A Qualitative Research Study on HIV Vulnerability among Young Key Affected Populations in Guyana
A Qualitative Research Study on HIV Vulnerability among Young Key Affected Populations in Guyana


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I. Executive Summary

Adolescents in Guyana live in a fast, technology-charged, promising, colourful, violent, and exciting world. It is a world with its own language, its own values, its own pulse, its own complexity and its own dangers. These dangers, especially for some adolescents, include a high risk of contracting HIV. It is a disease, which ‘their age, biological and emotional development and their financial dependence’ (Kaiser 2004) place them at a risk of contracting, especially young women who make up 57.4 % of new infections.

The danger is also real - persons who are younger than 25 years old, account for more than half of new HIV infections. Globally there are 5.4 million young people living with HIV\(^1\). Guyana has an HIV/AIDS prevalence of 1.1%. The country has made significant strides in HIV/AIDS prevention, and its efforts have been recognized both locally and internationally. Adolescents are viewed as a key demographic. The 2009 Demographic and Health Survey (DHS) in Guyana found that the age group of 15-19 years had shown a steep increase in the proportion of HIV cases moving from 3.66% in 2006 to 6.04% in 2009.

This study explores the vulnerability of Young Key Affected Populations (ages 10-24) to HIV/AIDS in Guyana. It examines the behavioural and socio-cultural factors that make adolescents vulnerable. The study sought to go beyond the numbers, to explore experiences, views and challenges through the eyes of adolescents themselves. The study used a comprehensive framework to organize the research, which included a review of structural features (laws, policies etc.), as well as the contextual characteristics (networks, services, socio-economic situation etc.) of adolescent vulnerability to HIV/AIDS.

The study gathered information from 352 adolescents; in rural (124 adolescents), hinterland (88 adolescents) and urban (140 adolescents) contexts, over a three-month period. The research team also conducted more than 50 interviews with key persons in the adolescents’ world including teachers, employers, parents, Probation Officers, religious leaders and their peers.

The adolescents engaged in the study included men who have sex with men, in school youth, youth in contact with the law, commercial sex workers and out-of-school youth.

This report was researched at a dynamic time when global funding is decreasing and several programs that directly provide services to youth are being scaled down or terminated, which makes Guyana’s pledge to ensure zero new transmissions and its MDG goals all the more challenging, especially for at-risk adolescent populations.

Limitations

There were several limitations including the time availability for field research, difficulties accessing several key groups especially MSMs and FSWs in rural and hinterland areas, and not being given access to schools in one region, permission to access records and personnel from a key ministry, in time for the development of the report. The range of adolescent sub-types that were required to be included in the study was quite broad, which made it difficult to comprehensively focus on, or gather data for one sub-group. The study relied on respondents to self-report sexual activity, although there was some triangulation done with other sources.

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\(^1\) Estimates show that more than 7,400 people become infected with HIV daily, 3,300 of whom are young people. Source: UNAIDS
**Key Findings:**

**Guyana's Policy and Legal Framework**
- Based on the desk review, and key informant interviews, it was found that the institutional framework for HIV and vulnerable adolescents in Guyana has been strengthened by major resource investments\(^2\) (by both Government and donors), as well as the introduction of key legal acts, policies across various ministries, and targeted agencies (NAPS, Adolescent Health Unit etc.), however, there are still several key gaps.
- There is no specific policy, or strategy for YKAP, and no national consensus on who Guyana's YKAP are, or specific guidelines for each individual category of YKAP especially those under the age of 18, which would help to ensure that deficiencies in policy and programmes are addressed.
- Civil society organizations are widely recognized as having played an important role in providing services to vulnerable populations, including YKAP, and this is increasingly reflected in national policies and programs that stress partnerships and coordination with NGOs. There are several national NGOs that advocate for the rights of key YKAP groups including MSM.
- The Ministry of Health serves as the focal ministry for HIV/AIDS, and adopts a very practical approach to the implementation of policy, including provisions for MARPs. The policies do not make an inter-category distinction, for example differentiating between adolescent FSWs, MSMs etc., whose needs and attributes are quite specific within the MARP category.
- The Public Health Ordinance (1834), which guides HIV/AIDS related health issues, has been described in a 2004 report as, “wholly incapable of addressing the public health issues raised by HIV/AIDS”.
- Key acts such as the *Sexual Offences Act* are not fully implemented and punitive laws that negatively impact at-risk populations, such as MSMs and FSWs, reinforce stigma and discrimination, and can potentially negatively affect access to services. A national assessment (2004) found several legal and constitutional gaps, which are directly relevant to YKAP, including the criminalization of same-sex partnerships, confidentiality and privacy laws etc.
- The empirical research revealed that there is a sense at the local level that the impartiality and effectiveness with which sexual offenders were handled by the justice system left considerable room for improvement, as well as the need to monitor the outcome of cases. It was highlighted that systematic weakness resulted in many perpetrators of rape and sexual abuse going unpunished, despite a perceived rise in these incidences, including cases of “step-daddy rape”.
- Key policies that have been developed to address discrimination, such as the National HIV Workplace Policy and the School Health, Nutrition and HIV&AIDS Policy, do not place any legal obligation on institutions and are largely voluntary. Other key policies such as the National Youth Policy and the National Sports Policy have either not been drafted or not been implemented. Policies such as the Workplace Policy do not refer to adolescents specifically, nor do the policies generally reflect the participation of adolescents/YKAP in their development.
- There are several key provisions in the Ministry of Education’s School Health Policy that were found to not have been widely implemented, such as the promotion of psycho-
social support in schools and capacity building for teachers and parents.

- The age of consent in Guyana is 16 years of age. This, among other things, requires the authorization of parents of sexually active YKAP who are under-age to have an HIV/AIDS test: however, this was generally reported as a prohibitive factor for accessing the service. There is some indication that the Ministry of Health has shown some flexibility with this provision.

- Although MoE and MoH were reported to have contradictory approaches (MoE promoting abstinence, MoH promoting safe sexual activity), this is not reflected in the provisions of the MoE’s policy regarding the distribution of condoms, which is to be determined by the school.

- There is a prevalent gap in knowledge of both adolescent Rights Holders (including several key agencies, local government authorities, teachers and private sector agencies), as well as that of Duty Bearers on the legal and policy provisions for adolescents in Guyana. For example, among key local government bodies such as Village Councils and Regional Democratic Councils, which affects their ability to support the rights of YKAP being upheld, as well as the introduction of programs that may potentially address key issues relevant to YKAP.

**Psycho-Social and Protection Issues**

- Many male and female YKAP were grappling with various psychosocial issues (feelings of abandonment, low self-esteem, trauma, bullying etc.) that were bottled up, and for which professional counselling was generally not available, resulting in feelings of isolation. In a few extreme cases, cutting, overdose and other forms of suicide had been attempted. In-school youth also stated that they wanted to have confidential counselling services available to them.

- Changing socio-economic dynamics (migration, absent mothers, single parents) and poverty have a direct effect on the type of support that young people have available to them in their homes.

- Poverty was generally viewed as a significant driver of adolescent vulnerability.

- There was a comparatively higher reporting of violence in urban schools than in those in the rural and hinterland areas.

- Adolescents with disabilities, and 10-14 year old adolescents who were out-of-school were found to be especially vulnerable and spent a significant period of their day unsupervised. Similarly, youth in contact with the law (including YPLHIV) did not have adequate sexual and reproductive health services and psycho-social support.

- Alcohol and, to a significantly lesser extent, marijuana/cocaine are perceived by key informants as being significant risk factors. However, although some male and female adolescents felt that consumption did place them at risk, others did not recognise the connection to increased risk, “it spruces up the night”.

- Suicide (Regions 1 and 6), teenage pregnancy (Regions 1 and 6) and teenage marriage (Region 6) were pronounced in both urban and rural contexts.

- There was mixed feedback on teachers and parents; some parents were adapting their parenting style to meet the needs of their adolescent children, while some did not speak to their children about reproductive health issues. Parents

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3 UNICEF defines this as children who have "exposure to violence, disaster, loss of, or separation from, family members and friends, deterioration in living conditions, inability to provide for one's self and family, and lack of access to services can all have immediate and long-term consequences for children, families and communities and impair their ability to function and be fulfilled."
were generally identified as needing to have skills to support HIV/AIDS prevention. This is a significant inhibitor to providing a supportive environment for adolescents. This was further exacerbated by the marked lack of formal support networks for youth in all categories, including the 10-14 and 15-19 age groups.

**Sexual and Reproductive Health Issues:**

- Although the sexual debut of adolescents was reported by several key informants as being at a very young age (11 and 12 years old), the study found that among in-school youth there was not a significantly high level of early sexual debut; of those who were sexually active in hinterland areas, the majority of reported sexual activity started at 14 years old for males and 15 years old for females. In rural areas, early sexual debut began at 15 years old for both sexes, and in urban areas there were some reports of early debut around 12 and 13 years old. Among FSWs, MSMs and youth in contact with the law these varied and responses were inconsistent, but these groups tended to be sexually active from a young age.
- Although there was sexual activity reported among the 10-14 age range, this tended to be more among males than female adolescents, and in the categories of youth in contact with the law, hinterland males and out-of-school (school aged youth).
- In a few cases, both male and female adolescents reported forced sex. Among Amerindian girls there was a notably higher reporting of rape and sexual abuse (from as young as 8 years old) than among other female cohorts in the same age range of different ethnicities. This was reinforced by interviews with several key informants including the police, School Welfare Officers and the Regional Chairman, who had concerns about the rate of abuse.
- FSWs and MSMs tended to have higher levels of awareness of HIV/AIDS than other cohorts. However, there are still knowledge gaps in terms of awareness and understanding on HIV/AIDS, and awareness efforts are still needed among various YKAP populations including youth in contact with the law and in-school youth.
- HIV/AIDS education was generally reported (teachers and students) to be taught in schools starting from Grade 6, and schools are a central source of information especially in the hinterland and to a lesser extent rural areas, where access to television, internet and cell phones is more limited than in urban contexts.
- HFLE and other programs that teach life skills and provide practical examples for youth are essential. However, their impact and effectiveness need to be determined, as no evaluation has been done of the program.
- There are still no extensive facilities or services available for adolescents (both male and female) who have been abused. In the hinterland areas, although there was a VCT present, it was used primarily for pregnant mothers.
- It was common among young girls and boys who had become sexually active to try to induce the same type of behaviour in their immediate circle, and peer pressure was widely cited as a general factor.

**Perceptions of the availability, accessibility, and quality of reproductive and sexual health and HIV-related services**

- Guyana’s focus on youth specific services is well founded, and it is suggested that these need to be expanded to widen both the scope of the populations served and the range of services, as well as
providing targeted services for specifically vulnerable youth populations.

- The quantity and variety of services (including through communications media) that are available to adolescents were much higher in urban areas than in hinterland and rural areas.

- Key groups such as out-of-school youth, FSWs, MSMs and youth in contact with law, have special service needs and barriers that make the accessing of services difficult. These include their remote location, stigma and discrimination (especially in rural areas), and in the case of out-of-school youth, their limited engagement with key services.

- Several key services provided by key agencies such as GGMC (Region 1) and various NGOs have been discontinued because of a lack of funding. Several initiatives for youth, Youth Friendly Health Services (YFS) and Community Care Points (MHSSS) were found to be critical, but HFLE is being stopped in school at a critical age (Grade 9) when youth are becoming sexually active, experimenting with alcohol or are under pressure to have sex.

- There are several key points of vulnerability in an adolescent's life, and one of the less obvious ones seems to be in the period just before they exit school and immediately after, as they adjust to a world without the social reinforcement for positive behaviour of a school environment.

- Adolescents were more likely to use NGO-run facilities and services than MoH facilities; this is because of the perceived poor quality of condoms and the heightened need for privacy and confidentiality.

- The use of condoms is not high among key YKAP groups (especially MSM and youth in contact with the law), the overwhelming majority of male youth in contact with the law (15-19 age range) respondents have had sex, but approximately only one third have ever used a condom. Attitudes among YPLHIV, and among youth in contact with the law, ranged from denial and fear to anger; and in one instances a desire to re-infect by not disclosing their status.

- Across all geographic locations there was a perception that condoms have a high failure rate, especially those condoms that are sourced from NGOs and hospitals, which meant that adolescents felt that they had to buy condoms, but they did not always have the finances to do so. In hinterland areas, there was a perceived lack of anonymous access to free condoms, and the relatively high price of "good" condoms in the shops (rough-rider: $500) was at times prohibitive.

- In rural areas, among sexually active 15-19 year old girls and boys, there was a significant reporting of unprotected sex. Even among older 19-24 year old educated females whose sexual partners were not monogamous, unprotected sex and unwanted pregnancies were also reported, especially in Region 1 and 6 (hinterland and urban). It was found that even though adolescents were aware of the risk and of means of protection, it did not always lead to behavioural change.

- Testing was generally found to be very low (except among YKAP and FSWs), especially among youth where services are largely unavailable (hinterland, rural). Among sexually active males there is a perception that condoms are the most vital form of protection and that testing was secondary. As such, they were less likely to be tested unless they were targeted in school campaigns, or the annual National Week of Testing, which was generally ad hoc.

- Sports and increased recreational facilities were some of the most requested facilities among youth, to
provide alternatives to risky behaviour and to promote awareness.

Stigma and Discrimination

- The School Health, Nutrition and HIV&AIDS policy makes no mention or provision for YKAP, and this may serve to both marginalize among others, LGBT and adolescents with disabilities, and impact their ability to enjoy their right to an education in a safe environment, that is not characterized by discrimination, and in which services such as counselling are available.

- Several key Duty Bearers (including teachers, schools, parents, Village Councils etc.) were found to lack the personal capabilities and organizational capacities to effectively support HIV/AIDS prevention among YKAP.

- Homophobia is strongest in urban and rural areas and the quality of life of adolescent YKAP is often affected.

- There was significant reporting of discrimination against female FSWs and male MSMs.
II. Acknowledgement

This report builds on a considerable body of experience, effort, research and commitment that has been invested in HIV/AIDS prevention in Guyana since the first case was documented in 1987. At the forefront of these efforts have been various government ministries, civil society organizations, parents, teachers and volunteers who have often gone unrecognized in their tireless efforts to reduce risk and vulnerability of Guyana’s youth. Several of these persons participated in the study, contributing their invaluable expertise and time.

The knowledge that this report has generated was largely made possible by the participation of adolescents themselves. More than 300 young persons from all walks of life across Guyana, who travelled to venues, and took the time to share their views, perspectives, dreams and sorrows with a small team of researchers. Many of them did so with an understanding that what they shared was valued, and their contribution would help to improve the situation of young people throughout Guyana.

In an effort to improve the responsiveness to HIV/AIDS in Guyana, the Ministry of Education with funding from UNICEF’s Youth and Adolescent Development Programme commissioned this study and were steadfast in their support to the research team.
### III. Abbreviations & Acronyms

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ARV</td>
<td>Anti Retro Viral</td>
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<td>CARICOM</td>
<td>Caribbean Community</td>
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<td>CBO</td>
<td>Community Based Organization</td>
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<td>CDO</td>
<td>Community Development Officer</td>
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<td>CRSF</td>
<td>Caribbean Regional Strategic Framework</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>CSO</td>
<td>Civil Society Organization</td>
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<td>FSW</td>
<td>Female Sex Worker</td>
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<td>EVAs</td>
<td>Especially Vulnerable Adolescents</td>
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<td>GRPA</td>
<td>Guyana Responsible Parenthood Association</td>
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<td>HFLE</td>
<td>Health and Family Life Education</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>LGBT</td>
<td>Lesbian Gay Bisexual Transgender</td>
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<tr>
<td>YKAP</td>
<td>Most At Risk Adolescent</td>
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<td>MARPs</td>
<td>Most At Risk Populations</td>
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<tr>
<td>MCYS</td>
<td>Ministry of Culture Youth and Sport</td>
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<td>MHSSS</td>
<td>Ministry of Human Services and Social Security</td>
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<td>MoAA</td>
<td>Ministry of Amerindian Affairs</td>
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<td>MoE</td>
<td>Ministry of Education</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
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<td>NCHA</td>
<td>National Commission on HIV and AIDS</td>
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<td>NAPS</td>
<td>National AIDS Program Secretariat</td>
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<td>NDS</td>
<td>National Development Strategy</td>
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<td>NOC</td>
<td>New Opportunity Corps</td>
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<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<td>PANCAP</td>
<td>Pan Caribbean Partnership against HIV/AIDS</td>
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<tr>
<td>PEPFAR</td>
<td>The United States President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PEHRB</td>
<td>People Engaged in High Risk Behaviours</td>
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<td>PLHIV</td>
<td>People Living with HIV/AIDS</td>
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<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategy Paper</td>
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<td>PMTCT</td>
<td>Prevention of mother-to-child HIV transmission</td>
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<tr>
<td>PTA</td>
<td>Parent Teacher Association</td>
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<tr>
<td>REDO</td>
<td>Regional Education Officer</td>
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<td>STD</td>
<td>Sexually Transmitted Diseases</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>SWO</td>
<td>School Welfare Officer</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>USAID</td>
<td>United States Agency for International Development</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>YKAP</td>
<td>Young Key Affected Persons</td>
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<td>YPLHIV</td>
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SECTION I
1. Introduction

Adolescents in Guyana are a key, and significant demographic; more than fifty percent of the total population is less than the age of twenty-four (Census 2002). Adolescents are a crucial catalyst for socio-economic development, and as such their well-being is inextricably linked to the development prospects of the country. These realities put into immediate perspective the potential impact of the world’s leading cause of adolescent mortality. As a Government of Guyana publication has highlighted, “as in other countries, HIV/AIDS affects the most productive age groups (20-49) in the society. This makes Guyana very vulnerable to the devastating impact of HIV/AIDS. HIV/AIDS is already the leading cause of death among these age groups in Guyana.4”

This qualitative research study on Young Key Affected Populations (YKAP), and their vulnerability to HIV/AIDS was commissioned by the Ministry of Education (MoE), with funding from the United Nations Children’s Fund (UNICEF). The aim of the research was to “gather and analyse qualitative data regarding the factors that contribute to the vulnerability of adolescents and young people to HIV”. The research was dual purposed in that it sought firstly to generate information and secondly, to create an action oriented framework to allow for identified gaps and challenges to be addressed by Duty Bearers in Guyana.

To that end, the study sought to generate information to determine the level of awareness and attitudes among 10-14 year old adolescents in urban, rural and hinterland areas, to gather additional data on 15-19 and 20-24 year old male and female adolescents, as well as MSMs, YPLHIV and FSWs in order to enable effective planning to

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deliver a comprehensive, culturally appropriate targeted programmes for HIV prevention and other health related activities for youth in Guyana.

The study spanned four geographical regions (Region 1, Barima-Waini, Region 2 Pomeroon-Supenaam, Region 4, Demerara-Mahaica and Region 6 East Berbice-Corentyne) representing three settlement types – rural, urban and hinterland.

1.1 Research Objectives

The objectives of the study were to:

- Gather and analyze qualitative data regarding the factors that contribute to the vulnerability of the most at risk and especially vulnerable adolescents and young people.
- To generate information from specific target groups on HIV: males and females aged 10-24 among the population of men who have sex with men, male and female sex workers, adolescents and young boys and girls who are out of school and unattached, boys and girls residing in children’s homes and places of safety, as well as those who are living with HIV.
- Determine the level of awareness and attitudes among 10-14 year old adolescents in Regions 2, 6, and 8 and gather additional data on 15-19 year old male and female adolescents in order to enable effective planning to deliver comprehensive, culturally appropriate target programmes for HIV prevention and other health related activities for hinterland youth of regions 1, 2, 7, 8, and 9.

1.2 Report Structure

This report is divided into six (6) sections of which this introductory section containing background information on the project, research objectives and methodology is the first. The second section outlines the legal and policy framework in Guyana.

Section three provides an outline of the three settlement typologies used in the research (rural, hinterland, urban) and integrates information obtained from secondary and primary sources, most notably the key informant interviews.

Section four presents the empirical research findings in five areas exploring knowledge and
awareness, sexual practices, the use of condoms and testing, alcohol and psychoactive substances, self and the wider world. It also includes four case studies that further explore key issues.

Section five is an analysis section which reviews the findings outlined in the previous sections, and incorporates a framework to explore key areas and make recommendations. These include comprehensive information and life skills, services, a safe and supportive environment and opportunities for participation. Section six outlines a YKAP Action Plan for Guyana, developed largely out of the findings of the study, including inputs from key policies and development plans.

1.3 Human Subject Protection
The Ministry of Health’s Institutional Review Board (IRB), in keeping with the guidelines of the Government of Guyana, approved the YKAP research project.

In instances where minors formed part of the focus group Parental Consent Forms, outlining the objectives and purpose of the study, were presented to parents for approval. Care was given to ensure that the rights of all informants to anonymity and confidentiality is respected and upheld. Key research ethics will be involved in how the data is handled, attributed and shared.

All of the persons who participated in the study were familiarized with the purpose and objectives of the study. The identity of all adolescent research participants has been withheld and throughout the report pseudonyms are used.

1.4 Limitations of the Study
- As with all rapid assessments there are limitations to the scope and depth of the research.
- The research team had great difficulty in recruiting adolescent MSMs, especially in rural and hinterland areas. We were told by one older MSM in Region 2 (Essequibo Coast) that there is significant discrimination and intimidation of MSMs and as such many of them had relocated to the coast. In Region 1 the research was conducted in January and we were told that the majority of the FSWs were not available as they had not returned from their

HIV Prevalence in Guyana

UNAIDS estimates that Guyana has an adult prevalence of 2.4% (range:1.0%–4.9%). Between 1987 and the end of 2006, a cumulative total of 7,831 AIDS cases have been officially reported to the Ministry of Health.

In 1987, there were 1.3 cases/100,000 population, but this increased to 56.2 cases per 100,000 population by 2003. Cases have been reported in all ten geographical regions of the country. The majority of the cases are among persons 20-44 age group. AIDS is currently the leading cause of death among the 20-49 age group. Overall, about 28% of the cases are female, but in the age group under 24, females account for the majority of cases. The overwhelming evidence is that the transmission of HIV is primarily through heterosexual exposure.

Source: Government of Guyana

www.hiv.gov.gy
holidays. The time did not permit travel to the ‘backdam’ area. In the urban centres the MSMs and FSWs that were sourced through NGOs tended to be older and outside the age range of the YKAP study.

- In Region 6 the Regional Education Office did not permit the research team to enter schools and conduct interviews because the research was conducted during a period of exams. Some in-school youth were accessed through gatekeepers, mainly local NGOs with their parents’ permission.
- Key interviews with various Ministry of Health personnel were not conducted, since permission from the Ministry of Health had not been obtained at the time of writing.

### 1.5 Methodology

The study was commissioned as a qualitative study (See TOR). Qualitative research is essentially social research (the collection, analysis and interpretation of data by observing human behaviour) and is differentiated from quantitative research because of its reliance on text and the analysis of data in its textual form. It “aims to understand the meaning of human action (Schwandt, 2001), and asks open questions about phenomena as they occur in context rather than setting out to test predetermined hypotheses” (Cochrane Qualitative Research Methods Group, 2006; Pound et al., 2005).

Qualitative methods have been successfully used in health research although there is a recognition that the demand for more evidence-based research and the use of standardized assessment criteria (Little, 2007). However, although subjective, qualitative research is also appreciated as a good complement to quantitative research in providing greater depth and understanding of social phenomenon.

The approach allowed the study to address two key elements of the research requirements: the need to understand local realities and perceptions of adolescents across Guyana, as well as, UNICEF’s practical need to design and implement programs that are responsive to the needs of at-risk youth in the country. The approach allowed for adolescents to be studied in their “natural environment” and allowed for the documenting of their behaviour, perceptions and sexual health related choices.

The study aimed to capture how adolescents interact and engage with the wider world where

### Key Terms

**Adolescence**

Adolescence is defined as “a period characterized by rapid physical, cognitive and social changes, including sexual and reproductive maturation, gradually building up capacity to assume adult behaviors and roles, which involves new responsibilities requiring new knowledge and skills.” For the purpose of this study, adolescent age range spanned 10-24.

**YKAP**

Young Key Affected Populations (YKAP) refer to 10-24 year olds who are most likely to be exposed to HIV or transmit it and whose lives are significantly affected by HIV. YKAP includes young people who inject drugs, young males who have unprotected anal sex with other males, young females, males and transgender people who are engaged in sex work and young people living with HIV.

**Vulnerability**

According to a UNAIDS definition, vulnerability results from a range of factors that reduce the ability of individuals and communities to avoid HIV infection. These may include: (i) personal factors such as the lack of knowledge and skills required to protect oneself and others; (ii) factors pertaining to the quality and coverage of services, such as inaccessibility of services due to distance, cost and other factors (iii) societal factors such as social and cultural norms, practices, beliefs and laws that stigmatize and disempower certain populations, and act as barriers to essential HIV prevention messages. These factors, alone or in combination, may create or exacerbate individual vulnerability and, as a result, collective vulnerability to HIV.
their sexuality is concerned and as it relates to HIV risk behaviours. The study will not limit youth responses to health-related aspects of their lives but will seek to obtain perspectives on several aspects – psychosocial, spiritual, legal and human rights and livelihoods (economic). The research used a variety of participatory tools including focus groups, mapping participant observation and semi-structured interviews.

1.6 Research Methods

1.6.1 Focus Groups
Focus groups were one of the main sources of knowledge generation within the project; 6-10 persons were invited to participate in focus group sessions mainly organized through schools and community leaders, "gate keepers". Focus groups can be defined as “facilitated group discussions using scripted questions that are generally populated by a homogenous audience of interest to the researcher” (Holsman 2002: 4). The method is useful for soliciting views and perspectives from a particular group and on a particular topic. The FG used open-ended questions and stratified respondents by category and sex.

1.6.2 Participant Observation
Participant observation was also used to observe local situations and interactions. These included observing youth centres, sports activities, entertainment areas etc. Observation was used to gain a more in-depth and closer familiarity with the situation of adolescents not only from the perspective of what they ‘say’ but also what they ‘do’.

1.6.3 Case Studies
Case studies were used to provide insight into two types of cases: “typical” cases and situations as reflected in focus groups and informant interviews, as well as to cases that represent deviance from the norm or minority issues – e.g. cases in which the experience of the adolescent is atypical.

1.6.4 Key Informant Interviews
KIIs were conducted with other non-adolescent stakeholders such as health and educational staff, parents, VCT staff, and private sector businesses in order to gain insight and perspectives of other key actors. This partially supported the validation of findings collected during the focus group and
1.6.5 Coding and Analysis
There are certain predetermined core steps that were observed in the post-research (focus group) phase. These are represented in the schematic below. The responses were taped, transcribed and coded using a computer program, MAXQDA\(^5\).

Diagram developed from Rennekamp and Nall paper (undated) Using Focus Groups in Program Development and Evaluation

1.7 Sampling
Purposive sampling strategies are designed to enhance our understanding of the selected individuals or sub-group. The research team sought to accomplish this by selecting “information rich” cases, that is individuals, groups, organizations, or behaviours that provide the greatest insight into the research question. Sampling strategies were adopted and revised throughout the research process, as more knowledge of the local context and subjects was obtained, in these instances, convenience sampling was also employed. For example, in Region 1 there was a higher reference to teenage pregnancy than in other regions and whilst at the Regional Office, the Chief Nurse facilitated interviews with a group of teenage mothers.

The study, by its nature required multi-stage sampling, as sampling was done at various levels.

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\(^5\) MAXQDA is a professional software for qualitative and mixed methods data analysis and allowed for the analysis of the large number of interview data that the study generated.
Firstly, the administrative regions in which the study was conducted, another parameter is the desire to reflect rural, hinterland and urban scenarios in the research. Purposive sampling was therefore used to identify the regions of focus. The regions selected were based on areas of interest for MoE and UNICEF for example, UNICEF is planning to conduct a study on “child friendly regions” in Region 2 which would make a strong case for gathering data from that region6.

Once the regions were identified, random sampling was used to select the districts/communities in which the research was conducted using Microsoft Excel’s Random Number Generator function. However, purposive sampling was predominantly employed since the study seeks to identify a particular sub-population as outlined in the table below and some communities/areas were recommended for study once information is generated.

A list of key centres and relevant institutions (NGOs, care homes, schools etc.) in each region was drawn up to support the identification of areas/centres/schools. These were then either purposively or randomly selected (communities, schools, VCTs etc.).

1.8 Identifying Focus Group Participants
Participant Driven Recruitment (PDR) was adopted to identify key individuals and groups (church, NGOs etc.) in the community. To some extent, snowball sampling was also used as adolescents provided the contact of and introductions to other participants. The researchers adopted a fluid and flexible process as information was obtained in the field and a clearer understanding of the local context was understood. Some areas/communities were purposively sampled based on the presence of relevant cases as identified by key persons such as school and health personnel, the Regional Chairman, Toshaos, NGOs and other community leaders.

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6 When this study commenced in 2011 it was conducted exclusively by UNICEF, as such in the initial stages UNICEF determined the study regions this was then revisited in late 2012 and MoE took influenced the selection of sites namely including Region 1 and Region 4.
1.9 Literature Review
Assessing Risk among Adolescents

Central to the study is the concept of risk among adolescents. One of the concomitant research challenges is how best to capture and explore risk among adolescents. One of the key areas explored in the literature is the perception of risk by sexually active and inactive adolescents. In the majority of literature surveyed, there is often a close correlation cited between HIV infection and risky behaviour.

The joint report, *Young People and HIV Opportunity in Crisis* (2002: UNAIDS, UNICEF, WHO) states that young people in particular are at especially high risk for contracting HIV. A 2007 study in the African Journal of Reproductive Health highlights some of the challenges of researching risky behaviour, namely that adolescents can identify their vulnerability based on their inaccurate perceptions of risk. It therefore becomes important to identify "between actual behavioural risk and perceptions of risk among adolescents".7

This is significant distinction, which speaks to the need to both determine adolescent perceptions about risk and compare those to what is known about HIV behavioural risk.

The study, "Perceptions of risk to HIV Infection among Adolescents in Uganda" also identified a broad range of factors that play a role in behaviour change which considered both "personal and environmental factors".8 Personal factors included variables such as "age, education, wealth, personal experiences, gender, personal beliefs/attitudes and self-efficacy,"9 and environmental factors included social norms and practices, institutional/national factors and infrastructure to support desired behaviour as well as information and influence from peers and the media.

1.9.1 Guyana HIV Prevalence10

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7 Ibid
8 Ibid
9 Ibid
Research on HIV among adolescents in Guyana can be firmly situated by key data and empirical research on the global context. The international data on adolescent HIV infection places the rate at 11.8 million young people living with HIV globally\(^\text{ii}\). Another key qualifier of this statistic is that globally, young people who represent one quarter of all persons infected by HIV are among the 15-24 year old age range. The majority of infected youth are women (7.3 million)\(^\text{iii}\). Approximately 5-6,000 young persons are infected every day in the developing world\(^\text{11}\). The situation is exacerbated by several key characteristics, which are key to the current study, namely that – youth are risk-takers, lack awareness and women are disproportionately affected\(^\text{12}\).

Guyana’s HIV situation is categorized as a generalized epidemic. In 2004, UNAIDS estimated that the prevalence of HIV infection among adults in Guyana was 2.5% (range 0.8 – 7.7%). In 2010, UNAIDS released a major report on HIV prevalence in Guyana, in which it was reported that HIV rates were stabilizing but still quite high. However, Guyana had one of the highest prevalence rates of HIV infection in Latin America and the Caribbean.

There are also signs of changing trends, for example the 2006 National AIDS Strategy stated that:

_The data demonstrate that while the early epidemic affected more men than women, there is an increasing feminization of the epidemic and more women are recorded with HIV today than men, especially in the age groups of 15 and 24. More than 90% of the recorded cases occur among the age groups of 15-49 (2006: 18)._

However there was preliminary evidence that by 2009 there were changes in this trend. UNAIDS reported that Guyana was the only country in the region with a one to one ratio of men to women living with HIV (2009) which suggested the importance of effectively targeting both sexes. According to the DHS, “a larger proportion of men 15-49 (10 percent) than women (1 percent) reported having had more than one sexual partner in the 12 months preceding the survey.

