Ministry of Public Health, in Partnership with UNICEF

Knowledge Attitude and Practice (KAP) Survey on Guyana COVID-19 Response

Mental Wellness of Adults and Adolescents – July 2020 Report
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Executive Summary

Introduction

This report details the procedures and findings of the Third Round of the Knowledge, Attitude, and Practices (KAP) Survey on specific themes related to the coronavirus disease (COVID-19). This Round of the survey differs from previous Rounds in that it seeks to assess how the changes to lifestyles occasioned by COVID-19 affects children less than age ten, adolescents (age 10-19) and adults.

COVID-19 was declared by the World Health Organisation (WHO) as a Public Health Emergency of International Concern on January 30, 2020 (WHO, 2020). COVID-19 was first confirmed in Guyana on March 11, 2020 when a 52-year-old woman who traveled to the country from New York was diagnosed with the disease.

The Ministry of Health and the United Nations Children’s Fund (UNICEF) are working jointly to implement a Knowledge, Attitude, and Practices (KAP) survey which seeks garner information on misconceptions or misunderstandings that may represent obstacles to the measures the authority would like to implement and potential barriers to behaviour change.

Objectives of the Survey

The Ministry of Public Health (MoPH) and the United Nations Children’s Fund (UNICEF) is working jointly to implement a Knowledge, Attitude, and Practices (KAP) survey which will garner information on misconceptions or misunderstandings that may represent obstacles to the measures the authority would like to implement and potential barriers to behaviour change.

A COVID-19 KAP survey will help to:

(i) Measure the extent of a known situation; and provide new tangents of a situation reality;
(ii) Enhance the knowledge, attitude, and practices of specific COVID-19 themes;
(iii) identify what is known and done about various COVID-19-related subjects;
(iv) Establish the baseline (reference value) for use in future assessments
(v) Suggest a context-specific intervention strategy
(vi) plan activities that are suited to the respective population involved.

Scope of the Survey

To achieve the objectives, this survey addresses key questions regarding the benchmark values for indicators of COVID-19. The data collected serve as a baseline, mid-line, and end-line values depending on the specific interventions. The survey focuses on identifying the risks associated
with knowledge, attitudes, and practices pertaining to the saving of lives under threat from COVID-19.

**Survey Method**

The survey population consists of children, youth, women, and men, residing in the 10 regions as all regions are engaged in the COVID-19 response programming. The targeted sample size of 664 persons determined independently using a 99% confidence level and 1% margin of error.

The survey employed a multistage sampling method involving both probability and non-probability designs. The survey design combined proportional probability sampling along with consecutive sampling involving systematic random selection. Three approaches were adopted i.e. Telephone interviews in the coastal regions; client-initiated, face-to-face interviews in the hinterland, and a self-administer questionnaire in a Survey Monkey platform.

**Ethics and quality assurance**

Each potential respondent was given full information about the survey including the purpose and potential benefits, their rights, and how the information collected will be used. They were also be informed that all data will be kept confidentially being only accessible by members of the survey team. Further, verbal consent was collected from all those who agreed to participate. Data checking and validation for completeness and consistency were carried out daily and corrections were done in real-time.

**Key Findings**

In total 1,184 interviews were conducted during the Third Round of the survey. This sample comprised 276 adolescents and 302 respondents who had children less than 10 years old living in their household. The sample comprised 67.2% females and 32.8% males.

**Knowledge**

As revealed from the analysis, 99.2% of respondents were aware of the term stress. Respondents mainly associated stress with symptoms of feeling tired, overwhelmed, or burnout (24.2%); feelings of irritation, anger, or being in denial (19.9%); feelings of uncertainty, nervousness or anxiety (19.2%); and feeling sad or depressed (13.3%).

All age groups in the sample felt that stress due to the pandemic was a serious problem with regional disaggregation revealing a similar pattern with respondents from all the regions indicating that stress due to disease is serious. All mean scores computed for age and regional disaggregation were above seven (7) on a scale of one (1) to 10. It should be noted that the mean score of Region 7 was nine (9.0).
Concerns about the risk of being exposed to the virus that causes COVID-19 was the main factor contributing to stress during this period (64.5%). Other factors included taking care of personal and family needs (49.9%), adapting to a different lifestyle (42.7%), uncertainty about the future (42.3%), limited access to food supplies (37.8%), and feeling that they were stuck and do not have many activities, 33.3%.

Adults were more of the view that concerns about being exposed to the virus that causes COVID-19 was contributing to stress than adolescents (66.5% for adults and 57.8% for adolescents). This concern was most prevalent in Regions 8, 5, and 7.

Nine categories of benefits of COVID-19 were detailed by respondents, namely: public safety and security, technological, social, economic, health, environmental, personal development, family, and religious benefits.

**Attitudes**

Both adults and adolescents acknowledged that their lives were different since the COVID-19 outbreak.

52.3% of adults reported that they felt normal ‘all the time or most days’ since the onset of COVID-19 while 48.0% of adolescents said they felt normal all the time or most days’ during this period.

Adolescents were affected more than adults as more of them were reporting challenges such as poor concentration (43.4% adolescents compared to 23.1% for adults); sleeping too much (33.3% adolescents compared to 17.8% for adults; sleeping too little (57.2% adolescents compared to 24.4% for adults); and eating too little (47.4% for adolescents compared to 11.1% for adults).

Further, compared to adults greater proportion of adolescents reported that they were irritable (48.6%), anxious (44.0%), sad or depressed (31.0%), considered acts of self-harm (25.8%), fearful (51.8%), frustrated (45.7%), lonely (48.5%), worried (50.6%), fatigue (36.0%), feeling hopeless (31.9%), on edge (37.1%), harboring persistent disturbing thoughts (19.1%), crying often (39.1%), withdrawing from others (35.4%), difficulty with daily functioning or neglect of roles (30.2%), increased their use of drugs (37.7%).

48.1% of respondents related that they experienced changes in mood, 27.9% stated that they had reduced interest or increased interest in texting or video chatting with their friends while stuck at home, 25.5% reported experiencing problems with memory, thinking or concentration, 22.8% said they lacked interest in activities they once enjoyed, and 22.8% revealed that they recognized changes in eating patterns.
In response to the mentioned challenges, respondents reported taking several measures, with 30.8% indicating that they would reach out to someone to talk to, 29.6% said they would withdraw from others and keep to themselves, 12.0% said that they would normally try to do something by themselves to take their mind off of the feeling, 7.0% said that they exercise or take walks, and 5.9% reported that they practice a hobby.

**Practices**

The analysis found that 82.5% of respondents said they had someone to share problems with, while 17.5% said they had no one to share problems with.

Respondents noted that they usually share their problems with close family members and love ones such as spouses, intimate partners, fiancé, siblings, parents; other relative such as grandparents, in-laws, cousins, aunts, and uncles; other individuals such as friends, supervisors and other work colleagues, neighbours, leaders, and members of faith communities; and supernatural being (God).

Respondents acknowledged receiving help from family members (43.4%), friends (23.7%), community including churches (10.5%), NGO other aid agencies (1.4%), government (2.6%).

Respondents also recounted several actions they took to reduce the stress related to COVID-19 and help make a connection with others. Among on the actions taken were: look for safe ways to offer social support to others especially if they are showing signs of stress such as the depression and anxiety (29.6% of respondents); connect with others through phone calls, emails, text messages, mailing letters or cards, video chat, and social media (27.8% of respondents); and remind me that everyone is in an unusual situation with limited resources (25.2% of respondents).

**Child wellbeing under Covid-19**

Findings show that 80.4% of respondents reporting that they had children age zero to nine years old in their household divulged that the children were at home during the day, 8.1% related the children were at the home of their grandparents or other relatives, 6.8% said they were in school, 4.1% said that the children were at work with them or with a parent or another relative, and 0.3% said that their children were in the house or friends or neighbours.

As is observed from the data, 90.9% of children were spending most of their time indoors during months following the outbreak of Covid-19.

Half of the children (50.0%) were under the supervision and care of their parents, 30.3% were under the supervision of grandparents or another relative, 5.3% were under the supervision and
care of teachers, 1.8% were under the care and supervision of friends and neighbors, and 0.4% were with paid caregivers.

The analysis also uncovers that 23.2% of respondents said they were concerned/worried about the arrangement for the supervision for their child/children during the months since the outbreak of COVID-19.

Among respondents who were concerned/worried about the arrangement for the supervision and care of their child/children, 64.5% of them explained that they were concerned about their child/children's health, and 50.0% disclosed that they were worried about their child/children’s safety and security.

Devices most used by children during the months following the outbreak of Covid-19 are computer/tablet 42.0%, television 17.4%, toys 14.6%, children's book 11.8%, writing or drawing materials 8.7%, and telephone and smartphone 5.6%.

