

National Women's Commission

National Gender Policy: Situation Analysis of Gender Issues in Belize (2010)

Government of Belize

National Gender Policy (Updated January, 2010)



Isis Enterprises

Research, compilation and writing by:
Adele Catzim-Sanchez
Belize ISIS Enterprises Ltd.
2009-1010

Commissioned by:
The National Women's Commission
Belize City, Belize

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List of Acronyms and Abbreviations

AAA	Alliance Against AIDS
AIDS	Acquired Immuno-Deficiency Syndrome
BAS	Belize Audubon Society
BCVI	Belize Council for the Visually Impaired
BEST	Belize Enterprise for Sustained Technology
BFLA	Belize Family Life Association
BTB	Belize Tourism Board
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CET	Center for Employment Training
CRC	Convention on the Rights of the Child
CSEC	Commercial Sexual Exploitation of Children and Adolescents
CSEC	Caribbean Secondary Examination Council
CSO	Central Statistics Office
DFC	Development Finance Corporation
DPP	Department of Public Prosecution
DNA	Deoxyribonucleic Acid
DV	Domestic Violence
ECEDC	Early Childhood Education and Development Centre
FACA	Families and Children Act
FSW	Female Sex Workers
GBV	Gender Based Violence
GDP	Gross Domestic Product
HFA	Hyogo Framework for Action
HFLE	Health and Family Life Education
HIV	Human Immuno-Deficiency Virus
ILO	International Labour Organization
IMR	Infant Mortality Rate
ITVET	Institute for Technical and Vocational and Training
LASC	Legal Aids Services Commission
M&E	Monitoring and Evaluation
MARPS	Most At Risk Populations
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
MSW	Male Sex Workers
NAC	National AIDS Commission
NCFC	National Committee for Families and Children
NDACC	National Drug Abuse Control Council
NEMO	National Emergency Management Organization
NGO	Non-Government Organization

NHI	National Health Insurance
NPA	National Plan of Action for Children and Adolescents
NPESAP	National Poverty Elimination Strategy and Action Plan
NRCIE	National Resource Centre for Inclusive Education
NWC	National Women's Commission
PAHO	Pan American Health Organization
PASMO	Pan American Social Marketing Organization
SEA	Southern Environmental Alliance
SIB	Statistics Institute of Belize
SRH	Sexual and Reproductive Health
SSB	Social Security Board
STI	Sexually Transmitted Infection
TIDE	Toledo Institute for Development and the Environment
TMWC	Toledo Maya Women's Council
U5MR	Under 5 Mortality Rate
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WIN BELIZE	Women's Issues Network of Belize
YES	Youth Enhancement Services
YWCA	Young Women's Christian Association

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1.0 Introduction

Belize is a country of immense diversity. Within its borders, are lush rainforests and the western hemisphere's longest and most healthy barrier reef system. Rich in natural resources, Belize is home to a small population of approximately 322,100 people of diverse cultures, ethnicities and religious affiliations. The sex and geographic distribution of the population remains balanced with 50% being women and approximately 50% living in rural communities.

Men and women in both urban and rural locations must benefit equitably from national development. Because men and women experience life differently, they require policies, programmes and actions that recognize these differences so that both can benefit from the development process.

In 1982 a National Women's Commission (NWC) was established to advise the Government on women's issues. Since then, the focus of the NWC's has expanded to incorporate a gender perspective. This shift was prompted by a realization that gender issues (or how men and women relate to each other in their public and private lives), reflect deeply entrenched socialized patterns of behaviour. Using a gender perspective shifts the focus away from small scale women's programmes towards seeking a fundamental shift in the legal, social and economic institutions that perpetuate gender inequities and inequalities. To understand the types of changes required, information on the "de facto" situation of men and women becomes important.

In 2001, the NWC undertook its first situational analysis of gender issues in Belize. The situational analysis was used to develop Belize's National Gender Policy (2002). To ensure that the provisions of the Policy remain relevant, this situational analysis of gender issues was commissioned in 2009. It is expected that this 2009 situational analysis will not only outline the current situation, but also to contribute to the updating of Belize's National Gender Policy (2002).

The National Gender Policy reflects Belize's local context in relation to its commitments under the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the International Convention on Population and Development (ICDP), the Convention on the Rights of the Child (CRC), the Millennium Development Goals (MDGs), numerous ILO Conventions as well as other related social and economic commitments.

2.0 Methodology

This situational analysis utilized diverse methods of data collection. The process was officially initiated at a two-day policy review conference. Major stakeholders of the National Gender Policy (2002) were invited to present the achievements and challenges

in the implementation of the Policy and to provide guidance on the process for updating the Policy to ensure its continued relevance.

The second step in the process was a comprehensive review of documents, including both national and international policies and plans of action as well as specific programmes aimed at addressing gender related issues. Information gleaned from these documents was complemented by one-on-one and focus group interviews with specific organizations and groups. These interviews comprised the third stage in the process.

The fourth stage included the drafting of the situation analysis and presenting this to key stakeholders for their feedback. The draft document was revised based on this input and then finalized for mass information sharing.

The process for developing the situation analysis met several challenges. The collection of some documents was an extremely time consuming exercise. Information and data continues to be widely disbursed and usually not in one central location. As a result the tracking down of research studies and the reproducing of documents required a much longer time than originally envisioned.

Furthermore, not having clear indicators for the implementation and monitoring of the National Gender Policy (2002) contributed to the lack of focus on specific data to be collected. Consequently, a “fish net” approach was taken and any and all data related to gender issues were reviewed. Within this “fish net” approach, special attention was paid to the collection of data that responds to the 2005 CEDAW Committees’ Concluding Comments for Belize.

Finally, because of financial and human resource constraints, the original design for the process had to be adapted. The originally proposed small working groups of key organizations to examine emerging issues were eliminated in favour of large group discussions. The human resource capacity of the NWC also created constraints. Dedicated to other important activities, the NWC secretariat did not have the capacity to arrange the logistics required of this national exercise. The consultant therefore improvised by taking advantage of other ongoing consultative processes to elicit the views, concerns and input of men and women in both urban and rural locations across the country.

This final product, even with all the constraints presented above, is truly a national document. It combines statistical data with the experiences of service providers and with the contributions of men and women throughout Belize.

3.0 Findings

There was overwhelming consensus among stakeholders of the continued high level of relevance of the five existing priority areas. Statistical data validated the need to continue to prioritize the areas of health, wealth and employment creation, education

and skills training, violence producing conditions and women in power and decision-making. Together, the statistical data and the experience of stakeholders allowed for a sharpening of areas of special attention within the five priority areas listed above. The proposed areas of special attention are:

Policy Priorities	Special Areas of Attention
Health	investing in primary health care programmes integrating sexual and reproductive health as a national development priority expanding injury prevention and treatment services geared to the special needs of women, men and children creating a comprehensive mental health package of services delivered at the local level expanding preventive health education services increasing access to health care for rural communities increasing male access to sexual and productive health and primary health care services
Education and Skills Training	elimination of gender based discrimination at all levels of the education system building opportunities for lifelong learning that is holistic, gender responsive, integrated and geared towards sustainable national development increasing support for “second chance” programmes for boys and girls who drop out of school and developing incentives for them to stay in school using formal and informal education to transform gender relations with the family, the community and in society
Wealth and Employment Generation	eliminating discrimination against women and men workers, including workers in the informal sectors expanding social safety nets for vulnerable women, men and children creating greater equity in child maintenance provisions increasing women’s access to land, credit and business development creating gender equity in labour force participation and employment mainstreaming gender into disaster management programmes
Violence Producing Conditions	establishing family support systems that transform gender relations expanding and strengthening child protection programmes creating psycho-social support mechanisms and resources for survivors of gender-based violence building institutional capacity to address gender based violence, crime and guarantee access to justice
Power and Decision-Making	increasing women’s participation in decision-making positions build institutional capacity for gender mainstreaming of all relevant policies, strategies and plans of action implement gender budgeting across the public sector and across civil society organizations

3.1 Healthy Citizens

Health, particular sexual and reproductive health, was raised as the single most important issue affecting women and men across the life cycle. For children, lack of accurate, age-appropriate information on sexual and reproductive health was a major cause for concern. For adolescents, lack of access to information and services was at the forefront of focus group discussions. For adult women, the issues of lack of comprehensive, affordable sexual and reproductive health services and low levels of men's participation were named as priorities to be urgently addressed in a National Gender Policy. Related child protection issues, poverty, HIV/AIDS and gender based violence were highlighted as well as the need to strengthen the links between policies, programmes and services addressing these issues.

3.1.1 Overview of Health Resources

Since 2004, the number of Government operated hospitals has remained the same. There are 7 public and 4 private hospitals registered in Belize. There were small increases in the number of health centres (from 40 in 2004 to 42 in 2008) and health posts (from 44 in 2004 to 51 in 2008) between 2004 and 2008. These health facilities which serve the entire population of 311,500 are centralized in urban locations¹.

Health workforce issues disproportionately affect women, who comprise a majority of those who deliver health services countrywide. An inventory of the health workforce conducted in 2009 reported that "inadequate staffing is a core weakness of the health system."² The current estimated ratio of healthcare providers per 10,000 population is 18.9. This ratio falls below the World Health Organizations' (WHO) recommendation of 25. While medical professionals from Cuba and Nigeria help to fill this gap, cultural and language barriers affect the quality of care provided. The rapid turnover (every 2 years) of these medical brigades also affects follow-up medical care.

Of all the healthcare providers employed in the health care delivery system only 486 or 38% were established positions in the public sector. Another 17% were volunteer health workers, 6.5% were contracted workers and another 6.5 % were open-vote, un-established positions.³ This lack of job security contributes to "staff turnover, chronic vacancies and general workforce instability"⁴ This situation impacts negatively on the health sector's ability to respond to the health needs of women and men throughout the life cycle. The strengthening of the health sector is therefore a national imperative if health services are to become more gender responsive.

3.1.2 Sexual and Reproductive Health

Belize has a Sexual and Reproductive Health Policy (2002) which articulates Government's commitment to the provision of comprehensive sexual and reproductive health (SRH) services to men, women and adolescents. It also states the right of children to age appropriate SRH information. However, the structure of the healthcare delivery system and having only 1 primary health care nurse and even fewer

gynaecologists per 5,000 population, severely limit the health sector’s capacity to provide comprehensive SRH services in the manner outlined in the SRH Policy.

The most visible SRH services in Belize are maternal and child care. These services are delivered through the Maternal and Child Health (MCH) Programme and are available throughout the country. The main focus on maternal and child care is consistent with the achievement of Millennium Development Goals 4⁵ and 5⁶. Other SRH services such as pap smears, STI diagnosis and treatment, breast examinations, HIV testing, family planning services, abortion and post-abortion care and the prevention and management of gender-based violence are offered in a fragmented manner and are not rationalized based on the needs of each district. At the Southern Regional Hospital, for example, there is an unmet need for general gynaecological services for women who are not pregnant. This is the case even though Dangriga reports the second highest HIV transmission rates in Belize.

The BFLA continues to provide the most comprehensive SRH services in Belize, albeit on a small scale. They provide organized cervical screening and integrated breast examination services, syndromic and laboratory diagnosis and treatment of sexually transmitted infections, voluntary HIV testing services and abortion and post-abortion services. Through the National Health Insurance (NHI) Scheme they provide pregnant and non-pregnant women with access to gynaecologists. Children also benefit from services provided by paediatricians.

3.1.3 Fertility Issues

The total fertility rate in Belize dropped from 3.4 in 2003 to 3.2 in 2005, 2.9 in 2007 and then 2.7 in 2008. Yet, according to the MICS Survey⁷, the use of contraception among women who are married or in unions is only 34.3% countrywide. Only the Belize District had close to 50% usage at 47.5%. The most popular use of contraception is the pill (10.8%) followed by female sterilization (8.9%). Sterilization is used mostly among married women. Contraceptive usage in the Stann Creek, Cayo, Corozal and Orange Walk District ranged from 30% to 34.1%. Toledo had the lowest usage rate at 23.4%. Urban women tended to use contraceptives more than rural women (38.8% compared to 29.4%). Maya women had the lowest rate of contraceptive use overall at 15.4%.

Table 1: Total Fertility Rate 2003-2008

2003	2004	2005	2006	2007	2008
3.4	3.6	3.2	3.0	2.9	2.7

Source: Ministry of Health. Health Statistics of Belize: 2003-2007 and 2004-2008.

The MICS Survey⁸ also revealed that almost one third of women who are married or in unions, have an unmet need for contraception and that the demand for contraception is “less satisfied” for younger women.

3.1.4 Adolescent access to SRH Information and Services

Although the teenage pregnancy rate decreased in the 1990s⁹ it remains high. Teenage pregnancy (births for every 1,000 adolescent women aged 15 to 19 yrs.) was 80.1 in 2007 and 76.8 in 2008. This translates to 20% of total live births or 1 in every 5 live births being delivered by teenage mothers. According to the Director of the Maternal and Child Health Programme, teenage pregnancies lead to early second pregnancies if adolescents are not provided preventive sexual and reproductive health services.

A review of 2008 ante-natal records demonstrate that in that year alone, 6 girls between ages 10 and 14 and 493 adolescent girls between ages 15 and 19 accessed maternal services for repeat pregnancies. This figure increased to 1,453 for young women between ages 20 and 24 years.

Table 2: Under 20 Fertility Rate 2003-2008

2003	2004	2005	2006	2007	2008
N/A	N/A	0.099	0.84	0.081	0.077

Source: Ministry of Health. Health Statistics of Belize 2003-200 and 2004-2009

For the period 2002-2006, adolescents accounted for 7% of all HIV/AIDS cases and in 2007, 4.1% of adolescent females were pregnant.¹⁰ This shows a high rate of unprotected sexual activity and the possibility of sexual abuse. In 2008, one quarter or 24% of the 5,646 women who accessed ante-natal services at a health centre were in the 15 to 19 age range. Of all women who accessed ante-natal services through mobile clinics, 15% were in the 15 to 19 age range. A further 0.8% and 0.4% of those who accessed ante-natal services in health centres and mobile clinics, respectively, were in the 10 to 14 age range.

Complications due to pregnancy, childbirth and the puerperium continue to be a cause of hospitalization for children 10 to 14 years.¹¹ This ranged from 11.9% (2003) to 8.2% (2008) of all hospitalizations for children in that age group. Complications due to pregnancy, childbirth and the puerperium are the leading cause of hospitalization for adolescents 15 to 19 years at 68.8% in 2003, 72% in 2005 and 69.7% in 2008. This indicates that in 2008 approximately 7.3% of adolescent girls within the 15 to 19 age range had unprotected sexual intercourse that resulted in hospitalizations for pregnancy related reasons. Overall, complications due to pregnancy, childbirth and the puerperium continue to be the leading cause of hospitalization for females of all ages (between 54.8% in 2003 to 56.8% in 2008).

Table 3: Pregnancy, Childbirth and Puerperium as a Leading Cause of Hospitalization for Children in Belize 2003-2008

Age Range	Year					
	2003	2004	2005	2006	2007	2008
10-14	11.9%	10.9%	13.3%	10.1%	9.7%	8.2%
15-19	68.8%	70.7%	72%	73%	74.4%	69.7%

Source: Ministry of Health (June, 2008). Health Statistics of Belize 2003-2007 and 2004-2008.

The early initiation of sexual activity at age 12 was reported in studies conducted in selected secondary schools in Belize.¹² A recent study¹³ was conducted on sexual behaviour among 1,900 persons (15-24 years) in Belize. The Study revealed that of the 947 respondents who were sexually active, 21% of male and 13.5% of female respondents had their first sexual intercourse before they turned 15 years. Another 55.9% of male and 48.9% of female respondents had already had their first sexual intercourse between ages 15 and 17. Therefore, a total of 76.9% of male and 62.4% of female respondents had been sexually active before they turned 18 years. Half of those who had sexual intercourse also used alcohol.

More male than female respondents reported having multiple partners, a trend that may be attributed to the acceptance of monogamy for women but not for men.¹⁴ Of significance was the low level of HIV risk perception among male and females with multiple sex partners. A total of 41% reported that they had no risk of HIV infection and 43.9% reported having some risk. Only 12.1% reported having a high risk perception. This demonstrates dissonance between behaviour and risk perception.

The Study found significant gender differences in HIV related attitudes and in condom use. Less females than males reported always using a condom, putting the females at risk of HIV even though they may have sexual intercourse with only one partner. Of those who were sexually active, 62.5% did not always use a condom during sexual activity. Of those who used condoms (37.5% of sexually active respondents), more than half or 57% accessed condoms from a supermarket, 24.2% from a pharmacy, 3.5% from a Government clinic or health centre and 3% from a friend or a neighbour. This demonstrates that sexually active adolescent boys and girls are not accessing condoms from public sector facilities, but rather from the private sector.

Of those who were sexually active, 58% had never taken an HIV test. The other 42% had taken an HIV test. The location for HIV testing was not elicited by the study.

Healthcare providers report an increase in adolescents' requests for STI/HIV and anti-natal services from both the public health system¹⁵ and the Belize Family Life Association (BFLA).¹⁶ However, the Medical Act requires the consent of a parent for health services to children less than 16 years. The legal age of consent (to sex) is 16 years. Therefore, even with the high adolescent and teen pregnancy rates in Belize and the high incidence of HIV among young women, adolescents do not have easy access to sexual and reproductive health services –including preventative services- without parental consent.

In cases in which the healthcare provider suspects sexual abuse or commercial sexual exploitation, they refer these cases to the Ministry of Human Development for follow-up investigation. Social workers' heavy caseloads and government's limited resources for mobilization, impact negatively of the effectiveness of the referral system.

As stated in the Sexual and Reproductive Health Policy (2002) and the corresponding Strategic Plan, adolescents have a right to sexual and reproductive health services. The best interest of the child is to prevail to ensure protection from sexual violence. Therefore, a revision of current legislation is being undertaken by the Ministry of Health and relevant guidelines are being developed to ensure the effective provision of SRH services to adolescent young women and men.

While the Ministry of Health scales up its SRH services for adolescents, BFLA continues to target adolescent men and women in the provision of overall sexual and reproductive health services. In Orange Walk, Belize City and Dangriga, special youth group activities are undertaken. This includes training to explore issues like gender based violence, conflict resolution, communication and negotiation skills. The BFLA has also developed a game called "Thorn". This game aims to enhance SRH education and stimulate behaviour change among adolescents and youth.

Consultations on the National Gender Policy call for strategies that guarantee children's access to SRH information as a basic human right. Proponents of children's rights point out a need to also strengthen the Health and Family Life Curriculum and Life Skills Education programmes delivered at the primary and secondary school levels as this aspect of prevention is key to preventing teenage pregnancy and STI/HIV transmission among adolescents.

3.1.5 HIV Transmission

The 2006 MICS Survey reported that countrywide 37.3% of women had comprehensive knowledge of HIV/AIDS transmission and 49.7% had knowledge of preventing HIV transmission. Only 39.7% of young women (15-24) had comprehensive knowledge about HIV transmission, a level that was comparable to all other age-groups. Comprehensive knowledge is defined as the proportion of young people 15-24 years who know two methods of preventing HIV and AIDS, reject two misconceptions and also know that a healthy looking person can be infected.

Women's level of education, area of residence and socio-economic status were correlated with knowledge of HIV. Only one half or approximately 50% of women who had heard of AIDS knew all three main ways of preventing HIV transmission. This illustrates the need to re-think the design, content and delivery of HIV education strategies targeting young women and their partners.

The estimated HIV prevalence rate for 2007 was 2.1%. This rate is expected to increase as Belize continues to catch up with HIV cases that are not yet diagnosed.¹⁷ Fewer men than women test for HIV. However, men who test for HIV have a higher rate of HIV infection compared to women who test. This demonstrates the continuing trend of men's

late access to health related services. Men do so when they already begin to experience symptoms of AIDS.

