 12 females, 4 males and 1 transgender person indicated that they did not know where to go/how to take action. There are a few organizations that provide support to persons living with HIV in Belize. These are the Collaborative Network of Persons living with HIV, the National AIDS Commission and UNIBAM.

When asked if they were aware of any laws in their country to protect people living with HIV from discrimination, 327 (66%) , including 191 females, 122 males and 9 transgenders persons stated that they do not know if there are any laws. This may be particularly due to the fact that there are not many laws in the country to protect persons living with HIV or key populations from discrimination. In 2013, 27% had heard about the Declaration of Commitment on HIV/AIDS which protects the rights of persons living with HIV. This is indicative of the fact that there still exists a low level of knowledge among persons living with HIV about their rights and the laws that exist or should exist to protect them from discrimination.

Graph 24: Percentage of persons who who know any laws in Belize that protect persons living with HIV Belize Stigma Index version 2.0 (N=495)

<table>
<thead>
<tr>
<th>Do you know if there are any laws in your country to protect people living with HIV from discrimination?</th>
<th>Do not identify as female, male, or transgender</th>
<th>Female</th>
<th>Male</th>
<th>Prefer not to answer</th>
<th>Transgender</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>I do not know if there are laws</td>
<td>0.4%</td>
<td>38.6%</td>
<td>24.6%</td>
<td>0.6%</td>
<td>1.8%</td>
<td>66.1%</td>
</tr>
<tr>
<td>No, there are no</td>
<td>0.2%</td>
<td>5.3%</td>
<td>3.2%</td>
<td>0.0%</td>
<td>0.4%</td>
<td>9.1%</td>
</tr>
<tr>
<td>laws</td>
<td>0.0%</td>
<td>13.9%</td>
<td>10.5%</td>
<td>0.0%</td>
<td>0.4%</td>
<td>24.8%</td>
</tr>
<tr>
<td>-----------</td>
<td>------</td>
<td>-------</td>
<td>-------</td>
<td>------</td>
<td>------</td>
<td>-------</td>
</tr>
</tbody>
</table>

Some persons sought to advocate and take some actions for their rights and that of others through campaigns, working with different organizations or reaching out to their community leaders over the past years. However, many do not have the knowledge and capacity to do so in a manner that can have any major impact.

*Graph 25: Percentage of persons who have taken some action to address stigma and discrimination against themselves and others* Belize Stigma Index version 2.0 (N=495)

<table>
<thead>
<tr>
<th>Action</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spoke to the media about issues of stigma and discrimination against people living with HIV</td>
<td>2.2%</td>
</tr>
<tr>
<td>Encouraged a government leader or a politician to take action about issues of stigma and discrimination against people living with HIV</td>
<td>3.2%</td>
</tr>
<tr>
<td>Encouraged a community leader to take action about issues of stigma and discrimination against people living with HIV</td>
<td>6.5%</td>
</tr>
<tr>
<td>Participated in an organization or educational campaign working to address stigma and discrimination against people living with HIV</td>
<td>11.1%</td>
</tr>
<tr>
<td>Provided emotional, financial, or other support to help someone living with HIV deal with stigma and/or discrimination</td>
<td>25.5%</td>
</tr>
<tr>
<td>Challenged or educated someone who was engaging in stigma or discrimination against other people living with HIV</td>
<td>33.9%</td>
</tr>
</tbody>
</table>

**SECTION G. STIGMA AND DISCRIMINATION EXPERIENCED FOR REASONS OTHER THAN HIV STATUS**

Overall, it was concluded that this question was the most difficult to be completed by the respondents. The questions were a bit confusing and some respondents were not sure how to respond to some of the questions. This may have impacted the results for this section.

Some person report experiencing discrimination not only because of their HIV status but also because of their sexual orientation or gender identity. This compounds the
emotional and psychological challenges for persons living with HIV who are also members of key populations.

