

Situation Analysis of Adolescent Pregnancy in Guyana



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Abbreviations & Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CARICOM	Caribbean Community
CDC	Centre for Disease Control and Prevention
CFNI	Caribbean Food and Nutrition Institute
CPA	Child Care and Protection Agency
CSW	Commercial Sex Worker
EMT	Emergency Medical Technician
FGD	Focus Group Discussion
GRPA	Guyana Responsible Parenthood Association
HFLE	Health and Family Life Education
HIES	Household Income and Expenditure Survey
HIV	Human Immunodeficiency Virus
IUD	Intrauterine Contraceptive Device
LAC	Latin America and the Caribbean
MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
MOPH	Ministry of Public Health
MSM	Men who have sex with Men
NAR	Net Attendance Ratio
PAHO/WHO	Pan American Health/World Health Organization
PHC	Primary Health Care
PMTCT	Prevention of mother to child transmission
SRH	Sexual and Reproductive Health
SitAn	Situation Analysis
STD	Sexually Transmitted Disease
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children Educational Fund
UNFPA	United Nations Family Planning Association
WHO	World Health Organization
WAD	Women Across Differences



Foreword

Honorable Minister of Public Health, Ms. Volda Lawrence



Adolescent Health has rapidly become one of the global critical issues in the Public Health sector with an alarmingly high number of girls below the age of 19 years giving birth annually. According to the Situation Analysis, recently conducted in Guyana by Ministry of Public Health Personnel in collaboration with UNICEF and UNFPA, Guyana is slated as having the second highest rate of adolescent pregnancy in the Latin American and Caribbean Region. The Analysis has further highlighted the complex and multidimensional nature of the situation, the major contributor being inequity and the prevalence in hinterland regions far exceeding the rates found along the coastal areas.

I wish to express my profound gratitude to the Research Team for the comprehensive report, inclusive of the recommendations, despite the setbacks and challenges faced with interviewing the participants and gathering of the relevant data. The Ministry is cognizant of the importance of evidence-based data in addressing pertinent health issues and wishes to acknowledge the Team's superb efforts in trying to ascertain the root causes of this alarming trend of adolescent pregnancy among our most vulnerable age group of girls, and to underscore the importance of a multi-sectoral approach if we are to grapple effectively with this problem and reverse the high incidence of adolescent pregnancy in our communities.

The Ministry wishes to assure the Team that this report would not find its place buried in the Public Health's archives, but that the recommendations will be examined, and targeted interventions based on the data will be implemented to address the structural factors that are contributing to Guyana's high ratings in Adolescent Pregnancy. As the time draws nearer for the realization of our goals envisioned for our adolescent girls in our Health Vision 2020, and as we embrace the 2030 Agenda and the Sustainable Development Goals, particularly Goal#3 and all its related aspects, the onus is on us all Ministry of Public Health as well as all the other Ministries and stakeholder Agencies to pool our resources to protect our girls, especially those in the Hinterland communities.

Our mandate seeks to ensure that our Guyanese population is among the healthiest in the Americas and the Caribbean and that all enjoy the good life. This legacy will not become a reality, but a nonentity, if we fail to intensify our efforts to lessen the high risks of disease and mortality, and the stranglehold that poverty has over this vulnerable adolescent group. It is my strong conviction that in unity there is strength, and so I urge all concerned to set aside some time to become familiar with the findings of this survey and to pledge their support and commitment so that this vulnerable group can have positive outcomes. Let us seek to uphold and work assiduously toward the fulfillment of their human and sexual and reproductive health rights, by creating avenues for their empowerment and the subsequent harnessing of their potential for economic productivity.



The wellbeing and good health of our nation are of paramount importance to the sustainability of our beloved country, and so I wish to reiterate my thanks to UNICEF, UNFPA and the Ministry of Public Health's Personnel for this Situation Analysis Survey, and I commit, on behalf of the Ministry of Public Health to utilize this data to formulate strategic Plans of Action to arrest this trend of adolescent pregnancy.

May God grant us the wisdom and energies to collectively impact the lives of all our Adolescents regardless of birth, race, creed, gender and sexual orientation, so that they can optimize the resources at their disposal, thereby guaranteeing through this process, a prosperous and healthy future.



Message

Representative of the United Nations Children's Fund, Ms. Sylvie Fouet



Early pregnancy is a challenge worldwide with 17 million girls below 19 years old giving birth annually and with 2 million births by girls below 15 years. In Latin America and the Caribbean, the rate is 66.5 out of every 1,000 teen girls. As per 2018 Situation Analysis, conducted by the Ministry of Public Health and funded by UNICEF, Guyana is among top-3 highest rate in the region with 90 out of 1,000 girls (15-19 years old) giving birth during 2010-2015 (only exceeded by Dominica Republic with 101 and Nicaragua 93) and with higher rates in the hinterland (105).

Adolescent pregnancy is recognized as a target within SDG-5 on gender equality and women's empowerment that contributes to the realization of other Goals such as SDGs 1, 3 and 4. In Guyana, one out of five teen girls are given birth in the last 20 years (covering 1997- 2016), being a silent alarm in term of obstacles to gender equality for girls.

Early pregnancy is both cause and consequence of child marriage and early union, sexual gender based violence and limited life projects for girls. In addition, socio-economic conditions play a key role; with poverty, level of education, area of residence, beliefs, traditions and culture having a strong correlation with behavioral patterns.

Pregnancy during adolescence has profound effects on teens, their off spring, their parents and family. When a teen girl becomes pregnant, her schooling often gets disrupted -or ends, her prospects of a job are dim, the health hazards due to complications from pregnancy and childbirth are huge.

Partnering with the Government, the UN System is committed to transform gender inequalities into better life conditions for girls in Guyana. Using initial highlights reported by UNFPA in 2015, the Study has been taken further by UNICEF with a research team to deepen the knowledge, understand the structural and underlying causes of early pregnancy and propose solutions to address them in a systematic and sustained manner. It is also an invitation to like-minded partners to accelerate responses to reduce and prevent teen pregnancies and to break the cycle.

Being a public health and equality issue, I thank Honorable Minister Lawrence for her lead in taking the matter across ministries and generate information to be used for targeted policies and programs aimed to reduce and prevent the first and second pregnancies in Guyana and in all circumstances. As one milestone last June, the Ministry of Education has adopted the national policy for the reintegration of adolescent mothers into the formal school system.



Message

Director of UNFPA at Sub-Regional Office for the Caribbean, Ms. Alyson Drayton



Adolescent pregnancy disrupts the present and future potential of our girls, creating new challenges in their psychosocial development, barriers to their educational and employment possibilities and in many cases, results in poor health outcomes. Adolescent fertility rates remain unacceptably high in Guyana and in our region, thwarting genuine development efforts to reduce inter-generational poverty. This Situation Analysis on Adolescent Pregnancy in Guyana which we initiated in 2015 with the collaboration of our sister agency UNICEF, could therefore not have been timelier. The focus on policy and legal frameworks is a most welcome one as teenage pregnancy is indeed a public health, human rights and equality issue.

The UNFPA 2018 State of the World Population Report tells us that adolescents often face barriers in accessing contraception, resulting in higher rates of teenage pregnancy which is more common among poor households. Their situation is further compounded by limited access to comprehensive sex education and age appropriate information about reproduction. The report cites early sexual debut, unprotected sex, high contraceptive failure rates and early union as contributing factors to high adolescent fertility rates.

The UNFPA Caribbean Sub-Regional Office which serves 22 English and Dutch speaking Caribbean countries, works to address this issue by focusing on the protection and fulfilment of girls' rights. This includes supporting comprehensive sex education and sexual and reproductive health care to help girls avoid pregnancy. UNFPA also advocates supporting girls who become pregnant so they can return to school and reach their full potential.

Our support to the preparation of this National Situation Analysis is also part of a wider effort aimed at recognizing our commitment to the 1994 International Conference on Population and Development (ICPD) in addressing adolescent reproductive and sexual health needs and in reducing levels of teenage pregnancy and the wide-ranging priority actions on reproductive health, gender equality and young people outlined in the Montevideo Consensus on Population and Development as a complementary monitoring framework for Agenda 2030 in the Caribbean.

The United Nations Population Fund (UNFPA) would like to commend the Government of Guyana and the Ministry of Public Health for your continuous commitment towards the reduction of adolescent pregnancy and we look forward to a sustained partnership towards eliminating adolescent pregnancy.



Acknowledgements

Guyana's Situation Analysis (SitAn) of Adolescent Pregnancy was carried out in 2018 by the Government of the Cooperative Republic of Guyana, through the Ministry of Public Health, in collaboration with the United Nations Children Fund (UNICEF). This SitAn is timely as the Ministry of Health and Sister Ministries are intensifying efforts to prevent the first and second pregnancies, among adolescents, in all regions of Guyana and in all circumstances.

This SitAn has benefited from the oversight of the Minister of Public Health, Honorable Ms. Volda Lawrence and UNICEF's Representative for Guyana, Ms. Sylvie Fouet. Guidance was provided by the Chief Medical Officer, the Deputy Chief Medical Officer and the Directors in the Family Health Unit of the Ministry of Public Health. Technical support was provided by the Country Liaison for UNFPA Guyana Mr. Adler Bynoe and the Monitoring and Evaluation Specialist of UNICEF Guyana, Mr. Michael Gillis.

Contracted by the Ministry of Public Health, Dr. Morris Edwards, Ms. Monica Miller and Dr. Christine Glover-Walton must be acknowledged for their excellent work in the conduct of this study. The support and cooperation of Ministries, Commissions and Departments and other stakeholders, especially adolescent mothers, is duly acknowledged and applauded.

Finally, the findings of this SitAn provide a strong baseline for more accurate conceptualization and design, implementation and monitoring and evaluation of national, regional and community-level projects and programs, across all sectors, for many years to come. It is expected that this study will pave the way for the continuous assessment of adolescent pregnancy and other social challenges that affect adolescents, especially the most vulnerable.



Executive Summary

Introduction

Adolescent pregnancy is a major problem worldwide with 17 million girls below the age of 19 years giving birth annually and about 2 million births occurring in girls below the age of 15 years. Most of these births occur in low- and middle-income countries. Globally, some 19 percent of adolescent girls are estimated to give birth annually.

Countries in West and Central Africa have the highest adolescent birth rates of all regions of the world, followed by East and Southern Africa. In Latin America and the Caribbean, the rate is 66.5 out of every 1,000 adolescent girls. Guyana is reported to have the second highest rate in Latin America and Caribbean with 90 out of every 1,000 girls between the ages of 15 and 19 giving birth during the period 2010-2015. This is exceeded only by the Dominican Republic in the Caribbean, with 101 out of every 1,000 girls, and Nicaragua in Central America with 93 out of every 1,000 girls of the same age.

Adolescent pregnancy as a percentage of all pregnancies in Guyana has remained between 19 and 22 percent from 1997-2016. There are socio-economic, regional and ethnic differences in the rates of adolescent pregnancy with the hinterland regions having higher rates than the coastal regions (105 versus 69) as well as rural areas having higher rates than urban areas (81 versus 55). The Indigenous Peoples have the highest rates compared with the other ethnic groups, as do girls from the lowest wealth quintile and lower educational background.

Methodology

The methodology for conducting this Situation Analysis on adolescent pregnancy in Guyana was based on a multi-method approach, that combined quantitative and qualitative elements in the triangulation for findings and conclusions. The quantitative part was based on a desk review of key documents from research, studies, publications, governmental policies and plans, and other relevant material. It also included national and international surveys such as demographic and health surveys, censuses, income and expenditure surveys, all of which provided information about adolescent pregnancy in Guyana.

The qualitative component was based on focus group discussions, key informant interviews and field observations. The qualitative component was conducted in regions 1, 3, 4, 6 and 9 where more than 112 stakeholders were involved in the process, resulting in more than 32 hours of recordings that were transcribed and analysed as inputs for this report.

Findings

The causes of adolescent pregnancy in Guyana were found to be complex and multifactorial, with inequity being found to be a major contributor to the occurrence. From the quantitative data reviewed, it was found that rates in the hinterland regions are higher than in the coastal regions and in both settings, rural areas had higher rates than urban settings. Indigenous Peoples had higher rates than the other ethnicities. Additionally, the factors that were found to be associated



with the highest rates of adolescent pregnancy included inequities such as poverty; lack of knowledge of comprehensive sex education and lack of access to contraceptives; the practice of certain sexual behaviors such as early initiation of sex- which almost invariably was associated with unprotected sex; and sexual violence and abuse. Additional factors were high secondary school dropout rates; living in overcrowded households; living in single-parent households which were usually female headed; and the culture of adolescent girls riding on minibuses and having sexual relationships with the drivers and conductors.

Lack of access to comprehensive sex education

Many of the adolescents obtained their information on sex and sexuality from their peers as most parents did not discuss these matters with them and therefore their information in many instances were both inadequate and inaccurate. Because of not being aware of the physical and emotional changes that occurred in adolescence, many engaged in sexual activity without contemplating that they would become pregnant. Additionally, their lack of use of contraceptives invariably exposed them to becoming pregnant and to Sexually Transmitted Infections (STIs) including the Human Immunodeficiency Virus (HIV).

Lack of access to and use of contraceptives

Several factors contributed to the low use of contraceptive by adolescents during sexual intercourse. Prior to becoming pregnant, some adolescents did not know about contraceptives, while others did not know where to access them. Another contributing factor to the low use of contraceptives was the anomaly between the age of consent and the age at which persons can access health services without the need to be accompanied by an adult, providing that they completely understand the nature of the service being provided (Gillick competence). The ages for consent and access are 16 and 18 respectively and most of the adolescents did not try to access contraceptives from health facilities as they were fearful of the attitudes of healthcare workers at these facilities and most were not in a financial position to purchase contraceptives.

An additional contributory factor was the attitude of health staff towards adolescents, especially when they sought sexual and reproductive health services. Staff were usually judgmental and verbally and emotionally abusive to the adolescent as they sought services. As a result, adolescents, whether pregnant or not were not enthusiastic to access the services being provided.

Sexual behavior

Most of the adolescents did not recognize that engaging in sexual activity before the age of 16 constituted statutory rape, and many of them became sexually active before they were 16. While the fathers of the children of the adolescent mothers were not interviewed, from limited conversations with some adolescent and young adult men, some were not aware that engaging in sexual activity with an adolescent below the age of 16, whether consensual or not, constituted statutory rape.



Difficult relationships with parents and family members

Some of the adolescents were from homes where they felt unloved and were consciously and unconsciously seeking love outside of the home and ended up in sexual relationships with men who they felt were showing them love and attention. In other instances, others began sexual relationships with men who were able to provide financial support either through gifts or actual monetary contributions. Other adolescents began sexual relationships through peer pressure as they would go out to parties with their peers and sometimes consume alcohol and other drugs and engage in sexual activity.

Sexual violence

It must be highlighted that while none of the focus group discussions identified sexual violence, including rape and incest, as causes of adolescent pregnancy, the key informant interviews did highlight that these frequently occur, especially in the hinterland regions, but that no region was immune to these occurrences.

Conclusion

Adolescent pregnancy is a major issue for Guyana with more than 20 percent of all pregnancies consistently occurring in this age group. As in other countries, the causes are complex and multifactorial. Socio-economic conditions play a key role in the occurrence with poverty, level of education, area of residence, beliefs, traditions and culture having strong correlation with behavioral patterns.

Unless the structural and other causes of adolescent pregnancy in Guyana are addressed in a systematic and sustained manner, the country will continue to have high rates of such pregnancies as well as continued exposure of this age group to increased rates of HIV and other STIs. With the discovery of oil in Guyana, the country has an opportunity to utilize the newfound resources to address many of the structural factors that contribute to the high rates of adolescent pregnancy.



Section 1: Introduction

Pregnancy among adolescent girls is a global problem, with the World Health Organization estimating that approximately 16 million girls 15-19 years of age and 1 million below the age of 15 years, give birth annually, with most (95 percent) of these births occurring in low and middle-income countries (WHO, 2012). According to the World Population Report of 2013, of the 7.3 million births that occur in girls below the age of 18 in developing countries each year, 2 million occur in girls below the age of 15. It is estimated that 19 percent of adolescent girls become pregnant before they reach 18 years. From 1990, there has been an overall slight reduction in the percentages of all adolescent pregnancies, however the Latin America and the Caribbean region is the only region that has seen an increase in the percentage of pregnancies among girls below the age of 15 (UNFPA 2013).

The world's adolescent birth rate stood at 50 per 1,000 adolescent girls for the period 2010-2015, with Africa leading all regions with the highest adolescent birth rate of 98 per 1,000 adolescent girls, followed by Latin America and the Caribbean with a rate of 67 per 1,000 adolescents. (UN Population Division, 2015). For Latin America and the Caribbean, Central America has the highest rate of 69 per 1,000 girls followed by South America with 66 per 1,000 girls and the Caribbean having the lowest of the LAC grouping with 60 per 1,000 girls.

Within Central America, Nicaragua has the highest adolescent birth rate at 81 births per 1,000 girls aged 15-19, while for South America, Guyana has the highest rate at 90 per 1,000 girls. Among Caribbean countries, the Dominican Republic has the highest rate at 101 per 1,000 girls. If Guyana is placed among Caribbean countries as is traditionally done, then it has the second highest rate amongst those countries (UN Population Division, 2015).

Adolescent pregnancy has health, economic and social consequences for the girls who become pregnant. 3.2 million of girls who become pregnant undergo unsafe abortions, while some 70,000 die annually from complications of pregnancy and childbirth; making deaths due to pregnancy the second leading cause of death among adolescents (WHO 2012, UNFPA 2015). The rate of occurrence of obstetric fistulae is higher in adolescent girls compared to their older peers. Many of these girls do experience missed educational and other opportunities, with denial of their basic human rights and their potential being unfulfilled. In many cases, there is a perpetuation of poverty and exclusion for these girls.

Not only do the girls suffer negative consequences of being pregnant in their adolescent years, but babies born to them face a substantially higher risk of dying than those born to women aged 20 to 24 years. Their babies face a 50 percent higher risk of being still-born or dying in the first few weeks versus those born to mothers aged 20-29. The younger the mother, the greater the risk to the baby. Newborns born to adolescent mothers are also more likely to have low birth weight, with the risk of long-term effects.

The UNFPA World Population report of 2015 highlights several underlying causes for adolescent pregnancy. These include: (i) child marriage, (ii) gender inequality, (iii) obstacles to human rights, (iv) poverty, (v) sexual violence and coercion, (vi) national policies restricting access to



contraception and age appropriate sexuality education, (vii) lack of access to education and reproductive health services and (viii) underinvestment in adolescent girls' human capital.

Adolescent pregnancies vary according to regions and countries of the world, within countries and across age and income groups. A common occurrence in every region is that girls who are poor, live in rural or remote areas and who are illiterate or have little education are more likely to become pregnant than those who are wealthier, live in urban settings and are more educated. Girls from ethnic minority groups, who have limited or no access to sexual and reproductive health, including contraceptive information and services are also more likely to become pregnant.

Robert Blum of the Johns Hopkins Bloomberg School of Public Health has developed an “ecological approach” to account of the full range of forces that are the drivers of adolescent pregnancy. This approach accounts for forces at the national level such as policies regarding adolescents' access to contraception or lack of enforcement of laws banning child marriage as well as factors at the individual level such as a girl's socialization and the way it shapes her beliefs about adolescent pregnancy.