Table 4: Cumulative HIV Cases, AIDS Cases and AIDS Related Deaths by Age and Sex 2003-2007

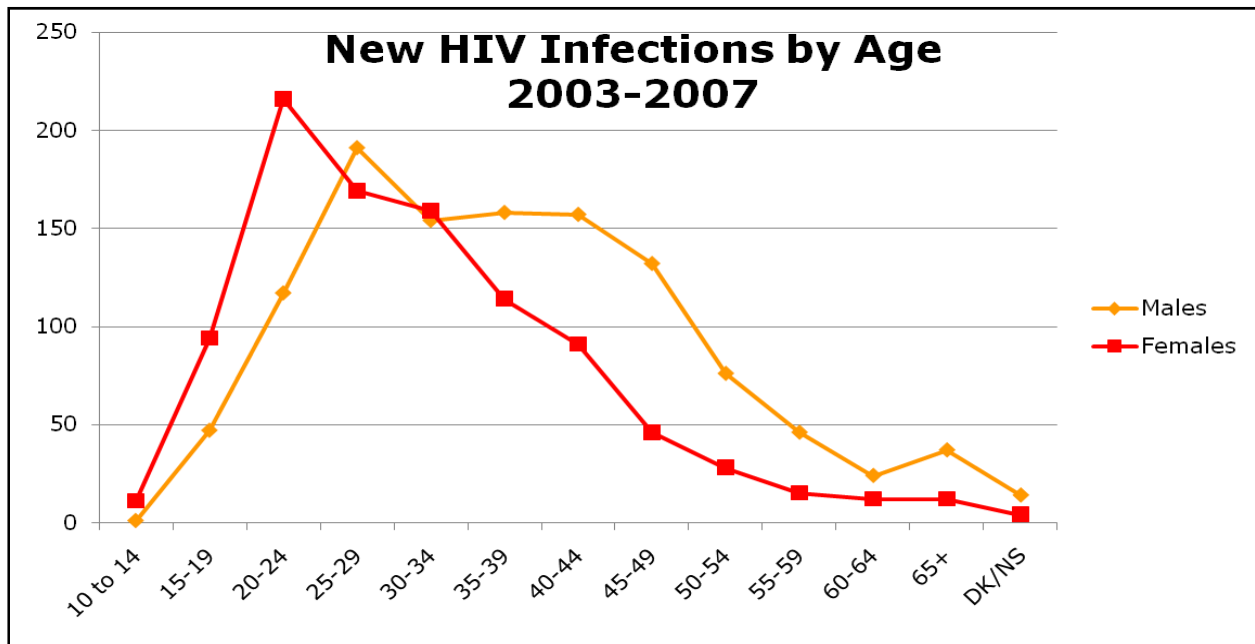
Table 1: Cumulative HIV Cases, AIDS Cases, and AIDS Related Deaths Reported by Age Group and Sex, 2003-2007						
<1 year						
	Male		Female		Both Sexes	
	<i>#</i>	<i>% of Total Reported Cases</i>	<i>#</i>	<i>% of Total Reported Cases</i>	<i>#</i>	<i>% of Total Reported Cases</i>
New HIV Cases	20	1.65	18	1.77	38	1.70
AIDS Cases	4	1.89	3	1.96	7	1.92
AIDS Related Deaths	5	1.85	7	5.43	12	3.01
0-14 years						
	Male		Female		Both Sexes	
	<i>#</i>	<i>% of Total Reported Cases</i>	<i>#</i>	<i>% of Total Reported Cases</i>	<i>#</i>	<i>% of Total Reported Cases</i>
New HIV Cases	61	5.02	57	5.60	118	5.29
AIDS Cases	14	6.60	11	7.19	25	6.85
AIDS Related Deaths	13	4.81	11	8.53	24	6.02
≥15 years						
	Male		Female		Both Sexes	
	<i>#</i>	<i>% of Total Reported Cases</i>	<i>#</i>	<i>% of Total Reported Cases</i>	<i>#</i>	<i>% of Total Reported Cases</i>
New HIV Cases	1139	93.82	956	94.00	2095	93.90
AIDS Cases	198	93.40	141	92.16	339	92.88
AIDS Related Deaths	257	95.19	118	91.47	375	93.98
15-49 years						
	Male		Female		Both Sexes	
	<i>#</i>	<i>% of Total Reported Cases</i>	<i>#</i>	<i>% of Total Reported Cases</i>	<i>#</i>	<i>% of Total Reported Cases</i>
New HIV Cases	956	78.75	889	87.41	1845	82.70
AIDS Cases	165	77.83	122	79.74	287	78.63
AIDS Related Deaths	190	70.37	101	78.29	291	72.93

Source: Epidemiological Profile of HIV/AIDS in Belize 2003-2007. Ministry of Health.

From 2003 to 2007, children under 1 year accounted for 1.7% of all new HIV infections, 1.92% of AIDS cases and 3.01% of all AIDS related deaths. During that period, children under 14 years accounted for 5.29% of all new HIV infections, 6.85% of AIDS cases and 6.03% of AIDS related deaths. Females in the under-14 age range were more affected than males within that same age range.¹⁸

Both women and men in the 15 to 49 age range, accounted for a majority of all new HIV infections (82.7%), AIDS cases (78.6%) and AIDS related deaths (72.92%). HIV infection is almost equally distributed among women (48.8%) and men (51.2%) but HIV infection disproportionately affects young women aged 15 to 25 compared to men of that same age group.

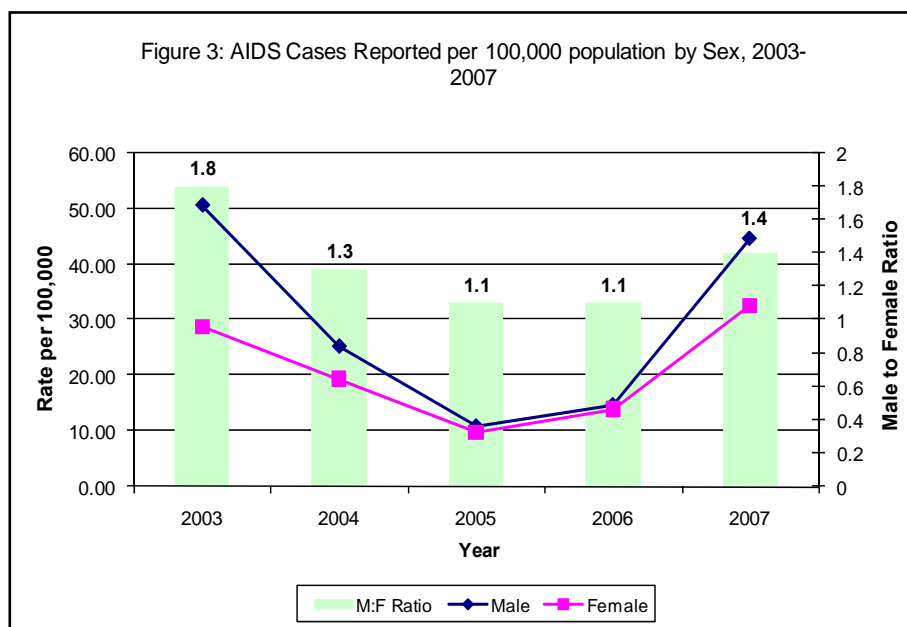
Figure 1: New HIV Infections by Age 2003-2007



An estimated 25% more women than men are in need of anti-retroviral treatment (ARV). These women are living with, rather than dying from, HIV. This is consistent with findings that men wait longer to seek medical attention, contributing to their high AIDS mortality rate compared to women with HIV.

The higher AIDS mortality rate for men impacts on gender roles within the family.²⁰ A family member, usually a spouse, sister, daughter, mother or grandmother, takes on the role of caretaker during times of illness. As the disease progresses, female partners of HIV positive men, may become the sole income earner within the family (sometimes in addition to their role as caretaker). Children also adapt to meet the changing needs of the family. At times children have to drop out of school to take care of younger siblings or engage in employment activities to help support the family.

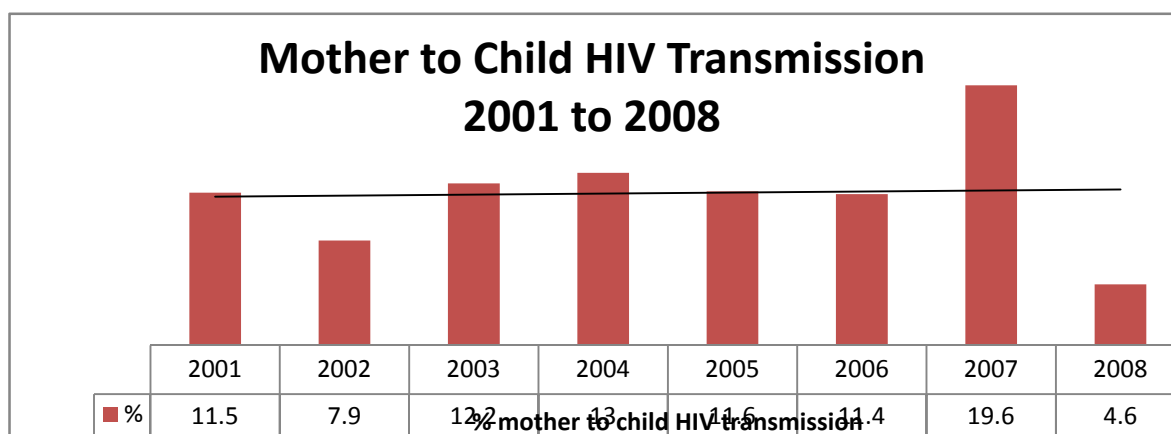
Figure 2: AIDS Cases Reported per 100,000 population by Sex, 2003-2007



Source: National AIDS Programme. Ministry of Health

The HIV prevalence rate is 0.9% -1% among pregnant women who volunteered to take an HIV test while receiving antenatal care. Vertical transmission of HIV from mother to child ranged from 11.5% in 2001 to 12.2% in 2003, to 11.6% in 2005, 19.6% in 2007 and then dropped to 4.6% in 2008. This drop can be attributed to greater effectiveness of the Prevention of Mother to Child HIV Transmission Programme (PMTCT).

Figure 3: Mother to Child HIV Transmission 2001-2008



Source: Maternal and Child Health Programme (2009)

This protocol has been scaled up to PMTCT Plus which allows for an expanded prevention programme. However, women's late access to ante-natal clinics and the lack of integration of VCT services compromises the work of the Maternal and Child Health Programme in further reducing mother to child HIV transmission.

A Study on HIV positive children (0-19 years) in the Belize and Stann Creek Districts in Belize revealed that 123 children in the Belize District and 140 children in the Stann Creek Districts were registered in the VCT database. Not all these children were receiving HIV related services as many were lost to follow-up (LTFU).

Overall, VCT services remain compartmentalized rather than integrated into the health system.²¹ This places an extreme burden on users of the health facilities and on the health workers themselves. The Ministry of Health recognizes the need to greater integration of STI and HIV services. Plans are currently underway for the phased implementation of provider initiated HIV testing and counselling services (PITC).

Belize's National HIV/AIDS Policy and National HIV Policy for the World of Work outline the strategic direction for the national HIV response. Together these Policies call for a human rights approach to programming. The Policies advocate for greater harmonization, coordination and collaboration as well as an increased focus on treatment and care services. This approach attempts to address issues raised in a Situation Analysis conducted by the National AIDS Commission's. The report states:

Because more than half of the organizations (37 of 57) are coordinating/ collaborating with only one other organization in carrying out their specific HIV/AIDS activities, this indicates that such coordination/ collaboration is yet weak and could be improved. The tasks are too big and complex for any organization to work without intensive coordination/ collaboration with as many other organizations that can complement or reinforce their own activities

*It is also true that the majority of the mentioned organizations are also concentrated in offering preventive activities and a limited number in treatment and care...besides treatment and care, more emphasis should be placed on support services and mitigation activities.*²²

Both public and private sector agencies continue to share HIV prevention messages. Since 2005, there have been greater attempts at integrating STI/HIV/AIDS prevention education and forging greater links between the HIV/AIDS and gender based violence.

A study on the links between HIV and domestic violence reported that situations of violence affect women's ability to "protect themselves from HIV, negotiate safer sex, and increase the range of situations that make them more vulnerable to HIV:"²³ The study found that knowledge of HIV is high among women who experience domestic violence and women who are HIV positive. These women know of prevention strategies (condoms, fidelity and abstinence) but most are not in a position to negotiate safe sex practices with their partners.

A reported 4.3 of every 10 respondents indicated that there was a high level of refusal to use condoms by partners of both groups (domestic violence and HIV positive women). This illustrates the limitations of preaching condom use to women in abusive relationship without also addressing their need for additional support. Women were

unable to negotiate safe sex even in the context of their husbands/companions having multiple sex partners and in the context of some women having engaged in transactional sex.²⁴ Although there are clear links between HIV transmission and domestic violence, users of domestic violence services had a low HIV risk perception which increased their vulnerability to the virus.

Over the last five years, the Women's Department and members of the Women's Issues Network have intensified their HIV prevention campaigns targeting young women and men. In 2008 alone, the Women's Department reached 31,918 persons through their personal development sessions which include topics like STI and HIV/AIDS prevention, gender sensitization and gender-based violence. Non-Government Organizations are similarly taking an integrated approach in HIV/AIDS prevention programming. Special attention is paid to meeting the HIV prevention needs of young women.

Non-government organizations like the Hand in Hand Ministries, Claret Care, BFLA, Alliance Against AIDS, PASMO, YWCA and YES act as referral points for persons infected and affected by HIV. This includes women, men, female sex workers, adolescents and children. BFLA has a collaborative agreement with PASMO for the provision of voluntary HIV counselling and testing services for PASMO's clients. BFLA also receives referrals for VCT and other SRH services from organizations like the AAA and Youth Enhancement Services (YES).

PASMO has made achievements in its provision of services to female sex workers. They have reached a total of 1,638 female sex workers in 2007 and 2008 combined. They have also conducted research on this population so that they can develop more effective strategies for behaviour change. Through their agreement with BFLA they are able to ensure that their clients access voluntary HIV counselling and testing services. They also provide their clients with access to condoms and water-based lubricants. Furthermore, they help their clients to develop self-efficacy plans aimed at diversification from commercial sex work into employment that reduces their risk of HIV transmission.

BFLA and PASMO reported that HIV stigma and discrimination remain high. This negatively affects access to services. They also noted the need for social protection programmes for their clients. Social protection is needed so that their clients can either diversify from commercial sex work and/or afford the cost of health care and other services imposed by HIV. For PASMO, a particular concern was the indiscriminate raiding of sex work institutions by police and immigration officials. This prompts female sex workers, who are mostly foreigners, to be highly mobile, moving frequently to avoid being captured. These indiscriminate raids disrupt the trust and rapport that PASMO builds with its female sex worker client base.

In collaboration with the Women's Issues Network (WIN Belize), the Alliance Against AIDS has implemented a psycho-educational, sexuality based model for behaviour change. This model was reported as being highly successful in assisting women in recognizing and addressing sex and sexuality issues that impact on HIV prevention

programming. This model aims to create behaviour change among targeted populations, including men and women in private sector agencies. Other HIV education effort focus mainly on a providing HIV related information.

Since 2005, there has been an increase in government funding as well as additional funding support of the Global Fund and the Pan American Health Organization. Coverage has increased significantly and in particular in the areas of prevention of mother to child transmission, the provision of free antiretroviral therapy and voluntary testing and counselling, significant progress has been made.

Major challenges lie in providing more effective HIV prevention messages, in integrating HIV services at the primary care level and in offering appropriate interventions targeting the most at risk populations (MARPS). MARPS include men who have sex with men, commercial sex workers, clients of commercial sex workers, mobile populations and incarcerated populations. Due to the clandestine lifestyle of some of these groups, and high levels of stigma and discrimination towards them, MARPS remain largely invisible in the national HIV response.²⁵ The need for more baseline and sentinel studies on specific at-risk populations is outlined as a top priority for more effective HIV programming.²⁶

3.1.6 Maternal Health

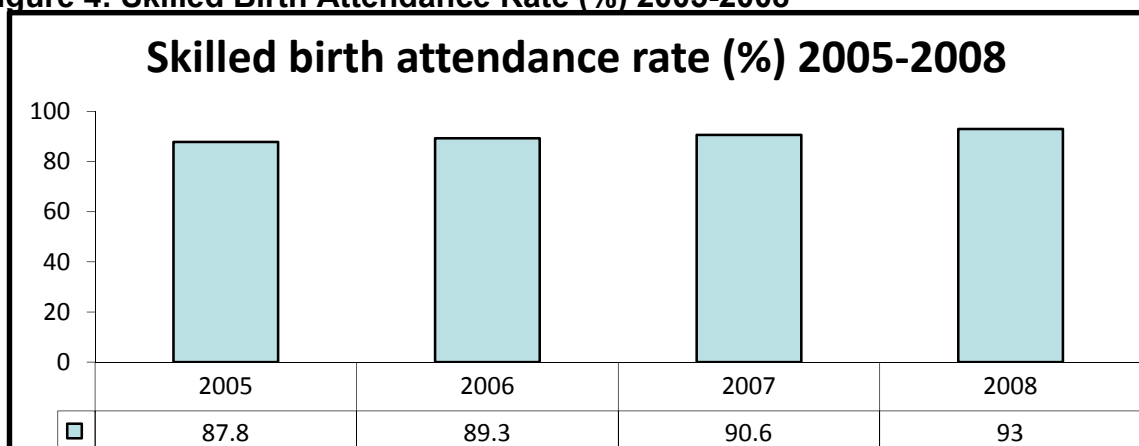
Over the last 20 years, Belize has improved its maternal mortality rate. Pregnant women now receive iron and folic acid supplementation to improve their maternal health and the health of the unborn child. Haemoglobin (Hb) testing is completed at the first and last trimesters. The result is a 50% reduction of anaemia during pregnancy. A special programme in Toledo of providing Iron and folic acid to all females ages 10 to 49 is being expanded to the rest of the country.

Coverage of antenatal care (by a doctor, nurse, or midwife) is high in Belize with 98.1% of women receiving antenatal care at least once during the pregnancy.²⁷ Ante-natal services were provided almost evenly by medical doctors (45.9) and nurses or midwives (46.6%).²⁸ Over 95% of deliveries in the Belize and Cayo Districts took place in a health facility compared to only 52.4% of deliveries in the Toledo District. Women living in urban areas and with secondary education or higher tended to access ante-natal care from medical doctors more than women living in rural areas and with less than a secondary school education.

In 2008, 93% of deliveries were managed by a skilled birth attendant compared to 87.8% in 2005. This represents an overall increase in women accessing obstetric care from skilled birth attendants.

While overall access to ante-natal care from skilled personnel remains high, the challenges of women's late access to ante-natal care and the high patient to doctor ratio in Belize threatened gains in maternal mortality.

Figure 4: Skilled Birth Attendance Rate (%) 2005-2008



Source: Maternal and Child Health Programme, Ministry of Health

Maternal and child health (MCH) data for 2008 revealed that 66% of pregnant women accessed antenatal care at health care clinics in their second trimester, 22% in their first trimester and 12% in their third trimester. Furthermore, 57.5% of pregnant women who used mobile clinics (most rural women) accessed antenatal care in their second trimester. Another 30.6% accessed care in their third trimester and only 11.8% accessed antenatal care in their first trimester.²⁹

Table 5: Maternal and Child Health Ante-Natal Care Records (2008)

Parity	Gestation in Weeks	Health Centre						Mobile					
		10-14	15-19	20-24	25-35	Over 35	Total	10-14	15-19	20-24	25-35	Over 35	Total
First pregnancy	<12	1	200	185	60	9	466	0	13	3	2	0	18
	13-27	2	623	347	106	6	1106	1	26	23	4	1	55
	28 and +	8	67	42	18	5	140	1	8	13	3	0	25
2 to 4 pregnancy	<12	3	86	257	262	26	634	0	3	8	7	0	18
	13-27	2	322	821	773	54	1972	0	20	65	44	5	134
	28 and +	0	49	146	106	13	314	0	9	34	19	0	62
5 or more pregnancy	<12	0	1	25	91	30	147	0	0	4	12	7	23
	13-27	0	2	61	419	190	672	0	0	5	68	25	98
	28 and +	1	1	18	108	67	195	0	0	9	44	13	66
Total Diagnosed High Risk This Month		1	107	147	149	86	501	0	0	0	1	2	3
Total		5	135	1902	194	400	5646	2	79	16	20	51	499

Source: Maternal and Child Health Programme, Ministry of Health.

Of the 50 children ages 10 to 14 who were pregnant, over one-fourth or 27% of them were diagnosed with high risk pregnancies. This goes down to 7% for those in the 15 to 35 age ranges and increases again to 20% for women over 35 years.

The Maternal Mortality Rate (per 100,000 live births) fluctuated between 40.4 in 2003, 134.1 in 2005 and 85.3 in 2007 and 56.6 in 2008. In 2008 a total of 4 maternal deaths were recorded.³⁰ Of these, 75% of them were caused by illnesses that could have been prevented³¹. Additionally, since 2007, at least three maternal deaths were of HIV positive women. This has raised the issue of whether a woman with a low CD4 count (advanced stages of AIDS) can, in the first trimester of pregnancy, request a legal termination of the pregnancy based on her health and the best interest of her other children, as stated in the Criminal Code.

Table 6: Maternal Mortality Rate (per 100,000 live births) 2003-2008

	2003	2004	2005	2006	2007	2008
MMR	40.4	63.9	134.1	41.8	85.3	42.5

Abortion remains a high controversial issue in Belize. Belize’s Criminal Code indicates that abortion is illegal. However it allows for a legal termination of pregnancies in specific cases in which two registered medical practitioners agree that it is necessary on the basis that having the child will cause harm either to the mother or to existing children. The Criminal Code states:

*111– (1) Every person who intentionally and unlawfully causes abortion or miscarriage shall be liable to imprisonment for fourteen years.
 (2) Every woman with child who, with intent to procure her own miscarriage, shall be guilty of a felony and being convicted thereof, shall be liable to imprisonment for life.³²*

Under medical termination of pregnancy the law allows two exceptions to the above illegal acts:

112-(1) A person shall not be guilty of an offence under the law relating to abortion or miscarriage when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith –that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or that there is substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.³³

The BFLA provides abortion and post-abortion services to women who qualify for legal termination of their pregnancies. However, the Catholic Church has initiated a campaign to amend the Criminal Code to remove the provisions under which these legal abortions can be provided.

3.1.7 Breastfeeding

Belize has a National Breastfeeding Policy. Breastfeeding and child nutrition programming are also integrated into the National Strategic Plan for Sexual and Reproductive Health Services. Over the last five years, three hospitals have been certified as “Baby Friendly”. These hospitals are supportive of breastfeeding practices.

The exclusive breastfeeding rate (at 6 months) varies depending of the source of data. It ranges from 3% collected in the Female Family Health Survey in 1999 to 10% based on data from the Mixed Indicator Cluster Survey (MICS) in 2006 and 24% from data collected by the Maternal and Child Health Programme (MCH).

The MICS data³⁴ reveals that up to one month, 20.9% of newborns are exclusively breastfed. This considerably declines to 6.4% by the third month. By 3 months and younger, a majority of children receive a combination of liquids or foods other than breast milk. By the end of three months, the percentage of children exclusively breastfed is below 10 percent and more than half (54.8 %) are being given other milk or formula and complementary foods. Only about 26.3% of children are receiving breast milk after 2 years.

Exclusive breastfeeding challenges include a lack of human resources to advance breastfeeding at the district level, the need to generate greater fathers’ support for breastfeeding mothers and the need to develop workplace strategies that support exclusive breastfeeding practices.

3.1.8 Child Nutrition

Globally, child nutrition is closely associated with shorter adult height, less schooling, reduced economic productivity and, for women, low offspring birth-weight.³⁵ In a study to determine the cost-benefits of addressing ten of the world’s greatest development challenges, child nutrition ranked highest. Investments in micronutrient supplementation, micronutrient fortification and de-worming had exceptionally high benefits compared to costs.

