AN ASSESSMENT:
THE SITUATION OF CHILDREN MADE VULNERABLE OR ORPHANED IN GUYANA

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HUMAN SERVICES AND
SOCIAL SECURITY

unicef

This is the report of the Assessment requested by the Ministry of Labour, Human Services and Social Security and UNICEF-Guyana in 2003.

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Foreword

The United Nations Convention of the Rights of the Child enshrines the right of every child to grow up in a caring and protective environment. This means that families and communities need support to ensure the best possible nurturing and care for children, especially those who for various reasons might find themselves at risk.

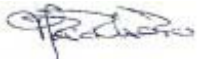
Throughout the world an estimated 143 million children are orphaned. In Guyana, this number is estimated to be 33,000 children. These children lose their parents for example due to illnesses, violence, suicide, accidents and many other reasons. Without the love and support of a surviving parent or "surrogate" caregivers, these children could become more vulnerable to all forms of violence, neglect, discrimination, exploitation and HIV/AIDS.

The HIV/AIDS epidemic has become one of the major threats in increasing the vulnerability of children. There are already an estimated 7,000 children in Guyana who have been orphaned and have lost one or both of their parents due to AIDS. The numbers are steadily increasing as more adults die of AIDS. The loss of a loving parent for children living with AIDS often implies rejection by their extended families and community because of the stigma around HIV/AIDS.

In doing a situation assessment of children orphaned and made vulnerable in Guyana, the Ministry of Labour, Human Services and Social Security and UNICEF wish to highlight the plight of these children and the urgency to ensure that they get the best possible care and enjoy growing up in families and communities that are nurturing and empowering. The ultimate challenge is to prevent children from finding themselves outside of a loving community and family environment.

Honourable Bibi S. Shadick
Minister in the Ministry of
Labour, Human Services and Social Security

Honourable Leslie Ramsammy
Minister of Health



Maria Do Valle Ribeiro
UNICEF Representative

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We would also like to acknowledge and thank the following organizations for their invaluable support and contribution to this project. The Ministry of Labour, Human Services and Social Security; The Ministry of Health; The Ministry of Education; The Ministry of Culture, Youth, and Sport; The Bureau of Statistics; The members of the Orphans and Vulnerable Children Advisory Board; Canadian Society for International Health; Catholic Relief Services; USAID; UNAIDS; the Non-Governmental Organisations, Community Based Organizations and Faith Based Organizations who were generous with their time, and provided information, guidance and support throughout the project.

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Thanks also to our families and friends who provided the emotional support needed to complete this task. We were very privileged to be involved in this effort and hope that this will be the start of a meaningful effort to address the needs of children at risk.

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Executive Summary

The social and economic factors contributing to children of Guyana becoming orphaned or made vulnerable have been cause for major concern. Increasingly, children suffer in various ways; some from abuse, others are exposed to various forms of violence, neglected or abandoned, and also have to face the challenge of them or their parents dealing with life threatening diseases such as cancer and HIV. These situations are magnified even more, due to the high rate of poverty that exists in Guyana and the fact that children who try to find places or persons to assist in meeting their needs are often met with several barriers, chief of which is the inadequacies of the services to fully support or assist them.

After Haiti, Guyana has the second highest incidence of HIV/AIDS in the Caribbean and AIDS is now considered the second leading cause of death in Guyana. Therefore children with the disease or who have parents with the disease will not only have to deal with the complications of this disease, but the likelihood of becoming orphaned at an early stage.

Children and adolescents who are orphaned, whether by the HIV/AIDS epidemic or other causes, are generally from families who have experienced the consequences of poverty, lack of access to services, discrimination and family disruption. These children are most often cared for solely by their mother, and some times with or without the assistance of other family members such as a grandmother Around the world there are children who lose their parents, either permanently or temporarily, children who experience natural and man made disasters, as well as pandemics and various forms of abuse. This is no different for Guyanese children. The factors that put our children at risk of being orphaned or becoming vulnerable are basically the same and create the same needs and challenges. However, the degree of some challenges may vary based on the cause.

This rapid assessment was therefore carried out to ascertain what is happening to children who fall in the category of OVC, regardless of the cause of orphaning or vulnerability. The assessment, which was done in all 10 Administrative Regions of Guyana, saw children and their caregivers interviewed, group discussions conducted and Key Informants in Organizations interviewed.

The loss of one of both parents is one of the single most devastating factors that contribute significantly to children falling into the category of being vulnerable. The death of a parent means that children are often left without the same level of care that was provided by the parent(s). For many children this translates into being deprived of individualized love, affection, attention and care. Other experiences for children include psychological trauma, that often is not acknowledged or dealt with – as was seen with a number of children interviewed; dropping out of school or attending school inconsistently; being targeted for stigma and discrimination (especially where the parents died from HIV/AIDS related illnesses, and to a lesser degree, suicide); increased physical, verbal, emotional and sexual abuse, which in some cases has led to an increased risk of HIV infection; and child labour.

Not unlike other parts of the world. The illness, death or absence of a parent means that the family's ability to provide economically for itself is negatively affected. Therefore, the needs of

the children are correspondingly affected. This leads to more and more children are forced to take on the considerable responsibility of supporting their family.

The findings have also revealed that more children than we know are in danger of becoming OVC or have already become OVC. Their challenges are great and the emotional pain created by their circumstances needs urgent attention. Organizations are unable to deal with the challenges faced and so their capacity needs to be built in order to respond effectively. On their own, many families are incapable of effectively meeting the needs of these children and if there is going to be a change in the pattern, an urgent response is needed.

No one agency will be sufficient to make this response, so an integrated and collaborated approach must be adopted if success is to be achieved.

Chapter 1 - Introduction

Country Profile

The Co-operative Republic of Guyana is located on the northern side of South America, bordering the northern Atlantic Ocean on one side and sharing borders with Suriname, Brazil and Venezuela on the others. Guyana, or British Guyana as it was known in the past, was originally a Dutch Colony in the 17th Century and by 1815 was taken over by the British. Guyana, an Amerindian word meaning "Land of many waters", achieved its independence in 1966. It is 214,970 sq km big and is divided into four natural regions; The Coastal Plain, the Hilly, Sand and Clay Region, the Highland Region and the Interior Savannahs. The Capital of Guyana is Georgetown.

The official language of Guyana is English, with some sections of the population speaking Amerindian dialects, Creole, Hindi, Urdu, and more recently Portuguese and Spanish. There are six main ethnic groups co-habiting in Guyana. They are East Indians, Afro-Guyanese, Amerindians, Chinese, Europeans, and mixed. Statistics released in 1991 from the Bureau of Statistics puts Guyana's population at 717,856. Based on the figures, Indo-Guyanese account for 347,094 or 48% of the population; Afro Guyanese account for 234,563 persons or 33%; Amerindian Guyanese number 45,333 or 6%; mixed Guyanese numbering 87,246 and accounting for 12%; while the Chinese numbering 1338, the Portuguese numbering 1964, and Whites numbering 318 account for the remaining 1% of the population.

Background

2001 Linden Care Foundation's outreach programme- brought the NGO in contact with OVC

2001 A pilot OVC care and support programme was started – saw vast growth

2002 Mark Loudon, a UNICEF consultant visited Guyana to sensitize key ministries about the effects and impact of HIV/AIDS on children

2002 The release of the "Children on the Brink" – quantified the scale of orphaning due to HIV/AIDS

2003 Birth of this Assessment

The OVC project was originally intended to focus on children who were orphaned or made vulnerable due to HIV/AIDS. At the outset of the planning, an Advisory Board was established to provide guidance and support for this project. Following discussions at the first and second Advisory Board meetings, it was decided that the Assessment should be expanded to included children who were orphaned or made vulnerable through other factors beside HIV/AIDS since many factors could be contributing to this phenomena in Guyana. As such, the project was expanded and the investigations began in December 2003.