45% of respondents felt that children had become more playful, while 36.4% believed their child/children had become happier, 32.5% further said that children had become more active.

Perception and Experiences of Adolescents as Reported by Adolescents

99.2% of adolescent respondents would have heard the term stress before and 86.6% of them were able to identify at least one symptom of stress.

The 15 to 19 years old age cohort had a mean score of 7.6 and the 10 to 14 years old age cohort had a mean score of 7.3 the perception index on how serious a problem stress due to COVID-19 is (with 1 being not at all serious and 10 be extremely serious).

Factors adding to adolescent’s stress during the pandemic included: concern about the risk of being exposed to the Coronavirus was adding to stress (57.6%), uncertainty about the future (44.9%), adapting to a different lifestyle (41.7%).

Only 11.5% of adolescents insisted that their lives remained the same as before. Concerning how the pandemic is affecting adolescents mentally/emotionally ‘all the time or most days: 57.0% of adolescents were sleeping too little, 54.8% were fearful, 51.1% were worried, 48.9% were lonely, and 48.1% were irritable. Among the more serious occurrences shared by adolescent survey participants included 44.4% were frequently anxious, 41.5% were crying often, 38.5% had increased drug use, 34.8% withdrew from others, 34.1% were regularly depressed, 31.9% felt hopeless, 25.2% frequently considered acts of self-harm, and 20.7% experienced persistent disturbing thoughts. Approximately three in ten 15-19 years old had no one to share their problems with.

Turning to behaviours that reduce the spread of the pandemic: 58.3% of adolescent respondents were staying more at home, 49.6% were washing their hands and using hands sanitizer more frequently, 37.7% had stopped attending social gathering now, and 34.1% were keeping a distance of at least six feet from others.
Actions taken by adolescents to reduce stress included: connect with others through phone calls, emails, text messages, mailing letters or cards, video chat, and social media (29.7% of respondents); taking breaks from watching reading or listening to news stories including social media (24.3% of respondents); connect with others, talk with people I trust about my concerns, how I am feeling, or how the COVID-19 pandemic is affecting me (23.2% of respondents); remind myself that everyone is in an unusual situation with limited resources (21.7% of respondents); look for safe ways to offer social support to others especially if they are showing signs of stress such as the depression and anxiety (20.7% of respondents).

**Conclusions**

**Knowledge**

Respondents are aware of the concept of stress and how it is manifested people’s lives and all age groups in the sample felt that stress due to the pandemic was a serious problem with regional disaggregation revealing a similar pattern with respondents from all the regions indicating that stress due to disease is serious.

There are several sources of stress affecting including worry about one’s own health and the health of loved ones, uncertainties surrounding financial situation or job, or loss of support services one relies on, adapting to a new lifestyle, and so on.

The greater concern among adults of being exposed to the virus that causes COVID-19 may have resulted from the well-known fact that as one gets older, their risk for severe illness from COVID-19 increases.

Notwithstanding, the challenging circumstances resulting from the current pandemic, it is useful that persons were able to identify beneficial outcomes.

**Attitude**

The evidence indicates that adolescents are more seriously affected by lifestyle adjustments due to COVID-19

Respondents confessed to experiencing a range of stress-related challenges which all confirm that stress due to COVID-19 is affecting people in a variety of ways.

**Practices**

It observed that the overwhelming majority of individuals had people to share their problems a substantial amount said they had no one to share their problems with. Further, the study notes that apart from faith community leaders respondents did mention access to any professional services.
Family members and friends were the main sources of support for individuals during COVID-19.

People are taking several actions to reduce stress due to COVID-19, some of these are very useful to themselves and others.

*Children Well-being under COVID-19*

Families with children require considerable support in taking care of children and ensuring their wellbeing during the COVID-19 situation.

With children spending most of their time during the day indoors, health-related issues and boredom are serious considerations in the design of any strategy to address child wellbeing during the pandemic.

They are significant levels of worry among parents concerning their children’s health and safety.

The survey notes the widespread access to electronic and digital media among children and notes that strategies should incorporate these in children’s learning, development, and health.

*Perception and Experiences of Adolescents as Reported by Adolescents*

The evidence that awareness of the concept stress was pervasive among adolescents. Both adolescent age cohorts considered stress due to COVID-19 as incredibly serious.

Undoubtedly, the data suggest that the pandemic has affected the lives of adolescents and that concern about the risk of being exposed to the coronavirus, uncertainty about the future, and adapting to a different lifestyle were the three main concerns that contributed to stress during the current pandemic. There is clear evidence that the pandemic is having devastating consequences on adolescents.

Not all adolescents have access to family and friendship circles to share their problems with. We also note the absence in reporting of access to professional help by adolescents.

In assessing the actions taken by respondents, the proportions of adolescents adopting them ranged from slightly unacceptable (stopped attending social gathering and social distancing) to moderately acceptable (washing hands and using hands sanitizer more frequently and staying home more). It is therefore apparent that there is need to reinforce the pandemic prevention guidelines.

While the responses on actions taken by adolescents to reduce stress are responsible and appropriate, the proportion of adolescents identifying with these practices are less than encouraging. In every practice less than one three adolescent survey participants affirmed them.

*Recommendations*
Knowledge

Knowledge-based interventions should first acknowledge that stress due to pandemics is natural and urge individuals to seek to cope with stress in a healthy way explaining that it contributes to them being healthier, protect the people they care about, and make their community stronger.

A range of media could be used including local television and radio, social media, and print media. Peer to peer information sharing and support is another useful option.

Further, individuals should be encouraged to brainstorm on support systems available to them and government and partners can expand and publicize available support systems.

Interventions here should first admit that we are experiencing a new normal and that there is no way to ensure one has zero risks of infection. It should be communicated that important that individuals to understand the risks and know how to be as safe as possible.

Further, advisories should point out that adults who are at increased risk of severe illness from COVID-19, and those who live with them, should consider their level of risk before deciding to go out and ensure they are taking steps to protect themselves.

Helping people adopt productive practices such as learning a new skill, connecting with family can be a useful approach in coping with the stress due to COVID-19.

Attitude

Programmes and guidance document on how adolescents and young people cope with the changes resulting from COVID-19, they type of support and activities parents and community groups can implement to support adolescents and young people, and what roles they can play in mitigating risks related to the current COVID 19 context. The WHO has developed a range of resources for this purpose.

Programmes and messages should target helping individuals build resilience against stressors by developing and strengthening core life skills, reducing focus and negative outcomes, guiding them where to find help, and focusing on positive outcomes.

Practices

Informal support systems can be leveraged to provide access to persons at risk due to stress. However, training is needed. This can be achieved through short courses online. Further, government and NGO services offering support should be publicised widely and hotline services should be expanded.
There is a need for more people to access support from government services and may need support in processing claims from the Government.

Efforts should be made to reinforce positive actions that can be undertaken during the pandemic as a means of coping with stress and offer support to others.

*Children Well-being under COVID-19*

Efforts should focus on how parents can incorporate responsive care and early learning into their children’s day-to-day life

Responsive caregiving here involves ensuring children’s health, nutrition, safety and security, and opportunities for early learning.

Snippets from UNICEF/WHO collaborative participant manual “Care for Child Development’ can be retrieved and creatively shared.

A whole-of-government and whole-of-society approach is recommended for addressing child wellbeing during and after COVID-19.

Parents and guardians should try to facilitate safe outdoor activities for children and help them to access development and educational programmes from various media sources.

Provide access to children on the digital and electronic platform on how they can sustain their health and others around them and games and exercise to keep them healthy and involved.

*Perception and Experiences of Adolescents as Reported by Adolescents*

Planners and programme managers can leverage this awareness of stress to secure the interest of adolescents in participating in stress management activities.

Government, Community based groups, and international partners should collaborate in expanding services to young people who are experiencing the range of stressors from the pandemic. These services must be taken into consideration existing stressors at this developmental stage. A peer-to-peer support network should also be considered.

Adolescents and their parents should also receive information on where they can access professional support. This would require cataloging of available services, and assessment of their adequacy and sharing of information on the listing of services with parents and adolescents.

Continual reinforcement of COVID-19 prevention guidelines among adolescents utilising multimedia platforms.

Interventions seeking to improve adolescents’ capacity to manage stress in general and particularly those related to the pandemic. These stress management interventions should utilise multi-media platforms
those preferred by adolescents (social media). Peer-to-peer communication can be instrumental in increasing the spread of stress management techniques among adolescents.
Background

Introduction
This report details the procedures and findings of the Third Round of the Knowledge, Attitude, and Practices (KAP) Survey on specific themes related to the coronavirus disease (COVID-19). According to the World Health Organisation (WHO), declared COVID-19 as a Public Health Emergency of International Concern on January 30, 2020 (WHO, 2020). COVID-19 was first confirmed in Guyana on March 11, 2020 when a 52-year-old woman who traveled to the country from New York was diagnosed with the disease.