In Belize, de-worming tablets are provided to children below 5 years. There is also an increase in calorie intake among children in preschools.³⁶ A total of 23.8% of children between 6 months and 5 years received vitamin A supplementation within the last 6 months prior to the MICS Survey in 2006.³⁷ Nevertheless, growth retardation and stunting rates among boys and girls indicate the need for additional investments.

The 2001 Poverty Assessment Study indicated that countrywide 17.9% of children suffered from growth retardation or stunting, with Mayan children showing the highest rates at 45%. The 2006 MICS Survey reported that 6.1% of children under-five were moderately underweight and 0.7% were severely underweight. Approximately 18% of children were stunted for their age and more than 2% were wasted or too thin for their height.³⁸ Children living in rural areas (23%) were more likely to experience growth

retardation compared to urban children (7.9%). An extreme situation was recorded for Mayan children. Approximately 50% of Mayan children had some level of growth retardation. The reverse trend surfaces for overweight children. There were more overweight children living in the urban areas (11.6%) compared to rural areas (9.2%).

Although there were no differences between boys and girls, a significant correlation was discovered between the growth rate of a child and the educational level of the child's mother. Children of mothers who had secondary or higher education (3.7% and 9.4%) were less likely to be underweight and stunted compared to children of mothers with primary or no education (7.1% and 21.6%).³⁹

3.1.9 Child Mortality

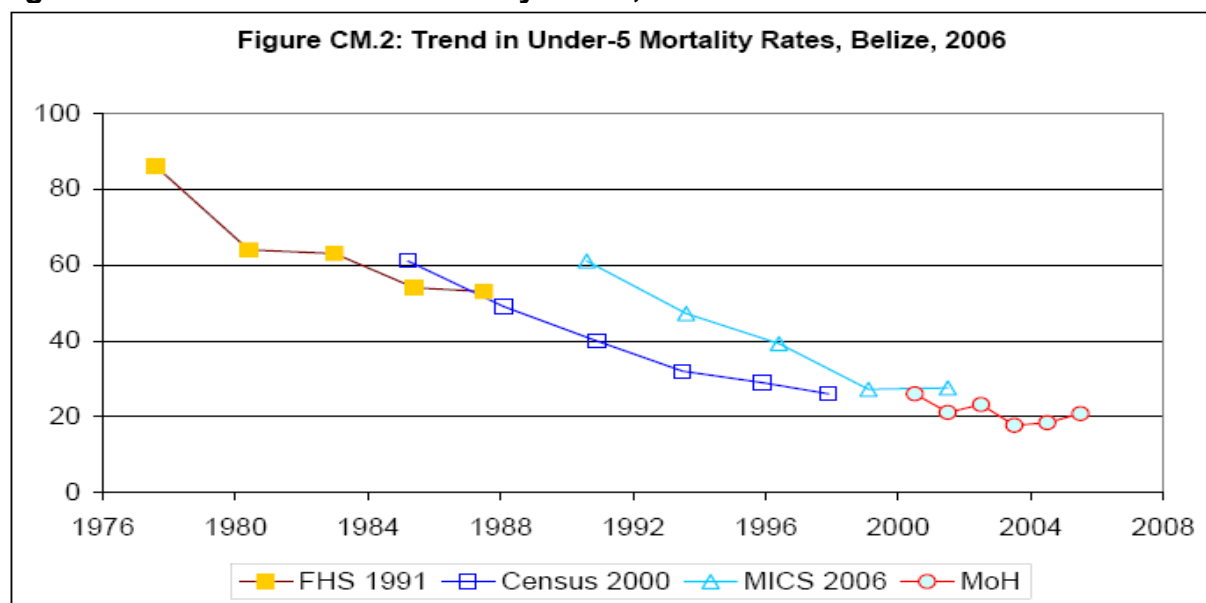
Neonatal deaths accounted for 40% of total under five deaths and 60% of total infant deaths.⁴⁰ The Infant Mortality Rate (per 1,000 live births) fluctuated between 14.8 in 2003, 19.6 in 2006 and 17.2 in 2007. Similarly, the estimated U5MR (per 1,000 live births) fluctuated between 2003 and 2007. The U5MR for 2003 was 17.8. This increased to 19.0 in 2004 and then to 24.6 in 2006 before decreasing to 20.5 in 2007. The U5MR estimate for 2008 was 17.0.⁴¹

As illustrated below, the MICS Survey reported a higher U5MR than estimated by the Ministry of Health. The MICS Survey estimate for 2006 was 27.6 compared to the 24.8 reported by the Ministry of Health. The MICS Survey reports that:

“While the trend indicated by the MICS survey results is in broad agreement with the estimates from the Family Health Surveys 1991, Census 2000 and the Ministry of Health’s administrative data sources, the results are considerably higher.”⁴²

In the MICS Survey, the two most important characteristics related to U5MR were the sex of the child and the level of education of the child's mother. Boy children had a much higher U5MR than girl children (35 compared to 19 per 1,000 births). Children with mothers who had a primary education had a higher U5MR than children with mothers who had secondary education (30 compared to 17 per 1,000 births). This illustrates that gender issues play a critical role in determining the U5MR in Belize.

Figure 5: Trend in Under 5 Mortality Rates, Belize 2006



Between 2003 and 2007 the three leading causes of death for children less than 1 year were slow foetal growth, foetal malnutrition and immaturity, hypoxia, birth asphyxia and other respiratory conditions, and congenital anomalies. For that same period, the causes of death for children 1 to 4 years fluctuated greatly and were related mostly to child safety issues and communicable diseases. Among the leading causes were accidental drowning and submersion, transport accidents, acute respiratory infections, HIV/AIDS, intestinal disease and diseases of the nervous system other than meningitis.

Child deaths caused by non-transport related safety issues were usually accompanied by widespread media attention. In some cases, issues of neglect and abuse were highlighted. It was usually the mother (since fathers are usually absent) who was investigated and castigated for these deaths. Leaving children alone to engage in employment activities or to buy food and non-food items was one of the reasons cited for children's vulnerability to accidents. This situation calls for greater support to working mothers, particularly single mothers, so that their children can be safe while they seek employment and engage in income generating activities.

Child deaths caused by transport accidents show similarities with the death rate for male adults, who show a high rate of mortality due to transport accidents. Road safety issues are therefore a major concern not only for men but for the children whose lives are impacted by a lack of safety measures.

3.1.10 Mortality of the Over Five Population

The leading causes of death for children 5 to 9 and 10 to 14 years between 2003 and 2008 were accidental drowning and submersion, transport accidents, acute respiratory infections and death caused by fire and flames.⁴³ As stated above, these reports are

consistent with child protection data which demonstrate that neglect remains the most prevalence form of child abuse reported in Belize. It is also consistent with the high rate of fatal transport accidents recorded and the low rate of use of seat belts and protective gears for children.

For those in the 15 to 19 age range, the leading causes of death were transport accidents and injuries that were either self-inflicted and injuries that were either accidentally or purposely inflicted by others.⁴⁴ This was consistent with the high crime and murder rate for young men who were victims of gang related murders.

The three leading causes of death for women (from 2003 to 2008) were diabetes mellitus, hypertensive disease, diseases of pulmonary circulation and other forms of heart disease. The three leading cause of death for men of all ages were transport accidents, HIV/AIDS and injury undetermined whether accidental or purposefully inflicted with the latter increasing over that period.⁴⁵

The three leading causes of death for men (from 2003 to 2008) were Injury undetermined whether accidentally or purposefully inflicted, transport accidents, Ischemic Heart Disease and HIV/AIDS.

Between 2003 and 2008, HIV/AIDS surfaces as one of the leading cause of death in Belize for men and women in the 20 to 49 age category.⁴⁶ Transport accidents and injuries whether self-inflicted or caused by another person were also leading causes of death for those in the 20 to 39 age group. For women over 50 years, diabetes mellitus and other chronic illnesses were a major cause of death.

This mortality trend reveals that more men than women die violently, either in transport accidents or as a result of injuries, whether self-induced, accidental or purposefully inflicted. Men with HIV also have a higher death rate than women with HIV.⁴⁷ On the other hand, women tend to die mostly from chronic illnesses that have a high association with genetic predisposition, lack of exercise and unhealthy eating habits.

3.1.11 Chronic Illnesses

The overall diabetes prevalence rate in Belize is estimated at 13.1%. However, the prevalence rate among women was 17.6% compared to 8.3% among men. The prevalence of diabetes mellitus was 3 to 5 times higher among older persons ages 40 to 66 and 65 and older. The presence of the disease was positively correlated with age, being overweight or obese, having hypertension, having elevated cholesterol levels and/or having wide waist circumference.⁴⁸ For women, ethnicity posed an additional risk factor. Women of East Indian, Mixed and Garifuna ethnicities had a higher prevalence rate than women of other ethnic identities.

The overall hypertension prevalence rate in Belize is estimated at 28.7%.⁴⁹ In a study, no major gender differences were noted in the prevalence rate for hypertension. However, the study reported a strong association between hypertension and diabetes

for both men and women. The diabetes prevalence rate was 3.5 times as high in women with hypertension and 2.5 times as high among men with hypertension. As in the case of diabetes, ethnicity was an associated risk factor for women but not for men.

Obesity was much higher among women (41.9%) than men (23.1%).⁵⁰ However, slightly more men (35.8%) than women (30.5%) were diagnosed with being overweight. As with the other two chronic illnesses discussed above, obesity increased with age and other associated risk factors.

For both women and men, obesity, diabetes, hypertension and high cholesterol levels are linked to lack of exercise and poor eating and drinking habits. For men, the situation was aggravated by alcohol consumption. For women, lack of exercise and poor eating habits were related to their reproductive roles as wives, mothers and caretakers of the family. Because of their multiple roles, women tend to have more challenges in finding time to exercise. They also tend to eat while cooking or eat food left by children. Some women also wait for other family members to eat first and then eat the “left-overs”. Women’s hormonal levels and their childbearing role also contribute to increases in weight gain during pregnancy, after childbirth, during perimenopause and when they become menopausal.

The study⁵¹ recommended that preventive education messages on healthy eating habits be targeted at both men and women and at children in the education system. They suggested that women be the primary target for messages on the effects of exercise. The study recognized that for women to exercise, they need support to manage their reproductive roles of wife and mother. Men’s support becomes an important step in helping women to stay healthy and vice versa.

The world of work in Belize does not provide incentives for health physical activities. Only a few organizations such as the Central Bank of Belize, the Belize Social Security Board and the Belize Electricity Ltd. encourage exercise through workplace programmes. This includes either interoffice sporting competition programmes for men and women and/or structured aerobic exercise classes provided at the worksite. National workplace policies to promote increased healthy physical activities are needed.

Within the community, issues of citizen security impact negatively on men and women’s access to safe spaces to engage in physical activities. The high crime rates make walking and running a prohibitive activity in Belize City. Addressing the crime situation is therefore an important aspect of promoting health lifestyles.⁵²

3.1.12 Gendered Patterns of Alcohol Consumption

A major health risk factor in Belize is substance abuse and dependence. As indicated above, this issue is related to risky sexual behaviour⁵³, domestic violence⁵⁴ and chronic diseases⁵⁵ and is believed to contribute to transport accidents. Substance abuse is also related to mental health problems, particularly for men.⁵⁶

One study on chronic diseases stated that men reported drinking alcohol more than women. Men also reported that when they drank, they ingested more drinks (8.5 drinks) than women (3.6 drinks). They also ingested more drinks on more occasions than women.⁵⁷

A separate study⁵⁸ on gender, alcohol and culture in Belize reports that four times more men than women reported drinking alcohol. Furthermore, of all drinkers, 44.7% of men compared to 18.3% of women drinkers exhibited hazardous drinking behaviours. Men drinkers were three times more likely than women drinkers to report symptoms that indicate alcohol dependence. For example, more men than women reported being unable to stop drinking once they started, experiencing memory loss and failing to do things they were normally expected to do.

More men drinkers than women drinkers also reported that their drinking behaviour had a harmful effect on their finances, their marriage or intimate relationships, work and/or schooling. Both men and women drinkers reported that their drinking behaviours had a harmful effect on their housework or chores. Of all the effects stated, the most reported harmful effect was the impact on household finances. Higher rates of alcohol consumption were reported by men and women in the lower compared to the higher income categories.⁵⁹

While more men than women report hazardous alcohol consumption patterns, the entire family becomes affected by this behaviour. In Belize, women partners of men drinkers are the ones who most seek help for their partners. This occurs when alcohol abuse or dependence impacts negatively on the family.⁶⁰

Though alcohol abuse/ dependence remains a risk factor for STI/HIV transmission, unplanned pregnancies, chronic illnesses and transport injuries, this issue has remained largely invisible in national policies and programmes. The work of the National Drug Abuse Control Council is therefore not integrated into National SRH and HIV plans or other interventions aimed at reducing the prevalence of chronic illnesses and transport injuries. Consequently, the NDACC is not given the priority it deserves and continues to operate with limited human and financial resources.

In the last quarter of 2009, the NDACC, with the support of PAHO/WHO, developed a draft Substance Abuse Policy. This policy includes recommendations for the institutional strengthening of NDACC and for priority substance related education and mitigation programmes to be developed.

3.1.13 Mental Health in the 21st Century

The national response to poverty, STI/HIV reduction, child abuse and gender-based violence all call for access to psycho-social support programmes. This includes mental health services, which though needed, are extremely limited.

Mental health services are currently equated with psychiatric care and treatment. Services are guided by the “Unsoundness of Mind Act” of Belize. Under this Act, mental health patients are “defective” and are “idiots”, “imbeciles” or “morally defective”. The Act states:

“defective” means-

- an idiot, that is to say, a person in whose case there exists mental effectiveness of such a degree that he is unable to guard himself against common physical dangers;
- an imbecile, that is to say, a person in whose case there exists mental effectiveness which, though not amounting to idiocy, is yet so pronounced that he is incapable of managing himself or his affairs or, in the case of a child, of being taught to do so;
- a feeble-minded person, that is to say, a person in whose case there exists mental defectiveness which, though not amounting to imbecility, is yet so pronounced that he requires care supervision and control for his own protection or for the protection of others or, in the case of a child, that he appears
- to be permanently incapable by reason of such defectiveness of receiving proper benefit from the instructions in ordinary schools;
- a moral defective, that is to say, a person in whose case there exists mental defectiveness coupled with strongly vicious or criminal propensities and who requires care, supervision and control for the protection of others, and includes every person affected by section 19”;⁶¹

Belize has one residential care facility and one community inpatient psychiatric unit with four beds. At all hospitals and in some outpatient clinics at least one psychiatric nurse is available to give psycho-tropic medication. However, there are no mental health day treatment facilities or community residential facilities in Belize.⁶²

Belize’s ratio of mental health workers per 100,000 population is 18. Of these only 2 are psychiatrists (0.6 per 100,000 population) who both work in government-administered facilities and in private practice. The majority of mental health workers are therefore psychiatric nurses (7.6 per 100,000 population) and other health or mental health workers (another 7.6 per 100,000 population).

In terms of physician-based primary health care clinics, 50% have assessment and treatment protocols available for key mental health conditions, but there are none available in the non-physician-based primary health care clinics. Yet, a majority of doctors choose not to attend mental health training sessions to refresh themselves on mental health conditions.⁶³ Only 6% of nurses participated in refresher training over a one year period (from 2005-2006), demonstrating that nurses, mostly women, remain the “backbone” of psychiatric care services in Belize.⁶⁴

Sex disaggregated data for mental health patients in 2006 demonstrates that women comprise over 59% of users of outpatient facilities, 49% of users of the community

inpatient facility and 38% of residents in the mental health hospital. Alternately, men comprise 25% of users of outpatient facilities, 44% of users of community inpatient facilities and 61% of residents in the mental health hospital. Children and adolescents comprise 16% of users of outpatient facilities, 7% of inpatient facilities and 1% of residents in the mental health hospital.⁶⁵ This pattern demonstrates that women tend to access mental health services in outpatient facilities and access services earlier than men. By the time men access mental health facilities their conditions are severe enough to require hospitalization. This accounts for men disproportionately high representation (61%) as residents in the mental health hospital.

Sex-disaggregated data for 2004 to 2008 indicates that women comprise a larger percentage of both old and new mental health patients. More women than men are diagnosed with mood disorders, relational problems, anxiety disorders, problems related to abuse and dementia/delirium. More men than women are diagnosed with psychotic disorders, substance induced disorders, childhood disorders and behavioural/physical disorders.

This pattern reveals that mental health issues for men tend to be related to the use of substances (drugs and alcohol) and to behavioural issues more than women. Mental health diagnoses for women tend to be related to mood, anxiety, relationship and abuse issues. These diagnostic categories are consistent with the gender role expectations of men and women in the Belizean society.

Table 7: Mental Health Diagnoses 2005-2008

Diagnosis	2004		2005		2006		2007		2008	
	M	F	M	F	M	F	M	F	M	F
Psychotic Disorder			1,931	1,275	2,219	1,632	2,598	1,750	2,032	1,602
Mood Disorder			670	1,730	860	1,837	855	1,905	492	1,284
Relational Problem			604	856	791	1,150	689	1,131	746	1,084
Associated Condition			238	600	246	535	192	471	58	229
Anxiety Disorder			323	502	379	547	354	505	294	524
Behav/phys			311	290	328	279	468	525	386	310
Substance Induced Disorder			400	28	518	47	542	30	537	39
Childhood Disorder			204	116	346	244	297	153	278	168
Problem Related to Abuse			53	89	56	237	40	99	14	40
Dementia/Delirium			36	49	37	71	36	100	73	96
Old Patients Seen			4,362	4,660	5,334	5,868	5,957	5,897	4,366	4,712

New Patients Seen	1,256	2,040	1,297	2,057	1,749	2,594	1,025	1,246
Total Patients	5,618	6,700	6,631	7,925	7,706	8,491	5,391	5,958

Source: Ministry of Health. Health Statistics of Belize. 2004-2008.

Providing mental health services to women, men and children remains extremely challenging given the limited cadre of mental health professionals available in Belize. The situation is even more aggravated by outdated mental health legislation, the lack of an approved mental health policy to guide a human rights-based approach, inadequate infrastructure for community based care and a lack of integration of substance abuse issues. Consequently, the provision of mental health services remains one of the greatest gaps in social sector programming in Belize.⁶⁶

This is the case even though the Domestic Violence Act (2007) and the Trafficking in Persons (Prohibition) Act (2003) both call for rehabilitation services for victims. Similarly, the National HIV Policy and the National Plan of Action for Children and Adolescents both call for the provision of psycho-social care, including professional counselling, for vulnerable populations. Proponents of these laws, policies and plans indicate that the provision of a human rights-oriented mental health framework and services, remains at the core of creating behaviour change that can lead to greater citizen productivity, citizen security and gender equity in Belize.

In response to the dire need for strengthening the current mental health framework, the Belize Mental Health Association spearheaded the development of a mental health policy and developed an updated Mental Health Bill. With the support of the Pan American Health Organization (PAHO), the Public Health Act was also revised and a Substance Abuse Policy has been drafted.

The draft Mental Health Policy and Act attempt to expand the definition of mental health to include psychological as well as psychiatric treatment services. In this expanded definition, professional counselling services would be legally recognized as a mental health service and mental health patients would no longer be considered “defective”, “idiots” or “imbeciles” as they are currently referred to. Together, these policies and legal changes can create a more effective and supportive mental health environment for vulnerable populations.

3.1.13 Men’s Access to Health Services

The HIV epidemiological profile presented above demonstrates that even though the rate of HIV infection for men and women in Belize is almost equal, men have a higher AIDS rate than do women. This trend may be influenced by men’s perceptions of health services and their patterns of access to health care.

In a study⁶⁷ on men’s participation in reproductive health programs, approximately half of the male respondents stated that “health services are for women and girls”. Health care providers who were interviewed concurred with this perception. They stated that

public sector sexual and reproductive health services focus on women's reproductive health and is narrowed primarily to maternal and child health. The study therefore concluded that men's sexual and reproductive health needs are not considered in Belize.

In the study, 30% respondents ever used health services and another 45% said that they had never used health services for any purpose. Some participants indicated that "they do not go to the hospital unless they are sick and "... they do not go for check-ups like females." Men rationalized this behavior by saying that "because men are more active physically it serves as preventative care for them and they are less likely to become ill."⁶⁸

This study concurred with the findings of the MSM study in stating that men who access health services prefer to do so abroad to preserve their privacy and confidentiality. Another interesting discovering is that men regularly seek health care advice and services from pharmacists as a first line of intervention.⁶⁹ They will go to health care providers, clinics or hospitals only as a last resort when their health has deteriorated.

This study mirrors global trends showing that men do not seek health services at the same rate as women. More women tend to seek health care services for preventive care and early treatment than do men. This pattern may account for why more AIDS cases are reported among men in each year respectively. While men tend to seek health care services when they are at the progressive states of various illnesses, women pay more attention to preventive care.

Belize's Sexual and Reproductive Health Policy has the intension of increasing men's access to SRH services. However, the entire health care delivery system would need to be re-oriented to meet the men's overall health care needs. The concept of community and family clinics has been proposed by Ministry of Health personnel. However, no specific plans have been developed and no human or financial resources have been allocated to ensure that this re-orientation takes place. In the meantime, men remain at a disadvantage in their access to overall healthcare services.

3.1.14 Greater Access for Rural Communities

Most health facilities are located in urban centres, therefore rural women, men and children are disadvantaged in their access to healthcare services. An inequitable distribution of medical equipment and supplies, an inequitable distribution of healthcare professionals in favour of urban areas and the differences in quality of health personnel in remote rural areas compared to urban areas further disadvantage rural communities.