Of the 60 (29%) men that indicated that they identify with one of the groups, 21 (35%) identified as MSM, 20 (33.3%) as gay/homosexual and 19 (31.6%) as bisexual.

The MSM that responded indicated that the discrimination most experienced was verbal assaults (3.2%) and remarks from family members (3.6%). Of those the 8 persons that responded to this question, 5 indicated that others who are MSM or have sex with men know that they are gay or have sex with men; 8 indicated that their family and/or friends know and 4 indicated that other persons in the community know. The situation is similar for men who identify as homosexual and gay.

Of the 8 persons that responded to this question, 2 said that they belong to a network of men who have sex with men while 6 stated that they do not.

Graph 27: Discrimination experienced by persons who identify as MSM Stigma Index version 2.0 (N=495)

Similarly, transgender persons have experienced more discrimination in the form of verbal attacks and remarks. The majority of those that have experienced this form of discrimination had experienced it within the past 12 months.

Graph 28: Discrimination experienced by person who identify as transgender within and before 12 months Belize Stigma Index version 2.0 (N=495)
Of the 13 persons that responded, 4 stated that they are in a support group, 8 said no and 1 stated that the question did not apply.

The situation is the same for women who have diverse sexual orientation and preferences but no as high as that experienced by men or trans persons. When asked if they currently or have previously identified as a member of any of the groups, 8 identified as bisexual, 1 as lesbian/gay and 2 as a women that have sex with women. Of the total number of females that responded, 217 said no, 24 preferred not to answer while 29 (11%) said that “yes” they have had sex with another woman. In response to this question 7 females, 1 male and 2 transgender persons stated that they identify as a sex worker; 17 females and 13, a total of 30 males indicated that they prefer not to answer. Similarly, as the other sexual diverse groups, the discrimination experienced was mostly verbal for sex workers and drug users.

Graph 29: Discrimination experienced by men drug users  Belize Stigma Index version 2.0 (N=495)
It is important to continue exploring how stigma and discrimination affects not only persons living with HIV but also those that are discriminated for other reasons such as sexual orientation and gender identity. In this study the number of sexually diverse persons identified was not significant as the study was not focused just on these populations. However, the findings do show these persons are reporting discrimination and many are also being affected by perceived or internal stigma and discrimination.

Graph 30: Discrimination experienced by all the groups Belize Stigma Index version 2.0 (N=495)
Based on these findings it is recommended that a more indepth study on stigma and discrimination be conducted specifically for persons living with HIV who are also marginalized and discriminated due to other non-HIV related factors.
CASE #1: KELLY

Kelly is a 34 years old woman who has been living with HIV for the past 11 years. Presently, Kelly’s HIV viral load is undetectable but who states that living with HIV hasn’t always been easy. Kelly shared that her life changed drastically on the 9th of December 2008 at the age of 23 years. Kelly went to an organization known as the Belize Family Life Association with some friends to do a routine medical check-up. It was at this time that Kelly found out that she was HIV positive. Kelly shares that she felt like a brick was smashed against her chest. She could not believe it and was devastated. It was at this time that she started to like a wreckless life. She drank alcohol and smoked a lot of weed and cigarettes. She would go clubbing every weekend doing everything she was not supposed to do.

One of her life changing moments with the disease was in late June 2012, 2 weeks before her high-school graduation. Kelly fell sick since all she did was drink and smoke and was barely eating. At the doctor’s office he looked at her and said “Kelly, if you don’t change your life style you won’t live to see your 27th birthday.” Then the doctor asked, “is there anyone or anything you care about that would suffer if you die?” Kelly sat there and thought about this question. After 3 days of reflection she decided to start taking her antiretrovirals. She decided to stop smoking weed. She continued drinking alcohol and smoking but not as excessively as before. Kelly was starting to realize that the HIV medications were helping her but that she needed to make bigger changes in her lifestyle. She looked to God for help. In April 2015 at the age of 30 her next life changing moment occurred when she found out that she was pregnant with her daughter, her first child. It was at this point that Kelly stopped drinking, smoking and decided to make the best decisions not for herself but for her daughter.