The Ministry of Health and the United Nations Children’s Fund (UNICEF) are working jointly to implement a Knowledge, Attitude, and Practices (KAP) survey which will garner information on misconceptions or misunderstandings that may represent obstacles to the measures the authority would like to implement and potential barriers to behaviour change.

Objectives of the Survey
This COVID-19 KAP survey will help to:

(vii) Measure the extent of a known situation and provide new tangents of a situation reality;
(viii) Enhance the knowledge, attitude, and practices of specific COVID-19 themes;
(ix) identify what is known and done about various COVID-19-related subjects;
(x) Establish the baseline (reference value) for use in future assessments
(xi) Suggest a context-specific intervention strategy
(xii) plan activities that are suited to the respective population involved.

SCOPE OF THE SURVEY
The survey is national in scope i.e. implemented in all ten regions. To achieve the objectives, this survey addresses key questions regarding the benchmark values for indicators of COVID-19. The data collected serve as a baseline, mid-line, and end-line values depending on the specific interventions. The survey focuses on identifying the risks associated with knowledge, attitudes, and practices on the saving of lives under threat from COVID-19.
Methodology

Research Design
The survey method that is used primarily is non-experimental correlational studies. It is convenient in obtaining information about people’s actions, knowledge, intentions, opinions, and attitudes through self-report (Polit and Beck 2010, p. 294). For this reason, this approach was adopted to achieve the proposed objectives.

Survey Population
The survey population consists of children, youth, women, and men, residing in the 10 regions as all regions are engaged in the COVID-19 response programming. The targeted sample size of 664 persons was determined using a sample size table. The sample size was determined independently using a 99 % confidence level and 1 % margin of error.

Table 1: Population and Sample by Region

<table>
<thead>
<tr>
<th>Regions</th>
<th>Population</th>
<th>% of total Pop</th>
<th># at 99% Conf.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barima-Waini</td>
<td>27,643</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Pomeroon-Supenaam</td>
<td>46,810</td>
<td>6</td>
<td>42</td>
</tr>
<tr>
<td>Essequibo Islands-West Demerara</td>
<td>107,785</td>
<td>14</td>
<td>96</td>
</tr>
<tr>
<td>Demerara-Mahaica</td>
<td>311,563</td>
<td>42</td>
<td>277</td>
</tr>
<tr>
<td>Mahaica-Berbice</td>
<td>49,820</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>East Berbice-Corentyne</td>
<td>109,652</td>
<td>15</td>
<td>97</td>
</tr>
<tr>
<td>Cuyuni-Mazaruni</td>
<td>18,375</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Potaro-Siparuni</td>
<td>11,077</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Upper Takutu-Upper Essequibo</td>
<td>24,238</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>Upper Demerara-Berbice</td>
<td>39,992</td>
<td>5</td>
<td>35</td>
</tr>
<tr>
<td>Total</td>
<td>746,955</td>
<td></td>
<td>664</td>
</tr>
</tbody>
</table>

Sampling
The survey employed a multistage sampling method involving both probability and non-probability designs. The survey design combined proportional probability sampling along with consecutive sampling involving systematic random selection (see table 1). The size of the primary sampling units was based on proportional population to size calculation. Each of the 10 clusters corresponded to the Regional Administrative Boundaries (see Appendix B). Secondary sampling units were based on the list of individuals selected at random from the telephone directory using
a predefined, computer-based algorithm or through consecutive sampling in areas where there is no landline telephone service.¹

Consecutive sampling was employed to survey residents in hinterland communities who do not have access to landline telephone service. The sampling frame was compiled from persons visiting health facilities over a two-weeks period, along with staff from the facilities. From the frame constructed respondents’ selection was based on a random process (systematic random sampling).

**Data Collection**

Guyana is a geographically diverse country and therefore data collection methods were adopted based on the specific areas/regions. The exercise, therefore, sustained the disadvantage of excluding persons who the chosen method is not able to capture for instance persons without telephones.

Data was collected from all ten regions. The regions were divided into two clusters: coastal and hinterland clusters. The Coastal cluster of regions comprised regions 3, 4, 5, 6 & 10, and the hinterland cluster comprised regions 1, 2, 7, 8, and 9. Three approaches were adopted i.e. Telephone interviews in the coastal regions; the client initiated face-to-face interviews in the hinterland and a self-administer questionnaire in a Survey Monkey platform.

1. **Telephone interviews** – Household numbers were randomly selected from Guyana’s 2019 telephone directory. The entire directory was downloaded in PDF and then exported to excel. A new excel sheet was prepared for each list of Surname under the individual letters (A, B, C D, etc.) letter. Each row of each sheet was considered, random rows were selected and the numbers for that region in those rows were highlighted to be called.

A data collection team was established for each region and teams were asked to randomly select from a bag with the 26 letters of the alphabet, the Surnames (starting with the selected letters) they will call in round one of the surveys. Oversampling was done in region 4 as this region has almost 42% of Guyana’s population. The number of interviews needed for each region was divided among the selected letters for that region. Please see example below.

¹ In many of these Regions mobile phones are ubiquitous, however, because of privacy issues it was not possible to build a sample frame using mobile phone users.
The questionnaire for the telephone interviews was placed in the Kobo toolbox online platform and placed on the interviewers’ tablets. The interviewers recorded the responses in the Kobo toolbox and submitted them in real-time for analysis. This process eliminated the data entry process.

2. **Face-to-face**: Respondents from the hinterland cluster of regions were engaged face-to-face. (when persons visited Social, health care and Community workers, every 3rd person as asked to participate in the survey, with replacement). The responses were also recorded in the Kobo toolbox and submitted in real-time to a central repository.

3. **Survey Monkey – Adult survey**: A link with the adult and adolescent surveys were shared on the websites of the Ministry of Public Health and UNICEF and circulated by email and WhatsApp.

4. **Survey Monkey Adolescents’ Survey**: A separate link with the mental wellness survey was prepared and circulated to adolescents via WhatsApp and on the websites of the Ministry of Public Health and UNICEF. The instruction of the survey included, ‘Please allow your parent or guardian to read the survey (or read it to them) and obtain their consent before participating in this survey.’ The first two questions in the survey were:
   - Has your parent or guardian read the survey (or you read it to them)? Yes/No
   - Have you received consent from your parent/guardian? Yes/No

   **If the response to either of those questions were no, the survey would disappear from the device.**

Fifty-three (53) interviewers were recruited and trained to capture survey data. Twenty-seven interviewers, based in Georgetown, and twenty-six in the hinterland.
ETHICS AND CONSENT PROCEDURES

To ensure that the key ethical principles for the conduct of evaluation involving human subjects were followed, each potential respondent was given full information about the survey including the purpose and potential benefits, their rights, and how the information collected will be used. They were also informed that all data will be kept confidentially being only accessible by members of the survey team.

Further, verbal consent was collected from all those who agreed to participate. For adolescents, they were allowed to participate once parents/guardians provided consent. All participants were also informed of their right to discontinue their participation at any point and the approaches, to ensure confidentiality, were being described. The responder’s name was not required.

QUALITY CONTROL

Data checking and validation for completeness and consistency were carried out daily from downloads from Kobo Toolbox, based on the uploaded entries to KoBo collect from the tablets. Data that were deemed inconsistent were highlighted and shared with the relevant coordination team for rectification and cleaning. However, quality control was ensured daily, with corrections carried out on a real-time basis within the first 48 hours of data collection.

DATA MANAGEMENT AND ANALYSIS PLAN

All quantitative data were analyzed using Excel and Statistical Package for the Social Sciences (SPSS). Based on the raw data, available for download from Kobo Toolbox, a master database was developed, and further data cleaning was carried out. A quantitative data framework was set up
in Excel for all validated data. A series of frequencies count, percentage, ratios, and other statistical methods will be employed in the analysis of the data.

Survey Limitation and Mitigation Measures
Owing to the difficulty in collecting data from hinterland and remote regions a non-probability approach was introduced. The limitation here is that there is no way to estimate the probability of including each person in a nonprobability sample, therefore every person usually does not have a chance for inclusion. Nevertheless, most research samples in medicine, psychology, and other disciplines are nonprobability samples (Polit and Beck 2010; Howit and Cramer 2011). To improve on this sampling technique the survey utilized a random approach to select respondents.

Another limitation of the survey is the use of telephone interviews. When using this method it is observed that respondents are often uncooperative on the phone when the interviewer is unknown. However, it is believed that the use of experience researchers along with pre-survey training mitigated this challenge.