⁷⁰

Belize City, in particular, has a high concentration of healthcare professionals compared to its population size. Sixty-five percent (65%) of pharmacists, 52% of practical nurses, 45% of professional nurses and 35% of physicians work in Belize City. This inequitable distribution of human resources is also prevalent in the Northern Region (Orange Walk and Corozal Districts). The Western Region was reported to have an equitable

distribution of healthcare professionals per population size.⁷¹ The Southern Region which has the country's highest poverty rates, high fertility rates and high rates of growth stunting among children, remains the most disadvantaged. Only 8.8% of physicians and 11.6% of nurse work in the Southern Region.⁷²

Across the country, the issue of quality healthcare services for rural populations surfaces.⁷³ While the management of health services has been decentralized to the regional level, rural men and women complain that this has not translated into an improved quality of service delivery. They report that health centres in rural areas often lack equipment, medical supplies and human resources. As a result, rural communities have to travel long distances to access basic health services. This increases the cost of health care services due to the added cost of transportation to and from health facilities which are centralized in urban locations.

The establishment of the National Health Insurance Scheme in the Toledo and Stann Creek Districts helped to improve rural access to primary health services. On specific days, the NHI-Operated San Antonio Polyclinic in Toledo provides men, women and children access to maternal and child health services, medical supplies, diagnostic facilities and laboratory testing. Only two other rural communities, both in or close to tourism destinations, have a polyclinic in Belize. These services are not available on a 24 hour schedule and medical care at night and on weekends still remains inaccessible.

Cases that cannot be addressed at the San Antonio Polyclinic are referred to the other NHI Polyclinic in Punta Gorda Town, to the Punta Gorda Public Hospital or the Southern Regional Hospital in Dangriga Town. Because the Southern Regional Hospital is located at least two hours from most Mayan communities in Toledo, accessing this hospital creates severe hardship on Mayan families. With the highest poverty rate in Belize, the socio-economic status of Mayan families does not allow them easy access to transportation and overnight facilities, both needed when travelling for medical care at the Southern Regional Hospital.

Because of an increased awareness of the need to make health services more accessible to rural populations, the residents from Toledo have established a health committee. This health committee includes women from Toledo. Through this medium it is anticipated that the quality of health services will improve for rural families in Toledo. Meanwhile rural communities in the other five districts remain disadvantaged in their access to medical services.

3.2 Education for National Development

The Government defines education as “the lifelong acquisition of knowledge, skills and attitudes for full personal development and for active participation in society.”⁷⁴ Through education, Belize proposes to build its human resource capacity for development. Belize's greatest education achievements in the last ten years are in the expansion of early childhood education services, the countrywide roll-out of the health and family life curriculum at the pre-school and primary education levels and the scaling up of vocational and technical education programmes countrywide. Yet, low primary and

secondary school completion rates and low levels of trained teachers⁷⁵ continue to impact negatively on Government's aspirations for a highly skilled labour force.

Efforts at revamping the education system and in improving the quality of education in Belize have intensified. A more human rights approach to discipline is being advocated by the Ministry of Education and more opportunities for teacher training have been made accessible at the district level. Discussions are underway to strengthen the Education Services Commission to improve administrative and coordination services for teachers across the education system.

3.2.1 Early Childhood Development Education

The Early Childhood Education and Development Centre (ECEDC renamed from the Pre-School Unit) was relocated and upgraded to meet its new responsibilities of early childhood development. Pre-school education has a 2 year duration and targets children ages 3 to 5 years. By 2009, a total of 80 new pre-schools were established in Belize, therefore increasing access to early childhood education programmes. The Ministry of Education attached pre-schools to primary schools to ensure access in both urban and rural communities.

Enrolment in pre-schools has increased from 3,100 students to 7,333 students over the last five years. The gross enrolment ratio increased from 26.8% in the 2001/2002 period to 35.7% in the 2007/2008 school year. Slightly more girls compared to boys are enrolled in pre-school education programmes. Because the government now pays the salaries for 215 (as opposed to 21 in 2003), pre-school teachers, early education programmes are also more affordable for parents.

To complement the establishment of new pre-schools and to ease the transition into pre-schools, the government has employed six new early childhood education coordinators to deliver early childhood activities with parents and communities. Additionally, the pre-school curriculum was revised to create linkages with the infant curriculum in primary schools. There is also an increase in public awareness and parent education activities taking place across the country.

The lack of legislation for regulating pre-schools is a major challenge for the effective roll out of pre-school education. The absence of regulations affects the standardization and quality of pre-school education in Belize. The lack of updated information on children not receiving early childhood education services and the reasons for this also limits the effective targeting of programmes. Human resource challenges impact on the quality of pre-school education provided. A lack of coordination and collaboration with other social sector ministries is also a major challenge in providing holistic services to pre-school aged children.⁷⁶

The completion and ratification of the draft Early Childhood Education Policy was highlighted as a priority for the Ministry of Education.⁷⁷ The draft policy framework promotes an integrated response to early childhood development. Parental support and

social protection programmes as well as community intervention initiatives were proposed as key elements of a strategy for enhancing early childhood development.⁷⁸

3.2.2 An Education System in Crisis

In 2008 alone, only 44.9% or approximately one-half of those who took the primary school examination (PSE) received satisfactory levels of performance in the English A category. This percentage increased to 57.3% for those who sat the Mathematics component of the examination. These results reflect a long-standing issue regarding the quality of primary education in Belize.

Table 8: Percentage of Candidates with Satisfactory Levels of Performance (SLP*) in CSEC English A and Mathematics 2008

District	English A			Mathematics		
	no. of Sitters	Satis. Number	Levels of Perf % of Sitters	no. of Sitters	Satis. Number	Levels of Perf % of Sitters
TOTAL	2,658	1,193	44.9	2,566	1,471	57.3
Belize	893	475	53.2	857	444	51.8
Cayo	556	227	40.8	518	217	41.9
Corozal	370	166	44.9	356	258	72.5
O. Walk	339	137	40.4	333	227	68.2
S.Creek	305	125	41.0	286	182	63.6
Toledo	195	63	32.3	216	143	66.2

3.2.3 Primary Education

At the primary education level, the net enrolment (83.7%) and gross enrolment (95.1%) figures remain high.⁷⁹ This is partially due to education cost-sharing measures implemented by the government as well as by the legalization of mandatory education for children aged 5 to 14 years. At the primary level there are more girls than boys enrolled in school. Even at this level, boys tend to have higher repetition and dropout rates than girls.

Table 9: Primary School Net Enrolment Rate 2008-2009

Gender	Enrolment	Population	% Enrolled
Males	29,423	35,587	82.7
Females	28,801	34,011	84.7
TOTAL	58,224	69,598	83.7

Source: Abstract of Education Statistics (2008-2009). Ministry of Education

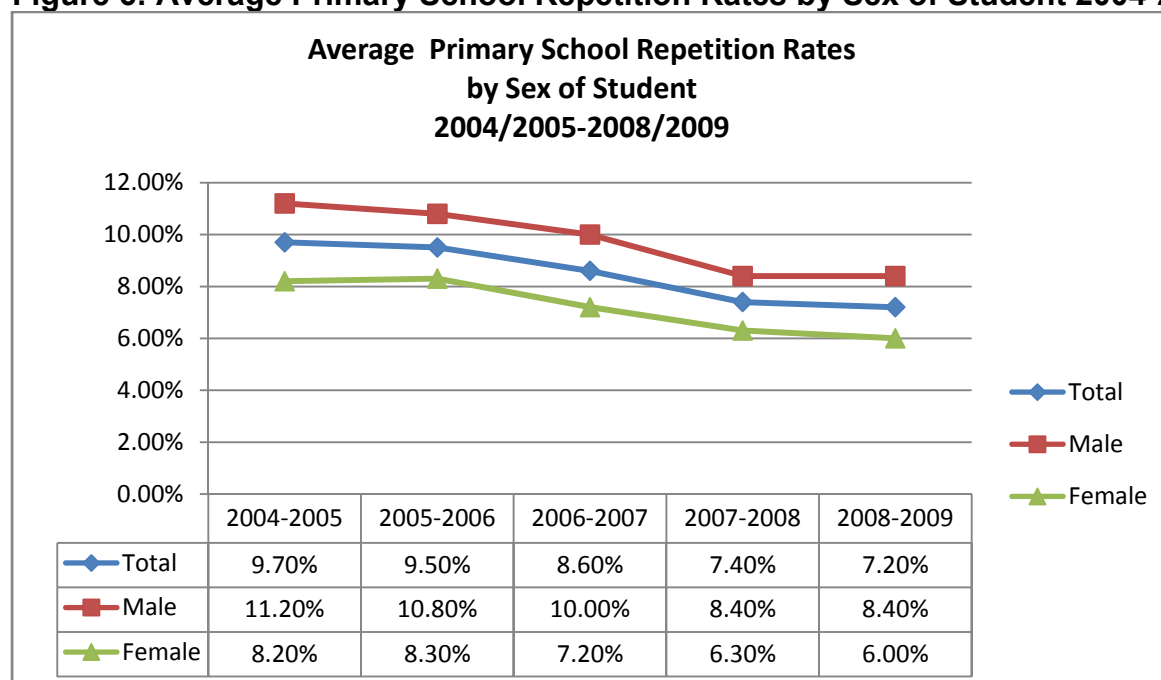
Table 10: Primary School Gross Enrolment Rate 2008-2009

Gender	Enrolment	Population	% Enrolled
Males	33,681	35,587	94.6
Females	32,477	34,011	95.5
TOTAL	66,158	69,598	95.1

Source: Abstract of Education Statistics (2008-2009). Ministry of Education

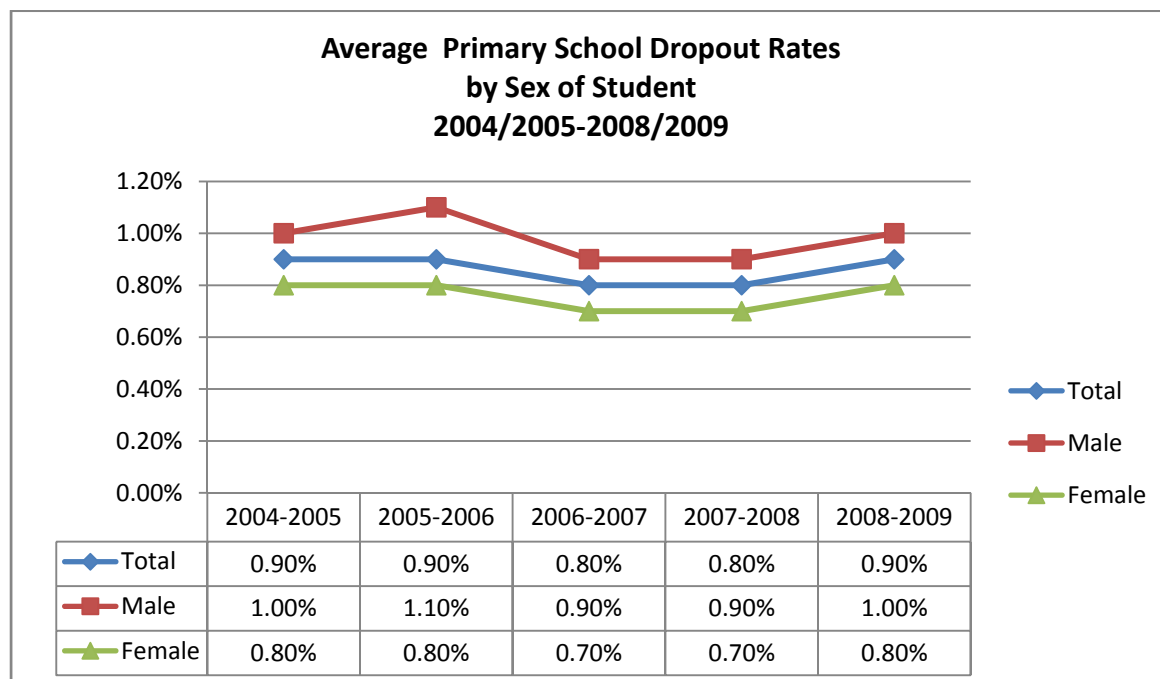
The average primary school repetition rate since 2004 shows a downward trend. However, the repetition rate for boys is consistently higher than the rate for girls, indicating a need to focus on the gender-related dimensions of this issue.

Figure 6: Average Primary School Repetition Rates by Sex of Student 2004-2009



The average primary school dropout rates show an increasing trend. This may indicate that rather than repeating the school year, children drop out of school completely. Again, the dropout rates for boys are consistently higher than the rate for girls.

Figure 7: Average Primary School Dropout Rates by Sex of Student 2004-2009



3.2.4 Secondary Education

The secondary school net enrolment rate for the 2008/2009 school year was very low at 40.7%. For boys the net enrolment rate was even lower at 37.4% compared to girls at 44.1%. The gross enrolment rate for the 2008/2009 school year was 53.5%. The enrolment rate for boys was also lower than for girls at 49.8% compared to 56.4% for girls.⁸⁰

While more girls than boys aged 13 to 16 years were enrolled in secondary school, the overall figures are still low. Having approximately one-half of boys and girls (13 to 16 years) attending secondary school means that the other half are either employed, are provided for by others or are on the streets. A few 13 to 16 year olds may still be in primary school or may have already graduated from secondary school. Either way, Belize's capacity for development is seriously compromised by the low secondary school enrolment and completion rates.

Table 11: Secondary School Net Enrolment Rate 2008/09

Gender	Enrolment	Population	% Enrolled
Males	6,314	16,895	37.4
Females	7,193	16,322	44.1
TOTAL	13,507	33,217	40.7

Source: Abstract of Education (2008). Ministry of Education

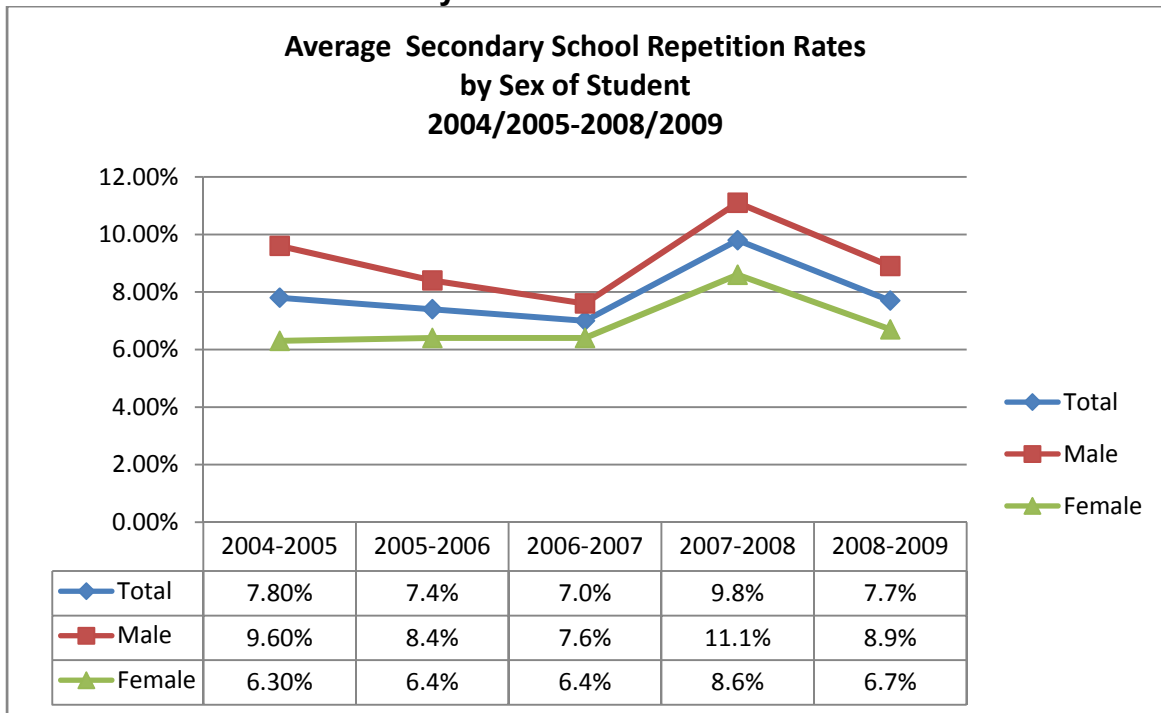
Table 12: Secondary School Gross Enrolment Rate 2008/09

Gender	Enrolment	Population	% Enrolled
Males	8,408	16,895	49.8
Females	9,207	16,322	56.4
TOTAL	17,615	33,217	53.0

Source: Abstract of Education (2008). Ministry of Education

At the secondary school level, there was an obvious dip in the repetition rate in 2006. The rate increased again in the 2007-2008 school year and tapered off slightly in the 2008-2009 period. The retention rate for boys was higher than for girls.

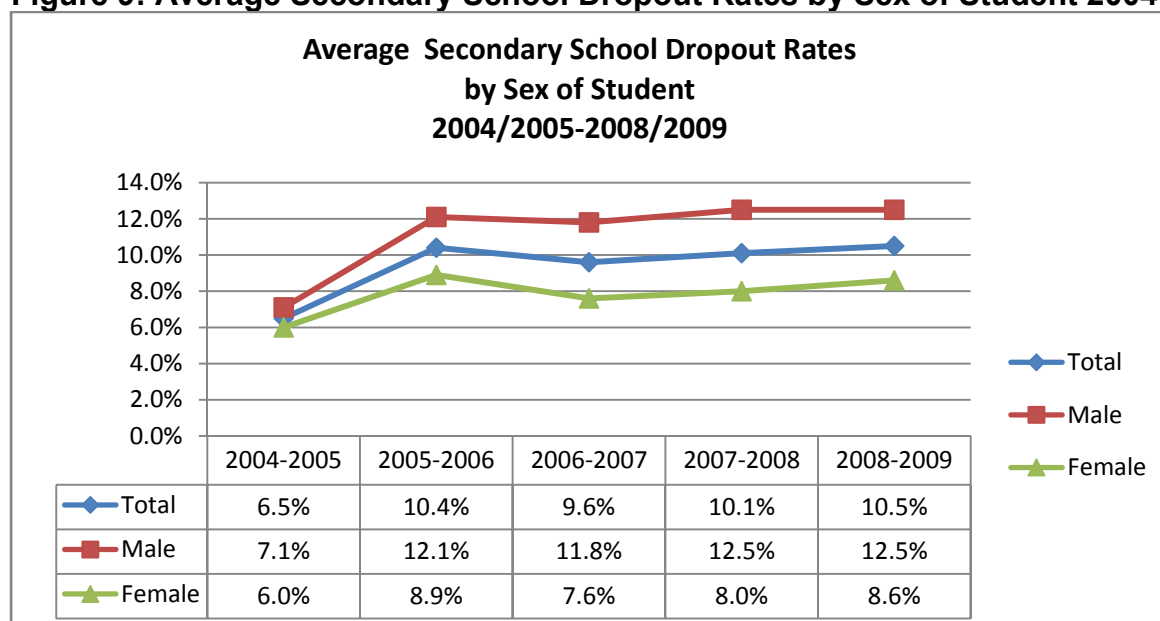
Figure 8: Average Secondary School Repetition Rates by Sex of Student 2004-2009



As with the trend at the primary school level, there was a reported increase in the secondary school dropout rate since 2004. Approximately one out of every 10 enrolled students drop out of secondary school. For boys, this increases to almost 1.3 out of every 10. The dropout rate for girls is lower but also shows an increasing trend.⁸¹

The higher primary and secondary repetition and dropout rates for boys compared to girls, indicates a need for greater gender responsiveness in education, including in the design and delivery of the curriculum and in the establishment of support mechanisms that will allow children to stay in school.

Figure 9: Average Secondary School Dropout Rates by Sex of Student 2004-2009



3.2.5 Teacher Training

A majority of the teaching workforce are women. At the pre-school level, a maximum of four men were teachers (2006-2007) compared to a maximum of 345 women (2007-2008). At the primary education level, women more than double the number of men teachers. The gender gap narrows among secondary school teachers and becomes almost equal among junior college teachers. Teacher training, teacher retention and teacher salary issues therefore affect women more than men.