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\(^\text{11}\) Source: World Bank: www.worldbank.org

\(^\text{12}\) Ibid
Additionally, a higher percentage of men (30 percent) than women (17 percent) reported having had sex with a person who was neither their spouse nor their cohabiting partner (higher-risk sex) in the year before the survey.” (DHS 2009: 218)

Other studies focused on the sexual health of men (Fields and Stephney, 2006) in Guyana have highlighted the importance of balancing the gendering of services since “Sexual Reproductive Services …are mainly geared towards addressing female issues.” Fields and Stephney make the case for targeting males from a young age since they are a high-risk group and normally have multiple partners.

The DHS (2009) found that knowledge of AIDS is “almost universal” and places it at 97% and another study (2007) places awareness among young people at 95.6%.13 Two hinterland regions recorded the lowest level of knowledge among women (Region 9 – 78%) and among men (Region 7 and 9 – 92% each). The study found a positive correlation between awareness, education and wealth among respondents. The study also found that knowledge and awareness was higher in urban areas than in hinterland and rural areas. The 2008/2009 BBSS highlighted a geographical trend in HIV cases in Guyana; there is a high incidence among urban centres13 - Region 4 (144.8 per 10,000 population) has the highest rate followed by Region 10 (86.6 per 10,000).

As reflected in Guyana’s National AIDS Strategic Plan, significant investments have been made since Guyana’s first reported case (1987) to the present day. This includes policy provisions, infrastructure (VCTs etc.), increases in public health funding, NGO facilities and personnel. There has also been a significant role played in HIV eradication efforts by civil society organizations such as GHARP, Merundoi and Artistes in Direct Support. As a USAID report stated, the number of VCT facilities doubled between 2005-2009, an indication that the Government of Guyana has “prioritized reducing transmission of HIV among adolescents, using peer education strategies to target both in-school and out-of-school youth.”

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13 Research was conducted in two urban regions as opposed to one rural and one hinterland region in the other contexts. This allowed for a greater understanding of the urban context.
There has also been some quantitative research done on HIV generally, and to a lesser extent on youth specifically. However, what is generally lacking in the research are the voices and perspectives of youth and of hinterland-specific data and information.

1.9.2 Key Studies on Adolescents and HIV in Guyana

The situation in Guyana reflects the international trend, that young people are especially vulnerable to HIV infection. A GHARP Report (2010) stated that this is "because they may have shorter relationships with more partners or engage in other risky behaviours." As stated in Guyana’s National AIDS Strategic Plan 2006-2011, young people are "disproportionately affected and there is an increasing feminization of the epidemic". More women than men between the 15-24 age range have HIV and this is a critical age bracket.

The following table provides a summary of key studies:

<table>
<thead>
<tr>
<th>Year</th>
<th>Author</th>
<th>Title</th>
<th>Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/4</td>
<td>Ministry of Health</td>
<td>Round 1 BSS+ Among In school youth</td>
<td>1-7, 9, 10</td>
</tr>
<tr>
<td>2003/4</td>
<td>Ministry of Health</td>
<td>Round 1 BSS+ Among Out-of-school youth</td>
<td>3, 4, 6, 10</td>
</tr>
<tr>
<td>2005</td>
<td>Guyana Ministry of Health</td>
<td>AIDS Indicator Survey</td>
<td>1-10</td>
</tr>
<tr>
<td>2005</td>
<td>GHARP</td>
<td>Qualitative Assessment of Barriers and Motivational Factors towards HIV Risk Reduction Practices among MARPS - Youth, FCSWs and their Clients in Guyana</td>
<td>4, 6, 8, 10</td>
</tr>
<tr>
<td>2006</td>
<td>Derek Fields and Orin Stephney</td>
<td>Male Participation in Sexual and Reproductive Health</td>
<td>3, 4, 6, 10</td>
</tr>
<tr>
<td>2007</td>
<td>Brian O'Toole et al</td>
<td>Knowledge and attitudes of young people in Guyana to HIV/AIDS</td>
<td>7 regions</td>
</tr>
<tr>
<td>2007</td>
<td>UNICEF</td>
<td>PRSP Consultation Among Most-At-Risk Youth in the Ten Administrative Regions of Guyana</td>
<td>1-10</td>
</tr>
<tr>
<td>2010</td>
<td>Molly Jenkins/GHARP II</td>
<td>Qualitative Assessment of MSM in Guyana Overview and Preliminary Findings</td>
<td>3, 4, 6</td>
</tr>
</tbody>
</table>

14 This report was prepared by Molly Jenkins a PhD student from the University of Washington. The report is titled, “Qualitative Assessment of MSM in Guyana, Overview and Preliminary Findings”.

15 The strategy states that 90% of HIV infected persons are in the age range of 15-49.
More than 4,000 young people were surveyed in 2007 (Brian O’Toole et al), to determine their HIV Knowledge and Attitudes in 7 of 10 regions. The study found that “one-third of the respondents reported having had sexual intercourse, but this figure was highest for males aged 15-20 years (48%) and lowest for females aged 12-14 years (15%).”

The study found sexual activity to be high among young people (24% of those aged 12-14) and higher among those aged 15 and over. In total 2 in 5 sexually active young people were using condoms. The report stated that the findings suggest, “that a sizeable number of young people appear to be engaging in risky behaviour, especially as most declared they were aware of the availability of condoms in their area, and only a minority considered that it lessened sexual pleasure.” These findings are consistent with those of an earlier study; MARPS (2005) study, which found that in-school and out-of-school youth had knowledge of STIs and knew where to access information but didn’t always use condoms.

1.9.3 Guyana’s At Risk Groups
Generally, research and reports on Guyana identify several at risk sub-populations including commercial sex workers and men who have sex with men (MSM).

The GHARP II study, "Qualitative Assessment of MSM in Guyana, Overview and Preliminary Findings", focused on MSMs in regions 3, 4 and 6 engaging 62 MSMs. The study found that MSMs are “highly diverse in terms of their profiles, behaviour, experiences, and attitudes,” however the study did not limit its participants to youth but covered a broad age range 16-61. Most of the men were receptive sex partners, they cited issues of stigma as well as issues within the care system (accusations of VCT counsellors publicly outing persons as being HIV+). The study also highlighted high alcohol and to a lesser extent drug use among MSMs. Interestingly, for this study, the researcher recommended that it was important to clarify among MSMs that the term ‘MSM,’ “is used to describe a behaviour, rather than an identity, and that any male is considered a MSM if they have sex with men—regardless of whether they are “straight,” “gay,” “bisexual,” or are married.” This is significant because it is possible that a very
important at risk group may be under-represented and not targeted effectively.

The MARPs study covered both MSMs and FSWs and found that there was generally awareness coupled with some confusion on HIV/AIDS “the main STI” and how to “deal with STIs”. (2005: 184) HIV was reported to be contracted, “if an infected man discharges semen in you” and “if an infected man with a rotten tooth kisses you”. (2005: 187). Condom use among FSWs appeared to be high based on the findings of the MARPs study.

The desk review found that women were considered to be a key and at-risk demographic because of the increase in infection rates reported both in Guyana and the Caribbean. As stated in the National AIDS Strategy:

*The data demonstrate that while the early epidemic affected more men than women, there is an increasing feminization of the epidemic and more women are recorded with HIV today than men, especially in the age groups of 15 and 24. More than 90% of the recorded cases occur among the age groups of 15-49 (2006: 18).*

Central to an understanding of vulnerability of adolescents and risks is the context in which they live and their interactions with key actors (peers, parents etc.), which clearly have a direct impact on how they feel and the choices that they make. As such, it is not just places or “hot spots” that put them at risk, but the persons that they interact with in the outside world.
SECTION II
2. Policy and Legal Framework

2.1 Introduction
The adequacy, responsiveness and relevance of Guyana’s policy, and legal provisions for affected youth populations and at-risk adolescents, is central to determining the extent to which there is an enabling institutional framework, and legal environment to govern HIV/AIDS related matters among vulnerable adolescents. By extension, it is also central to ensuring that the rights of both children and adolescents are protected and upheld under the law. It is therefore important that Guyana’s institutional framework is aligned with international and regional laws, and the provisions in conventions that Guyana is a signatory to, or member of, such as the Convention on the Rights of the Child.

The objective of this section of the report is to determine what the current framework is, the extent to which it comprehensively addresses key issues related to youth, male and female YKAP, and to identify gaps. The analysis in this section integrates relevant key studies that assess the local context. In general, there is a paucity of legal research and analysis that has been done on the legal environment for Most at Risk Persons (MARPs) or Young Key Affected Populations (YKAP) in Guyana.

The YKAP study used a broad definition of who were ‘most at risk’ adolescents and included generally accepted at-risk populations (MSMs, FSWs, drug users) with other groups such as youth in contact with the law, out-of-school youth etc.. As such, this section generally examines what the provisions are for youth and where possible, identifies key national policies, laws and institutions that are relevant to at risk adolescents.

The documents reviewed in this analysis include:

- National Development Strategy 2001-2010

The PRSP (2011-2015)  
**Guyana National HIV Prevention Principles, Standards and Guidelines**  
National Health Strategy 2008-2012  
National HIV Workplace Policy  
National Education Policy\(^17\)

One challenge was that several of the key policies are in draft including:

- National Youth Policy  
- National Sports Policy\(^18\)  
- National Health Vision 20/20

And therefore an analysis of the law becomes especially important. In 2004, the National Aids Committee commissioned a comprehensive review of Guyana’s legal framework, which formed the basis of the legal analysis, along with more current reports and findings.

Key findings:

- Based on the desk review, and key informant interviews, it was found that the institutional framework for HIV and vulnerable adolescents in Guyana has been strengthened by major resource investments\(^19\) (by both Government and donors), as well as the introduction of key legal acts, policies across various ministries, and targeted agencies (NAPS, Adolescent Health Unit etc.) but there are still several key gaps.
- There is no specific policy, or strategy for YKAP, and no national consensus on who Guyana’s YKAP are, or specific guidelines for each individual category of YKAP, especially those under the age of 18, which would help to ensure that deficiencies in policy and programmes are addressed.
- Civil society organizations are widely recognized as having played an important role in providing services to vulnerable populations, including YKAP, and this is increasingly reflected in national policies and programs that stress partnerships and coordination with NGOs. There are several national NGOs that

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\(^17\) Current policies are highlighted in bold.  
\(^18\) A copy of the draft Sports Policy was obtained through the UNICEF office and reviewed.  
\(^19\) Though there was indication from both government and civil society quarters that these investments were steadily declining.
advocate for the rights of key YKAP groups including MSM.

- The Ministry of Health serves as the focal ministry for HIV/AIDS and adopts a very practical approach to the implementation of policy, including provisions for MARPs, the policies do not make an inter-category distinction, for example differentiating between adolescent FSWs, MSMs etc. whose needs and attributes are quite specific within the MARP category.

- The Public Health Ordinance (1834), which guides HIV/AIDS related health issues, has been described in a 2004 report as, “wholly incapable of addressing the public health issues raised by HIV/AIDS”.

- Key acts such as the Sexual Offences Act are not fully implemented, and punitive laws that negatively impact at-risk populations such as MSMs and FSWs reinforce stigma and discrimination, and can potentially negatively affect access to services. A national assessment (2004) found several legal and constitutional gaps, which are directly relevant to YKAP, including the criminalization of same-sex partnerships, confidentiality and privacy laws etc.

- The empirical research revealed that there is a sense at the local level that the impartiality and effectiveness with which sexual offenders were handled by the justice system left considerable room for improvement, as well as the need to monitor the outcome of cases. It was highlighted that systematic weakness resulted in many perpetrators of rape and sexual abuse going unpunished despite a perceived rise in of the incidence of these, including cases of “step-daddy rape”.

- Key policies that have been developed to address discrimination, such as the National HIV Workplace Policy and the School Health, Nutrition and HIV&AIDS Policy, do not place any legal obligation on institutions and are largely voluntary. Other key policies such as the National Youth Policy and the National Sports Policy have either not been drafted or not been implemented. Policies such as the workplace policy, do not refer to adolescents specifically, nor do the policies generally reflect the participation of adolescents/YKAP in their development.

- There are several key provisions in the Ministry of Education’s school health policy that were found to not have been widely implemented,
such as the promotion of psycho-social support in schools and capacity building for teachers and parents.

- The age of consent in Guyana is 16 years old, and this does, among other things, require the authorization of parents for sexually active YKAP who are under-age to have an HIV/AIDS test, which was generally reported as a prohibitive factor for accessing the service. There is some indication that the Ministry of Health has shown some flexibility with this provision.

- Although MoE and MoH were reported to have contradictory approaches (MoE promoting abstinence, MoH promoting safe sexual activity) this does not reflect the provisions in the MoE’s policy regarding the distribution of condoms, which is to be determined by the school.

- There is a prevalent gap in knowledge of both adolescent Rights Holders (including several key agencies local government authorities, teachers and private sector agencies), as well as Duty Bearers on the legal and policy provisions for adolescents in Guyana. As well as supporting key local government bodies such as Village Councils and Regional Democratic Councils to support the rights of YKAP being upheld as well as the introduction of socio-economic programs that allow for alternative livelihoods.
2.2 National Legislation and Policy

The analysis of legislation and policy seeks to respond to seminal questions, such as the extent to which the HIV adolescent situation is reflected in national development strategies, the extent to which national poverty reduction strategies include plans to address HIV-related vulnerabilities among adolescents and the extent to which this informs and guides the work of implementing ministries.

These vulnerabilities encompass a broad range of sectors including economic (poverty, unemployment), social (health, education, juvenile reform, sexual abuse, gender based violence and even political (participation in youth groups, representative bodies etc.). One objective of this aspect of the research was to explore the extent to which there were policy provisions that were supported by law. As such, this section explores the policies and programmes of several key ministries including health, education and youth.

There are inherent challenges in assessing a legal

Caribbean Regional HIV and AIDS Partnership Framework 2010-2014

This is a five-year strategic framework to support implementation of Caribbean regional and national efforts to combat HIV and AIDS. It is aligned with the Caribbean Regional Strategic Framework 2008 – 2012 (CRSF).

A key objective of the CSRF is to, (1) reduce vulnerability to HIV and (2) establish comprehensive, gender-sensitive and targeted prevention programs for children (9-14) and youth (15-24) and (3) achieve universal access to targeted prevention interventions among MARPs.

There are six (6) strategic goals:

1. An enabling environment that fosters universal access to HIV prevention, treatment, care and support services;

2. An expanded and coordinated multi-sectoral response to the HIV epidemic;

3. Prevention of HIV transmission;

4. Treatment, care and support;

5. Capacity development for HIV/AIDS services; and

6. Monitoring, evaluation and research.

It emphasizes a focus on underserved PEHRB’s and MARPs and at-risk-youth.
framework for Most At Risk Adolescents, namely because several of these behaviours are illegal, specifically, drug use\textsuperscript{20}, prostitution\textsuperscript{21} and homosexuality\textsuperscript{22}. Therefore an analysis of the law becomes especially important.

Guyana’s policy efforts have been widely acknowledged for being reflective of international best practice, rights-based, practical and progressive.

The previous National Development Strategy identified health as a key priority and elaborated a strategy for Guyana’s national HIV/AIDS response based on:

- Implementation of the National HIV/AIDS Prevention Plan

\textsuperscript{20} In Guyana, illicit drug use is penalized by the \textit{Narcotic Drug and Psychotropic Substances (Control) Act}, Chapter 35:11. According to Bulkan (2004), “the Act penalizes certain acts relating to narcotic use. This includes the possession of any “pipe or other utensil” used in connection with the “smoking, inhaling, or sniffing or otherwise using” of opium, cannabis, heroin or cocaine. The legislation contains no provisions whereby needle or syringe exchanges could be facilitated – quite the contrary, possession of such implements is strictly forbidden on pain of severe penalties. Moreover, although the Minister is empowered to make regulations to carry out the purposes of this Act, 108 providing for needle or syringe exchanges would NOT be included among such powers, and to achieve this (if desired), legislative intervention would be required.”

\textsuperscript{21} In Guyana it is illegal to keep a premises “a common bawdy house” for the purpose of prostitution. It is also an offence to “to loiter or importune any person in a public place for the purpose of prostitution.\textsuperscript{115} According to Bulkan, “these offences make it illegal to carry out commercial sex work in a house and on the street – in other words the law seeks to outlaw prostitution indirectly by prohibiting the means or facilities for carrying it out.”

\textsuperscript{22} In 2012, an envoy by Dr Edward Greene to Guyana served as a catalyst for review of Guyana’s laws concerning LGBT. However, it is currently a criminal offence to be gay. “According to the Criminal Law (Offences) Act of Guyana, Section 352: Any male person who, in public or private, commits, or is a party to the commission, or procures or attempts to procure the commission, by any male person, of any act of gross indecency with any other male person shall be guilty of a misdemeanour and liable to imprisonment for two years. Section 353: Everyone who (a) attempts to commit buggery; or (b) assaults any person with intent to commit buggery; or (c) being a male, indecently assaults any other male person, shall be guilty of felony and liable to imprisonment for ten years. Section 354: Everyone who commits buggery ... shall be guilty of felony and liable to imprisonment for life. The law does not specifically define “buggery”, “gross indecency”, or “indecent”. (Bulkan, 2004)

The framework advocates for several key policy changes within the Caribbean:

- Enabling and improving access to effective, non-discriminatory prevention, care, treatment and support services for PEHRBs and MARPs
- Addressing legislative barriers to the provision of effective prevention, care, treatment and support services for at-risk youth
- Expanding existing national policies on counselling and testing to allow for the accreditation of non-medical personnel and the use of non-traditional sites for rapid HIV testing
- Developing, implementing and enforcing policies to reduce attitudes of stigma and discrimination by health care workers, employers and other service providers against PLHIV and PEHRBs
- Engaging religious and community leaders and other prominent opinion shapers as advocates in developing a human rights advocacy framework to reduce stigma and discrimination
- Ensuring that laws regarding sexual abuse and gender-based violence are implemented and enforced
- Advocating for access to effective legislative redress for HIV and AIDS-related stigma, discrimination, and acts of violence
- Supporting policy reform to promote partner notification of Tuberculosis (TB), Sexually transmitted infections (STI), and HIV status as a public health strategy.
In Guyana, the 1834 *Public Health Ordinance* regulates public health. This law, was assessed in the 2004 study and found to be, “wholly incapable of addressing the public health issues raised by HIV/AIDS – preceding as it does the latter’s outbreak by almost half a century”.

There were amendments in 1989 specifically to address AIDS, however the NAC found, “the bulk of its provisions are outdated and inappropriate for addressing the unique characteristics of this disease.” It concludes that, “the *Public Health Ordinance* does not directly address HIV prevention issues such as requiring the provision of information or education, nor does it guarantee access to treatment comprising health services, medication and other medical procedures. Notification is required only of AIDS and not HIV.”

The law currently brands HIV/AIDS as an infectious disease, however, “persons suffering from an infectious disease may be forcibly isolated and detained until they are no longer infectious by order of a Justice of the Peace acting on the certificate of a sole medical practitioner, and the lone safeguard is that the Director of Medical Services is empowered to intervene if the detention exceeds 6 months.”

Several international agencies, including UNAIDS have called on states, as reflected in its International Guideline No. 4, to “review and reform criminal laws and correctional systems to ensure they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups.


awareness of the impact that HIV/AIDS can have on Guyana’s national development and specifically its social, economic growth. There is a clear link made with poverty reduction and health. The strategy outlines 8 priority areas, one of which is health, and which directly references communicable diseases and specifically HIV, tuberculosis and malaria. In addition, within the education priority sector, HIV/AIDS is also identified and strategized for as a priority.

The strategy documents several of the successes over the years with regard to HIV/AIDS reduction:

"HIV cases which had increased from 400 cases in 2001 to peak at 1356 in 2006 began declining and by 2008 only 959 cases were reported. Remarkably, reported AIDS cases decreased from 435 in 2001 to less than 24 in 2008, indicating clearly the benefits of the investment by the Government and its partners in providing care and treatment with Anti-Retroviral (ARV) medicines in the fight against HIV/AIDS.

Prevalence for HIV as measured by ante natal testing done in 1995 and three serial ANC surveys in 2000, 2004 and 2006 indicates steady decline from 5.6% (2000) to 1.5% (2006). HIV remains concentrated in the more populated urbanized Regions (4 and 10) and less prevalent in the hinterland Regions of 1, 7, 8 and 9."

2.2.2 PRSP Priority Sector: Health Reducing Communicable Diseases: HIV, STIs, Tuberculosis and Malaria

The health policy outlined by the government has eight (8) priority areas of focus, of which HIV/AIDS is one. There are also other reinforcing and related areas of reform, including (i) improving quality care, (ii) ensuring access to health services for every citizen (including people with disabilities) and (iii) health systems strengthening. The development of policy and its prescriptions has largely evolved during the several decades of experience in addressing the HIV/AIDS epidemic in Guyana.

The current policy is directed at reducing the spread of HIV and the consequences of morbidity and mortality rates on socio-economic development. The policy states that, “particular

Guyana’s Labor Force

At the time of the last census, two-thirds of the total population was of a working age (15-64 years old) GIn 2002 it was two-thirds of the total population (475,219 persons)

“In Guyana, males enter the labour force from age 15 and their activity rate rises sharply to 86 percent by age 20-24, and after that rises sharply to more than 90 percent until the 45-49 age group. From age 50, we notice a progressive attrition from the labour force because of retirement and death.

Like the males, small proportion of the females enters labour force from age 15 which is the legal age at work entry in Guyana, and then the rate rises and remains high in the main working age groups, and marking the maximum average in 40-44 years (42 percent) before declining.”

Guyana Census 2002
attention will be paid to the needs of vulnerable and most-at-risk populations."

The targets for HIV are "people of all ages", the adult population being aware of their status, pregnant mothers and people living with HIV. It does not specifically reference youth or at-risk populations. In general persons who are less than 16 years old require parental consent to be tested in a VCT.

HIV/AIDS funding in recent years has resulted in testing facilities (VCTs) in each region (at fixed centres), through NGOs and mobile teams. The policy reiterates the focus on pregnant mothers and states that, it provides services to 90% of pregnant women in Guyana. It also focuses on treatment – the provision of free ARVs to PLHIV. It does recognize some shortcomings in monitoring (page 80). It also proposes streamlining approaches through the development of Standard Treatment Guidelines.

The PRSP identifies the development of a new health sector strategy (Vision 20/20). The PRSP focuses on HIV generally and in a much more limited way on youth specifically. Youth are mentioned in relation to the law and then in making the provision of health services "people-focused and user-friendly". The document identifies the expansion of the Youth Friendly Health Centre Initiative in regions 1,7,8 and 9 i.e. Guyana’s hinterland regions.

2.2.3 PRSP Priority Sector: Education

Strengthening school health, nutrition, HIV & AIDS in the curriculum

A core strategy for HIV/AIDS within the education sector is the implementation of the Health and Family Life Education (HFLE) program in schools. Another key area is the establishment of “a mechanism for psycho-social counselling in schools in collaboration with NGOs and CBOs”.

Based on some recent experiences, the Ministry plans to progressively establish a mechanism for psychosocial counselling in schools. Teachers will be trained in this area and the participation of NGOs and Community Based Organizations (CBO) will be encouraged.
2.2.4 National AIDS Strategy 2007-2011

The National AIDS Strategy, which is the policy instrument of the National Commission on HIV and AIDS (NCHA) will shortly be replaced by that National HIV Vision 20/20. Apart from the National Commission on HIV and AIDS, the other key agency is the National AIDS Program Secretariat. At the time of writing there was no information available on the content of the new policy.

The strategy was largely consistent with current international policy principles. It expounded a multi-sectoral, evidence-based and targeted approach. It also endorses the role of non-state actors such as civil society groups and the private sector. It does not present a structure of how these bodies will contribute to the realization of the strategy.

The strategy identifies several key issues that are relevant to the current study:

- Young people are disproportionately affected
- It identifies issues of adequate resources to implement the plan
- Treatment is working and is being accelerated
- Lack of knowledge of one’s status was an issue affecting a broad range of sub-populations (Thus, only 17% of MSM, 28% of FSW, 32% of GUYSUCO employees, 34% of uniform services personnel, 55% of out of school youths and 66% of In-school youths knew of the availability of VCT (BSS 2004).
- Significant numbers of in and out of school youth did not have significant knowledge – (between 14% and 38% of In-school and out-of-school youths who lack a comprehensive knowledge of the methods of prevention for HIV. Males have less knowledge of the prevention methods than female. More than 50% of the rural population, more than 30% of FSW and MSM and 15% of the uniform services lack this knowledge.)

Vulnerable populations identified in the document are:

- Blood donors
- Pregnant women
- STI Patients
- FSW
2.2.5 HIV/AIDS Workplace Policy

The National HIV Workplace policy was developed to combat discrimination in the workplace for PLHIV under the purview of the MHSSS. Key aspects of it include:

- Recognizing HIV/AIDS as a workplace issue;
- Confidentiality and Non-discrimination on the grounds of status;
- Recognition that women are more likely to be infected;
- The introduction of prevention measures such as training and awareness.

The policy does not expressly refer to adolescents (it refers broadly to “all age groups”, employers who may have YKAP in their employ etc. The policy does not require any legal obligation on the part of employers.

This policy is a landmark development since it seeks to address a critical issue for YKAP and YPLHIV, that of discrimination. According to the 2004 assessment, “By far the most common instance of discrimination directed against PLHA exists in relation to employment.” The NAC Assessment also clearly outlines that several of these policy provisions have no legal basis in law.

It states that there is “no law that specifically allows or prohibits HIV screening for employment purposes. However, the combination of constitutional provisions and other legislation impact indirectly on this issue. Article 149A which provides that no person shall be hindered in the enjoyment of his or her right to work, that is to say, the right to free choice of employment, and article 149D which guarantees to all persons equality before the law, and equal protection and benefit of the law. Although untested to date, the combined effect of these Constitutional guarantees would make it supremely difficult for the State to refuse employment to someone on the basis of that person’s HIV status, Therefore, while there is no specific mention of HIV/AIDS, the definition of ‘disabled person’ is wide enough to capture this condition.”
The Workplace Policy also seeks to address, and makes provisions for key issues related to privacy, stigma and confidentiality.

The NAC in their 2004 national assessment explores in great detail these issues and their basis in the law. It noted that the 2003 amendment of the Constitution, “inexplicably repealed article 40 (privacy), replacing it with a bare statement that contains no mention of privacy at all. The result is that in Guyana there is no express right to privacy in the Constitution, and our Bill of Rights cannot be invoked to protect the sanctity of medical information.”

The NAC recommends:

- In addition to the above, public health legislation or general anti-discrimination legislation should be specifically amended to prohibit HIV screening for employment purposes.

### 2.2.6 National HIV Prevention, Principles, Standards and Guidelines

A key document within the national framework is the guidelines developed by the Ministry of Health, which along with the HIV strategy form the backbone for HIV prevention in Guyana.

There are five principles with a standard and a wide range of implementation guidelines to achieve prevention:

1. Multi-sectoral, multi-dimensional and reaches everyone
2. Based on and driven by the promotion, protection and respect of human rights, diversity, gender equality, and addresses the most vulnerable and the drivers of the epidemic
3. Based on science; is targeted, focused, evidence-informed, and developed, delivered and maintained at a high level of excellence
4. Locally-adapted and prioritized according to the epidemiological scenario and socio-cultural contexts
5. Informed by continuous research and innovative technologies
Within the standards there are specific references that are relevant for YKAP:

For example under principle 2:
- Prioritizes and focuses on those most affected by and most vulnerable to HIV
- Reaches those most marginalized and vulnerable to HIV
- Takes into account economic disparities and other inequities

Principle 3:
- Is age-appropriate and relative to level of cognitive development
- Reaches people, based on established risk profiles
- Analyses the individual, couple/relationship, group and societal factors that impede and support healthy relationships

Principle 4:
- Is locally adapted and informed by socio-cultural contexts
- Is user-centered and user-friendly

There are also places in which adolescents are specifically referred to usually within the context of schools:

- Focus on the needs of adolescents and work in close tandem with the Ministry of Education to ensure that the schools play an active role in protecting adolescents against HIV infection
- Design appropriate HIV prevention programs to target disproportionately affected groups including women and youth, that are relevant in their socio-cultural settings
- Provide sexuality and reproductive health education to adolescents and young adults, including HIV awareness
- Design evidence-informed activities for out-of-school youth in high-risk and high prevalence areas
- Provide sexuality and reproductive health education to adolescents and young adults, including HIV
- Address and take gender norms and ‘masculinities’ into consideration that put boys and men at higher risk for HIV infection and of infecting others
- Provide information and education on issues that impede HIV prevention, such as HIV-related stigma and discrimination, sexual violence and abuse, as well as gender insensitivity and inequality, through school and teacher college curriculums

The Guidelines like many other key policy documents, including the National Guidelines for HIV Counselling and Testing, as well as the National HIV/AIDS Workplace policy places a high premium on confidentiality. This is a principle that is of especial importance to youth generally and male and female YKAP in particular. (Guyana Prevention Guidelines, page 23).

For example the Guidelines state it is required to: "Build trust among users of HIV prevention services, by establishing systems to ensure that strict confidentiality is maintained for all persons accessing HIV prevention services and all information is retained securely"

However, in the NAC examination of the legal provisions for confidentiality, it was found instances in which these could be put at risk as AIDS (and not HIV) was made a "notifiable disease". It states that the "the certificate must state the name of the patient as well as the address of the building where s/he lives". The result is potentially that, "in the event of legal challenges it is entirely possible for inconsistent standards to be applied". The NAC report makes several key high-level recommendations including that:

- "Provision should be made for the protection of the confidentiality of medical information. The legislation should be clear as to the types of information to which protection attaches"

- The legislation should clearly specify on whom the duty of confidentiality is imposed, and should include not only health care workers but also all other persons who may come into contact with personal information.

- The legislation should specify remedies for breach of its provisions: be they
disciplinary proceedings, criminal sanctions or both."

2.2.7 Ministry of Health

The Ministry of Health Strategic Plan
The Ministry of Health is the National focal point on HIV/AIDS programming and policy implementation in Guyana. Falling under the MoH is the National AIDS Program Secretariat (NAPS).

Since the 1990s Guyana has developed and implemented policies to address HIV/AIDS. In 1997, the comprehensive policy stated the policy of MoH was to, inter alia, “disseminate information to as wide a cross-section of the population as possible, and particularly those sub-populations at greater risk.” It also makes provision for various aspects including prevention, condom promotion and care. NAPS developed in 2006 policy guidelines for HIV/AIDS in Guyana. There is also a National AIDS Committee (NAC), which includes civil society bodies and youth focused NGOs.

At the time of writing the MoH was in the process of drafting its Health Vision 20/20. As such, the basis of this analysis centers on the Strategic Plan 2008-2012.

There are a number of goals in the MoH strategy that if achieved, will have a direct impact on youth including (i) equity in distribution of health knowledge, opportunities and services (ii) consumer-oriented services: people focused and user friendly, (iii) high quality services (and good value for money).

It prioritizes HIV prevention and specifically key drivers such as, “the programme will target health promotion and risk reduction in six risk factors and determinants of health: tobacco, alcohol, psychoactive substances including cocaine and marijuana, harmful diet, physical inactivity, and unsafe sex.”

More significantly, it sets the target “60% of health centers are youth-friendly by 2012, with at least

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23 According to a UNAIDS publication, Keeping Score III: The Voice of the Caribbean People, of the three requirements of having a National AIDS Strategic Plan, a National Strategic Plan with a Budget and a National M&E Plan, Guyana does not have a Strategic Plan with a Budget but fulfils all other best practices.
two YFS in each region” and in particular, mobile YFSs in the hinterland regions 1, 7, 8 and 9, and a School Health Plan.

A key mechanism for the MoH’s goals was the, “Adolescent and Young Adult Health and Wellness Programme which will improve the health and well-being of adolescents (age 10-19 years) and youth (age 15-24 years) by increasing access to youth-friendly services, and promoting knowledge, skills and healthy behaviours, thereby enabling adolescents and young adults to make healthy choices.”

2.2.8 Ministry of Education Policy

The seminal policy document guiding the activities of Education institutions in Guyana is the School Health, Nutrition and HIV&AIDS Policy. It includes an operational framework, which outlines the roles of various entities as well as the integration of key international and regional policy frameworks including the CRC, MDGs, EDUCAID and FRESH.