Definition OVC

Orphans are children, under 18 years, of whom at least one or both of their biological parents have died through causes such as HIV/AIDS, other illnesses, violence, suicide or other causes

- *Vulnerable children* are those children who are:
  - Living without one or both parents because of long term or permanent (national or international) migration
  - Living with one or both parents who are chronically ill
  - Living without caregivers
  - Living on or who spend most their time on the streets
  - Living in orphanages or other institutions of care
  - With a disability
  - Are juvenile offenders
  - Are survivors of various forms of violence and/or neglect.

Assessment Objectives

The main objectives of the project were to:

(a) Identify children who are vulnerable or orphaned;

(b) Determine how children are being affected within their families and identify gaps and priority areas for interventions;

(c) Identify children's coping mechanisms and what supports are available to them within and outside of their communities;

(d) Identify the needs of families providing care for the children in their care; and to

(e) Develop and maintain an inventory of NGOs and other institutions that provide services to orphans and vulnerable children;

A subsequent objective of the Assessment was:

(f) To work with key stakeholders to identify priorities for intervention in order to develop and launch a communication plan.

Selection of Children and their Caregivers

The Assessment targeted children from birth to 18 years who are orphaned or made vulnerable in all of Guyana's 10 administrative regions. With assistance from the Bureau of Statistics and data from the 1991 Guyana Population and Housing Census[1], the population of children in each region was estimated and the number of children constituting a 0.05% sample was calculated (Table 1). This was done according to the distribution of ethnic groups in the region (Table 2) and in collaboration with the "Voices on Children: Experiences with Violence:" Study being carried out by the Government of Guyana and UNICEF. Because of the special interest by the OVC Project and its Advisory Board in children orphaned and made vulnerable by HIV/AIDS, it was suggested that an average of 33% of the children sampled should be OVC due to HIV/AIDS (TABLE 2).

[1] The 2002 Preliminary Census Report had not been published at the time of estimation

Table 1: Breakdown of number of children and caregivers to be interviewed per region

Region	Total Population *	Population of Children	No. of children in .05% of population	Number of Caregivers to be interviewed
1	32, 853	18, 069	9	9
2	47, 468	16, 614	8	8
3	104, 836	36, 693	18	18
4	324, 043	113, 415	56	56
5	56, 419	19, 747	10	10
6	155, 648	54, 477	27	27
7	26, 367	14, 502	7	7
8	10, 010	5,506	3	3
9	26, 843	14, 763	7	7
10	43, 211	15, 124	8	8
Total	**827, 698**	**308, 909**	**153**	**153**

* Bureau of Statistics, Guyana Population and Housing Census, 1991

Table 2: Specific selection criteria of children and caregivers per region

Region	Afro-Guyanese	Indo-Guyanese	Amerindian-Guyanese	Mixed Guyanese	Total Children	OVC by HIV/AIDS
1	1	0	5	3	9	3
2	1	4	1	2	8	2
3	4	12	0	2	18	6
4	25	23	0	8	56	18
5	3	6	0	1	10	3
6	5	20	0	1	27	9
7	2	2	2	1	7	2
8	0	0	3	0	3	1
9	0	0	6	1	7	2
10	5	0	1	2	8	2
Total Children	**46**	**67**	**18**	**22**	**153**	**48**

* Bureau of Statistics, Guyana Population and Housing Census, 1991

Methodology

An exploratory cross-sectional qualitative design was chosen using Group Discussions (GD) and Key Informant Interviews to gather data from the children themselves as well as those who take care of them. This was aided by the gathering of some quantitative data to help inform the extent to which children were becoming orphaned or vulnerable. Information was gathered from a variety of sources, such as the children themselves, caregivers, teachers, Non-governmental organizations (NGO), community based organizations (CBO) as well as Government Agencies and Ministries. Secondary data collection was also done. The questionnaires were structured to provide information pertaining to:

- How children are affected in the household/community;
- Coping strategies of households;
- How coping strategies are affected by knowledge and attitudes about various issues responsible for the realities faced by OVC;
- Social, cultural and religious influences and resources;
- Community support for affected households;
- Availability and accessibility of services for these children and their families;
- Identifying the needs of the families and;
- Identifying sustainable methods of intervention for communities.

The persons who participated in the group discussions as well as the interviews were all selected with the help of NGOs and Government Agencies and Organizations offering care to OVC, or dealing at all with any family issues. The children were first identified, and then they were matched with a caregiver within their specific homes. The goal of this Assessment was to interview 153 OVC and caregivers, however 165 OVC were interviewed. The extra numbers were made up by five (5) street children and seven (7) children residing in Orphanages. There were two (2) additional caregivers interviewed, who were both from the different Orphanages from which OVC were interviewed. These were with the goal of figuring out if there were any differences in the needs of children and caregivers in orphanages or children who are street children.

Three (3) research assistants were trained to assist in the data collection which took place between December 2003 and April 2004.

Analysis of Findings

The qualitative findings were grouped and analysed thematically. The Quantitative data was entered and analysed by Statistical Package for Social Sciences (SPSS) version 12.0.

Report on Findings

For the purpose of this report the findings with children, their caregivers and organizations are reported separately. The report also includes a literature review and a directory of the organizations that provide services to OVC and their caregivers throughout Guyana.

Chapter 2 – Findings of Orphans and Vulnerable Children

Demographics

Children who participated in the Assessment were between the ages five (5) and eighteen (18) years. This is in keeping with the objective of the project to interview children up to 18 years. There were 165 children interviewed in this Assessment. One hundred and fifty three (153) of them were interviewed along with their caregivers but there were seven (7) from orphanages and five (5) who were children living on the streets (street children). The needs of all groups were similar, but specific situations relating to the two latter groups will be detailed where applicable. Most of the children interviewed were females. The split was 97 females and 68 males. Among these, there were 3 males and 4 females from Orphanages and all the street children were males.