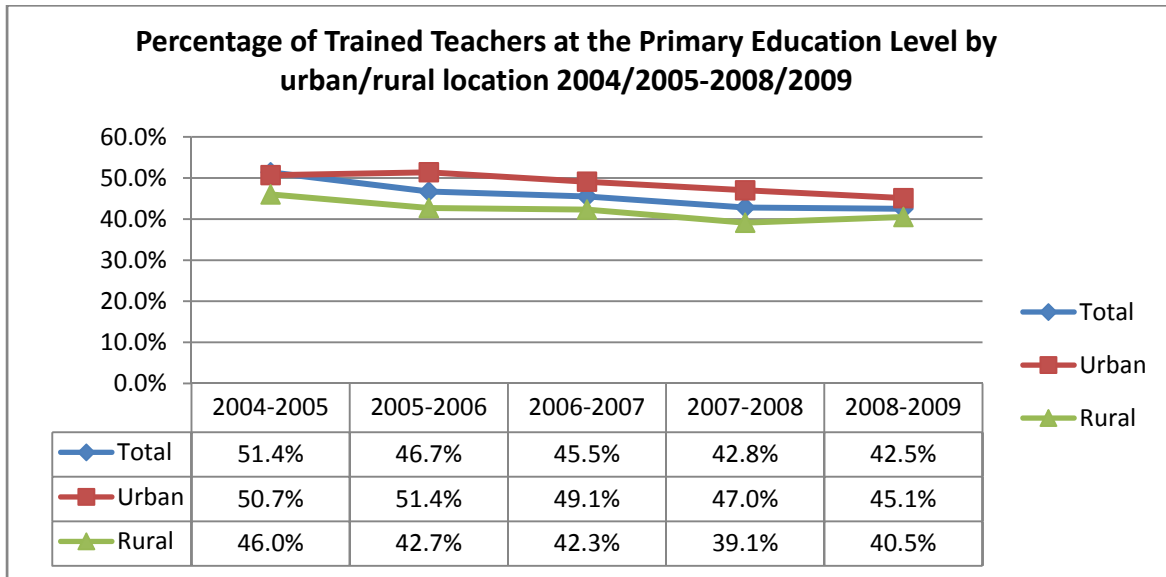
Table 13: No. Of Trained Teachers by Employment Level within the Education System 2004-2008

School Year	Preschool		Primary		Secondary		Junior College	
	M	F	M	F	M	F	M	F
2004-2005	2	254	746	1918	529	585	70	82
2005-2006	3	279	796	2033	568	602	85	90
2006-2007	4	287	803	2057	575	631	85	88
2007-2008	3	345	820	2097	574	642	94	85

Source: Ministry of Education. Statistics at a Glance. 2004 to 2008

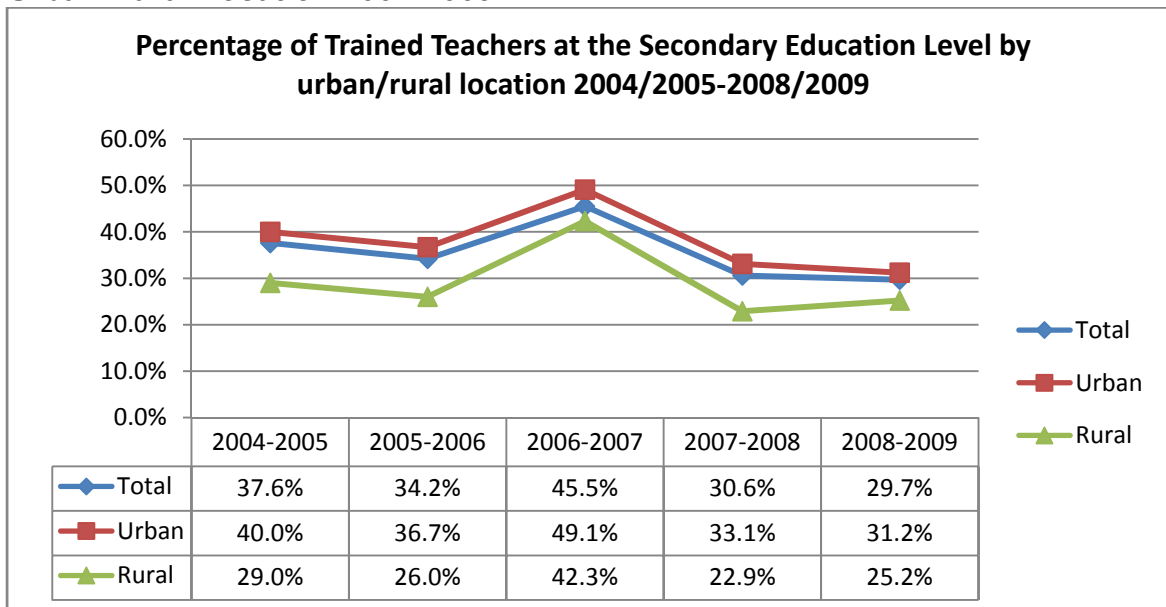
Despite efforts to increase teacher training programmes, the percentage of trained teachers at the primary education level shows a decreasing trend. Whereas almost one-half were trained in 2004, only 42.5% were trained in the 2008-2009 period. Differences in the percentage of trained teachers in urban and rural locations, though small, still reveal a greater need to improve the quality of education delivered within rural schools.

Figure 10: Percentage of Trained Teachers at the Primary Education Level by Urban/Rural Location 2004-2009



Similarly, at the secondary school level a downward trend in the percentage of trained teachers is also evident. While this downward trend affects both urban and rural schools, rural schools are more disadvantaged than urban school. In rural areas, only one-quarter or 25% of teachers working within secondary schools are qualified to teach at that level.

Figure 11: Percentage of Trained Teachers at the Secondary Education Level by Urban/Rural Location 2004-2009



3.2.6 “Second Chance Programmes”

While the drop-out rates are increasing, programs for training young women and men who drop out of the formal education system remain limited. These are mostly implemented by civil society organizations like the YWCA and the Youth Enhancement Services. Both organizations operate on meagre human and financial resources. Their goal is to provide “second chances” for young girls to either re-integrate into the formal education system or learn a marketable skill.

These young women are often victims of sexual exploitation or child abuse and live in poverty. Counselling, life skills development and peer group support has proven successful in helping these young women to transform their lives. Some young women who benefited from these programmes are now university graduates. Others are now small business owners or are employed in the hospitality industry.⁸²

Similar programmes for boys also exist. This includes TUBAL and the YMCA. These organizations also provide literacy education and life skills programming. With this type of support, boys have an opportunity to learn a marketable skill.

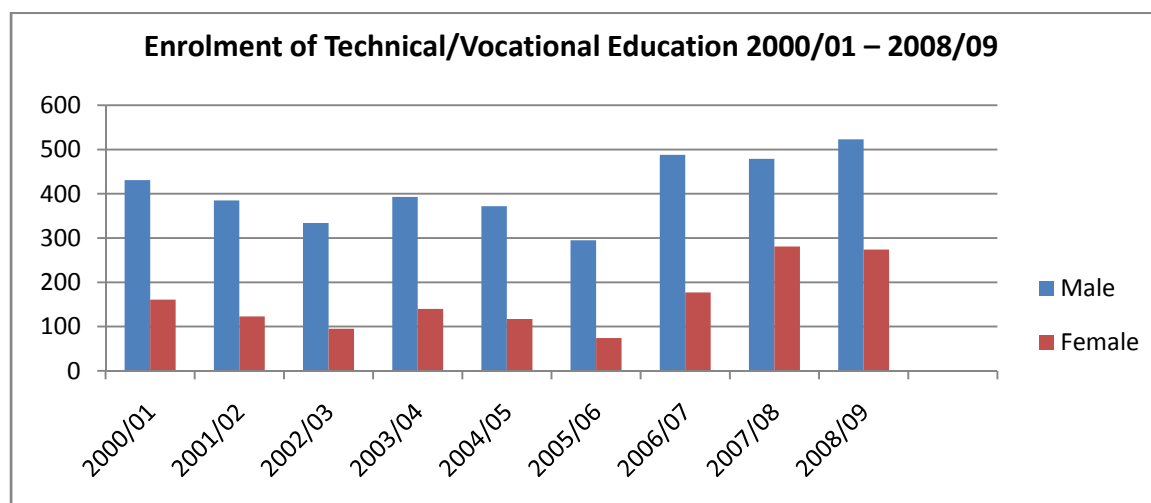
These “second chance” programmes help young men and women to develop into productive citizens and stay away from criminal activities. It also provides early school leavers an opportunity to re-think their lives and re-invent themselves and create a more positive future. Yet, these programmes have not been articulated nationally as contributors to crime reduction or to creating productive citizens. Rather, they are perceived as marginal to overall crime prevention programming, employment generation and national development.

3.2.7 Vocational and Technical Education

Vocational and technical education for boys and girls has increased since 2000. This increase was stimulated by Government’s investment in creating Centres for Employment Training (CETs) in each district. The CETs later evolved into a more comprehensive curriculum for technical and vocational education delivered through Institutes for Vocational Education and Training (ITVETs). The ITVETs accept children at age 15. This programme is therefore not a “second chance” programme for children who drop out of primary school or the first two years of secondary school where the majority of dropouts occur. Rather, the ITVET programme is envisioned as a technical school that aims to produce technicians who are qualified to meet the technological and technical needs of Belize now and in the future.

Unlike primary, secondary and tertiary education, boys continue to outnumber girls in the enrolment of technical and vocational programmes throughout the country. The enrolment of girls has increased since 2006.

Figure 12: Enrolment of Technical/Vocational Education 2000-2009



Teachers⁸³ indicate that ITVET programmes are positive and can keep children, especially boys, within the education system. While teachers understand and support the need to develop a cadre of highly qualified technicians who can advance to tertiary education in Belize or abroad, they remain concerned that Belize is still not addressing the need for keeping children in school or finding ways to re-integrate early school leavers into the education system.

3.2.8 Inclusive Education

Teachers countrywide indicate that they have worked with students who have some form of disability.⁸⁴ In one case, a secondary school teacher reported that she has a student with a learning disability that was not diagnosed at the primary school level.⁸⁵ Schools in Belize City also report that they encounter children who need special attention which they as teachers, are not trained to provide. While no data exists regarding the rate of children with special education needs in Belize, teachers perceived this to be a growing issue that affects learning, retention and dropout.⁸⁶

The National Resource Centre for Inclusive Education (NRCIE) advocates for the mainstreaming of children who have special needs. Decisions regarding mainstreaming are made based on the child's type of disability and learning capacity. The Centre also assists in diagnosing learning disabilities. NRCIE trains teachers to manage special needs children so that these children can maximize their learning potential. A Special Olympics Programme is also organized to ensure greater integration of special needs children in recreation and sporting activities.

The NRCIE reports that children and adolescents with special needs have a right to sexual and reproductive health information and services. Ethical issues of

contraception, sexual activity and child bearing are therefore now a part of the discussion on the human rights of children and adolescents with special needs. Supported by the United National Population Fund (UNFPA), NRCIE has been able to provide sexual health information to targeted children and adolescents and their parents.⁸⁷ In cases in which the children and adolescents cannot make decisions for themselves, the parents develop the skills needed to make the best decision on behalf of their special needs child.⁸⁸

Inadequate human and financial resources limit NRCIE's capacity to expand special needs services countrywide. Currently, services are mainly Belize City-centred even though teachers are increasing demanding support for managing special needs children across the country.

Adults with special needs, except for those with visual impairment issues, remain invisible in Belize. The Belize Council for the Visually Impaired (BCVI) continues to provide services to those that are visually impaired. The Rotary Club provides wheelchairs to people who are unable to walk. Other adults with special needs do not have access to services in Belize.

3.2.9 Sexual and Reproductive Health Education

The implementation of the HFLE Curriculum is affected by a reluctance (on the part of the catholic school authority) to fully implement the sexual and reproductive health component of the curriculum. Even at the tertiary level, a catholic school management authority forbids the sharing of information on male and female condoms. Furthermore, teachers across denominational school authorities indicate their discomfort and lack of experience in discussing sexual and reproductive health issues with their students.⁸⁹ They prefer to engage other agencies who they feel are better equipped to deliver this information. Many children are therefore not receiving the sexual and reproductive health information as outlined in the HFLE Curriculum. This situation persists even in the context of teenage pregnancy, commercial sexual exploitation of children and adolescents, and high HIV transmission rates, especially among young women.

3.2.10 Gender Mainstreaming of the Curriculum

The Ministry of Education recognizes that the gender dimensions of education can no longer be ignored. Currently, the Women's Department conducts gender awareness sessions for teachers and students.⁹⁰ Members of the Women's Issues Network (WIN Belize), also conduct gender education sessions with students.⁹¹ Other agencies, like the National AIDS Commission, facilitate gender and sexuality education for teachers, when possible. This approach, while a good start, is ad hoc, dependent of resource availability, small in scope and does not easily translate into gender responsive education programming.

In a workshop, a Ministry of Education representative called for a “Gender-based Communication Strategy”⁹² for the education sector. She also recommended the integration of gender issues in the school curriculum and in teacher training programmes. Beyond this, a more gender responsive education system will require a complete re-thinking and re-structuring of education to appeal to the learning styles, interest levels and gender-related needs of boys, girls and adolescents.

3.2.11 Linking Education and Nutrition

The onus for human resource development is not the sole responsibility of the Ministry of Education. Chronic malnutrition has a devastating effect on children’s capacity for learning, especially during their formative years. Teachers across the country report that children go to school hungry.⁹³ Hunger affects their energy levels, their ability to concentrate and their learn potential.

A 2007 study⁹⁴ on child malnutrition in Belize states that, “programs need to target the critical periods of child development, when irreversible damage has not yet occurred.” The report further argues that “focusing on children under two years of age and pregnant mothers will bring the largest benefit in terms of human development as well as the largest return on investment to the country.”⁹⁵ To enhance the country’s human resource capacity therefore requires that inter-linkages between health and education programs be clearly articulated and that social sector programming becomes more truly integrated and child centred.

3.2.12 Moving Forward

Historical inequities in the distribution of education resources exacerbate existing gender and social disparities in the education system.⁹⁶ Operating within a rapidly changing technological era and within the context of regional integration, make for even greater development challenges. Investing in building human resource capacity for development is therefore a national imperative.⁹⁷

A National Education Summit (2006) and a Conference on the “Unspoken Gender Dimensions” of Education (2007) made comprehensive proposals for enhancing education in Belize. They proposed the need to not only focus on establishing more classrooms, increasing staff size and equipping schools. They recommended an increased focus on addressing the “environmental issues that stand in the way of attending school” and that hamper learning. The Education Summit⁹⁸ conducted in 2004 called for social issues like crime, hunger, poverty and gender socialization and learning disabilities to have a more central place in the discussion on how to improve the education system.

More specific recommendations included the need to re-distribute education financing, address poverty in targeted communities, create incentives to attract and retain qualified teachers, reduce the student to teacher ratio, expand vocational education, re-introduce

gardening, integrate the expressive arts, expand continuing education opportunities, build character education and civic pride, create an integrated student support system and align the curriculum with national development priorities.

3.3 Wealth Creation and Poverty Reduction

The global financial crisis inevitably affects Belize. As a small open economy with a narrow base of exports, Belize is highly vulnerable to exogenous shocks. Real GDP output has declined from 9.3% in 2003 to below 3.0% in 2007 and 2008.⁹⁹ A visible decline in tourism receipts since 2006 has affected women who took advantage of job opportunities within the tourism industry. The tourism industry grew exponentially in the last decade.¹⁰⁰ Simultaneous with the growth of the tourism sector, was Belize's increased recognition of its vulnerability to natural disasters. Natural disasters like hurricanes and floods have negatively impacted on economic growth and stability, particularly in the affected communities.

Gross Domestic Product figures for the first quarter of 2009 show that the Belizean economy contracted by 2.2% in real terms when compared with the same period of 2008. However, since February of 2008, Belize has benefited from a price decrease of 9.6% for "Transportation & Communication" items and a price decrease of 5.6% for "Rent, Water, Fuel & Power" items. The cost of food items remained high with a 3.4% price increase between May 2008 and May 2009.¹⁰¹ The result is increased poverty in Belize.

3.3.1 The Multiple Faces of Poverty

Poverty data for 2002¹⁰² indicates that 33.5% of the population was poor with 10.8% being indigent. Of these 33.9% of men and 33.2% of women were considered to be poor. Children 0 to 17 years had the highest poverty rate of 39%. The poverty rate for youth (14-17 years) was slightly lower at 33.9% and the rate for older persons (over 65 years) was 26.5%.

Poverty was highest in the Toledo District (79%) and lowest in the Belize District (24.8%). However, the poverty assessment recognized that pockets of extreme poverty persist in "southside" communities in Belize City. Furthermore, a poverty assessment conducted in three "southside" communities in 2005¹⁰³, confirmed that the quality of life of the "southside" population is compromised by crime and poverty related issues.

Poverty among female headed households was 21.8% compared to male-headed households at 25.5%. While male-headed households demonstrated the higher levels of poverty than women-headed households, this cannot be used as an indication of more poverty among men than women as women experience poverty differently than men.

Issues related to poverty for women and men were illustrated in the 2006 public consultation report on poverty in Belize.¹⁰⁴ That study outlined the multiple faces of

poverty. In their accounts, poverty had not only an economic face, but also a social, psychological and spiritual face. Issues related to stress, low self-esteem, depression, hopelessness, cynicism and dependency were highlighted under the psychological face. Issues of crime and violence, absentee fathers, lack of education, lack of good governance, teenage pregnancy and increased discrimination against vulnerable populations comprised the social face of poverty. Many of these issues disproportionately affect women.

In Toledo, which has the largest share of the country's poor population, a majority of households are headed by men. However, alcoholism and gender-based violence remain rampant within Mayan households in that District. Poverty for Maya women, therefore, extends beyond a lack of finance; it encompasses domestic violence, high fertility rates and low levels of access to quality health and education services.¹⁰⁵

Preliminary results from a more recent poverty assessment conducted in 2009 suggest that poverty across the population has increased from 33.5% to approximately 43%. Household poverty increased from approximately one out of every four households in 2002 to approximately one out of every three by 2009. The level of indigence also increased from 11% in 2002 to 16% in 2009. This increase in poverty levels across districts was linked with Belize's economic vulnerability as well as its vulnerability to natural disasters, including hurricanes and floods.¹⁰⁶

The report recognizes poverty as being "more wide-ranging than those based on income alone" and states that "general concept of well being was used to bracket these non-income aspects of poverty".¹⁰⁷ The 2009 assessment also posits that poverty in Belize tends to be chronic rather than transitional and that poverty reduction efforts must consider issues of income distribution and economic growth if poverty is to be reduced.

3.3.2 Child and Spousal Maintenance Issues

Child and spousal maintenance issues are addressed in the Family Court in Belize City and in magistrate courts in the other districts. Personnel from the Family Court in Belize City recognize the importance of children's access to child maintenance. In collaboration with the National Committee for Families and Children (NCFC), the Families and Children's Act was amended to include the provision of child maintenance for children out of wedlock. A legal amendment was also made to extend the time within which a maintenance case can be lodged (from 1 to 3 years) for children born out of wedlock and in which the pregnancy was not recognized.

Prior to these amendments, children born out of wedlock did not have easy access to child maintenance. However, the process for changing the legislation did not include changes to the child and spousal maintenance provisions of the Marriage Persons (Protection) Act, therefore creating disparities in favour of children born out of wedlock. The legal framework for child maintenance will need to be considered more holistically so that differences in the treatment of children in and out of wedlock can be eliminated.

The spousal maintenance provisions are not gender neutral. The law does not consider spousal maintenance for men. The law assumes that men and women play traditional gender roles with men as the sole economic provider of the household. The reverse situation is not envisioned. Furthermore, spousal maintenance provisions are allowed only until such time that the woman gets married or co-habitates with another man. Again the assumption is that her husband needs to take care of her until she finds another man. Once she finds another man to take care of her, the responsibility of economic support is then transferred to this other man.

Besides being gender specific, the spousal maintenance provisions are outdated and do not reflect the current cost of living. The Family Court¹⁰⁸ has therefore proposed that spousal maintenance provisions be amended to be more gender neutral and consistent with the current cost of living.

A major challenge in the enforcement of child and spousal maintenance orders is the lack of human and financial resources for monitoring compliance with the orders. For example, while the Family Court in Belize City has bailiffs employed specifically to increase access to justice on family matters the magistrate courts in the other districts have no such support system in place. Magistrate courts rely on police officers who double up as bailiffs. This compromises the quality and timeliness of service delivery. This capacity issue impacts negatively on the quality of life of the children involved.

This issue was highlighted in the National Plan of Action for Children and Adolescents (NPA). The NPA recommended the establishment of a Family Court in each district. Resource limitations have delayed this process which remains a long-term goal. Alternative interim strategies are being proposed. This includes the establishment of a roving Family Court which attends to family matters on specific days of the week in each district town.

3.3.3 Valuing Women's Reproductive Roles

Women have primary responsibility for child rearing. The related issues of absentee fathers and lack of resources for the effective enforcement of child maintenance legislation place single mothers at a distinct economic disadvantage. Additionally, the fact that pregnancy is biologically determined makes maternity-related employment discrimination a major gender issue. Social security provisions for maternity leave, though extended from 12 to 14 weeks, have room for improvement.

For fathers who want to be involved in child rearing, paternity leave is not a legal requirement. It is voluntarily practiced by some organizations. Organizational paternity leave policies usually allow a three day leave from work immediately after the birth of a child. Women's organizations indicate that this three day leave does not encourage active male participation in child rearing. The legalization of paternity leave requirements and an extension of the days is recommended.

The labour department¹⁰⁹ reported an increasing number of complaints regarding employers firing pregnant women or refusing to pay the difference in maternity payment provided by the Social Security Board. Consequently, it is at the time when women are most in need of economic support that they fall victims to employment related discrimination.

In 2004, a teacher from the Toledo District was fired by a Catholic primary school for being a pregnant, unwed teacher. In 2004, the NWC took this case of gender based employment discrimination to the Supreme Court. The Supreme Court Judge ruled in the favour of the teacher who had been fired. The catholic school authority was instructed to compensate the teacher with a \$100,000 reward. This decision was appealed. The verdict remained but the monetary award was reduced considerably. The National Gender Policy (2002) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), were used by the Judge to make his ruling in the case. Since then no other cases of terminations of unwed pregnant teachers have been officially reported to the NWC. However, in a recent 2009 workshop with teachers, several of them claimed that this practice continues.

Legislation for the economic valuing of women’s domestic labour in marriage dissolution exists. However, no action has been taken to ensure equity in women’s access to justice so that men do not continue to have an unfair advantage over them during court hearings on this matter. Formulas for the economic valuing of domestic work beyond marriage dissolution cases also need to be developed.

3.3.4 Labour Force Participation

There were 12,650 more men and 10,017 more women in the labour force in September, 2007 compared to April, 2002. Women’s labour force participation rate increased slightly from 38.8% in April, 2002 to 45% in April, 2007 and then decreased within that same year to 41.8% in September, 2007. However, the unemployment rates for women ranged from 15% in April, 2002 to 13.1% in April, 2007 and then increased to 18.6% in September, 2007 while the unemployment rates for men during that same period ranged from 7.0% to 8.4%.