The policy is quite comprehensive on a broad range of areas related to youth in government learning institutions.

- It requires education agencies to provide information on HIV/AIDS sensitive to “gender, religious, cultural, socio-economic diversity, age etc.”
- The main instrument is the Health and Family Life Education (HFLE) program, which is the vanguard program for HIV education in school.
- Out-of-classroom learning through school-based youth clubs, festivals etc. and the promotion of peer support programs
- The promotion of psycho-social support for students and employees, in collaboration with NGOs, FBOs etc.
- Ensure no discrimination against PLHIV (including students and teachers)
- It requires that all records, notes and other documents that make reference to an employee or student living with HIV shall be treated as confidential and kept in a secure place.

These requirements are in keeping with the CRC, which states, “to ensure that primary education is available to all children, whether infected, orphaned or otherwise affected by HIV/AIDS.”

It requires and acknowledges the participation of youth and parents in the design and development of policy. For example (page 18) it states that “latex condoms shall be

The Committee on the Rights of the Child, in a General Comment No. 3, has identified certain strategies that State Parties to the Convention on the Rights of the Child are obliged to adopt in relation to children. Some of these strategies and interventions are as follows:

State legislation and strategies should address all forms of discrimination that contribute to increasing the impact of the HIV/AIDS epidemics.

The child should be put at the centre of the response to the pandemic, adapting strategies to children’s rights and needs.

The participation of children as peer educators, both within and outside schools, should be actively promoted.
available at the education institutions free to employees” and leaves for interpretation risk reduction measures “in relation to students” to be, “determined in collaboration with parents, guardians and students of legal age”.

It also makes provisions for parents and community education programmes. Quite importantly, the policy makes provisions for education institutions to, “foster networks or parenting organizations to improve parents’ access to skill building, information and services through after-school programmes or other special initiatives”. The MoE committed to “promote on-going education on SHN/HIV through diverse media strategies targeting parents, guardians and care-givers in the wider community”.

The policy does not make specific reference to at-risk adolescents in schools and does not specifically address the issue of abstinence.

2.2.9 Ministry of Culture Youth and Sport
The Ministry of Culture, Youth and Sport (MCYS) is another key agency in the national response. The ministry has been involved in a number of activities related to youth employment (through vocational training) and the support of Youth Friendly Spaces. MYCS also promoted youth participation in clubs and training and awareness on HIV/AIDS through its facilities.

The Ministry is currently drafting two key policy documents:
- National Youth Policy
- National Sports Policy

A copy of the draft National Sports Policy was obtained from MYCS. The sports policy has as a specific objective: to effectively use sports as a way to engage youth in positive activities and reduce the incidence of HIV/AIDS infection, drug and alcohol, smoking and criminal behaviour.

The policy in its current form does not specifically mention YKAP, nor does it outline in great detail how the objective will be achieved or measured.

The only actions referenced in the document are:
3.4.1 Financing for youth programs that use sport as a tool to achieve social development goals
3.4.2 Sharing of best practices in the use of sport for social development

"While most of the world has been moving towards the decriminalisation of homosexual acts, sodomy and same sex activity remain illegal in Guyana and in ten other countries in the Caribbean.”

Dr. Christopher Carrico, University of the West Indies, Rights Advocacy Project (U-RAP)
2.2.10 Ministry of Human Services

Guyana’s legislative framework has, in recent years reflected a strong response to countering vulnerability among children and youth. There have been several notable introductions of law, which have sought to ensure the safety, wellbeing and protection of children.

- Criminal Law Offences, 2005
- Child Care Protection Agency Act, 2009
- Status of Children Act, 2009
- Adoption of Children Act, 2009
- Protection of Children Act, 2009
- Sexual Offences Act, 2010
- Custody, Contact, Guardianship and Maintenance Act, 2011
- Child Care and Development Services Act, 2011

The Status of Children Act, Adoption Act and Protection of Children Act all advance Guyana towards meetings its obligations to the CRC to ensuring that “legal, economic and social protections for children orphaned and otherwise affected by HIV/AIDS to ensure their access to education, inheritance, shelter, health and social service, as well as to feel secure in disclosing their HIV status.”

The Sexual Offences (Amendment) Act was passed unanimously by the National Assembly on January 3, 2013 but has not been brought into effect as it is awaiting Presidential assent.

2.2.11 Age of Consent

The established Age of Consent in Guyana is sixteen (16) years old, and this was an age established to protect children from sexual and other means of exploitation. However, as in other countries it has created a problem in terms of access to HIV testing and other services for young, sexually active adolescents who are required to get parental consent. Some NGOs such as SASOD have called for the age of consent to be raised to 18 years.

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25 The Convention on the Rights of the Child (CRC) Committee on the Rights of the Child released a general Comment on HIV and the rights of the Child in which it stated that the Committee, “is concerned that health services are generally still insufficiently responsive to the needs of children under 18 years of age, in particular adolescents. As the Committee has

Removal of Punitive Laws in a Must

“Caribbean authorities have the opportunity to reinforce the supportive and protective environment for men who have sex with men, sex workers, drug users, young people and young people living with HIV to protect themselves against stigma and discrimination and adopt protective practices against the transmission of HIV. Leaders in the government and civil society must work together to remove punitive laws.

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Snapshot of Caribbean Legal Framework 2010

56% of countries report no legal protection against HIV-related discrimination
75% of countries report laws and regulations that present obstacles to HIV services for vulnerable population groups
69% of countries criminalize same sex activities among consenting adults
81% criminalize aspects of sex work
19% of countries have HIV-related travel restrictions
19% of countries have HIV-specific laws that criminalize HIV transmission

Source: Keeping Score III: The Voice of the Caribbean UNAIDS
A key issue among human rights and LGBT activists in Guyana has been the criminalization of sexual preferences. NGOs such as SASOD, have objected to the Ministry’s decision to retain s. 351 of the Criminal Law Offences Act Cap. 8:01 as a “violation of the human rights to privacy, equality, non-discrimination and health.”

A University of the West Indies Rights Advocacy Project (U-RAP) headed by Dr Christopher Carrico found, that “while most of the world has been moving towards the decriminalisation of homosexual acts, sodomy and same sex activity remain illegal in Guyana and in ten other countries in the Caribbean, all of which were formerly British colonies”.26

Similarly the NAC report, found that "there is a substantial body of anti-discrimination legislation in Guyana, contained in both the Constitution and in specific statutes that seek to promote equality between the sexes and prevent discrimination" but that do not cover those related to "sexual orientation".

The report also quotes a USAID finding that, “Criminal laws prohibiting specific sexual activity between consenting adults in private, such as adultery, sodomy, fornication or acts ‘against the order of nature’ or social order or morality, can impede the provision of HIV/AIDS prevention and care programmes.”

And notes that, “MSM from the lower social classes are less able to cope with local attitudes to same-sex relationships. This group of MSM has adopted strategies to cope with the lack of acceptance of their lifestyle and to survive socially. Unfortunately some of these strategies may place them at increased physical and psychological health risks. Practices like picking up partners and paying for sex with one night stands, for example, potentially increase MSM risk of infection with STDs including HIV”. (NAC Report, 2004, page 127)

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noted on numerous occasions, children are more likely to use services that are friendly and supportive, provide a wide range of services and information, are geared to their needs, give them the opportunity to participate in decisions affecting their health, are accessible, affordable, confidential and non-judgemental, do not require parental consent and are not discriminatory.
The NAC report recommends:

- The prohibited grounds of discrimination in the Constitution as well as in the *Prevention of Discrimination Act* should be expanded to include HIV status and suspected HIV status.

It also calls for reforms for another vulnerable population – prisoners, and suggest that the Prison Act should also be amended to address communicable diseases such as HIV.

Specifically the NAC calls for four key legal reforms:

- The provision of HIV-related prevention information and education to both inmates and staff
- Access to means of prevention, including condoms, and access to care and treatment
- Facilitating voluntary testing and counselling programmes
- The provision of guidelines regarding confidentiality of medical information and
- The prohibition of segregation and isolation
SECTION III

3. Regional Context

3.1 Introduction

The purpose of this section of the report is to describe the socio-economic context in each representative environment (rural, urban, hinterland), and to elaborate on the factors that influence youth vulnerability or that support and reinforce a supportive environment. Each region has its peculiarities, but the purpose of this section is to identify and extrapolate general trends as determined by their frequency in discussions with key stakeholders. In some instances where there was variance, or characteristics and attributes of one area or group, which were considered to be important or affecting a specific sub-population, these are also captured.

The information found in this section is based on both primary and secondary data sources. It is based on responses drawn from numerous key informant interviews, which included regional officials, civil society organizations (including youth groups), health and education personnel and private sector representatives. The emphasis was to reflect where there was consensus on issues, and general themes that emerged from the dialogue. This has helped both to understand the context as well as community/regional norms and the attitudes and concerns of key persons. One limitation of this approach is that the research team was not able to meet with every organization engaged in activities related to youth.

This information was combined with observations made by the research team, and secondary data that were obtained from national or local sources. The use of multiple sources was done to triangulate the findings of focus group discussions, and in-depth interviews with adolescents who participated in the research. It also serves to provide a rich account of the perception of youth by key persons in their environment. Several of the contextual characteristics, socio-economic and cultural features highlighted here are outlined specifically because of their relevance to the study of youth and HIV/AIDS vulnerability.
The report also includes Regional Profiles developed by Youth Researchers and Regional Focal Points who supported the research of facilities linked to HIV/AIDS and youth. A general approach of the field research was to obtain the view of key persons that interact with youth, to have a deeper appreciation for the context and the institutions and people that youth engage with and that influence youth. It also helped to triangulate information obtained from youth in the focus groups.

3.1.1 Hinterland Context

**Region 1 (Barima-Waini)**

Region 1 was categorized as a hinterland location for the purpose of the study.

The administrative region covers an area of 20,399 kilometers and has a population of 24,275 persons (Census 2002). It has the seventh largest population in the country and is predominantly populated by Amerindians (largest) followed by mixed race, and small populations of Afro-Guyanese and East Indians. It is considered to be a region with a very high rate of poverty (80%) Source: World Bank.

The region has three sub-districts: Moruca, Mabaruma and Matarkai. Region 1 has strong links to Venezuela as persons migrate there and have family links.
The research visited all three sub-districts including Port Kaituma which is a central site for gold exploration activities. Several of the communities are quite central and most facilities tend to be concentrated there – however, the region typically has a number of satellite and remote communities that generally rely on these hubs for a variety of services and supplies.

The main sources of employment in the region centre on mining, logging, copra production, and primary activities such as small scale farming and fishing. Many Amerindians engage in subsistence agriculture and farming is widely practiced and a sizeable number of the indigenous population of Guyana is considered to live in poverty. The region is also the site for companies such as Amazon Caribbean (AMCAR), which purchases heart of palm from riverain communities.

Shell Beach, on the northernmost top of Guyana is a site for conservation activities mainly turtle conservation and management. The community of Hosororo also produces cocoa for sale on the local market and internationally. As a result of these initiatives there are several economic

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27 the World Bank reported that the Guyana poverty assessment found that an estimated 43 percent of the population fall below the poverty line using data from the recent Living Standards Measurement Survey. And that the incident of poverty was highest among Amerindians, some estimates place the number of Amerindians living below the poverty line at approximately 80%.
empowerment activities aimed at women, as well as environmental clubs aimed at youth. These industries employ a small number of persons. As does administrative jobs, mainly in the capital – Mabaruma and in communities in the positions of teachers, community health workers and the village administration.

3.1.2 Hinterland Context  
**Region 2: Pomeroon-Supenaam**

Region 2 was categorized a rural location for the purpose of the study. The vast majority of Guyana’s territory is considered to be rural (Census 2002). The region covers an area of 6,195 kilometres and has a population of approximately 49,253 persons (Census 2002) and is the fifth highest populated region in the country. The region consists of a varied geographic layout, which includes a capital town (Anna Regina), several coastal villages that cover a long stretch between the Supenaam River to the Pomeroon riverain communities.

There are nine (9) communities:
- Mashabo
- Capoey
- Tapakuma/St Denny’s
- Mainstay/Whyaka
- Wakapoa
- Kabakaburi
- Akawini
- Bethany
- St. Monica

The largest ethnic groups are Indo Guyanese, Amerindian, Mixed and Afro-Guyanese. The region is a key hub with transportation points Charity and Supenaam as gateway communities for mining activities. The lucrative returns from mining and other commercial activities have led to an influx of cash and new businesses in the region.

At Charity these include various clubs and restaurants, which are all located within a small radius of each other. The region is also known for its rice plantations, which employ a significant amount of labour, among whom there is a high prevalence of alcohol use. There has also been an increased level of internal migration as families leave riverain communities and the Pomeroon and settle at Charity and other communities along the coast. This has also resulted in new family
dynamics such as an increase in single mothers, step-parents and indigenous families relocating on the coast.

There are 75 schools (Nursery, Primary and Secondary) within the region and there are four dormitories in the region:

- Aurora (64 students)
- Anna Regina (124 students)
- Charity (57 students)
- Wakapoa (57 students)

3.1.3 Urban Context

**Region 4 and 6 (Demerara-Mahaica and Berbice-Corentyne)**

Region 4 (Demerara-Mahaica) and Region 6 (East Berbice-Corentyne) were categorized as urban locations for the purpose of the YKAP study and most of the research was conducted in Georgetown (Region 4) and New Amsterdam, Corriverton (Region 6). Region 4 covers an area of 1,843 kilometres and has a population of 310,320 persons (the largest of all the regions). Region 6 has the second largest population of 123,695 and covers an area of 36,234 kilometres.

Region 6 is the largest geographical region in the country. Region 4 and 6 has the first and second largest populations respectively. In Region 4 the largest sub-population is of Afro-Guyanese, followed closely by Indo-Guyanese. In Region 6 it is the reverse with a comparatively much smaller portion of the population being Afro-Guyanese. The size of the population is significant when understanding the coverage and scope of the HIV/AIDS response and issues of access.

The urban regions were generally characterized as having comparatively higher levels of access to a wide array of services including VCTs, youth groups, recreational facilities, job opportunities and social services. Unlike in rural and hinterland areas the youth populations were much more diverse.

In Region 4 interviews were conducted with several key stakeholders including NGOs (Lifeline Counselling, Help and Shelter, SASOD, GRPA, PANCAP), sports related groups (Guyana Football
3.1.4 Perceptions of Risk and Vulnerability

Throughout the interviews there was a consistent thread of responses in terms of what the perception of what factors put adolescents at risk within the region:

- **Ineffective parenting** and lack of parenting skills, including the ability of parents (mothers and fathers) to effectively communicate with adolescents about issues related to reproductive health, and to provide necessary emotional support.
- **Lack of facilities and services targeted at youth** was also quite frequently cited especially in rural and hinterland areas.
- **Difficult home situations** including alcoholic parents in the home, single parent homes, violence and poverty.
- **Drugs and alcohol consumption** among adolescents and its availability in schools – There was also a clear and explicit link made between alcohol consumption and sex (including unprotected sex) among young people.
- The absence of **recreational facilities** – including specific opportunities for female adolescents, resulted in adolescents not having enough opportunities to socialize in a safe and productive environment. Several key programs were seen as limited in scope/reach or un-sustained.
- The **lack of employment** among adolescents was identified as a contributing factor and in hinterland areas the, (gold) **mining sub-culture** which was characterized by high levels of alcohol consumption, casual sex and sex with FSWs.
- **Use of alcohol** (including bush rum) and drugs. It was reported that alcohol and drugs were being sold and was present in hostels and in school facilities.

28 As noted previously, within Region 2 youth perception of alcohol use was extremely lenient and youth also mentioned that they found that depression and thoughts of suicide usually occurred around their parents fighting.
Peer pressure was also felt to be a contributing factor to risky behaviour among adolescents; in addition, pressure by adults on both female and male youth to engage in sex was also cited especially among social service providers.

3.1.5 Facilities and Services
One of the significant findings of the study was the limited availability of VCT services in hinterland areas. Although it is generally represented in the literature that there are VCT sites in each region, it was found that in Region 1 these services are primarily for pregnant mothers registered at clinics. Some people described the region, as having “no VCT facilities” and this is largely because the testing facilities that do exist are not openly marketed for the general public.

In the region, two Peace Corps volunteers had helped to establish a Youth Friendly Space within the Regional Administration compound. The volunteers were concerned about the sustainability of the space (despite having a Regional Youth Officer involved) and lamented the fact that it was predominantly youth from the nearby Mabaruma area who visited. At the time of the interview, they were trying to mobilize children from the North West Secondary Dorms to use the facility. The volunteers had also organized a mini-Glow Camp for 25 girls over the summer at the PYARG, which also organizes youth camps.

When the research team visited the hospital at Port Kaituma and requested to have a HIV test on a Saturday, we were told to “come back on Wednesday” as that is when the test would be available. It was mentioned in other interviews that this largely centres on the availability of the Medex. At Moruca it was reported by the Probation and Social Services Officer that, “when we take them [persons in their care requiring a test] to the hospital, they sometimes don’t have the test and the Medex told me they reserve it for pregnant mothers”.

One Medex explained that they have a limited number of kits. She said that “I requested kits three times for last year from MCH,” and eventually got some kits from Mabaruma. The Medex’s motivation is therefore to ensure that there are enough testing kits for pregnant mothers.

“When we take them [victims of sexual abuse] to the hospital, they don’t have the test and the Medex told me they reserve it for pregnant mothers”.

Social Service Professional
There are a number of HIV/AIDS related projects that have been implemented in Region 1 but several of them have come to an end including Youth Challenge Guyana. The Guyana Red Cross having the greatest coverage in the region. The Ministry of Amerindian Affairs, the Guyana Geology and Mines Commission (GGMC) have had projects and GGMC up until recently provided testing in mining areas including Five Star, Baramita, 14 Mile and Matthews Ridge. This service was discontinued because of the lack of funding. It was mentioned that the older youth (older than 18 years old) and male, were the ones getting tested.

The Guyana Red Cross concluded a project, “Together We Can” which focused on strengthening HIV-related skills of 10-24 years old, expanding prevention projects and enhancing the community environment for the adoption of safer practices. Many of the services and approaches that were mentioned included free testing, peer-to-peer outreach, the introduction of youth clubs, edutainment, and information and condom dissemination.

Condoms were said to be more difficult to access in far out and remote communities in the region. The cost to buy condoms was considerably higher ($300) than in other regions (starting at $100). But taxi drivers and shop owners mentioned that when they received batches from the Red Cross and other sources they would display and distribute them.

In the rural area there were no Youth Friendly Health facilities and the CARE Point, which was established by MHSSS with funding from UNICEF was placed in a non-secular location (a church) and is not currently in operation.

There are several VCT’s including one at Charity, Anna Regina and Suddie. The main hospital at Suddie has very good facilities and is a hub for the region. One of the key non-governmental organizations in the region is Hope for All, it is well known and highly visible within the region.

The urban areas (Regions 4 and 6) had a greater number of facilities and services than those in rural and hinterland areas. However, these facilities service a significantly larger population. Berbice has a developed medical facility and several VCT sites as well as counselling and support groups for PLHIV. There are several active NGOs including
FACT (Corentyne) and Comforting Hearts and Bricklayers United (New Amsterdam). They also had strong links and greater awareness of programs, funding sources etc. than in other regions. There was also strong awareness, support and programs being generated out of the private sector, for example Banks DIH and the Berbice Chamber of Commerce, to address youth and HIV/AIDS.

Health officials and NGOs in particular had strong linkages and worked together to capitalize on the strengths and resources of the other. HIV/AIDS awareness among this group was high and they were at the forefront in providing a range of services and activities including: health fairs, mobile units, house-to-house testing, health walks, peer-to-peer education, VCT, awareness raising etc..

Condom distribution was also highly profiled and widespread with various campaigns being mentioned; Stand Up for Condoms, "no rubber, no ride", and Keep the Light On.

There were also innovative facilities for youth such as the Youth Friendly Hospital found at Rose Hall, though unfortunately as the funding has come to an end the facility seemed to be at risk of closing down. The staff at the facility said that they were uncertain of what was the future of the facility. Both the Ministry of Health personnel and NGOs related that it was difficult to get access to enter schools to conduct awareness sessions.

The police service was extremely active in the youth community and ran a scouts program that targeted at-risk youth. The scouts also target male and female youth of various age groups: Scouts – 7-11 (Cubs), 12-15 Explorers and 16-19 Adventurers. In addition there is a juvenile section within the New Amsterdam station.

Several persons including the Regional Chairman acknowledged the investments that were being made to combat HIV/AIDS in the region but questioned the impact that it was having, "We spending a lot of money that’s not reaching the people."

As was related on the Essequibo Coast (Region 2) quite strongly, "what" was being taught and done was important as "how" it was being done. As such, it was important to "come down to the level" of young people of different backgrounds and
ethnicities. Persons also mentioned that some of the ways of targeting youth were out dated, for example Merundoi’s radio in an age when, it was felt, many youth do not listen to the radio.

In general, the urban-based regions like Region 4 had physical access to a wider range of services and facilities than those in other regions. There was greater reference to programs, advertisements; NGOs that deliver HIV/AIDS related services etc. GRPA for example, organizes health fairs, career fairs and fun days that target youth. There were also innovative programs such as the Prevention with Positives (PWP) program promoted by GHARP, which was meant to reduce risk of people being infected. Some NGOs, such as Lifeline, mentioned that the funding for some of their programs was reducing, which would have an impact on their ability to provide services.

One informant mentioned that pregnant teens were referred to Women Across Differences for services, but that no similar facility existed for adolescent males.

One of the priorities of the Government of Guyana has been the rolling out of the National HIV & AIDS Workplace Policy. To this end the ILO has provided training to the Guyana School of Agriculture (GSA) and Guyana Sugar Corporation (GUYSUCO) on HIV/AIDS education to the students in the apprenticeship program.

GHARP has a SCARF project, which included screening for STDs, condom promotion and distribution, adhere to medications, risk assessment and risk reduction counselling, family planning. Organizations such as SASOD also advocate for youth that are gay, lesbian and transsexual.

Several of the groups were part of a wider regional or international network. The GRPA has a Youth Advocacy Movement (YAM), which falls under the International Planned Parenthood Federation.

A teacher at Multilateral Secondary School said that the school encourages youth to join Youth Groups and Clubs as well as Christian Clubs. And private schools such as School of the Nations mentioned the presence of various clubs including youth, sports and environmental clubs at the school.

"Young men drink and whatever follows".

Community Development Officer

"Kamwatta does not tolerate alcohol and I don’t think that I’ve ever had a report for that area for teenage pregnancy or molestation".

"Fast money, fast everything – the fast money is the drugs that sells on the street...these young boys throw up a fancy house. And you go to a rum shop and see how much of these boys a drink. I surprised when me daughter tell me that even at UG they selling alcohol. If me go to the beach [63 Beach] now, or on Sunday, if you see how many girls and boys a drink."

Parent
Overall, as in other regions, there tended to be greater collaboration between some agencies rather than others, for example the Guyana Red Cross has a close working relationship with the schools as does the Welfare Officer. The police also stated that they were conducting awareness drives in schools, but it was not clear whether there was communication between, for example the Guyana Red Cross and the police and the extent to which messages, strategies and approaches were consistent and complemented each other.

Alcohol and Psychoactive Substances

Many key informants identified alcohol as being an issue and connected it with sexual activity and in particular unprotected sex among youth. This vulnerability was identified as significant across all contexts – urban, rural and hinterland. In hinterland and rural areas alcohol was the most commonly used stimulant, in contrast, urban areas tended to have greater use of marijuana and alcohol.

A Social Service professional in a hinterland area stated that one village, Kamwatta, “does not tolerate alcohol and I don’t think that I’ve ever had a report for that area for teenage pregnancy or molestation”. Similarly the Community Development Officer (Ministry of Amerindian Affairs) said that it was the culture of drinking among young men that led to other at-risk behaviour, “young men drink and whatever follows”.

Various types of alcohol were mentioned with vodka being the most common in Moruca and Mabaruma where it retails for $500 for a quarter bottle, which makes it comparable with buying a meal, and relatively affordable. In addition, locally brewed alcohol, rum and beer were also mentioned. Informants also mentioned the influence of parents and adults who drink in the home and in the presence of children; this was known as the “home effect”.

Several persons in the teaching profession mentioned that both females and males use alcohol, and that they begin drinking from a very young age. Adolescents were reported to be drinking in schools and covering it up by disguising the alcohol by mixing it with aerated drinks. Although drug use was mentioned, and the presence of "Amerindian..."
rastas” there was some evidence to suggest that drug abuse is less prevalent than alcohol abuse.

A Probation Officer mentioned that there was greater stigma to marijuana than alcohol. Marijuana, which was the most often mentioned drug reportedly costs $1,000 for a joint (which is significantly more than what was reported in areas like Georgetown and Berbice $200/$300).

The urban centres of both Region 4 and 6 had significantly higher reporting of drug use than in rural and hinterland areas. The Regional Chairman pointed out that marijuana was locally cultivated in Canje Creek and that the market for the drug was the coast. Key informants generally painted a picture of a drug that was highly addictive, destructive and that was both accessible and cheap.

There were various prices quoted from GY $40 for a ‘front toe’ or stub of marijuana to between GY $100-$200 for a joint. A “weed bag” containing approximately 35 grams was reported to cost GY $300. This is significantly cheaper than in the rural and hinterland areas. The research team did not find much reporting of drugs that were being injected into the system and it was mentioned that most of the drugs were inhaled and smoked. Drug abuse [predominantly marijuana was reported] was felt to be more prevalent among Afro-Guyanese adolescents, and among adolescents, males were felt to be more prone to use drugs than females.

A police sergeant related that youth as young as 17 and 18 years old were also selling narcotics in schools. As such the police department, which is active in the youth community, was promoting the Drug Abuse Resistance Program (DARE) in schools.

As in all other regions, including rural and hinterland contexts, alcohol use among youth was identified on multiple occasions as being part of youth culture and one that had a strong causal driver that put youth at risk of HIV and other negative health outcomes.

As in other contexts, the inter-generational nature of the issue was often highlighted, as one interviewee stated on the subject of youth and alcohol, “it’s a tradition” and another said, “its part of the culture”. One Indo-Guyanese parent stated that from second form children were found drinking alcohol in the schools. She also mentioned

“I is be like Matlock when I take my matters [cases of sexual abuse to the police] cause I want justice”.

NGO Staff Member (Urban)
that being a shop owner who sells alcohol, children would try to get her son to get alcohol for them.

It was also reported that there has been an increase in the use of alcohol among female adolescents, which several persons described as a worrying development. One salient observation made by a community development volunteer is that increasingly “girls who have subjects and are educated in high school” are observed drinking and hanging out in bars. It was surmised that youth are “striving to find an identity”.

Sexual Activity
The majority of respondents in hinterland areas felt that the sexual debut among young girls and boys was at a young age – pre-teen or early teens as answers ranged from 11 years old to 15 years old. In terms of the number of girls in the class or school who were sexually active, the percentage given ranged from between 10-50%.

Respondents also referred to the fact that youth and young girls in particular were being pressured by their peers, and males, to have sex and indulge in other practices such as consuming alcohol.

It was reported by the REDO, that the region had called all the taxi drivers together and warned them about interfering [troubling or taunting] with school children, as they have zero tolerance for such interference. The REDO was of the opinion that this had had an impact on the conduct of transport providers.

As in other contexts, informants were generally of the view that adolescents were sexually active from a very young age – pre-teen and early teenage ages were commonly given. In the rural areas of Skeldon, Orealla and Black Bush Polder, it was felt that there was a general culture of early sexual debut among teens.

One nurse stated in response to the question of when generally youth became sexually active that, “if you have to come to an average, you have to come down to 13”. At the Angoy’s Avenue Youth Friendly Space the age of 11 was suggested.

Many informants painted a picture of girls who were more emboldened and worldly, for example one mentioned “having sex regardless of [school] uniform or no uniform.” One informant said that

“[Tapir conductors] brainwash the girls and tell them that they got this and they got that...and the girls are so stupid that they take on whatever they tell them.”

Father, #64 Village
girls as young as 15 years old like to “play big woman”.

An NGO representative noted the rise in “freaky sex” among youth, “winky blinky” the practice of rubbing the penis on the eyeballs, and the practice of anal and oral sex. It was widely state that girls are, “developing faster” and were seemingly more mature compared to youth in earlier years. In discussing sexual practices with the Child Protection Officer, it was stated that it was not always the case that sex between young girls and older men was transactional because, “some girls just sex for sex”. One Angoy’s Avenue peer educador reflected the flippant attitude of youth to sex by citing a popular local saying among them that, “HIV is in style and I have to catch it”.

It was reported that girls were “dressing according to their size and not their age” and another person referenced the fact that female adolescents often dressed, “inappropriately”.

The desire for material things and even basic food items and supplies was also cited as an example of the new culture of consumerism and poverty among young girls that was driving them to engage in risky behaviour. It was reported that young girls were increasingly partnering with older men and a few persons mentioned relationships with powerful businessmen (and in some instances resident expatriates) who deliberately cultivate and pursue much younger girls.

Along the Corentyne, a group of parents highlighted an issue similar to that of minibus conductors in Georgetown but with “Tapir Boys” who they viewed as predatory in that they would entice girls with “nice music” and “waive the fares”. It was an issue that was raised at the Parent Teacher Association (PTA) but not much was being done about it.

In the rural context, there was general consensus among key informants that sexual debut among teenagers was at a very young age and predominantly in the early teens. Generally the ages given were between 12-15 and several respondents made mention of the fact that amongst Amerindian youth the age of sexual debut was considerably lower. However, as in other regions the study found that though youth at young ages 10-14 and less than 15, did report to having started to have sex at a young age, there was nothing to suggest that this was among a significant majority of adolescents.
Some of the key persons who directly interacted with youth, such as teachers and Probation Officers, seemed to be out-of-touch with them and in some cases prejudiced.

**Sexual Predators**

In hinterland areas, some persons saw hot spots, or vulnerable areas as being those that were remote communities, or specific villages like Rincon and Kabura. Poverty was often used to explain situations that were putting young girls at risk.

There were multiple references to single parents or families that could not afford to meet the needs of their children. In these instances the parents or mothers, would support their children having relationships with persons (sometimes significantly older) who could provide for them. One informant said that these persons were often business people from Georgetown and Berbice. These persons would go to the families and “whatever there is a need of, they will offer to help with the child”. A police sergeant said that “because of needs” persons take advantage.

The health professional stated that young girls usually get pregnant “for someone who assist them”.

In the rural contexts, many interviewees referred to the causal nature of youth relationships. It was reported that there was a worrying trend among girls to have multiple boyfriends (though not necessarily to be sexually active). It was reported that girls were increasingly promiscuous and aggressive. And that the culture generally was to, “see a thing and catch a fling,” meaning to have a quick, random and casual sexual encounter.

| Registered | 248 persons | 41 on ARVs |
| Actively attending | 108 persons | 80 on ARVs |
| Children HIV+ | Ages 0-14 | 4 males, 3 females |
| | Ages 15-24 | 2 males |

**Sexual Abuse**

Sexual abuse was a key concern of several Duty Bearers in both hinterland and urban contexts. The Regional Chairman, Regional Health Officer, various head teachers, Peace Corps Volunteers, School Welfare Officers and the police all mentioned sexual abuse as a problem in the hinterland context.
The Probation Officer in one sub-district mentioned many specific cases involving girls as young as age six. The perpetrators were usually a member of their immediate family including grandfathers and uncles. However, several persons mentioned that there had been a rise in "stepfather rape" since changing social and family dynamics meant that stepfathers were raising children. Mothers were in some cases reported as abandoning their children in the sense that they continued to live in the house of the abuser.

Many persons said that they felt that the legal support and facilities were not in place to deal with the problem. It was also reported that in Mabaruma there was no Probation Officer in the sub-region. And several persons said that abusers were getting off lightly as they were coming out on bail and returning to the homes in which abuse was carried out. The MoAA CDO stated that parents were left, "looking for justice because the men still walking free". This was queried with the police and it was stated that in the case of incest they could be held for 72 hours and in the case of rape for 45 days.

However, the police were aware of the fact that it was a problem and noted that "sexual abuse trips the children out" and that "this is what is destroying the children of today".