Figure 1: Sex of Children who participated in the Assessment

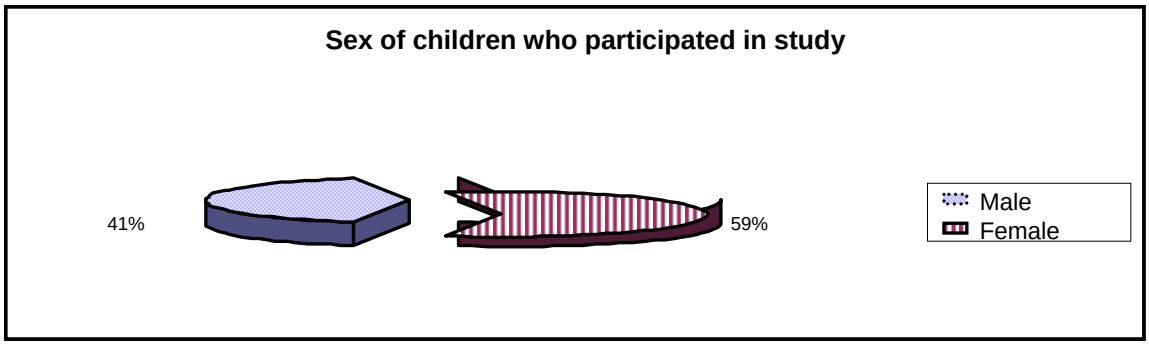


Figure 2: Age Group and Sex of children in the Assessment

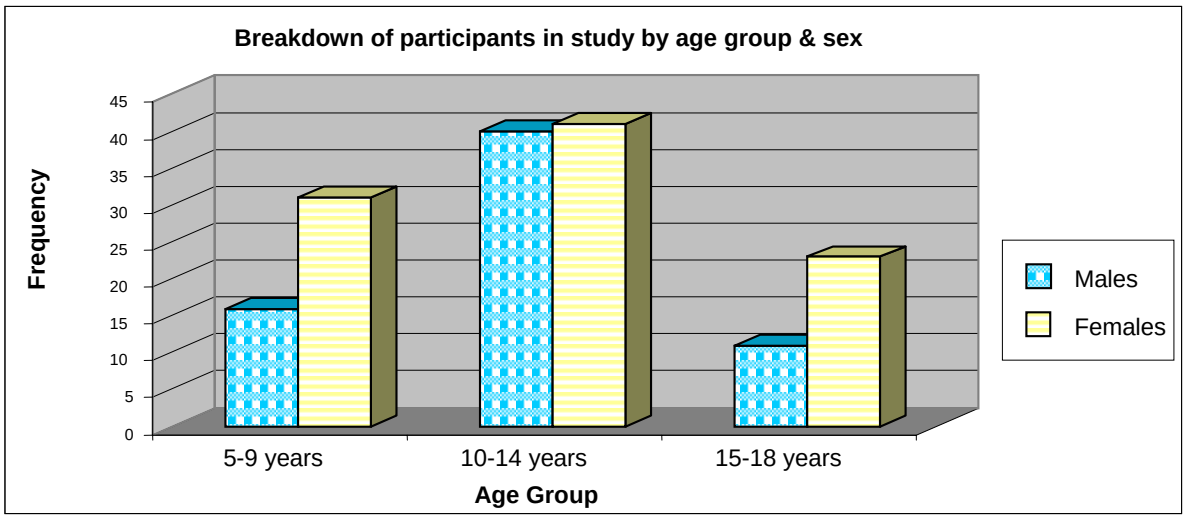


Figure 3: Number of children in the Assessment broken down by Regions

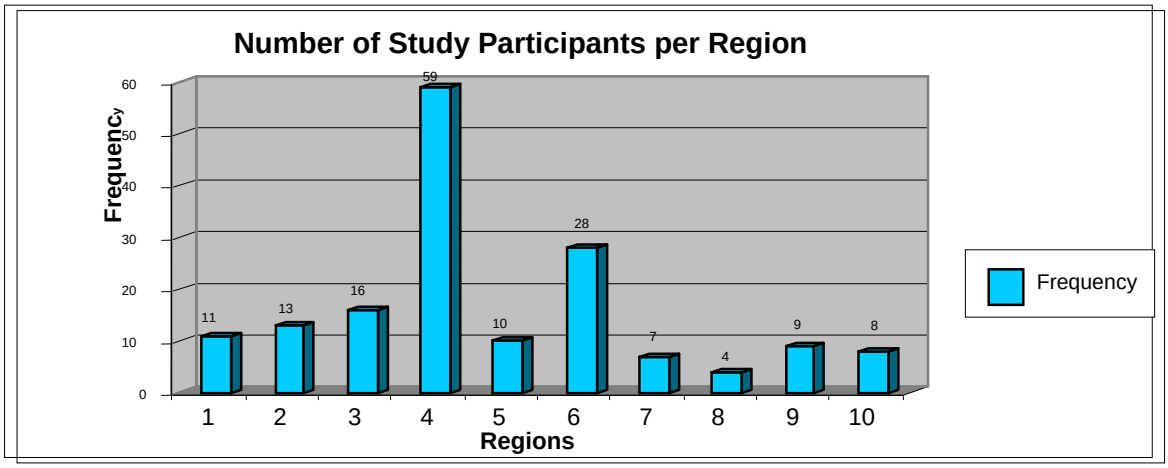


Table 3: Regional Distribution of children in the Assessment, showing also those attending school

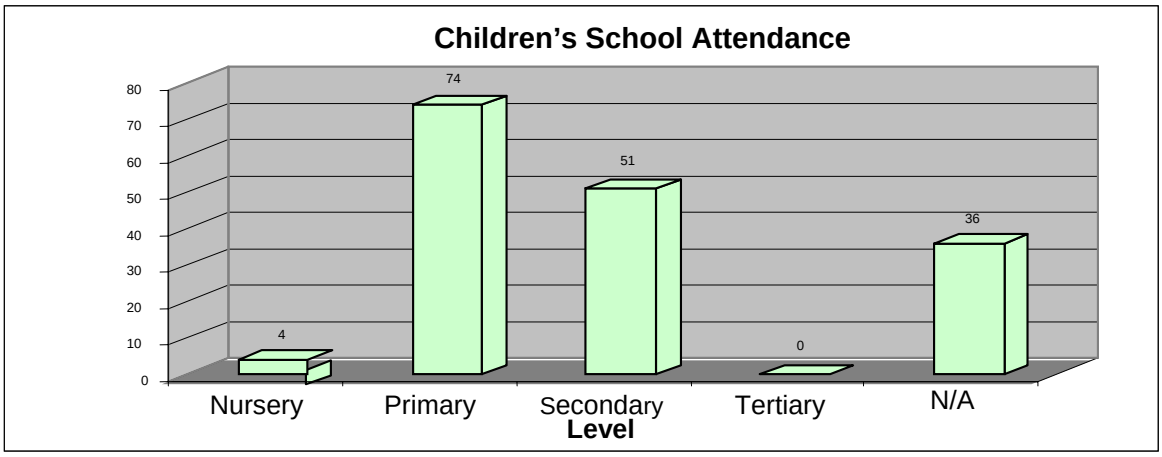
Region	Age	Male	Female	Attending School Yes	Attending School No	Total	Comments
1	**5-9**	1	0				
	10-14	4	1	4M	2M		
	15-18	1	4	4F	1F		
	Subtotal	**6**	**5**	**8**	**3**	**11**	
2	**5-9**	5	4				
	10-14	1	1	7M	0M		
	15-18	1	1	6F	0F		
	Subtotal	**7**	**6**	**13**	**0**	**13**	
3	**5-9**	0	4				
	10-14	6	3	6M	1M		
	15-18	1	2	5F	4F		
	Subtotal	**7**	**9**	**11**	**5**	**16**	
4	**5-9**	6	6				
	10-14	18	13	23M	8M		
	15-18	6	9	23F	5F		
	Subtotal	**30+1=31**	**28**	**46**	**13**	**59**	One boy did not know his age, but was in school
5	**5-9**	1	3				
	10-14	3	3	4M	0M		
	15-18	0	0	6F	0F		
	Subtotal	**4**	**6**	**10**	**0**	**10**	
6	**5-9**	2	6				
	10-14	4	11	4M	3M		
	15-18	1	3	17F	3F		
	Subtotal	**7**	**20+1= 21**	**21**	**6 + 1**	**27+1=28**	One child did not recall her age, but knew she just left primary school

Region	Age	Male	Female	Attending School Yes	Attending School No	Total	Comments
7	**5-9**	1	3				
	10-14	0	1	1M	0M		
	15-18	0	2	5F	1F		
	Subtotal	**1**	**6**	**6**	**1**	**7**	
8	**5-9**		0				
	10-14		3	0M	0M		
	15-18		0	4F	0F		
	Subtotal		**3+1 = 4**	**4**	**0**	**4**	Age of one **girl** missing
9	**5-9**	0	3				
	10-14	3	2	3M			
	15-18	0	1	5F	0M		
	Subtotal	**3**	**6**	**8**	**1F**	**9**	
10	**5-9**	0	2				
	10-14	1	3	1M	1M		
	15-18	1	1	5F	1F		
	Subtotal	**2**	**6**	**6**	**2**	**8**	
	TOTAL	**68**	**97**	**133**	**32**	**165**	

Level of Educational Attainment

Seventy four (74) of the children in the Assessment had either attained or were pursuing a primary level education. Another forty one (41) had been pursuing or attained secondary education. The thirty six (36) in the "not applicable" category were either too young or out of school for a variety of reasons; some of which were that they ran away from home and are now living on the streets, they don't like school any more, they are not registered, they are too ill to work, their caregiver are not sending them, there are financial constraints in the family or they are caring for sick parent/s or siblings.