According to this model, pressure from all levels would conspire against girls and lead to pregnancies whether intended or not. At the national level, laws may prevent girls from accessing contraception while community norms and attitudes may block her access to sexual and reproductive health (SRH) services or condone violence against her when she manages to access these services. Family members may force her into marriage where she has little or no power to say no to having children. Schools may not offer sex education and therefore girls must rely on information which is often inaccurate from peers about sexuality, pregnancy, and contraception. Additionally, their partners may refuse to use a condom or forbid them from using any contraception.

Country profile

Guyana, the only English-speaking country in South America, is 216,000 Km² in size and lies on the northeastern coast of the South American continent. It is bordered by the Atlantic Ocean to the northeast, Suriname to the southeast, Brazil to the southwest and Venezuela to the northwest (Figure 1). The country is divided into 10 administrative and geographical regions, numbered from 1-10 (Table 1). Geographically, the country can be divided into coastal and hinterland regions with Regions 2,3,4,5,6 and 10 comprising the coastal division and 1,7,8 and 9 in the hinterland division.



Figure 1: Administrative and geographical map of Guyana



Data from Guyana’s most recent census conducted in 2012 established its population at 746,995 persons, with the adolescent population numbering 157,858 (21.1 percent of the total population). Adolescent females comprised 76,712 (20.4 percent) and males 81,146 (21.8 percent) [Guyana Bureau of Statistics, 2014]. The majority (89 percent) of the population (662,261) resides along the coastland and 10.9 percent (81,623) in the hinterland region (Table 1). Almost three quarters (73.6 percent) of the population live in rural areas, with 72 percent of households being found in these rural areas. Almost two thirds of the urban population reside in Region 4, where the capital Georgetown is located (MICS 2014).

Table 1: Administrative Regions, Area and population in Guyana (2012)

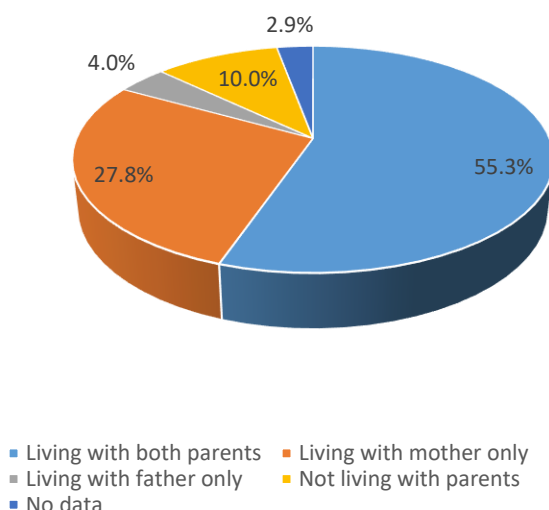
#	Name of Region	Area (km)	Population	Population per km	Region	Urban/Rural
1	Barima-Waini	20,339	26,941	1.32	Hinterland	Rural
2	Pomeroun – Supenaam	6,195	46,810	7.56	Coastland	Urban
3	Essequibo Islands – West Demerara	3,755	107,416	28.61	Coastland	Rural
4	Demerara – Mahaica	2,232	313,429	140.43	Coastland	Urban
5	Mahaica – Berbice	4,190	49,723	11.87	Coastland	Rural
6	East Berbice – Corentyne	36,234	109,431	3.02	Coastland	Urban
7	Potaro – Siparuni	47,213	20,280	0.43	Hinterland	Rural
8	Cuyuni – Mazaruni	20,051	10,190	0.51	Hinterland	Rural
9	Upper Takutu – Upper Essequibo	57,750	24,212	0.42	Hinterland	Rural
10	Upper Demerara – Berbice	17,040	39,452	2.32	Coastland	Urban
	Total	214,999	747,884	3.48		



Source: Guyana National Bureau of Statistics, 2012 Census

Slightly more than half (55.3 percent) of children live with both parents, with 27.7 percent living with their mothers, 4 percent living with their fathers and 10 percent not living with their parents (Figure 2). 66 percent of households are headed by males and the other 34 percent by females (MICS 2014).

Figure 2: Children's living arrangements, Guyana, 2014



Source: MICS 2014

Guyana is a multiethnic country with six ethnic groups, five of whose fore parents came from India, Africa, Europe and China, and the final group comprising the Indigenous Peoples. The Indo-Guyanese at 33 percent comprise the largest ethnic group, followed by Afro-Guyanese (29 percent). The Indigenous Peoples comprise 10 percent of the population.

Economy

Guyana has recently been classified as an upper middle-income country with a GDP of US\$4,090 in 2015. Agriculture, forestry, fishing and mining constituted 28 percent of the GDP, with bauxite, sugar, rice, gold and timber being responsible for 83 percent of all exports and are the primary source of jobs in the country. The country's economy grew by 4.7 percent annually between 2005 and 2014, but real GDP growth declined by 3.1 percent in 2015 due to the fall of commodity prices for its major exports. Preliminary estimates for 2016 revealed a growth rate of 3.3 percent due to increased outputs from mining, agriculture and fishing. With the discovery of oil off Guyana's coast and production set to commence in 2020, there is the promise of increased revenue for the country to finance its development needs. (World Bank).

Poverty

Guyana's last poverty measurement was conducted in 2006 using the Household Income and Expenditure Survey (HIES). In this HIES, two poverty lines were defined; extreme and moderate



poverty. Extreme poverty is based on a normative food basket having 2,400 calories for an adult male as defined by the Caribbean Food and Nutrition Institute (CFNI), while moderate poverty included an allowance for non-food items and was estimated by determining the share of total consumption devoted to those items.

Using these measurements, extreme poverty was defined as persons earning below the monthly average cost of the food basket for an adult male and this cost was estimated at G\$7,550 per month (US\$1.25 per day). Moderate poverty was defined as those earning less than G\$10, 494 per month (US\$1.75 per day) [Guyana Poverty Reduction Strategy Paper, 2011-2015].

From the last poverty measurement of 2006, 36.1 percent of the country’s population was living in poverty with 18.6 percent living in extreme poverty. Both poverty and extreme poverty were more pronounced in the hinterland regions of the country (Table 2).

Table 2: Poverty rates by area, Guyana, 2006

Area	Poverty classification	
	Moderate Poverty (percent)	Extreme Poverty (percent)
National	36.1	18.6
Urban Coastal	18.7	7.3
Rural Coastal	37	17.1
Rural Interior	73.5	54

Source: Guyana Poverty Reduction Strategy Paper 2011-2015

While most of the poor in the country are found in Region 4 because of population distribution, Regions 8, 1 and 9 are the regions with the highest percentage of their individual populations living in poverty at 94 percent, 80 percent and 74 percent respectively (Table 3).

Table 3: Poverty distribution by Regions, Guyana, 2006

Region	% of population living in poverty	Share of poor population
Barima-Waini	80.06	3.18
Pomeroon – Supenaam	51.94	6.25
Essequibo Islands – West Demerara	40.09	14.08
Demerara – Mahaica	24.56	42.43
Mahaica – Berbice	42.58	6.11
East Berbice – Corentyne	28.45	15.76
Potaro – Siparuni	61.42	2.48
Cuyuni – Mazaruni	94.28	1.48
Upper Takutu – Upper Essequibo	74.38	2.96
Upper Demerara – Berbice	39.36	5.26
National	36.1	100

Source: Guyana Poverty Reduction Strategy Paper 2011-2015



Purpose and objectives of the SitAn

The purpose of the situation analysis was to understand the factors that contributed to adolescent pregnancy in Guyana and to propose viable solutions that can be used to reduce the prevalence of this issue.

The objectives of the situation analysis were:

1. To obtain information about the status of adolescent pregnancies in Guyana by establishing the determining factors, needs, services.
2. To prioritize interventions to address the problems identified.

Methodology

The methodology for conducting the situation analysis followed the format of the “Guidance on Conducting a Situation Analysis of Children’s and Women’s Rights-Taking a Rights-based, equity-focused approach to Situation Analysis (UNICEF, Dec 2012) and the UNICEF Global Assessment on Situation Analysis of Children’s and Women’s Rights (UNICEF, June 2012).

As such, the methodology included a desk review, quantitative data review, focus group discussions and key informant interviews.

Desk/Data Review

A desk review was conducted by a previously hired consultant and the research team was asked to review the desk-review report. The desk review conducted by the previous consultant was fairly robust and key documents from research, studies, publications, governmental policies and plans, and other relevant material were cited. The list of documents reviewed is in the Appendix.

A quantitative review was executed of national and international surveys, demographic and health surveys, censuses, income and expenditure surveys. A key document that was extensively used in this data review was the 2014 Guyana Multiple Indicator Cluster Survey (MICS), a collaborative effort between UNICEF and the Guyana Bureau of Statistics. The main objective here was to identify trends in specific indicators and to map any disparities and to determine links to sources of inequities.

Data Collection

A total of 16 Focus Group Discussions (FGD) were conducted in Regions 1 (Barima-Waini), 3 (Essequibo Islands-West Demerara), 4 (Demerara-Mahaica), 6 (East Berbice-Corentyne) and 9 (Upper Takutu-Upper Essequibo). These Regions were selected based on existing data on adolescent pregnancies, with those with the highest percentages being given priority. 23 FGDs were planned but only 16 were conducted (Appendix 7). These FGDs were used to collect primary data. Focus groups were conducted in the board rooms of the National AIDS Programme Secretariat in Region 4 and the Regional Offices in the other regions, using a standardized focus group guide. The FGDs were audiotaped. Each FGD comprised five to eight participants and lasted



between forty-five minutes to an hour. Two FGDs lasted one hour and forty-five minutes and two hours respectively.

Key informant interviews were conducted with representatives from the Ministry of Public Health (MOPH), healthcare providers, the Child Care and Protection Agency, the United Nations Children Education Fund (UNICEF), the United Nations Family Planning Association (UNFPA), the Guyana Responsible Parenthood Association (GRPA) Red Thread, Women Across Differences, head teachers, religious leaders, village captains (Toshaos) and fathers of babies of pregnant adolescents (Appendix 7). Interviews were conducted primarily in the offices of organizations and in boardrooms using a standardized interview guide with each discussion being audiotaped. The selection of regions for conducting key informant interviews followed the same rationale as was used for conducting the FGDs. A total of 20 Key Informant Interviews (KIIs) were conducted.

Data analysis and report preparation

The data review allowed the research team to identify some trends, before starting data collection in the field. The audiotaped FGDs and interviews were transcribed verbatim into Microsoft Word. Data from both interviews and focus groups were then analyzed using thematic analysis. This type of analysis takes an “inductive” approach, analyzing transcripts and notes with a view to identifying key themes or “codes” arising either directly from the data or in line with previously identified themes. The coding scheme was developed into a spreadsheet (OpenOffice Calc) and data exploration and analysis involved manually color-coding the themes and cutting and pasting them together to create a classification system and for ease of cross-referencing.

Triangulation happened between methods and sources within the same region and among regions. The information obtained from the FGDs was triangulated with those of the KIIs to look for synergies and related themes. This triangulation was done to look for corroboration between the findings of the FGDs and KIIs. The comparison among the qualitative information from the regions was then triangulated with the quantitative data to inform the conclusions described in this report. Data, investigator and methodological methods were used to triangulate the information that was obtained by FGDs and KIIs. Further, the framework for conducting this Situation Analysis followed UNICEF’s suggested three steps for conducting a situation analysis (Figure 3) (UNFPA)

Figure 3: UNICEF’s suggested steps for conducting a situation analysis

Step 1	Assessment of the manifestations of child rights shortfalls and inequities in child outcomes
Step 2¹	Analysis of the major causes of child rights shortfalls and inequities
Step 3	Validation of the analysis for the realization of child rights with equity

¹ The three levels of Causal analysis are immediate, underlying and structural causes. These are defined as: (i) Immediate causes are events or circumstances that can by themselves produce an effect; (ii) underlying causes are conditions that by themselves will not produce an effect, but must be present for the effect to occur; and (iii) structural causes are factors or events that are further back in the chain but deeply influence the effect and include social relations, socio-economic situations and social norms that influence all other causes.



In step 1, the major shortfalls and inequities of child rights were assessed. Causal analysis was the main tool used in analyzing step 2. This analysis utilizes three levels; immediate, underlying and structural causes. After identifying the causes, bottlenecks and barriers, specific issues and/or situations that are preventing children from accessing their rights are identified and framed within the determinant framework (Figure 4). In step 3, validation of the process occurred through follow up meetings with representatives of the steering committee of the SitAn.

Figure 4: Key determinants for barriers and bottlenecks

	Determinants	Description
Enabling environment	Social norms	Widely followed social rules of behavior
	Legislation/policy	Adequacy of laws and policies
	Budget/expenditure	Allocation and disbursement of required resources
	Management/Coordination	Roles and Accountability/Coordination/Partnership
Supply	Availability of essential commodities/inputs	Essential commodities/inputs required to deliver a service or adopt a practice
	Access to adequately staffed services, facilities and information	Physical access (services, facilities/information)
Demand	Financial access	Direct and indirect costs for services/practices
	Social and cultural practices and beliefs	Individual/community beliefs, awareness, behaviors, practices, attitudes
	Timing and continuity of use	Completion/continuity in service, practice
Qty	Quality of care	Adherence to required quality standards (national or international norms)

Source: UNICEF Guidance on Situation Analysis (UNICEF, Dec 2012)

Limitations of the study

There were some limitations that were encountered that affected the scope and depth of the study. These limitations included:

1. The research team had difficulty in getting the fathers of the babies of the adolescent mothers to participate. Despite agreeing to be interviewed on many occasions, they did not present themselves at the time of the focus group discussions, citing inability to get time off from work when further contacted.
2. A few of the adolescent mothers did not keep the appointments they had agreed to.
3. There were logistical challenges in arranging the interviews in the hinterland locations and the expected level of participation was not achieved.
4. There is limited quantitative and qualitative data available on adolescent pregnancy in Guyana as very few studies have been conducted on this population.



Section 2: Findings of the SitAn

Policy and Legal framework

An understanding of the legal, social and economic context in Guyana can provide useful insights into the cause of the rates of adolescent pregnancies in the country.

Legal Framework

Article 154 A (1) of the constitution of the Cooperative Republic of Guyana incorporates the right to health, which is embodied in seven of the main international human rights Conventions/Treaties. In addition, Article 40 (1) of the constitution specifically guarantees that “every citizen has the right to free medical attention and to social care in the case of old age and disability”. Consequently, public health care services in Guyana are offered free of charge to all persons. Further, the 2008 *Regulations made under The Health Facilities Licensing Act 2007*, section 13, states that all persons seeking service at a health facility (public or private) shall be treated equally regardless of age, place of birth, race, creed, nationality, gender and sexual orientation.

Based on the National Reproductive Health Strategy for Guyana, 2014-2015, Guyana has several legislations governing sexual and reproductive health such as the Medical Termination of Pregnancy Act, Marriage Act, Domestic Violence Act, Sexual Offences Act, and the Protection of Children’s Act.

Marital age, sexual consent and protection of children

Chapter 45:01 of the *Marriage Act* consolidates and amends the law relating to marriage. The Act stipulates that persons 18 years and older can get married without requiring consent; whilst 16 and 17-year-old persons require the consent of their parents or the court. However, where a girl under the age of 16 becomes pregnant she may marry a man over the age of 16. She may marry a male under the age of 16 if that male admits that he is the putative father of the child.

Chapter 8:03 of the *Sexual Offences Act* is an Act to reform and consolidate the laws relating to sexual offences and to provide for related matters. The Act states that the age at which a person can consent to sexual activity is 16 years old. It also states that any person who engages in sexual penetration of a child below 16 years of age or causes the child to engage in sexual penetration with a third party commits the offence of rape.

The *Protection of Children Act* came into force in 2010 and provides for the protection of children at risk or in difficult circumstances by placing them in the assistance or care of the Child Care and Protection Agency. Under this *Act*, a child is any person under the age of 18 or any person over the age of 18 who has special needs, who is under care or protection by virtue of any law, has a disability or is certified by the Director of the Child Care and Protection Agency (CPA) as being in need of care and protection.



Legal abortion

Chapter 32:05 of the *Medical Termination of Pregnancy* governs the medical termination of pregnancies. This Act aims to enhance the dignity and sanctity of life by reducing the incidence of illegal abortion and to enhance the attainment of safe motherhood by eliminating deaths and complications due to unsafe abortion. It prescribes those circumstances in which any woman who voluntarily wishes to terminate her pregnancy may lawfully do so. The Act covers termination of pregnancy by medication, surgical procedures or by other means.

In Guyana, abortion was once criminalized under the *Criminal Law (Offences) Act*, Chapter 8:01. With the passage of the *Medical Termination of Pregnancy Act* Chapter 32:05 (1995) the termination of pregnancy was legalized in certain circumstances. The law outlines specific conditions under which pregnancies can be terminated. Before any abortion can be performed, the pregnant woman must undergo counselling (details of this are set forth in the accompanying regulations) and wait 48 hours before making her final decisions. Notably, a woman of sound mind does not need the consent of her parents, guardian, or husband to obtain an abortion.

Protection against domestic violence including sexual abuse

The Domestic Violence Act of Guyana was passed in December 1996 to give legal protection to persons who have suffered abuse or are at risk of suffering domestic abuse. Any person who is suffering domestic abuse is automatically eligible to be protected by the Act. Any abused person - adult or child - can get protection from: a spouse, fiancé or reputed spouse, or partner with whom they live, a relative or any person with whom the victim has had a sexual relationship.

There have also been some important recent developments to enhance the legal and policy-based environment for the realisation of sexual and reproductive health (SRH). In July 2014, the Ministry of Human Services and Social Security launched a National Plan of Action (which was supported by UNFPA) for the complete implementation of the *Sexual Offences Act* of 2010. The implementation of the Action Plan will see police officers, doctors, emergency medical technicians (EMTs), prosecutors, social workers and members of the judiciary and magistracy undergo capacity-enhancement training in dealing with victims and crimes of sexual abuse. In February 2015, after recognizing deficiencies in the *Domestic Violence Act of 1996*, the Ministries of Human Services and Legal Affairs launched the *Domestic Violence Regulations* with the aim of creating easier access to justice for victims of domestic violence, including the minimization of delays in the hearing of domestic violence matters by courts of law.

Health Policy and Initiatives

Sexual and Reproductive Health (SRH) Strategy and Policy (2014-2020)

The Government of the Cooperative Republic of Guyana recognized that the attainment of the Programme of Action of the International Conference on Population and Development (ICPD) as well as the Millennium Development Goals (MDGs) [a precursor to the Sustainable Development Goals] is possible in many respects through the employment of proven, high-impact and cost-effective measures that can have positive impacts upon the sexual and reproductive health of



women, men and young people. As such, a Sexual and Reproductive Health (SRH) Policy and an accompanying Strategy were drafted as a key step, as the Government scales up the response to sexual and reproductive health in Guyana.

The SRH policy and strategy were drafted by the Ministry of Health (now Ministry of Public Health) in collaboration with the United Nations Population Fund (UNFPA), the Technical Committee for Sexual and Reproductive Health and other key stakeholders, including UNICEF and PAHO. The aim of the policy and strategy is to achieve universal access to sexual and reproductive health services in Guyana. The Policy sets out the Government's commitments for the delivery of SRH services and is accompanied by an SRH strategy which sets out the actions that will be taken to realise the policy commitments. The SRH Policy and Strategy is designed to be used by policymakers, programme managers and planners involved in the delivery of SRH services.