Survey Results
Demography
A total of 1,184 interviews were completed during the Third Round of the survey. The minimum age for participants in the survey was 9 years old and the maximum age was 94 years old. The mean age of survey participants was 37 years and the standard deviation was 17.8. The mean differed significantly from the sample collected in Round 1 and Round 2 of the survey (see table 3).

Table 3: Age: descriptive statistics

<table>
<thead>
<tr>
<th>Summary Statistics</th>
<th>Round 3</th>
<th>Round 2</th>
<th>Round 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Respondents</td>
<td>1184</td>
<td>962</td>
<td>1217</td>
</tr>
<tr>
<td>Minimum</td>
<td>9</td>
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<td>Maximum</td>
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<tr>
<td>Mean</td>
<td>36.7</td>
<td>41.4</td>
<td>40.9</td>
</tr>
<tr>
<td>Std. Deviation</td>
<td>17.8</td>
<td>16.3</td>
<td>16.3</td>
</tr>
</tbody>
</table>

Looking at the age distribution of the sample, 15.5% were 18 years or younger, 16.3% were from the 18 to 24 years old age category, 18.2% where from 25 to 34 years old age category, 17.1% where from the 35 to 44 years age category, 13.0% we’re from the 45 to 54 years age category, 10.5% were from the 55 to 64 years age category and 8.4% were 65 years or older. Further, 1.1%
of the data on age were missing (Table 4). The sample also has 276 persons of adolescent age (10-19 years old).

Table 4: Age distribution of sample

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 18 years old</td>
<td>183</td>
<td>15.5</td>
</tr>
<tr>
<td>18 to 24 years old</td>
<td>193</td>
<td>16.3</td>
</tr>
<tr>
<td>25 to 34 years old</td>
<td>215</td>
<td>18.2</td>
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<tr>
<td>35 to 44 years old</td>
<td>203</td>
<td>17.1</td>
</tr>
<tr>
<td>45 to 54 years old</td>
<td>154</td>
<td>13.0</td>
</tr>
<tr>
<td>55 to 64 years old</td>
<td>124</td>
<td>10.5</td>
</tr>
<tr>
<td>65 years and older</td>
<td>99</td>
<td>8.4</td>
</tr>
<tr>
<td>Total</td>
<td>1171</td>
<td>99.9</td>
</tr>
<tr>
<td>Missing data</td>
<td>13</td>
<td>1.1</td>
</tr>
<tr>
<td>Total</td>
<td>1184</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As depicted in the chart below 67.2% of the respondents were females and 32.8% of the respondents were males.

Figure 1: Sample distribution by gender (n=962)
As presented in the table below, the 35 to 44 years age category was the modal age group for females in the sample; and the 25 to 34 years age category was the modal age group for males.

Figure 2: Sample distribution by age and gender

Regional distribution of the sample indicates:
- 0.9% of respondents were Region1,
- 5.6% of respondents were from Region 2,
- 18.8% of respondents were from Region 3,
- 31.5% of respondents were from Region 4,
- 6.0% of respondents were from Region 5,
- 10.2% of respondents from region 6,
- 1.6% of respondents were from Region 7,
- 1.4% of respondents were from Region 8,
- 3.4% of respondents were from Region 9, and
- 3.6% of respondents were from Region 10.
- 17.1% of respondents were from Georgetown
Regarding the education levels of respondents, 22.1% of the sample informed interviewers that they were educated beyond secondary education, 43.5% completed up to secondary education and 21.3% started but did not complete secondary education. The data also revealed that 8.9%
of the sample completed up to primary education, 3.2% of the sample started primary but did not complete that level and 0.9% of the sample had no formal education.

Figure 4: Distribution of sample by education level (n=940)

It was observed from the data that 47.5% of respondents were single or never married, 33.9% were married, 9.3% were living together with an intimate partner and 1.6%, 3.2% and 4.5% were separated, divorced, or lost a partner through death, respectively.

Figure 5: Sample distribution by marital status (n=936)
Knowledge

The survey queried whether respondents had heard of the term ‘stress’. Based on the responses, there was widespread use of the term ‘stress’ with 99.2% of the respondents claiming that they have heard of the term stress used before.

*Figure 6: Have you heard the term ‘stress’ before?*

According to the data 24.2% off the sample associated stress with symptoms of feeling tired, overwhelmed, or burnout; 19.9% associated stress with symptoms of a feeling of irritation, anger, or being in denial; 19.2% associated stress with feelings of uncertainty, nervousness or anxiety; 13.3% associated stress with feeling sad or depressed; 8.3% linked stress with lacking in motivation, 7.0% linked stress with having trouble concentrating; and 4.5% linked stress with having trouble sleeping. The responses indicate that respondents are quite aware of the effects of stress on Individuals.

*Figure 7: Respondents' views on symptoms of stress*
Figure 8: Perception of how serious a problem do you think stress (due to COVID 19) is at this moment by age and region.
Concerning stress due to COVID-19, as is observed from the data in the charts above, that all age groups in the sample felt that stress due to the pandemic was a serious problem. Regional disaggregation reveals a similar pattern with respondents from all the regions indicating that stress due to disease is serious. All mean scores computed for age and regional disaggregation were above seven (7) on a scale of one (1) to 10. It should be noted that the mean score of Region 7 was nine (9.0).

When asked what were some of the common factors that can add to stress during the COVID-19 pandemic, respondents reported that concerns about the risk of being exposed to the virus that causes COVID-19 was the main factor contributing to stress during this period (64.5%). Other factors included taking care of personal and family needs (49.9%), adapting to a different lifestyle (42.7%), uncertainty about the future (42.3%), limited access to food supplies (37.8%), feeling that you are stuck and do not have many activities 33.3%, learning new communication tools and dealing with difficulties 13.3%.

*Figure 9: Respondents perspectives on the common factors that can add to stress during the COVID-19 pandemic*

Disaggregating the data of respondents who felt that concerns were about being exposed to the virus was contributing to stress by age and then by region yield some noteworthy results. The
analysis indicates that adults were more of the view that concerns about being exposed to the virus that causes COVID-19 was contributing to stress than adolescents. Comparatively, 66.5% of adults felt that concerns about being exposed to the virus that causes COVID-19 was contributing to stress, while for adolescents only 57.8% felt so. In the Regions, this perception was highest in Regions 8, 5, and 7.

**Figure 10: Percentage of respondents of the perception that concerns about the risk of being exposed to the virus that causes COVID-19 is contributing to stress by Age group**

![Percentage of respondents of the perception that concerns about the risk of being exposed to the virus that causes COVID-19 is contributing to stress by Age group](image)

**Figure 11: Percentage of respondents of the perception that concerns about the risk of being exposed to the virus that causes COVID-19 is contributing to stress by Region**

![Percentage of respondents of the perception that concerns about the risk of being exposed to the virus that causes COVID-19 is contributing to stress by Region](image)
Notwithstanding evidence of several factors contributing to the stress during this period, respondents were able to identify nine categories of benefits derived from the changing situation related to the pandemic. The benefits reported are summarized in the table below:

| Social Benefits                       | ▪ Communicating with friends overseas  
|                                      | ▪ A chance to bond                   |
| Family Benefits                       | ▪ Adequate family time                
|                                      | ▪ Understand the people you live with  
|                                      | ▪ Families building stronger relationships 
|                                      | ▪ Family Interactions                |
| Religious Benefits                   | ▪ A stronger connection with God      |
| Economic Benefits                    | ▪ Helping families financially        
|                                      | ▪ Manage to save money                |
| Personal Development                 | ▪ A chance to introspect and rest     
|                                      | ▪ Availability of time to assess my future  
|                                      | ▪ Discover new things about yourself and your surroundings as well 
|                                      | ▪ Learning to deal with life struggles that can assist me in the future 
|                                      | ▪ Improving my Agricultural skills  
|                                      | ▪ It gives me more time to focus on myself and study 
|                                      | ▪ More time to complete unfinished work  
|                                      | ▪ It gave us time to reassess my priorities and get my life in order 
|                                      | ▪ Learning new skills 
|                                      | ▪ More Time to be innovative       
|                                      | ▪ More time to concentrate on hobbies and discover new hobbies 
|                                      | ▪ Persons are more mindful and thoughtful in decision making 
|                                      | ▪ Acquire more knowledge via the internet, books, etc. 
| Health Benefits                      | ▪ Working from home provided an environment with less pressure from things like travel and social anxiety issues. 
|                                      | ▪ You can focus on your mental health and wellbeing  
|                                      | ▪ More time to learn and take care of yourself  
|                                      | ▪ Value life more  
|                                      | ▪ People are no longer disregarding things such as washing their hands anymore |
| Technological Benefits               | ▪ Online classes                      
|                                      | ▪ Improved ability to work online      
|                                      | ▪ Acquire more knowledge via the internet |
| Environmental Benefits               | ▪ Reduction in pollution.             
|                                      | ▪ It is helping the environment to recover and replenish |
| Safety/Security Benefits             | ▪ Fewer crimes are being committed    
|                                      | ▪ Saving lives, away from road fatalities |
Attitudes

Respondents were asked how their lives have been impacted since the onset of COVID-19 in the country. The chart below depicts responses from adult and adolescent respondents. In the main, respondents both groups felt that their lives were different since COVID-19, but they were managing (adults 28.2% and adolescents 33.2%). However, 3.8% of adults and 1.6% of adolescents send it was difficult for them to survive. Further, 10.2% of adults and 9.5% of adolescents said that their lives have been interrupted or changed and 7.9% of adults and 5.7% of adolescents claimed that their lives have remained the same as before.