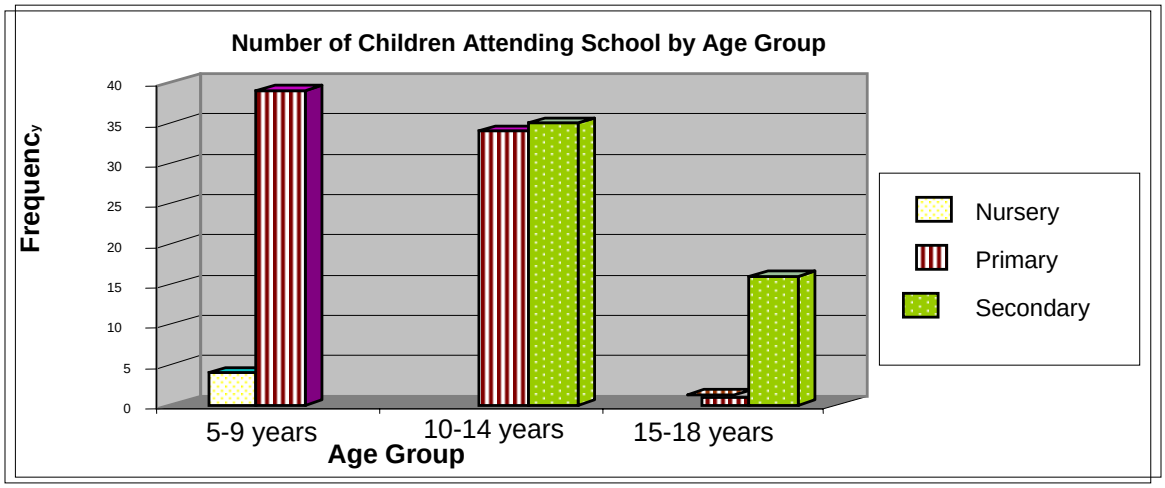
Figure 4: Children's School Attendance



School attendance was recorded for one hundred and twenty-nine (129) of the children. This was broken down as 4 children in nursery, 74 in primary school and 51 in secondary school. In the 5-9 age group, there were 4 children attending the nursery and 39 in primary school; in the 10-14 age group, there were 34 children in primary school and 35 in secondary school; and in the 15-18 age group, there was one (1) child in primary school and 16 children in secondary school as seen in Figure 5. A total of 77.9% of males and 82.4% of females in the Assessment were attending school.

Ten of the 36 children who were not in school gave reasons such as not of the school age (six were too young), being a street child, not being registered, too ill to work, truancy, caregiver not sending due to financial challenges and caring for sick parent/s or siblings. One child expressed that he had no desire to go to school. Some children reported a combination of reasons listed earlier. The other 26 were employed in full time jobs.

Figure 5: Break down of school attendance by age group



Children and work

Of the 36 children not in school, twenty six (26) of them were working on a full time basis. Of the working number (26), there were 17 males and 9 females all falling between the ages of 10 and 18 spread over six regions as seen in Table 4.

Table 4: Work Experience by Age group and Region

Region	Age Group	Number	Total
1	10-14	2	
	15-18	3	5
2	10-14	0	
	15-18	0	0
3	10-14	1	
	15-18	0	1
4	10-14	6	
	15-18	5	11
5	10-14	0	
	15-18	0	0
6	10-14	4	
	15-18	0	4
7	10-14	0	
	15-18	0	0
8	10-14	0	
	15-18	0	0
9	10-14	1	
	15-18	1	2
10	10-14	1	
	15-18	2	3
Total	**10-14 =** **15-18 =**	**15** **11**	**26**

Fourteen children (8 boys and 6 girls between the ages of 10 and 18) reported their employment in a variety of ways such as casual jobs including vending, domestic work, sales, bus conductor and car washing, others reported that they do whatever they can to earn an income. Domestic work was reported only by girls and the boys gave a combination of reasons.

The distribution of those employed can be seen in Table 5. Highest levels of employment were seen among boys and in Regions 4, 1 and 6 respectively. When asked if they thought they were earning fair wages for the jobs done, the 22/26 said "yes" and the remainder said "no". Of those who said "yes" there were 14 males and 8 females and among those who said no there were 3 males and 1 female.

Table 5: Period of employment by Age Group and Region

Period	Region										
Sex	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Total**
<1 year											
Males	2	0	0	2	0	1	0	0	1	0	6
Females	1	0	0	0	0	0	0	0	1	1	3
1-5 years											
Males	1	0	0	7	0	2	0	0	0	1	11
Females	1	0	1	2	0	1	0	0	0	1	6
Total											
Males	3	0	0	9	0	3	0	0	1	1	17
Females	2	0	1	2	0	1	0	0	1	2	9
Grand Total	**5**	**0**	**1**	**11**	**0**	**4**	**0**	**0**	**2**	**3**	**26**

Health Issues

There were a total of four hundred and forty-five (445) children among the 153 caregivers (2 caregivers from Orphanages excluded). This gives a ratio of 2.9 children per caregiver. All 165 children interviewed as a part of this Assessment were among the 445 children of the caregivers. The four hundred and forty five (445) children among the one hundred and fifty three caregivers were between the ages two months to eighteen years (2 months – 18 years). The caregivers were asked about the health status of all the children in their care. Their responses included information on the all except the street children and children in orphanages that were interviewed as a part of the Assessment.

Registration of Births

Of the same four hundred forty-five (445) children, thirty-six (36) did not have birth certificates. The reasons for this are:

- No application was made for 13 children
- Caregivers had applied and were awaiting the birth certificates for 8 children
- Two (2) children were born in Venezuela and one (1) in Suriname but returned to Guyana without their births registered
- Caregivers did not know if 12 of the children were registered.

Of the children in the Assessment, the caregivers reported not having birth certificates for 6 of them for the reasons listed above.

Immunization

Of this number (445), nineteen (19) children had no immunization cards. The card for one was forgotten at the clinic on the last visit, and caregivers were not aware of whether another eighteen (18) had this record. The nineteen without immunization cards included nine (9) children who participated in the Assessment.

Visits to the doctor

One hundred and eighty five (185/445) of these children had visited a medical doctor in the last year, with greatest frequency being in the last three months. Eighty-seven (87) of these visits were due to illness, again most in the last three months to the time of being interviewed. Caregivers recalled causes of 81 of those visits. Common causes were the flu, malaria, HIV and skin rashes- including ring worms. Asthma and limb or finger fractures were also high on the list of causes. Other reasons included a case in which an abortion was done. Medications were prescribed for eighty-one (81) of the eighty-seven (87) visits, but on nine (9) occasions these were not purchased mainly due to insufficient funds (4 occasions), unable to get more time off from work (3 occasions) and the lack of transportation to get the prescription filled (2 occasions). Three of the four caregivers who reported that they were unable to purchase the medications due to lack of funds were caregivers of children with HIV.

Accessing Health Services

Children relied on their caregivers to access the health care they needed. There were a few however who had mixed experiences when they tried to use the health services for themselves and these occasions were mainly for a caregiver or another sibling.

Nutritional Information

The children were not very good at long-term nutritional recall. All children had at least one cooked meal daily consisting of protein, carbohydrate and sometimes fruits and vegetables. More than sixty percent (>60%) were having at least three cooked meals daily.

Parental situation

Most of the children in the Assessment (93) reported that their parents were alive but they were not necessarily living with them. Seventy-two (72) or 43.6% reported that at least one of their parents was deceased. The report on the death of parents was broken down as follows:

- Nine (9) children had both parents dead (5 HIV reportedly deceased due to HIV and its complications)
- Forty-one (41) children had lost their mothers
- Twenty-two (22) had lost their fathers.

Most of the children who participated in the Assessment lived with their parents; however some lived with grandparents and other relatives and friends. As indicated earlier, seventy-two children in the Assessment had been orphaned by the loss of either or both parents. An additional thirty-two (32) children reported that their parents were seriously ill. Of this number there were nineteen (19) fathers who were seriously ill. Although they reported the illness of their parents, they were not necessarily living with these ill parents but had knowledge of their parents' health status.