The overall goal of the strategy is to contribute to the national efforts towards the improvements of the Sexual and Reproductive Health status of all women, men and young people living in Guyana, reduce maternal mortality, improve the survival of all new-born babies and ensure that people can:

- Have healthy sexual development and maturation and have the capacity for equitable and responsible relationships and sexual fulfilment
- Achieve their desired number of children safely and healthily, when and if they decide to have them
- Avoid illness, disease and disability related to sexuality and reproduction and receive appropriate care when needed
- Be free from violence and other harmful practices related to sexuality and reproduction.

To accomplish these goals, eight targets were identified. All eight targets are relevant to the Sexual and Reproductive Health of adolescents, directly or indirectly. The Strategy has the following 4 groups of strategic directions:

Strategic Direction 1- Legal and Policy Reform

Strategic Direction 2- Making Pregnancy and Childbirth Safer

Strategic Direction 3- Access to Reproductive Health Care for All

Strategic Direction 4- Promoting Beneficial Services and Addressing Harmful Practices

Adolescent and Youth Sexual and Reproductive Health falls under Strategic Direction 3, the aim of which is to improve the quality of life and maintain sexual and reproductive health of adolescents through Youth Friendly Health Services.

The strategic actions that should be taken to realize the 13 policy commitments (as per the SRH Policy) are as follows:



1. Legislation should be amended or enacted to ensure that adolescents have access to appropriate and quality reproductive health services and commodities, including contraception and emergency contraception without the need for parental consent at least at the age of consent with entrenched confidentiality protection.
2. Health care providers should be educated on their legal duty to report and provide adolescent/youth with guidelines they must follow in relation to minors who are or who appear to be victims of physical or sexual abuse or violence.
3. Adolescents must have access to age-appropriate accurate information as well as quality sexual and reproductive health services and commodities through age-appropriate, safe and confidential programmes to provide medical, psychosocial and other necessary support to adolescents and youth who are victims of physical or sexual abuse or violence.
4. Ensure access to sexual and reproductive health information and services for adolescents and youth in difficult circumstances including those who are out-of-school, living in poverty, living with disabilities, living with HIV and single mothers.
5. Comprehensive research should be conducted on the perceptions, attitudes, and behaviour of adolescents and youth regarding their sexual and reproductive health. This information should be used to develop evidence-based policies and programmes and to ensure effective service delivery.
6. The provision of comprehensive age-appropriate SRH education and information for adolescents and youth throughout all levels of the education system and the health care system to promote the benefits of delayed sexual debut, and to empower adolescents and youth to protect themselves against unwanted pregnancies, sexually transmitted infections and HIV.
7. The provision of comprehensive age-appropriate SRH education and information for adolescents and youth throughout all levels of the education system and the health care system on a range of sexual and reproductive health rights and issues, including the importance of consent, mutual respect and non-violence in relationships, responsible parenthood, gender equality and equal rights within families.
8. Support non-governmental youth organisations and schools to strengthen their involvement in the design, implementation and evaluation of sexual and reproductive health programmes and policies that concern them, including adolescent/teenage pregnancy, sex education, sexually transmitted infections and HIV/AIDS.
9. Ensure teachers and health care workers receive training to deliver age-appropriate SRH education and services in schools and health centres and that the delivery of SRH education conforms to human rights, ethical, professional and gender-sensitive standards.
10. Partner with the Ministry of Education (Departments of Education as well as the Department of Culture, Youth and Sport) to improve and expand 'edutainment' programmes for in-school



and out-of-school adolescents to cover a full range of sexual and reproductive health issues, with the active involvement and participation of adolescent and youth, and non-governmental organisations involved in SRH and youth interests.

11. Ensure that male sexual and reproductive health issues and male responsibility in sexuality are included in SRH education curricula at all levels of the education system.
12. Increase male participation in the delivery of SRH education to avoid the feminisation of reproductive health.
13. Engage parents and community leaders in the development of mechanisms to foster a supportive environment for adolescents and youth to access the SRH information and services they need.

Health Vision 2020: A National Health Strategy for Guyana 2013-2020

The Ministry of Health's Health Vision 2020: A National Strategy for Guyana, 2012-2020, in addressing service priorities for improved health outcomes, highlights the need to strengthen facilities and capacities to promote sexual and reproductive health to, among other things, promote behaviour change, increase contraceptive prevalence, develop the evidence base for targeted interventions, promote screening for sexually transmitted infections, promote health education and enable SRH services to meet the needs of persons living with disabilities. Currently sexual and reproductive health services are available throughout all levels of the public health care sector, at private health care facilities and through some non-governmental organisations.

Health Vision 2020 targets clinical preventative family health services and health promotion strategies while ensuring a continuum of health care coverage and access for all populations. It targets families and communities, reduced maternal, infant and child mortality, improved adolescent health, healthy aging, strengthened rehabilitation services and the integration of services for at-risk populations and the disabled. Health Vision 2020 uses the approach to health that is referred to as the "Health Across the Human Life Course" approach.

Addressing the issues-Protocols and Guidelines

There are several organizations and institutions that provide health programs and services for adolescents and youths in Guyana. To encourage greater utilization of SRH services, these organizations and institutions have developed protocols to guide both the service provider and beneficiary as to what is to be done and what should be expected, respectively. This section will highlight some of the different organizations providing SRH services and the protocols that they have in place.

Non-Governmental Organizations (NGOs)

Non-governmental organizations include the following:

1. The Guyana Responsible Parenthood Association
2. Help and Shelter



3. Every Child Guyana/Child Link

Guyana Responsible Parenthood Association

The Guyana Responsible Parenthood Association (GRPA) is a non-governmental provider of sexual and reproductive health services in Guyana. Its integrated services include gynaecological exams, contraception distribution, cervical cancer screening, abortion services, and STI testing and treatment.

The GRPA has a Policy and Code of Conduct for the Protection of children, young people and vulnerable adults. The purpose of the policy is to provide a set of guiding principles and minimum standards for creating a safe environment for children, young people and vulnerable adults at all levels of the association. In order to maintain its integrity, GRPA will only collaborate with other organisations that come in contact with children, young people and vulnerable adults, if they agree with the standards and principles of the GRPA on protection of children, young people and vulnerable adults.

Help & Shelter (H&S)

Help & Shelter is one of the NGOs in the forefront of the fight against violence in Guyana, particularly in the areas of domestic, sexual and child abuse. The organisation provides counselling, court support and shelter services to victims/survivors and conducts public education/awareness activities. It also provides support services for children who are affected and/or exposed to violence and child abuse. For its work with children, H&S has a Child Protection Policy. It applies to everyone who works with H&S in any capacity, whether paid or unpaid (collectively called H&S representatives) and covers incidents that have occurred both before and after the start of the relationship with H&S.

In addition, H&S has developed several protocols that guide its work on sexual and domestic violence. The protocols provide guidance for Social Workers, Police Officers, Prosecutors, the Magistrates' Courts and their staff on how to deal with victims of sexual violence and for health workers and the critical role they play in helping to combat domestic violence.

Every Child Guyana/Child Link

Child Link uses a children's rights-based approach to achieve positive changes in the lives of vulnerable children in the short-term. It provides counselling and capacity building directly to children, parents and caregivers, community groups and service providers. Through its programs, child protection policies, procedures and tools that can be used by governmental and non-governmental organizations in Guyana have been developed. Of specific importance is the Child Care Workers Casework Management Manual. Wherever possible, this manual provides generic information for a range of individuals who work with vulnerable children in various contexts and organizational settings.

Governmental Organizations

Governmental organizations include the following organizations:



1. The Ministry of Social Protection
2. The Ministry of Public Health

Ministry of Social Protection

The Handbook of Good Practices

The Handbook of Good Practice was developed in 2009 by the Child Care and Protection Agency of the Ministry of Labor, Human Services and Social Security (now Ministry of Social Protection) in collaboration with the NGO-One Life Project of Everychild Guyana/Child Link. The manual contains the "Guidelines on the Child Protection Agency Processes and Procedures and on Good Practice in Relation to Children's Rights, Child Protection and the Psycho-social Support of Children and their Families".

Domestic and Sexual Violence Protocols

With assistance from UNICEF, the Ministry has developed protocols for professionals working with survivors of gender-based violence. These protocols will ensure quality service delivery, making sure cases are referred to the right service providers.

Ministry of Public Health

National Package of Essential Health Services

The National Package of Essential Health Services, formerly the Publicly Guaranteed Package of Health Services (PPGHS) outlines the minimum standards for maternal care, PMTCT and baby friendly services and targets child and maternal health and nutrition. Health workers received training in the integrated PMTCT/Maternal and Child Health approach.

Autonomous Agencies

Autonomous agencies that are associated with adolescent rights include:

1. The Rights of the Child Commission
2. Indigenous People's Commission

Rights of the Child Commission and Indigenous Peoples' Commission

Strategic Plans and a reporting/complaints protocol for the Rights of the Child Commission and Indigenous Peoples' Commission have been developed to provide a clear, focused and comprehensive framework for child rights, in line with the mandates of these commissions.

Other Available Protocols and Guidelines

Several other protocols and guidelines are also available:

- Family Health Manual 2012, Maternal and Child Health Department, Guyana
- Community Health Workers Manual 2007, Guyana



- Prevention of Mother to Child Transmission Manual 2011, Maternal Child Health Department, Guyana
- Labor Ward Guidelines 2010
- Emergency Obstetric Care Guidelines 2012
- Sexually Transmitted Infections Guide
- Managing Complications in Pregnancy and Childbirth 2007, WHO
- Managing New-born Problems 2003, WHO
- Family Planning: A Global Handbook for Providers 2007 UNAIDS, John Hopkins Bloomberg School of Public Health, WHO
- Sexually Transmitted and Other Reproductive Tract Infections 2005, WHO
- Woman Centred Post Abortion Care and Manual Vacuum Aspiration (Ipas)
- Reproductive Health Strategy 2004, WHO
- Supervision Checklist and Score Card for Health Facilities - MCH
- Monitoring Tools for Antenatal Care – MCH
- Health Quality Assessment Tools – MCH 2011

Adolescent Health Programmes and services

The following is a list of health programs and services that are available to adolescents:

1. Adolescent health clinics.
2. Community parenting support group.
3. Adolescent health and wellness day.
4. Teenage pregnancy clinic.
5. Health and family life education.

Adolescent Health Programme

The adolescent population has been identified as a group which rarely visits health facilities to access services and information for many several reasons. One of the most common reasons is the seemingly judgmental attitude of healthcare providers and the perceived lack of confidentiality at some healthcare facilities. To encourage behavioral change, greater access and increased use of services by adolescents, health authorities in many countries have implemented youth-friendly health programs. Guyana embarked on such programs in 1999. The UNFPA pilot Adolescent SRH Programme was executed in the pilot sites of Victory Valley, Beterverwagting and Port Mourant.



Adolescent-Friendly Health Services

The first adolescent friendly health centres were established at Port Mourant, Beterverwagting and Victory Valley in 1999, followed by the introduction of youth-friendly health services which were formally introduced in Guyana in and around 2000 as Youth-friendly Health Centres, with the first such centre being officially launched at the Dorothy Bailey Health Centre on South Road, Georgetown in 2004. At that time, this initiative aimed at addressing the social and spiritual needs of adolescents who were encountering problems such as teenage pregnancy, HIV/AIDS, suicide, substance abuse and other related social problems through advice, counselling and other means of support. In addition, the centre was equipped to help young people study, play, enjoy recreational activity and generally spend time in a normal constructive atmosphere.

From the year 2000, the Adolescent Health UNIT with the support of the CDC and UNICEF established 19 youth-friendly spaces across the country with the objective of providing a safe space for adolescents to learn and receive health information at specified sites.

UNICEF, over the years, has provided both financial and technical support in the areas of capacity building and training for peer educators in Regions 4, 6 and 10. In addition, training and capacity building support were given to health care providers in the area of adolescent orientation. Additional support was provided to the unit for the launch of Youth Empowerment projects in Regions 4 and 10. Technical support is also given in the areas of monitoring and reviewing of youth-friendly services and secondary schools and health clubs.

The UNFPA partnered with the Department of Youth to establish Youth Friendly Spaces which seek to ensure the involvement of young people in the design and implementation of services and activities which address their health and well-being. As part of this initiative, young people are trained as peer educators so that they can serve as advocates of adopting healthy lifestyles. In addition, these peer educators also support other youth in behavioral change. Since the initiation of this program in 2006, 12 Youth Friendly Spaces have been established in six of the 10 Administrative Regions and more than 200 young persons were trained as peer educators. If peer educators do not have the capacity to deliver services, they refer their peers to other health centres and social service agencies.

Commencing in 2014, support was provided to execute the WASH Programme in collaboration with the Ministry of Education in dormitory schools in Regions 2, 7 and 9. This support evolved along with the initiatives of the unit which focused more on adolescent responsive services for the pregnant and non-pregnant adolescent. UNICEF also supported strengthening and viability of services in Regions 8 and 9 with the provision of Information, Education and Communication (IEC) materials for adolescents as well as early child hood development. Health care workers were trained in adolescent health orientation and subsequently monitoring and supervisory visits were supported throughout in the sub-regions of Regions 8 and 9.

In 2015, the roll out of the Adolescent Health Programme commenced and sought to take health services directly to adolescents across the regions. At the time of this SitAn, the program has been implemented at 24 health centres to date, starting with the introduction of antenatal clinics



for pregnant adolescents. These clinics will seek to prepare adolescents for motherhood and fatherhood and provide them with support to cope with their new roles in life. In this regard, youths can access educational materials, information, and youth-friendly services in the areas of gender-based violence, teenage pregnancy, peer pressure, drugs and alcohol, sexually transmitted diseases, including HIV, among others. It is expected that counselling will also be available at the centres.

Community Parenting Support Groups (CPSG)

Adolescent Community Parenting Support Group is a program that is being spearheaded by Adolescent Health Unit of the Ministry of Public Health, working in collaboration with Ministry of Social Protection and Ministry of Education. The program targets both adolescent mothers and their partners and teaches them about parenting skills. Adolescents meet their health care providers in a “sacred” environment and receive in depth prenatal education and tailored education on family planning. These health care providers undergo special training to address these issues on the coast fortnightly and with those in the interior locations once a month. There are special sessions directed towards the male partners focusing on prenatal education, the male involvement in parenting and neonatal care and male acceptance of a family planning method. A further component was the introduction of Lamaze birthing and labor exercises which are done at the centres. This initiative is currently available at 24 health centres and has the following objectives:

1. Reduction of repeat teenage pregnancy
2. Reduction in adolescent maternal mortality rate and infant mortality rate
3. The empowerment of pregnant adolescent girls to provide them with comprehensive prenatal information and with contraceptive advice at 32 weeks of their pregnancy

The Ministry of Education provides care packages for the mothers while the Ministry of Social Protection social support to mothers who need such support for example in the case of partner violence.

Teenager Pregnancy Clinic

A teenage pregnancy clinic was set up at the Georgetown Public Hospital Corporation, the national referral hospital, in early 2013. This clinic is expected to contribute to decreasing the number of deaths among adolescent mothers by providing young girls with the information and counselling they need to safely manage current pregnancies and prevent unwanted pregnancies. It also provides girls with life skills education and prepares them for re-integration into society. (UNFPA, Government of Guyana, 2014).

Additionally, as part of the overall thrust of the Ministry of Health (now Ministry of Public Health) in promoting Youth Friendly Services, adolescent antenatal clinics have been introduced at 25 health centres. Others are expected to be rolled out in a phased manner. The Ministry has launched the adolescent health package at these centres.



In all the 10 administrative regions, pregnant teens are now being seen separately from the adult female. This facilitates adequate, elaborated antenatal care which is further complimented by the services accessed in the community parenting groups.

Adolescent health and wellness day

This targets adolescent in-and out-of-school. It is a day set aside where adolescent-friendly health care providers open their health centres to provide health services and education to these youths. Schools are targeted and specific classes are invited to the centres and general health checks for each child is encouraged. A file folder is opened for each case and a record is kept.

Safe Motherhood Initiative

The Safe Motherhood Initiative which was launched in Nairobi, Kenya in 1987 is an international effort to raise awareness of all the issues surrounding maternal mortality and to get the commitment of all the stakeholders, governments, development partners, civil society and others to take steps to address this public health challenge. The concept of safe motherhood means ensuring that all women receive the care they need to be safe and healthy through pregnancy and child birth and the initiative promotes the right of women, mothers and newborns to attain the highest quality of health in support of the human rights approach to development. The pillars of safe motherhood include preconception care, prenatal/antenatal, care of high-risk pregnancies, clean and safe delivery including the availability of safe blood, and postnatal care.

In Guyana, the 'Safe Motherhood Initiative' is being implemented by the Maternal and Child Health Department of the Ministry of Public Health at all levels of health care. This intervention seeks to ensure a "healthy mother and baby" by basing interventions on five pillars:

- Pre-conceptual care (care before pregnancy through paying attention to nutritional status, HIV and immunization of boys and girls and looks at health education to promote the prevention of pregnancy)
- Antenatal or prenatal care
- Clean and safe delivery
- Management of high-risk pregnancy
- Postnatal care

Adolescent Mothers Initiative

The Adolescent Mothers Initiative was developed in 2008 as a partnership between Women Across Differences (WAD), a local non-governmental organization and the UNFPA, under a one-year project "Reducing Unplanned Pregnancies among Adolescent Mothers". The overall objective of the initiative is to reduce second and third pregnancies among adolescent mothers. The initiative offers SRH and family planning education as well as counselling, coaching, life skills and income earning skills. The expected changes for individual participants or for the group were:

- A reduction in unplanned pregnancies



- Increased self-confidence through access to SRH/Family Planning information and services
- Acquisition of entrepreneurial knowledge and literacy skills
- Adoption of more positive lifestyles.

Beneficiaries were identified with the assistance of three health centres and the Georgetown Hospital Corporation.

Through the eyes of the beneficiaries, WAD learned a number of lessons including that young women wish for love and to be given second chances in life and the possibility that with an appropriate and supportive environment, their hopes of a bright future can become a reality. It was also noticed that once they improve their self-esteem and self-understanding, they have a desire to “pick up the pieces”, improve their literacy skills and/or complete their secondary school programme. Over the seven years of the Programme, the organisation boasts a 90 percent success rate among adolescent mothers, where there was no second or third pregnancy and that many of the young mothers returned to school to complete their education.

The Guyana Responsible Parenthood Association (GRPA) launched an initiative in March 2015 that seeks to send at least 100 adolescent mothers back to school. The organisation is encouraging persons to contribute tangibly to assist in this goal. The main objective of the Association is to develop high-quality sustainable services and programmes specifically in the area of sexual and reproductive health. Prior to this latest initiative, for several years GRPA operated the Olga Bourne Youth Centre which catered exclusively to adolescent girls and mothers, providing an educational facility that allowed adolescent girls and mothers to continue their education and acquire a skill.

HIV and AIDS Services

HIV and AIDS services are available at all levels of the public health system in varying degrees. HIV and AIDS services, primarily in the areas of voluntary counselling and testing, care and treatment are available at the three highest tiers of health care facilities. There is also a small number of donor-funded NGOs that provide some services to key populations –men who have sex with men (MSM), commercial sex workers (CSWs) and miners. In general, services are more readily accessible at health facilities on the coast, compared with the hinterland and riverine areas. However, at some health posts and health centres in these areas, staff trained to conduct HIV testing and counselling are rotated and are, therefore, not available on a full time basis at every health post or health centre.