Sexual abuse (including rape and incest) was identified as a key issue by informants. Some posited anecdotally, that there was a higher prevalence of incest and suicide among Indo-Guyanese families but this should also be seen within the context of Indo-Guyanese having a significantly higher population. As in other regions, including the hinterland areas, it was reported that there was sexual abuse perpetrated by step-fathers on children in their care, in addition to typical abusers like fathers, uncles and grandfathers.

As in other regions, there was mention of discontent among persons who were involved in reporting cases of sexual abuse. One NGO worker stated that because these can involve powerful persons and alluded to corruption, "bribery" among officers charged with bringing perpetrators to justice. The NGO worked credited having established relations with the police as well as the dedication of a senior police Inspector with improving the chances of perpetrators being brought to justice and homes being made safer.

"Some parents who a drink and get entangle with them own lifestyle, they gon get less time, or sometime no time with them children. Those children now, end up doing what they feel like".

Indo-Guyanese mother, Corentyne
Pandit on the Corentyne also echoed this by saying that people with responsibilities are not taking them up, because “in Guyana if you have money you are the leader...so I do what I want and I give money to Tom, Dick and Harry and my case is closed”.

It was also a concern among Indo-Guyanese parents on the Corentyne that teachers, including young male teachers were having sex with students. They stated that there were “many such cases” but that the families were ashamed to raise it.

It was reported that Amerindians females tended to be more prominent and in demand as sex workers. However during the meetings held with FFSW Amerindian females were not overly represented. It was stated that young Amerindian girls were visible when the large ships come in to port. This was not observed in the field.

Within the Indo-Guyanese community, a Pandit stated that, “we have some boys and girls living in poverty, material wise, and so men and women, young people of tender age once they are offered money and they are in poverty...they will take the money just to get something to eat, something to drink, a nice piece of clothes and they will sell themselves.”

**Recreation & Entertainment**

Most persons throughout the regions felt that there were not enough recreational activities and facilities for youth. In the Moruca area they were successfully promoting cricket for girls, and boys were involved in various activities including football.

One Headmaster related that when a private person had hosted a 5-day football match at Christmas under floodlight, the place was packed. In total eight teams participated. “You could see the inquisitiveness, the vibe, young people want something to do.”

In Region 6, as in other regions, and despite being an urban area many persons referred to the fact that there were inadequate facilities for youth, that the private sector did not have youth friendly recreational businesses and that there was a need to have more facilities available for male and female youth.

The Angoy's Avenue Youth Friendly space for example, attracts 30-35 persons a day. And it was
observed that there were a number of youth and activities being conducted in this very well managed space.

In many of the areas in which the research was conducted there were several new entertainment businesses that had sprouted up in recent years to cater for the general increase in income in the region.

In Mabaruma key informants referred to the several well-known bars. In Moruca these included the shops and bars around Kumaka. One proprietor of an entertainment spot where several youth who were interviewed said that they went to swim, does not sell alcohol or cigarettes to youth and has a strict policy of adult supervision for youth.

Key informants complained about the culture that was being introduced in the region, for example one woman referred to “some slack show from [George]town” and lamented the fact that, “girls are not focused on education, it is all about the road and having fun.”

In Port Kaituma, the entire central area is populated with multiple drinking places, discos and entertainment areas. Alcohol (including high end, expensive alcohol) is on sale in many locations and consumed widely by both male and female youth. There are comparatively higher numbers of hotels and rooms available for rent. Commercial sex workers are easily accessed in Port Kaituma and these include female sex workers from riverain Amerindian communities as well as girls from Georgetown, Brazil and Venezuela. It was reported that Amerindian girls are usually paid less, are quite young and come in groups. Or tend to rent rooms and stay there with more than one girl. The girls were reported to use alcohol and engaged in casual sex whilst inebriated for alcoholic drinks in some cases.

This was also reflected on the maps of youth as well as in the interviews. These include restaurants and shopping centres, bars and pool halls.

**Prostitution**

This was raised as a key issue especially among persons who interacted with youth from low-income homes and inner-city youth. It was highlighted by an NGO staff member, that “sex for money,” was on the increase for male and females.
The culture of sugar daddies and older men providing favours for younger girls who have sex with them is common. One person said that “girls “friend” with men who give them thing”.

It was reported among several informants that poverty was resulting in several girls engaging in sex in return for “things”. Some of these girls tended to have anal sex in order to leave their hymen intact.

**Employment**

In hinterland and rural contexts, informants widely reported that employment opportunities available to youth who have finished school are limited.

As one hinterland interviewee stated, “they come out of school and nothing happens”. Mabaruma was described as a “stagnant community” with limited opportunities for those children who had invested in their education and staying in school. As a result many of them leave home for other interior locations, Venezuela and Georgetown to search for opportunities.

The region has witnessed a *gold boom* in recent years, which has attracted both male and female youth who have been unable to find work and who are seeking “fast money”. Working in the “bush” is traditionally seen as a lesser profession to other more coveted jobs like teaching but there is some indication that that is changing. One headmaster explained that the earning potential of mining far outstrips those of other professions. He explained that for the last two consecutive years the top performing boys of the secondary school had given up teaching for gold mining. One student had five grade ones. The salary of an unqualified teacher is approximately $45,000 per month and a youth working in the mining sector can earn approximately $150,000 to $200,000 per month. Young people therefore have a disposable income that is much higher than they could usually expect.

The gold boom has meant that a number of youth in school, and out of school are fast flocking to mining sites seeking employment. One informant said that mothers also take their children out of school to join fathers and other siblings in the “backdam” to prospect for gold. The majority of these persons are male, who engage directly in the extraction of gold and to a lesser extent females who cook, work in shops and work as sex workers.

Photo: Opportunities in the gold mining areas have resulted in several young men having the resources to purchase cars, which they use as taxis.
As a result of the mining boom, several changes have occurred; an increase in the disposable income of young people, an increase in the purchase of vehicles for transportation (cars to be used as taxis mainly) and a rise in entertainment and other facilities to cater for the needs of youth (see below).

"Gold Money Flowing"

Another factor, is a certain sub-culture notable in areas like Port Kaituma where miners work a “quarter” (six weeks) and then emerge to ‘the landing’ or neighbouring towns to let off steam and enjoy themselves. This excess can involve the consumption of copious amounts of alcohol/drugs, partying and sex all of which are readily available. It normally involves all night sessions and partying that can go on for days. One group of young miners who was interviewed stated that they deliberately avoided the landing so as to not get sucked in to this lifestyle and lose their money.

The miners usually have in their possession large sums of money that they have recently been paid and are known to spend excessively. Many informants referred to this sub-culture and drink and excess in the interviews, the Regional Health Officer referred to it as “craziness time” and “a lot happens” “gold money flowing” and, “lots of partying and drinking”.

In the rural context, several persons made reference to both the fact that secondary school dropout was ‘high’ (actual levels were undetermined) in the region, as well as the fact that youth did not have many gainful employment options. Female adolescents were felt to have a more limited number of options and many of them turned to supermarkets and other low paying jobs. Among male adolescents it was reported that they tended to be employed in area like mining, logging and at the rice mills.

One person stated that because young men were starting to work at a young age (15 years and up) and were within an environment of predominantly older men that they were adopting several of their attitudes and behaviours including alcohol consumption, unprotected sex, sex with multiple partners and drug use.
It was also mentioned that the presence of gold mining and gold miners meant that there was a culture at Charity and in other areas of partying and revelry. Typically “bush men” would conduct mining activities for a quarter (six weeks) and then come to places like Charity and Anna Regina in search of entertainment. The men would often bring with them large sums of money and pursue women including adolescents.

The School Welfare Officer felt that the dorms are also a risky environment for young people. There was a report of a suicide in the Charity dorms apparently by a young boy who had been bullied.

**Consumerism**
The increase in disposable income in the Region is demonstrated in many ways.

In Moruca it was mentioned several times that cellular phones had only been introduced four years ago, but since its introduction along with Internet and DVDs, there has been an impact on youth culture. One person said that “blackberry is the first thing” that is purchased and the researchers observed several youth who had cell phones. The headmaster one secondary school complained that cell phones were creating a greater possibility for men and male youth to engage female youth in the dorms. As a result a security guard was placed in front of the door of the dormitory.

Some persons spoke of young girls exposure to “American style of dressing” meant that young girls were increasingly dressing up and looking older than their ages, and using make-up. In an interview with young soldiers it was reported that young girls were dressing and it was difficult to tell who was a young girl. The research team also observed two 11 and 12 year olds dressed up who looked considerably older, which may put girls at risk of being treated as much older women.

**Civil Society**
It was found in all regions and contexts that NGOs are central to the HIV/AIDS prevention and awareness. In the rural context, Hope For All, the leading NGO in Region 2 was engaged in several activities including:
- Condom distribution on Monday’s at Charity when there are a lot of parties and entertainment
- Working with In and Out of School Youth
- Providing care hampers to youth
- Conducting HIV awareness session and counseling
- Running a mobile VCT that services the riverain communities
- Summer camps for youth.

Hope For All was the only organization engaged in HIV/AIDS activities that had significant scope in terms of the areas covered and the number of persons who benefitted from the services provided.

Another local NGO, the Pamona Youth Group reported as also working with youth but noted that it was difficult to keep them engaged and their membership has dropped from 30 to 15.

**The Church**

In all of the contexts, the church was present though the perceived role of the church in addressing adolescent HIV vulnerability varied.

The *Arya Samaj* [Hindu faith] said that they promote “moral living” and that the Mandir has a sizeable youth population (approximately 30-40%) of the total members. The Pandit at the Arya Samaj said he addresses what the scripture says about moral living and how people are affected by decisions and actions. Some of the Mandirs were also found to have youth groups.

The *Arya Samaj* had developed some culturally appropriate education kits in a national HIV/AIDS project funded by UNICEF, which ended five years ago and these activities were not sustained. The Arya Samaj is not currently capable of addressing HIV/AIDS education.

A vicar of the Catholic Church noted that it has a Catholic Youth Centre (CYC) on Brickdam, which has programs to support youth through various stages of their lives and addresses issues such as sex, marriage and HIV/AIDS. It was also mentioned that the pastors are encouraged to talk to their congregation about HIV/AIDS. However, like the vicar, the Pandit said that he preferred to refer to others on issues related to HIV/AIDS as he did not have enough knowledge.

“Now I no longer preach too much of scriptures, I preach on social issues.”

Young Hindu Pandit, Corentyne

“Angoy’s Avenue want praying out”

Nurse at New Amsterdam family centre

“At one PTA meeting [Tagore Secondary] the teachers say that they surprised that the cleaner report and tell them how much condom paper and wrap they find. So from then the PTA advise, especially girls that going to the party, they must wear pants and not dress.”

Indo-Guyanese parent discussing school parties
There were differing views captured of the role of religious bodies within the region. One priest, active in social work stated that, “pastors need to move from the pulpit and into the lives of people and the homes of people”. This was typical of churches in urban areas where there was a strongly held view that the church had a role to play in addressing HIV issues.

In discussions with a group of Indo-Guyanese parents, the general consensus was that HIV/AIDS and sexual reproductive health issues should not be discussed in the Mandir, but should be addressed in the home and in school.

However, the Pandit at the Mandir was young and echoed the views of the pastor, stating that it is important to address the root issues of these problems. He himself was active in the community and, “if you want to understand something, dive in the trench”.

The church was mentioned as a key and stabilizing factor in hinterland communities. There are several religious denominations including Jehovah Witness, Catholic and Christian. Many youth confirmed that they attend church and though the dominant message seems to be of preaching abstinence, the church also ran activities for young people.

One woman captured this by saying, “them girls alright because them girls are church girls.”

In rural areas, the research team engaged two religious representatives, one of the Anglican church and the other an Imam at a local learning institution. These two interviews captured two opposing views of the role of religious institutions in the fight against HIV/AIDS. The Muslim leader was aware of the problem of HIV/AIDS, but it was not felt that the disease had to be addressed directly through awareness and education but rather through the teaching of “God Consciousness” which would help youth to control their desires. The school promoted abstinence from sex, alcohol and drugs.

The Anglican Church saw a greater and more direct role and through its youth group which meets regularly, it would invite persons to speak on various subjects of concern to youth including HIV/AIDS. However, senior members of the church had never received training on HIV/AIDS and could

“Them girls alright because them girls are church girls.”
not themselves support HIV/AIDS education and awareness.

However, both the Muslim and Anglican religious leaders reported a need to have more activities for youth including outings and religious clubs in schools.

Suicide
The research team was unable to visit one recommended site, Black Bush Polder, a community where suicides rates were said to be the highest in Guyana. The remarks made by informants tend to suggest that adolescents are a significant sub-population among suicide cases and that these often involve affairs of the heart/relationships. This issue was felt to affect Indo-Guyanese youth more than any other ethnic group.

Parents also stated that they were sometimes afraid to correct or discipline their children for fear that they would “drink poison” in retaliation, which was described as a “bigger problem”.

A Pandit related that in the close knit Indo-Guyanese communities that people were “talking out [disclosing]” the private affairs of young people, which was leading to suicide.

Counselling
One person stated that many youth had “rage pent up in them” and this was because of various issues including their relationships with their parents, many had things that they “hold against their parents”. Counselling was a means identified by a few persons (especially HIV/AIDS NGO staff) as an important service that should be available to youth.

The HIV/AIDS support group run by the Bricklayer Association (NGO) in New Amsterdam has 195 members in 2011 and 220 in 2012. A Corentyne-based Pandit stated that, “People have nobody to tell their story to, they can’t trust people. I have a set of things in my brain, I can’t eat, I can’t sleep, I can’t talk. The thing is I have all of these problems who am I going to tell, when I go and tell somebody and that somebody go and blow me out in the open air, then what do I become”.

The emotional state of young people was referred to on a number of occasions and they were painted as being vulnerable and having to deal with a number of issues. The Headmistress at a secondary school stated that, “young people have a lot of
Several persons identified the need and importance of life skills and of having counselling available for youth. It was recommended that each school should have a School Welfare Officer and that teachers should receive training on dealing with youth, at-risk youth and on issues related to HIV and sexual activity among youth. It was also highlighted that the general policy of the public school system is to promote abstinence.

However, private schools such as School of the Nations had a Guidance Counsellor and the Vice Principal is responsible for counselling females. An NGO representative stated that girls often have low self-esteem and are easily influenced. The main source of information on this in Region 2 came from the Social Worker at the Family Health Clinic in Suddie. It was reported that a monthly support group meeting was being held and provided information on various topics. The attendance was affected by the discontinuation of Public Assistance through the MHSSS, which was seen as an incentive for several persons. It was noted that food hampers were being distributed by NAPS.

Parenting
Many persons blamed poor parenting and limited parental skills as being the reason for children being put at risk. It was felt that parents don’t speak to their children and as such, “what they know is what they find out for themselves”.

"As soon as they start to get big, as soon as they get menstruation and at high school ... from 14 or 15 [years old]"
Mother

To me it start from 12 and 13....”
Father

“Yeah, yeah”
Other mothers agreeing

Parents discussing age when children start to have sex
Social and Probation services all stated that parents were letting their children down by not reporting abuse and by neglecting them.

As was common in other regions, in the capital, parenting and in particular poor parenting skills and parenting presence was identified as key issues. Among youth in low income and economically recessed areas it was reported that there are numerous single parents and the single parents tend to have multiple partners and neglect their children. One sports leader stated that the, “generation gap between parents is narrowing and so parent dress like youth and party with their kids”. This was cited as an example of conditions that lead to at-risk behaviour among youth and a reduced social control.

Georgetown was the only region in which parental facilities were reported as being available in the form of the Guyana Mother’s Union although it was reported that it currently does not have the capacity to integrate HIV/AIDS. The Mother’s Union stated that theirs was a regional program with 92 active counsellors.

At one private school, with a school population of mostly middle-income students, it was reported that “parents are unaware of what’s going on with their children” and that many of them are “too busy”.

As in the capital (Region 4) Berbice also cited poor parenting as a key issue in reducing the nurturing and supportive nature of the home environment. Several persons mentioned that such homes provided limited parental guidance and support as parents were neglecting their children. These homes were often characterized as having other social problems (drug and alcohol abuse, domestic violence etc.) that affected the wider family, which put children at risk. It was mentioned that children from such families were often left unattended and were in some instances found to be wandering on the streets. One informant described this as the “absence of a family setting”.

It was also mentioned especially among health and social workers that in these households, children as young as age 13 were having sex with their parents’ knowledge. In addition, changing dynamics in the socio-economic environment meant that mothers were often out working and not as present in the

“No!”
Parent in response to question of whether sexually active daughter [already interviewed] is sexually active...

...Explanation

“Because the latest she comes home from school is four o’clock, from school she comes home.”

“What they know is what they [youth] find out for themselves”.
home. Among middle class Indo-Guyanese parents it was found that they are also changing the way that they parent which is different from how they were parented.

Mothers were widely viewed as the parent most likely to be responsible for the behaviour of their children. In some instances children were left in the care of guardians, such as grandparents who could not provide the level of parental guidance that was required.

It was also reported in the Angoy's Avenue area that there was a high number of single parents living in the area. And overall, a common remark was that parents lacked the skills to talk to and support adolescents in matters related to their sexual and reproductive health.

In an interview with some Indo-Guyanese parents it was mentioned that parents do talk to their children, and felt that "some parents do not all" some have an “open relationship,” which is not typical in indo-Guyanese rural families. In one family they said that as compared to their own upbringing they “talk” more than “beat” their kids.

One middle-income mother said that she approaches it by saying, “today we will talk as friends” and uses storylines in movies to broach the issue of sexual reproductive health. A lot of the education centred on “girls getting fooled” by boys. It was related that this was a reason why girls were being taken out of secondary school, “because she will get carried away with Tapir boy and will not come home back”.

A pandit related that parents were not making time for their children, nor were they spending quality time together as a family. “I got to go to the rice field, my wife got to go clean some body house, me go send the pickney to school when they come back pon an afternoon me didn’t check their book”. He also mentioned that a sizeable number of parents do not go to school to find out about how their children are doing in school.

3.1.6 Peer Pressure
These two factors were identified as having a significant impact on youth culture. It was felt that Peer pressure was a key issue among youth.

Several persons also mentioned the influence of media (television, internet, mobile phones), which

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“This is their last year in school, so them will do all that them got of do. From 3rd, 4th and 5th form that is when the problem start with boy and them things.”

Father, discussing sexual activity in school

“Young girls are fascinated by fancy things.”
is readily accessible in these areas. According to one informant, “what is learnt on television, or from friends is what they [youth] go with”. In an interview with Indo-Guyanese parents, one mother lamented that they tried to monitor what her children watched but they [the children] were one step ahead. The children were not allowed to have cell phones but they did have access to the Internet and computers in the home.

Several persons also referred to Facebook and texting as ways that adolescents were communicating and engaging with each other in spaces that were unregulated. As in other regions, reference was made to the “Americanization” of the society, which influenced a wide range of behaviour and attitudes from type of dress, tattooing and sexual practices.

It was also reported that music and the lyrics in popular songs was also having an influence on youth. This was reinforced by the presence of loud music in various locations (streets, bars, restaurants etc.) as well as the actual citing of songs among youth, for example in articulating his disdain for homosexuals, one Afro-Guyanese 14 year old male sang the song, “don’t BB me” much to the amusement of his peers.

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their children” and that many of them are “too busy”.

3.1.7 Teenage Pregnancy
Teenage pregnancy was widely reported as being unplanned and was viewed as an indicator of condom use among adolescents.

At the New Amsterdam Family Health Centre it was reported that there was “a lot of teenage pregnancy” as an example the statistics of the two previous years were cited.

<table>
<thead>
<tr>
<th>Year</th>
<th>15-19 year old mothers -</th>
<th>Births</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>2012</td>
<td>54 of 210 births</td>
<td>(26%)</td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td>60 of 240 births</td>
<td>(25%)</td>
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In instances when the mother is less than 16 years old, it was reported that these are reported to the Social Worker. To a lesser extent teenage births were attributed to sexual violence, the medical staff reported two cases of rape by an uncle that had resulted in pregnancy. It was approximated that these early births affected Afro-Guyanese and Indo-Guyanese adolescents equally.

In hinterland areas it was reported that the pregnancies tend to be unplanned, in some instances involves sex with other teenagers and to be a significant number of the total number of births each year.

As one HIV/AIDS trainer stated that “every time you blink is another teenager pregnant. It seems that we are wasting our time and money. Even the HIV community facilitators are getting pregnant”.

In Moruca it was reported that of 73 births in 2012, 7 of them were less than the age of 19 (9%). When probed further head teachers and REDOs did not have specific data but said that it happen “one, one time”. The CDO recalled that there were four such cases in Barima. One School Welfare Officer said that they tended to get pregnant from the age of 12 and 13. A health professional stated that “one of my fears is the under-15s getting pregnant” and they are getting pregnant for she also provided statistics reflecting the fact that between the ages of 15-19 there were 189 cases of females requiring antenatal care. This is 25% of the total number of pregnancies.

**Teenage Pregnancy**

A recent presentation on “Knowledge, attitudes & practices of reproductive health, of teenagers attending the Georgetown Public Hospital (GPHC) Obstetric Unit” found that at the GPHC July 2009- June 2012, 3776 births to women <20yrs and an average of 1265 per year (June 2009-June 2012)

<table>
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of live births were to mothers who are <20 years old

The average age difference between the mothers and the fathers of the children was father was 6 years the largest was 32 years

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Number of teenagers</th>
</tr>
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<tbody>
<tr>
<td>20%</td>
<td>of live births were to mothers who are &lt;20 years old</td>
</tr>
<tr>
<td>64%</td>
<td>of the teenage mothers said they regretted the first time they had sex</td>
</tr>
</tbody>
</table>
| 22%        | Disclosed that they had been raped at some point in the past

“Every time you blink is another teenager pregnant. It seems that we are wasting our time and money. Even the HIV community facilitators are getting pregnant”. 
3.1.8 Transient Populations

In Region 1 [hinterland] the steamer boat was mentioned within the context of bringing foreign ways to the community as well as persons from outside. In Port Kaituma there was a significant sub-population that was mobile and that came and went including both miners and sex workers.

There is also movement of youth, especially males as they work on trucks that run between hinterland locations.

In the rural context, several persons made specific mention to indigenous youth in a number of areas. It was mentioned that families were migrating from the lower and upper Pomeroon and settling along the Essequibo Coast. It was identified that the riverain communities were generally seen as vulnerable as children had to travel vast distances, in some instances unaccompanied.

The Community Development Officer identified Mashabo, Capoey and Mainstay as areas where there were issues of alcohol consumption.

3.1.9 Adult Attitudes towards Youth

For example, a teacher recalled a conversation in which a colleague had told her, "Miss you would be surprised to hear that some of our students are HIV positive." To which she replied in horror, "no way". It was also suggested that there was a need to get rid of the "bad apples". And some teachers seemed out of touch with the adolescent nature of the school population and their needs.

There was also some indication that persons who come in contact with adolescents needed greater training in how to engage youth and cultural sensitivity, and the development of inter-personal skills.

Several persons including a taxi driver and former mini-bus owner felt that girls were "hot" and were aggressive in their pursuit of males.

3.1.10 Youth in Revolt

Overall, there was extensive mention of the limited morals and values that youth possessed. This was raised in various contexts, for example the teacher of one school branded youth behaviour as being "appalling" at both school and in public. Another informant attributed the "decline in morals and values" to the abolition of flogging at schools.

“Parents are out of touch with their children. They have to find family time. They have to sit down and talk with them [their children].”

Grade 8 Coordinator,
Anna Regina Secondary
Another informant mentioned that young girls regularly displayed “vulgar behaviour” as they would “sit on bus conductors laps.” Persons also expressed the view that youth were not, “serious about life” and did not want to work even when they were given the opportunity.

3.1.11 Condom Use
There were various views on the current situation of youth and condom use in urban areas. It was mentioned among persons in contact with inner-city and impoverished youth that condoms were not being used by 70% of youth. Another view was that the habit of using a condom was catching on though not among young married couples where a partner may not be faithful.

The representative of the Guyana Football Federation mentioned that condoms were being distributed and that the HIV epidemic was being controlled. However, it was evident that it was not always being widely used. The coach stated that two young people on the football team had died of HIV/AIDS.

3.1.12 Communication
Several persons mentioned the influence of communication instruments on adolescent behaviour. They identified the television and Internet as a negative source of influence, as one commented “sex sells”. One informant recommended that there should be greater censorship of what adolescents were exposed to and another lamented the influence of “Jamaican and American” culture on youth.

It was recommended that awareness and informational campaigns and products that target youth should be graphic and shocking so that they would get the message.

3.1.13 Indo-Guyanese Cultural Norms
In both interviews with youth and in discussions with key informants it was revealed that the predominantly Indo-Guyanese cultural practice of “asking home” for girls was significant in understanding the situation of young girls. It was reported that in some instances parents viewed a girl being “asked home for” as an indicator to take a more lenient approach to parental control. “Asking home” is one step before an actual engagement and is more of a promise than a commitment.
As such the betrothed was having sex at a young age with the older male. In an interview with parents, it was also mentioned that because of the shame that girls might bring to the home when they are caught having relations with “tapir conductors” that it was better for them to marry them off. It was also reported that this practice is less common now but it does happen. They also acknowledged that some parents allowed boys to sleep with girls once they had asked home for them.

It was reported that some children get married at the age of 14 and 15 years old. It was not determined if these marriages were registered. This was seen as a way to “avoid problems,” when they are “going out with boys and then they gon get involved and then they will get pregnant...then they [the parents] gon end up with a kid home”. It was felt that a girl getting pregnant out of wedlock was an act that brought shame to the family.

3.1.14 Youth with Disabilities: The Deaf Community

Efforts to interview deaf youth were not successful because of restricted access to schools, however the research team did meet with two teachers of deaf youth one of which was a Peace Corps volunteer with a strong background in HIV/AIDS.

It was reported that the deaf are “riddled with knowledge gaps” and awareness on HIV/AIDS because of the lack of materials and programs that specifically target persons with disabilities. Among the deaf are several deaf youth who have intellectual and other challenges that result in them even having a very basic understanding of their bodies.

Many of the materials and programs that are developed for HIV/AIDS do not take persons with disabilities into consideration. For example scenes/images are often culturally inappropriate, “there’s never anyone in a wheelchair” and the fact that because there are shut-ins and persons with low education levels, it is often not easily understood. Even in instances when sign language is used, it is assumed that the deaf person is a competent signer. The deaf often have problems with colour blindness, which makes the use of the colours red (for danger) and green ineffective.

Because several of them are also have physical disabilities, it also places them at high risk for

“HIV/AIDS is a hearing disease”

Peace Corps Volunteer

“Since this TV with all them fancy show, that get a lot of young people carried away...and them series that they watch every day.”

Parent
sexual abuse. The Peace Corps volunteer remarked that she had not encountered a single deaf person who had been tested despite the fact that the deaf are considered to be promiscuous. The reliance of caretakers, and the strong influence of the church position on abstinence, was felt to possibly hinder their ability to get tested and to access condoms.

3.1.15 Hot Spots
For the purpose of this study, hot spots are defined as places where it is perceived that high risk activities take place.

In the urban context, Region 6, the most common response to the question of where was an area or place where youth were vulnerable was Angoy’ Avenue.

In addition “the streets” or “the road” were mentioned as a hot spot since there was a culture of liming and socializing on the main street. Several persons mentioned a fast food location as an area where youth were put at risk for this reason, as it was popular with young persons. Similarly in Village #64 it was mentioned that the road provided open access to young girls by older men and boys.

Based on observation it was noticed that, as is common in Georgetown on the seawall at certain days of the week, the main road is used as a place for teens to hang out, drink and interact with their peers. In addition to this there were a number of bars, clubs and eating places that were identified.

Informants also viewed some schools as being “hot spots” and a place where children were vulnerable, and where children from low-income homes and neighbourhoods attended. These included “Donkey College”/Vryman’s Irving, Berbice Educational College, Canje Secondary School and New Amsterdam Multilateral School. However one Indo-Guyanese father stated that it was not only limited to low-income families as, “I think that a lot of the wealthy off people their children are involved in a lot of things...because they have the money, they believe say that they can do what they want to do.” On the Corentyne they also referred to the “back street areas” which are poorer neighbourhoods.

One Pandit on the Corentyne who is also a Counsellor gave the example of a young girl whose parents were essentially having her prostitute in order to bring money into the home.

“TV is a problem. I am guaranteeing you any TV station; you go and see how many sexual activity they put out there. Music – listen to our songs, and I really get angry when they play these songs and...there are certain TV shows and songs that when you hear them you’re somebody else...these songs and shows they trigger you.”
In the rural context, there were a number of places that were cited as being where poverty and vulnerability was high; overwhelmingly Charity was singled out as being a key area where adolescents were at risk. The Charity area on Monday was largely seen as a time of the week when there is partying and socializing. As a result NGOs such as Hope For All would distribute condoms at Charity on Mondays.

This was followed by another area Supenaam, these two locations were generally described as hubs and “points of entry”. Several persons mentioned that there were a number of “short stop” hotels that had sprung up in these areas. And one of the youth informants also mentioned that she had been taken to a hotel and had sex there with a young teacher who was not from her school.

Other specific locations included:
- Anna Regina
- Dartmouth
- Onderneeming
- The Pomeroon area
- Charity Housing Scheme
- Lima Sands
- NOC

It was mentioned by the Police at Charity that youth in Charity used drugs and alcohol and that they could openly be seen liming at nightspots in the evening. This was also observed by the research team and reinforced by interviews with adolescents during the course of the study. It is ironic that the Police station is yards away from these locations.
SECTION IV

4.1 Empirical Evidence on Most At Risk Adolescents

This is a seminal section of the YKAP Study report since it addresses several of the key aspects of the study, and also because it reflects the views of adolescents themselves who participated in the study. The research required the design and analysis of a participatory qualitative study on a range of young people to understand the context in relation to risk and vulnerability to infection, and to understand their experiences with services for adolescents at high risk for infection and young people who were HIV positive. The sessions also involved youth drawing and discussing “their world”, both the narrative and images from these sessions are used within this section of the report.

Specifically the study was required to determine:

- Psycho-social and protection needs
- Sexual and reproductive health and HIV-related needs
- Perceptions of the availability, accessibility, and quality of reproductive and sexual health and HIV-related services
- Experiences of stigma and discrimination and its effects on their practices and service use
- Challenges and aspirations.

In addition to the focused discussions with youth, In Depth (one-on-one) Interviews (IDIs) were held with youth to drill down to some of the key issues, such as early sexual activity among 10-14 year old girls, unprotected sex among MSMs, poverty as a driver for sexual activity, and safe sex practices among 15-19 males. In order to have a comprehensive understanding, these findings were triangulated with those presented in the final analysis, Section 4.

The focus groups were held with youth within the age ranges of 10-14, 15-19 and 20-24. The adolescents were again divided by sex and the groups ranged from between 6-12 persons. In total 56 FGDs were held and 352 adolescents were engaged as follows:
The findings are significant as a lone component, but it also reinforces the legal and contextual findings presented in Sections II and III. It is also an important precursor to Section VI, which outlines an action plan that is meant to capture the most “appropriate forms of service delivery to identified male and female YKAP and YPLHIV.

Key Findings

Psycho-Social and Protection Issues\(^{29}\)

- Many male and female YKAP were grappling with various psychosocial issues (feelings of abandonment, low self-esteem, trauma, bullying etc.) that were bottled up, and for which professional counselling was generally not available, resulting in feelings of isolation. In a few extreme cases cutting, overdose and other suicide forms had been attempted. In-school youth also stated that they wanted to have confidential counselling services available to them.

- Changing socio-economic dynamics (migration, absent mothers, single parents) and poverty have a direct effect with the type of support that young people have available to them in homes.

- Poverty was generally viewed as a significant driver of adolescent vulnerability and several schools, communities, areas “hot spots” and family dynamics were cited as being a major cause for early sexual debut and sexual exploitation.

- There was a comparatively higher reporting of violence in urban schools than in rural and hinterland.

- Adolescents with disabilities and 10-14 adolescents who were out-of-school were found to be especially vulnerable and spent a significant period of their day unsupervised. Similarly youth in contact with the law (including YPLHIV) did not have adequate

\(^{29}\) UNICEF defines this as children who have “exposure to violence, disaster, loss of, or separation from, family members and friends, deterioration in living conditions, inability to provide for one’s self and family, and lack of access to services can all have immediate and long-term consequences for children, families and communities and impair their ability to function and be fulfilled.
sexual and reproductive health services and psycho-social support.