Figure 12: Which statement best describes your life since COVID-19

Analysis of the data shows that 50.4% of the sample reported that they ‘feel normal’ all the time or most days. For adults, 52.3% said they ‘felt normal’ all the time or most days since the onset of COVID-19. On the other hand, only 48.0% of adolescents said they felt normal ‘all the time or most days’ during this period. Data also indicate that adolescents were affected more than adults as more of them were reporting challenges such as poor concentration (43.4% adolescents compared to 23.1% for adults); sleeping too much (33.3% adolescents compared to 17.8% for adults); sleeping too little (57.2% adolescents compared to 24.4% for adults); and eating too little (47.4% for adolescents compared to 11.1% for adults).
Figure 13: Respondents reporting on how they feel ‘all the time or most days’ due to changes resulting from COVID-19

Again, it is observed from the data evidencing the numerous challenges respondents were reporting that they faced ‘all the time or most days’ that greater proportions of adolescents were reporting on many of these challenges when compared to adolescents (see chart below). Greater proportion of adolescents reported that they were irritable (48.6%), anxious (44.0%), sad or depressed (31.0%), considered acts of self-harm (25.8%), fearful (51.8%), frustrated (45.7%), lonely (48.5%), and worried (50.6%).
Figure 14: Respondents reporting on how they feel ‘all the time or most days’ due to changes resulting from COVID-19

A similar tendency is observed when we assess conditions such as fatigue or low energy, feelings of hopelessness, jumpy or an edge, persistent disturbing thoughts, crying often, and withdrawing from others. As depicted in the chart below, significantly larger proportions of adolescents were reporting that during this period they were ‘all the time or most days’ fatigued (36.0%), feeling hopeless (31.9%), on edge (37.1%), persistent disturbing thoughts (19.1%), crying often (39.1%), and withdrawing from others (35.4%).
Adolescents also reported that for the period under review ‘all the time or most days’ they found difficulty with daily functioning or neglect of roles (30.2%) and increased their use of drugs (37.7%). In comparison, adults in the sample said that for the period ‘all the time or most days’ they increased consumption of alcohol (14.7%) and experienced loss of interest or pleasure in activities they previously enjoyed (20.9%).
Respondent's views were solicited on whether it is normal for someone to feel sad during this time, because they miss their friends or because sports and school and hanging out is not happening. In response, an overwhelming amount of respondents felt it was normal (90.6%).

Figure 17: Respondents’ views on whether it is normal for someone to feel sad during this time, because they miss their friends or because sports and school and hanging out is not happening

Next, the survey examined whether respondents had experienced a range of scenarios. In all, 48.1% of respondents related that they experienced changes in mood, 27.9% stated that they had reduced interest or increased interest in texting or video chatting with their friends while stuck at home, 25.5% reported experiencing problems with memory, thinking or concentration, 22.8% said they lacked interest in activities they once enjoyed, 22.8% revealed that they recognized changes in eating patterns, 18.5% said they experienced ongoing irritability, rage or anger, 16.3% said they noticed changes in appearance such as a lack of basic personal hygiene, 15.1% reported that they found themselves sleeping all the time, 14.1% said they had a hard time sleeping, 12.7% said they had frequent conflicts with family members, and 6.8% related that they had increased in risky or reckless behaviours.
Respondents were then asked what they did when they experience these feeling or scenarios. In the main, 30.8% reported that they would reach out to someone to talk to, 29.6% said they would withdraw from others and keep to themselves, 12.0% said that they would normally try to do something by themselves to take their mind off of the feeling, 7.0% said that they exercise or take walks, and 5.9% reported that they practice a hobby.
Practices
Considering the foregoing, respondents were asked if they have someone to share problems with. The analysis found that 82.5% of respondents said they had someone to share problems with, while 17.5% said they had no one to share problems with.

Figure 20: Do you have someone to share problems with
When asked who were the people they can talk with when they have problems respondents stated that they speak with close family members and love ones such as spouses, intimate partners, fiancé, siblings, parents; other relative such as grandparents, in-laws, cousins, aunts, and uncles; other individuals such as friends, supervisors and other work colleagues, neighbours, leaders, and members of faith communities; and supernatural being (God).

Further, the survey inquired as to who respondents would have received help from since the onset of COVID-19. Respondents shared that they received help from family members (43.4%), friends (23.7%), community including churches (10.5%), NGO other aid agencies (1.4%), government (2.6%).

*Figure 21: Persons or agencies respondents received help from during the COVID-19*

When asked what behaviours they were doing more now than a month ago, 67.8% of respondents disclosed that they were staying more at home, 66.6% recounted that they were washing hands and using hand sanitizer more frequently, 50.8% related that they had stopped attending a social gathering, 48.1% acknowledged that they were keeping a distance of at least six feet, 32.0% confessed to checking the news more frequently, and 8.8% said they were informing people of illness symptoms.
Respondents also recounted several actions they took to reduce the stress related to COVID-19 and help make a connection with others. Among the actions taken were:

- look for safe ways to offer social support to others especially if they are showing signs of stress such as depression and anxiety (29.6% of respondents).
- connect with others through phone calls, emails, text messages, mailing letters or cards, video chat, and social media (27.8% of respondents).
- remind myself that everyone is in an unusual situation with limited resources (25.2% of respondents)
- taking breaks from watching reading or listening to news stories including social media (24.3% of respondents).
- connect with others, talk with people I trust about my concerns, how I am feeling, or how the COVID-19 pandemic is affecting me (23.5% of respondents).
- remind myself of my crucial role in fighting this pandemic (21.9%).
- talk openly with family and friends about how the pandemic is affecting me (19.4%).
- spend time outdoors either being physically active or relaxing (9.5%).
- communicate with friends I mean turning social distancing (8.0%)
- take breaks and stretch, exercise, or check in with my family, and friends (7.9%).
- using alcohol or other drugs (including prescription drugs) as a means of coping (7.3%).
- ask how to access mental health resources (1.1%)
Figure 23: Actions taken by respondents to reduce stress due to COVID-19
This subsection of the survey examines the many ways COVID-19 has affected children across the country. The analysis is based on 302 (25.5% of the overall sample) positive responses to the query of whether respondents had a child/children age 0-9 years old in their home or the families reporting having children under 10 years old in their home.

The survey first investigated where children spent most of their days since the COVID-19 outbreak. As is gleaned from the data, 80.4% of respondents reporting that they had children age zero to nine years old in their household revealed that the children were at home during the day, 8.1% said the children were at the home of their grandparents or other relatives, 6.8% said they were in school, 4.1% said that the children were at work with them or with a parent or another relative, and 0.3% said that their children were in the house or friends or neighbours.

Figure 24: Where child/children spend most of the day
As is observed from the data, 90.9% of children were spending most of their time indoors during months following the outbreak of Covid-19 and only 9.1% of respondents reported that their children were spending most of their time outdoors.

*Figure 25: Where has [NAME] spent most of their time in the months following the outbreak of Covid-19?*

Having presented the location of the children during the COVID-19 period, another important question is under whose supervision and care children were under during daytime in the months following the COVID-19 outbreak. According to the data, half of the children (50.0%) were under the supervision and care of their parents, 30.3% were under the supervision of grandparents or another relative, 5.3% were under the supervision and care of teachers, 1.8% were under the care and supervision of friends and neighbors, and 0.4% were with paid caregivers. As depicted in figure 27, the analysis uncovers that 23.2% of respondents said they were concerned/worried about the arrangement for the supervision and care for their child/children during the months since the outbreak of COVID-19.

When asked what they were concerned/worried about, 64.5% of respondents explained that they were concerned about their child/children health, 50.0% disclosed that they were worried about their child/children’s safety and security, 48.4% said they were worried about their children’s schoolwork, 16.1% indicated that they were concerned that they had to take time off from other activities such as work to take care of their children, and 6.5% said their worry was associated with the extra money they had to pay for their caretaking arrangement.
Figure 26: Under whose care and supervision children were under during the day since the outbreak of COVID-19

Figure 27: Were you concerned about the arrangements?
Further, we assess the various types of devices that children had access to during the months after the COVID-19 outbreak. As is observed from the data 72.8% said that children had access to television, 68.2% reported that their children had access to children's book, 63.9% indicated that their children had access to toys, 62.3% informed that children in their household had access to computer or tablet, 52.0% claimed that children in their household had access to writing or drawing materials, and 35.8% said that children in their households had access to telephone or smartphone.