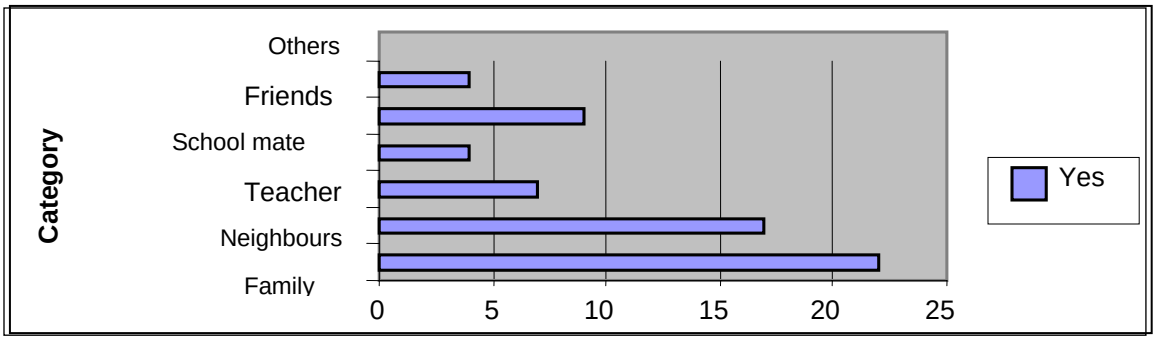
The children in the Assessment reported that when their parents are ill, mainly other relatives, especially grandmothers and other siblings care for them. They reported that there were times when other siblings were placed outside the home. The decision about which sibling would be placed with some one else was influenced by age and sex of child. Parents found it easier

to place the older boys in the care of others. Many of these instances were made as short-term arrangements but were never changed.

Children were told a number of things about the absence or death of their parents. Some caregivers and other relatives openly discussed these causes while others did not and gave the reason of "sickness" as the cause. Some reasons shared with the children included HIV, murder, suicide, malaria and migration. The children in the orphanages were placed there mainly because of the physical or sexual abuse in the home. Instances of abuse were not just between parents, but often towards the children. The sexual abuse was towards the girls and the physical abuse was towards both girls and boys, including those on the streets. One street boy in Region 4 shared that his grandmother used to verbally and physically abuse him so badly that he got tired of it and ran away, leading him to have no desire to go to school, but to earn a living and so support himself. He shared that he goes to see his siblings when he knows that his grandmother is not at home.

Most children had not experienced negative treatment since the absence or death of parents. Where negative experiences were recorded, persons displaying such behaviour included family members, neighbours, teachers and friends. These persons were also reported as being the ones who were also most sensitive and supportive in a positive way.

Figure 6: Categories of person who treat children in a negative manner since parent's illness, absence or death



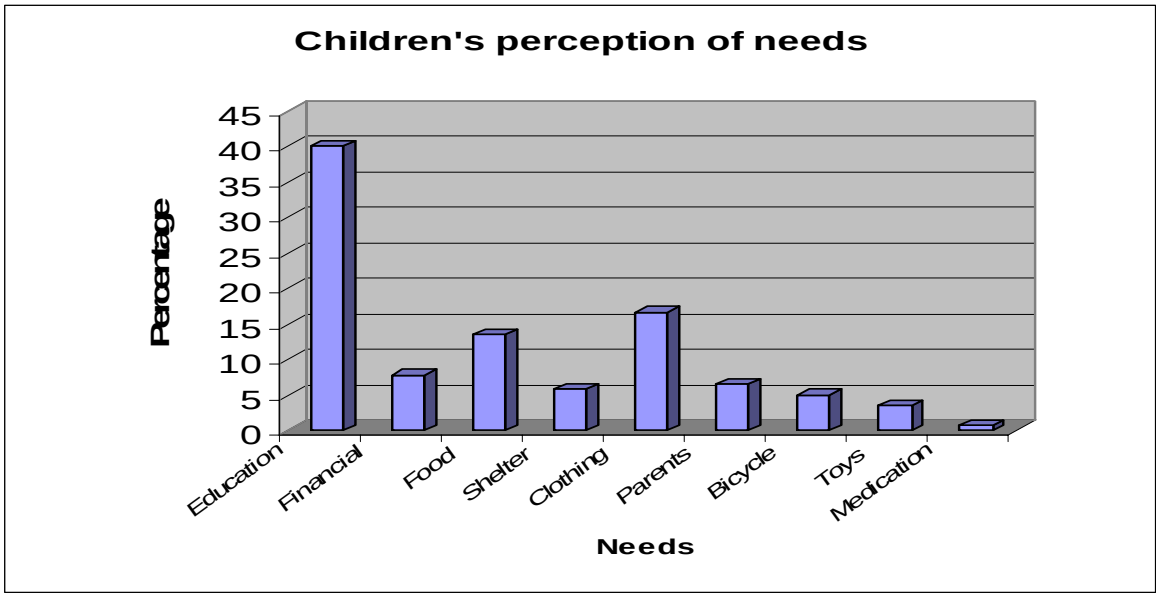
Twenty (20) children shared that they were aware of their parents' HIV situation and an additional eighty-five were aware of what the 'problems' were with their parents illness, absence or death. Children who were told about their HIV positive parents were told between three months and one year ago. Most children knew of their parents' situations (illness, absence or death) for over one year as some expressed that they 'lived with them so they saw'. Persons who discussed these situations with the children were mainly their mothers; followed by grandmothers; aunt and uncles; siblings and neighbours.

Children's perception of their greatest needs

The children interviewed in this Assessment were able to articulate their needs very well. The following figure details what these were. The category "Education" was created from the need for school supply, assistance with school work, computer to help with school work and

uniform to attend school. This need was ranked highest and was seen in all regions across all age groups but mainly in Regions 4, 6 and 5. It was also seen mainly among females in the 10-14 age group.

Figure 7: Children's perception of their needs



The basic needs could be categorized to include "Food, Clothing and Shelter" and if these three items were put together, they would form the second area of greatest needs. Children in all regions identified the need for food as a great need. Most frequent reports of this need were received in Regions 4, 6 and 2 from girls in the 10-14 and 5-9 age groups respectively. Children in eight regions (Regions 2 and 8 excluded) reported their need for clothing. More than 50% of children who reported this need were from Region 4 and were mainly girls in the 5-9, followed by the 10-14 age group. The need for shelter was reported in six regions (no reports in Regions 2, 5, 7 and 8) and highest expression of this need was in Region 4. Both boys and girls in the 10-14 and 15-18 age groups made equal reports of Shelter as a need.

The need for financial assistance was reported mainly in Regions 4, 3, and 5 among the 10-14 and 15-18 age groups. Both boys and girls made equal reports of this need. No report of financial assistance as a need was received from Regions 7, 8 and 9.

Girls in the Assessment were more expressive of the emotional needs such as wanting to have their parents around, the need for guidance, love and support or to be with their "own family". It was also noted that three boys in Regions 3 and 4 expressed that they needed a father around as a role model. These expressions were mainly seen by girls and boys in the 10-14 and 15-18 age groups.

The need for bicycles was expressed equally by girls and boys across all the age groups in Regions 3 and 4 only. In four regions (2, 3, 4 and 7) children expressed the need for toys.

This need was expressed more by boys. Girls from regions 3 and 4 in the age group 5-9 expressed the need for medications to help them get well.

Feelings about life

When asked how they felt about their lives now, the responses were mixed. Most children placed with a caregiver, apart from the parent/s, felt that their lives were better off or that they were satisfied with their present living situation. Many of the children in the Assessment were very ambitious, excited about their lives and making plans to further their education and pursue a career. Some said they were happy, confident, felt accepted and supported by their caregivers, family and friends. The children who expressed the above were mainly those who felt that their needs were met. Others felt that they were in a bad situation with which they were unhappy, dissatisfied and felt scared and sometimes pressured. Some of the children who expressed unhappiness said they had already ran away from home and were living with other relatives/family friends, in orphanages, or on the streets. There were two occasions in which the children asked the interviewers to 'take me to live with you'. Children on the streets and some of those who were working said that they had to work too hard and that their daily existence was a struggle, even though many of them felt that they were paid fair wages for what they did.

Utilization of other services

In order to assist in meeting the above-mentioned needs, just about half the number of children (85: 32 Males; 53 Females) in the Assessment (not including those from the Orphanages or on the streets) accessed health care services in the past year. The experiences were mixed as equal numbers reported that this experience was positive and negative (30/85 children who accessed services had both positive and negative experiences). Children in all regions accessed the health care system with which they were familiar.