- Alcohol and to significantly lesser extent marijuana/cocaine is a significant risk perceived by key informants as putting adolescents at risk, but although some male and female adolescents felt that consumption did place them at risk, among others the connection to increased risk was not realized, “it spruces up the night”

- Suicide (region 1,6), teenage pregnancy (region 1,6) and teenage marriage (Region 6) were pronounced in both urban and rural contexts.

- There were mixed feedback on teachers and parents; some parents were adapting their parenting style to meet the needs of their adolescent children; some did not speak to their children about reproductive health issues. Parents were generally identified as needing to have skills to support HIV/AIDS prevention. This is a significant inhibitor of providing an environment that is conducive to being supportive for adolescents. This was further exacerbated by the marked lack of formal support networks for youth in all categories including 10-14 and 15-19.

Sexual and Reproductive Health Issues:

- Although the sexual debut of adolescents was reported by several key informants as being at a very young age (11 and 12 years old), the study found that among in-school youth there was not a significantly high level of early sexual debut; of those who were sexually active in hinterland areas the majority of reported sexual activity started at 14 years old for males and 15 years old for females, in rural areas at 15 years old for both sexes and in urban areas there were some reports of early debut around 12 and 13 years old. Among FSWs, MSMs and youth in contact with the law this varied and responses were inconsistent but tended to be sexually active from a young age.

- Although there was sexual activity reported among the 10-14 age range, this tended to be among males more so than female adolescents and in the categories of youth in contact with the law, hinterland males and out-of-school (school aged youth).

- In a few cases, both male and female adolescents reported forced sex, and among Amerindians girls there was a notably higher
reporting of rape and sexual abuse (from as young as 8 years old) than among other female cohorts in the same age range of different ethnicities, this was reinforced by interviews with several key informants including the police, School Welfare Officers and the Regional Chairman who had concerns about the rate of abuse.

- FSWs and MSMs tended to have higher levels of awareness of HIV/AIDS than other cohorts. However, there are still knowledge gaps in terms of awareness and understanding on HIV/AIDS and awareness efforts are still needed among various YKAP populations including youth in contact with the law and in-school youth.

- HIV/AIDS education was generally reported (teachers and students) to be taught in schools starting from Grade 6 and schools are a central source of information especially in hinterland and to a lesser extent rural areas where access to television, internet and cell phones is more limited than in urban contexts.

- HFLE and other programs that teach life skills and provide practical examples for youth are essential though their impact and effectiveness needs to be determined as no evaluation has been done of the program.

- There are still no extensive facilities or services available for adolescents (both male and female) who have been abused. In the hinterland areas, although there was a VCT present it was used primarily for pregnant mothers.

- It was common among young girls and boys who become sexually active for them to try to induce the same type of behaviour in their immediate circle and peer pressure was widely cited as a general factor.

**Perceptions of the availability, accessibility, and quality of reproductive and sexual health and HIV-related services**

- Guyana’s focus on youth specific services is well founded, and suggestion that these need to be expanded to widen the scope both of the populations served and the range of services, as well as providing targeted services for specifically vulnerable youth populations.

- The quantity, and variety of services (including through communications media) that are available to adolescents were much higher in urban areas than in hinterland and rural areas.
• Key groups such as out-of-school youth, FSWs, MSMs and youth in contact with law, have special service needs and barriers that make the accessing of services difficult including their remote location, stigma and discrimination especially in rural areas and in the case of out-of-school youth, their limited engagement with key services.

• Several key services provided by key agencies such as GGMC (Region 1) and various NGOs have been discontinued because of a lack of funding. Several initiatives for youth, Youth Friendly Health Services (YFS) and Community Care Points (MHSSS) were found to be critical but HFLE is being stopped in school at a critical age (Grade 9) when youth are becoming sexual active, experimenting with alcohol or under pressure to have sex.

• There are several key points of vulnerability in a adolescent’s life and one of the less obvious ones, seems to be in the period just before they exit school and immediately after, as they adjust to having to a world without the social reinforcement for positive behaviour of a school environment.

• Adolescents were more likely to use NGO-run facilities and services than MoH facilities; this is because of the perceived poor quality of condoms and the heightened need for privacy and confidentiality.

• The use of condoms is not high among key YKAP groups (especially MSM and youth in contact with the law), 90% of male youth in contact with the law (15-19 age range) respondents have had sex but only 33% have ever used a condom. Attitudes among YPLHIV among youth in contact with the law ranged from denial, fear to anger and in one instance a desire to re-infect by not disclosing their status.

• Across all geographic locations there was a perception that condoms have a high failure rate (40% among urban males in Region 4), especially those that are sourced from NGOs and hospitals, which meant that adolescents felt that they had to buy condoms but they did not always have the finances to do so. In hinterland areas, there was a perceived lack of anonymous access to free condoms, and the relatively high price of “good” condoms in the shops (rough-rider: $500) was at time prohibitive.

• In rural areas, among sexually active 15-19 year old girls and boys, there was a significant
reporting of unprotected sex. Even among older 19-24 educated females whose sexual partners were not monogamous, reports of unprotected sex and unwanted pregnancies was also reported especially in Region 1 and 6 (hinterland and urban). It was found that even though adolescents were aware of the risk and of means of protection, it did not always lead to behavioural change.

- Testing was generally found to be very low (except among YKAP and FSWs), especially among youth where services are largely unavailable (hinterland, rural). Among sexually active males there is a perception that condoms are the most vital form of protection and that testing was secondary, and as such, they were less likely to be tested unless they were targeted in school campaigns, or the annual National Week of Testing, which was generally ad hoc.
- Sports and increased recreational facilities were one of the most requested facilities among youth, to provide alternatives to risky behaviour and to promote awareness.

Stigma and Discrimination

- The School Health, Nutrition and HIV&AIDS policy makes no mention or provision for YKAP and this may serve to both marginalize LGBT, adolescents with disabilities, and impact their ability to enjoy their right to an education in a safe environment, that is not characterized by discrimination, and in which services such as counselling are available.
- Several key Duty Bearers (including teachers, schools, parents, Village Councils etc.) were found to lack the personal capabilities and organizational capacities to effectively support HIV/AIDS prevention among YKAP.
- Homophobia is strongest in urban and rural areas and the quality of life of adolescent YKAP is often affected.
- There was significant reporting of discrimination against female FSWs and male MSMs.
4.2 What do adolescents know about HIV/AIDS?

A key aspect of the study was to determine the sexual, reproductive and HIV needs of adolescents. This was gathered from adolescents through a series of participatory exercises that included a pictorial display to gauge knowledge, a timeline that gauged sexual practices and the timing of knowledge and activity in the lives of adolescents. One of the first steps was to determine their knowledge levels. The study sought to go beyond numbers in order to determine the factors that accounted for the knowledge that they had.

The knowledge and awareness levels on HIV/AIDS amongst youth generally, and male and female YKAP specifically are generally considered to be a significant measure by most international institutions. An adolescent, who is knowledgeable, is arguably better equipped to navigate risk, or to understand the consequences of risky behaviour. As outlined in the MDGs a key indicator is the "proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS".

The UNGASS list of indicators, that specifically relate to "Knowledge and Behaviours" are:

- Percentage of young people aged-15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
- Percentage of young people most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
- Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15
- Percentage of men reporting the use of a condom the last time they had anal sex with a male partner

For the YKAP Study timelines and focused discussions were generally used to determine...
typical behaviour and to build consensus among the group (where possible) about what is common for a particular group. This also helped to determine between variance and a-typical occurrences.

Children tended to access HIV/AIDS awareness from multiple sources throughout their lives, which would tend to reinforce and sustain safe sex information. As the timelines demonstrate, for a number of children their initial awareness of HIV/AIDS normally comes from an immediate family member, or from an external source (television, poster, pamphlet); the latter is especially in urban and to a lesser extent rural areas.

Several children also had experiences of persons in their immediate family and communities dying of AIDS, or having contracted HIV. This was especially prevalent among youth in contact with the law, out of school youth and indigenous youth. Suggesting a correlation between poverty and HIV, but also reinforcing the seriousness of the disease, as several persons who were referred to were young.

Young girls tended to have accessed information from their mothers, but with some probing this did not seem to include much information and took the form of general warnings about boys who would “fool them...” These conversations did not necessarily provide information on safe sex
practices. This is also consistent with meetings with mothers, including mothers of children in contact with the law who did not generally speak to their children about reproductive health, or were embarrassed to do so. However, respondents did cite their parents as a source of information.

Several of the In-School Youth and other populations (SMW, MSM), said that they were taught about HIV/AIDS in school. The In-School youth mentioned subjects such as Social Studies and Integrated Science in which HIV/AIDS was taught. However, several of these adolescents were unable to dispel popular misconceptions about how HIV/AIDS is spread. What this research highlights is the importance of evaluating the quality and consistency of how HIV/AIDS is taught in schools.

The majority of adolescents (including those who had gotten exposure at home etc.) said that they received exposure to HIV/AIDS education starting from Grade 6, when youth are approximately 10 years old but have had some exposure before that. In several cases HIV/AIDS education preceded puberty and the forming of partnerships with the opposite sex, kissing and sexual debut. The majority of In-School youth practiced abstinence and saw the ending of the secondary school as being a landmark for commencing sexual activity. However, as that period draws closer, older adolescents several of whom (including teenage mothers) displayed weak sexual maturity and decision-making skills were receiving less support (HFLE ends in Form 3) and had limited social reinforcement.

The awareness levels among Amerindian youth were markedly lower than in other areas. And they were more likely to have fewer exposure opportunities than their counterparts in urban and rural areas. Several persons, including Amerindian females, mentioned youth camps as an experience that they enjoyed and one from which they were able to gain many practical skills that related to life skills and sexual and reproductive health. These included how to use a condom, body image and dealing with unwanted male attention.
The awareness levels among both 10-14 and 15-19 age ranges were found to be low and inconsistent. They tended to have fewer awareness sessions from parents. They also mentioned fewer practical experiences of learning how to put on a condom and to store it correctly. Although the 15-19 year old males had slightly better awareness than the girls, it was still lower when compared to other regions.

The social networks of male youth tend to have a positive role in influencing safe sex practices. For example, many male youth mentioned that they had heard of condom use from another male relative (brother, cousin usually) and they tended to obtain condoms from these sources rather than from health centres. This was especially the case for the youngest cohort (10-14 years old) and sexually active. Almost all the Region 1 respondents said that they got condoms from friends/relatives or bought them at shops, they tended to rely almost exclusively on these sources.

Several children who had been exposed to training in schools (from Grade 6) and who had heard about HIV from members of their family still believe that it was possible to contract it from a mosquito. MSMs and FSWs had a heavy reliance on NGOs both for information on safe-sex practices and services. Several persons, mentioned NGO services such as Bricklayers Association, Hope for All, Merundoi and Artistes in Direct Support.
4.2.1 In-School Youth

Some girls, who discussed sexual health issues and relationships with their parents (and more often than not their mothers) tended to have general discussions about relationships, for example 10-14 year old girls in Moruca discussing what their mothers told them at 10 years old:

M: So what type of things your mom told you?
R: Must take boys who could take care of us and so
R2: And don’t drink and beat us up and so

They also went on to mention the Be Safe program:

R: Bad touches. And put inside some box like write if anybody touch you or so, write it and put it in the box

For in school-youth the majority of persons tended to identify condoms as a means of protection but in both the 10-14 and 15-19 categories, there were still unable to reject major misconceptions about HIV, the most common of which was that it could be contracted from a mosquito and secondly, to a lesser extent, there was an unwillingness to share food with someone who was known to be HIV+ because of the fear of contracting the disease. This was especially the case among 10-14 youth of both sexes. Persons also mentioned needles and kissing as a means of becoming HIV positive, and the majority of participants, both male and female, did not feel that it was possible to look at a person and tell whether s/he was HIV positive.

It was evident when the quality of exposure and education in the school was strong because the children seemed at ease discussing sex, and they were generally quite knowledgeable about sexual reproductive health. They could identify means of preventing HIV and could dispel popular misconceptions. For example, In-school females aged 10-14 in a rural area:

M: Tell me about it
R: (laughing) Miss the male and female vagina
R: As soon as we go to that part, everybody start laughing
M: And what was the thing about the zebra?
R: Is a man penis getting stiff and hard and the woman vagina
However, though many younger cohorts could identify ways of prevention there were still a few (and in some cases a larger number) who are still unable to debunk popular misconceptions across all age ranges.

Girls 10-14 (rural)
Cindy\(^{30}\): Like if someone that is HIV positive and they inject themselves with the needles and then someone else use it, it is possible that person could be infected.

Moderator: OK, and Tifanie said that when you get bite with a mosquito you can get HIV.

Tifanie: Yes, because sometimes like if somebody it has bitten and then it go and bite somebody else.

Alicia: No, you don’t get it from mosquitoes.

Among older cohorts (especially females) the uncertainty persisted. For example, among seven 15-19 University of Guyana (Berbice campus) students there was still some confusion. This was typical of females in this age range; they tended to have a smaller sub-group who were unsure. These misconceptions, though prevalent among 10-14 males, were less prevalent among 15-19 age range as compared to females.

Moderator: And what about like, mosquitoes?
Participants: No, no.
Moderator: Are you sure? You can’t get HIV from a mosquito?
Participant: No, cause we woulda already get it.
Moderator: OK, anyone else think that you can’t get it? Or anybody that’s unsure?
Fench: I’m unsure.
(Another girl raises hand)
Moderator: You’re unsure. The two of you are unsure.

Jazz: I was at first but then one teacher explain how you cannot get infected through a mosquito bite.

Moderator: So now you’re?
Jazz: Pretty sure.

In Region 2, five of ten 15-19 female respondents concluded that you could become positive through a mosquito, their male counterparts (consistent with other regions) in the same age category, across

\(^{30}\) All the names used are pseudonyms adopted for the exercise.
regions were much more aware. One explanation for this could possibly lie in the life patterns across the sexes, most in school youth said that they had chores to do after school and spent more time in the home, whereas boys reported less restriction and had greater exposure. Males were more likely to refer to information obtained from other males (especially about condom use) than their female counterparts.

<table>
<thead>
<tr>
<th>Charity Secondary (Rural)</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>15-19 Girls (10 participants)</td>
<td>15-19 Boys (8 participants)</td>
</tr>
<tr>
<td>R: Actually it’s saying [referring to photo] that you can’t get HIV through um sharing food mosquitoes and um holding the person hand and socializing.</td>
<td>M: Anything else?</td>
</tr>
<tr>
<td>M: Who else think that you can get it through sharing food and a mosquito bite?</td>
<td>Um a mosquito, you cannot get AIDS from a mosquito</td>
</tr>
<tr>
<td>R: Miss I think you can.</td>
<td>You sure?</td>
</tr>
<tr>
<td>R: You can.</td>
<td>Because like if like mosquito share AIDS all of us would be having AIDS because mosquito bites each one of us</td>
</tr>
<tr>
<td>M: Anybody else? The 2 of you 3, Lisa you think so 4, anybody else? What you think Maria</td>
<td>You agree, y’all agree? All of y’all agree? You could get it from a mosquito? How many of you think you could get it from a mosquito?</td>
</tr>
<tr>
<td>Miss yes</td>
<td>OK show of hands? How many, 1, ok one out of 8.</td>
</tr>
<tr>
<td>So 5 of you think yes</td>
<td></td>
</tr>
</tbody>
</table>

It was only in Region 4 that both boys and girls could consistently and confidently dismiss major misconceptions.

### 4.2.2 Out of School-Youth

There were several age ranges of out of school youth that were engaged in the study. These include, 10-14 males (rural), 15-19 males urban and, 15-19 females (pregnant mothers).

Among the 10-14 male 31, rural youth there was a very basic knowledge of HIV, the six males who

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31 The group “The Bling Bling Gang” was identified as a result of meetings with various regional officials who identified Riverstown (Essequibo Coast, Region 2) as being an area with high truancy rates and one where young children were known to be out of school. The meeting took several attempts to set up since the Ministry of Social Services had recently been in the area and there was a palpable fear among adults that the research team was there to apprehend the youth and “take them away”. The meeting was held in the home of one of the youth who participated in the research and whose grandmother consented to having the focus group at her home.
participated in the study stated an array of responses that showed both high levels of understanding and also reflected major misconceptions:

- It was possible to contract HIV from a mosquito (all)
- If you kiss somebody or have a bad tooth you could become HIV+
- It was not possible to tell from looking at a person if they were HIV+ or not
- It has no cure and attacks your immune system
- Condoms protect you from HIV infection

There were also positive outcomes in instances where out-of-school youth were involved in sport, exposed to NGOs, and had parent(s) who educated them on HIV and reinforced these messages and practices.

For example 15-19 boys who were out of school were quite knowledgeable:

R: Is a condom [referring to image] You got to use a condom
M: Why?
R1: To protect yourself
R2: Injected needle could pass it on
R3: If you mouth burst...blood transfusion
M: What about the mosquito?
R2: Nah
R1: Nah, is a human transmitted infection

4.2.3 Female Sex Workers
In keeping with the national statistics, FSWs tended to have both a good knowledge of the disease and were knowledgeable of how to protect themselves. Most of them mentioned having learnt about HIV in school. This group (urban) in Region 6 was attached to a local NGO and had frequent exposure to HIV/AIDS related awareness through the peer-to-peer education program run by the NGO. Several of the women were mothers, and had long term partners.

As in other low-income groups, the women also had personal experiences of relatives and close family

"First when I hear about AIDS is when me uncle died. I ask mommy what he dead from and she said that how, is AIDS."

FSW, Region 6

"I was like 15 but I never forgot what I see...how it [HIV] eat out your immune system"

The children were all out of school youth who were not working. All of the children who participated in the study had consent forms signed by their parents and guardians.
members who were positive or had died from the disease.

“The first time I heard about HIV is at my secondary school. They had, a ammm, organization, come into the school and was like show us on a TV, a video about HIV and how you can contract the virus. [mumbling] and that was like, I was like, fifteen years old but I never forgot what I see...how it eat out your immune system, that is the first time I heard about HIV and that was in school ...That [video] stay with me forever, since I heard about HIV, gonorrhea, syphilis... because we turn young lady and they say that once you have it, once you gonna become young lady and like you see your menstruation, in case you to have sex, you know how to protect yourself.”

Like other cohorts their education came from multiple sources throughout their lives, for example:

**Nurses on mother-to-child transmission:**
“One of the most, amm, part you could get HIV is from mother to child...transmission. Like if a mother, when the baby is in her, the baby, if she is HIV positive – and I learn from a nurse – the baby would not be HIV positive. But when the baby do born, you cannot nurse the baby and if you do nurse the baby. That is the most important part that could infect the child.”

**Other Sex Workers:**
“Me ain know about them, so I used to live with whores them right? So me whores them, i know they always get a condom. So certain things...

**From NGOs**
“Yes, you got to tell the boy don’t break it ‘cause you could get it. They explain to you so properly that, you know, even if the man ain breaking you could still get it. And then we never used to get them information. When you push in, before you come, sometimes they break, they break in you.”

**Tattoos**
Tattoos were also popular among FSWs and they identified it as being a practice that put them at risk.

“The other day, I nearly like, because I like tattoo and I went to put on a tattoo on my breast. I get another two tattoo, I just see a tattoo and I like it, but when I go to put on this tattoo, I did not carry tattoo, Region 6

Tattoos are an increasingly visible part of youth culture in Guyana and many ad hoc tattoo parlors were observed during the research.

“The other day,...I went to put on a tattoo on my breast. I get another two tattoo, I just see a tattoo and I like it, but when I go to put on this tattoo, I did not carry my own needle. I was too anxious to put on this tattoo, so I not...when this boy go to put on this tattoo I say ‘Oh Christ’, then I realize that I playing with my life.”

FSW, Region 6
my own needle. I was too anxious to put on this tattoo, so I not...when this boy go to put on this tattoo I say ‘oh Christ’, then I realize that I playing with my life.”

4.2.4 Men who have Sex with Men (MSM)
The MSM populations who were interviewed for the study fell between the 15-19 or 20-24 category and all demonstrated good levels of knowledge. The MSMs who were sourced for the study were done using “gatekeepers”, local NGOs that had a history with the participants and had in most cases already exposed them to training and education opportunities related to HIV/AIDS.

However, they also said that among some young males there were still knowledge gaps.

R: Yes, yes, is a prevalence that the younger generation still is at risk.
M: And why is that
R: Ignorant of the fact. They still is ignorant. I would still say ignorant of the fact because...the NGOs doing an excellent job

The younger generation of MSMs (teenagers) were described by a peer educator as having a complacent attitude.

“We look out for our little sister [other MSM] them...some of them are so much rude, they are very rude. They arrogant. When I say rude...not you lil girl...some of them are so rude. 'What the [expletive] ya'll telling me, ya'll done had ya'll time, is we go round, leave we alone', you understand me?

I does call them 'cliffhanger', that's like when you playing the game on the 'Price Is Right' [yodels] go till you drop, go.”

4.2.5 Young People Living with HIV
At the NOC in Region 2, an FGD was conducted with three YPLHIV. The three individuals (2 males and one female) ages 15-19 had started to have sex at ages 12, 13 and 15. Based on their responses all of the youth came from inner city Georgetown and one specifically reference being from Albouystown.

M: So, before you had sex, when was the first time you heard about HIV?
R: My father does work at Georgetown Public Hospital
M: Do you remember what age you were when you heard?
R: The first time I know me father, I was round the age of like 10
M: So ten is when you heard about HIV? What about when you were in school?
R: Miss they never tell me about HIV in school.
M: So they never told you about safe sex, about your body and that type of thing?
R: Miss I was like 10 when I heard about HIV?

Among urban YPLHIV interviewed in Georgetown (8 persons, mixed sex group) similar sentiments were shared in that they did have some knowledge of HIV from school (Form 1) and from the television.

### 4.2.6 Youth in Contact with the Law

As stated in this FGD with young females (10-14) at New Opportunity Corps displayed the same levels of knowledge about HIV as other cohorts with some believing that it was possible to get infected by sharing food and by a mosquito:

**Ema:** Like you could get it from food miss
**Moderator:** You could get it from food?
**All:** Yes miss

They all agreed that it was not possible to look at someone and tell if they were HIV+

**Roshnie:** Don’t matter what you could have HIV and you could be big and strong, fat normal fine

The 10-14 females also demonstrated a much more worldly and practical knowledge of HIV/AIDS. For example they referred to the use of pills (ARVs). They knew of the dangers of condoms bursting and putting partners at risk of contracting the disease, and referred to mother to child transmission which few other females in the same age range did. The older males 15-19 had knowledge en par with boys in other age ranges but touched on other information that other groups did not mention:

**Ziggy:**
**Orin:** I know bout all like if you kiss somebody and they lip buss you can get it
**Moderator:** Huh, if you had anal sex
**Orin:** Two man and one of them got AIDS
**Ziggy:** Running is healthy [referring to image of athlete]
4.2.7 In Depth Interview
‘Girls, Girls, Girls’

One of the typical behaviour patterns among adolescents who were out-of-school, and significantly either truant or not working was a higher likelihood of being sexual active, with numerous partners as compared with their peers who were of the same age. This case study sheds light on a number of key factors both positive and negative and cuts across several key themes; such as the occurrence of a traumatic event (parents’ divorce, forced sex etc.) and the impact on sexual activity, the importance of social networks and peers etc. There were a small amount of young men in the age categories of 10-14 and 15-19 who described their first sexual encounter as being forced and one described it as being rape.

Martin, is a nineteen (19) year old afro-Guyanese male living in a rural area on the Essequibo Coast (Region 2). He is handsome, popular and has a well-honed physique because of his love of football and other sports. He parties fairly regularly and considers himself to be a moderate drinker. He also uses marijuana occasionally (about once a month). He was born in Guyana but spent a lot of his life living in a neighbouring country.

His sexual initiation was unwanted and forced. He was nine years old and encountered a friend of his parents who owned a small bakery. The woman was thirty-nine (39) years old at the time and got permission from his mother for him to stay overnight and help her to bake bread. She then forced him to have sex with her, which he described and which clearly left emotional scars:

“Whole night the woman buss up me thing [penis], like when I watch this woman here, like I want murder she, boy I hate she like... you know ‘cause is bare pain”.

When he went home he told his father, because he was bleeding and had burst a vein. His father then relayed this to his mother, “somebody buss up he virgin”. He did not relay any action being taken against the woman, but did have support from his parents.
“You see me old lady and me old man is they say the best friend you suppose to have is your mother and your father cite you does don’t hide nothing from them two so if you got something to like, you know, like you getting a problem with your girl or some [expletive] call your mother or your father cite you talk to them.”

His mother “forced” him to have an HIV/AIDS test shortly after he would never have another test. His mother was raised in Venezuela and there is exposure regularly “every minute” to HIV/AIDS related programs. Martin also got exposed in a “Sexologia” class dedicated to sex education. HIV/AIDS was integrated into other subject classes.

A few years after the incident, at age 11, he started to have girlfriends. Several of the girls that he had causal sex with were with women who were having sex with his cousins and his friends. He has since had sex with multiple girls, including young girls (who get away from home when their parents are sleeping) that he meets on Monday night at Charity’s night scene. He has a main girlfriend who he is sexually active with along with other girls who he is also sexually active with.

‘cause he [his cousin] went deh with the girl first, and I go and deh with the girl, the girl tell me come [ejaculate] just so because [name] is come just so. I say what, no man I can’t go just so, hold on it aint gonna tek me long to put on a condom. So I say you can’t catch me so easy man, I got to deh real, real, real, real, pissing drunk, I could deh with a woman without condom."

“Yea I get more than one girl man cite, but certain girls not … dehing with you alone, that what more you really don’t do [expletive] with cite, like what is done you wife.”

Martin has two key practices. He is aware of the dangers of alcohol and is open to the use of marijuana, which his mother endorses because of its benefits to the body. He reported that even when he was under age he was able to buy alcohol at clubs in Charity except for one bar [name of bar withheld] “because …you is got to show ID card to go up deh”.

“First thing when you over drink alcohol you does always want go bare back [without a condom], if you ain’t got you focus up, gone you gone.”
“Weed is nah really “drugs” you know. Weed is a good thing for a man body, but you is can’t do it too steady cite if you smoke a joint of weed every month it good for you body cite.”

“I know nuff people who does smoke weed by we side deh and them man is big and fat cite, like up to me big sister is smoke weed.”

Martin understood the importance of condom use, this is largely because of the influence of his mother and his deep distrust of women.

“No boy you don’t trust yourself now a days boy because sometime you aint know what she got man, you can’t see in she body and say, you know, that she got AIDS, you got to always go protected.”

“Even me mother is tell me that mommy say watch certain girl (name) you don’t trust cite because a woman could just now deh with a man ‘round the corner deh and she could come home by you and she dry, dry, dry again cite but you see we man now when we kick two water by the turn deh and we pull up by we wife we can’t really kick three more water you understand me.”

Martin did not have much faith for the quality of condoms that are distributed freely and at the hospital so he prefers to buy them in the store. His mother also gives him condoms whenever she goes to the hospital. His relationship with his mother is such that she is aware of his sexual practices.

“Because mommy know me and this girl is friend and mommy catch me and this girl sexing. Mommy don’t tell me nothing cite, all she’s tell me, (name) when you going and do something make sure you get on a condom. To mommy that is a must don’t take them bluff with condom at all.”

When he was seventeen, he returned to a VCT to support a pregnant girlfriend. He feels that if the girlfriend is not HIV positive then he is not positive and there is no need to be tested.

“I went deh with one of me friends girl and she get pregnant and you know them is got to test themselves all like when them test themselves like when them get pregnant to get baby and them [expletive], so that means if she aint got me aint got.”
4.3 What are the relationship and sexual practices of adolescents?

In the chapter, the sexual and relationship practices of adolescents cover a wide range of areas including age of first boyfriend/girlfriend, sexual debut, nature and number of relationships etc.. Because of the importance of condoms and testing, this is dealt with in the proceeding chapter.

The majority of children in school were not found to be sexually active. The majority of in-school youth generally said that they wanted to delay sexual debut until they had completed school or until they were older mainly placed at around 18 years old. The school and social environment tended to have positive role in reinforcing such behaviours and choices among both male and female adolescents. Girls, especially in rural and hinterland areas also mentioned the number of after-school chores that they had which kept them preoccupied.

This finding ran counter to the view of Key Informants in decision-making and service delivery roles that believed that many adolescents both male and female were having sex. However, it was quite common for males to become sexually active at a slightly younger age than girls, but this was generally around the age of 14 and 15. In instances where young women were found to be sexually active at a pre-teen age, it was usually because of a violent act such as rape, or as the result of peer pressure.

A common characteristic of a relationship network of some male adolescents who were sexually active, was to have one dominant partner, referred to as a “wife,” “wifie” or “girlfriend” and numerous other partners, “spare wheel” “playmate” “plaything” that were more casual. This was also the case with girls but to a lesser extent, and their secondary partners were usually not males that they had sex with. Some girls mentioned that their boyfriends possibly had other girlfriends, or that they were unsure or how monogamous their relationship was. Among MSM respondents this was a lot more prevalent and the “main/dominant” relationship was with one or more males (up to three reported), supported by a range of other causal relationships.
There was reporting among both male and female adolescents of being raped, or having been forced to have sex, one male adolescent described his sexual debut as being “like a rape”. Like their female counterparts they tended to carry the emotional scars of these experiences with them but with fewer opportunities to discuss their experiences since this did not reconcile with male stereotypes or macho behaviour that young men are expected to display.

Many young men who had sex at a young age tended to have an unplanned and unprotected sexual debut.

It is important to understand what the term “boyfriend” connotes among female youth. Most of the male and female adolescents that we interviewed had a boyfriend or girlfriend. They tended to be a person who they liked, and in whom they could confide, do homework, text and meet socially. For others it connoted a sexual relationship. In the 10-14 age range in hinterland areas, there were few boyfriend relationships reported. This was to some extent borne out by the fact that the sexually active girls said that they made their debut at circa 15 years old. Similarly, in rural and urban contexts having a boyfriend/girlfriend described either a platonic or a sexual relationship.

For example among 15-19 in-schools, Indo-Guyanese females:
M: So when you say, like a boyfriend, right? Are you kissing your boyfriend, or...?
R: No
R: Well I don't really have one right now, but when I was in form four ... it was just a friend, like just for a two week or so...
M: So what would you do, like talking on the phone?
R: No, in school...just talk
M: So what makes him special that you call him a boyfriend? Cause you talk to many boys, or you like him a lot?
R: Yeah, it used to be like, you know any time, like school work and stuff he's normally help me.

Among Indo-Guyanese in rural areas, there was also mentioned of arranged marriages, but this was not commonly reported. There was a strong sense of social control and stigma related to a loss of virginity, or having a relationship and being unmarried as this would bring “shame” on the family. Having sex meant having to be married, with very few other options in between.

R: I was engaged at sixteen
M: And how old was the boy?
R The boy, was um, twenty, twenty-one....
R ...I got away one time...
R ...confusion, problem, peer pressure, everything and he just come, collect me from school and I go, unexpected. I didn't know he was going to carry me away. We went, we went over the river, spend the night...not gonna le. We spend the night without doing anything, because I was just confuse.. and now I came back home, Mommy bring the police everything...and I still didn't go home because I was already engaged. They say if I go back home, leaving this guy [mumbling]

M: They [parents] think you’re “finished” if you sleep with a boy?
R: Yes, it means you lost your virginity already, no man would ever want you. Who gon want somebody that...already finish?

A common trend among adolescents, across all categories (MSM, out-of-school youth, in-school-youth) was the prevalence of opportune, spontaneous sex; at school sports, in the toilet, on the grass etc. where neither partner expected to have sex, and as a result, did not come prepared to have protected sex.
In addition, although many girls referred to peer pressure as a contributing factor to sexual initiation, many young males, especially those who came from troubled backgrounds or had emotional issues, tended to mimic the sexual patterns of their peers, i.e., there seemed to be a higher probability that they would also be sexually active. This speaks to the role of social networks and peers in informing relationship and safe sex practices.