When interrogated as to which device did children use the most in the months following the outbreak of Covid-19 the data show that computer/tablet was the most used device (reported by 42.0% of respondents). This was followed by television 17.4%, toys 14.6%, children's book 11.8%, writing or drawing materials 8.7%, and telephone and smartphone 5.6%.
Figure 29: Devices that children had access to since the outbreak of COVID-19

Figure 30: The device reported to be most used by children
What other effects did COVID-19 have on children? As is observed from the data, 45% of respondents felt that children had become more playful, while 36.4% believed their child/children had become happier, 32.5% further said that children had become more active.
Perception and Experiences of Adolescents\textsuperscript{2} as Reported by Adolescents

This analysis of the perception and experiences of other adolescents under COVID-9 is based on 276 adolescent respondents in the sample. Of the 96 adolescent boys in the sample, 36.8% were from the 10-14 age category and 63.2% were from the 15-19 age category. The sample of adolescents comprised 180 girls of which 34.6% were from the 10-14 age group and 65.4% were from the 15-19 age group.

*Figure 32: Distribution of adolescents in the sample by gender and age group*

Major life changes are generally associated with stress in adults and adolescence alike. So examining and highlighting adolescents' knowledge, attitudes, and practices regarding stress are necessitated considering the complex challenges resulting from COVID-19. First, the data show that adolescents are aware of the term stress. The evidence indicates that 99.2% of adolescent respondents would have

\textsuperscript{2} The World Health Organization (WHO) defines an \textbf{adolescent} as any person between ages 10 and 19 years old.
heard the term stress before and 86.6% of them were able to identify at least one symptom of stress.

Figure 33: Proportion of adolescent respondents that are aware of stress

The top five symptoms of stress identified by adolescents were

- feeling tired, overwhelmed or burned out (31.4%),
- feelings of irritation, anger, vex, or in denial (24.3%),
- feeling uncertain, nervous, or anxious of the future (18.8%)
- feeling sad or depressed (10.5%), and
- lacking motivation (6.5%).

Figure 34: Adolescents views what are symptoms of COVID_19
The high mean scores for both adolescent age cohorts on the perception index (see figure 27) reflect how dangerous a problem respondent felt that stress due to COVID-19 was. Drawing from the data on perception index on how serious a problem stress due to COVID-19 is (with 1 being not at all serious and 10 be extremely serious), the 15 to 19 years old age cohort had a mean score of 7.6 and the 10 to 14 years old age cohort had a mean score of 7.3. Both means are indicative that adolescents consider stress due to COVID-19 as incredibly serious.

Figure 35: Perception of how serious a problem stress due to COVID-19 is at the moment
Adolescents were of the view that concern about the risk of being exposed to the coronavirus, uncertainty about the future, and adapting to a different lifestyle were the three main concerns that contributed to stress during the current pandemic. A total of 57.6% of adolescents mentioned that concern about the risk of being exposed to the Coronavirus was adding to stress, 44.9% opined that uncertainty about the future was adding to stress and 41.7% suggested that adapting to a different lifestyle was contributing to stress. Other views posited by more than one-fifth of adolescent respondents relating to factors that were adding to stress included feeling that they were stuck and did not have many activities (35.9%), taking care of personal and family needs (30.4%) and limited access to food supplies (23.6).

How has the COVID-19 pandemic affected the lives of adolescents? Undoubtedly, the data suggest that the pandemic has affected the lives of adolescents. Only 11.5% of adolescents insisted that their lives remained the same as before. As shown in figure 28, 66.1% of adolescents affirmed that their lives had changed but they were managing, 19.1% declared that their lives were interrupted, 3.3% articulated that they found it difficult to survive as a result of the changes.
Adolescent survey participants itemised several ways in which they were affected emotionally and mentally by the lifestyle changes due to the Coronavirus pandemic. The top five occurrences reported by adolescent survey participants were sleeping too little, fear, worry, loneliness, and irritability. A total of 57.0% of adolescents mentioned that they were sleeping too little, 54.8% revealed that they were fearful, 51.1% disclosed that they were worried, 48.9% claimed that they were lonely, and 48.1%, reported being irritable ‘all the time or most days’ due to changes consequent to the pandemic (figure 29).

Among the more serious occurrences shared by adolescent survey participants included a total of 44.4% of adolescents communicating that they were frequently anxious, 41.5% conveying that they were crying often, 38.5% divulging that they had increased drug use, 34.8% withdrawing from others, 34.1% regularly depressed, 31.9% feeling hopeless, 25.2% frequently considering acts of self-harm, and 20.7% reporting persistent disturbing thoughts.
Having noted the immense difficulties that adolescents are facing because of life changes associated with the Coronavirus pandemic, an important consideration, particularly for adolescents, is whether they have someone to share their problems with. In the absence of someone to discuss their problems with, adolescents become vulnerable to grave psychological and medical consequences that in extreme cases can create vicious cycles of loneliness, depression, eating disorders, harmful substance abuse, decreased productivity, and persistent thoughts of self-harm: or worst yet morbidity or mortality. The findings on this issue are satisfactory but not ideal. The situation is acceptable for 10-14 years old with over nine of ten of them affirming that they have someone to discuss their problems with. However, for the 15-19
years old approximately three in ten had no one to share their problems with (table 5). One of the female adolescent participants in the survey stated flatly:

Buddy [brother] my boyfriend left me, my mother over-reactive, my Lil brother got common entrance, my big brother deh ah farren [oversaes] , my friends dem stressed.

This outpouring is indicative of the plight of some adolescents.

Table 5: Proportion of adolescent survey participants who had someone to share problems with

<table>
<thead>
<tr>
<th>Age group</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14 years old</td>
<td>93.3%</td>
<td>6.7%</td>
</tr>
<tr>
<td>15-19 years old</td>
<td>69.4%</td>
<td>30.6%</td>
</tr>
</tbody>
</table>

The survey also compared actions that participants were doing more now than a month ago. The data show that 58.3% of adolescent respondents were staying more at home, 49.6% were washing their hands and using hands sanitizer more frequently, 37.7% had stopped attending social gathering now, and 34.1% were keeping a distance of at least six feet from others.

Figure 38: Behaviours study participants are doing more now than one month ago
Adolescent survey participants also narrated several actions they took to reduce the stress related to COVID-19 and help make a connection with others. Among the actions taken were:

- connect with others through phone calls, emails, text messages, mailing letters or cards, video chat, and social media (29.7% of respondents).
- taking breaks from watching reading or listening to news stories including social media (24.3% of respondents).
- connect with others, talk with people I trust about my concerns, how I am feeling, or how the COVID-19 pandemic is affecting me (23.2% of respondents).
- remind myself that everyone is in an unusual situation with limited resources (21.7% of respondents).
- look for safe ways to offer social support to others especially if they are showing signs of stress such as depression and anxiety (20.7% of respondents).

It is important to note that adolescents have prioritised communication and sharing in their stress response. This signals the level of importance adolescents place on sharing and communicating. There were some other encouraging responses such as adolescents reporting that they sought safe ways to offer support to others showing signs of stress (20.7%), reminding themselves of their crucial role in curbing the pandemic (19.6%), communicating with friends while maintaining social distancing (13.8%), spending time outdoors being more physically active or relaxing (13.8%), talk openly with family and friends how the pandemic is affecting them (10.7%), taking breaks to exercise or check in with family and friends.