Health and Family Life Education

In contemporary society, young people are confronted with a multiplicity of options and increasing social pressures, which require sound social, cognitive and emotional/coping skills. They are required to make healthy and productive lifestyle choices. It is the education system that is expected to equip youths with the requisite knowledge, skills and attitudes to become



well-adjusted adults, capable of effectively functioning in and contributing to society. It is with this in mind that the Health and Family Life Education (HFLE) program was introduced into the school curriculum. However, the program is designed for implementation in Grades 1 to 9 and it is not currently implemented in all schools in Guyana.

HFLE encapsulates the required body of knowledge in a comprehensive life-skill educational program that can be integrated across the curriculum. It is how teachers can impact and reinforce the positive behaviors that young people are expected to adopt and display. Beyond that, through increased awareness, students are given a safe and open environment in which they can address a wide range of issues affecting young people, including perennial issues such as poverty, neglect, various forms of abuse, sex, violence, health and well-being.

To address violence in schools, UNICEF has supported the Ministry of Education in nurturing a systematic, structured approach that can promote respectful, caring interactions among children, parents and teachers. This collaborative effort termed ‘Positive Discipline’ is a discipline model which focuses on positive points of behavior. Beginning with children, there is collaborative work to encourage the investigative and creative nature of children to research, present and promote the benefits of positive discipline.

This initiative began in 2016 with a year of intense activity such as a poster competition, essay writing, debates and jingle competitions among others. UNICEF contributed to and facilitated the national debating series as well as the national poster and jingle competitions on Positive Discipline with children across primary schools in Guyana.

Sports and Culture for Development (SC4D)

The Sports and Culture for Development Programme draws upon the intrinsic attraction of sport and culture among adolescents and is envisioned to help build their personal, social and emotional character, while promoting healthy and positive lifestyles.

Recognizing that structured sports, physical activities and cultural expressions are healthy and safe alternatives for adolescents (10-19 years), and that sports and culture are both preventive as well as responsive interventions for adolescents who are exposed/at risk or made vulnerable due to violence and abuse (physical, sexual, emotional), the signed Government of Guyana/UNICEF Programme of cooperation 2012-2016 focused on adolescent development and participation, especially for those adolescents in the hinterland and rural areas and those at risk.

They are also taught basic musical skills using the guitars, keyboards and drum sets provided as part of the UNICEF Programme. The Programme is currently being conducted in all hinterland dormitory schools and in some rural communities.

Contradictions between policy and legal frameworks and reality

There are some contradictions between the legal and policy frameworks that contribute to adolescent pregnancies in Guyana. The *Sexual Offences Act* states that the legal age of consent is 16. However, the same act states that where a girl under the age of 16 becomes pregnant she



may marry a man over the age of 16. She may marry a male under the age of 16 if he admits that he is the putative father of the child. Hence, in both these instances, if marriage occurs, the adolescent girl will bear the child.

Under the *Indian Labour Act*, female descendants of Indian immigrants in Guyana can get married at age 14. Once married, if she becomes pregnant, she can legally bear a child. While these laws exist, the prevalence of adolescent pregnancies due to these circumstances is extremely low.

Other contradictions that contribute to adolescent pregnancies include the limiting of access to contraceptives to persons below the age of 18 years and the Constitution of Guyana which guarantees the right of every citizen to free medical services. Additionally, there is also a contradiction with the 2008 *Regulations made under The Health Facilities Licensing Act 2007* and what obtains in practice. Section 13, states that all persons seeking service at a health facility (public or private) shall be treated equally regardless of age, place of birth, race, creed, nationality, gender and sexual orientation. This means that adolescents should legally be able to access contraceptives at a public health facility without restriction.

The draft SRH Strategy and Policy 2014-2020 seeks to address some of these contradictions. As already mentioned above under the section dealing with the strategy and policy, the policy commits to amending and enacting legislation to ensure that adolescents have access to appropriate and quality reproductive health services and commodities including contraception without the need for parental consent at least at the age of consent with entrenched confidentiality protection. In addition, among other things the policy seeks to ensure that adolescents have access to age appropriate and accurate information as well as quality sexual and reproductive health services and commodities through age-appropriate, safe and confidential programmes to provide medical, psychosocial and other necessary support to adolescents and youth who are victims of physical or sexual abuse or violence.

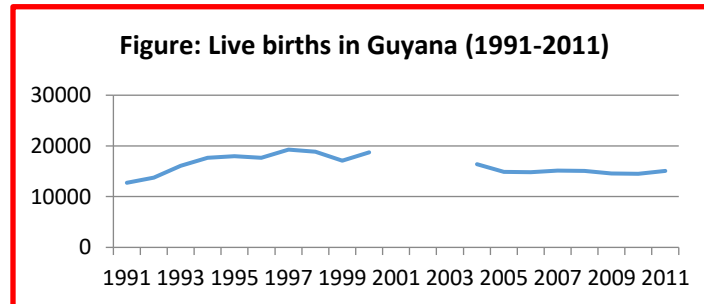
If these strategies and policies are successfully achieved to any major degree, they would go a long way in helping to reduce adolescent pregnancies in Guyana. It is worth noting that this would be in keeping with the CARICOM Integrated Strategic Framework for the reduction of adolescent pregnancy which was approved by the Council for Human and Social Development (COHSOD) in 2014.

Prevalence of adolescent pregnancy

Overall, births in Guyana have seen an increase from 13,700 in 1991 to 19,300 in 1997 after which there has been a decline through 2011 (Figure 5). In Guyana, adolescent pregnancies have varied from 19.7 percent-23.7 percent of all pregnancies for the period 1991-2011 (PAHO/WHO 2015) and has been between 20-22 percent for the period 2015-2016 (Ministry of Public Health 2017). In 2014, the adolescent birth rate was 74 per 1,000 women, marginally lower than the country's general fertility rate of 81 per 1,000 (MICS 2014). While this rate may seem to contradict that of 90 per 1,000 on page 12, it should be noted that the MICS uses household data while the UN population report uses population projections, hence the difference.



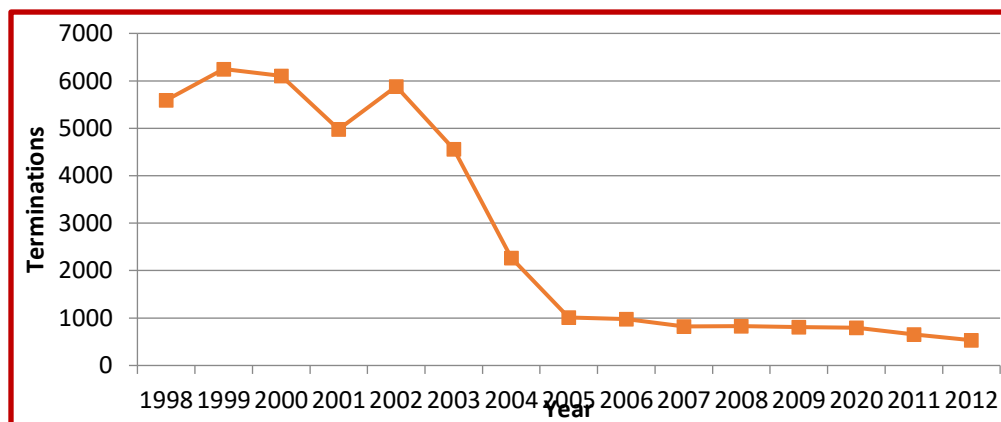
Figure 5: Live births in Guyana, 1991-2011



Source: Health @50 in Guyana (PAHO)

The number of births could have been significantly higher as there are high rates of abortions in the country. Abortion became legal in Guyana in 1995 with the passage of the Termination of Pregnancy Act, which stipulated up to what stage of pregnancy abortion would be allowed as well as who could perform the abortion (Medical Termination of Pregnancy Act). It is worth noting that the highest numbers of abortions were reported in the year immediately after the act was passed. However, there started to be substantial reductions in the number of cases reported and in 2015, only 212 cases were reported to the MOPH (Figure 6). This dramatic reduction in the number of cases reported in 2015 compared to 1996 may suggest that there is gross under reporting of cases of abortion. Because pregnancy in adolescence is stigmatized, it is quite likely that a substantial number of abortions could have been performed on adolescent girls.

Figure 6: Termination of pregnancies in Guyana 1998-2012

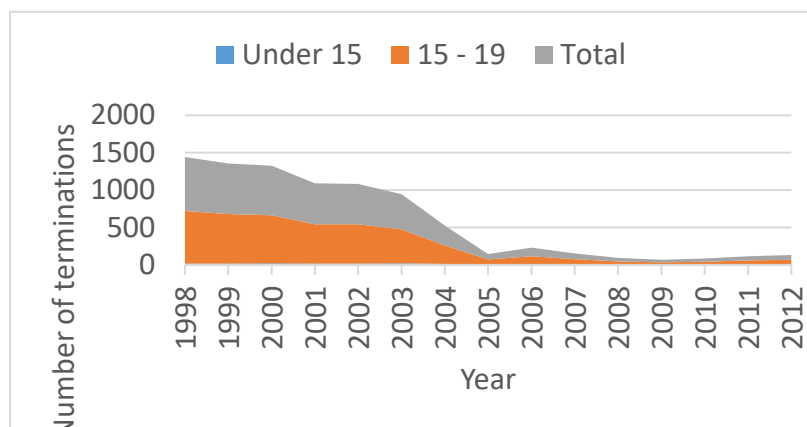


Source: Health @50 in Guyana (PAHO)

Pregnancies terminated in adolescents for the period 1998 to 2012 followed a similar trend as the overall trend seen in all terminations for the same period. In both adolescents below 15 years and those aged 15-19 years, there were dramatic reductions in the number of cases (Figure 7).



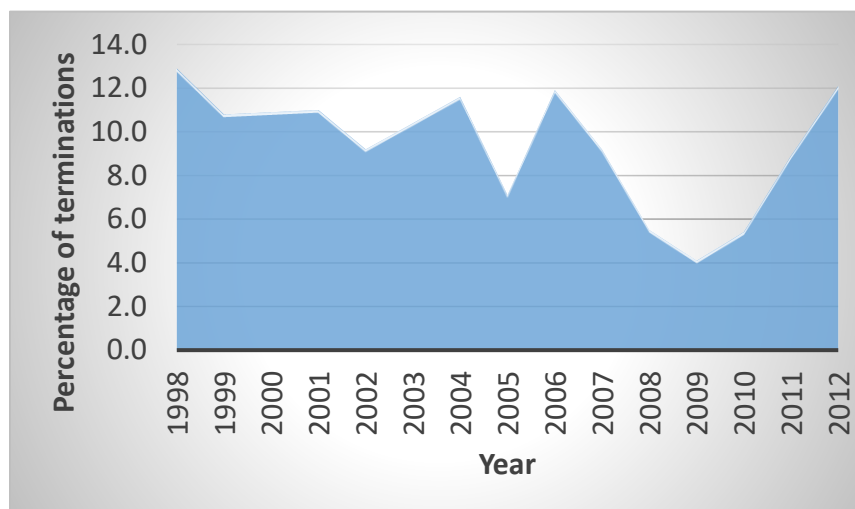
Figure 7: Pregnancies terminated in adolescents <15 years and those 15-19 y.o. in Guyana, 1998-2012



Source: Ministry of Public Health Statistical Unit

For the most part, the number of adolescent pregnancies terminated hovered between 10 and 125 percent of all terminations except for 2002, 2005, 2007, 2008, 2009, 2010 and 2011 where they were between 4.1 percent and 9.2 percent (Figure 8).

Figure 8: Teen pregnancies terminated in Guyana as a % of total terminations, 1998-2012



Source: Ministry of Public Health Statistical Unit

The regional distribution of pregnancies shows marked variations. In 2015 and 2016, the Hinterland Regions of 1,7,8,9 had the highest rates of adolescent pregnancies. In 2015, the overall adolescent pregnancy rate was 55.16 per 1,000 adolescent females. The rate in Region 1 was almost three times the national rate, while those of Regions 7 and 8 were double the national rate and Region 9 almost twice the national rate. In 2016, the national rate was a bit lower at 52.44 per 1,000 adolescent females, while the rates in Regions 1,7,8,9 were almost twice the national rate (Table 4)



Table 4: Adolescent pregnancies and rates in Guyana by region (2015-2016)

Region	Females 12-18 yrs.	Pregnancies		Rate per 1,000		% of teen pregnancy	
	2012 census	2015	2016	2015	2016	2015	2016
1	2,601	382	275	146.86	105.72	9.7	8.7
2	4,177	273	221	65.35	52.9	6.9	7.0
3	8,334	501	420	60.11	50.39	12.8	13.3
4	23,563	1,234	1,056	52.37	44.81	31.5	33.5
5	4,215	203	165	48.16	39.14	5.2	5.2
6	9,132	565	497	61.87	54.42	14.5	15.8
7	1,260	155		123.01		3.9	
8	809	95	77	117.42	95.17	2.4	2.4
9	2,168	231	230	106.54	106.08	5.9	7.3
10	3,286	270	182	82.16	55.38	6.9	5.8
Total	59,545	3,285	3,123	55.16	52.44	100	100

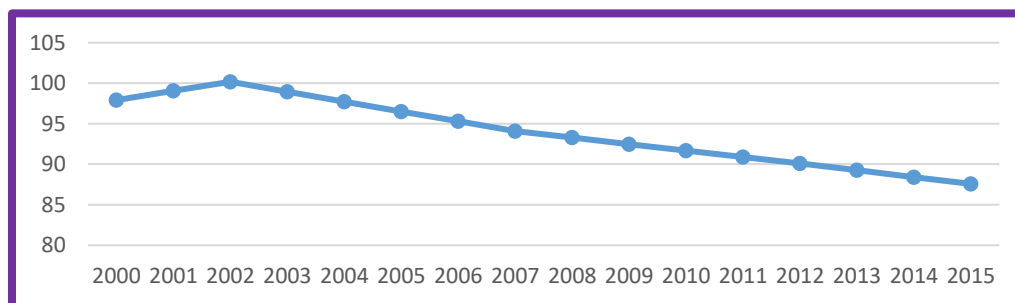
Source: Ministry of Public Health Statistical Unit

Adolescent births: Trends by region

According to data from the World Bank, the adolescent fertility rate in Guyana, except for an increase between 2000-2002 has been showing a progressive decrease through 2015. From a high of 100.18 births per 1,000 women in 2002, the rate has decreased to 87.57 births per 1,000 women in 2015 (Figure 7). This rate in 2015 was higher than the rate of 74 per 1,000 women quoted in 2014 from the MICS survey. It is quite likely that the World Bank is using data from the UN population report, which would explain the difference.

However, the adolescent birth rate shows major disparities in the coastal versus the hinterland populations with the adolescent birth rate in the hinterland regions 1,7,8,9 being almost three times that of the coastal grouping at 187 births per 1,000 women (MICS 2014).

Figure 7: Adolescent fertility rate in Guyana 2000-2015



Source: The World Bank

<http://data.worldbank.org/indicator/SP.ADO.TFRT?locations=GY>



Table 5: Fertility rates by age group and area (2012-2014)

	Geographic area						
	Urban	Rural	Coastal	Urban Coastal	Rural Coastal	Interior	Total
Age							
15-19	55	81	69	59	72	105	74
20-24	141	150	132	133	131	255	148
25-29	118	144	128	118	133	190	136
30-34	79	105	86	79	90	161	97
35-39	60	53	49	64	43	102	55
40-44	14	16	12	15	12	43	16
45-49	2	1	1	3	1	2	2
TFR	2.3	2.7	2.4	2.3	2.4	4.3	2.6
GFR	72.8	84.5	73.2	73.0	73.3	137.9	81.3
CBR	19.1	22.4	19.8	19.0	20.2	31.6	21.5
TFR: Total fertility rate per woman age 15-49							
GFR: General fertility rate per 1,000 women age 15-49							
CBR: Crude birth rate per 1,000 population							

Source: MICS 2014

Data from the 2014 MICS, revealed that fertility patterns in Guyana from 2012-2014 varied by location of residence. The total fertility rate is slightly higher in rural areas at 2.7 births compared with urban areas with 2.3 births. However, the rate in interior locations is almost twice that of coastal areas (Table 6).

Table 6: Adolescent birth rate by regional grouping

Regional grouping	Birth rate	Adolescent fertility rate
Region 1,7,8,9	187	6.5
Region 2,3	67	2.3
Region 4	71	2.4
Region 5,6	65	2.5
Region 10	49	
Total	74	2.6

Source: MICS 2014



Section 3: Factors contributing to the situation of adolescent pregnancy

The factors contributing to adolescent pregnancy in Guyana were complex and interwoven and include: (1) lack of access to comprehensive sexuality education, (2) sexual behavior, (3) lack of access to and use of contraceptives, (4) lack of knowledge of contraceptives, (5) barriers to access of contraceptives, (6) early child bearing, (7) lack of economic opportunities, (8) difficult relationships with parents and family members, (9) alcohol consumption, (10) minibus culture, (11) school dropouts, and (12) intergenerational pregnancy.

The following are in-depth descriptions of the numerous factors contributing to adolescent pregnancy in Guyana.

Lack of access to comprehensive sex education

Most of the adolescents did not have access to comprehensive sex education. Some had been exposed to Health and Family Life Education, while others were not. Children were not able to discuss sex and sexuality with their parents, especially with their mothers. Most got their information from their peers, which poses the question as to the accuracy and comprehensiveness of the information that they receive. Quotes from the children regarding discussing sex and sexuality are highlighted below.

When asked with whom they had discussions regarding sex and sexuality, and with whom they felt most comfortable discussing these issues, most gave answers similar to the following where they expressed an inability to discuss sex with parents. Most discussed sex and sexuality with their friends.

And when asked why they felt more comfortable discussing sex with their peers rather than with their parents, the answers revealed the fear and sometimes shame that they felt. . The two quotes below are typical examples of the reasons given by pregnant adolescent girls about why they have difficulty discussing sex and sexuality issues with parents:

“Because my mother will ask ‘who you sexing?’ If you go and ask certain questions they would think that you begin.”

“I di shame to go tell me aunty that I sexing.”

One of the key informants provided the following insight into the difficulty that parents face in relation to discussing sex and sexuality with their children:

“What we find happening is like Indian parents, they do not touch on some topics in their home as simple as menstruation. The Indian mothers, some of them, I am not- it’s not a generalized statement, right. You find that they do not talk about sex, they do not talk about menstruation, they do not talk about relationships because they feel that’s not what they should do. They were brought up finding it out by themselves so they follow the same trend. They leave the children, if I may say, to the wolves.”