A critical period in a young person’s sexual life seems to be the period just before they depart school (3rd, 4th, and 5th form) and when they leave school. Many youth then would more likely begin to party and have sexual encounters. This includes after they have left school and this was reflected in comments with both male and female respondents including teenage mothers.

Because of the prevalence of new means of communication (such as cell phones and internet) in all of the sites (cell phones more so in hinterland areas) these devices were being used to connect youth and to place both female and male youth in contact with older adolescents and more mature adults with whom they may not ordinarily have access. In Region 1, a female respondent reported being offered money for her cell phone number and at some schools the use of cell phones had been banned.

There was a general distrust on both sides (male and female), as reflected in this quote:

‘Cause she could just now deh with a man and pull up, “ow baby” remember you ain’t gonna know. Cause women is a thing you don’t really trust at all you know.”

4.3.1 In-School Youth

Most female, in-school youth did not report sexual activity and in general, those who were sexual active were a small percentage of the group (possibly 10-30%). Most girls said that they felt that they would be ready to initiate sex when they, “were older [usually late teens, or early 20s] or when they had left schools.

In instances where girls were sexually active, a few of them mentioned peer pressure as being the cause, usually in combination with alcohol or being
at a place or event where there was minimal or no supervision.

For example one Afro-Guyanese female [15-19] in an urban setting recounting how her female friend was instrumental in her having sex for the first time at thirteen:

R: She [her friend] was like 12 when she lose hers. She said "I went and do this thing this thing feel good" and "If you nah gon do it you can't be in our crew anymore." I didn't tell my mother it was like rape, cuz I was like sleeping. When I wake up I see the guy on top of me and I just wash off and never come back.

...That's what I thought, I thought he would always be there for me. But he listens to he mother and he felt bad about what he did. He sister call he and tell he "She don't like you she got another man etc." At the age of 15 I started having sex again."

4.3.2 Out of School-Youth

Generally the male 10-14 years old were aware of condoms though their sexual practices, which were usually opportune and hurried, meant that they were usually not protected.

M: So when the girl is there...like where you would be?
R: Like if you hurry to do it, you don't have time to put on condom
M: So normally you does be in a hurry to do it, because you would be doing it where?
R: A fowl pen
R: A bush
R: A old house
R: A hut, in the water, on a tree
[Boys laughing]

Emotionally the boys expressed a variety of responses including humour, fear and apprehension at having had un-protected sex with one suggesting that he was too young ("too small") to become infected. Pregnancy seemed to be the most worrisome issue for females, but both pregnancy and HIV/AIDS was spoken of among male even it was first referred to among males. Generally, youth revealed some of their confusion and worry after they had had sexual intercourse.
M: How do you feel – you get scared?
R1: Me does feel like wha if she come back and tell me she pregnant.
M: You worry about that, you don’t worry about her saying I got HIV?
R1: Yeah, I does frighten like if she got AIDS
M: So how you feel, you nervous you worried?
R1: Heart beating
M: After, or, all the time?
R1: All the time
M: Or maybe yall not thinking about HIV and getting girls pregnant? You think about it or you don’t?
R2: No
R3: Don’t think about it...I small

Their sexual partners were multiple and involved girls who were not significantly older than they were.

M: You think that they are? That they have other boyfriends?
R: They got other boys
R: You would think they don’t have, and is you alone, but they is got nuff [many] boyfriends!
M: Your girlfriend is the same Ramesh?
R: She deh all bout [laughing]
M: What about you Ethan, you think your girlfriend is going with other boys?
R: Yeah

The respondents demonstrated earlier engagement with the opposite sex as compared with other youth in the same category who were in school. Half of them described having had a first girlfriend from an early age and that this involved kissing. One boy who was not involved in sexual activity had started groping girls, which he described as “lash and run” (quick sex).

**4.3.3 Young Gold Miners [20-24]**

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32 A 2002 study by Carol Palmer et al, *HIV Prevalence in a Gold Mining Camp in the Amazon Region, Guyana*, found that 6.5% of 218 were HIV positive. The report noted that the “high percentage of HIV infection provides a reservoir for the virus in this region, warranting immediate public health intervention to curb its spread.
Most of the young men who were interviewed in Region 1, got involved in mining at a young age (between 14-17). Several of them had dropped out of school, and a few of them had completed school. One boy was the top student for his year.

Miners described the lifestyle in their trade. Generally, they worked for several weeks, approximately six weeks (a quarter) and would then come out to the landing. Because of the known temptation some miners said that they avoided the area in order to abstain from risky behaviour and to save their money:

“All gold mining port is like that, you know. If you go to Port Kaituma, when you coming out the mines, you come down to the landing, just like Bartica, you go up into the mine to come down the piece of landing. When you come down now, you get temptation to start spending your money. Got a lot of woman, got a lot of beers…”

It was not definite that they would have sex, it would depend. But some said that they would tend to trust the women (FSW) they usually have sex with, and others said they did not. Alcohol was generally mentioned and this tended to impair decision-making.

R: Normally you going and look for a piece of money, women [FSWs] going too. She got a family so anybody come and want have sex with she...might be two pennyweight
M: What’s the value of two pennyweight?
R: Gold selling for twenty thousand a pennyweight
M: That’s about $40,000?
R: Yea. Is just like for an hour...five minute or a hour. All depends...
M: It means you could spend a lot of money on stuff like that...on women
R: Every individual I see, don’t spend all that [money] on a woman...maybe one and two time [not often]. Mostly any one of we is just go and buy thing [alcohol, food], but it got people [who do buy sex regularly].

4.3.4 Teenage Mothers [15-19]

Within Region 1 it was frequently cited that teenage pregnancy was a key social issue. Teenage
pregnancy along with sexual abuse and incest were the most often cited issues in the region that affect women. It was found that 25% of the recorded births from January to October 2012 were to women less than 18 years old. Pregnancy among young people was used as a gauge of use of protection, especially since both pregnant mothers and care givers at health centres and hospitals stated that these pregnancies were largely unplanned.

In Region 1, three young mothers were interviewed, two of whom had become pregnant as teenagers. What is evident is the low emotional intelligence displayed and despite the age range (i.e. being over 18) limited of respondents who became pregnant because she thought she was infertile, she never used protection, which suggests that the primary deterrent for using protection is family planning. And another simply did not use protection. Both became pregnant after the left secondary school and one was a teacher. Both girls are, one year later, still in relationships with their partners but neither is certain if they are in exclusive relationships.

4.3.5 Men who have Sex with Men (MSM)

The MSMs who were interviewed were confined to urban centres. As in other studies, it was difficult to get MSMs who were willing to participate in rural/hinterland because of the stigma and discrimination. In Region 2, it was reported that most of the MSMs had moved to Georgetown and several persons made homophobic remarks.

In Region 6, the MSMs were sourced through a local NGO and was a mixed group [male respondents who were over the 24 year ceiling] which allowed for an inter-generational discussion.

The majority of MSM respondents who were interviewed described themselves as “female” and as “bottoms”. Overall the MSMs painted a picture of a very close knit and vibrant social life that was characterized by multiple partners and lots of sexual activity. They described themselves and their community as being “promiscuous” which they knew put them at risk. They would have multiple partners and the partners would not be knowledgeable about the other partners. The relationships were also to some extent

“I had an affair with a guy for thirteen years and a wife, a beautiful wife and two beautiful kids and we’re still together. The wife, people does complain to her and she stop me a day on the road and she ask me, but I could not have say ‘yes’ you deny the fact.”
transactional since one MSM was living with an older MSM though not in an exclusive relationship.

It was reported that:
“In a homosexual setting is very rare...very, very rare, because, amm, I would want to say we always crave for more. Something better, something flashy.”

For example, in one case, one MSM was having primary relations with three main partners, but also having sex with other men, who were referred to as “playmates” and “sex mates”. Some of the partners were also married or bisexual. The group also referred to men who were married and kept their homosexual relations on the “down low”.

**Tops and Bottoms**
Everyone in the group considered themselves to be females “bottoms,” or receivers, which places them at greater risk.

The MSMs stated that there was a new practice of being “flexible” i.e. being both a top and a bottom although this was looked down on by older men.

**Under Age Partners**
Interestingly, older males (above the age of 24) stated that their preference was for much younger boys, including ages that were below the age of consent.

“And the craving is getting deeper and always a yearning for more, and younger bloods.”

Another said that:

“By the time you reach twenty, you expire”.

“I love young boys!”

Most of the MSMs became active in the early teens 14 and 15, but felt that among the younger generation they were becoming sexually active at a much young age ten, eleven and thirteen. They also described younger boys as being aggressive.

One MSM who was in his late forties described being pursued by a younger male (aged 10) from who and his anxiety about it:

“Every day this lil child coming for this ice [to buy], me getting cold sweat, fever...why this guy looking at me, smiling, smiling...but nine, ten, always with a broad smile and when he watch you underneath.”
Sexual Enhancers
The respondents also referred to products that allowed for longer gratification, which they also saw as putting them at risk as it potentially resulted in more sporadic unplanned sex as described below.

"Now you have a particular product selling at the drugstore called Last Long, is for the male partner to use, I wouldn’t call the drugstore name, but one is being sold for the sum of GY$500, the other $1000. One is for 4 hour, one is for 8 hour...the longevity...for the penis, ok. So is a lot of sexual enhancement out there. Now he might go to his girlfriend when he already use this product, but due to the agony the girlfriend get rid of him. Remember, he did not ejaculate to get that fusion out, so the only way now ‘oh, [expletive], I living through the same street with Antiman [name given].’"

Sporadic Sex
The group stated that one of the sexual practices that put them at risk was an unplanned, and sporadic sexual encounters. This was consistent with what was reported among other male cohorts. They said that they may meet someone in the toilet, or end up having sex in a burial ground or on the grass. So they were not prepared and did not have protection.

Money
Respondents said that younger MSM were attracted to them because of their wealth, but dismissed the notion that it gave them power over young males.

"Working as a public servant, they watch you, they know is your pay day, you leave to go to the washroom...these are some of the advantages and the challenges that the MSM face in the field or in the air or in the community. Especially, for the men who are not working, young out of school men and those drop out of school, because remember they have their needs to be met, ok. Now they approach you, you go to the back washroom to urinate...please for $500. Sometimes he ain even want you to urine, he will take out his penis and he would show it to you, you understand?"

Another said that amongst MSM, money was not always the motivation, but pleasure was:
“If I may, they have a lot of them that does not approach you for money, they approach you ‘cause they wanna feel nice…I want you give me a lash off [oral sex] or...or...I want to have sex with you.”

4.3.6 Young People in Contact with the Law

There was a higher incidence of sexually active males and females among this cohort. This was also the case for girls across age ranges 10-14 and 15-19 years old.

Girls 10-14 FGD, New Opportunity Corps

R: 12 years [sexual debut], the person was older
M How old was he?
R: 17
M He was 17, ok, anybody else want share?
R2: Miss well me the person was older than me and he was 18
M: And how old were you?
R2: 13

Forced Sex

The incidences of rape that were discovered during the research were mainly among girls and less among boys, however a few boys recalled being raped as children or forced into having sex.

This emerged during the ‘timeline’ exercised in which respondents were asked to identify what age they were when they had their first sexual experience.

Boys 10-14, Scouts Group, New Amsterdam Police Station

M: And where do these things [men approaching boys for sex] happen? Where would they be?
R: In a old house...
M: So they would be in the old house and the people would call you in? And they would call you in?
R: Miss, on the road they take you in [to the house] and they rape you.

Youth in Contact with the law, Males 15-19

“Miss 9 [first had sex], miss, is not really sex miss like I de miss to me like I de get rape, miss.”
Another said:

“I remember I didn’t want kiss the girl, but she forcing me to kiss she and I didn’t want kiss she and I still end up kissing she because she force me.”

**Female 15-19, In-School Youth**

Felicia: So, um, two things, how about if you’ve been abused in your early age um is that sexually active?

M: Yes, rape is sorta [sort of] means that you had a trauma in your life like something that was very traumatic. So you wanna put like say roughly when, or anything like that, or you don’t want to talk about it? ‘Cause if it’s something that makes you uncomfortable, you don’t have to talk about it.

Kelly: 13

M: 13 good. Anybody else?

Felicia: 15

M: If like anybody want say, like something that was traumatic, where you didn’t want to do it and you want to include it, you just say trauma and we put it as an age you don’t have to say that it was like boyfriend and girlfriend. Alright.

Tia33: 17

M: 17 [repeating]

Brea: Abused at 5

M: Ok, we’ll put trauma down here.

Maria: Miss, age 9

M: OK, so that’s a trauma. Anybody else?

Brea: Sex at 15

Persons were given the option not to reveal anything that made them uncomfortable and at the end of the session were invited to discuss it further if they so wished. In one such case, Crystal, now aged 15 and being educated on the coast, recounted in private, that she was raped in her village (hinterland) at age 8 and again at age 9. She has brothers and sisters and later said that her sister had told her mother that she was molested by her cousin.

She remembers that the first incident occurred during Amerindian Heritage Month because her

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33 All the names used are pseudonyms adopted for the exercise.
father was drinking excessive amounts of alcohol. Up until she started Charity Secondary

When she was age 11, during a class in which STIs were being discussed, she realized that it was not normal for your uncle to sleep with you, up until ten she had thought that it was. She was so overwhelmed and felt so bad that she had to get up and leave the class, which is when her teacher realized that something was not right. She then wrote a letter to her teacher explaining what had happened to her. She said that two days later, the teacher invited her over to dinner and would eventually tell her she’s not the only person it happened to. She would eventually tell two teachers that she had been raped and one in particular has continued to take an interest in her and would give her treats. “But all of them tell me that I have to "forget about it and move on", but I can't forget. They don't understand my feelings.”

Healing

Crystal loves to write and documents her life in stories. She wrote a essay about her experience called, "The Most Momentous Incident in My Life". At the time she had showed it to her mother, telling her that it was something she made up, but she dismissed her. "I showed it to Mum but she said, "you don't have anything good to write."

When she was 15, she had a vaginal infection and her teacher who told her "you can tell me everything," took her to the doctor. She was confused about whether she was a virgin or not and she asked her teacher, "if I could still be a virgin". When her mum came out from the river she was vexed that she didn’t know about the hospital visit. She responded to her mum by saying, “see how I does feel because when I tell you things you don't take interest in me, so I have to tell someone who takes an interest in me.” She has never been tested for HIV/AIDS.

She said that she hated boys after the incident and does not want to have a boyfriend until she is ready. "I feel like I will never do it! "Her uncle has moved and now lives in Bartica, her plan is to buy a gun and take revenge when she leaves school. She plans to graduate as the best student in the school and has topped the region in the past. Her school performance is what gives her the courage to move on. She feels suicidal "nuff time" especially when she has problems with her mother, she feels that her mother does not give her the support she needs.
4.3.7 Young People in Contact with the Law

In Depth Interview
Girls with Early Sexual Debut
"Every Best Friend, has A Best Friend"

Through a senior Social Worker in Region 2, three teenage Amerindian adolescents (Angel, Kelly and Madonna\(^{34}\)) who had run away from home and had been briefly trafficked, were identified and interviewed individually (in one case Angel and Madonna together) to understand what were some of the drivers behind young girls in this age range. The interview provided insight into the social networks of teenagers - the reasons for low levels of protection, self-esteem and peer pressure. It also speaks to the psychosocial and protection needs of young girls. One of the common recommendations among young girls, including Kelly whose story is presented here, was to have counselling available to guide them through difficult and confusing periods of their lives.

The sexual debut in all three cases was before the age of 15 and unprotected.

In one case, Angel was pressured by her friend Kelly (same age range) to have sex, “she had it and she used to tell me, it’s good and I should experience it”. She felt pressured to have sex. Angel described sex like an initiation, she said that “Kelly had done it already and I feel stupid. She [Kelly] used to say that she big already and I is small”. Angel then had unprotected sex at her 14\(^{th}\) birthday at a party even though her boyfriend (16 years old at the time) was willing to wait. She said she would not have had sex at 14 years old if she had not been pressured. After she had sex with her boyfriend who had other sexual partners she never had sex with him again even though they remained in a relationship for a year. She would think about it often and regretted having sex, it affected her school performance and she dropped back in school, she went from scoring between 50-60% in class to 40%. She then went on to another boyfriend with whom she has sex, he is out of

\(^{34}\) All the names used are pseudonyms adopted for the exercise.

“Kelly had done it already [had sex] and I feel stupid. She [Kelly] used to say that she big already and I is small. It wasn’t something that I wanted”.

Angel
15 years

“I don’t like telling mummy certain things...because case we get into an argument she will throw in me face.”

Kelly
15 years
school and she was attracted to him because he was cute and dressed nicely. She regularly has sex with her current boyfriend who is 18 and they always use a condom.

Madonna (15 years old), her friend, ran away from home because she was “bored at home and wanted to go to Georgetown”. She also had sex at the age of 14 at a “wedding house” [place where a wedding is held usually a private house, or hotel], she had been drinking at the time. If she had not been drinking, she said she would not have had sex. She meets with him after school and at the weekend. She also has another boyfriend who she met at a club. Her main incentive for using a condom is that she does not want to get pregnant. Madonna fights regularly with her parents and feels that the teachers at the school ignore them, and brand them as “bad girls”

Kelly, who initiated Angel into having sex with boys said that she started to have sex with her boyfriend when she was 11 and he was 16 years old and out of school. They dated for one year and he told her that he was going to marry her. When he left her she decided to “bruk wild”.

Kelly generally distrusts adults and her friends with sharing her feelings. She is convinced that the social worker has been spreading rumours about her, that she has slept with “a whole set of boys” when she was in Bartica (the location to which they girls were trafficked). She only tells some things to her girlfriends because, “every best friend has a best friend”.

Kelly feels that the males that she has had sex with don’t care about her, she now feel suicidal because she thinks constantly about the things that she has done with boys from the age of 11 to now. She feels “ashamed” and that she “doesn’t have much worth”. She has tried to mix up sleeping pills (that she bought at the pharmacy) and to take her life. She feels the trigger for her behaviour stems from her father leaving the home and her parents’ divorce. She found dealing with this difficult and having to deal with her boyfriend abandoning her at around the same time. “Everything is difficult...just being a teenager is difficult.”

She does not have a good relationship with her mother. She related that her mother heard on the street about some of the things that she was involved in and came home and slapped her in the face. She feels that her mother embarrasses her by
saying “plenty hurtful things...I don't know why she make me, I just bring disgrace on the family.”

Her sexual and social activities include:

- Sex with two teachers at a hotel when she was fourteen, their ages were about 23/24
- She has sex at hotels with guys
- Having slept with approximately 20 boys
- Usually slept with the majority of them one time
- Started drinking alcohol at 12, drinks in the clubs at Charity, consuming about 17 beers in one night paid for by gold mining male friends
- She has been tested once – last year
4.4 Are adolescents using condoms and getting tested?

There were mixed and inconsistent responses as it relates to adolescents and HIV prevention. In general, condoms were identified and were used as the first line of defence against infection. As such, many people equated using a condom with not having to be tested regularly, which opened them up to exposure.

Among Female Sex Workers and MSMs there was a higher tendency to get tested, especially if they were able to access services that they trusted. However, this was by no means uniform. Condom use among MSMs was also not uniform, and even though men were aware of the dangers, the spontaneous situations meant that they were often unprepared and unprotected. Among male youth in contact with the law there was the highest incidence of practicing unsafe sex. Males between the ages of 15-18 provided reasons such as discomfort and lack of knowledge for being the reason for not using a condom.

In hinterland areas, where testing facilities were not available youth tended to be conscious of wearing condoms and even among young cohorts (10-14) claimed to always use condoms when they had sex. Among young 10-14 out-of-school youth in rural areas, condom use was not widely practiced, however among older age ranges they were much more likely to use condoms largely because they were sharing partners and did not trust their female sex partners or, were afraid of getting HIV/AIDS or getting a girl pregnant. Among older girls, the fear of becoming pregnant seemed to be greater motivation for safe sex than the risk of contracting HIV.

Civil society organizations (CSOs) were more likely to be mentioned as a source of condoms and testing that any other institution. Several persons felt that the quality of free condoms were poor, which exposed them to risk.

In order to ensure confidentiality, some adolescents (mainly older adolescents 20-24) who are mobile tend to get tested in other regions (when mobile) such as Georgetown, rather than close to where the
lived. However the generally knew where to go to get tested if they wanted to. Many reported “shame shyness” as a reason that keeps them away from both public and possibly even NGO facilities. This is the same for accessing free condoms.

4.4.1 In-School Youth

With the exception of girls who reported being raped or sexually molested, there was, in general limited reporting of sexual activity among girls in the 10-14 category across the regions.

In Region 1, boys in the 15-19 age range said that they started to have sex usually around the age of 14 years old. And some boys in that age range said that they were sexually active. One 14 year old said that condoms, “Is a must”. They were motivated to use condoms for fear of contracting HIV, STDs and getting girls pregnant. They could obtain condoms from the Red Cross. One boy said he had had sex with five girls and had used condoms but had never gotten tested. When asked, the boys also produced condoms. Parties, sports meets and other events that led to chance encounters among boys meant that in some instances (including the first sexual encounter) protection was not used.

In older males (15-19) in Region 2 (rural) there was not much reporting of sex but in some instances it was reported as being unprotected. Males tended to become sexually active at age 15. This was mirrored in the same female category and was also mainly unprotected.

4.4.2 Female Sex Workers

Female Sex Workers, generally understood that they were at risk. Some of them demonstrated extreme discipline and protocols for ensuring that they were protected in both their private and personal lives.

“If I want a baby, I go to Comforting Hearts or I come to brickwall [Bricklayers Association] or whatsoever and me and he gon come in the room and we gon do the test together and then when the test come back we gon have unprotected sex, but we make sure the test run for six months, that’s how I do it in my relationship, but how long no rubber….no ride…”

HIV prevention was not the only motivation for protection:
“I don’t want children that’s why I don’t sex with a condom and I don’t like doing abortion so that’s how I protect myself and my relationship.”

“A sex worker tell me, she normally use a condom and this condom burst and she ain realise this condom burst, right now she’s pregnant.

Another said:

R: All of that too. Another thing how I does do is, I go at Comforting Heart, I have my card, every three months, I repeat my test and I carry he [partner] along with me, every three months.

[Laughter]

R: I ain shame to say, every three months we go to Comforting Heart and we sit down and we do it. Sometimes the girl might watch me, so watch me. I say ’ I come to know me status, what going on? This young man here too’. Every three months I do my HIV test, I have my white card…”

The FSWs were also conscious about the quality of the condoms they received. They felt that the local NGO’s “durex” condoms were of good quality. Some said they preferred to buy them. They did not use female condoms:

“The female one [condom] ain make it, it ain make it.”

4.4.3 Men who have Sex with Men (MSM)

MSM’s generally displayed a strong awareness on the role of condoms as a means of protecting themselves from contracting HIV. They also were more likely than other groups to be tested along with sex workers and miners.

Dialogue with Urban (Region 4) MSM FGD

M: So what is the relationship [of a condom] to HIV?

R: That is one of the safest thing right now, the only safest thing we have right now is condom

R1: But that is not the condom for we

R2: You should abstain

R3: How many of us is abstain, you is abstain?

“Everything for me is for woman. And they have a lot of them who is also open out and no matter how you try to educate them, I know that they will, they does go without condom. Right now there’s a MSM who is living in my community who is HIV positive and I try my best, I try all my best, because she’s HIV positive and she will go with young men without a condom.”

Peer Educator/MSM
M: Some people say it is not safe, why do you say it is not safe?
R: It could burst
R2: If you put water in the condoms, you is see holes inside
R: Sometime in penetration it could burst if you don’t properly lubricate yourself

Several persons openly admitted to not using a condom consistently i.e. every time they had sex because of the sporadic nature of the event. A fleeting opportunity that had to be grasped:

“I was attending UG, there was this guy up Corentyne, we were in the same class and he was like, he always wanted, always wanted me. I left to go to the washroom and he followed me… and I had it in the washroom without a condom.”

Another incident:

“I on the road, I see this driver and I’m like ‘Oh my God’, I would [not] get this opportunity again. You don’t care if you don’t have anything [condoms], you just go and put yourself at risk.”

Another said that he does not worry about using condoms because he knows the people he goes with, even though he has multiple sex partners and engages in threesomes with a married man and another girl.

Another common pattern was to have unprotected sex in the teenage years, or the “wild years” as one referred to it, when they first became sexually active and then to start to use condoms and get tested later on. For example, one MSM had been sexually active for 5 years before he started using a condom.

“Well even though you were informed of it you still ain’t use to use it. In reality, it ain kick in. It now filtering in. remember we are a young generation and the learning process takes time to adapt to certain changes.”

There was also dual reporting on the use of condoms among young MSM in that it was also reported:

R: The men now, or the young boys, they are so health conscious that even if you don’t have...they have

“First she ask me if I find out I am HIV positive what I would do? I tell she I won’t want my family to know cause they gon hate me.”
M: They have a condom? So you think sex now is really safe among MSMs?
R: Yes
R: To a degree

The reporting on testing was also mixed; some said that they tested regularly, for example in one case for the last five years he got tested everything three months. Another said that in the last five years he had been tested twice.

The preference was to be tested at an NGO, because “I trust and rely on the people that works here.”

There was also some trepidation at the idea of being tested based on fear of being exposed but others were not afraid to be tested:

“Most persons are scared to be tested. They have friends, relatives working there and they talking.”

R: I talk to most guys, they are afraid to have the test
M: So you never got tested?
R: I got tested, I am not afraid. And I telling my friend them, don’t be afraid.

4.4.4 Young People Living with HIV

One male 15-19, who was interviewed at NOC said that they became aware of their status when they arrived there as it was compulsory to have a test.

Some persons said that they were not expecting to have sex and did not have a condom.

One female YPLHIV reflected:

“They say carry a condom with you all the time but if a person says they not planning to be sexually active any time soon, they wouldn’t carry a condom with them. But being in the time and place and the opportunity presents itself and they don’t have a condom, what would happen? So I think whether you want to or not, you should carry a condom.”

Most of the youth interviewed at NOC (15-19 male and female) said that they were surprised and got tested because of having been required to do so by social services. One male (Peter) seemed to be in denial about his condition.
Shenise\textsuperscript{35}: First she ask me if I find out I am HIV positive what I would do? I tell she I won't want my family to know cause they gon hate me. Then she tell me that I HIV positive but that won't change anything.

M: So you remember how you felt that day?
Shenise: Yeah, I cried at the clinic, I didn't want to go home back.
M: And when you heard Akeem, you were surprised?
Akeem: I was surprised
Peter: I came here (NOC) and I found out
M: How did you feel about it?
Peter: Well it wasn't the end of the world
M: Were you sad?
Peter: Well, is life.

Shenise said that she contracted HIV from a tattoo that she had gotten. Akeem, said that he was not knowledgeable about HIV/AIDs. Peter did not like wearing condoms:

M: Peter, you ever used [a condom]?
Peter\textsuperscript{36}: No
M: So why is it that you never used?
Peter: I did not want to ...I did not feel comfortable using them

\textbf{4.4.5 Out of School Youth}

The boys were aware of where to obtain condoms and mentioned that they could be obtained from the health centre or purchased in stores for $100. They knew where to get them but unlike most other boys in that age category they relied on friends and male relatives to supply but were not typically wearing a condom when they had sex.

M: So tell me this is really important, when you had sex with girls were you wearing a condom?
R: No
R: The girl wears a condom
M And she gave it to you to wear?
R: No she had a condom

\textsuperscript{35} All the names used are pseudonyms adopted for the exercise.

\textsuperscript{36} All the names used are pseudonyms adopted for the exercise.
M: Female condom?
R: Yeah, it got da!
M: I know. Ethan, Ramesh you?
R: No
M: You don’t wear one?
R: Never

Because of social stigma, the boys tended to generally hide their sexual activity from their parents and the parents of their sexual partners. This fear prevented them from safe sex and being tested for HIV.

M: And Bob why you didn’t go and get tested?
R: He frighten his mommy
M:Alright where do you have to go?
R: Health centre
R: You’s want drink gramazone and poison yourself [Ethan to Bob] you frighten the girl father
M: What are you afraid of? That people hear?
R: No, I frighten the doctor tell me I got AIDS.

4.4.6 Youth in Contact with the Law

At the NOC, the majority of male respondents have had sex. Only approximately one-third have ever used a condom. One male responded that he didn’t use it, because I didn't have one” another said that it was uncomfortable to wear one. As in other groups (MSM) similar behaviour was demonstrated, in which adolescents were aware of the dangers but willing to take the chance.

**Males 15-19, New Opportunity Corps**

R: I never had sex with one
M: You never did?
R: Never had it with condom
M: Ok. So you know where to go like how, Ziggy [other participant] since you would be free to talk like why you didn’t use the condom?
R: Miss ’cause me ain’t had none.

Male youth also said that condoms cost around $100 to $300 dollars:

M: Ok, so you could go and get the money, it’s easy to get the money to buy condoms?
R: No miss, only if you working, or you getting money from your mother.
Males 15-19, New Opportunity Corps:

M: And when you decided to have sex with her right you already knew lots of things about HIV and so
R: Yes miss
M: Ok, so you felt like you know enough? When you had sex with the girls, were you using a condom?
R: No miss
M: You weren’t using a condom, none of you?
R1: No
R2: No

Females 10-14 New Opportunity Corps:

M: All of y’all using a condom?
R: Except the time [when she was raped].
M: Right, of course, everybody else would be using it [condom]? And your boyfriends know how to put it on when they want to use it, or you ask them to use it?
All: Both
M: Both, and why would you use it?
R1: Protection
R2: Because you don’t know what they will be doing on the road
M: Right ok, and do you know like all of you know where to go and get one? Selena you know where to go and get one?
R: A test miss?
M: No a condom
R: They always got [available]
R1: Always got

In terms of health concerns - older male cohorts (20-24) those who were in contact with the law, were [despite being unprotected], primarily worried about contracting HIV/AIDS after the fact, more so than impregnating a female.

R: Yes miss, worried if she got AIDS or if she get pregnant
M: So but you didn’t go and get tested or anything like that but you ask her if she’s pregnant or so?
R: Yeah, I ask she.
M: And what she said?
R: Me aint ask she if she pregnant, I ask she if she get AIDS
M: Before or after [sex]?
R: After
M: And what she said?
R: She said no.
M: And you were with her for a long time like she was your girlfriend for a long time?
R: Yeah miss
M: Like how long?
R: Miss, since primary school
M: And she’s still your girlfriend now?
R: No
4.4.7 In Depth Interview
Condom Use Practices and Testing

The empirical evidence suggests that behavioral change among at risk groups is complex. For example, there is evidence among both out-of-school youth and YPLHIV that they did have some knowledge of HIV/AIDS prevention strategies but still engage in risky behaviour. A report on the subject states that, “HIV prevention is neither simple nor simplistic. We must achieve radical behavioural changes—both between individuals and across large groups of at-risk people—to reduce incidence. Once achieved, it is essential that such changes are sustained. Although cognitive-behavioural, persuasive communications, peer education, and diffusion of innovation approaches to change are beneficial within a combination prevention framework, behavioural science can and must do better.”

Similarly in the NAC 2004 report, Bulkan draws on lessons that address this phenomenon, “…mass media campaigns flooded many of these countries, but failed to result in behaviour … people do not change deeply-entrenched behaviour, such as sexual practices, simply on the basis of intellectual awareness that the behaviour may be dangerous to them.” One of the key questions that this research generated was why, given the risks were adolescents not consistently wearing condoms.

Before we sat down with Dharshanie (male MSM 34 years), we knew that he was positive and was having unprotected sex with other men. We knew this because one of the peer educators had mentioned him in the discussions and we requested a meeting. We then found out that he was outside of the age range, but we decided to use the opportunity of someone who was willing to talk, to explore his life experiences when he was younger.

When Dharshanie37 was 12-years old his mother died, which worsened the bad relationship that he had with his father. In the same year he started to have sex for the first time with a neighbour who was male and 16 years old. They had unprotected sex and Dharshanie had no understanding then of

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37 All the names used are pseudonyms adopted for the interview.
HIV/AIDS or the dangers. At 14 he left home and went to live at his grandmother’s house. At the time, “me tell me I can do what me feel to do, you know. I don’t have nobody like to tell me anything.”