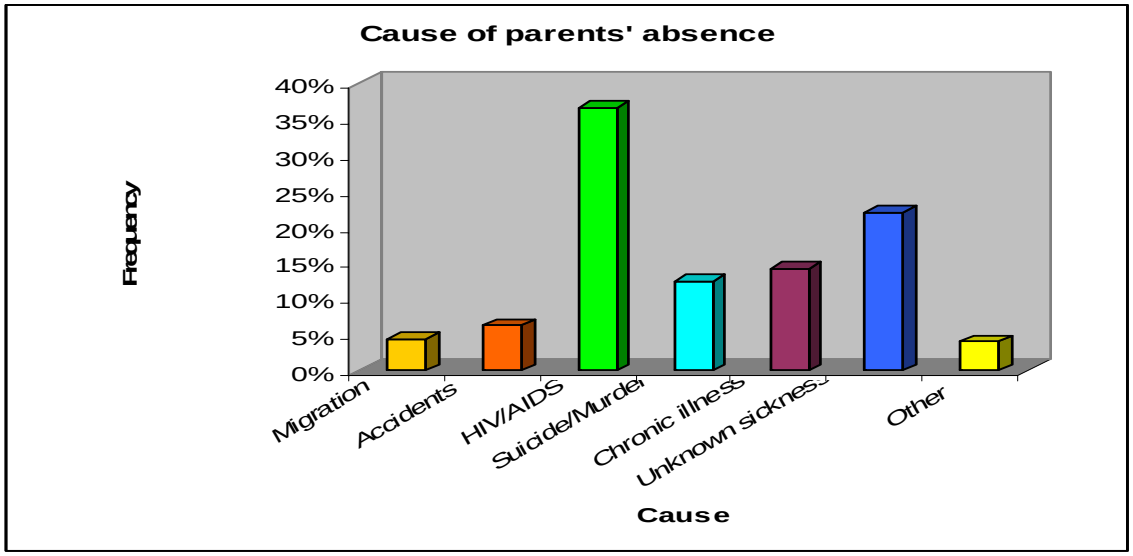
Apart from the health care services, another twenty percent of children (more boys than girls) accessed services from other organizations and more than three quarters of this group rated the services as good to excellent. Choices in this selection were 'Terrible, Poor, Good, Very Good and Excellent'. Only two children rated these services as 'terrible or poor'. These services were accessed for food, clothing, shelter, and counselling.

Causes of Vulnerability

Both children and caregivers reported the same reasons for the absence or death of parents of the children in the Assessment. Many children had the opportunity to discuss their parents' absence or death for the first time during their interviews. There were times when the children expressed feelings of hurt, resentment, hatred, fear and relief. Some of the children were not as able to articulate their feelings as clearly as others, but the look of sadness on their faces spoke a thousand words.

Role modelling provided by fathers were not recorded to be very positive as many of the comments made about fathers were negative for example; "he takes and traded drugs", "he beats my mother", "he abused my mother and us children, that is why we are in this orphanage", "he doesn't help my mother to support the family" and "he has other women, in fact he has HIV and has gone to live with another woman and I don't think she knows".

Figure 8: Cause of parents' absence or death



The main cause of absence was due to HIV/AIDS (37%) which saw more mothers report absent due to this cause. This was followed by Unknown Illness (22%) again with more women absent due to this cause. The other category with more mothers absent was Suicide/Murder (13% total category but more cases of women). The categories featuring fathers' absence more than mothers' absence were Chronic Illness and Accidents. These categories featured 14% and 6% parental absence respectively. The category "Other" saw parents being dead due to reasons such as "Jumbee"[2], snake bite and one mother being burnt to death.

Advice to HIV positive Parents

Children had a variety of advice for parents who were HIV positive. The more popular view of these children was that the parents should have some type of dialogue with their children about their condition. The following statements were made by some children:

"Inform the children; be positive when you speak about it"
"Tell the truth, be honest"
"Get children tested early"
"Don't be harsh with children"

Some on the other hand felt that the information should be shared late or not shared at all as seen in the following comments:

"Tell when you are ready to die"
"Don't inform the children".

Advice to children with HIV positive parents

The advice to children with HIV positive parents was all around showing love and support to their parents. Some of these are recorded below:

[2] Jumbee is a Creolese word referring to various forms of supernatural forces

"Don't change, still love them"
"Treat them well, get help" (medical and other)
"Have a positive attitude"
"Accept the situation"
"Do the best you can"
"Do not reject them"

Letter to Parents in heaven

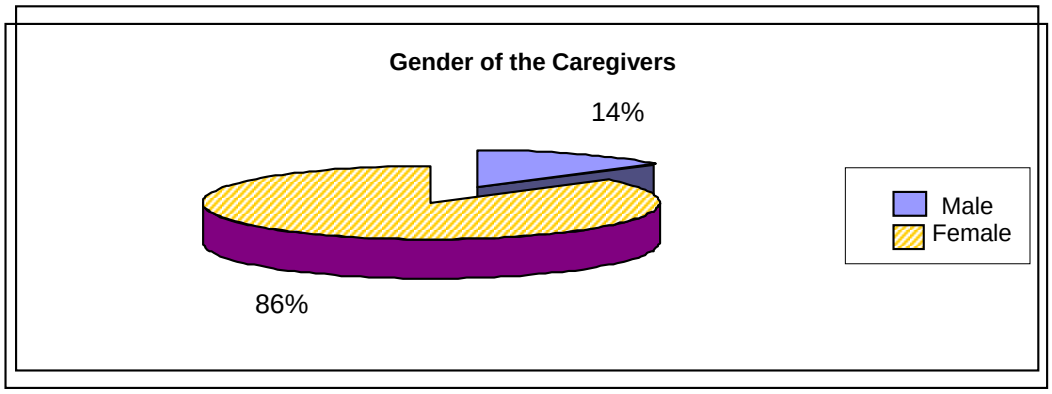
The children were asked what they would like to say to their deceased parents (in heaven). Many of the children who had lost parents expressed how much they missed and loved them. Some expressed regrets and apology for their behaviour and insensitivity as which they exhibited towards their parents when they were younger. The younger children were concerned about how parents were doing now, as they did not seem to fully understand the concept of death, which is understandable for their age and stage in life. Clearly though, the overriding expression was that children would have preferred being with their parents if they had to make a choice. Thirteen children expressed this clearly in the following words "Please come back". Another twenty-four said, "I want to be with you".

Chapter 3 – Caregivers Findings

Demographics

More than three-quarters (86%) of caregivers surveyed were females while 14% were men as illustrated below.

Figure 9: Sex of Caregivers



Parents (mother and or father) account for just over half (50.3%) of caregivers surveyed while Grandparents account for little over a quarter (26.5%) of caregivers. Other persons providing care to these children included aunts and uncles (8.4%) and siblings (5.2%).

The age range of care givers was between 30 years to 70 years old, with most persons (93 persons) being in the 30 – 49 years age group. It is also important to note that there were forty-two caregivers who were over fifty years of age, including five who were over seventy years of age. Parents were under fifty years of age, while the grandparents and other relatives and caregivers were mainly over fifty years old.

Most caregivers were single and had only achieved a Primary level education. Just over 30 % had achieved a Secondary level education and only twelve persons achieved tertiary level education. This was reflected in the employment status of these caregivers as most had either been employed in part time or casual jobs. Just about fifty percent (50%) of these caregivers received no additional income, but for those who received, more than 38% received from family and friends abroad and in other places in Guyana while the others received from the other NGOs, and government agencies.