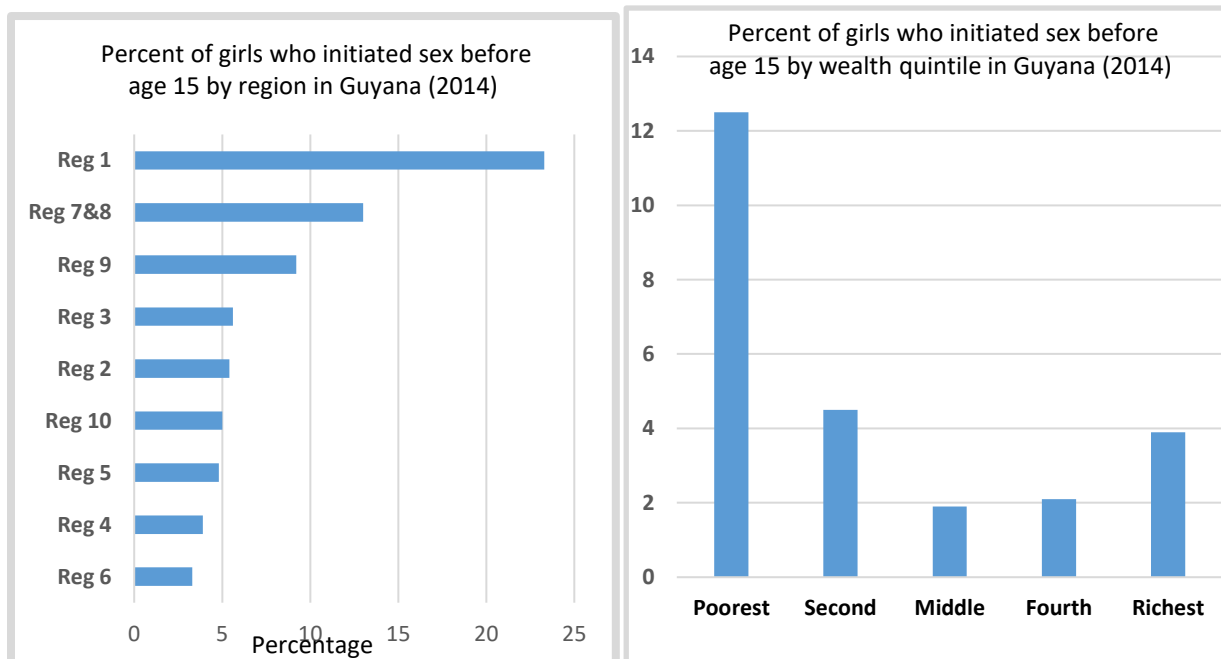


Sexual behavior

According to the *Marriage Act* of Guyana, the official age of sexual consent in Guyana is 16. Data from the Guyana MICS revealed that 21 percent of young women aged 15-24 years reported that they had sex, while 42.8 percent of men of the same age had had sex. Of those individuals reporting being sexually active, almost one in every 20 (4.9 percent) women reported that they had sexual intercourse before the age of 15, while 12.6 percent of young men reported having had intercourse. In addition, some 11.8 percent of women aged 15-24 years reported having had sex within the past year with a partner who was 10 or more years older than they were (MICS 2014).

There are disparities in the rates of adolescent women having sex before age 15 according to income and education levels, as well as according to area of residence and ethnicity. Regarding income and education, 12.5 percent of girls in poor families have rates that are more than twice the national average, while girls living in interior locations and who are of Indigenous origin have rates that are double or even greater than the national rate (9.6 percent and 10.9 percent respectively). Further examination of the individual regional rates demonstrates that almost one in every four girls from Region 1 had their sexual debut before age 15 (Figure 8).

Figure 8: Percentage of girls who initiated sex before age 15 by Region, wealth quintile and ethnicity, Guyana 2014.



Source: Guyana MICS, 2014

Twelve (12) percent of sexually active young women aged 15-24 years had sex with a non-marital, non-cohabitating partner, while 36.7 percent of young men of the same age had sex with a non-



marital, non-cohabitating partner. 57.2 percent of young women aged 15-24 years used a condom with such a partner, while 87.5 percent of young men reported such use.

The fact that girls are having sex before age 16 is in stark contrast to chapter 8:03 of the *Sexual Offences Act* of Guyana in which the legal age of consent is 16 years and anyone who engages in sexual penetration of a child under 16 years of age or causes the child to engage in sexual penetration with a third party commits the offence of rape. A contradiction therefore occurs between the *Sexual Offences Act* and section 138 of the *Indian Labour Act* which permits male descendants of Indian immigrants in Guyana to marry at age 15 and females at age 14. So, on the one hand, descendants of Indian immigrants can marry and have sex before age 16 while other ethnicities cannot have sex before age 16.

Lack of access to and use of contraceptives

Most adolescents knew where to obtain contraceptives (condoms) but were unable to access them. They could speak to their availability at public health facilities such as health centres as well as at private pharmacies. However, they could not obtain contraceptives because they were aware that contraceptives could only be accessed at public health facilities from the age of 18 years. They were very vocal about the age of consent to sex being 16 years of age but they would have to wait until they were 18 years old before they could obtain them from public facilities.

Lack of knowledge of contraceptives

Some of the adolescents had little knowledge about contraceptives. Some on the other hand associated contraceptives with condoms and in fact only knew of condoms as a protection against sexually transmitted infections and HIV.

The lack of knowledge about contraceptives is aptly demonstrated by the following quote of one of the adolescent girls from one of the secondary schools.

“Miss I ain’t know ‘bout dem things.”

Barriers to accessing contraceptives

Even after they had delivered their babies, many adolescents found it very difficult to access contraceptives at public health facilities mainly due to the attitudes of the staff of these facilities. The type of treatment they experienced at these facilities is aptly summed up by the quotes of two of the adolescents when they went to public health facilities to obtain contraceptives after they had delivered their babies.

“Miss, when I went to get contraceptives I went with my card. Hear she, ‘Come let me check your card.’

Hear she, ‘How old are you? 15?’

Lil girl like you coming for injection.

Lil girl like you taking man early!’



Miss, if you hear she and she proper ruff up mi batty when she give me the injection.”

Based on the embarrassing reception that she experienced, the second adolescent had to seek contraception at a private pharmacy. She relayed her experience with the following quote: *“The woman say, ‘You puss hot.’ They does go on pon you like it’s any of their business. I said, ‘All right, don’t bother.’ So I went to Medicare and get it.”*

Adolescents expressed very strong views about the need to have an alignment of the age of consent and the age for accessing contraceptives at public health facilities.

Some of the quotes regarding this alignment of age of consent to sex with age of accessing contraceptives are given below. This view was also expressed by many key informants. The following is a quote from one of the key informants interviewed:

“Regardless of the age, they must be able to go and collect contraceptives. I think if they want to collect some they should get it because if they want to have sex they would.”

Another key informant also shared the feelings about alignment of the age of consent to sex with the age at which adolescents can access contraceptives. However, in this instance - unlike in the other cases where persons wished that the age of access to contraceptives be reduced to 16 (age of consent) - this key informant wanted the age of consent to be increased to 18 (the age of access to contraceptives). It should be pointed out that these views regarding the inability of persons who have attained the legal age of consent is a misconception of the law as the law states the once the 16-year-old fully understands the nature of the service, they can access it (Gilllick competence). The following quotes are examples of these views:

“But you can purchase contraceptives from 18. If it were up to me I would move the age of consent to 18. You would be more mature; you would have been out of school by then. You should be able to think differently. The two should go together.”

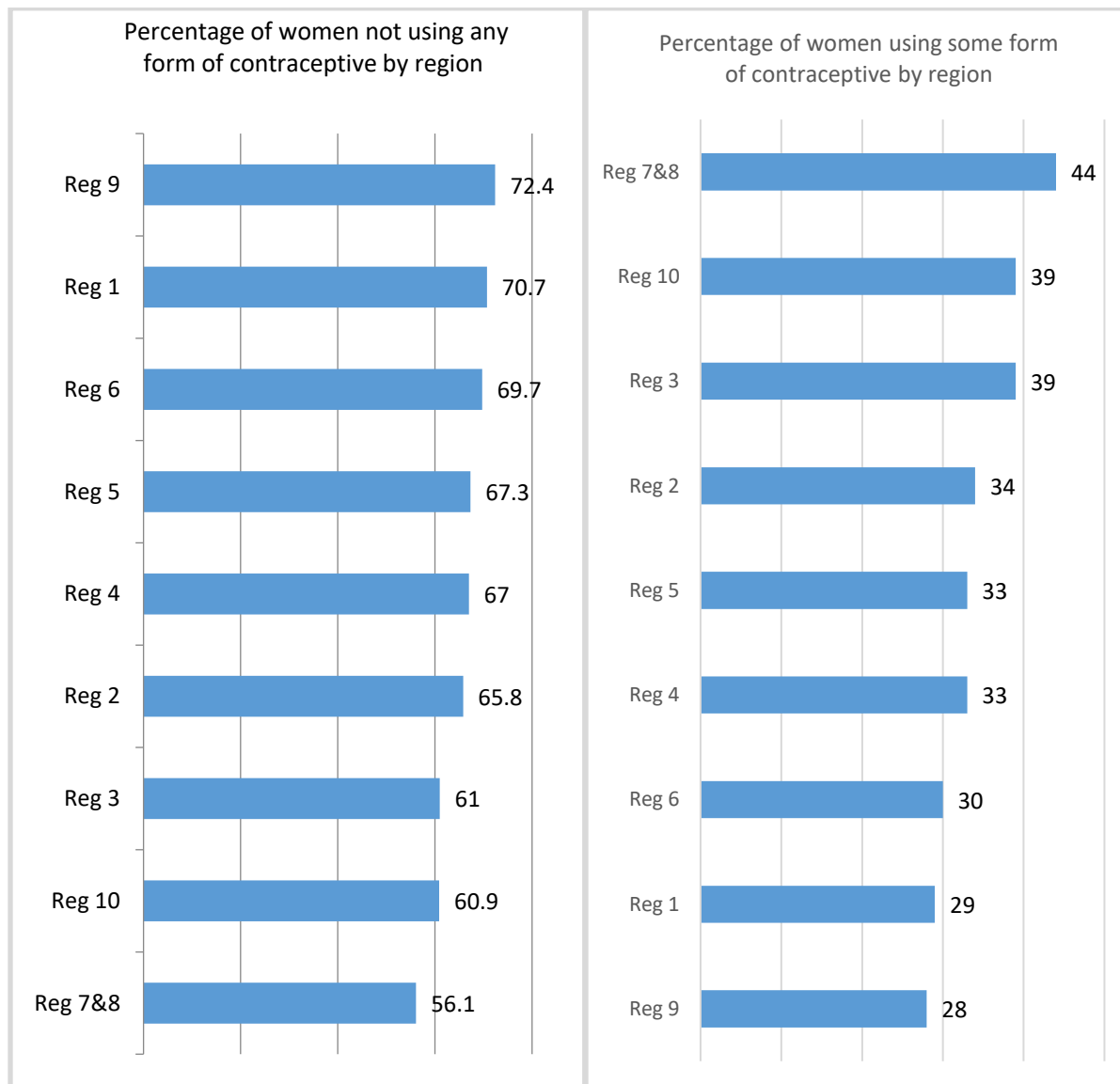
“To go and have contraceptives to prevent pregnancy then why dey got- why the age of consent is at 16? They should at least raise it to 18 or something, or maybe drop the age down so that anybody can go and have contraceptive.”

While the adolescents were aware of the commercial availability of contraceptives at pharmacies, most of them did not actually speak about purchasing them and their experiences of trying to make such purchases.

While overall use of contraceptives by women in Guyana is very low (less than 40 percent), those who reside in regions 7 and 8 had the highest reported use. However, women residing in regions 1 and 9 reported the lowest use of contraceptives, with less than 30 percent of women in both regions reported using contraceptives (Figure 9).



Figure 9: Percentage of women using and not using any form of contraceptives by region.



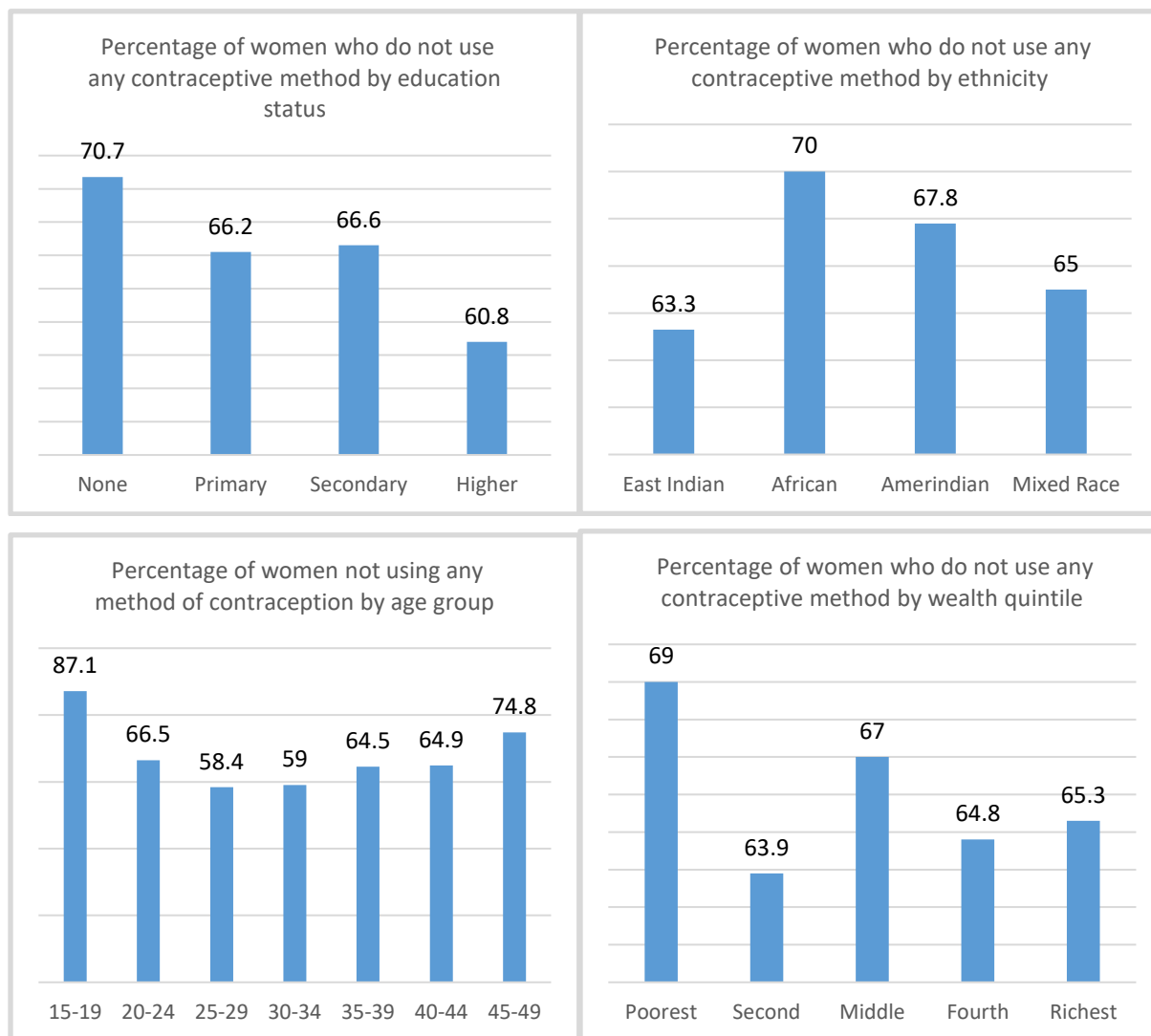
Source: Guyana MICS 2014

Women who did not have any schooling had the lowest reported use of contraceptives, while women of Afro-Guyanese descent were the ethnic group with the lowest recorded use of contraceptives, with 7 in every 10 Afro-Guyanese women reporting that they did not use any form of contraceptives. Indigenous women reported the second lowest use of contraceptives as 6 in every 10 did not use any form of contraception (Figure 10).

Among adolescents, contraceptive use was extremely low with 87 percent of girls reporting that they did not use any form of contraceptives (Figure 10).



Figure 10: percentage of women not using any form of contraceptive by education status, and ethnicity.



Source: Guyana MICS 2014

Contraceptive method mix

The common types of contraceptives in use in Guyana include oral contraceptive pills whether combined oestrogen and progesterone pills or progesterone only pills; long lasting injections such as Depot Provera; Intra-uterine contraceptive devices and condoms. All forms are available to adolescents including, surprisingly, intra-uterine contraceptive devices (IUD). Some women, including adolescents, in a limited way, practice other methods such as coitus interruptus and the use of rhythm method, spermicides and tubal ligation.

The number of adolescents accessing contraceptives for the first time from health facilities varied during the period 2010-2014 depending on the type of contraceptive. Injectable contraceptives



were the most common type of contraceptive used, with progressive increase in numbers from 2010 through 2014. For oral contraceptives, there were increases in numbers accessed from 2010 through 2013, but a significant reduction in 2014. Condom uptake followed a similar pattern to oral contraceptives, with IUDs following intermittent increases followed by reductions and then increases over time (Table 7).

Table 7: Contraceptive use by new adolescent users (attending health facilities) in Guyana 2010-2014

Year					
Contraceptive type	2010	2011	2012	2013	2014
Oral	227	248	288	133	70
IUD	37	51	47	60	79
Injectable	253	325	393	511	575
Condoms	168	333	325	283	262
*Other	25	68	393	44	285

Source: Guyana MICS 2014

*Other includes pregnancy kits, tubal ligation and spermicides.

As with adolescents accessing contraceptives from public health facilities for the first time, adolescents continuing to access contraceptives from these facilities, injectables were the preferred type of contraceptive followed by oral contraceptives and condoms respectively. Use of injectables progressively increased from 2010 through 2014, while the use of oral pills increased from 2010 through 2012, but then decreased dramatically during 2013 and 2014. Condom use increased greatly in 2011 over 2010 but then showed a progressive reduction every year thereafter (Table 8). This data shows that the most common methods used among adolescents are short term contraceptive methods with greater discontinuation rates than long-term reversible methods and therefore greater chances of unwanted pregnancies.

Table 8: Contraceptive use by continuing adolescent users (attending health facilities) in Guyana 2010-2014

Year					
Contraceptive type	2010	2011	2012	2013	2014
Oral	706	906	975	315	144
IUD	48	57	55	66	87
Injectable	641	912	1100	1515	1590
Condoms	393	879	771	734	532
Other	38	51	540	51	72

Source: Guyana MICS 2014

*Other includes pregnancy kits, tubal ligation and spermicides.



Availability of contraceptives

Data from the MICS survey indicates that 55 percent of women in Guyana report that their demand for contraception is satisfied. Overall, total met need at 34 percent is 6 percent higher than unmet need at 28 percent. Unmet need is lowest in Region 6 at 22 percent and highest in Region 1 at 40 percent. Unmet need is also higher in urban areas than in rural areas at 32 percent and 27 percent respectively and in interior areas than in coastal areas (34 percent and 27 percent respectively).

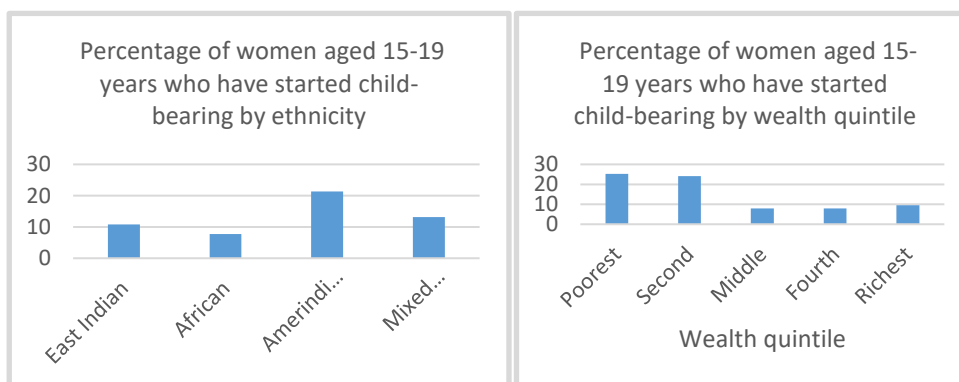
Unmet need is highest among adolescents at 62 percent and in Indigenous Peoples 37% and lowest in older women and Indo-Guyanese 22%(MICS 2014).