He described that as being the time that he “bruk out” and started to drink, party and have sex with multiple men. Most of these relationships were casual and Dharshanie would usually go out three times socially during the week and would pick up a male partner for the night to have sex with. He never had a constant partner and considered himself to be unlucky in love.

“It got men who move hand to hand you know. Sometime they come they see she [MSM], they like she, sometime they can go with you too. Actually, abi [MSMs] is a different type of people... you know, you want to feel good, that’s why you do that [sex] and sometimes you see another one, you gone again...”

One of the constants in Dharshanie’s life was alcohol and sex and alcohol went together. Dharshanie loved music and loved to dance and to “display” himself.

“I drink and I get high, you know sometime when you over drink and you get high, if you not know what you doing. Sometime you see one guy you fall in love with him...you pick him up from the bar, you gone you do you thing.”

He worked as a casual worker doing odd jobs for people and also occasionally had transactional sex. They payment was sometimes in money [“if they got”] or in alcohol at the bar. During this time, due largely to the influence of friends he would use condoms but not consistently, “in and out”. He would especially not use a condom if he had been drinking.

“Actually I spend time with guy like they is come and visit me at me home, do what they gotta do and just, you know...hit the road after that.

When he developed a problem with his eyes he went to the New Amsterdam hospital and as part of the treatment he did a test. At 25 years old he discovered that he was HIV positive. He estimates that before then he slept with, “Oh Lord, extremely nuff” men.

He was surprised to be HIV positive, but received counselling which he was satisfied with. What he

“I never had love, trust me, never, never, never! That is the reason I put myself like this. Me never get luck like with a person who love you and who can tell you them things. So anything you catch you gone with.”
was not happy about was that it took 2.5 weeks before he was able to start his free course of treatment because the drugs were not available. He claims that the doctor at the hospital [name given] told members of his family that he was positive. During that time he joined the support group at FACT and got support from members of the group every month [third Monday]. He attended once a month, except for bouts when he was ill but was less interested to attend because the NGO no longer distributed free items, and the cost to travel was quite high. He relies heavily on hand outs and from money he receives from family who live abroad.

He does have sex, his preference is for younger men and he is able to find lovers who are about 20 years old, but sometimes he get males that are 16 years old. He collects condoms from the health centre, usually a month’s supply. He believes that it is possible to “catch out” [detect] young males who are positive if they do not insist on wearing a condom.

“Actually if they come to me and them hussle me, and we deh pon something and if they go bare back with you - watch them. If you is a careful man, you want to wear a condom, that mean you is a safe man. You know? Don’t make no body fool you, any man go like that, done know what they deh got”.
4.5 Are adolescents using alcohol and other psychoactive drugs?

The prevalence of alcohol was quite notable among all age ranges, sexes, and across all settlement types (urban, rural, hinterland). This was a consistent thread throughout multiple discourses with adolescents.

Whereas younger cohorts (10-14) may clearly distinguish undesirable behaviours (sex, drugs etc.) as bad or risky, they generally did not view alcohol in the same way. The significant number of respondents (including those in the 10-14 categories) had tried alcohol at a young age, and in some cases, had done so with the consent or knowledge of their parents. In most cases they had been introduced to it in a semi-controlled environment and drank various amounts ranging from a sip, to a glass or a bottle of beer. They tended to drink around occasions such as Christmas, weddings, sports meets, Heritage celebrations, and parties for the first time. This was also around the time and at the same events, when they would have sex for the first time.

Among males (MSMs, older cohorts 15-19, 20-24) alcohol in large quantities was a common characteristic of their social lives. Equally among girls who were sexually active or were promiscuous they tended to use alcohol and some directly attributed alcohol to unprotected sex. Many reported that they were likely to go “bare back” i.e. without a condom when they were intoxicated. Alcohol was observed to be readily available and generally inexpensive (approximately $500 for a quarter bottle of vodka).

Some youth referred to bars and clubs where alcohol was sold and generally, there were no barriers to obtaining alcohol – either through friends, stealing from the home, or buying it in shops even though they were underage.

There were no reports of drug use that involved a needle. Most adolescents who were exposed to needles outside of a hospital, tended to be within

“I think if they really want to get people they should state a really effective point, like it doesn’t make you look cool to have unprotected sex and smoke”

Female, Region 4

“First thing, when you over drink alcohol you does always want go bare back, if you ain’t got you focus up, gone you gone.”

Spanish, 19 years old Afro-Guyanese, out-of-school youth
the context of having a tattoo, which was popular among young people. There was not a lot of reported drug use but drugs, and in particular marijuana was mentioned more in urban settings. The price was reported by both youth and adults to be cheaper (starting at $200/300) in urban areas than in rural and hinterland areas where the cost was more prohibitive ($1,000).

4.5.1 In School Youth

Similar to out-of-school youth and other cohorts, alcohol consumption was generally seen as acceptable whilst other behaviors such as having kissing, having a girlfriend, smoking marijuana was seen as unacceptable behaviour. Most young male and female adolescents and pre-adolescents (10-14) have some sort of initiation with alcohol use during this age range. In some instances it is a one off or occasional drink, and inevitably it occurs at a function or in the home with the consent of parents.

An example from a rural area, male 10-14 (Suddie Primary)

- M: What about alcohol like have you ever had alcohol. How many of you had alcohol by hands 1, 2, 3, 4, 5, 6, 7. [seven persons]
- M: Often or one time?
- R1: One time
- R2: Miss a couple of time
- M: OK, like what would you drink, cool aid?
- R: No Ivanoff vodka
- M: What do you drink Kevin?
- R: Banks [beer], shandy
- M: And where are you getting it from?

"Miss I don’t steal, I does ask them first. Miss, when I go to the lake with my uncle, before I go I ask my mommy and daddy if we can drink alcohol, then they say “tek a drink”.

Diagram: Frequency of coding occurrence of the word ‘alcohol’ in all of the discussions with adolescents
R: At the liquor shop
R: Miss, I would drink like when it’s a holiday, or my father or my mother birthday
M: You would steal some, or they would give it to you?
R: Miss I don’t steal I does ask them first, miss when I go to the lake with my uncle and so, before I go I ask my mommy and daddy they if we can drink alcohol, then they say “tek a drink”.
M: How many of you got parents that you think drink too much.
Six children indicated that a parent(s) drank too much.

4.5.2 Out of school Youth 10-14
Similar to youth in other age categories the FGD respondents had tried alcohol but not in large quantities and mainly on special occasions, and in particular at Christmas time when they would spend long periods of time on the streets.

M: Anybody else? Anybody here drinks alcohol? What age yall started drinking...no you won’t get in trouble
R: Eight and nine and so
R: But we don’t drink to get drunk, like Christmas time and so
R: Beer one-one time

Apart from alcohol the respondents did not claim to have tried any other substances such as marijuana. Some also mentioned cigarette smoking but this was not excessive or common.

“Well one time when we de small after we see big people trying it, this time we have 70 dollars and we send he [pointing at Ramesh] to buy two, and we try it, and then we choke, cough up and so we throw it away”

4.5.3 Young Adults 20-24

There was some indication that sports often served as a deterrent for teenage drinking.

M: How old were you when you first start drinking?
R: Me aint even know...twenty
M: So how come you start drinking late?
R: I was the sportsman for the town
What type of sport?
Anything, volleyball, football

Young gold miners described the drinking scene at the landing:

“If you go to Bartica ... all of a sudden you don't know what happen, you get drunk, money done. A dog better than you right now, in Bartica. People would know you, so you got to got a head fuh now pick up...nuff young man come to Bartica from this area [Region 1] and had to turn back...with no money. A man I know come down with $500,000...next morning he ain got no money.”

4.5.4 Youth In Contact With The Law

Among 10-14 female youth at the New Opportunity Corps, drinking was not reported to be excessive; it was used to deal with stress and was usually taken in small amounts with the knowledge of adults.

Miss, I don't drink
Once I had um I don't know what it's call but I had friends and she tell me was lovely and I go and drink and since that day, the only time I ever drink alcohol is when I leave home and I see the alcohol bottle, and I take a little.
But any of you drink regularly?
No
One time time I drink alcohol and [inaudible] and it was my stepfather birthday and I just pick it up 'cause I de thirsty and I throw it down my throat and I walk down the step and fall down.
When we get like birthday and easter and so the my family does buy like [inaudible] and sometimes I does go and hide and take the Malibu.
OK, but ya'll don't generally drink a lot
No
Miss, when I'm stressed out when people say things behind my back which is not true [drinks]
4.6 What are their views of self, and their world?

This section encapsulates those views that youth shared that speak to their emotional well-being, their dreams and concerns.

Adolescents generally, including those in contact with the law, had aspirations to work in a variety of professions including being doctors, cashiers, pilots, lawyers and teachers.

**Feelings**

There were both observations and reporting of low self-esteem and sadness. Some youth in the hinterland areas reported feeling sad when they were away from home and in the dormitories. Others also reported having unsupportive caregivers. Some boys in the 15-18 categories in rural areas placed their self-esteem at “medium” or neither high nor low, girls in the same category reported as being “medium to high”. The adolescents often painted a picture of being isolated and having no one to talk to about their problems, especially as girls in particular distrusted their girl friends (every best friend has a best friend) on matters related to their sexuality.

They also presented their views of the outside world both positive and negative, including places where they like to go and places where they felt were a danger to them “hot spots”. These were often in synch with what the adults said. In addition, they talked of people who were supportive of them and cited instances in which they felt unsupported. Boys generally tended to say mother, friends, cousins etc. and girls to a lesser extent. The youth who were in contact with the law at NOC, said that they could speak to the Welfare Officer, Pastor and one mentioned a guard. Many persons, girls especially, said that they wanted a counsellor or someone who they could discuss what they were experiencing confidentially.

Several youth across all age categories stated that there were times when they felt stressed out and overwhelmed. Some youth, including those in contact with the law said that they had had suicidal feelings. Among younger in-school cohorts feeling of depression and sadness usually centred on when
there were problems in the home with their parents
and “parents fighting” was a common response.

Discussion with ten (10) 10-14 In-school males (rural):

M: Never had any feeling like that, like what
would make you feel sad or depressed?
R: Miss when my parents quarrel.
R1: Miss, when they [parents] have fights
M: How many of your parents fight a lot, 1,2,3,4 [persons raising hands] and then
you feel sad?
All: Yes miss

There was also a lot of indication among youth in
contact with the law that they had generally been
living in an environment that was not supportive.

4.6.1 Young People Living with HIV/AIDS, New
Opportunity Corps

M: If you think back, what were you doing at this
time of your life? Were you living home with
your family?
R: Yes miss
M: How old were you when you started having a
boyfriend or girlfriend?
R: Miss is only because of my family certain things
happen to me, if my mother didn’t move out, I
won’t a deh whey I deh

4.6.2 In school youth 15-19 years old (Male)

Several adolescents including in-school youth and
sex workers mentioned, or explored the issue of
discrimination as a key characteristic of the outside
world of young people who are considered as
‘different’ because of their sexuality.

R: Everyday we hearing something ‘cause all the
young boys them talking ‘bout it.
M: So you would hear about it regularly people
talking about it, like what kind of things they
would be saying
R: How that person got AIDS and something
discriminating.

In conversations with MSM and FSWs this hostility
was quite pronounced, and was by far much more
frequent, and more violent that among other
cohorts.

“Because some of
the teachers in the
school believe that
once you hit 14 or
15 then you want to
have a boyfriend. So
whenever they see
you talking to a guy,
any guy, they would
just assume well
that’s her boyfriend
and they would just
go and think
otherwise.”
FSW, Region 4:

"Like what bother me really is the discrimination and the stigma about my work. Now okay, nobody buys sickness, okay, you go with somebody we all know that you condomize, but we all know that even if you use a condom, they are not 100% safe, it can burst right? And we can contract it like that, so I want to know the reason why people still discriminating others and all of us in one circle and we are entitled to get any STIs, STDs, or HIV and AIDS. In South Central we are having a lot of that and that is what getting me perturbed. The discrimination. That is all we not having any other problem but the discrimination."

MSMs also cited violence and discrimination and a few cited their homes as a place that they had a strong attachment to because it was the only place where they felt safe:

R: It shorten, it limit the things you could do, is like if you want to work in this place and it is homophobic, and you really want to work here, they got people outside there....
M: Anything else that makes you unhappy? Apart from the way people treat you, like anything else in society that affects you life?
R2: Sometimes I am very skilled but due to my sexuality I am being prohibit from doing what I want to do. So I think job discrimination due to my sexuality is annoying with me but with a lot of others.

In another example among MSM:

"They gat this new thing now when you passing they call out whores! whores! whores!"

It was also common for them to refer to the limited amount of support (emotional, financial etc.) that they received from family, often from a young age:

M: So what makes you happy?
R: Persons who accept us for who we are, who do not criticize our sexuality
R2: Friends and family
R3: Friends and family who don't reject you, especially in this community you find it hard to continue living your life.

Urban and rural adolescents who were interviewed also showed hostility towards homosexuals and in some cases they held extreme views.
4.6.3 Male 15-19, Youth In Contact with the Law, NOC

M: So what y’all think about men who have sex with men?
R: You could buss up them head miss
R1: Can kill some of them
M: You think it’s wrong?
All Yeah, miss.
R A’int worth living, miss
R1: They ain’t worth living
R They ain’t supposed to get rights

Among girls especially there was a prevalent sense of isolation when they had to deal with issues related to boys and sex, this was because they often did not trust their girlfriends, “every best friend has a best friend”. And in some instances they had difficulties relating to their mothers. Apart from typical “teenage issues” these examples also highlighted fracture homes, mothers who were economic migrants, parents who were alcoholics in the home and poverty, all of which had an impact on adolescents.

4.6.4 Youth in Contact with the Law, Female 10-14

“Well for me, I fed up hear my mother ballin’ one thing in me ears, and I just get fed up and on a morning I tell them I want go NOC. I can’t live with it no more because me cousin me and she was in like, I went in a higher class than she and she use to behave more better than me, but my situation use to be why I behave so, but mother fail to realize that me cousin use to get mo better treatment that me because me mother de hardly deh in the country.”

4.6.5 Youth in Contact with the Law, Female 15-19

R: Miss when I tell me mother she don’t believe me
M: She don’t believe you?
R: If tell me grandmother something she will say I lie. You lie or you bad or something like that. So I don’t tell she nothing I just deal with matters in my own hand

Girls generally were concerned about how their teachers viewed them and felt that teachers often attributed behaviours to them that were inaccurate.
4.6.6 Females 15-10, In-school Youth (rural)

M: So give some examples. What bothers you, for example?
R: Because some of the teachers in the school believe that once you hit 14 or 15 then you want to have a boyfriend. So whenever they see you talking to a guy, any guy, they would just assume well that’s her boyfriend and they would just go and think otherwise.
R2: Or the rest of teachers hear that this child has a boyfriend, or that boy has a girlfriend
M: So in your school the teachers look down on you and talk about you if they see you have a boyfriend?
All: Yeah.

Many of the groups who were most-at-risk, FSWs, MSMs, out-of-school youth and youth in contact with the law, had ambitions to do something differently and find a profession. They seemed to want to have a means to contribute productively and to be seen beyond the stigma of the labels that society had given to them: thief, prostitute etc.

4.6.7 Self Harm

Apart from suicide cases that were reported among key informants, adolescent responses to stress and depression varied from being angry to self-harm. This included cutting, suicidal feelings and drinking tablets and lethal substances.

Youth in Contact with the Law 10-14 Female

R: Anything happen to me like when I have confusion with my step father he drink and start cussing and I just cuss he and I just drink tablets and kerosene
M: You drink kerosene?
R: Yea

4.6.8 Relationships with Men

Female adolescents, especially among in-school youth and youth in contact with the law, recalled experiences of being groomed by older men for sex.

One girl said that a taxi driver at Charity offered her several thousand dollars if she would give him her number. Other girls spoke of relationships or encounters, prior to which men (ranging from a few years to several years older) had approached them continuously. It was often a difficult experience to

Suicide in Guyana

In 2012 it was reported in the local media that “Guyana has by far the highest suicide rate among countries in the Caribbean, according to the World Health Organisation (WHO.) Guyana has also been listed in the top ten most suicidal countries, earning the ninth position which statistics reveal 45 suicides per 100,000 people. However, statistics show that of the more than 45 people who kill themselves, about one-fourth are women.

Suicide is recognized as a serious public health issue in Guyana with between 150 and 200 deaths annually. Statistics from 2003 to 2007 period show that there were 946 reported suicides in Guyana.

The statistics indicate that suicide is the leading cause of death among young people 15-24 and the third leading cause of death among persons aged 25-44. Suicide rates are consistently highest in Region Six followed by Region Two.
navigate in terms of being able to judge the sincerity of what they [the female adolescents] were being told. In most cases they were being approached on the road.

Another source of confusion for girls was in their interaction with the opposite sex

“Yea you’re confused. You just want to know if he likes you or he just wanna use you like all the rest.”

One female recounted an abduction, NOC 10-14 female:

“Well me went to send some food for my lil cousin because he was in jail and I give my aunty to send it. So a day I come home and was going in a car and this man, I tell he I like to go in the back seat, I don’t like to go in the front seat especially when me alone with the driver, so I go in the back seat and he said no come in front, I said no I gon go at the back and he said come in front so I go in front and he started to drive and he wind up all of the glasses and you know he press down the locks and he just ask me if I have a boyfriend [inaudible] and he ask, “would you like to have a boyfriend” and I said no...So he ask me if I ever sex and he go fo hold my hand and he carry me ‘til to canje so I say wha’ you going the side now, he say going and get a lil’ discuss and I just get scared and I just seh open the door just stop the car I just come out and he didn’t want me to so I just holla, scream out and people was walking and like he get scared and I just open the door and run out”

Girls also relayed strategies that they adopted to get rid of unwanted attention including saying that they had a boyfriend and in one instance responding with, “ok Uncle” to make the adult aware of his seniority to her (14 years old).

Among out-of-school youth (school aged) the males that were interviewed say themselves as being under attack by the Probation Officers who they considered to be hostile, so they developed whistle signals to communicate with each other and protect themselves.

They did not have much trust in Social Services and there was a palpable fear and distrust of this Ministry in particular. Because of this the boys had developed an early warning system to allow them to escape detection.
M: So what about the call signs
   [making noise]

M: What does that mean?

R: Come

M: What else?
   Ling, ling

M: What’s that

R: Means people deh round or people coming

R1: Trouble

M: Ok, what else

R: Monkey whistle

M: How does that go?
   [Whistling]

M: What da means?

R: Place clear

“Don’t BB me!”

It was not only females who were being approached by older males. Young male adolescents [10-14] also referred to similar situations.

R: Miss, I gon break it down in syllables, right?
   Good. Don’t laugh, cause that’s not something to laugh about. Miss, he mean, that you go, like, Brandon..

R1: Hey, hey, don’t call me name!

R: All right, John go...No, hold on, hold on, hold on. I gon find a name. Say [name] leave here, and he walking down the road and he want $500, he gon go by Harry Paul...
   [Laughter]

R: Man, ya’ll laughing this thing...
   [Laughter]

R: ...and he said ”I gon give you the bamzy [anus] for $500”
   [Laughter]

R: [Singing] Don’t bb me...[referring to a popular song]
   [Laughter]

“”All like them man that’s sell drugs, cocaine they don’t really care ‘bout you. As long as them get money just buy and collect they don’t care they like destroy you.”

4.6.9 Truancy
As can be seen from the map, the boys spend a lot of time staying away from the roads and roaming in areas away from the main road (afraid of being detected by the authorities), covering a wide area without adult supervision. Key areas for them included an abandoned house, the park, the backdam and the pools hall.

They did not spend much time at home, with one of the aging guardians complaining that sometimes she did not see him for the entire day. In all cases it was never reported that the boys would sleep outside of the home but they would generally return late or for meals. In all instances, it was not the case that the parents were not aware of the children being out of school. One child stated that his mother had told him that he could stay at home but that he had to avoid the road to avoid being detected by social services.

Some of the circumstances for not attending school were not solely financial but also because they were being yelled at and ill-treated in the school, for example, being lashed by teachers. In one instance, one child did not have a birth certificate and cited this as being the reason for not being in school. They did not see teachers or other community leaders as persons that they turned to ...and relied more on the filial ties that they had developed among themselves.

M Yall want to spend a few minutes talking about why you don't like to go to school, when we interview other kids they say they don't like to talk to the teachers. The teacher does holler on we
All: Yeah
R: The teacher does want to holler up
M: They like to holler at you?
All: Hmmm
Yeah
R: They like shame you up
Bob: Embarrassing you
R: So yall remember yall decide no I don’t want to go back to school?
He: lazy
Ethan: Me don’t have birth paper
M: If you had birth paper you could go?
Bob: Me don’t want to go to school because when them teacher embarrass me I feel bad ...got to wait till my passion cool.

Anna Regina boys 15-19 sketch map showing key areas of importance to them – religious centre, their homes, school and recreational areas.

4.6.10 Hot Spots
Most of the areas identified by youth as hotspots were largely consistent with what were provided by adults – these included bars, clubs, buses, car parks/central points and the streets. The latter (thoroughfares) were referred to quirt a bit across groups. Youth, including both boys and girls were acutely aware from a young age [10-14 age range]

Girls 10-14, In school, Region 2 (rural)
Discussion as the girls (ten of them) are drawing their maps:
M: Is there any place in your community, or where you go a lot where you think is not a good place or that you don't like at all or who you think the person hurt me, or something like that considered a bad person, or a bad places not good for children or girls your age.

R: Clubs
R1: The bus shed
Several: The beach

M: Do you think the beaches are bad?
R: Yeah, because when you cross the road ...
the liquor restaurant

M: So why did you say the bus shed
R: Because they have men smoking
R2: Miss the places that are deserted
R3: The bus park

Boys 10-14, Scouts Group, New Amsterdam Police Station

M: And where do these things [men approaching boys for sex] happen? Where would they be?
R: In a old house...
M: So they would be in the old house and the people would call you in? and they would call you in?
R: Miss, on the road they take you in [to the house] and they rape you.
4.6.11 In Depth Interview
The Tale of Three Sisters

One of the key issues that the HIV/AIDS prevalence highlights is the vulnerability of females to infection. There are a number of causal factors that have been explored in this report that may explain why, poverty, low self-esteem, peer pressure, alcohol etc. As this report highlights there are many opportunities to negatively influence behaviour but there are also positive ones. This case study reflects the story of how cultural factory, poverty and attitudes are not only putting girls at risk but limiting their socio-economic options from a young age.

Ashanti (not real name) is a 12-year-old Indo-Guyanese and lives in Charity. During our research, several pointed out the small wooden house as the home of two sisters who have transactional sex. She agreed to meet and got consent from her father to be interviewed. She says that she goes to school but has not been for the past two days because she bought a shoe and it got destroyed. She has an interesting perspective of school attendance, which is largely driven by her own desire to attend, “when I stop go I don’t want go no more, and when I start go I don’t want stop.” She says the girls in the school dorms have told her that the place is “boring”.

Her sisters are not at home.

She is the youngest of three sisters, one of her sisters is fourteen and lives home with a man. She has a baby that is three months old. She moved out of the home last year, and moved in with the father of the child who now speaks to his daughter over the phone as he is in jail for piracy. Ashanti knows other teenage mothers at her school who had a baby and went back to school but her sister didn’t. It’s not that no one is trying:

“She get baby in town and two social worker trying to put she in intensive care...but me father tell she he ain want she go back to school”.

Her other sister is nineteen years old. She also has a child that is about to turn four, with a man who is a fisherman and came to the region from time to time. She doesn’t quite live with him as he already has a wife and family of his own. When they split up she got another boyfriend, a miner from Port
Kaituma. She also had another boyfriend. Ashanti says that her sister is now pregnant again and she is certain that the child is for one of the two boys.

Meanwhile, Ashanti doesn’t mind being alone at home, “Yeah, I does deh being around me father. I does enjoy that.” Her mother died seven years ago and they are close, he can tell her anything and she can tell him anything. Her father is a contractor and she gets up early in the morning when he is working and prepares breakfast. They also have a little shack in front of the property, which was used as a shop but which is no longer used.

What she doesn’t like is her older sisters discipline:

“Me big sister tell me don’t go to school, how I got to clean up the house, wash clothes and I just go and cry in the shop ’cause I ain suppose to be washing clothes.”

Ashanti doesn’t have a boyfriend but she has friends who do and three of her female class mates are sexually active.

“They don’t care what people talk or so. They just living according to themself. You ain got to be a bad girl...as long as you lime with bad company you getting bad name. People just talk about you...”

She also doesn’t drink, much.

“In 2011 I drink Christmas eve night. I had money and I tell me [younger] brother, let we buy a quarter vodka and a one litre Pepsi. They drink almost all the drink and like half of the quarter left, and I throw all together and drink...and me sister come home and she get a brown pants and I tell she that’s a nice purple pants...”

Now she takes “one one” shot when her sister is at home. As she starts to loosen up, Ashanti shares that she did have a boyfriend when she was 11. He was nineteen years old.

Where did she meet her boyfriend?

“Kumaka...I used to lime and so. We was friends before and he tell me he like me. But i didnt know if I like he. He say let he be me boyfriend, I say no problem.”

Question: What boyfriend mean at eleven though?
“I didn’t thinking how far he was thinking, he thinking about sex, but I been thinking just normal talking.

Question: How you know that’s what he thinking?

“He tell me”

Question: How long after?

“Couple months after and I tell he no, I ain ready, me friend is tell me she boyfriend is ask she for sex and they is fight about it.”

Did she learn anything from her sisters?

“Them never tell me nothing about boyfriends! In school them is get teachings, social studies...whatever is happen to me friend I is glad it don’t happen to me.”
SECTION V

5. Analysis and Recommendations

This section of the report will synthesize some of the key findings based on various sources of information contained in the previous sections, desk review, policy and legislation framework as well as the findings of the empirical research.

Adolescents in Guyana are a key demographic; the sheer size of the youth population, the importance of youth to national development outcomes, and youth susceptibility to HIV/AIDS has ensured their visibility. The latter has resulted in a national response in Guyana that has been characterized by an increase in the services available to adolescents including key facilities and programs such as the Adolescent Unit within the Ministry of Health, the Health and Family Life Education (HFLE) program within schools, and the establishment of Youth Friendly Health Centres and spaces throughout the country. The vulnerable adolescent that this study describes is one that is characterized as being multidimensional, for example early sexual debut was often linked to other social ills such as teenage alcohol consumption, low levels of education, poverty and sexual abuse. As such, an integrated response is the most appropriate and essential.

It is evident from the government policies reviewed in Section II of this report, that combating HIV/AIDS is a national priority and that youth are a priority. What is also evident, from both the legal review and the field research, is that there are critical gaps in areas such as the legal provisions for HIV/AIDS in the Health Ordinance (1834), the criminalization of the sexual acts which affects key YKAP demographic – young MSMs, and the Sexual Offences Act, which has not been fully implemented. Policies such as the National Workplace Policy which could potentially be a key measure in reducing discriminations against YKAP is largely voluntary and its implementation was not visible in rural and remote areas where many vulnerable adolescents work. The School Health, Nutrition and HIV&AIDS policy makes no mention or provision for YKAP and this may serve to both marginalize LGBT adolescents, and impact their ability to enjoy their right to an education in a safe environment, that is not characterized by discrimination, and in which services such as counselling are available.
What the research has found is that there should be a common consensus on who the at-risk or key adolescent populations are, in order for them to be effectively targeted for programs and services. There were hidden populations such as sexually active adolescents with disabilities who were perceived to be at-risk and who were not featured in the literature. “Adolescent” is often used synonymously in the literature as referring to someone who is in school, however some of the most vulnerable groups were found in institutional centres and out-of-school. As both examples highlight, there is a need to focus specifically on adolescents, which will inform the strategies, approaches and messages used. For example, a FSW or MSM who is in his/her fifties cannot be compared with a 15 year old and neither can all of their needs.

The DHS has highlighted, “widespread stigma and discrimination in a population can adversely affect people’s willingness to be tested for HIV as well as their adherence to antiretroviral therapy. Reduction of stigma and discrimination in a population is, thus, an important impetus to the success of programs targeting HIV/AIDS prevention and control.”

The 2007 research study of Brian O’Toole et al, highlights the high prevalence of discrimination that exists in the country, 68% of adolescents who were interviewed felt that it was not ‘ok’ to have a homosexual relationship.

This research has further reinforced the central role that schools play in the lives of adolescents, but it has also shown that several planned services and programs outlined in the School Health, Nutrition and HIV&AIDS policy have not been widely implemented – namely the provision of counselling services, the distribution of condoms, and the capacity development of teachers and parents on HIV/AIDS. The research highlighted that even though parents and teachers are a key stakeholder in the eco-social context, they are often ill equipped to deal with the changing needs of their adolescent children, including children who become sexually active at a young age, sexually active children with disabilities and those who may be in same sex relationships.

The plan to equip every in-school youth with life skills highlights the lack of life skills among the adolescents, including those who are especially
vulnerable, who may not be in school and are already in the workplace (at goldmines, in brothels etc.) or have dropped out of school. These adolescents, ie those who are out of school, were found to more likely to be sexually active and at-risk that those who were in schools. However, one opportunity can be found in the presence of civil society bodies who traditionally are closer to these sup-populations and whose services adolescents seemed much more comfortable in accessing.

Recent research suggests that adolescents are sexually active at young ages (the BSS 2008/2009 placed the age of first sex at 14 years old) and that among 15-19 years old adolescents there has been an increase in infection (from 3.66% in 2006, to 2.5% in 2007, and by 2009 accounting for 6.04% of the infected population). The presence of early sexual debut and the lifestyle choices of adolescents are a challenge to more traditional and conservative views held by key Duty Bearers such as teachers and parents which will has had a direct impact on how YKAP are treated. A good example of this is the lack of debate on condoms in schools, or the presence of same through school counsellors.

As the DHS has highlighted, "social acceptance of condom use among young people is a key factor determining use of condoms to prevent the sexual transmission of HIV and other STIs, as well as to prevent early pregnancy. However, educating youth about condoms is sometimes controversial, with some saying it promotes early sexual experimentation."

The DHS found that only 49% of in school youth who were sexually active were using a condom, and only 19% of them had been tested. These findings all have significant implication for the achievement of related MDG indicators: (i) HIV prevalence among population aged 15-24 years, (ii) condom use at last high-risk sex, and (III) the proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS.

This research project found that testing was generally low among sexually active adolescents except for MSMs and FSWs and this can be partly attributed especially in hinterland areas to the lack of facilities and in other areas of the importance of privacy and confidentiality to adolescents.

A critical strata in the delivery of social services is at the micro and meso levels i.e. community and
regional administrative level, which was found in both human resources and organizational capacities to be deficient in their ability to support YKAP. Many regional level officials in key and strategic positions lacked basic data on important social issues in their region such as HIV prevalence, sexual abuse rates, teenage pregnancies etc. and so their ability to guide programs, plan or respond to issues was limited and unstructured. Even though vital data often flows upward from within various agencies within the region to the national level the processed data is not always fed back down. Stakeholders at the micro and meso levels also did not demonstrate an awareness of key laws, acts and policies that related to adolescents and at-risk adolescents. This study also revealed the lack of uniformity in the availability and quality of health services such as VCTs and condom distribution since these were increasingly sparse as one moved from urban to rural contexts and from rural to hinterland.

Another critical aspect linked to the scope and reach of programs is the importance of coordination and the maximization of resources and efforts through collaboration and integrated planning. This would require both national and regional bodies to work together to plan who does what and where with all stakeholders including NGOs, INGOs, CBOs and government agencies.

The 10-14 adolescent populations were a key cohort in the research, especially with the intention of both understanding behaviour and practices but also to putting the vulnerable 15-18 cohort into perspective. Among 10-14s the research found low and inconsistent awareness of HIV in hinterland areas and limited information being obtained from teachers and parents when compared to other regions. One adolescent stated that they, “learn how to put on a condom by watching movie”. In rural areas parents and teachers are a key source of information for children, though the confusion of whether HIV could be contracted by a mosquito suggests that the accuracy of information is questionable, but also it reinforces the need for sustained and multiple sources of information to reduce the risk of misinformation.