Kelly knew it would be rough bringing a life in this world given the circumstances but she had to show her baby and the world being HIV + shouldn’t define you. So Kelly chose to post on about her HIV status and her live with HIV on Facebook. She shared that a few friends and family were mad but she let them know that she didn’t do it to hurt them. She it to free herself from a burden she was carrying for almost 11 years. Since then a few friends have accepted her and others she forgave and moved on with her life. Kelly’s life isn’t perfect but with God leading her and with her 3 ½ year old baby as her strength she is no longer afraid nor ashamed of saying “yes, I am HIV + but one thing!” Kelly says that she wants to always be remembered as a brave honest
and strong black woman who didn’t allow her disease or discrimination define her and her live.

**Case Study #2: MONICA**

Monica is a 26 year old Hispanic woman living with HIV. Monica found out that she was HIV positive when she was breast-feeding her daughter. Her child started getting sick and she got concerned and took her to the health centre. It was at this point that she found out that both her and her daughter were HIV positive. She had infected her child with the breast milk. Monica shared that when she started visiting the health centre, a woman who works there as a cleaner, found out about her condition. This woman brought the story back to their village and everyone became aware that she was positive and that she had infected her daughter through breast milk. The entire village became aware as the news spread like fire. Now, it’s difficult for Monica to reach out to anyone in the village because everyone there knows her story. Monica shared that she goes to the health centre for her medication people look at her and they gossip about her. Monica shares that what has been most difficult to deal with is the fact that there are nurses that do not keep her information confidential. She knows of two persons that work at the clinic that have shared her information with other people that don’t need to know.

Monica is scared of going to the health centre for the medication and so now has decided not to go. She only goes for her medication when she is starting to feel sick or when her child is sick. As long as the same persons are working at the health centre she believes that many persons will not go to access their medications. Monica says that she knows that nurses and doctors sign an oath to keep patient’s information private. She can’t understand why these persons are still allowed to work at the clinic. Monica shared that her children also have a difficult time at school as the other kids make fun of them and they are always caught up in fights because of her condition. She has tried to speak with the teachers but they say that they can’t do much about it because the children learn from the gossips at home. Monica says that it hurts her to see her children suffering because of her condition and she wishes that the school could give them more protection.
CONCLUSIONS AND RECOMMENDATIONS

Respondents were unclear about the difference between their sex and their gender identity. There is need for greater education on the topic of sexuality and the differences between one's gender and one's sex at birth.

Most of the people interviewed stated that they were not excluded from any social, religious and family activities, but they preferred to exclude themselves from activities. There is need to give greater attention to the issue of perceived versus felt stigma and discrimination. Even though the majority of persons living with HIV do not experience actual exclusion, they choose to exclude themselves due to fear.

The number of key populations represented in this study was not significant, however, it can be concluded that they do experience discrimination that is not HIV related as well. This compounds the psychological challenges for members of the key populations. Thus, it’s important to put in place programs that cater specifically to the needs of key populations. It is also recommended that a study on stigma and discrimination be conducted with key populations to be able to identify a more significant number.

The majority of interviewees access their HIV care and treatment at public or government facilities. This means that more focus needs to be placed on ensuring that public or government facilities are sensitized and have the capacity to work with persons living with HIV and key populations. In particular there is need to continue focusing on the issue of confidentiality as this is a key challenge for persons living with HIV that refuse to access services or do so under much distress.

Even though the percentages are not very highly, interviewees still perceive that they are gossiped about, verbally abused and denied their rights due to their HIV status and their gender identity/sexual orientation. This means that stigma and discrimination are still very much issues that persons living with HIV need to contend with on a daily basis. There is need to continue the efforts to introduce non-discrimination laws that will protect persons living with HIV and key populations.