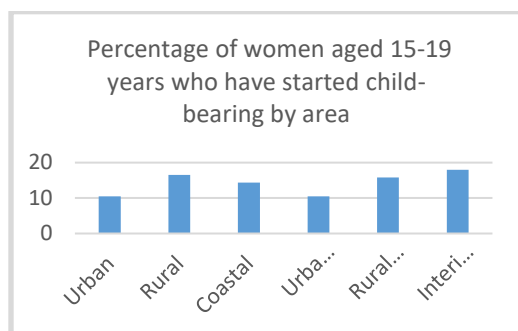
As mentioned earlier, many adolescents had only little knowledge about contraceptives while others associated contraceptives only with condoms. They were therefore not asked about whether their contraceptive needs were being met.

Early child bearing

Indigenous adolescents, adolescents from the poorest wealth quintile and adolescents residing in interior and rural areas constituted the groups who had started child bearing at an early age. A quarter of adolescents from the poorest wealth quintile and 21 percent of Indigenous adolescents respectively had started child bearing (Figure 11). Based on feedback from the fields, it is customary for Indigenous Peoples to start child bearing at an early age. Lack of educational and economic opportunities are also reported contributory factors.

Figure 11: Adolescent child bearing by ethnicity, wealth quintile and area, Guyana, 2014





Source: Guyana MICS 2014

Lack of economic opportunities

Especially in the hinterland areas which are predominantly populated by the Indigenous population, the parents of adolescents experience a severe lack of economic opportunities. Most economic activities in those areas are centred on gold and diamond mining and extraction of lumber, with the main players being from the coastland and Brazilian immigrants. The resident Indigenous population of these areas is mainly engaged in subsistence farming or in the service industries, with very little ownership of either mining or lumber enterprises. As a result, many adolescents are left unsupervised and have greater opportunity to engage in sexual activity, resulting in increased adolescent pregnancy.

Overcrowding and financial insecurity

Many of the adolescents who were pregnant were from homes that had relatively large numbers of family members, comprising six or more persons in addition to the adolescent herself. Family members included siblings and/or extended family members. Many of these households were single parent and usually female-headed. The prevailing theme among these single-parent female-headed, overcrowded homes was that the financial needs of the adolescent were not being met. As a result, many were in the habit of accepting gifts from males who were not relatives. Some of the supporting quotes made by some adolescents are highlighted below.

One of the girls described her relationship with an older man in the following manner:

“Well I had this big man and I use to get things because he like me. We never had sex. He never ask for sex, who use to give me anything. Sometimes when my grandmother gone to work and I hungry, I go by the man to get things to eat. When I got to go to school, I use to go by he and he used to see me as he daughter because he children them di big.”

Another of the girls who had an adolescent pregnancy described her stepfather with the following words:

“He is a drunk. When he wuk he money is to buy rum. When you go to he and ask he anything he don’t give you anything he would say you ga ask you aunt. She and all sometimeish. She would give sometimes cause I going secondary school. She wants give me \$200.00 fuh go to school. So, I had to go and get man as I had money to get.”



Unsupervised children

With female-headed single-parent households where the mother has to work, many of the girls were left unsupervised and had the freedom to become sexually involved. In the hinterland regions, there were more unique reasons for children being left unsupervised. Unlike their counterparts on the coastal regions, the girls from the hinterland regions did not necessarily belong to single-parent, female-headed households. Instead, their parents engaged mainly in subsistence farming and would leave their homes early in the mornings to go to their farms and leave their children unsupervised. And like their counterparts from the coastal regions, they were left unsupervised, creating the opportunity to become sexually involved. Some Indigenous adolescents also attend schools in the hinterland regions where they are housed in dormitories which have inadequate supervision. While these dormitories house boys and girls separately, due to the lack of adequate supervision, there are ample opportunities to engage in sexual activities.

Lack of recreational facilities

In the hinterland regions, adolescents suffer from a lack of recreational facilities compared with their counterparts on the coast. While adolescents on the coast may have access to games arcades, malls and sports facilities, from the feedback of both focus group discussions and key informant interviews, adolescents in these communities do not have recreational facilities to channel their energies. In fact, there are more bars and drinking spots that comprise the only form of recreation. As a result, many adolescents find that alcohol consumption is a major enticement and so they engage in partying and drinking as their form of recreation. As a result, many adolescents find that alcohol consumption is a major enticement and so they engage in partying and drinking as their form of recreation. These challenges persist even though UNICEF has partnered with the Ministry of Education to implement the SC4D program in the hinterland regions.

Difficult relationships with parents/other family members

In some of these homes, the children had quite difficult parent-child relationships, usually with their fathers but sometimes with their mothers. Because of these relationship issues, they felt unloved and were vulnerable to the charms of males.

Alcohol consumption

The SitAn found that alcohol consumption by adolescents also plays a role in the occurrence of adolescent pregnancy in Guyana. While alcohol is consumed by adolescents in all regions, it is much more prevalent in the hinterland regions. As a result of alcohol consumption, adolescents lose self-control and are unaware of the consequences of their actions. In many instances, they become so inebriated that they don't recall much of what has happened. This is exemplified by the following quote of one of the key informants:



“Well most teenagers- I’ve talked to most of them and when, when it happens, they say sometimes they were drunk and when it happen, they couldn’t remember what happen so far.”

Adolescents are not the only ones consuming alcohol which impacts the occurrence of adolescent pregnancy. Some adolescents observe their parent/guardian consuming alcohol and experience the effects of this alcohol consumption.

Minibus culture

One of the prevailing themes among adolescents and key informant was the “minibus culture” where adolescent girls would ride in minibuses and have relationships with the drivers and conductors of the bus.

“Like you ga choke up, that is why they does tell you brace the wall because whoever by the bus windows got to go down, you got to be on top. Miss, they do tell you that if you is a woman don’t sit down on a woman’s lap sit down on a male lap.”

In many instances they are encouraged to overload the buses (which are legally allowed to transport 14 passengers) with as many as 20 or more passengers. The passengers are encouraged to sit on each other, with girls forced to sit on the laps of males.

“Miss, sometimes you go pon di park and you see you school friend get on a short skirt and she get she uniform high and she get man an she say, ‘I like this conductor, I like that conductor’ and you would say man I see what she doing so you want do it.”

The reported experience of one of the school girls who was never pregnant was quite astonishing. She described the case of a 14-year-old who allegedly ran away from home and became sexually involved with a minibus driver. Her case is stated below, and her experience has been echoed in with variations by others, including key informants:

“I have a friend and her mother doesn’t live with her and because of the things that she does, now, well the family blame it on her mother because the mother is not around her. Well she ran away from home and she is 14 years now but when she was 12, her grandmother sent her out and she went with a bus driver. I was asking her, ‘How, why would you dig something like this when you are so young?’ She was like, ‘It was out of temptation,’ because she likes the bus driver and he is 42 and he has children her age and he and his children are not the same as he doesn’t make joke with his little girls. And I was like, ‘Why would you want to do the same thing to somebody else child when you don’t want it to be done to your child?’ I mean that he is an adult and should have better knowledge not to have sex with a girl especially if you have daughters and you will be around your daughters. Every day you will look at them and as a man you wouldn’t, can’t imagine doing this to them and have a daughter so he supposed to have that common sense of knowledge to know that I can’t do this to a girl especially if I have a daughter her age even if she wants to do it. He is not supposed to be allowing her, so he should be punished a bit more than the child. She is the child so she is now experimenting so all kind



of things are happening to her right now, so he supposed to be the bigger person right now and say, 'Let me wait right now' so he should be punished severely."

Another of the never pregnant adolescents shared her very intriguing opinion on the rationale for adolescents to be involved with minibus conductors or drivers. Her views were endorsed by other adolescents.

"There are some girls like the minibus conductor. There are some girls who like they have a father will look down to his daughter and compliment her. Treat her a certain way. Some girls lack that and they look for it from other people like the bus conductor. The bus conductor will tell them these things. They good, because they never heard it before, so they would say that they feel good. 'I am good because he tells me so."

Intergenerational pregnancy

Quite several pregnant adolescents had either their mother or a sibling who was pregnant when they were teenagers.

"Well my other sister-the one before me- she did the same but she was older. She got pregnant too and she said she always used to imagine good stuff about me. I would grow up to get somebody good, have a happy life then make a child. Then she found out I was pregnant."

Exploitation of Indigenous Peoples

Some of the adolescents that were in the focus groups as well as key informants were of the view that Indigenous Peoples in the hinterland regions are sexually exploited. Sexual exploitation occurs at various levels, whether at school, or home or around mining camps. Below we have the experience related by one of the two fathers of the babies of adolescent girls, who also happens to be of Indigenous descent.

"Most of the time in Guyana you will find the majority of girls who are pregnant at a young age are from the interior of Guyana. They are mostly Amerindians. So, one time, my brother girlfriend is Amerindian and I was with her and a 12-year-old she was there and she was pregnant. She was eight months pregnant, it was sad to see because she lives a life and yet she has a baby. So, I have seen that there are some people who tend to disrespect them but I think that we all should be treated equally because people all have their own way of making decisions but the girl she was there and she was crying as it was not the first time she was pregnant but rather her second child. Her first child was at ten and she said that they exploit them in the interior. These big men would see them and have sex with them then they would just leave them."

Secondary school attendance

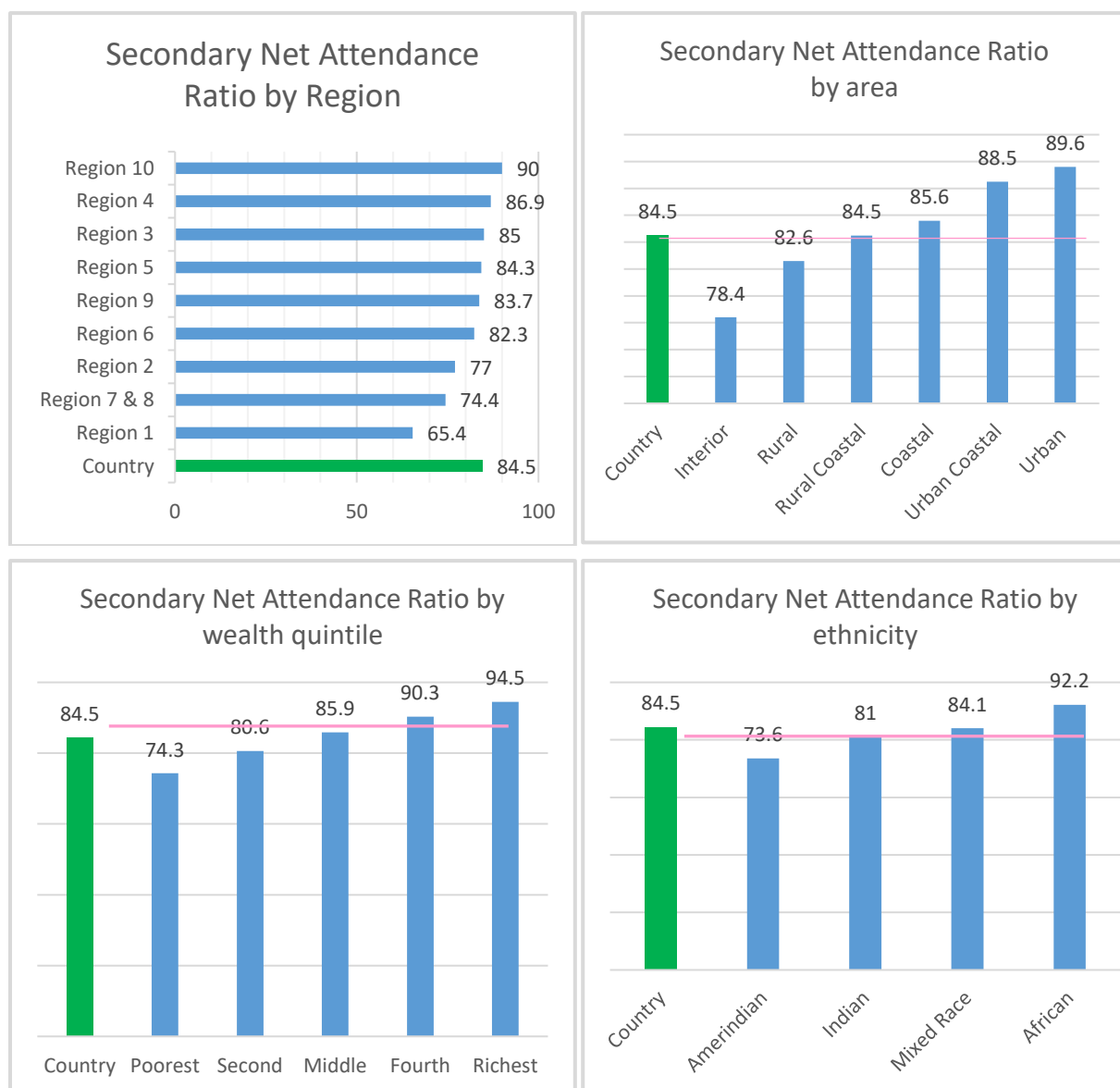
Children of adolescent age generally are the ones who have entered or are about to enter secondary schools. In that regard, Secondary Net Attendance Ratio (NAR) and the proportion of out-of-school youth are parameters that are used to measure attendance in school. NAR and out-



of-school youth information have been found to be correlated with area of residence, ethnicity and economic status.

Data from the 2014 MICS indicated that Net Overall Secondary Net Attendance Ratio in Guyana was 84.5 percent in 2014, with girls at 88 percent slightly more than boys with 81 percent, meaning that among students enrolled in secondary schools, some 15 percent do not go to school (MICS 2015). NAR varies by region and area, wealth quintile and ethnicity (Figure 12).

Figure 12: Secondary Net Attendance Ratio in Guyana by Socio-economic characteristics, 2014

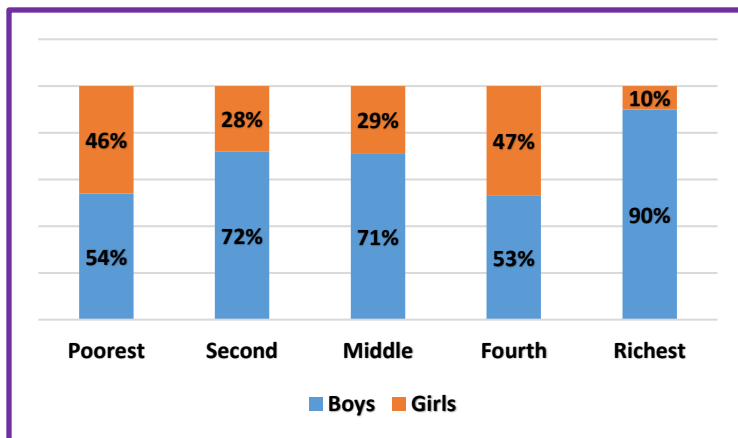


With regard to children being out of secondary school, 22% of boys and girls between the ages of 12 and 16 are out of school. More boys are out of school than girls with 63.7 percent of the out of school population being boys and 36.3 percent being girls. Being out of school is influenced



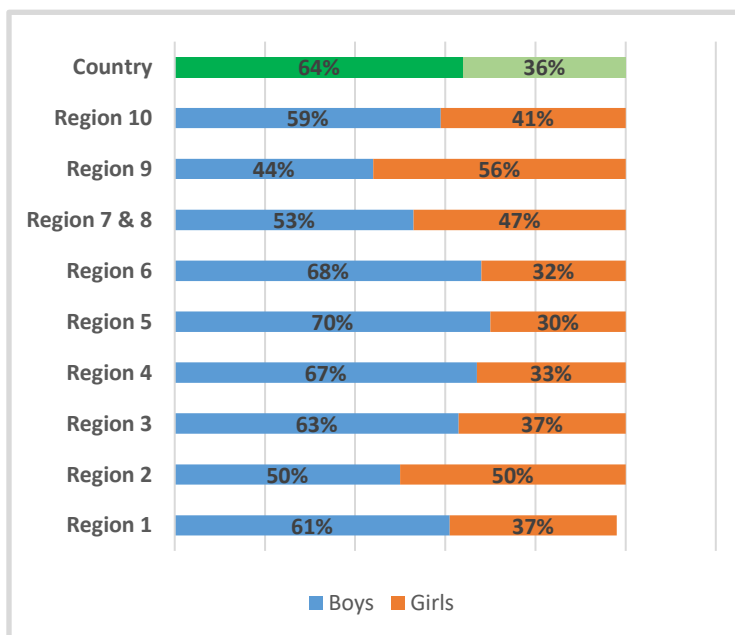
by socio-economic conditions. Poverty causes an almost similar number of boys and girls to be out-of-school (Figure 13). Among out-of-school children, 46 percent of them in the poorest quintile are girls while only 10 percent of girls in the richest quintile are out of school (Figure 14).

Figure 13: Percentage of secondary-level out-of-school students by gender and wealth quintile in Guyana, 2014



There are also stark differences in the regional distribution of out of school children. In Regions 7 and 8, 50 percent of the secondary-level out-of-school population are girls and in Region 9, more girls are out of school than boys (Figure 14)

Figure 14: Percentage of secondary-level out-of-school students by gender and region in Guyana, 2014

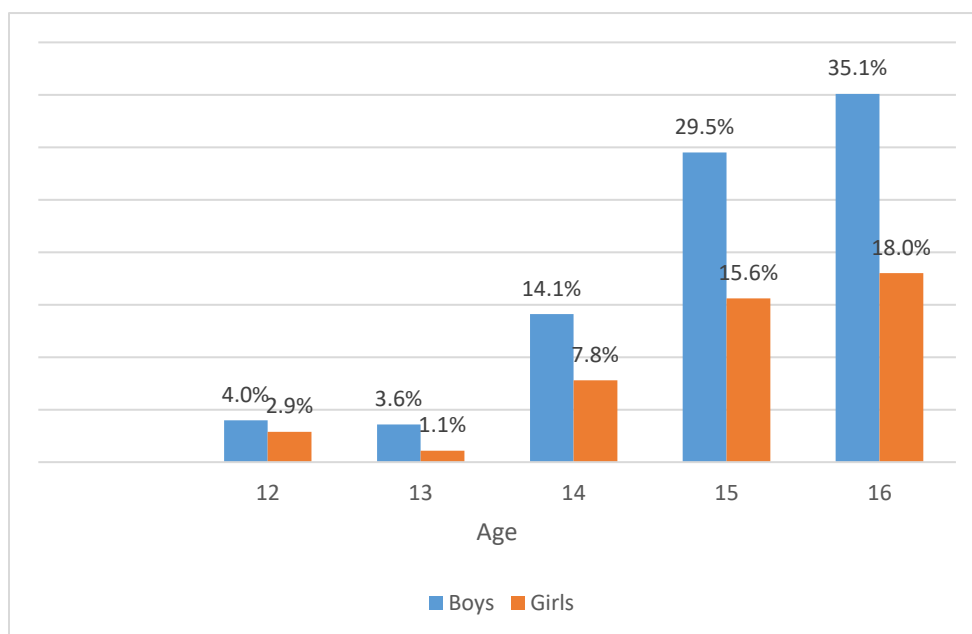


Source: MICS 2014



Data from the Ministry of Education for the academic year 2011/2012 shows that there was a school dropout rate of 7 percent for that year. Data from the 2014 MICS illustrates that at age 14, boys and girls start dropping out of school with increased frequency and this reaches a point where at age 16, 35.1 percent of boys and 18 percent of girls will have dropped out of school (Figure 15).