While the responses in the foregoing paragraph are responsible and appropriate, the proportion of adolescents identifying with these practices are less than encouraging. In every practice less than one three adolescent survey participants affirmed them.
Figure 39: Steps taken by survey participants in responding to the stress caused by COVID-19

- Connect with others through phone calls, email, text messages, mailing letters or cards, video chat, and social media: 29.7%
- Take breaks from watching, reading, or listening to news stories, including social media: 24.3%
- Connect with others. Talk with people I trust about my concerns, how I am feeling, or how the COVID-19 pandemic is affecting me: 23.2%
- Remind myself that everyone is in an unusual situation with limited resources: 21.7%
- Look for safe ways to offer social support to others, especially if they are showing signs of stress, such as depression and anxiety: 20.7%
- Remind myself that I have a crucial role in fighting this pandemic: 13.6%
- Take breaks from work, exercise, or check in with my family, and friends: 15.2%
- Communicate with friends while maintaining social distancing (at least 6 feet): 13.8%
- Spend time outdoors, either being physically active or relaxing: 13.8%
- Talk openly with family and friends about how the pandemic is affecting me: 10.9%
- Using alcohol or other drugs (including prescription drugs) as a means of coping: 2.7%
- Ask about how to access mental health resources: 2.5%
Conclusions and Recommendations

<table>
<thead>
<tr>
<th>Key Findings</th>
<th>Conclusion</th>
<th>Recommendation</th>
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</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>Respondents are aware of the concept of stress and how it is manifested people’s lives</td>
<td>Knowledge-based interventions should first acknowledge that stress due to pandemics is natural and urge individuals to seek to cope with stress in a healthy way of explaining that it contributes to them being healthier, protect the people they care about, and make their community stronger.</td>
</tr>
<tr>
<td>99.2% of respondents were aware of the term stress. Respondents mainly associated stress with symptoms of feeling tired, overwhelmed, or burnout (24.2%); feelings of irritation, anger, or being in denial (19.9%); feelings of uncertainty, nervousness or anxiety (19.2%); and feeling sad or depressed (13.3%).</td>
<td>All age groups in the sample felt that stress due to the pandemic was a serious problem with regional disaggregation revealing a similar pattern with respondents from all the regions indicating that stress due to disease is serious.</td>
<td>A range of media could be used including local television and radio, social media, and print media. Peer to peer information sharing and support is another useful option. Further, individuals should be encouraged to brainstorm on support systems available to them and government and partners can expand and publicise available support systems.</td>
</tr>
<tr>
<td>All mean scores of respondents’ perception of how serious problem stress (due to COVID 19) is at this moment for age categories and regional disaggregation were above seven (7) on a scale of one (1) to 10. It should be noted that the mean score of Region 7 was nine (9.0).</td>
<td>There are several sources of stress affecting including worry about one’s health and the health of loved ones, uncertainties surrounding financial</td>
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period (64.5%). Other factors included taking care of personal and family needs (49.9%), adapting to a different lifestyle (42.7%), uncertainty about the future (42.3%), limited access to food supplies (37.8%), and feeling that they were stuck and do not have many activities 33.3%.

Adults were more of the view that concerns about being exposed to the virus that causes COVID-19 was contributing to stress than adolescents (66.5% for adults and 57.8% for adolescents). This concern was most prevalent in Regions 8, 5, and 7.

Nine categories of benefits of COVID-19 were detailed by respondents, namely: public safety and security, technological, social, economic, health, environmental, personal development, family, and religious benefits.

The greater concern among adults of being exposed to the virus that causes COVID-19 may have resulted from the well-known fact that as one gets older, their risk for severe illness from COVID-19 increases.

Interventions here should first admit that we are experiencing a new normal and that there is no way to ensure one has zero risks of infection. It should be communicated that important that individuals to understand the risks and know how to be as safe as possible.

Further, advisories should point out that adults who are at increased risk of severe illness from COVID-19, and those who live with them, should consider their level of risk before deciding to go out and ensure they are taking steps to protect themselves.

Notwithstanding, the challenging circumstances resulting from the current pandemic, it is useful that persons were able to identify beneficial outcomes.

Helping people adopt productive practices such as learning a new skill, connecting with family can be a useful approach in coping with the stress due to COVID-19.
<table>
<thead>
<tr>
<th>Table: Attitude</th>
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<tbody>
<tr>
<td><strong>Both adults and adolescents acknowledged that their lives were different since the COVID-19 outbreak.</strong></td>
</tr>
<tr>
<td><strong>52.3% of adults reported that they felt normal ‘all the time or most days’ since the onset of COVID-19 while 48.0% of adolescents said they felt normal all the time or most days’ during this period.</strong></td>
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<tr>
<td>Adolescents were affected more than adults as more of them were reporting challenges such as poor concentration (43.4% adolescents compared to 23.1% for adults); sleeping too much (33.3% adolescents compared to 17.8% for adults); sleeping too little (57.2% adolescents compared to 24.4% for adults); and eating too little (47.4% for adolescents compared to 11.1% for adults). Further, compared to adults greater proportion of adolescents reported that they were irritable (48.6%), anxious (44.0%), sad or depressed (31.0%), considered acts of self-harm (25.8%), fearful (51.8%) frustrated (45.7%), lonely (48.5%), worried (50.6%), fatigue (36.0%), feeling hopeless (31.9%), on</td>
</tr>
<tr>
<td><strong>The evidence indicates that adolescents are more seriously affected by lifestyle adjustments due to COVID-19</strong></td>
</tr>
<tr>
<td><strong>Programmes and guidance document on how adolescents and young people cope with the changes resulting from COVID-19, they type of support and activities parents and community groups can implement to support adolescents and young people, and what roles they can play in mitigating risks related to the current COVID 19 context. The WHO has developed a range of resources for this purpose.</strong></td>
</tr>
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</table>


edge (37.1%), harboring persistent disturbing thoughts (19.1%), crying often (39.1%), withdrawing from others (35.4%), difficulty with daily functioning or neglect of roles (30.2%), increased their use of drugs (37.7%).

48.1% of respondents related that they experienced changes in mood, 27.9% stated that they had reduced interest or increased interest in texting or video chatting with their friends while stuck at home, 25.5% reported experiencing problems with memory, thinking or concentration, 22.8% said they lacked interest in activities they once enjoyed, and 22.8% revealed that they recognized changes in eating patterns.

In response to the mentioned challenges, respondents reported taking several measures with 30.8% indicating that they would reach out to someone to talk to, 29.6% said they would withdraw from others and keep to themselves, 12.0% said that they would normally try to do something by themselves to take their mind off of the

Respondents confessed to experiencing a range of stress-related challenges which all confirm that stress due to COVID-19 is affecting people in a variety of ways.

Programmes and messages should target helping individuals build resilience against stressors by developing and strengthening core life skills, reducing focus and negative outcomes, guiding them where to find help, and focusing on positive outcomes.
feeling, 7.0% said that they exercise or take walks, and 5.9% reported that they practice a hobby.

<table>
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<tr>
<th>Practices</th>
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<tr>
<td>The analysis found that 82.5% of respondents said they had someone to share problems with, while 17.5% said they had no one to share problems with.</td>
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<tr>
<td>Respondents noted that they usually share their problems with close family members and love ones such as spouses, intimate partners, fiancé, siblings, parents; other relative such as grandparents, in-laws, cousins, aunts, and uncles; other individuals such as friends, supervisors and other work colleagues, neighbours, leaders, and members of faith communities; and supernatural being (God).</td>
</tr>
<tr>
<td>It observed that the overwhelming majority of individuals had people to share their problems a substantial amount said they had no one to share their problems with. Further, the study notes that apart from faith community leaders respondents did mention access to any professional services.</td>
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<tr>
<td>The informal support system can be leveraged to provide access to persons at risk due to stress. However, training is needed. This can be achieved through short courses online. Further, government and NGO services offering support should be publicised widely and hotline services should be expanded.</td>
</tr>
</tbody>
</table>

Respondents acknowledged receiving help from family members (43.4%), friends (23.7%), community including churches (10.5%), NGO other aid agencies (1.4%), government (2.6%).

Family members and friends were the main sources of support for individuals during COVID-19.

There is a need for more people to access support from government services and people may need support in processing claims from the government.
Respondents also recounted several actions they took to reduce the stress related to COVID-19 and help make a connection with others. Among on the actions taken were: look for safe ways to offer social support to others especially if they are showing signs of stress such as the depression and anxiety (29.6% of respondents); connect with others through phone calls, emails, text messages, mailing letters or cards, video chat, and social media (27.8% of respondents); and remind myself that everyone is in an unusual situation with limited resources (25.2% of respondents).

<table>
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<tr>
<th>Children Well-being under COVID-19</th>
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<tr>
<td>Findings show that 80.4% of respondents reporting that they had children age zero to nine years old in their household divulged that the children were at home during the day, 8.1% related the children were at the home of their grandparents or other relatives, 6.8% said they were in school, 4.1% said that the children were at work with them or with a parent or another relative, and 0.3% said that their children were in the house or friends or neighbours.</td>
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People are taking several actions to reduce stress due to COVID-19, some of these are very useful to themselves and others.

<table>
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<tr>
<th>Efforts should be made to reinforce positive actions that can be undertaken during the pandemic as a means of coping with stress and offer support to others.</th>
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Families with children require considerable support in taking care of children and ensuring their wellbeing during the COVID-19 situation.

With children spending most of their time during the day indoors, health-related issues and boredom are serious considerations in the design of any strategy.