The majority of the interviewees indicated that they have disclosed to those that are closest to them such as their partners, children and family members but many still prefer not to disclose when it is not necessary or to their employers or teachers who they fear
may discriminate most against them and affect their employment or education. It’s essential to continue focusing education and advocacy at the workplace and in schools.

Interviewees stated that they experience feelings of shame, guilty and have a low self-esteem in relation to their HIV diagnosis which directly affects the acceptance of their diagnosis and the disclosure of the same. The majority of the respondents are struggling with these mental health issues which means that there is a need for more psychological support for persons living with HIV. This needs to be available throughout the entire process from testing to learning to cope with HIV especially as it relates to stigma and discrimination.

The majority of laws are unaware of laws that protect persons living with HIV in Belize. This may be due to the fact that there are not many laws that are specifically designed to protect persons living with HIV. However, there are general laws that can protect them such as the Labour Act which stipulates non-dismissal or refusal to employ someone due to their HIV status. There is need for continued education on legislation, human rights as well as building the capacity of persons living with HIV and key populations to advocate for themselves.
BIBILOGRAPHY

Belize Funding Request to the Global Fund, 2018

Cost Modelling for Sustainable HIV/AIDS Finance Planning in Belize, 2017

Labour Force Survey 2017, SIB

Ministry of Health HIV and TB Surveillance Report 2018

UNAIDS Global Report 2018
Annex 1: Questionnaire

Annex 2:
Informed Consent Form

To be completed by the interviewee and the interviewer. My name is ________________________________

I am administering a questionnaire about the experiences of people living with HIV, particularly in relation to stigma and discrimination.

I have provided you with an information sheet that describes the purpose of this questionnaire and how the information collected will form part of a larger survey that is being conducted in this country to document some of the experiences of people living with HIV. The information sheet also outlined what types of information you will be asked, how we will keep this information confidential and the potential risks involved in your participating in this survey.

Before we begin the questionnaire, I would like to make sure that you are voluntarily willing to participate in this survey and that you have obtained all the information that you need to make an informed choice about your participation.

This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. You do not have to decide today whether or not you will respond to this questionnaire. Before you make a decision, you can talk to anyone you feel comfortable with about the questionnaire and/or the survey.

Please feel free to also contact the project team leader if you have any questions or concerns about this questionnaire or the survey. These are the contact details for the team leader:

Name: Martha Angelica Carrillo

Contact details:

601-8553

If, however, you choose to respond to this questionnaire and participate in the survey, I will ask you some questions about some of your experiences as a person living with HIV, in particular those related to stigma or discrimination. I expect that the interview will take between two and three hours. Before asking you whether or not you would like to be a participant, I would like you to know that:

1. Your participation in this survey is entirely voluntary. It is your choice whether to participate or not.

2. You are free to not answer any of the questions in the questionnaire.
3. You may stop participating in the interview at any time that you wish.

The information collected in this interview will be kept strictly confidential. To help ensure confidentiality, I will not write your name on the questionnaire or this form, and I will not write down particular details that would allow you to be identified. If you would like to know more about the measures that we are taking to protect confidentiality, please ask me to provide you with these details.

Your participation will include my providing you with a list of services that are available in our community, including health care, social support and legal services.

Do you consent to participating in the interview? Yes _________________ No ________________  If NO: Thank you for your time.

If YES: Thank you for agreeing to take part in this project.

By saying yes, that means that you have read the information on the information sheet, or it has been read to you. You have had the opportunity to ask questions related to the questionnaire and the People Living with HIV Stigma Index 2.0 survey and any questions you have asked have been answered to your satisfaction. You consent voluntarily to be a participant in this project and you understand that you have the right to end the interview at any time.

If you agree, I will now sign this form to confirm that your consent has been obtained. Signature/initials of interviewer. ______________________________________________________________________ Date of interview ______________________________________________________________________

Your verbal consent is all that is needed to go ahead with the interview. If you feel comfortable enough doing so, however, you can also sign your name or initials below to indicate that you have consented in writing to participating in this interview.