Figure 15: Percentage of out-of-school children by age and gender in Guyana, 2014



Effects of adolescent pregnancy

Adolescent pregnancy had effects across the board on the adolescents who became pregnant, the father of their babies and members of their communities. Many of the adolescents experienced negative reactions from their families, fathers of their babies and communities when they became pregnant. One of the adolescents expressed that she would cry every day. Reactions of most parents were not supportive as related by one adolescent who recounted what she was told by her parents: *“Me daddy tell me go drink poison...Mummy ah say she nah want me and the family ain’t taking me”*

Girls were not spared negative reactions from the fathers of their babies. One adolescent recounted the desertion that occurred when her baby’s father learned of her pregnancy:

“When I got pregnant and then when me child born six months he start running me frustrated because he had another woman and she start calling me so I had to let she had it and then he call me back and say, ‘Don’t call back me phone you causing a problem between me and me girl.’”



Members of the community also reacted negatively to adolescents becoming pregnant. Even the school children that were never pregnant could relate their experience and understanding of the reaction of the community to adolescent pregnancy. This is expressed in the two quotes below:

“Everybody look down on each other in this area. Miss, they life done, everything finish for them miss.”

“Nobody didn't they tell me nothing. Yeah, they just talk about me a lot. Because like talking about you, that how you get pregnant, and watch like every time you go out on the road just staring you down”

The head teacher of one of the secondary schools gave a very poignant account of the effect on the staff of his school on learning that one of their students had gotten pregnant:

“Well what happened to one of our student from the beginning, from Grade Seven-excellent student; participated in everything and we were shocked when she dropped out and then we learnt that she is pregnant and I think half of the staff cried when we learnt that you know sometime you don't expect certain things.”

One adolescent related the sad and traumatic experience of an adolescent boy committing suicide after his girlfriend became pregnant and the police became involved. His quote is stated below:

“He had - he had sex with a girl and they had police thing and he drink poison and kill he self. He was sixteen. The girl is alive and the baby was aborted.”

A healthcare worker from one of the interior locations used the negative response that she experienced as an adolescent who became pregnant to motivate her to higher achievements in her life. Her quite uplifting quote is highlighted below:

“All you all know to do is make children. And you had this constant, you know, you're a nobody in society. So all these things that motivated me to, you know, get qualification and move up to show them well although I have children I can still do something for myself. Da was one of the motivating factors.”

Many of the adolescent girls expressed regret at becoming pregnant as adolescents as this prevented them from completing school and therefore, they felt that they had lost opportunities that would have been available to them if they had not become pregnant. While many of the adolescents interviewed expressed the desire to have been able to complete their schooling, none were actually reintegrated into school. However, some key informants expressed the desire for there to be some form of reintegration into the school system as exemplified by the following quote:

“You know give them that chance many of them would be ashamed. It takes the brave ones to come back into the normal settings but if you have an outside institution where everybody of the same nature would go to they might be more comfortable there.”

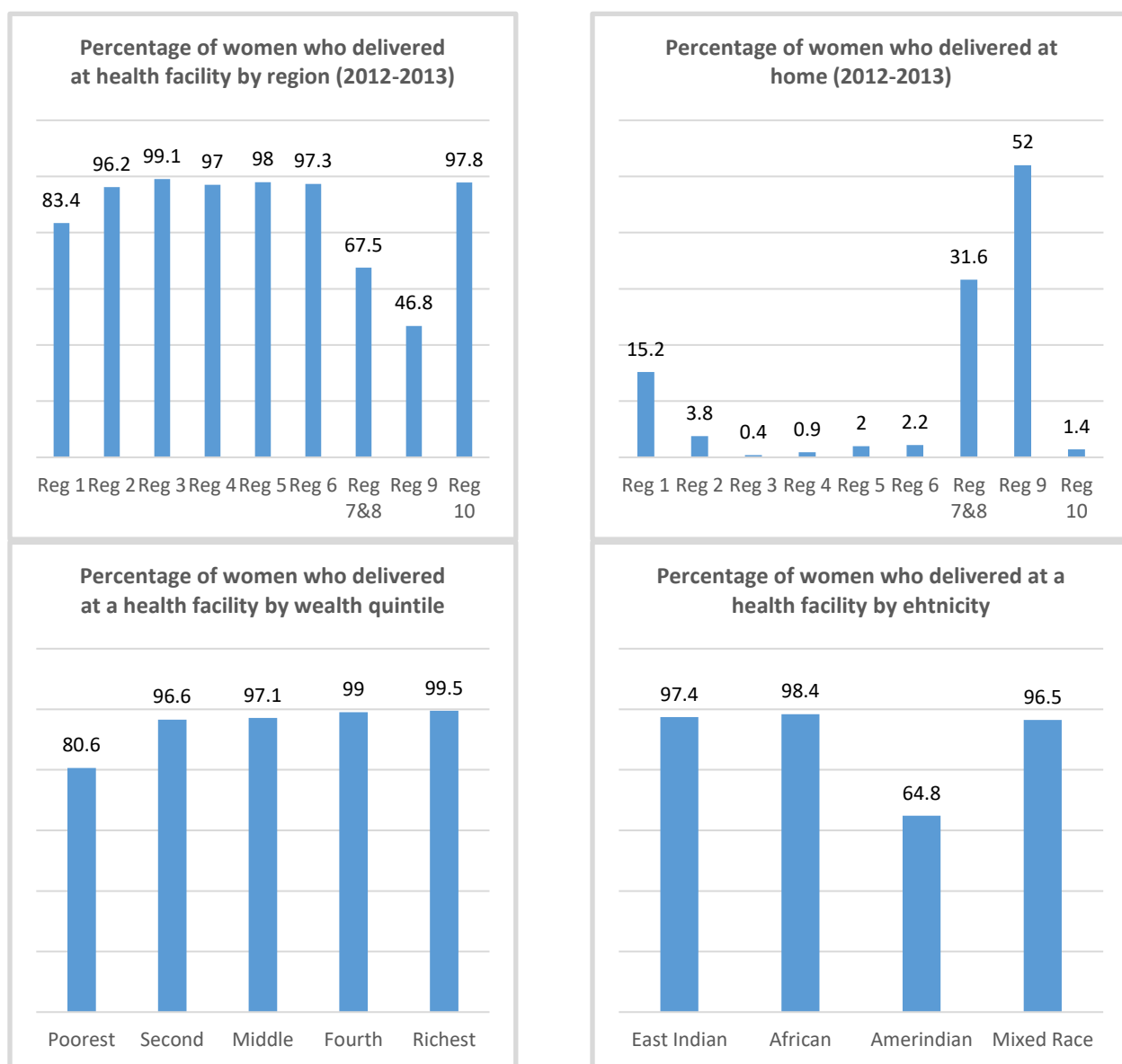


Services utilized by adolescents during and after their pregnancy

Utilisation of antenatal and postnatal services

Utilisation of antenatal and postnatal services varies by ethnicity, wealth quintile and region of residence. While most pregnant women on the coastal regions delivered at health facilities, only 47 percent of women from Region 9 delivered their children at a health facility. Only 65 percent of Indigenous women delivered at a health facility compared to almost 100 percent of women of other ethnicities (Figure 16).

Figure 16: Place of delivery by Region, wealth quintile and ethnicity, Guyana 2012-2013.



Source: MICS 2014



Providers of postnatal care

The services adolescents received after they have delivered their babies follow similar trends to what has already been noticed with factors influencing adolescent pregnancy. Overall, 60 percent of women in urban areas have their births attended by physicians compared to 40 percent in rural areas, while 51.7 percent in coastal areas are attended to by physicians compared to 19 percent in interior locations. 72 percent of women of higher education have their deliveries performed by physicians while only 13.2 percent of uneducated mothers have theirs done by doctors. 14.3 percent of Indigenous Peoples have their births attended by physicians. This makes them the ethnicity with the lowest percentage in this area while more than half of Afro and Indo-Guyanese births are attended by physicians. Only 37.4 percent of mothers below the age of 20 years have their births attended by a physician (MICS 2014).

Barriers adolescents face in accessing postnatal services

Adolescents also had quite harrowing experiences when they went to maternity units to deliver their babies. The experience of one adolescent is quoted below:

“Miss, one time they treat you good another time they treat you anyhow like they get up on the wrong side of the bed. Because is when you go to deliver and you in lil pain and you pull their hand they does start going on pon you. What could you do? One of them say ‘Hello, shut you mouth! You didn’t going on so when you di taking it and now you making noise!’”

Some healthcare workers appear to be very insensitive to the needs of pregnant adolescents and to those who have given birth. Based on the example given in the comment above and from other experiences communicated by adolescents to the interviewers, healthcare workers appear to be very judgmental of adolescents who become pregnant and seem to have no problem expressing their personal feelings to adolescents instead of providing the needed health care in a professional and sensitive manner.

Some of the adolescents have had to access postnatal services on their own as parents and the fathers of the babies of the adolescent mothers leave them to attend clinic by themselves. These girls expressed the desire to have been accompanied to these clinics.



Section 4: Conclusion and Recommendations

Conclusion

Adolescent pregnancy is a real issue for Guyana with more than 20 percent of all pregnancies in the country consistently occurring in this age group. There are multiple structural causes of adolescent pregnancy in Guyana as well as bottlenecks when it comes to addressing the issue. Socio-economic conditions play a major role in the occurrence of these pregnancies with poverty, level of education, area of residence, beliefs, traditions and culture having strong correlation with behavioural patterns. Girls who live in rural and hinterland areas, with little or no education and who are from the poorest households are the ones most likely to become pregnant as adolescents.

From the situation analysis it can be concluded that there are three interconnected immediate causes of adolescent pregnancy. These are early sexual debut, unprotected sex and early marriage. Each of these immediate causes is influenced by underlying and structural causes of poverty, individual behaviour, beliefs and traditions, sexual abuse and violence.

Regarding early sexual debut, 5 percent of women had their first sexual encounter before the age of 15 with women from poor families, those living in the interior and those of Indigenous descent having the highest rates. While the actual interviews conducted in the SitAn did not elicit what proportion of these initial sexual encounters was consensual or forced, the 2009 BBSS states that almost a quarter of secondary school girls were forced to have sex at the time of their first sexual encounter. Additionally, with repeated reference to the occurrence of incest in Guyana especially in the hinterland regions, reportedly as culturally accepted by some traditions and motivated by consumption of alcohol and other drugs, it can be concluded that sexual violence is a contributory factor to early sexual debut and concomitant adolescent pregnancy.

Many adolescent girls come from homes with uncaring, disengaged or uninformed parent(s) and as a result, look for love and attention outside their home. Peer pressure and the absence of dialogue with parents are contributory factors to early sexual debut. Lack of supervision of adolescents especially in single parent homes and in the hinterland regions is an additional contributory factor to early sexual debut.

Sexual activity among the adolescents in this situation analysis is characterised by low use of contraceptives, resulting in unprotected sex. There is limited knowledge about contraception and many of the adolescents associated condoms as the only form of contraception. The majority are not empowered to use contraceptives and/or encourage their male partners to use them. These adolescents also face legal and health system bottlenecks that limit their access to reproductive and sexual health services. Many persons, including adolescents erroneously believe that the law prohibits minors from accessing reproductive and sexual health services. While the legal age of consent in Guyana is 16, the law states that once the minor fully understands the nature of the service being provided, they can access those services without being accompanied by an adult, by way of the application of the Gillick Competence.



Some religious beliefs also influence the use or lack of use of contraceptives by adolescents as there is the belief that any discussions about condoms and contraceptives or making them available will encourage young people to have sex. Many adolescents do not go to adults when they have questions about sex as the response that they usually encounter is one of punishment rather than education or advice and therefore exposes especially adolescent girls to the risk of becoming pregnant or contracting HIV and/or other STIs.

While early/child marriage is uncommon in Guyana, more than 13 percent of adolescents 15-19 years were married or in union according to the Guyana 2014 MICS. East Indian and Indigenous girls constituted the greater proportion of these adolescent girls who were married or in union as were girls from rural and interior locations and those from the poorest and second quintiles, underlying; the role of socio-economic factors in the contribution to early/child marriage.

Under the old Indian Labour Act of Guyana, East Indians girls were permitted to marry from as early as the age of 14 years, and this practice still continues, which is now in violation of the Sexual Offences Act.

The contribution of individual behaviour to adolescent pregnancy is influenced by knowledge acquired in school and at home. While Guyana has institutionalised the Health and Family Health Education programme as a tool to address sexuality and other topics promoting wellbeing, teachers are still selective in the application of the topics they teach regarding sexual behaviour and sexual education due to their discomfort in talking about sex. As a result, there is no conclusion as to the effectiveness of HFLE in achieving its objectives.

Unless the structural and other causes of adolescent pregnancy in Guyana are addressed in a systematic and sustained manner, the country will continue to have high rates of such pregnancy; exposing adolescents to increased rates of HIV and other STIs. With the discovery of oil in Guyana, the country has an opportunity to utilise the newfound resources to address many of the structural factors that contribute to the high rates of adolescent pregnancy.

Recommendations

The following are recommendations in various areas for addressing adolescent pregnancies in Guyana.

Coordination

Guyana does not have a national strategy and attendant action plan to address adolescent pregnancy. With adolescent pregnancy consistently being at such high level, it may be prudent for this to be identified as a national crisis which requires urgent and systematic attention. To address this national “crisis”, the following recommendations (in keeping with the CARICOM Integrated Strategic Framework for the Reduction of Adolescent Pregnancy) are deemed to be appropriate:

- The absence of a national, multi-sectoral strategic plan should be prioritized and one should be developed in a timely manner by the Ministry of Public Health.



- Two or three-year, costed operational plans should be developed with their appropriate monitoring and evaluation plans. These operational plans must be cross-sectoral and include action taken by health (i.e services) education (i.e retention in the education system) and social protection (i.e violence, abuse, economic support to single mothers).
- A multi-sectoral, national coordinating body should be established by the Ministry of Public Health to coordinate the development, implementation and monitoring of such strategic and operational plans.
- Annual reports should be tabled at the highest national level.
- Every effort should be made to implement the CARICOM Integrated Strategic Framework for the reduction of adolescent pregnancy

Accountability

This study has identified that there is inadequate enforcement of the law in many cases of statutory rape, incest and other forms of sexual violence against adolescents. As a result, many persons have lost faith in the justice system the enforcement of the law.

- Those responsible for enforcing the law must be held accountable whenever the law is not administered as it should be regarding such cases.
- Undercover law enforcement officers and others such as from the Ministry of Social Protection should monitor and regulate safety practices for mini-buses. The Ministry of Public Security (which regulates transport) should also be involved to ensure safety and security on the roads. Educational training to min-bus, taxi drivers and traffic police and awareness campaigns targeting drivers should be considered.
- Parents and guardians should be held accountable for cases of statutory rape and incest whenever they occur and they accept monetary rewards for not prosecuting these cases.
- Awareness raising and education programs must be designed specifically to work with minibus drivers and conductors focusing on the prevention of sexual abuse, violence, pregnancies and STIs.

Communication and public awareness

There is little evidence that there is a systematic approach to addressing adolescent pregnancy in Guyana, such as consistently raising public awareness of the problem, highlighting what are the contributory factors and the interventions to be or are being implemented to reduce its prevalence. In this regard, the following recommendations are proposed:

- The design and implementation by the Ministry of Public Health of a comprehensive information, education and communication strategy that targets the issues identified from evidence-based data (collected from the monitoring and national statistics identified below).



- The development of such a strategy should include multi-stakeholder involvement so that there is national ownership and buy in.
- Communication must be done using as many- or if resources permit, all- means of mass and interpersonal communications for effective reach.
- Systematic monitoring of the implementation of this strategy with its attendant operational plan and making the necessary adjustments as they occur.

Education

Health and Family Life Education has been identified by the CARICOM member states as the main pillar for addressing life skills and sexuality issues in schools. Unfortunately, in the Guyana setting, many teachers find great difficulty in teaching HFLE to address sex and sexuality issues affecting the age groups that have been identified to receive such teaching. Proposed recommendations to address the deficiencies identified among teachers should include:

- Innovative approaches to work with teachers to empower them to deliver HFLE in a more effective way. Approaches should include quantitative and qualitative studies among teachers to identify the barriers and solutions for effectively teaching HFLE.
- Having identified the barriers and solutions, plans should be developed on how to support teachers and implement, monitor and evaluate these approaches.
- Innovative ways of incentivizing teachers should also be explored.
- Have behavior counsellors available at all schools in the country and increase the channels of communication between teachers and students for topics related to social behavior, sexuality and comportment.
- Support should be given to a new UNFPA initiative to pilot the capacity building of a core of HFLE specialist teachers to deliver HFLE in schools.
- Research should be conducted on the reasons for the high school net enrollment and dropout rates and targeted interventions should be developed to address them.

Community engagement

Establishing safe recreational areas

The SitAn identified the lack of recreational activities especially in hinterland areas, notwithstanding the UNICEF-supported SC4D program. All necessary steps should be taken to establish safe recreational spaces where adolescents can pursue after-school and other recreational activities.

- Many communities have community grounds and centres and every effort should be made to ensure that these facilities are kept in appropriate condition and that the centres are adequately equipped.



- Various mechanisms can be pursued to establish and maintain such facilities including government funding, public/private partnerships, philanthropic donations and community mobilization efforts.
- Businesses should be encouraged and incentivized to establish recreational facilities.
- As the country prepares to benefit from the massive oil discoveries, every effort should be made to advocate and plan for the use of “petrodollars” to develop all communities especially the hinterland regions to ensure that all citizens have access to modern recreational facilities.
- The UNICEF supported SC4D program must be evaluated and its successful components expanded as necessary.
- UNFPA supported Department of Youth community adolescent/youth friendly spaces initiative must be evaluated and its successful components expanded as necessary

Behavioral change

The MOPH in collaboration with community groups should embark on a sustained behavioral change campaign utilizing both mass media and interpersonal approaches to target behaviors that generally foster "accepting attitudes" of many of the negative factors that contribute to adolescent pregnancy.

Engagement of religious organizations

Religious bodies and the many community groups should be empowered to play a more meaningful role in disseminating information on sex and sexuality to adolescents. This would facilitate adolescents being able to make informed choices as they will be more aware of the consequences associated with the choices they make.

Youth groups and sports organizations should be resourced and supported to strengthen their advocacy on adolescent issues such as pregnancy, violence and HIV. Youth groups can be potentially instrumental in disseminating information to adolescents to raise awareness on adolescent sexual and reproductive health and on the exercise of their sexual and reproductive rights as well as promoting non-violent behaviors.

Social and medical services

The community parenting support group and adolescent wellness day initiatives are steps in the right direction to addressing adolescent pregnancies. However, they are currently limited in scope.