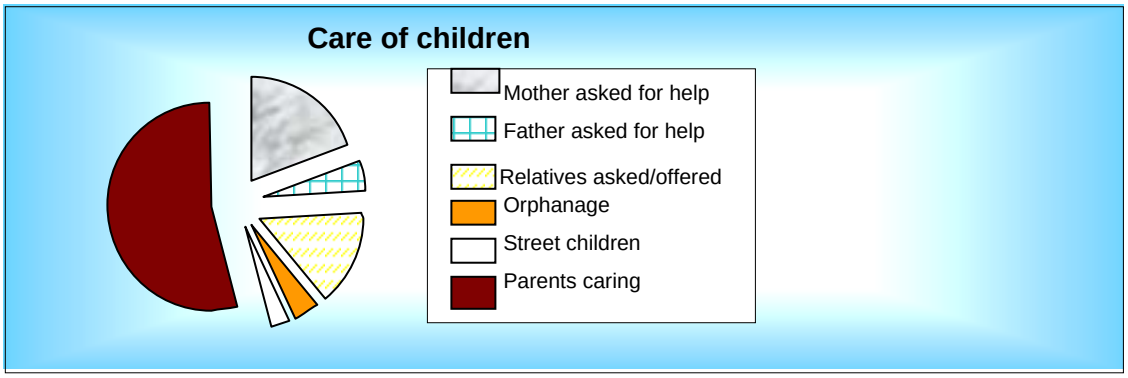
Table 6: Educational level of caregivers by Regions

Educational Level	Region										Total
	1	2	3	4	5	6	7	8	9	10	
Primary	3	5	12	29	5	21	2	4	3	3	92
Secondary	6	2	4	19	5	3	3	0	1	5	48
Tertiary	1	0	0	8	1	0	1	0	0	0	11
None							1				1
Total	**10**	**7**	**16**	**56**	**11**	**24**	**7**	**4**	**9**	**8**	**153**

Caring for Children

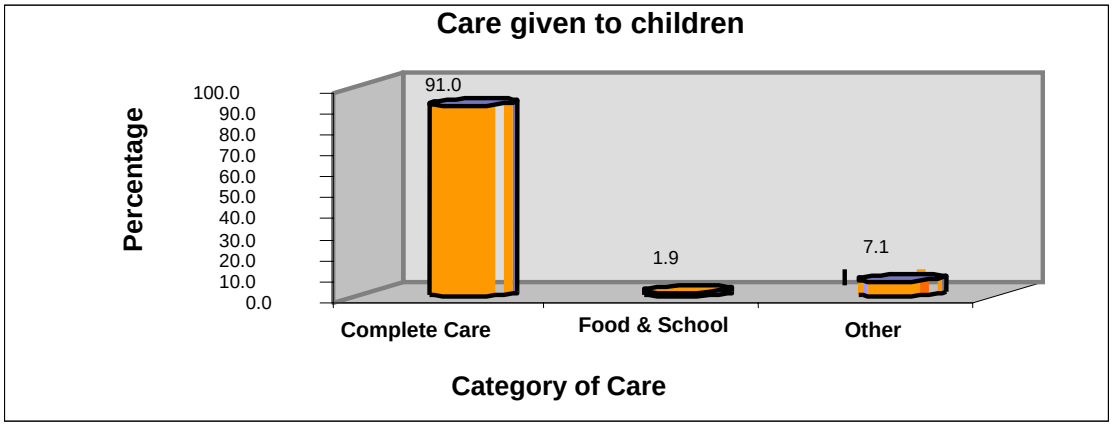
In keeping with the findings that parents are the main caregivers and where help has been solicited on behalf of the children, it has been done mainly by the mother (21%).

Figure 10: Care of children



Over thirty percent (30%) of persons had been caring for these children since birth and over 45% have been caring for them for between three and seven years. Ninety one percent (91%) of persons caring for children are offering complete care to them. Other care offered includes food, schooling and clothing. Care given to children was not dependent on the caregivers' educational background as most caregivers had full responsibility for the children in their care. Caregivers sometimes depended on other relatives and friends to provide the financing for things they needed to care for the children.

Figure 11: Kinds of "care" provided to children by caregivers



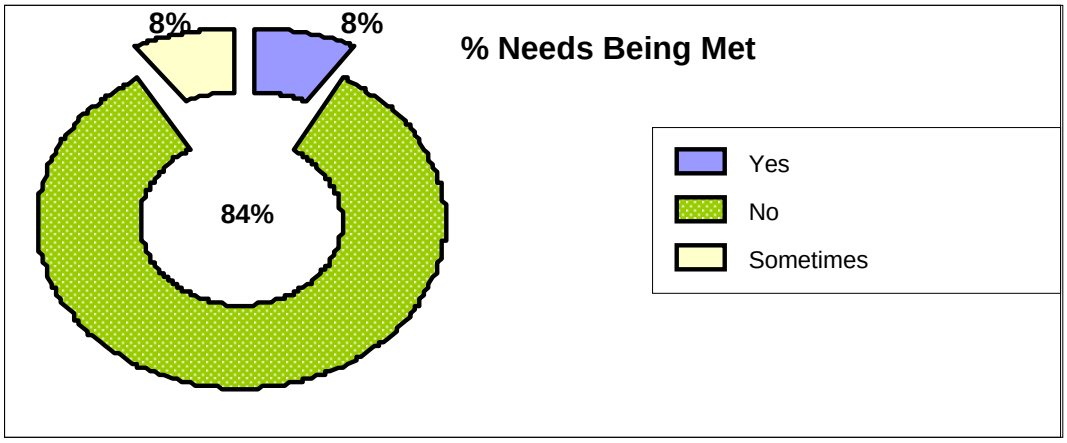
When caregivers were asked to identify their greatest needs, there was mainly need for financial assistance. This was followed by the need for a better home and assistance from family members.

Table 7: Greatest needs of caregivers

Caregivers' Needs	Frequency
Financial	46.4%
Home	15.3%
Family Assistance	10.8%
Food	9.9%
Clothing	6.8%
Employment/Better jobs	5.9%
Health Care	5.0%

Eighty-four percent (84%) of respondents indicated these needs were not met.

Figure 12: Are needs met?



Caregivers reported that the needs of OVC are similar to their needs and those of the other children in the household, but that the extent of these needs varied. Some caregivers who were not parents indicated that the children needed the love, belonging, guidance and presence of their parents. Caregivers also ranked the educational needs (books and school supplies, uniform, transportation to go to school, lunch and assistance with getting school work done) of the children as the most significant of the children's needs. Some caregivers commented on the need for "parents to be around. Specific statements of the fathers' absence or lack of involvement in the care of the children were cited. This need was not just noted by grandparents, but mothers and children as well. In 5% of the households, older siblings were made responsible for the younger children even though the parents were alive. These were all instances in which the parents (mainly mothers) were ill. These sibling caregivers and seemed overwhelmed in meeting their needs as well as those of others in the household. Their greatest need expressed by the child-headed families was the need for "Guidance and Love" as seen in Table 8. The category "Health Care" included medication for HIV positive children and assistance to transport them to a health care provider when this was necessary.

Anecdotal reports from the caregivers were that the needs of the children were more often met than their own needs as caregivers, as persons tended to be more compassionate towards the needs of children. They also reported that they made greater sacrifices for the children than for themselves. Apart from family members, other places from which assistance was received for children include the faith-based organisations and public assistance schemes.

Table 8: Greatest needs of OVC as identified by the caregivers

Needs	**Frequency**
Educational	33.3%
Clothing	22.2%
Food	19.9%
Guidance and Love	7.7%
Financial	7.1%
Parents to be around	4.4%
Home	3.7%
Health Care	1.7%

Caregivers identified financial barriers as the greatest to meeting the children's needs. This included their own financial constraints due to insufficient funds or low paying jobs or their inability to work. Some caregivers spoke of being HIV positive or at the stage of AIDS and this prevented them from earning a meaningful income, as they were often ill. Others reported that there was insufficient family support and that rainfall or floods destroyed their crops. There were still others who were too old to be employed and had to depend on other relatives for their support.