However, please remember that verbal consent is all that is needed. You do not have to provide us with written consent, but you can if you would like to.

I have read the information on the information sheet, or it has been read to me. I have had the opportunity to ask questions related to the questionnaire and the People Living with HIV Stigma answered to my satisfaction and understand that I have the right to end the interview at any time.

Signature/initials of interviewer
Date of interview

Annex 3:
Field Team Confidentiality Agreement

Annex 4:

Memorandum of Understanding

Between

INTERVIEWER NAME

and Collaborative Network for Persons Living with HIV (C-NET+)/REDCA+

This Memorandum of Understanding (MOU) sets for the terms and understanding between the C-NET+/REDCA+ represented by Adi Mai and Diego Grajalez, Focal Points, for Stigma Index in People Living with HIV (Index), Version 2.0, Belize

Background

The People Living with HIV Stigma Index (INDEX Version 2.0), uses a methodology designed to be developed and implemented by and for people with HIV, by the Global Network of People Living with HIV (GNP+), the International Community of Women Living with HIV (ICW), the International Planet Parenthood Federation (IPPF) and the Joint United Nations Program on HIV / AIDS (UNAIDS). Since 2008, this study has been carried out in more than 90 countries, more than 2,000 people with HIV have been interviewers and more than 100,000 have been interviewed (GNP+, 2018). Its execution will provide information, through the collection of experiences on stigma, discrimination and the rights of people with HIV, compare different situations, measure changes in certain periods and provide documentary bases. (User's Guide, 2018).

The overall objective of the INDEX Studies, defined in the User Guide, is to broaden the understanding of the scope of the ways in which stigma and discrimination arise and are faced by people with HIV in different countries, hoping it can be used to local, national and global level to fight for the enjoyment of equal Human rights of people with HIV. (User's Guide, 2018).

Purpose

This MoU is to ensure that the activities conducted through this project will be carried out as per the agreed terms:
The goals will be accomplished by undertaking the following activities:

- Conduct 500 Interviews among seven (7) interviewers
- To conduct the interviews in the strictest of confidentiality, if at any time this confidentiality is breached, the researcher will immediately be suspended from the study
- All information collected should not be shared with anyone
- The interviews should be conducted with the strictest privacy, Interviewer and Interviewee only at all times
- No other incentive will be provided to the interviewees other than $10.00 Bze
- The care and security of the tablets is the full responsibility of the interviewer
- The tablet will be returned with charger at the end of the study
- The interviewer agrees to receive BZE $45.00 per interview ($30.00 per Interview, $10.00 for transportation and $5.00 for data to upload the completed questionnaires)
- The interviewer agrees to receive the first payment of 50% after 50% of the interviews are completed and reported to REDCA+, and the final payment when the survey is completed.

**Reporting**

- At the end of each day I will upload the interviews conducted at the end of each day.
- I will inform Mr. Diego Grajalez (637-2933) and Mr. Evelio Cocom (610-6338) via text of the number of interviews conducted that day
- I understand Mr. Diego Grajales and Ms. Adi Mai – REDCA+ will be doing Monitoring and Evaluation visits to the areas where I will be doing my interviews

**Funding**  The funding of this project is provided by REDCA+ (Specify that this MOU is not a commitment of funds)  

**Duration**  This MOU becomes effective upon signature by myself and the Ms. Derricia Castillo-Salazar, Logistics Coordinator (REDCA+) and Ms. Lizet Aldana for MC Consultancy. It will be effective until June 30th, 2019, or otherwise decided if all interviews are completed before said date.
Contact Information of Interviewer

Name: _____________________________________,

Address: _____________________________

Telephone: ______________________________,

E-mail: _____________________________________________________

Signature:________________, Date: _____________________________

Derricia Castillo – Salazar  Logistics Coordinator  REDCA+

Diego Grajalez  Focal Point  REDCA+