- There is a need to have a phased and comprehensive expansion of the Community Parenting and Support Groups and Adolescent Wellness Day initiatives to more than the present 24 health centres. In addition, to expand these initiatives, they must be systematically monitored and evaluated to ensure that they are achieving the desired results.



- Service providers should receive proper training on adolescent health and well-being, including communication techniques for exploring complex issues with adolescents and their parents, including sexuality, alcohol and substance use, violence and abuse and mental health.
- The Adolescent Mother's Initiative, which has similar objectives to the Community Parenting Support Groups but also includes an element dealing with income generation, should also be scaled up to more areas across the country.
- Social and medical services should be developed and implemented using the rights-based approach.

Monitoring systems and national statistics

Guyana does not have a system that collects data and systematically monitors risk and protective factors for adolescent pregnancies. In fact, data is only collected on the number of pregnancies that occur in the country and then this data is disaggregated according to age groups including girls of adolescent age. Additionally, qualitative studies are not conducted to ascertain the risk and protective factors. To address this deficiency, it is therefore recommended that the following are implemented:

- The Ministry of Public Health in collaboration with the Ministries of Social Protection and Education should determine what data exists on risk and protective factors for adolescent pregnancy and establish where the gaps are and establish a system for systematically collecting such data.
- Having established the gaps in data, the two ministries should convene stakeholder meetings with all relevant stakeholders, including the civil society and international partners to prioritize the gaps to be addressed.
- A national repository should be established of all the data collected and systematically analyzed, interpreted and used to inform targeted interventions to address the factors that are deemed most relevant.
- Stakeholders should agree upon and establish the frequency with which the data would be collected to determine trends, test hypotheses and monitor and evaluate interventions.



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Appendix 2: Interview guide – Ever pregnant Adolescents



THEMATIC AREAS	POSSIBLE QUESTIONS
<p>Living arrangements and family relationships prior to becoming pregnant (Poverty)</p>	<ul style="list-style-type: none"> i. With whom did you live prior to becoming pregnant? i. Describe the type of relationship you had with family members (mother, father, siblings etc) i. Did you feel loved and appreciated always by family members? (probe) v. Please tell me about the relationship you had with family members – Probe - Is there any specific family member with whom you did not have a good relationship? How did this make you feel and what was your reaction towards that person?
<p>Economic status of the family/how well your needs were being met before becoming pregnant (Poverty).</p>	<ul style="list-style-type: none"> i. Do you believe that your parents were financially capable of providing for all of your needs? Explain what gave you that impression. ii. Was there any male, other than a relative, who gave you things (money or other items) that you were not getting from your parents, or who just gave you gifts. Explain how it started. Please tell me about any male relatives who gave you things? iii. Did you ever become sexually active with an individual (including relatives) who would have given you gifts (money, clothes, food etc.)?
<p>Discussions about sexual and reproductive health (early sexual initiation).</p>	<ul style="list-style-type: none"> A. Prior to becoming pregnant, with whom have you ever discussed sex or sexuality? How did this happen? B. Please tell me about the persons that were most influential in providing information on sex/sexuality? (what were you told, were you told about what you need to do other than using contraceptives, so as not to get pregnant) C. Do you feel comfortable engaging in discussions about sex and sexuality with older persons? Younger persons? Why?
<p>Contraceptive use / access (Risk behavior, interpersonal sexual violence, incest)</p>	<ul style="list-style-type: none"> i. At what age did you have your first sexual experience? How did it happen? ii. Did you agree or were you forced to engage in sexual activity? Why do you feel this happened? Do you think you were ready to start having sex? iii. Was any contraceptive used during your first sexual encounter and after? (why/who introduced it/how often was it used) iv. Do you know where to go to acquire information on contraceptives and to access them? v. Have you ever attempted to access contraceptives (from a clinic, organization etc.)? vi. How did the persons providing the contraceptives respond to your request? How did that make you feel? vii. Please tell us of any other contraceptive needs you may have?
<p>Attitudes & behaviors that are likely to result in pregnancy (individual behavior)</p>	<ul style="list-style-type: none"> i. What are some of the behaviors adolescents engage in that put them at risk of becoming pregnant? ii. Please tell us what do you think influence these behaviors? What of peer pressure? Explain why you think so. iii. Do these behaviors put adolescents at risk of being exposed to anything other than becoming pregnant?
<p>Access to services</p>	<ul style="list-style-type: none"> i. Did you ever go to the maternity clinic? From when? ii. Please tell us of anyone who accompanied you to the doctor during your pregnancy? Please explain why. iii. What was the reaction of the clinic staff? iv. What are your views about the service that you received? v. What other services did you go to (WAD, GRPA, MOPH)? Are there any Health centres in your area? vi. Please share your views about those services that you received.



Discovery and reaction to the pregnancy	<ul style="list-style-type: none">i. How did you find out that you were pregnant?ii. How did your family find out that you were pregnant?iii. What was the reaction of family members to your pregnancy?iv. How did the person responsible for you becoming pregnant react when he was told? How did that make you feel?v. How did the reaction of family members affect your relationship with your partner? How did that make you feel?vi. How did your partner's response to your pregnancy affect your relationship with your family? How did that make you feel?
Impact of pregnancy on teenager	<ul style="list-style-type: none">i. How has becoming pregnant affected your life (academically, psychologically, socially, financially)? Were you able to go back to school? Learn a trade? Start a business? Etc? Maybe we can probe a bit on psychologically....
Recommendations	<ul style="list-style-type: none">i. What would you like to be done that will contribute to teenagers making choices that are not likely to result in them becoming pregnant? Who should be doing this?ii. What type of support would you like to see being made available to pregnant teenagers (services etc.)?iii. Are there any other suggestions you would like to make?



Appendix 2: Interview guide – Never pregnant Adolescents

ISSUES	POSSIBLE QUESTIONS
Living arrangements and family relationships	<ul style="list-style-type: none"> v. With whom are you living? i. Describe the type of relationship you have with family members (mother, father, siblings etc) i. Do you feel loved and appreciated at all times by family members? How does this make you feel? i. Is there any specific family member with whom you do not have a good relationship? How does this make you feel and what is your reaction towards that person?
Economic status of the family/how well your needs are being met.	<ul style="list-style-type: none"> iv. Do you believe that your parents are financially capable of providing for all of your needs? Explain what gives you that impression. v. Is there any male other than a relative who gives you things (money or other items) that you are not getting from your parents, or who just gives you gifts? Explain how it started. vi. Does any male relative give you gifts? Do your parents know about this? vii. Were you ever sexually active with an individual who gives you gifts (money etc)?
Discussions about sexual reproductive health.	<ul style="list-style-type: none"> D. With whom have you ever discussed sex or sexuality? How did this happen? E. Who are the most influential persons providing you with information on sex/sexuality? (What are you being told, are you told about what you need to do other than using contraceptives so as not to get pregnant?) F. Do you feel comfortable engaging in discussions about sex and sexuality with older persons? Why?
Knowledge about and access to Contraceptives	<ul style="list-style-type: none"> viii. Do you know where to go to receive information on sex/sexuality and to access contraceptives? ix. Have you ever attempted to access contraceptives (from a clinic, organization etc.)? x. What was the reaction of the persons there?
Attitudes and behaviors	<ul style="list-style-type: none"> iv. What are some of the behaviors adolescents engage in that put them at risk of becoming pregnant? v. Are these behaviors influenced in any way by peer pressure? Explain why you think so? vi. Do these behaviors put adolescents at risk of being exposed to anything other than becoming pregnant?
The impact of a pregnancy on a teenager	<ul style="list-style-type: none"> i. If you were to become pregnant as a teen, how do you think becoming pregnant will affect your life: academically, socially, psychologically, and financially? How will that make you feel? ii. How do you think others (family members, peers etc) will react to you being pregnant?
Access to services	<ul style="list-style-type: none"> vii. Where can teenagers go to access services during and after their pregnancy?
Recommendations	<ul style="list-style-type: none"> i. What would you like to be done that will contribute to teenagers making choices that are not likely to result in them becoming pregnant? Whom would you want to do these things? ii. What type of support would you like to see being made available to pregnant teenagers (services etc)? iii. Are there any other suggestions you would like to make?



Appendix 3: Interview guide – Parents Of Pregnant Adolescents



THEMATIC AREAS	POSSIBLE QUESTIONS
Living arrangements and family relationships prior to teenager becoming pregnant (Poverty)	<ul style="list-style-type: none"> i. With whom was your daughter living prior to becoming pregnant? ii. Describe the type of relationship she had with family members (mother, father, siblings, etc.) iii. Is there any specific family member with whom she did not have a good relationship? How do you feel about men other than relatives giving young girls gifts? What of male relatives?
Economic status of the family prior to the teenager becoming pregnant (Poverty).	<ul style="list-style-type: none"> i. Do you believe that you were financially capable of providing for all of her needs? Explain what gave you that impression. ii. Was there any male other than a relative who gave her things (money or other items) that she was not getting from you, or who just gave her gifts? Were there any male relatives who gave her things? iii. How do you feel about men other than relatives giving young girls gifts? iv. What would be your reaction if you found out that your adolescent daughter is receiving gifts from a male other than their relatives? What about male relatives? Why?
Discussions about sexual and reproductive health (early sexual initiation).	<ul style="list-style-type: none"> i. Have you ever had any discussion on reproductive health (changes at puberty, emotional changes etc.) with your daughter? Do you think this is important? Why? ii. Have you ever discussed sex with your daughter? Do you think it this is important? Why? iii. Do you feel comfortable engaging in discussions about sex and sexuality with your child? Why? iv. What are your views about teenagers receiving information on sex and contraceptives from other sources? With which sources are you most comfortable? v. When should young girls/boys be introduced to contraceptives? vi. What age is appropriate for girls/boys to have sex? Why? vii. What would be your response if you found out that your child started having sex before that age?
Attitudes and behaviors that are likely to result in pregnancy (individual behavior)	<ul style="list-style-type: none"> i. What are some of the behaviors teenagers engage in that put them at risk of becoming pregnant? ii. Who/what do you think is most influential in causing them to engage in these behaviors? iii. Do these behaviors put teenagers at risk of being exposed to anything other than becoming pregnant?
Access to services	<ul style="list-style-type: none"> i. Did your daughter go to the clinic? (if yes) From when did she start going? and who introduced her to the clinic? ii. Have you ever accompanied her to the doctor (clinic) during her pregnancy? Please explain why. iii. What was the reaction of the clinic staff? iv. What are your views about the service that she received? v. What information do you have about other services being offered to pregnant teenagers?
Impact of the pregnancy	<ul style="list-style-type: none"> A. What was the impact of the pregnancy on your daughter? B. How has the pregnancy impacted the family? C. How has the pregnancy affected your family's relationship with the community? Probe: Religious organization
Discovery and reaction to the pregnancy	<ul style="list-style-type: none"> i. How did you find out that your daughter was pregnant? How did that make you feel? ii. What was your reaction to finding out that your daughter was pregnant?



	<ul style="list-style-type: none"> iii. What was the reaction of others (family members, friends, community etc) to your daughter becoming pregnant? iv. How did the person responsible for her becoming pregnant react when they were told? How did that make you feel and how did you react? v. How is your child coping with having a baby/child?
Recommendations	<ul style="list-style-type: none"> iv. What would you like to be done that will contribute to teenagers making choices that are not likely to result in them becoming pregnant? Who should be doing this? v. What type of support would you like to see being made available to pregnant teenagers (services etc.)? vi. Are there any other suggestions you would like to make? vii. What do you want for your life? Your dreams?

Appendix 4: Interview guide – Fathers of Babies of Pregnant Adolescents

D. Interpersonal and household relationships at time of pregnancy

- i. At the time that the teenager got pregnant, with whom were you living?
- ii. Describe the type of relationship you had with others in the household?

E. Economic status of the family/how well her needs were being met: prior to becoming pregnant.

- i. Do you believe that her parents were financially capable of providing for all of her needs? Explain what gave you that impression.
- ii. Did you give her things (money or other items) that she was not getting from her parents? Explain how it started.

G. Discussions about sex and contraceptives

- i. At the time that she got pregnant, how would you describe your relationship with the teenager?
- ii. Before she got pregnant, did the two of you ever discuss contraceptives or condoms? What was the nature of such discussions?
- iii. Did you and her discuss sex?
- iv. Were you comfortable having such discussions/?
- v. Was she comfortable? Why do you think so?

F. Contraceptive and condom use and access

- i. Was any contraceptive including condom used during your first sexual encounter and after? (why/ who introduced it/ how often was it used)?
- ii. Do you know where to go to access information on sex/sexuality and to access contraceptives?
- iii. Did the teenage girl know where to get contraceptives and condoms?



- iv. Do you know if she ever tried getting contraceptives or condoms (from a clinic, doctor, family planner, etc.)?
- v. Have you ever attempted to get contraceptives or condoms (from a clinic, doctor, family planner etc.)?
- vi. What was the response and how did you feel?

G. Discovery and reaction to the pregnancy

- i. At the time that the teenager became pregnant, how did you first learn about it?
- ii. What was your reaction?
- iii. How did significant others (such as wife, sexual partners, family, significant other) discover that you had gotten a teenager pregnant?
- iv. How did others in your household learn about the pregnancy?
- v. What was their reaction?

H. Impact of the pregnancy

- i. How did the pregnancy affect your relationship with significant others?
- ii. How did it affect your relationship with other people in your household?
- iii. Did the pregnancy in any way affect you financially?
- iv. Did you view this pregnancy as a burden (social, psychological financial)?
- v. Did the pregnancy change the nature of the relationship between you and the teenager? Please explain.

I. Access to services

- i. Have you ever accompanied her to the doctor during her pregnancy? Please explain why.
- ii. What was the reaction of the clinic staff?
- iii. What are your views about the service that she received?

J. Attitudes and behaviors

- i. In your opinion, what are some the things that young girls do that can make them get pregnant at an early age?
- ii. In your opinion, how do friends and acquaintances influence these behaviors?
- iii. In what way(s) are these behaviors influenced by the makeup of the family?
- iv. In your opinion, how does the household in which a young girl lives influence these behaviors?



- v. How do these behaviors put young girls at risk of being exposed to anything other than becoming pregnant?

K. Recommendations

- i. What would you like to be done and by whom that will contribute to young girls making choices that are not likely to result in them becoming pregnant?
- ii. What type of support would you like to see being made available to pregnant teenagers (emotional, financial, type of services etc.)?
- iii. Are there any other suggestions you would you like to make?

Appendix 5: Interview guide - Key Informants

<u>Teenage pregnancy</u>	What are some of the factors that contribute to adolescent pregnancy in Guyana? (a) Economic/poverty, (b) Socio-cultural and (c) Structural
	What would you like to be done that will contribute to teenagers making choices that are not likely to result in them becoming pregnant? Who should be doing this?
<u>Providing S&RH information</u>	What are your views about adolescents receiving information on sexual and reproductive health?
	Who/What do you think are the appropriate sources for providing this information?
<u>Programmes/Services</u>	What programs and services are you aware of that are in place to address teenage pregnancy?
	What policies, programs and/or services does your organization offer to address teenage pregnancy?
	What are the barriers that you face in executing your programs/services?
	How do you propose that these barriers be addressed? And whom should be addressing these barriers?
	What type of support would you like to see being made available to adolescents (services etc)?
	Are there any other comments/suggestions you would like to make?

Appendix 6: Survey respondents by type

Survey respondent type	Number
Ever pregnant female adolescent	52
Female parent of ever pregnant adolescent	24
Father of baby of pregnant adolescent	2
Male student who never got a female pregnant	12
Never pregnant adolescent female student	12
Religious leader	2
Healthcare provider	4



Health care policy maker	1
International organization representatives	2
Adolescent NGO service provider	3
Total	114

Appendix 7: Focus Group Discussions and Key Informant Interviews planned and conducted

Activity	Target group/individual	Comments
Region 4 Central		
Key informant interview	Head teacher Brickdam Secondary	Conducted
Key informant interview	Head of Maternal and Child Health	Conducted
Key informant interview	Director of Guyana Responsible Parenthood Association	Conducted
Key informant interview	Head, Guyana Pandit Council	Not conducted
Key informant interview	Head of Guyana Council of Churches	Conducted
Key informant interview	Central Islamic Organisation of Guyana	Conducted
Key informant interview	Youth and Adolescent Development Officer UNICEF	Conducted
Key informant interview	Head of Women Across Differences (WAD)	Conducted
Key informant interview	Head of Red Thread	Conducted
Key informant interview	Director Child Care and Protection Agency	Conducted
Focus Group Discussion	Adolescent boys who were never fathers or responsible for a pregnancy (Brickdam Secondary)	Conducted
Focus Group Discussion	Adolescent girls who were never pregnant (Brickdam Secondary)	Conducted
Focus Group Discussion	Ever pregnant adolescent girls 15 years and older	Conducted
Focus Group Discussion	Parents of ever pregnant adolescent girls	Conducted
Focus Group Discussion	Fathers of the babies of pregnant adolescent girls	Only one participant attended so conducted as a key informant interview
Region 4 East Coast Demerara		
Focus Group Discussion	Ever pregnant adolescent girls 15 years and older	Conducted
Focus Group Discussion	Parents of ever pregnant adolescent girls	Conducted
Region 4 East Bank Demerara		
Focus Group Discussion	Ever pregnant adolescent girls 15 years and older	Not conducted
Focus Group Discussion	Parents of ever pregnant adolescent girls	Not conducted
Region 3		
Key informant interview	Head Teacher West Demerara Secondary	Conducted
Focus Group Discussion	Ever pregnant adolescent girls 15 years and older	Conducted
Focus Group Discussion	Fathers of the babies of pregnant adolescent girls	Not conducted
Key informant interview	Health care provider	Conducted
Region 1 Mabaruma		



Focus Group Discussion	Ever pregnant adolescent girls 15 years and older	Conducted
Focus Group Discussion	Parents of ever pregnant adolescent girls	Conducted
Focus Group Discussion	Fathers of the babies of pregnant adolescent girls	Only one participant attended so conducted as a key informant interview
Focus Group Discussion	Adolescent boys who were never fathers or responsible for a pregnancy (Brickdam Secondary)	Conducted
Focus Group Discussion	Adolescent girls who were never pregnant	Conducted
Key informant interview	Health care provider	Conducted
Key informant interview	Tashao/Senior Councillor	Conducted
Region 9		
Focus Group Discussion	Ever pregnant adolescent 14 years and younger	Not conducted
Focus Group Discussion	Ever pregnant adolescent girls 15 years and older	Conducted
Focus Group Discussion	Fathers of the babies of pregnant adolescent girls	Only one participant attended so conducted as a key informant interview
Focus Group Discussion	Parents of ever pregnant adolescent girls	Conducted
Focus Group Discussion	Adolescent girls who were never pregnant	Conducted
Focus Group Discussion	Adolescent boys who were never fathers or responsible for a pregnancy	Conducted
Key informant interview	Health care provider	Conducted
Key informant interview	Tashao/Senior Councillor	Conducted
Region 6		
Focus Group Discussion	Ever pregnant adolescent girls 15 years and older	Conducted
Focus Group Discussion	Parents of ever pregnant adolescent girls	Not conducted
Focus Group Discussion	Adolescent boys who were never fathers or responsible for a pregnancy (Corentyne Secondary)	Conducted
Focus Group Discussion	Adolescent girls who were never pregnant (Corentyne Secondary)	Conducted
Key informant interview	Head Teacher Corentyne Comprehensive	Conducted