Table 14: Main Labour Force Indicators 2002-2007

Indicators	2002	2003	2004	2005	2006	2007 April	2007 Sept.
Employed Labour Force	84,720	89,222	95,911	98,589	102,234	111,835	107,657
Unemployed Labour Force	9,453	13,215	12,580	12,127	10,573	10,423	14,859
Unemployment Rate	10.0%	12.9%	11.6%	11.0%	9.4%	8.5%	12.1%
Youth Unemployment Rate	N/A	N/A	N/A	N/A	N/A	N/A	24%

Indicators	2002	2003	2004	2005	2006	2007 April	2007 Sept.
Labour Force Participation Rate	57.3%	60.0%	60.3%	59.4%	57.6%	61.2%	59.0%
Men							
Employed Labour Force	58,852	60,571	63,468	64,878	67,909	72,490	71,502
Unemployed Labour Force	4,728	5,734	5,731	5,217	4,522	21,950	6,590
Unemployment Rate	7.5%	8.6%	8.3%	7.4%	6.2%	5.8%	8.4%
Youth Unemployment Rate	N/A	N/A	N/A	N/A	N/A	N/A	18.7%
Labour Force Participation Rate	78.6%	78.4%	78.1%	76.4%	75.6%	77.8%	77.5%
Women							
Employed Labour Force	26,138	28,651	32,443	33,711	34,325	39,454	36,155
Unemployed Labour Force	4,725	7,481	6,849	6,980	6,051	5,933	8,269
Unemployment Rate	15.3%	20.7%	17.4%	17.2%	15%	13.1%	18.6%
Youth Unemployment Rate	N/A	N/A	N/A	N/A	N/A	N/A	32.8%
Labour Force Participation Rate	38.8%	41.9%	43.0%	42.9%	40.4%	45%	41.8%

Source: Statistics Institute of Belize

There were 12,650 more men and 10,017 more women in the labour force in September, 2007 compared to April, 2002. The data reveals that although there are slight increases in women's labour force participation rate since 2002, less than half of women over 14 years old participate in the labour force. The highest women's labour force participation rate is recorded for the Belize District where approximately 50% of women are in the labour force. Approximately three-fourths of men over 14 years participate in the labour force. Even though women's labour force participation rate is much lower than men's, their unemployment rate is consistently more than twice the rate of men's.¹¹⁰

Approximately 60 percent of working women are employed as service and shop sales workers and clerks, or in elementary occupations. Women also make up 18 to 20 percent of the labour force that are professionals, legislators, senior officials and managers.¹¹¹ One half of all clerks, service workers and shop sales workers and less than one half or (40%) percent of legislators, senior officials, and managers are women.

Men tend to be represented primarily in agriculture activities, in the forest and fisheries sectors and in the defence force.

Even in sectors in which women comprise a majority of the work force, they still experience more unemployment than men. Women outnumber men in the health sector by more than two to one, but among unemployed health workers, women outnumber men by three to one.¹¹² Women also comprise the bulk of educators at the primary and secondary school levels. Belize provides no for those who wish to make nursing or teaching a lifelong vocation.

Women from both the nursing and education fields are actively recruited by the United States. This leads to the continuous migration of trained nurses and educators, thus leaving a heavy burden on the Belizean society. Belize invests in the education of nurses and teachers but receives minimal benefits when these when nurses and teachers migrate.

A recent UNDP report used labour statistics to show that:

“The average earnings of males and females reflect inequality in earnings, and demonstrate that women are at a higher risk of poverty, as the proportion of women earning less than \$600 was significantly higher than the proportion of males. The proportion of women in the highest income bracket was 1.5 percentage points lower than the proportion of men in the same bracket. In addition the levels of the average, median and modal incomes were lower for women than those for men.”¹¹³

This gender disparity in income levels was also reported in a socio-economic study of 12 coastal communities in Belize.¹¹⁴

Unemployment among youth is considerably higher than the national average. The youth unemployment rate (14-24 year olds) ranged from 19.2% in 2002 to 24% in September, 2007.¹¹⁵ Among this population, women’s unemployment rate was also approximately twice the rate of men’s.

3.3.5 Minimum Wage Provisions

Recognizing the need to reduce poverty and to create equity in employment, the Government of Belize equalized the minimum wage for female and male dominated jobs.¹¹⁶ More effective strategies for the enforcement of the minimum wage, particularly among construction, domestic and piece-rate workers, remain outstanding. Linked to this is the fact that social security legislation does not legally consider a household to be a place of employment. Consequently, neither the Labour Department nor the Belize Social Security Board monitor homes for compliance with labour and social security legislation, thus limiting benefits to those employed therein.

The passage of legislation on Equal Pay for Work of Equal Value also requires special strategies to ensure its effective implementation in Belize. Thus far, no precedents have been established as no cases have been legally challenged.

The Government continues to invest in skills training and employment projects targeting poverty reduction among women in Belize. Over the last two years, a special project was established to target single mothers in “southside” communities in Belize City. This project, piloted a holistic approach to employment creation for single mothers living in poverty. The project offered life skills training, child care and job placement services alongside the economic skills training curriculum.¹¹⁷ This approach recognizes women’s reproductive role of child care as well as the self-esteem and violence issues that hinder women’s access to employment. This project was implemented by the YWCA and the Women’s Department. A similar approach is being undertaken in a Belize Rural Women’s Employment Project, also being implemented by the YWCA.

3.3.6 Social Security

The Belize Social Security Board (SSB) is Belize main social safety net programme for the working population. The SSB provides both long and short term employment benefits. This includes the following benefits: old age, survivors, and invalidity pensions and sickness, work injury and maternity benefits. As stated in the 2009 Poverty Assessment Report¹¹⁸, unemployment benefits are not provided.

Because less than 50% of women participate in the labour force, only this group qualifies for SSB benefits. Furthermore, women’s high unemployment rate and their tendency to be unemployed for longer periods than men place women at a disadvantage in qualifying for some social security benefits.

Women’s length of maternity leave was extended from 12 weeks to 14 weeks and maternity benefits are provided to both women and their spouses or partners. For employed women, maternity leave benefits are dependent on the amount of social security contributions being paid. Therefore those with the lowest income levels also receive lower amounts in maternity benefits. In 2005, a total of 4% of social security expenditures were for maternity allowance and 10% were for maternity grants. Men qualify for a one-time maternity grant when their spouse or partners become confined for childbirth.

To compensate for older women’s history of non-employment in the formal workforce, the Government of Belize instituted a non-contributory pension scheme. Older persons receive \$100 monthly. In the case of this special pension scheme, only one older person per household can qualify. A woman and her husband cannot both be collecting pension from the SSB. Overall, pensions for older persons accounted for 7% of all SSB expenditures in 2005.¹¹⁹

3.3.7 Access to Credit

Private sector and quasi-government lending institutions have not established any special measures for targeting an increase in loan disbursement to women borrowers. In fact, banking institutions continue to arbitrarily practice outdated protocols in requiring husbands to sign onto their wives loans.¹²⁰

Civil society organizations provide micro-enterprise development finance to women. More recently, the civil society sector (NGOs and Credit Unions) has partnered with Government to make credit more accessible to women. Through the Belize Rural Development Project, micro-credit grants have been disbursed to more women than men.

The Belize Enterprises for Sustainable Technology (BEST) has provided 31% and 35% of the value of total loans to women. Similarly, women constituted 38% of all borrowers in 2008 and 45% of all borrowers from January to September, 2009. Based on an analysis of borrowing trends within BEST, women tend to access credit for household items and small business development while men access credit to buy equipment and transportation. BEST also reports that men tend to be in a much better position to offer land as collateral compared to women. However, women still have a higher loan repayment rate than men.¹²¹

3.3.8 Gender and Disaster Management

Belize is nestled along the Atlantic Coast of Central America between Mexico and Guatemala. Geographically, Belize remains highly vulnerable to tropical cyclones like hurricanes and floods. Natural disasters affecting Belize since 1978 include:

- Hurricane Greta (1978)
- Hurricane Mitch (1999)
- Hurricane Keith (2000)
- Tropical Storm Chantal (2001)
- Hurricane Iris (2001)
- Hurricane Dean (2007)
- Tropical Storm Arthur (2008)

The increased frequency of hurricanes, storms, floods and forest fires requires the development of a multi-tiered risk management mechanism for Belize. Annually, risk and disaster management policies and plans aim to achieve greater integration and participation of local communities. With the support of UNDP, the discussion on gender integration has begun.

Worldwide, and in Belize, there is increasing recognition that women must be included in disaster management programming at the decision-making levels. As stated by one report, this is necessary not only because women are “more vulnerable” but because

“they have different perspectives and experiences to contribute (for example, in implementing adaptation measures).”¹²²

In 2005, Belize ratified the United Nations Framework Convention on Climate Change (UNFCCC) and the Hyogo Framework for Action (HFA). The HFA commitments call for the integration of gender perspectives in all disaster risk management policies, plans and decision-making processes. This extends to risk assessment protocols, early warning systems, information management systems, and education and training programmes.¹²³

Women carry the extra burden of family care in planning and preparing for disasters. Their responsibilities begin prior to a disaster, and extend through to the post-disaster period. Disaster management personnel in Belize report that women, more than men, feel pressured to ensure that their homes are returned to normalcy after a disaster. Furthermore, many responders such as nurses, social workers and police officers are women. This presents an added gender related dimension to disaster mitigation programming. Women responders, more than men, have the dual responsibilities of family and child care at home as well as responding to their community in times of disaster. Men, usually don't have this dual responsibility. Instead they play a different role in times of disasters.

A Study¹²⁴ outlined the gender differentiated impact of disasters on men and women. While women place emphasis on family care and cohesiveness, men are mostly concerned with the physical security of the family and the family property. These gender roles increase men's risk of mortality during disasters. In Central America, for example, there were more immediate deaths among men during Hurricane Mitch not only because “men were engaged in open-air activities”, but because they also took fewer precautions when facing these risks.¹²⁵ This illustrates society's perception of men as the “heroes” who must take undue physical risk to protect their family and secure their property.

The Study¹²⁶ stated that one of the main indicators of the difference in disaster vulnerability between men and women is employment and income. Women begin at a disadvantaged position with lower wages and increased unemployment than men. During times of disaster, women's ability to earn an income is further compromised. Women engaged in small scale informal economic activities are especially vulnerable. They have no access to employment benefits or social safety net programmes. In Belize, during Hurricane Dean, damage to backyard gardens and fruit trees seriously affected the cultivation and sale of fruits, which was a primary source of income for rural women and their families.

Heightened tensions during and after disasters also create increased vulnerabilities for domestic abuse and sexual violence. This situation disproportionately affects women and children. For example, living in large, crowded shelters exposes women and children to sexual abuse and exploitation. The psycho-social component of Belize Disaster Management Plan recognizes this gender related vulnerability. The plan calls

for the immediate provision of basic mental health counselling to victims. This approach diffuses tensions imposed by disasters and helps victims to cope with their grief.¹²⁷

Belize's National Security Strategy (2009) includes a section (section 8) on actions to reduce the risks associated with rapid and slow-onset natural and human caused hazards.¹²⁸ It includes the strengthening of Belize's 12 National Operational Committees and other Special Committees coordinated by the Belize National Emergency Organization (NEMO). Actions also include:

- the development of a centralized information database centre to enable precise damage assessment and needs analysis processing
- the implementation of public education and awareness campaigns on the importance of mitigation and the effects of rapid and slow onset hazards
- the implementation of the national alert or warning system, and
- the active engagement of children, key private and public sector stakeholders, and local communities throughout the process¹²⁹

The Ministry of Health and PAHO have developed a disaster mitigation plan focused on psycho-social intervention for the most vulnerable populations. This plan takes advantage of the different layers of the national response structure and proposes a multi-tiered psycho-social response. This plan considers the mental health needs of women, children and men, mostly in the post-disaster period.

On a more national scale, gender mainstreaming of the national response to disasters can consider:

- Ensuring that data is disaggregated by sex and that gender analysis of the data is completed as soon as the data is collected and consolidated.
- Prioritizing the restoration of family life as soon as possible.
- Conducting and responding to Social impact assessments
- Conducting mental health assessments as part of the wider social impact assessments and ensuring that these services are available immediately
- Ensuring that the psycho-social response includes access to food, shelter, clothing and recreation (especially for children)
- Prioritize keeping families together and the evacuation of women and children.
- Special attention is to be placed on the needs of pregnant women in the risk planning and mitigation and in the post-disaster period.

The wider issue of gender integration in climate change policies and programmes is an emerging issue globally and in Belize. Since 2007, the Secretariat for the Convention of Biological Diversity has begun to consider gender issues as critical to an effective response to climate change issues.¹³⁰ Using the traditional knowledge and experiences of both men and women and enhancing women and children's participation in re-forestation programmes, for example, has proven effective in some countries.¹³¹

In Belize, women are involved as Executive Directors of natural resource management agencies, including the Fisheries Department, the Belize Audubon Society (BAS), the Toledo Institute for Development and the Environment (TIDE) and the Southern Environmental Association (SEA). Women are also leaders in local environment related advisory councils. However, a gender perspective calls for a greater examination of how climate change issues, beyond the scope of natural disasters, affect men and women and how the different needs and capacities of both sexes can be utilized to maximize Belize's development potential.

3.4 Gender-Based Violence

Gender based violence encompasses child abuse, domestic violence, commercial sexual exploitation of children and adolescents, commercial sex work, human trafficking, rape and sexual assault. This section attempts to provide as much information as possible of these different types of violence in Belize.

3.4.1 Child Abuse

Over the last decade, the Government has continuously upgraded the Department of Human Services and the Community Rehabilitation Department to respond to child protection issues. Even with these investments, these Departments struggle to keep pace with an increasing demand for child protective services.¹³²

Data from the Department of Human Services demonstrate that children ages 5 to 9 years and 10 to 14 years comprise the majority of children referred for child protective services. This is followed by children ages 1 to 4 years. Girls (approximately 58%) have a higher referral rate than boys (approximately 43%). Children ages 5 to 9 are most vulnerable to neglect, abandonment, physical and emotional abuse while children ages 10-14 are most vulnerable to sexual abuse.

Mothers are the main perpetrators of neglect while both mothers and fathers perpetrate physical and emotional abuse. Alleged perpetrators for physical and emotional abuse also included teachers and babysitters. Non-familial persons (not related to the family) are the main alleged perpetrators of sexual abuse, followed by stepfathers and fathers.

Table 15: Types of Child Abuse Reported Countrywide 2004-2007

Type of Abuse	2004	2005	2006	2007
Neglect	452	299	451	567
Wandering	11	11	18	6
Abandonment	208	82	77	95
Sexual abuse	335	287	327	318
Physical abuse	270	170	213	226
Emotional abuse	54	27	37	25
Trafficking	3	2	22	49
Total Child Abuse	1,330	893	1,102	1,298
Total other support services	694	415	821	923

Source: Department of Human Services. Child Protection Data from 2004 to 2007.

A lack of consistency in the legal definition of a child, gender biases in existing legislation and a lack of coherence in laws addressing child protection issues, creates inefficiencies and ineffectiveness in the comprehensive delivery of child protective services¹³³.

The lack of human resources, both human and financial, within the Human Services Department, limits the number of cases to which the Department can respond.¹³⁴ Social workers in the Department of Human Services in Belize City manage an average of 60 cases simultaneously. Their counterparts in the other districts manage all referred child protection cases as there is only one child protection officer in each district.¹³⁵ Other social workers or colleagues working within the Ministry of Human Development may assist with the caseload but they too have other specific duties to perform. Together these issues, despite the persistence of child protection officers, affect the outcome of child protection cases.

The Ministry of Human Development operates under the principle of “best interest of the child”. Whenever possible, once children are not in eminent danger, they are kept within their family circle. If children must be separated from their families, the Department develops a case plan that may include strategies aimed at family reunification. During this process, it is necessary for the family or magistrate courts to deliver care orders and interim care orders for the child. Parental education is usually a condition of the interim care order and parents must participate in these programmes if they wish to be reunited with their children. Child protection officers are expected to provide this parenting education to mothers, fathers and guardians and to follow-up on the outcome of child protection cases. While children do benefit from this process, the provision of “care orders” is regularly delayed as a result of resource limitations within the justice system and because of the child protection officers’ high volume of work.

The outcome of child protection cases depends on the collaborative efforts of public and civil society organizations. The NCFC has therefore developed a National Child Protection Protocol that outlines clear child abuse response procedures for multiple government and non-government service providers. This includes the:

- Ministry of National Security
- Ministry of Human Development
- Ministry of Health, Health Facilities and Professionals
- Ministry of the Attorney General
- Ministry of Education
- Childcare Professionals, Ministries, Agencies and Facilities, and
- Citizens of Belize

While the National Child Protection Protocol comprehensively addresses child abuse issues, multi-sectoral collaboration continues to be a major challenge. There is a lack of adequate monitoring systems to ensure greater levels of application of this Protocol within the relevant agencies. While the Ministry of Human Development continues to scale up its programmes, it cannot, on its own, seek to bring a higher level of protection to vulnerable and/or “at risk” children.

3.4.2 Commercial Sexual Exploitation

In 2006, a study¹³⁶ was conducted to examine the situation of commercial sexual exploitation of children and adolescents (CSEC) in Belize. Over 150 men and women interviewed in 3 districts confirmed the existence of CSEC among children below 18 years. These community level interviews were complemented by case studies of thirty victims of CSEC. The study revealed that CSEC manifests itself in different ways: in brothels, on the streets and even in boys, girls and adolescents attending school. In some cases the parents participated and promoted these CSEC activities. Poverty was identified as a major cause of CSEC. The lack of family cohesion and stability and an increased appetite for consumer products (bling bling) were also noted as contributing factors.

The “client”-exploiters of these victims were primarily male adults of varying ages and of Belizean nationality or residents in the country. The underage victims not only received money in exchange for sexual activity. They also received payment “in kind” in the form of food, payment of school expenses (for example, books or fees), and other forms of payment.

Most service providers and the population at large indicated that they did not report CSEC when they knew or suspected that it was taking place. The victims shared that they also did not report CSEC or sexual abuse. The victims did not report sexual abuse, especially those that occurred before they were 12 years old, due to the shame and social stigma attached to the victims of these crimes.

Currently, CSEC is not explicitly a crime under the laws of Belize.¹³⁷ The Criminal Code does not specifically address commercial sexual exploitation and its related offenses, such as sex tourism and pornography. It only addresses carnal knowledge, rape, and sexual assault as criminal offences.

In carnal knowledge cases regarding sexual contact with underage persons between the ages of 14 and 16, the victim's character is explored in the court and is used to determine whether the sexual act was illegal and, therefore, constitutes a crime. The law is therefore extremely hostile towards children. This approach violates the fundamental rights of victims and even more so, of the children whose lives are affected by CSEC.

Furthermore, the present wording of legislation used to deal with the sexual exploitation of children is gender biased and does not afford adequate protection to boys and males who are raped or prostituted. It also does not consider that women can be perpetrators of CSEC.

Another problem encountered is the belief that children "are the property of their parents". Consequently, this contributes to parents intervening in the legal process withdrawing accusations of sexual abuse (since CSEC is not yet explicitly a crime). One report states, "This power that parents hold is, in fact, the main reason cited for withdrawal of accusations brought before the law courts, based on reasons that are far from the child's best interests."¹³⁸

The CSEC Study points out that the only sexual offence law in Belize that takes a human rights approach is the "Trafficking in Persons (Prohibition) Act of 2003. This Act states that the victim's sexual behaviour is "irrelevant and inadmissible" and that the legal age of sexual consent cannot be used as a defence in the crime of trafficking in persons.

The "Act" has a section on the Protection of victims of trafficking in persons (II, page 170, Article 6, Assistance to and protection of victims of trafficking in persons) and mentions the provision of housing, counselling and information, medical, psychological and material assistance and employment, educational and training opportunities, special needs of victims (especially children), and physical safety etc. It also mentions that the state will work with non-governmental organizations to provide these services.

In 2006, the Youth Enhancement Services (YES), an advocate on child abuse issues, expanded its programme to include CSEC issues. In 2007, it continued to give visibility to CSEC in Belize. This advocacy and public awareness effort was complemented by a rehabilitation programme designed to assist CSEC victims and their families. YES collaborates with the Ministry of Human Development and with the NCFC to execute these activities. A major outcome of this collaboration is the development of a draft CSEC Bill. The next step is to introduce this draft Bill into the official legislative process.

3.4.3 Other Sex Crimes

In 2008, 38 cases of rape and 98 cases of carnal knowledge (carnal knowledge and unlawful carnal knowledge) were lodged at police departments countrywide.¹³⁹ In 2009, the police department reports a decrease in new rape and carnal knowledge cases to 30 and 62 cases respectively.

However, in 2009, the Magistrate Courts¹⁴⁰ reported that 112 cases of carnal knowledge, 29 cases of unlawful carnal knowledge, 38 rape cases, 31 cases of indecent assault, 9 cases of incest, 31 cases of indecent assault, 7 cases of attempted rape and 7 cases of unnatural crime were lodged across the country. This totalled 224 cases resulting from gender-based violence and comprised approximately 4% of all crimes lodged at the Magistrate Courts in 2009. Murders resulting from domestic violence are recorded under the murder category without reference to the element of domestic violence.

Sexual offence cases are lodged at the Magistrate Court for a preliminary inquiry before proceeding to trial in the Supreme Court. If a case takes an unreasonable amount of time to come up for review, the case is “struck out” by the Magistrate in order to preserve the defendant’s right to the timely administration of justice. Incomplete investigations, weak evidence and a lack of human resources contribute to long delays in preparing a sexual offence case for the preliminary inquiry. Many cases are therefore dropped before they are heard in the Supreme Court. Even when cases ascend to the Supreme Court, there is a low rate of convictions as most cases are dropped either before the trial begins or while the trial is in progress.

Between 2005 and 2007, approximately 100 cases of rape and indecent assault were reported annually. In 2005, 12 cases resulted in convictions. In 2006 and 2007, only 6 and 5 cases, respectively, resulted in convictions. Almost the same number of cases resulted in acquittals annually. For each of the three years reported, a majority of cases had not yet gone to trial.

One study¹⁴¹ reported that most sexual offence cases are not prosecuted due to either a lack of evidence or the withdrawal of cases. For the years 2002 to 2005, only 8% of unlawful carnal knowledge cases and 20% of carnal knowledge resulted in convictions. In the case of unlawful carnal knowledge, which is a sex crime against a minor (14 to 16 years), 58% of cases were deemed “nolle prosequi” or not able to be prosecuted. The other 38% of cases resulted in acquittals. In the case of carnal knowledge, 51% of cases were dropped on the basis of “nolle prosequi” and 28% of cases resulted in acquittals. On average, approximately one-half or 50% of all sexual offences cases were dropped before they went to trial.

In relation to sex crimes, a request for “nolle prosequi” is entered by the office of the Department of Public Prosecution (DPP) for the following reasons.