Among out of school youth and those in contact with the law, sexual debut tended to be at an early age and most importantly, it was usually not safe sex. A key factor in the vulnerability of this cohort is the context, and factors such as, older-male
predators, unsupervised settings (especially for out of school youth, parties), alcohol availability and peer pressure all contributed to sexual debut, although the majority of 10-14 year olds were not sexually active. The study did reveal that a small population of both male and female adolescents who experienced traumatic events by the age of 14, such as forced sex and sexual abuse, for which they generally did not disclose until they were older because of the lack of persons to confide in, or places to seek services. In some instances pregnancy was the only reason why abuse was brought to fore. Even in instances in which children did disclose being abused teachers, parents and communities were ill equipped to provide adequate support. Many children who are abused and live in rural or remote areas have limited possibilities to receive professional counselling. For this cohort of YKAP the national implementation of the Sexual Offences Act is critical.

The 15-19-age range is one that is critical in terms of the key changes that adolescents experience. The study found that some of the knowledge gaps found among some 10-14 adolescents persisted among this age range especially in hinterland areas and to a lesser extent in rural and urban contexts. What becomes more critical for these age ranges are the social networks which both positively (teachers, the church, sports) and negatively (peer pressure, sexual predators) influences their behavior. Gender roles also play an important role, for example teenage girls often said that school and the fact that they were expected to do chores in the home meant that they didn’t have as much opportunity to be in ‘hot spots’ and which preoccupied them.

The majority of school aged girls and boys were not sexual active. The 2007 youth study by Brian O’Toole et al also found that these 48.6% of youth surveyed wanted the person to be a virgin and 46% felt that a woman should remain a virgin until she is married and 37.2% for men. In the same study it was found that, “one-third of the respondents reported having had sexual intercourse, but this figure was highest for males aged 15–20 years (48%) and lowest for females aged 12–14 years (15%). Moreover, those who knew and followed their religion’s teaching were much less likely to have engaged in sexual intercourse (18%) than those who did not (45%). This held true irrespective of gender and age group.”
For men socially constructed views of their masculinity is also a key factor and many male adolescents demonstrated that this included having more than one girlfriend and keeping traumatic sexual experiences such as rape a secret. However, the majority of male adolescents viewed the use of a condom as being socially acceptable and many younger men said older brothers and relatives had told them that they should use condoms.

What the study did highlight, especially among the 15-19 and 20-24 age range, is the challenges of behavior change even though many adolescents could state the different forms of prevention and were aware of the importance of condoms or the risks of unprotected sex they would still have unprotected sex. The reasons given for this tended to be that they did not have a condom at the time, that they didn’t have money to buy one if they did not want to use those distributed freely and the fact that the sex was spontaneous. Even when adolescents had had risky sex and were worried of having contracted HIV (more so than getting a girl pregnant for some males) it was not enough to compel them to get tested. Adolescents were generally receptive to life skills and many said that they had obtained practical from youth camps held in the summer. However, within the schools many of these vital lessons were being discontinued at Grade 9 when most adolescents are starting to have sexual relationships.

The YKAP study generated a wide range of information on adolescent vulnerability and the factors and conditions that lead them to adopt most-at-risk behaviours including:

- Economic poverty and unemployment
- Alcohol use predominantly
- Peer pressure
- Sexual abuse
- Prevalence of spontaneous sex and a,
- Lack of awareness, or awareness combined with a decision to not apply safe sex practices

It has also highlighted a need to change and reframe the way that certain behaviours of sub-populations are understood. For example, Commercial Sex Workers are often targeted in bars, in kaimoons [makeshift brothels] etc.. However, the research highlighted that transactional sex involves a wide spectrum of activity that makes it even more difficult to target adolescent at-risk populations.
Among older and younger women, transactional sex tends to take the form of commercial sex, a group defined as being professionals who depend on sex work for their income.

However, there are a range of new behaviors among adolescents specifically opportunistic sex work, where female and male YKAP "occasionally and opportunistically engage in sex in exchange for gifts, money, etc." and, there is also a third category of survival sex workers, characterized as sex work practiced in situations of "dire need either for the person or their dependents", this can include items such as food, clothing, etc.

In the latter two instances, both male and female YKAP tended to be equally characterized by.

The current “gold rush” in hinterland areas, lack of alternative livelihoods and poverty means that both sex workers, opportunistic and survival sex will continue and may even increase. Because of the high rate of mobility and migration among persons who get employment from mining areas it poses a direct risk to other partners and potentially to efforts of reducing new cases of infection.

As funds for HIV/AIDS dwindle, numerous critical programs that target at-risk-populations may be affected and as such, creative and low-budget, high impact initiatives should be utilized especially those that are community based and driven, or that address multiple issues and involve multiple actors.

The study has shown that whomever youth come in contact with can have a strong influence on their well-being and their development. As such, several key persons including field level government officers, teachers, storekeepers and parents should
have a greater awareness of issues specific to adolescents (including male and female YKAP) and should be supported to develop skills to provide the correct response and adequate support.

Several of the “hot spots” identified in the study were at business establishments (bars, clubs etc.). Or are in areas where other members of society, parents, adults etc. are present (tapirs, buses, car parks) and who can contribute to reducing risk in these areas. Of equal importance, peer pressure has emerged as a key issue that needs to be addressed.

**Recommendations**

**Advocacy**
There should be advocacy at the both the national and international level on the importance of making provisions for YKAP, including funding for expanded services (government and non-government), and for the rights of key populations such as MSM, CSWs, and adolescents with disabilities in urban, rural and hinterland areas.

Key laws such as the implementation of the Sexual Offences Act, the development and implementation of the National Youth Policy and ending of punitive laws, which negatively impact YKAP populations, should be central to advocacy strategies.

**Policies and Guidelines for YKAP**
In order for key adolescent populations to be effectively targeted there should be specific policies/guidelines that firstly clearly outline who they are and what approaches and programmes are being developed for them. These could include a broad range of provisions such as legal advice, counselling, alternative livelihoods opportunities and day care facilities.

**Knowledge & Skills for key Duty Bearers**
The research identified many gaps in the understanding of both the laws of Guyana that are relevant to youth as well as key policies\(^{38}\). Community and regional level agencies and individuals who come in contact with adolescents

\(^{38}\) The School Health, Nutrition and HIV&AIDS policy of the Ministry of Education is a key policy document. There are several provisions including providing counseling services in collaboration with CSOs, opportunities for youth to participate in determining implementation for example condom distribution in schools, and parent and community education programmes which are especially relevant.
or at risk adolescents, should have the skills, capabilities and capacity to plan for and manage integrated social development initiatives. Relevant up-to-date data relevant for demographics, presence of facilities and programs, adolescent health, education and economic development should be provided to relevant authorities including village councils, CBOs, CDOs, SWOs and regional authorities.

Key laws and policies that relate to adolescents should be summarized and provided to all official offices as a single source document and regularly updated. Guidelines on how to plan for or deal with issues like reported teenage drinking; sexual abuse, drug abuse etc. should also be disseminated with consideration to socio-cultural contexts.

**HIV/AIDS Awareness**
Knowledge gaps, and under-served areas (where information and programs are limited) among adolescents should be addressed through investments in HIV/AIDS awareness campaigns especially among adolescents in remote hinterland locations where mining is prevalent.

Communications methods should also reflect the changing use of social media and communication tools in Guyana especially cell phones, the internet, television and Facebook.

Youth camps (including those offered by government, private and NGO groups) across the country should have one streamlined approach to HIV/AIDS awareness and skills development, which should be practical, professionally done and accurate.

**HIV/AIDS Materials**
Education materials should reflect the broad range of Guyana’s adolescent population including the adolescents with disabilities, and adolescents who have different sexual preferences such as adolescent LGBT.

**Program and Policy Development**
Existing programs that target youth should be reviewed to determine the extent to which at-risk populations and YKAP are adequately targeted. Key populations such as 10-14 and 15-19 adolescents should be targeted with tailored information.

In the instance when new policies and programs are being developed such as the National Youth
Policy and the Guyana HIVision 20/20 these should integrate the views, and reflect both the needs and rights of YKAP.

**Improved Information and Skills for PTFAs**
PTAs and PTFAs provide an opportunity to engage parents and develop their skills and capabilities to support adolescents generally and YKAP specifically. PTAs can play a key role in implementing the MoE’s health and HIV policy.

**Improved Monitoring and Data Collection**
Key offices, such as the School Welfare Officers, should be provided with skills to conduct basic data collection and collation to monitor trends and to plan programs based on an analysis of issues.

**Inter-Agency Coordination**
It is critical for key institutions both at the national, and especially the regional levels, to coordinate their response and to be aware of how their efforts contribute to HIV/AIDS reduction among vulnerable adolescents and some of these partnerships should be formalized and coded.

**Evaluation and Expansion of HFLE**
HFLE is an innovative initiative that many potential at-risk adolescents can benefit from, however HFLE currently stops at a critical juncture (Grade 9/Form 3) in an in-school adolescent’s life and should be continued. Given the knowledge gaps in in-school youth it would be useful for the program to be evaluated and its impact determined.

Opportunities should also be sought of providing life skills to out-of-school populations including the those with disabilities, truant youth and young workers, MSMs and FSWs.

**Improved Services**
There is a need for improved and expanded services and facilities for youth, the study revealed that youth do not have much confidence in free condoms distributed by the MoH, and many said they preferred to purchase them, when they could be afforded. They also had reservations in using facilities where their privacy might be compromised.

**Hinterland VCT Services**
VCT Services should be expanded within hinterland areas with a strong investment in mobile clinics and possibly through partnerships with CBOs/NGOs in
establishing permanent testing facilities in key hot spots such as mining areas.

Alcohol and Drug Abuse Prevention
Underage drinking and alcohol and drug addiction programmes should be developed for adolescents, including those that are out of school and young adults 17-24 who have joined the workforce.

Peer Pressure
Peer pressure should be addressed in schools along with other related issues such as bullying and alcohol consumption in schools. Female adolescents and to a lesser extent male adolescents said that peer pressure played a significant role in shaping their decision to engage in risky practices.

Recreational Facilities
Recreational facilities and sports are of critical importance to youth and these should be introduced with the intention of providing alternatives sources of entertainment and especially those that directly integrate HIV/AIDS awareness and life skills. Private-public partnerships could be used to support the increase in safe and commercially viable, youth-friendly spaces.

Civil Society
Civil society organizations (NGOs, FBOs, CBOs) are well placed to provide services to YKAP, and their presence should be encouraged in hot-spot zones such as Port Kaituma, CBOs can be especially effective and similarly specialized organizations such as the Women Miners Association can play a key role in targeting YKAP and in ending discrimination.

Counselling Services
The School Health, Nutrition and HIV&AIDS policy provides for counsellors in schools and this should be viewed as a critical service for adolescents. Schools where counselling services are needed should be piloted in schools with high incidences of teenage pregnancy and those that have high reporting of other social issues (truancy, violence, alcohol abuse etc.).

Role of the Private Sector
Private businesses should be monitored to ensure that premises are safe and secure for adolescents, which includes observing the laws of Guyana and
especially not condoning the sale of alcohol to underaged children.

Bars, clubs, transport providers and hotels should all be part of a local compact to protect children and ensure that adolescents produce identification before entering, and that their staff does not target young males and females.

Businessmen, and other powerful persons have been identified, as occasionally grooming young girls and boys for sex and this practice should be addressed by the social committees of the Chambers of Commerce and the Private Sector Commission.

The timing of the broadcasting of music and television programmes that have mature content, or that are considered lewd or suggestive, should also be reviewed by private companies and they should be encouraged to support more ‘family friendly’ broadcasting.

School and Context
The school should be seen as a wider part of the community and their responsibility for children should extend beyond the school gates. Schools should be proactive in addressing problems that affect adolescents outside of the classroom. In Region 1, the REDO and Educational Department has been proactive in addressing a common issue of public transport operators (taxis, buses etc.) conducting themselves in a proper manner and making public transport safe for adolescents.

Youth Participation
New programs, policies and services that are being developed for youth should be designed and implemented where possible with their participation and their insights and perspectives should be valued. Youth should be involved in critical decisions that affect them such as the age of testing at VCTs (parental consent is currently required for adolescents under 16) and the distribution of condoms in schools.

There is some evidence that policies and programs that are developed are done in consultation with youth. However consultation is on the lower rungs of the ‘participation ladder’ and agencies should aspire to stronger partnerships that empower youth such as their participation on committees and the joint implementation of programs.
Youth Organizations
Youth groups, sports groups should be encouraged and should with knowledge that supports a better understanding of HIV/AIDS policy and practice. Youth groups should be resourced and supported to strengthen their advocacy on health related issues and YKAP youth should be supported to form representative bodies especially in areas or regions where the HIV/AIDS prevalence is high or there is risk of an increase such as in mining areas.

Youth organizations could potentially be 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.
ANNEX 1

REPORT ON THE WORKING SESSION ON HIV VULNERABILITY AMONG YOUNG KEY AFFECTED POPULATIONS IN GUYANA

UNICEF/MINISTRY OF EDUCATION
Grand Coastal Inn, East Coast Demerara
May 14, 2013

Rapporteur: Andrea Bryan-Garner

PURPOSE/OBJECTIVES

To present the findings of the Qualitative Research Study on HIV Vulnerability among Young Key Affected Populations (Most At Risk Adolescents) in Guyana

To provide a platform to discuss issues arising from the report by sectors, and to plan the way forward

Welcome and Opening Remarks

Chief Education Officer – Mr. Olato Sam opened the session by highlighting the importance of such a gathering, taking into consideration what drives stakeholders to commit to the task at hand on a daily basis. He re-emphasized the ultimate goal of shaping the course for the adolescent population in Guyana, and congratulated UNICEF, and the lead researcher and her team for their efforts and hard work in capturing the voices of Guyana’s young population through the study.

In examining the situation of adolescents in Guyana, he opined that gaps needed to be filled regarding this group of individuals, in an effort to provide the necessary safety nets for those without strong domestic environments to guide and support them. He noted that with some of the weaknesses that exist in the school system, the necessary support mechanisms for adolescents were lacking. He spoke of the role of stakeholders to legitimise the voices of adolescents and their experiences, and the need to respond in a way that can consistently target this particular group and provide the support services that they will need to help them cope.

All present were welcomed and asked that they recognise those who are slipping through the cracks on a daily basis, as the ones who are going to be the beneficiaries of all the hard work and efforts today, thereby sending a clear message that they do exist as an at-risk population and need our help and support as the duty bearers in our society.

The proceedings were then handed over to the lead consultant on the research project, Ms. Esther McIntosh for the Presentation of Findings.
KEY POINTS FROM PRESENTATION by Esther McIntosh – Lead Researcher

- Target Group of study - 10 – 24 years (in school youth, out of school youth, MSMs, female sex workers) Note: Out of school youth are not necessarily going to the institutions that we normally target. They are extremely vulnerable and recent findings show males are at risk as well.
- At a very young age, those in the study said they started kissing, using cigarettes and alcohol. They have heard about HIV and some had girlfriends before hearing about condom use.
- It was found generally that institutions exist but there are gaps
- A National youth policy is critical, since everything else depends that
- They do not want their parents to know they are sexually active, but parental permission is necessary for adolescents to get tested at VCTs
- Many of the successes are at risk because funds are running out to sustain them
- Alcohol consumption is prevalent and alcohol is accessible
- Poverty is a huge driver
- There is a lack of recreational facilities across the board. Recommendation is to get businesses to provide safe spaces
- Communication – presence of cell phones/internet. Parents are unable to regulate what young people are exposed to. There are some suggestions for censorship or the creation of educational games/apps
- Peer pressure/teen pregnancy – schools in other countries are very proactive in dealing with teen pregnancy, however with sexual abuse sometimes it is not preventable
- ‘Asking home’ – if a boy asks a family for their daughter’s hand in marriage, they would allow a relationship. But shame forces young people to hide what they are doing, which forces them to get married sooner and can result in a higher incidence of suicide.
- Many young persons said they had suicidal thoughts as a result of parents arguing at home, not relationships. Some take substances and engage in cutting themselves
- Sexual abuse – ‘step daddy’ rape and incest came out very strongly amongst youth and duty bearers. Services and facilities were very poor. Victims are as young as 6 years old and there is no way of dealing with the trauma. Schools in particular are critical; school life is an anchor for them. In school youth were not as sexually active.
- There was also a strong sense of anger, especially if sexually abused, and no outlet for that anger. It is recommended that
counselling be provided to deal with their issues. HFLE allows them to talk about these sensitive issues.

- There is a prevalence of single parent headed homes, blended families, and a lot of absent mothers e.g. guards
- The majority of young men were having unprotected sex
- Hotspots: Where are young people vulnerable? – one girl said ‘Everywhere’. In some instances – ‘the road’ is the hotspot, where people hang out, and places such as car parks, bars and hotels. A lot of businesses allow girls who look very young to enter hotels to have sex.
DISCUSSION ARISING FROM PRESENTATION

**Alistair Sonaram – SASOD**
Mr. Sonaram asked if there were plans by the Ministry of Education to review the sex and sexuality theme in the Health & Family Life Education (HFLE) Programme with the objective of making it about sexual orientation and gender identity. The aim of which would be preventing violence against persons of different sexual orientation in the school system.

The question was referred to the HFLE Coordinator, **Mrs. Colleen King-Cameron**, who noted that there are no plans at the moment to review that aspect of the curriculum. However, it was noted that if there is a position in relation to that issue, the Ministry is willing to welcome input, since like any curriculum, it is under constant review and the content is always being reshaped and redefined.

**Esther McIntosh** mentioned that it was a significant point which is reflected in the report as a weakness. It is not only youth of a different sexual orientation in the schools and how they see themselves reflected, there are other marginalised populations e.g. persons with disabilities. In one of the quotes it was mentioned that HIV is a ‘hearing’ disease. One person interviewed for the study said that some persons with disabilities tend to be colour blind and red is used as a colour for prevention. Persons with disabilities are rarely represented in HIV material. If you are looking at vulnerable youth and at risk adolescents, their needs and rights should also be reflected. She mentioned that the school policy which exists is somewhat flexible and leaves room for the PTA and the schools to make decisions about those issues.

**Karen Roberts – PAHO/WHO** asked if there is any projection/recommendation that addresses strengthening or enhancing the curriculum of the teachers’ training programme to empower them to be able to deal with these sensitive sexual and reproductive health issues.

Based on her past experience, teachers would make requests regarding some aspects of the curriculum that they were not comfortable teaching. She referred to the presentation which highlighted that the school played a very central role in some of the communities, and felt that teachers needed to be equipped with special skills to be able to provide the support in the various roles they play within the school.

**Esther McIntosh** responded by saying that when she read the School Health and Nutrition HIV/AIDS Policy which is available online, there are three (3) key aspects that are very relevant to this target group – one of them is strengthening the capacity of both the teachers and the parents, and if the policy was implemented, many issues would be addressed. She also highlighted the importance of good relationships between the teacher and the students, and the need to change the perception of intimidating authority figures.

**DCEO Doodmattie Singh** - agreed with training for teachers to improve their level of comfort teaching sensitive issues, but stressed the need for training of parents also. She mentioned that even if equipped with life skills and information about sex and sexuality, when living in an abusive home, those skills may not be fully utilized. She also spoke about the influence of Peer Pressure and lack of parental supervision.
Malcolm Marcus - Secondary Head teacher, Region 1 addressed HFLE in the school setting as a good idea if there is a specific teacher who specialises in teaching HFLE, and maybe another pure subject area. He gave an example from his school of one teacher - Patrick Ashley, who had received extensive prior training via NGOs, and was very helpful when it came to issues of that nature.

Paula Sampson – GRPA - spoke of the burdens carried by teachers themselves, especially those who may have been affected by Gender Based Violence. Those in difficult circumstances may need special attention before being able to deal with the sensitive issues of the children.

Esther McIntosh – Stated that another thing to note is that some of the key people in the school system are the school welfare officers, and they should also be acknowledged for the job they do.

Secondly, she said that the report is not suggesting that the teacher should be counselling children. Counselling should come from someone who is trained to do so, but the teacher should have the skills to recognize the needs of the child and take the necessary follow up action.

Representative from NGO, United Brick Layers
She raised the fact that NGOs are the foot soldiers who carry the burden. Children need the HFLE programme from nursery onwards, not just about HIV but other topics. She spoke of the need to work together to make a better brighter future for our children.

DCEO agreed and noted that HFLE is in the curriculum from nursery through secondary. In nursery school it is not taught as a separate subject but integrated. She applauded teachers for their hard work with children, who have a range of abilities, attitudes and behaviours, that are often moulded from different home environments which is difficult.

WORKING SESSION:
Inter-sectoral working groups comprised education, health, and civil society groups. Each group looked at the key issues of the report presented, priority areas and recommendations

GROUP PRESENTATIONS:
(Health including MOE, NGOs, MOLHSSS) Strengths, Gaps and Recommendations for the Ministry of Health

Ministry of Health Group: Presented by Ms. Vyfhuis
Key issues:
- Suicide
- Disabilities
- Alcohol (substance abuse)
- Teenage Pregnancy (sexual and reproductive health)
- Sexuality Issues
- Sexual Abuse
- HIV/STIs
The group felt all their key issues were interrelated. e.g. some clients might attempt suicide because of HIV/AIDS. People with disabilities in our society are often rejected, and they are also abused in some ways. Persons affected by HIV/AIDS might also turn to alcohol or substance abuse.

The study also highlighted that these were some of the key issues that contributed to some of the behavioural challenges that made these groups vulnerable and at risk for HIV, so in both ways that is how they can be grouped with Health issues.

Priority Areas:
1. Sexual abuse
2. Suicide (which deals with Mental Health)
3. Alcoholism

Recommendations:
- Review health policies (eg. Ref. Pg 4 of report about the 1834 health ordinance, youth policy is also in draft) to address existing gaps with reference to adolescents and HIV. (Age of consent is 16, but to have an HIV test you must be accompanied by an adult if you are 16, yet an abortion can be done at 13 without the consent of an adult. With a good youth policy, it should be able to cover all of this to make it more comprehensive for adolescents)
- Strengthened health education and life skills for health care providers and communities accessing health services. (to address information given to adolescents and treatment of teen mothers)
- Integration of specific services to address alcoholism, suicide prevention and sexual abuse at the primary health care facilities.
- Strengthened youth friendly health services. (where youths can go to access information/counselling etc.)

Questions/comments:
Questions were raised regarding realistically achieving the integration of services at the Primary Health Care level, and whether the Youth Friendly Health Centres should be restarted. The response given by the group spoke of the need to have a broader range of services, since just a few services are available and even fewer, if any, are tailored to adolescents.

The MoH responded to the issue of youth friendly centres and highlighted their push for HIVision 2020, which is the new strategy for HIV. This includes training the existing healthcare workers at the Health Centres to be more youth friendly. Before, it was a funded position paid by a separate department, and now since that department has closed the aim is to integrate this service into the normal healthcare service.

It was noted that there are other components that make a service ‘youth friendly’ and the MoH was encouraged to ensure that those other components are in place, including opening late on Fridays and on Saturdays. It was unfortunate that after a
lot of thought, support and effort, the youth friendly centres could not have been sustained without additional funding.

One suggestion was that there could be one room in the schools that does not look like a classroom where a counsellor (possibly provided by an NGO) can play a role, and young people can access services and address their issues. Caution about the NGOs and their selection criteria was recommended.

The Ministry of Human Services had expressed some concern regarding the quality of persons who apply for counselling positions, and currently, the UG curriculum is being revised so that students spend a longer period of time in the classroom/counselling sessions before they can be certified as a counsellor. NGO personnel would have to fulfil that criteria in order to provide the highest possible standard of service.

It was suggested that UNICEF can fund 20 counsellors from each region to attend UG, and give them the highest possible training. UNICEF is currently supporting the University to complete the revision of the curriculum which is Phase 1, and has also funded ECD training for NGOs.

The MoE expressed the need to have counsellors, at least in each school cluster, if not in each school.

Group work - (NGOs including MOE, MOH)- Strengths, gaps and recommendations

NGO Group presentation – Alistair Sonaram
Group members from MoE, RC Church, Artistes In Direct Support, United Bricklayers, Ministry of Home Affairs & SASOD

Key issues
- Most NGOs that are here did not see the report beforehand
- Most NGOs were not involved in the information gathering process (much information is available from NGOs as their reach is wide)
- The limitation of not finding enough MSM’s could have been avoided had NGOs been contacted
- No mention was made of the NGO contribution in the implementation of the HFLE Program
- It is felt that the issues highlighted are not new but have been repackaged in a new way
- No mention of the need to strengthen the services that must be put in place to deal with the issues that arise from the implementation of HFLE
- Limited mention of Trafficking in Persons (TIP) and Commercial Sex Workers (CSW’s)

Priority Issues
- How to deal with persons of different sexual orientations – new approaches are needed and new thinking is required (especially within the school system.)
- Education of adults who can be part of the solution. (Ignorance is still part of the discrimination that a lot of persons face. Parents should be invited to workshops on how to counsel their children)

**Recommendations**
- If underlying views are not addressed, no change can be realised
- Civil society inclusion is needed throughout the processes and not just at the end, to avoid biased reports
- Follow up and feedback are necessary as many reports are done and no further action is taken
- Strengths of youths must be highlighted as NGOs have seen that many youths are not as vulnerable as we may think. Parental interference and the lack of channels of expression give way to vulnerability
- Schools must find other ways to engage parents e.g. PTA meetings which are integral in understanding what is happening with a child within the school setting, but often suffer from poor scheduling. Meetings normally occur at 3:00pm, or 11:00am on Saturdays and Sundays
- Parenting classes are needed for both teachers and the parents of their pupils.

**Questions/comments:**
The researcher indicated that SASOD was included in the information gathering process, and a transcript and recording are available. She said they were quite comfortable with the number of NGOs that they spoke with, and used the UN action plan which speaks to youth participation. One of the recommendations was to look at forming CBOs at the local level e.g. in mining areas where young people are vulnerable if not much is being done. If they are organised they can have a voice and speak on their own behalf. She agreed that there are a lot of issues which are resurfacing, and that it is time for action, but the research team’s job was to say what was found.

**Group work (Education including MOH, NGO, MOHA, MOLHSSS) Strengths, gaps and recommendations for the Ministry of Education**

**Education Group Presentation** - Presenters: Ms. Persaud & Ms. Moses

Group members – Guidance officers, School welfare officers, child care and protection officers, teachers and personnel from GRA.

The group felt that there is a moral decline, and in order to address these issues there are a number of things that need to be taken into consideration. They preferred not to prioritize the issues since they are all important to move our nation forward. Key issues and recommendations were dealt with simultaneously in their presentation.

**Key issues and Recommendations:**
- High reports of violence in urban schools as opposed to rural and hinterland areas
Recommendation - Extensive facilities and institutions to mold/correct behaviour: youth groups etc.

- Adolescents with disabilities and age 10-14 out of school youth are unsupervised a lot of the time

Recommendation - Structured programmes organised/designed: Community Based Rehabilitation (CBR) Programmes

- Social ills – suicide, teen pregnancy, abuses of all types etc.

(pronounced)

Recommendation - Trained and confidential personnel who are morally inclined

- Drug use and abuse contributes to risk

Recommendation - Massive campaigns with adequate staffing and resources, increase collaboration of social services: police, health, child care etc.

- Lack of poor parenting skills

Recommendation - Effective use of the PTA Programmes e.g. Mentoring Programmes, greater involvement of NGOs: Peer education and peer counselling, other governmental organisations/agencies

Priority Areas:

- Staff (qualified, certified and professional)
- Ensure the policies to address youths are revised and enforced
- Collaboration/network systems should be strengthened
  - Ministry of Health e.g. if there is a malaria problem in Region 1, do not just go and take care of the health issue, tell MoE which can help via Education’s health sector, and share ideas. Instead of being reactive, there is a need to become more proactive
- Involvement of the community (business/corporate)
  - Businesses are not often involved in what is being done e.g. A small football group can keep young people from being idle - healthy body, healthy minds. Footballs and gear might be needed which can be sourced from the store. Other aspects of sportsmanship can be taught – leadership, speech making.
- Understand/monitor youth culture: music, dress code (style & fashions, sex tools/toys, tattoos, piercings etc.) Help youth through the messages and get into their psyche in order to understand them and ourselves.
- Review of HFLE and its methodology. (In some cases both methods of inclusion and timetabled sessions could work together to cater for different learning styles.)
• Inclusion of sporting activities

Questions/Comments:
There is a need to come out of a classroom setting; instead of ‘chalk and talk’, perhaps chat with children in the yard, take walks which may encourage young people to listen to you more. They tend not to relax when they see a figure of authority in front of the classroom but may open up if having fun.

It was also felt that LGBT views and issues should have been reflected in the report. Another question raised was the group’s position on morality. The response given was that people look at you by how you live your life e.g. your decorum as a school welfare officer and the importance of setting good examples.

There was also mention of incestuous relationships, but it did not come out strongly in the report; however case studies were highlighted.

It was noted that the PTAs were again mentioned and as the NGO group highlighted in their presentation, creative ways should be sought to get parents involved and if the parents don't come to the schools, agencies have to go to them. The parents of children with the most challenges rarely attend PTA meetings, since between 3 – 5pm on weekdays most parents are at work; however having those meetings on another day would mean a sacrifice for the teachers.

One suggestion addressed the many parents who are security guards, and proposed that parenting sessions can be conducted at the guard service instead.

MoCYS shared their best practice, where they have parenting bodies in communities and conduct home visits along with the MoE, since poverty is a factor and many parents cannot afford to travel frequently.

Utilizing FBOs more was another suggestion since they are usually located in almost every community and frequented by community members. It was also felt that FBOs can be approached to assist with counselling, but in a structured way so it is not strictly religious but more of an open dialogue.

Internship after high school: when adolescents exit the school system, they should be able to cater for themselves. Employers would often work persons to the bone for a meagre wage, however if properly regulated, internships can provide valuable working experience at the end of high school or university. Many vacancies call for years of experience which young people do not possess.

HFLE came into focus once again and it was noted that it encompasses more than the topics discussed; it is about developing life skills. Young people need to be equipped with these life skills, so when they go into the world of work or are with their peers, they will know what they believe and know how to say no or how to respond appropriately to situations. The curriculum can be examined in relation to developing adequate life skills for young people to deal with situations as they arise.
NEXT STEPS

Inter-sectoral collaboration
MoE was charged with taking the lead through an inter-sectoral response to the study which is now available. Stakeholders can be brought in since the MoE is well placed to take the lead and spearhead collaborative efforts with the other agencies, so that children can have the support they need to grow up to be productive citizens. The focus should now be on how this will be accomplished.

The DCEO noted that they must work with the recommendations to look at what can be done now and within a timeline, and develop a strategic plan so each child can be the best adult he/she can be.

There was a call for UNICEF to bring participants or representatives from the organisations together within a year’s time, to share success stories and to follow up. The way forward is to take the recommendations back to the respective organisations, share them and, work with them to develop a strategic plan. The starting point would be to look at what can be done in the short term with few resources.

Often, things can be done with conscious effort, e.g. following up on whether the HFLE skills curriculum is being implemented (send out a few persons to check, sit in the classroom.) Some initiatives however will require financial resources, which were not budgeted for in the current year, and these will have to wait until the end of the year or next year.

Participants noted that the current interaction between all sectors is limited, and that work is often done in isolation, which speaks to the need for better planning and integration, even with NGOs. The need for early strategic planning was stressed.

Conclusion
UNICEF’s Regional office held a regional workshop in Jamaica, to assess the situation of at risk adolescents. With this report, Guyana has documented what is occurring, and now has the evidence based knowledge, to begin to address the needs of adolescents, in an effort to provide them the best environment in which to become productive adults.

It was also suggested that the MoE convene a smaller meeting to decide on a plan of action, based on the recommendations from this workshop. The Ministry indicated that this workshop was a priority and from this study a plan of action will be developed.

Those present were thanked and the inter-sectoral approach was highly praised as a key strategy towards the development of the adolescents, and addressing their many needs.


iii Ibid


v USAID Guyana HIV/AIDS Health Profile, 2010


vii O’Toole et al


___ WHO Statistics on Guyana, December 2005

Jenkins, Molly (2010) Qualitative Assessment of MSM in Guyana Overview and Preliminary Findings, GHARP II Publication

Wills, Magda Fiona (2005) Qualitative Assessment of Barriers and Motivational Factors towards HIV Risk Reduction Practices among MARPS: Youths, FFSWs and their Clients in Guyana. GHARP Internal Publication


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