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<tr>
<th>Efforts should focus on how parents can incorporate responsive care and early learning into their children’s day-to-day life</th>
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Responsive caregiving here involves ensuring children’s health, nutrition, safety and security, and opportunities for early learning.
As is observed from the data, 90.9% of children were spending most of their time indoors during months following the outbreak of Covid-19.

| Half of the children (50.0%) were under the supervision and care of their parents, 30.3% were under the supervision of grandparents or another relative, 5.3% were under the supervision and care of teachers, 1.8% were under the care and supervision of friends and neighbors, and 0.4% were with paid caregivers. The analysis also uncovers that 23.2% of respondents said they were concerned/worried about the arrangement for the supervision for their child/children during the months since the outbreak of COVID-19. Among respondents who were concerned/worried about the arrangement for the supervision and care of their child/children, 64.5% of them explained that they were concerned about their child/children's health, and 50.0% disclosed |
| They are significant levels of worry among parents concerning their children’s health and safety. |
| Snippets from UNICEF/WHO collaborative participant manual “Care for Child Development’ can be retrieved and creatively shared. |
| A whole-of-government and whole-of-society approach is recommended for addressing child wellbeing during and after COVID-19. Parents and guardians should try to facilitate safe outdoor activities for children and help them to access development and educational programmes from various media sources. Provide access to children on the digital and electronic platforms on how they can sustain their health and others around them and games and exercise to keep them healthy and involved. |
that they were worried about their child/children’s safety and security.

| Devices most used by children during the months following the outbreak of Covid-19 are computer/tablet 42.0%, television 17.4%, toys 14.6%, children's book 11.8%, writing or drawing materials 8.7%, and telephone and smartphone 5.6%. 45% of respondents felt that children had become more playful, while 36.4% believed their child/children had become happier, 32.5% further said that children had become more active. |
| The survey notes the widespread access to electronic and digital media among children and notes that strategies should incorporate these in children’s learning, development, and health. |

**Perception and Experiences of Adolescents as Reported by Adolescents**
99.2% of adolescent respondents would have heard the term stress before and 86.6% of them were able to identify at least one symptom of stress.

The evidence that awareness of the concept stress was pervasive among adolescents.

The 15 to 19 years old age cohort had a mean score of 7.6 and the 10 to 14 years old age cohort had a mean score of 7.3 the perception index on how serious a problem stress due to COVID-19 is (with 1 being not at all serious and 10 be extremely serious).

Both adolescent age cohorts considered stress due to COVID-19 as incredibly serious.

Planners and programme managers can leverage this awareness of stress to secure the interest of adolescents in participating in stress management activities.

Factors adding to adolescent’s stress during the pandemic included: concern about the risk of being exposed to the Coronavirus was adding to stress (57.6%), uncertainty about the future (44.9%), adapting to a different lifestyle (41.7%).

Undoubtedly, the data suggest that the pandemic has affected the lives of adolescents and that concern about the risk of being exposed to the coronavirus, uncertainty about the future, and adapting to a different lifestyle were the three main concerns that contributed to stress during the current pandemic.

Only 11.5% of adolescents insisted that their lives remained the same as before.

There is clear evidence that the pandemic is having devastating consequences on adolescents.

With regard to how the pandemic is affecting adolescents mentally/emotionally ‘all the time or most days: 57.0% of adolescents were sleeping too little, 54.8% were fearful, 51.1% were worried, 48.9% were lonely, and 48.1% were irritable. Among the more serious occurrences shared by adolescent survey participants included 44.4% were frequently anxious, 41.5% were crying often, 38.5% had increased drug use,

Government, Community based groups, and international partners should collaborate in expanding services to young people who are experiencing the range of stressors from the pandemic. These services must take into consideration existing stressors at this developmental stage.
| 34.8% withdrew from others, 34.1% were regularly depressed, 31.9% felt hopeless, 25.2% frequently considered acts of self-harm, and 20.7% experienced persistent disturbing thoughts. | A peer-to-peer support network should also be considered. |

| Approximately three in ten 15-19 years old had no one to share their problems with | Not all adolescents have access to family and friendship circles to share their problems with. We also note the absence in reporting of access to professional help by adolescents. |

| Adolescents and their parents should also receive information on where they can access professional support. This would require cataloging of available services, and assessment of their adequacy and sharing of information on the listing of services with parents and adolescents. |
References


Appendix A: Regional Map of Guyana

Guyana Electoral Districts
1. Barima Waini
2. Pomeroon-Supenaam
3. Essequibo Islands - West Demerara
4. Demerara - Mahaica
5. Mahaica - Berbice
6. East Berbice - Corentyne
7. Cuyuni - Mazaruni
8. Potaro - Siparuni
9. Upper Takutu - Upper Essequibo
10. Upper Demerara - Berbice
## Appendix B: Survey Team

<table>
<thead>
<tr>
<th>Survey Team</th>
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<tbody>
<tr>
<td>Hon. Minister of Public Health Ms. Volda Lawrence</td>
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<tr>
<td>UNICEF Representative Ms. Sylvie Fouet</td>
<td>Oversight team</td>
</tr>
<tr>
<td>UNICEF Deputy Representative Mr. Irfan Akhtar</td>
<td></td>
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<tr>
<td>Dr. Ertenisa Hamilton</td>
<td>Survey Managers</td>
</tr>
<tr>
<td>Mr. Michael Gillis</td>
<td></td>
</tr>
<tr>
<td>Dr. Clement Henry</td>
<td>Sampling, Data Analysis, and report writing team</td>
</tr>
<tr>
<td>Mr. Michael Gillis</td>
<td></td>
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<tr>
<td>Mr. Ato Heyliger</td>
<td>Sampling support</td>
</tr>
<tr>
<td>Dr. Patrick Matala</td>
<td>Technical Support</td>
</tr>
<tr>
<td>Ms. Jewel Crosse</td>
<td>Communication for Development support</td>
</tr>
<tr>
<td>Mr. Frank Robinson</td>
<td>External Communication Support</td>
</tr>
<tr>
<td>Mr. Kelvin Daly</td>
<td>Information Technology support</td>
</tr>
<tr>
<td>Ms. Melissa Joseph-Wade</td>
<td>Logistics support</td>
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<tr>
<td>Dr. Umadai Rattan</td>
<td>Supervisor</td>
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<tr>
<td>Dr. Lauren Bancroft</td>
<td>Supervisor</td>
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<tr>
<td>Ms. Tandica Marshall</td>
<td>Supervisor</td>
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<tr>
<td>Medex Wilton Benn</td>
<td>Supervisor</td>
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<tr>
<td>Dr. Farrah December</td>
<td>Supervisor</td>
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<tr>
<td>Ms. Nickishaw Khan</td>
<td>Supervisor</td>
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<tr>
<td>Dr. Delroy Pyle</td>
<td>Supervisor</td>
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<tr>
<td>Dr. Samantha Kennedy</td>
<td>Supervisor</td>
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<tr>
<td>Ms. Kewana Carrington</td>
<td>Supervisor</td>
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MoPH and UNICEF team
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<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Mr. Ato Heyligar</td>
<td>Supervisor</td>
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<tr>
<td>Ms. Shivhana Bruce</td>
<td>Supervisor</td>
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<tr>
<td>Ms. Sheneca Castello</td>
<td>Supervisor</td>
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<tr>
<td>Akeeta Kingston</td>
<td>Interviewer</td>
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<tr>
<td>Leonie Braithwaite</td>
<td>Interviewer</td>
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<tr>
<td>Mr. Sylvester Nanan</td>
<td>Interviewer</td>
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<tr>
<td>Mr. Odley Paul</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Noelene Siland</td>
<td>Interviewer</td>
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<tr>
<td>Mr. Kevin Johnson</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Amanda Scott</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Shemika Smartt</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Debra Pollard</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Collet Baird</td>
<td>Interviewer</td>
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<tr>
<td>Mr. Michael O'Donoghue</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Shandel Archer</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Alicia Singh</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Nichelle Cadogan</td>
<td>Interviewer</td>
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<tr>
<td>Mr. Adrian Sukhdeo</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Sharon Hope</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Hannah Smith</td>
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<tr>
<td>Ms. Auvrel Lyte</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Alicia McLeod</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Nicolette Thomas</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Candacy Gonputh</td>
<td>Interviewer</td>
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<tr>
<td>Medex Anasha Venture</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Natasha Layne</td>
<td>Interviewer</td>
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<tr>
<td>Name</td>
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<tr>
<td>Mr. Neala Misir</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Leauta Hubbard</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Dawn Pearson</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Dhanwanttie Ramdeholl</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Basantie Lallbachan</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Patricia Ramnauth</td>
<td>Interviewer</td>
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<tr>
<td>Mr. Lenski Henry</td>
<td>Interviewer</td>
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<tr>
<td>Mr. Balraj Sanase</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Leandre Stellingburg</td>
<td>Interviewer</td>
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<tr>
<td>Ms. Vanessa Wong</td>
<td>Interviewer</td>
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