- The complainant was unwilling to testify or proceed with the case

- The complainant left the jurisdiction or was unable to be located
- The non-appearance of the accused or the accused being out of jurisdiction
- The non-appearance of witnesses
- The prosecution was unable to prove an element/s of the offence.¹⁴²

Prosecuting a sexual offence case is challenged by a lack of human resource capacity within all relevant agencies that play a role in collecting evidence and preparing a case for trial. This includes:¹⁴³

There is a lack of access to medical professionals trained to conduct forensic examinations of children, women and men who are victims of sex crimes. This leaves many victims, especially those in rural communities, waiting overnight or for several days before they can be duly examined for evidence. The evidence tends to get overlooked during the examination or gets washed away or contaminated during the process.

One observation by the DPPs office is that medical professionals are not instructed by police officers, to ask for the item of clothing worn at the time of the alleged assault. The clothing is not usually entered as evidence and cannot be used by the prosecution to advance their case.

Even when medical examinations are completed and forensic evidence is gathered, the Police Department does not have DNA capacity and is unable to match DNA specimens from the victim with those of the alleged perpetrator(s). The weight of a sexual offence case then rests on the testimony of the medical officer, the police officer who investigates the case, the victim, the defendant and if possible, any witnesses to the crime.

Police officers from the Sexual Offences Unit or from the Criminal Investigation Branch (CIB) usually investigate sexual offence cases. The Sexual Offences Unit operates a regular work schedule of 8:00 a.m. to 5:00 p.m. and is not readily accessible during evenings, nights and on weekends when most domestic violence and sexual offence cases occur. The victim's police statement is then recorded in spaces with limited privacy. This lack of privacy and the stigma attached to sex crimes, become a deterrent to victims who initially wished to pursue legal action against their alleged perpetrators.

Medical professionals who are from foreign medical brigades on short term contract usually prefer not to participate in trials where they have to give expert testimony. At times, they cannot participate since they would have already returned to their country of origin prior to the completion of the investigation. Their expert testimony is therefore not guaranteed.

Victims are usually not willing to testify in their own trial because they experience double victimization in court. In the case of the Criminal Code language such as "known moral character" and "not being a common prostitute" are used in referring to the victim. The character of the victim is questioned and is used to determine the legality or illegality of

a sexual offence case. Victims are also required to face their alleged perpetrators in trial. For children, this becomes a daunting task which many prefer to avoid because of fear of the perpetrator and/or because they wish to avoid having to re-live their experiences in the presence of their perpetrator.

For boys and men who are raped, the charge of rape cannot be lodged since the law does not consider boys and men to be victims of rape. The law also does not consider women to be perpetrators of sex crimes. This creates a gender bias that limits access to justice for boys and men.

Even when cases reach the stage of a preliminary inquiry, alleged perpetrators who are represented by attorneys, have a legal advantage over victims who are not likewise represented. The view of staff from the DPP's office is that because Magistrates in the Family Court and the Magistrate Courts are not qualified attorneys-at-law, they are not always aware of all the evidentiary procedures required in presenting a sexual offence case and are unwilling to rule against attorneys who raise procedural objections.

Furthermore, attorney's clever use of the law to delay the preliminary inquiry process, also impacts on the outcome of the case. During this drawn out process, the victim or his or her family, sometimes withdraw the case in a deliberate effort to move on their lives. Cases that are delayed for an unreasonable amount of time are then "struck out" by the Magistrate.

Because forensic evidence gathering (which is one of the most critical aspects of ensuring access to justice) remains grossly inadequate, and because of all the related issues of stigma, double victimization, gender biases and delays in going to trial, the prosecution is usually rendered helpless in presenting a solid sexual offence case to the Supreme Court.

The legislative framework for addressing the above stated sex crimes remains gender biased, outdated and fragmented. In 2005, the Attorney General's Ministry issued a White Paper on Criminal Justice Reform. This Paper recognized the need to strengthen the criminal justice system. It made specific recommendations that would enhance protection for victims of sex crimes as well as victims and witnesses of other violence crimes.

The recommendations included the establishment of a Sexual Offences Unit at each Police Station nationwide, making the spouse a competent witness for the prosecution, removing the requirement for evidence of children to be corroborated, and providing additional protection measures for victims, caregivers and witnesses of criminal acts.¹⁴⁴

The NCFC and the NWC have also recognized the need to make the legislative framework more cohesive, more gender neutral and more human rights-oriented. In this regard, the NCFC and the NWC have included specific legal reform provisions in the National Plan of Action for Children and Adolescents (NPA) and the National Gender Policy (2002).

3.4.4 Domestic Violence

Reported cases of domestic violence over a 6 year period ranged from 1,240 cases in 2003 to 1,669 cases in 2008. A majority of victims of domestic violence are in the 20 to 49 age range. They are mostly women and are either in married or in common-law unions, followed by single women, women who are separated and women in visiting relationships. Since 2004, between 6% and 8% of domestic violence reports were of pregnant women.

Although a majority of the cases were reported by women, there was a visible increase in the percentage of cases reported by men. This increased from 11% and 12% in 2004 and 2005 to 18% of cases in 2008. Both women and men reported psychological violence and physical violence. Mostly women reported sexual violence although at least one case of sexual violence was reported by men on an annual basis. A large number of cases were categorized as “other”.

A majority of reported cases were repeated incidents rather than new incidents of domestic violence. A majority of domestic violence cases were reported in the Belize and Corozal Districts, followed by the Orange Walk and Cayo Districts. The Stann Creek and Toledo Districts have the lowest reported cases of domestic violence. Twice the number of domestic violence cases were reported in urban than in rural areas. The centralization of the response to domestic violence may be responsible for this urban majority.

Persons of all educational levels reported domestic violence although a majority of the reports were of women who had completed a primary education, followed by secondary education. The Creole and Mestizo ethnic groups who comprised a majority of Belize’s population also had the highest reported cases of domestic violence.

Across the country, the reported aggressors were mostly common-law spouses, followed by spouses and ex-spouses. The aggressors tended to fall within the same age group as victims (20 to 49 years) although in some cases older men in the 50 to 59 age range and those in the 15 to 19 age range were also reported aggressors.

There was no consistency in the domestic violence referral system. In 2004 80% of cases were referred by or to the family court or magistrate. In 2008, this changed to 2.2% of cases. In 2004, 10% of cases did not indicate their point of referral. This increased to 20% of cases in 2005. Since 2007, the majority of cases were referred to or by the Police Department followed by the Women’s Department.

Many domestic violence cases still go unreported. A focus group session with Mayan women in the Toledo District¹⁴⁵, for example, revealed that the main problem they face daily is domestic violence. Almost all of these women experienced domestic violence in their homes and knew of other women in their communities who also lived in situations of domestic violence. They reported that in some cases when the spouses are not around, their boy child takes on the role of perpetrator. Yet, most of these cases were

not reported or lodged in the domestic violence registry for that district. Among this group of women, domestic violence was linked to alcohol consumption and to patriarchal notions of women and children as men's property.

A study on domestic violence and HIV¹⁴⁶ revealed that:

- Almost half of the women living with HIV reported physical violence by an intimate partner.
- Almost four in every ten ever-pregnant women suffered physical violence by a partner.
- Three in every 10 reported sexual violence and 5.7 in every 10 women living with HIV ever married/partnered had experienced physical and/or sexual violence by an intimate partner.

The study further revealed that violence against women constitutes a barrier to access to services. For example, 2.2 out of 10 HIV positive women and 3.3 out of 10 of women living in domestic violence reported that they have to ask their partner's permission before seeking health services. Another, 6.6 out of 10 women living in domestic violence and 3.5 out of 10 women with HIV had experienced physical and/or sexual abuse and were injured as a result of the violence.

As was the case with victims of CSEC, domestic violence victims experience all types of violence which tends to permeate their lives.¹⁴⁷ This reveals the need to address the problem of violence, in all its forms, during women's life cycle rather than as isolated events. Because men tend to constitute the majority of perpetrators of violence, violence by men must also be addressed across the life cycle.

This report confirms the links between domestic violence, HIV and women's access to health services. It illustrates that these issues must be addressed from a human rights perspective and must be understood to be integrated. This means that resources for HIV, sexual and reproductive health issues, domestic violence, child protection and related issues of gender-based discrimination must be considered as a whole rather than as separate issues that have no connectivity.

A study on the links between domestic violence and HIV revealed that there was a significant level of acceptance of gender norms related to "women's obedience to their partners/husband, the obligation of women to have sex with their partners and the reasons under which it is acceptable that a man can physically abuse a woman".¹⁴⁸ This cultural aspect of violence against women was also reported in the study on commercial sexual exploitation of children and adolescents.¹⁴⁹ The findings of a study on male participation in health services are also consistent with these results.

The male participation study conducted in Belize in 2004 reported that of a sample of 384 men (15-44 years), 20% of respondent agreed that "if a woman betrays a man, he can hit her". A total of 29% agreed that "it is the man who decides what type of sexual relationship the couple should have". A total of 64.6% stated that "when a man forces

his own wife to have sex with him it is not rape". This shows the need to address cultural values on women's rights as a central component of the strategies to address HIV and VAW.

Sensitization on gender-based violence has been mainstreamed into the training curriculum for new police officers and a gender-based violence unit has been established within the police department. Only two shelters for battered women serve women and children across the country. The rehabilitation and economic empowerment of battered women are major gaps in the national response.

A National Plan of Action for Gender-Based Violence (2007-2009) was developed to complement ongoing advocacy and education initiatives. A new Domestic Violence Act and increased national awareness of gender-based violence served as the catalyst for an improved response. The five goals contained in the Plan include the promotion of an integrated response that addresses law enforcement and health, a reduction in gender-based violence, providing comprehensive support services for victims, rehabilitating perpetrators and promoting a zero-tolerance approach to gender-based violence.

Major achievements noted by the Women's Department included the development of procedures for receiving, handing and pursuing complaints, although the impact of these procedures has not been adequately assessed. The Women's Department reported an increase in community awareness of the domestic violence act and services but stated the need for more awareness, especially in rural communities. The Department¹⁵⁰ provided training on the domestic violence and child abuse registration systems as well as the use of this registration system by front-line responders. Another achievement was the establishment of two shelters for battered women as well as the establishment of support groups for survivors. One of the most significant achievements was the amendment to the Domestic Violence Act which calls for the rehabilitation of perpetrators and for stiffer penalties for the breach of protection orders.

Sexual harassment legislation exists. While there are many anecdotal reports of sexual harassment within the world of work, no cases have been tried in court. In two stakeholder interviews, women reported a need for more public education on this issue as well as amending the law to simplify the sexual harassment reporting procedures.

3.4.5 Sex Work

In recent study¹⁵¹ on sex workers in Belize revealed that several categories of sex workers exist. This ranges from commercial sex workers who have had a wide range of sex work experience to those who engage in informal types of transactional sex. The categories are:

- Female sex workers who have international experience working in brothels. These sex workers identify sex work as a profession. They are clear with regard to their SRH needs and can compare their access to SRH service in Belize to their experience in other countries.

- Female sex workers who became sex workers while in Belize. This category includes women who voluntarily came to Belize and those who are victims of human trafficking. These women do not necessarily have experience in the identification of their SRH needs. They are able to share their experiences in doing sex work, the challenges they face and the health related issues they have had to confront.
- Local sex workers who are known as “street walkers” do not work in brothels. They walk the streets at times when they think their services are in demand. This includes nights on the weekends but also days on which tourists are more easily accessible. Street walkers also target cruise tourism passengers so this type of sex worker is visible in Belize City and Dangriga Town. Transactional sexual activity takes place in hotels, motels or private dwellings.
- Local sex workers who frequent bars to pick-up clients are another type of sex worker. These sex workers, including men, have regular bars or pick-up spots where they hang out. At these locations, they are able to “pick-up” or be “picked-up” by clients. The arrangements can be formal or informal but results in transactional sexual activity in hotels, motels or private dwellings.
- Transactional sexual relationships between adults. This is the case of women or men who have one or multiple boyfriends. These sex workers perform sexual favours, usually in their homes or the homes of the “boyfriends” in exchange for direct cash transfers or for the payment of utility bills, personal care treatments (hair, nails, and clothing) on a regular basis.
- Male sex workers who have multiple or regular boyfriends, usually married men, who pay for sexual services. Not much information is readily available on this type of sex worker, although initial feedback from a few MSWs indicates that they operate in a more clandestine manner than female sex workers, alcohol and drugs are a normal aspect of sex work activity and clients can be in denial of their orientation towards having sex with men.
- Transgender sex workers are also making their presence known. Not much official information has been recorded on this group of sex worker.

This wide range of sex work categories calls for a targeted response to the overall needs of these populations. In a discussion in Dangriga Town¹⁵², women who live in poverty revealed that sex work activity is their only alternative for survival. Sex work allows them to feed their children, pay their utility bills and survive from day to day. To them, sex work is not about foreign women entertaining local and foreign men, it is a viable economic activity that local women and men resort to when they need to put food on the table. They indicate that the viability of this industry is largely dependent on the sexual appetites of men who, most times, are the consumers of paid sexual encounters.

Because of the relationship between sex work, poverty, human trafficking and the increased cost of living, addressing this issue will require a complete re-thinking of how best to either legally recognize and regulate sex work and/or create viable economic alternatives for men and women sex workers.

BFLA and the PASMO as well as the AAA and Claret Care all provide services to sex workers. BFLA is implementing a sexual diversity project which allows SRH services to be provided to both men and women sex workers as well as to men who have sex with men. PASMO has also been able to engage these populations in behaviour change communication campaigns.

The Ministry of Health is also attempting to enhance its outreach to these vulnerable populations. The Ministry is in the process of developing guidelines for the provision of SRH services in a way that will respond to the special SRH needs of these groups.

Beyond the provision of SRH services, the overall legislative framework for dealing with sex work has to be reviewed. This includes laws governing brothels and laws that will determine the rights and responsibilities of sex workers and the rights and responsibilities of clients of sex workers. Addressing the root causes of sex work and the regulation of sex work activities would be a step forward in the fight against HIV/AIDS in Belize.

3.4.6 Psycho-Social Care and Support Services

Organizations that provide child protection and gender empowerment services realize that women and girls' mental health issues must be addressed, if they are to take advantage of health, education and wealth and employment creation opportunities.¹⁵³ This falls under the broad category of psycho-social care and support services.

Currently, there is no protocol for the provision of psycho-social care and support services in Belize. Psycho-social care and support normally includes the ongoing psychological support and social welfare services offered to vulnerable or at-risk populations. It includes the provision of counselling activities, child abuse and neglect counselling, support groups, pastoral care, care giver support and bereavement counselling.¹⁵⁴ It also includes the provision of nutrition counselling and other forms of counselling such as family planning. It includes social welfare services such as the provision of basic food baskets, clothing support, access to shelter and access to cash and in-kind support that allow children to stay in school.

The provision of national psycho-social care services remains in limbo with no Ministry taking full responsibility. The social welfare component has been relegated to the Ministry of Human Development. However, this Ministry is overburdened with addressing child protection issues and with implementing women's empowerment programmes. The social welfare system, not just in this Ministry, but across sectors, therefore needs a major overhaul.

Regarding the mental health component of psycho-social care, the Ministry of Human Development is responsible for the coordination and follow-up of comprehensive services for their clients. This includes client in-take interviews, the investigation of cases and ensuring access to justice. Cases requiring professional counselling are referred to Belize's only counselling centre located in Belize City. One professional staff provides services to all clients from all over the country.

There are no other professional counselling services available throughout the public sector, except for the services provided by psychiatric nurses. The limited availability of professional counselling services, as stated in the section on health, remains one of the most serious gaps in social sector programming in Belize.

3.4.7 Crime and Rehabilitation Issues among Youth

The National Security Strategy of Belize (2009) recognizes that Belize is a drug transshipment point and that drug trafficking is Belize's greatest criminal threat. This is the case because, "drugs offer sufficient profit at each stage of the trade"¹⁵⁵ to allow access to resources for large scale criminal activity. Young people, mostly young men, are easily recruited into this drug operation. Gang related crime and murders, especially among young men living in poverty in the south side of Belize City, are a part of this larger criminal network which transcends national borders.

Additionally, the United States' practice of deporting Belizeans who come in conflict with the law impacts on crime in Belize. Between 2004 and 2007, a vast majority of deportees were men, primarily between the ages of 20 and 39 years.

Table 15: Belizean Deportees Arriving in Belize by Sex 2004-2007

Year	Male Deportees	Female Deportees	Total Deportees
2004	158	15	173
2005	152	10	162
2006	137	15	152
2007	151	18	169

In 2008, a total of 103 cases of murder, 532 cases of robbery, 1,302 cases of burglary and 1,413 cases of theft were reported by the Police Department. In 2009, a total of 97 cases of murder, 526 cases of robbery, 1,286 cases of burglary and 1,332 cases of theft were lodged at the Police Department.

Table 16: Types of Crimes Reported to the Police Department 2008-2009

Type of Crime	2008	2009
Murder	103	97
Robbery	582	526
Burglary	1,303	1,286
Theft	1,413	1,332

In 2009 alone, 1,749 cases of possession of controlled drugs and 315 cases of drug trafficking were lodged at magistrate courts across the country. There were also 137 cases of attempted murder, 63 cases of murder, 512 cases of burglary, 457 cases of handling stolen goods, 909 cases of theft and 326 cases of robbery lodged at magistrate courts across the country.

Regarding murder charges lodged between 2004 and 2009, 27% of cases were disposed in 2004, 28% in 2005, 29% in 2006, 32% in 2007, 57% in 2008 and 25% in 2009. This shows an overall rate of between one-fourth and one-third for most years with the exception of 2008 in which over one-half of all cases were disposed. The overall conviction rate for murder cases was estimated at below 10%.

The murder rate has not abated despite efforts to curb criminal activity. The 2009 Poverty Assessment Report¹⁵⁶ states that, "The murder rate in Belize (31 per 100,000 population) is now one of the highest in the world", with about one-half (40%) of murders occurring in Belize City's South Side communities. Motives for the murders, as reported in the study, included robbery, altercations/ disputes and feuds, drug dealings and domestic disputes. Many of the murders were gang-related and boys below 15 years being deliberately recruited into this type of criminal activity.

This high crime rate affects children in various ways. The high mortality and morbidity rate of young men due to injuries afflicted, whether accidentally or purposeful, indicates that they are not only perpetrators, but also victims of violent crimes. Insights into the lives of young people, including young men, indicate some of the root causes for criminal activity.

A Study on crime and violence reported that violence begins in the home and continues across society.¹⁵⁷ Children who were interviewed reported that they were not safe at home, at school or in their neighbourhoods. The report concluded that children and youth in Belize suffer from deficits such as a lack of love and that these deficits, contribute to the crime and violence rampant in the Belizean society.

The Poverty Consultation Report 2006 corroborates these findings. The Report portrays young people views on poverty as "no love from my family" and "living in areas where drugs, HIV/AIDS, crime and people having sex to help themselves happens" and "a little girl playing with a match to try and make something to eat, and the house burn down because nobody is home with them".¹⁵⁸ During the consultations, young people also indicated that they experienced child abuse, commercial sexual exploitation, harsh treatment at school and crime in the streets and that a poverty plan must address all these issues in an integrated manner.¹⁵⁹

Another major concern for young people over 15 years was their high unemployment rate and their related vulnerability to engaging in criminal activity as a means of survival.¹⁶⁰ Issues of participation in local, regional and national level governance, employment and better access to health care, including sexual and reproductive health were also prioritized by other youth.¹⁶¹ Additionally, young men's high mortality rate

resulting from traffic accidents and the high HIV mortality rate of young men and women were also highlighted.¹⁶²

Because of the poverty, child abuse, school dropout and malnutrition, children face a grim reality in Belize. In this context, it becomes difficult for young people to imagine a future of hope, freedom from violence and respect for humanity. This becomes a serious concern for national development planning as the feeling of hopelessness, despair and apathy rings through in the voices of vulnerable or at-risk young people.

A Caricom Commission Report states that “young people generally see themselves making progress towards their dreams and aspirations in 5 years, although those who grapple with survival on a day-to-day basis are so consumed with hopelessness and despair that they are either resigned to being dead, struggling or incarcerated in five years; or unable or afraid to envision tomorrow because today is so dark and uncertain.”¹⁶³ Related to this, 85% of young people aged 15 to 29 indicated that they would migrate to another country if they had the opportunity and resources to do so.

Child care institutions for children who are relinquished from their parents or who have been legally remanded have not proven effective. These institutions lack the human resource capacity and the requisite infrastructure to offer adequate rehabilitation programmes. Children and adolescents usually reside in these facilities until some intervention on their behalf is made by family members or by members of the community. In these cases, children get a chance to reinvent themselves and steer clear of criminal activity.

In some cases, no family or community intervention takes place and children reside in these facilities until they turn 18 years and can no longer remain in a child care facility. In other cases young people graduate out of child care institutions into juvenile detention facilities or prison where the hope of rehabilitation becomes even slimmer. Belize’s juvenile detention facility is located on the same compound as the prison for adults. This opens the space for greater orientation toward criminal activity.

One example of a community-oriented approach to crime prevention is the Community Policing Unit located in the Yarborough Area in Southside Belize City. Although this Unit reported that it was successful in defusing issues that were potentially volatile, it remains the only such unit in Belize. Lessons from the experience of this Unit may be useful in re-orienting the approach of the Police Department, especially the approach to dealing with minors engaging in criminal activity.

A National Youth Development Policy was developed in 2006. It outlines strategic interventions for addressing the above stated issues. However, implementation has been slow. Meanwhile, the critical situation of adolescents and youth continues to worsen.

The National Security Strategy (2009)¹⁶⁴ recognizes that there are wider socio-economic and global issues (such as international drug trafficking) that impact on

Belize's high crime rate. The Strategy calls for a more integrated response to the crime situation. For example, it includes the strengthening of the education system to reduce school retention and drop-out rates which lower children's vulnerability to recruitment in criminal activity. However, it is unclear who is to provide leadership for the coordinated implementation of this Strategy. Currently, the Strategy remains a collation of actions to be implemented separately by various line Ministries.

3.4.8 Access to Justice

Laws related to gender based violence are fragmented. Different types of gender-based crimes, particularly sex crimes, are considered under separate legislation. Crimes are included under the Criminal Code, the Summary Jurisdiction (Offences) Act, the Indictable Procedure Act, the Domestic Violence Act, the Families and Children Act, the Evidence Act, the Trafficking in Persons (Prohibition) Act and the Sexual Harassment Act.¹⁶⁵

Strengthening the criminal justice system and ensuring respect for the rule of law is a priority goal outlined in Belize's National Security Strategy (2009). The Strategy recognizes the judiciary as the "cornerstone" of the criminal justice system and as a "guarantor of individual freedoms and equal treatment of all Belizeans regardless of their ethnic background, gender, religion or political beliefs."¹⁶⁶ This Strategy is timely given the urgent need to invest in creating a more equitable justice system in Belize.

A former Director of Legal AID Services (LASC)¹⁶⁷ reported inequities in women and children's access to justice. She indicated that while the LASC was established to reduce these inequities, it does not have the human or financial resources to effectively respond to all cases. Agencies working to eliminate gender-based violence corroborate this situation. Personnel from the Department of Human Services, the Womens Department, and Haven House state that many women and children are left without access to legal representation when they report cases of gender based violence. Furthermore, many women, due to lack of information on their rights, are fearful of visiting the police station or the courts to seek legal redress due to the stigma associated with these types of crimes.

Access to justice will require the enforcement of existing laws and amendments to laws that are outdated, gender biases or contain discriminatory language.¹⁶⁸ This includes the enforcement of laws that protect the rights of survivors of gender based violence. This includes the enforcement of:

- sexual abuse reporting legislation
- the rule of confidentiality for minors so that don't have to re-live their experiences of abuse by confronting their perpetrators in the courtroom
- provision for the appointment of amicus curea (friend of the court) to protect the rights of children, especially in cases in which the parent or guardian is the perpetrator or an accomplice to the perpetrator or has cause to withdraw the cases involving their children.

- curfew laws as a deterrent for the involvement of minors in criminal activity in the night time.

Legal amendments¹⁶⁹ are also required to ensure greater gender equity. This includes:

- amending the rules on how survivors of sexual abuse provide evidence and how they are allowed to testify. In this case, the use of technology was proposed¹⁷⁰ as an effective mechanism for preserving the rights of the victim while getting the required evidence from them.
- redefining rape so that it can be gender neutral and can include other forms of sexual abuse, rather than only the penetration of penis to vagina. Currently, sexual abuse or penetration using an object or rape of a boy or man does not qualify as rape under the law
- increasing the penalties for sexual offences as well as increasing the minimum years of sentencing of the perpetrator This is aimed at ensuring that sexual assault becomes a more serious offence.
- eliminating disparities in the maintenance of children born in and out of wedlock
- clarify the adultery provisions for married women when no such provisions are made for men.

While legal changes were being advocated men and women across the country point out that access to justice is not only about the creation of new laws; they argue that equity in the administration of justice is also about strengthening mechanisms that will result in greater enforcement.¹⁷¹ The high rate of “nolle prosequi” not only for sex crimes but for murders and other serious crimes is testimony to the breakdown of law and order in the society and of the society’s limited capacity to respond effectively.

Only one family court exists in Belize. This Family Court is located in Belize City. The other five districts do not have family courts. Rather, they process family matters in the Magistrates Court. Magistrates who operate Magistrates Court in these other five districts have limited training in family matters and have limited human and financial resources to hear the wide range of cases that come before them. One concrete example is the fact that Magistrates Courts outside Belize City do not have bailiffs. They use police officers who assume this role, if and when, they are available to do so. Citizens who live outside of Belize City and who have family issues before the court are therefore greatly disadvantaged in their access to justice.

The Police Department also requires significant investment. In 2010 the Police Department’s credibility was questioned publicly in media reports of police brutality, dishonesty and participation in murder activities. As a result, the participants in one focus group in the Stann Creek District raised concern regarding the screening process for police officers, the qualifications for entry into this profession, the level of training provided and the level of performance monitoring for police officers.

As presented above, gender equity in access to justice is impeded by issues far beyond the scope of gender issues. A complete reform of the justice system and the

strengthening of institutions mandated to promote citizen security are national imperatives that will, along the way, result in greater equity for women, men, girls and boys.

3.5 Gender Equity as a Measure of Good Governance

Good governance assumes high levels of transparency and accountability within governing institutions across the public or private sectors. These governance issues inevitably spur dialogue on the type of institutional systems required of a transparent and accountable democracy. While some people perceive greater levels of women's political participation as foundation for democracy, others see women as the hope for a democracy that is gender responsive and that promotes equity in access to health, education and wealth creation opportunities, while simultaneously addressing issues of citizen security. For others, increasing women's access to political leadership is a rational move toward creating a more balanced democracy in which the experiences of both men and women can be harnessed and directed toward the higher goal of sustainable national development.

3.5.1 Women in Leadership Positions

The Belize scenario demonstrates the need for employing special temporary measures to increase women's political participation in Belize. Since 1984 only 14 women have offered themselves as candidates in national general elections. Of these women, 4 have won seats in the National Assembly. Of those who won, only 2 were appointed as Cabinet Ministers with full Ministerial powers. In 1998 an additional woman was appointed Minister of State and had limited access to Cabinet proceedings. Of those who won in national general elections, all were relegated to social sector Ministries, mainly the Ministry of Human Development. In one other case, a woman who was defeated in the national general election, was appointed Special Envoy for Gender and HIV (2003) and was named Senator (2005).¹⁷²

According to a leading women's political advocate, "Belizean women fare better when they stand for Municipal and City Council elections largely because the political system is based on proportional representation (a slate) as opposed to the First Past the Post System where one candidate is measured against the other as in national elections."¹⁷³ However, only two of nine municipal bodies are headed by women. In 2009, a woman was re-elected to serve her second term as Mayor of Belize City. In that same year a woman was elected to serve her third term as Mayor of San Pedro.

At the village level, by 2004, 89% of the total elected councillors were men, and 11% were women. Women also comprised 11% of the village council chairpersons in 2004.¹⁷⁴ Presently, only 27 of 193 women are chairpersons of village councils.¹⁷⁵

In nationwide consultations with young women and men, there was overwhelming support for increasing women's political participation at the highest levels of government. Young women in one district were particularly adamant about women's access to decision-making positions as a prerequisite for achieving gender equality and equity. In another district, young men advocated strongly for young women to become leaders in all spheres of life, including politics. Among adult men and women, there was a general consensus of the need to completely re-structuring Belize's governance system if any type of equity is to ever to be achieved.

A Study on opportunities for women's political participation¹⁷⁶ concluded that women's reproductive role within the family and society, lack of support from political parties and gender socialization patterns create barriers for political participation. The Study also revealed that women tended to be active in party politics and in leadership positions within their communities at either young ages (before having children) or in their late forties and fifties (when their children are grown). Overall, during their lifetime, women were most active in faith-based institutions across the country. The consideration of special temporary measures for advancing women's political participation was proposed.

A Political Reform Commission was established in 1999. It spent one year reviewing all aspects of Belize's governance system and made 103 recommendations for political reform. Included in their review was the recommendation to implement special temporary measures to increase women's political participation. The Commission could not reach a consensus on this issue and it was therefore not recommended.¹⁷⁷ The Report states, "The majority of the Commission does not recommend that a quota system for the appointment of women to public bodies be enacted for Belize."¹⁷⁸

However, the Women's Agenda of the People's United Party (PUP) still advocated for at least 30% of public office positions to be held by women. As a result, women were appointed to senior public offices. This includes appointments as Senators, CEOs of Government Ministries, Directors of Government Departments and Executive Directors of Quasi Government Bodies. This trend has continued across government administrations.

Currently, out of the 13 seats in the Senate, five are held by women, including the position of President. the Executive Directors of the Development Finance Corporation (DFC), the Social Security Board (SSB) and the Belize Tourism Board (BTB) are all women. The President of the National Institute for Culture and History is also a woman. The CEOs of the Ministries of Human Development, Economic Development, Natural Resources and Labour are all women. The Director of the National Emergency Management Organization (NEMO) is a woman. While this situation shows an increase in women's access to leadership positions, political power, which is concentrated in the hands of the Cabinet, remains male dominated.

Since 2000, the NWC implemented a few bi-partisan political training sessions for women. More recently, in 2009, the NWC launched a capacity building program for

women aspirants to political office. Applications for this program surpassed the established quota, demonstrating women's high level of interest in being trained to become political leaders. Some participants in this training programme will offer themselves as candidates for the 2010 village council elections.

Organizations like the TMWC have also taken on the challenge of increasing women's political participation. The TMWC is training indigenous Maya women who aspire to become village council leaders or village alcaldes.¹⁷⁹

At the level of local government, women have had greater success in offering themselves as candidates and in winning municipal and village council elections. The Mayor of Belize's most populated commercial centre is a woman. A recently approved National Policy on Local Government makes provision for continuing support for gender equity at the level of local government.¹⁸⁰

3.5.2 Gender Budgeting

Belize has also begun to break ground on major macro level issues that impact on women's empowerment nationwide. This includes preliminary work on the promotion of gender budgeting in Belize. Efforts to achieve this medium to long-term goal were initiated by a Gender Integration Committee comprised of both Government and civil society organizations. In 2008, the work was advanced by WIN Belize.

WIN Belize has conducted sensitization sessions in the mass media and with senior government officials. Though limited in success, this process has opened dialogue on the need to move toward a more program oriented budgeting process that allows for greater transparency and accountability of national outcomes. In 2008 and 2009, Belize's national budget development process benefited from nationwide public consultations. In 2010, this practice was discontinued.

A new three-year budgeting cycle has been introduced and in principle this is to facilitate a more programme oriented approach to budget development. However, there are still no concrete steps being taken to advance a specific gender budgeting agenda within this new budgeting process..

4.0 Cross-Cutting Issues

Three major issues transcend the five priority areas outlined for a National Gender Policy. These are related to the critical role of the family in creating a more just and equitable society, the need for more capable local institutions and people and the demand for greater accountability of national planning processes.

4.1 Gender Role Socialization

The impact of gender role socialization from birth cannot be understated. The differentiation of colours, blue for boys and pink for girls, is deeply engrained in Belizean culture. This socialization pattern determines how boys and girls are treated within the

home, at school and within society. It dictates our notions of masculinity and femininity and our eventual opportunities and vulnerabilities as men and women.

The impact of gender role socialization is obvious within the home. Women are socialized to be homemakers and men are socialized to be the main income earners. Although more women are entering the paid work force, their role as homemaker does not change. Instead, they are expected to perform their productive roles alongside their reproductive roles. No similar expectation is made of men. Even when men do not play their productive roles, they are not expected to perform their reproductive roles within the home environment.

This situation is evident among families with people who are infirmed or elderly. The women within the home are expected to assume the job of caring for these persons. This is the case even when the older person is a relative of the man and not the woman. Furthermore, in situations in which both men and women are HIV positive, it is still the woman who is expected to care for the HIV positive man and children, in addition to caring for herself. If the HIV positive woman is too sick to perform this reproductive role, then another woman assume this responsibility. There is no similar expectation that the HIV positive man will care for the HIV positive woman or children. This situation impacts on the overall health of women.

Similarly, in the case of chronic illnesses, the fact that women are overburdened with both productive and reproductive responsibilities leaves them less time for recreation and exercise. This significantly increases her vulnerability to chronic non-communicable illnesses like diabetes and hypertension. On the other hand, men's recreational (such as alcohol consumption), risk taking (such as speeding on the highway) and aggressive (fighting and murders) activities determine their life expectancy. Both are related to the gendered roles of femininity and masculinity that are fashioned from birth.

The case is similar for disaster management personnel. The women nurses, police officers and military personnel are expected to manage the needs of their families during times of disaster while at the same time perform their productive roles in their communities. Men, on the other hand, focus more on protecting the home and property and engage in more risk taking behaviours. This impacts on men's rate of morality compared to women disaster workers.

In addition to playing a significant role within the home, gendered roles have a significant impact on women's economic advancement. Her reproductive responsibilities, if not shared by her partner, leaves her less time to engage in self-development activities. It is also more challenging for a woman to balance her role of managing child care responsibilities and domestic chores with a regular work schedule. When there is need for overtime work, the woman must make arrangements for someone else, usually another woman, to assume her child care responsibilities – a task which men do not usually have to be concerned about. This double burden also leaves a woman with less time to take advantage of training and re-training opportunities and to access jobs (usually at the management level) which require much

travel or time away from home. Furthermore, the assumption that the man is the primary income earner leads to differentiation of salaries between men and women even when they have the same level of work responsibilities. This situation puts men at a clear advantage in the world of work.

Socialized concepts of women as sex objects and men as the sexual aggressors has severe implications for addressing gender based violence. Deeply engrained notions of women and children as property and women as sexual objects who “tempt”¹⁸¹ men into illegal sexual activity permeate society. Men report that adolescent young women who appear to pass a 90 pound test (done by observation) are ready for sexual activity. There is no regard for the child as a person. Rather, the child is perceived to be a sex object who exists to “pleasure” men. These socialized concepts are further reflected in a legal framework that examines women’s moral character to decide the outcome of rape and carnal knowledge cases. The high rates of sexual abuse and assault of children and adolescent women and the low rate of convictions points to this dichotomy between tradition and human rights.

Cases of sexual abuse and assault demonstrate that the legal framework is based on traditional patriarchal concepts of masculinity and femininity. Laws governing sexual abuse assume that only women and girls can be sexually violated and that only men can be the perpetrators of these crimes. Furthermore, the language towards women who engage in sex work remains derogatory. There is no similar derogatory labelling of the clients (mostly men) who pay for sex. This socialization pattern of women as sex objects and of men as heroes begins in childhood and is further reinforced in adulthood.

Traditional concepts of men as leaders and women as followers translate into more men in leadership positions. Men are assumed to be the natural leaders who are encouraged and supported in their quest to become political leaders. Women on the other hand, struggle to gain access to leadership positions and must fight even harder to retain those positions. As a result the Cabinet and House of Representatives have no women representatives. Women’s access to positions of political leadership, within this context, can only be promoted through special temporary measures aimed at creating gender equity within the system of governance.

Overall then, gender socialization has a serious deep-seated impact on the way our society unfolds, whether within the home or at the level of government. Gender equality and gender equity cannot therefore be achieved without a complete re-orientation of our concepts of masculinity and femininity which are promoted from birth onward.

4.2 The Pivotal Role of the Family

Whether related to health, education, wealth creation, violence producing conditions or political leadership, the family plays a pivotal role. In the case of health, genetics and socialization patterns combine to determine each person’s predisposition to health conditions. Substance abuse and dependency, mental health and chronic illnesses have both a lifestyle and a genetic component.

Women's predisposition to chronic illnesses and to STI/HIV is related to the composition of their bodies as well as the notion that women should carry the double burden of domestic work, caring for the children, the sick and the elderly and have no time for exercise and recreation. On the other hand, men's greater tendency to abuse substances and develop AIDS is related to notions of masculinity and risk taking behaviours. Many of these notions of masculinity and femininity are taught at very young ages beginning within the family circle.

In the case of education, the MICS survey confirms that the education levels of mothers has a direct positive impact on child development. The higher the education level of the mother, the better her children fare on several child development indicators. The education level of the father has no similar effect on the development of their children. Furthermore, Gillett's study points out that gender and family factors are positively correlated with a child's tendency to complete secondary school. In focus groups, children who stayed in school indicate that having a supportive family environment is conducive to being productive in school and later in life. Those who have dropped out of school indicate that having a mentor or "just one person to notice and care for them" made them want to go back to school or learn a marketable skill. This helped them to "turn their lives around". This is the role being played by staff members at the YWCA and YES who act as surrogate mothers to girls who are early school leavers. The success of these programmes, then, is not based solely on the curriculum; rather, it is inextricably linked to the love, attention and guidance offered to the girls who enrol in these programmes.

The 2009 Poverty Assessment identified Belize as experiencing chronic poverty. This means that the cycle of poverty, if left unaddressed, passes to the other generation. This type of poverty creates vulnerabilities for children as seen in the growing CSEC problem in Belize. Child neglect and abuse also results when parents, including single parents, have to work long hours away from home, leaving children unattended and exposed to the ills of society. The reality of teenage parenting and child abandonment due to migration, substance abuse or other reasons also leaves a permanent mark on the wider society. As demonstrated in one study on crime and violence, children who were more exposed to criminal activity tended to live with one parent, usually their mothers. The shirking of fathers' parental responsibilities and the challenges of the child maintenance system creates even more vulnerabilities for the children involved.

Socialized patterns of behaviour and what Rosberg called love "deficits" also contribute to the high rates of crime and violence, including gender-based violence. The ingrained violence is so culturally accepted that the removal of corporeal punishment from the Education Act has created mass resistance from teachers and parents countrywide. This shows how much work is needed to embed a human rights perspective in the psyche of the Belizean society.

Even women who have become leaders tell of the important role that both their mothers and their fathers played in their lives.¹⁸² In many cases, these women reported that they modelled their behaviours on a parent or a person who played that parental role.

Although the family environment plays such a critical role in early gender socialization and on determining a child's level of vulnerability to crime and violence, little attention is paid to family strengthening. The Department of Human Services has a Community and Parent Empowerment Programme (COMPAR) which operates with such meagre resources that it is virtually invisible. Early childhood development officers who provide parent education in communities also have limited resources. Investments in these programmes remain marginal considering the daunting task being undertaken. Meanwhile, resources continue to be misdirected toward programmes that treat the symptoms of a dysfunctional society rather than its root causes. Taking a family systems approach to development is required if Belize is to uncover a new path toward gender equality and gender equity and the realization of human rights for all.

4.2 Capacity Building

The issue of capacity building filtered through each section of this report. The inadequate human resource situation in the health sector, the low percentage of trained teachers at all levels of the education system, the high student-teacher ratio, the small numbers of social workers in the Department of Human Resources, the capacity limitations of police officers and other professional paint a grim picture of Belize capacity for development.

The implementation of any national policy or action plan, including the National Gender Policy, will continue to be affected by this human resource deficit. In this context, a national human resource development strategy is urgently needed. This strategy can consider: ongoing skills training programmes, adult and continuing education initiatives, incentives for retaining qualified Belizean, incentives for repatriating qualified Belizeans from abroad, streamlining the public sector, aiming for higher quality standards and upgrading the pay scales to be consistent with the cost of living.

Given this national context, gender equality and equity cannot be achieved without a deliberate, concerted and genuine effort to transform education in Belize. Education for life and lifelong learning are prerequisites for a more skilled, qualified, motivated, self-sufficient, gender aware and human rights oriented society.

4.3 Monitoring and Evaluation

A recent study¹⁸³ that examined 32 public policies in Belize concluded that policy development in Belize tends to be “front-loaded”. Much effort is placed on research to inform policy options. Energies are also directed at advocacy and public awareness aimed at policy development and acceptance by the Cabinet of Ministers or the Houses of Parliament. However, very little effort is usually placed of resource mobilization for the implementation, monitoring and evaluation of those policies. Consequently, many policies remain filed away or forgotten until an agency, usually an international

development organization, prompts the revisiting of issues that led to the initial formulation of the policy.

More recently, again with the support of international development partners, Belize has begun to move towards greater accountability of policies and action plans. The National Committee for Families and Children (NCFC) and the National AIDS Commission (NAC) are two agencies that have taken seriously their responsibility to monitor and evaluate specific plans of action. In the case of the NCFC, a monitoring framework was developed to monitor the National Plan of Action for Children and Adolescents. The NAC has also developed a Monitoring Plan to monitor the National Strategic Plan for a Multi-sectoral Response to HIV. Both action plans include gender related indicators.

While these organizations are making breakthroughs in monitoring and evaluation, their individual efforts are constrained by the lack of a wider culture of accountability. Monitoring and evaluation systems do not exist within implementation bodies in the public or private sector and data is not collected in a manner that allows for easy retrieval and analysis. In fact, in some cases data, even when collected, is simply reported in tables or charts. No one, either within the Government or in the Civil Society Sector is charged with translating this data into useful information that is used to plan more effectively. This type of data analysis is not supported by national protocols which may account for why this situation persists.

There is no national protocol that outlines the flow of data or the most effective system or mechanism for monitoring and evaluation. This creates a lack of formality regarding monitoring and evaluation and makes accountability very difficult. The absence of a technical body (such as the past Social Indicators Committee) to decide on the most useful indicators for Belize, define the metadata, decide on the level of disaggregation and on the process for data analysis, monitoring and evaluation results in a fragmented approach to planning and implementation. This also makes the establishment of baselines and the comparison of data over time a virtually impossible task as it creates challenges in monitoring progress in the achievement of international and local commitments. Monitoring and evaluation in Belize is therefore like “spitting in the wind”.

This situation results in an inability to effectively report on the impact of projects, programmes, plans of action and policies. An evaluation¹⁸⁴ of the 1998-2003 National Poverty Elimination Action Plan (NPESP), for example, states that, “the approach to poverty reduction over the first five years of the strategic action plan was insufficiently strategic or planned” and that “no overall strategy was developed”. This NPESAP did not include a monitoring and evaluation framework and therefore was unable to indicate with confidence that it achieved what it had set out to achieve. In fact, current indications are that poverty has increased by 10% and that Belizeans are experiencing chronic poverty.

The effectiveness in monitoring and evaluating the implementation of action plans related to the National Gender Policy will be impacted by this current monitoring and evaluation context in Belize. A more holistic approach will therefore need to be taken,

with specific actions outlined for the legalization, formalization and institutionalization of M&E systems in Belize. This will require:

- a national process of defining Belize's major development indicators,
- determining the metadata for these indicators,
- determining what data is already being collected and what gaps exist
- determining how the data will be collected and by whom,
- outlining how the data will flow through the M&E system within and across organizations,
- indicating how the data will be analyzed,
- stating how the data and its analysis will be shared with key stakeholders and
- outlining how all this will be used for more effective national planning

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