Caregivers in all regions, except Region 3, expressed that their greatest need was for financial assistance to meet their basic needs. The caregivers in Regions 4, 6, 2, 3, 9 were the most expressive about financial assistance as a need. Region 3 expressed that food and financial

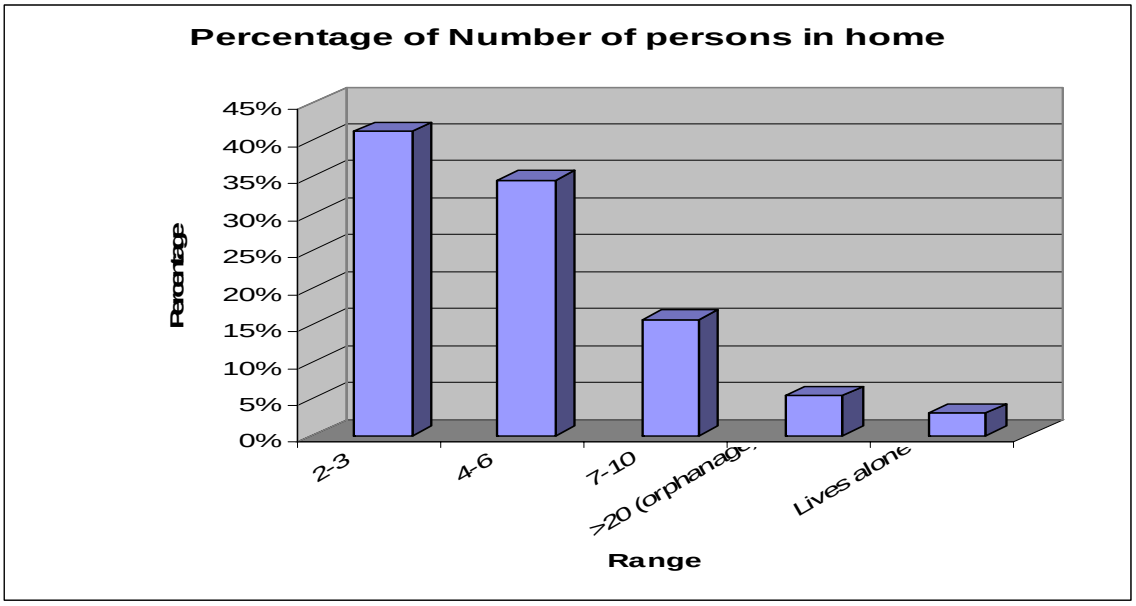
assistance were their greatest needs. When weighted by regions, Region 4 had the greatest needs of the overall needs expressed. This was followed by Regions 6 and 3 respectively with over 50 % of the needs expressed in those three regions. The least expression of needs was from Regions 2 and 7.

All regions except Region 8 expressed the need for assistance in providing a better home or improving their home situation. The need for food was expressed most in Regions 3 and then 6. Caregivers in Regions 4, 5, 6 and 9 were most expressive about the need to be employed or for better jobs in order to provide for their families. Caregivers in Regions 2, 3, 4 and 7 spoke about the need for assistance to provide medication or attend to the health care needs of the children.

The Home Situation

The research showed that there were over 50% of the homes with four to ten (4-10) occupants. The 5% of homes with greater than twenty persons were the orphanages, and the 3% (5 children) of those who lived alone were street children. The remaining 40 % were households with 2-3 occupants.

Figure 13: Numeric Profile of Number of Persons in Homes



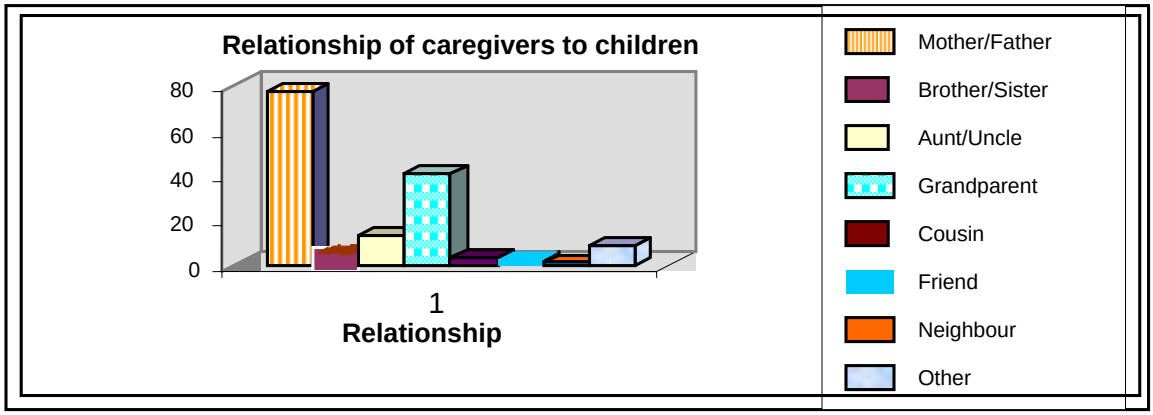
In this Assessment, just over 50% of the caregivers were parents (78 persons). The next largest group of caregivers were the grandparents (41 persons) followed by uncles/aunts (13 persons). Other categories included siblings (8 persons), Orphanages, Cousins and other relatives, friends and neighbours.

Where other persons apart from parents were offering care, this was initiated by several sources. There were times when the mother or father asked for help. Caregivers reported that in some cases children took it on to themselves to find help and so they ran away to them as a close relative or friend. There were other times when the children were placed in care by

the state due to problems in the homes. In the orphanages for example, many of the children in this Assessment were from homes in which they were physically and sexually abused. Others experienced great levels of violence as one parent may have been killed by the other, or where the parents were physically abusing each other, but more often it was the mother being beaten by the father.

Parents' absence was seen to be a result of many factors. There were the reasons of physical abuse, murder and suicide and there were those parents who went away to another section of the country or another country, to seek more meaningful employment in order to support the child/children left behind.

Figure 14: Relationship of caregivers to children



Just about 50% of households reported that the parents had been absent. Not all these cases were from deaths, but where children had lost only one parent, it was mainly that they were maternal orphans. There were a variety of causes of absence of parents. It should be noted that more than one third of the children (37%) had lost their parent/s to HIV/AIDS. Chronic diseases (14%) and Murder/Suicide (13%) also ranked high as causes of absence/death. Other causes included absence caused by migration to other areas of the country or to another country, mother dying in childbirth, malaria, unknown illness, and instances of "Jumbee" or voodoos entering and killing the parent/s.

Caregivers' utilization of other agencies

Just over ninety percent of persons look to their relatives and friends to help meet their needs. Apart from the help received from family and friends, just over eight percent of caregivers had never gone to others to help meet their needs. Those who sought external assistance did so from NGOs and Government agencies in particular and also from their church and the schools in which children were enrolled. The assistance received included food; clothing; help with completing home work from school and procuring educational materials; transportation to take children to a health care setting or financial assistance to care for medical needs and counselling for the children. Some caregivers expressed that even to have someone else speak with children was a great help, as it not only helped the child, but also made the burden of care easier for the caregiver.

Helping children to cope with parents' illness and death

Some caregivers expressed that they utilized different methodologies to help the children in their care cope with the absence or death of the parents. Most said they talked with the children while some said that they treated them well in an effort to downplay the effect of the absence. Others tried to meet children's needs as best they could, provided comfort for them when they were obviously grieving and some mentioned that they didn't converse with the children as they thought it was a better way of helping the children to cope. Some caregivers also said that they themselves were not coping with the situation of the absence and so they were not in a position to help the children to cope.

Expressions of anger and resentment came mainly from the parents and especially those who discovered they were HIV positive and then found out that the partner's status was previously known. Mothers were more often the ones in this position. One father spoke about his HIV status and indicated that he had talked with the family about it. This family was getting counselling to deal with the challenges of the disease. The children were allowed to speak about it only with their parents but to no one else outside the home.

Issues surrounding disclosure of HIV status

Some caregivers expressed that caring was sometimes difficult. Those who spoke about their HIV status said that they were sometimes treated negatively by others including family members and persons they "expected to behave better" towards them. They found it especially painful emotionally when this treatment was also shown to the children. The caregivers with HIV positive children found it particularly difficult to watch these children suffer. They expressed that at times like those they were burdened with the guilt of HIV transmission to the children. There were times however, when persons were compassionate towards them and gave willingly of their time and resources to assist them, these cases however, were not reported as much as the negative experiences.

Custodial Planning

Only eleven (11) of the 155 caregivers interviewed had made plans for what would happen to their children in the event of the caregivers' death. Caregivers who had done this were all over the age of fifty years (50), and had asked relatives both locally and internationally to be responsible for their children. There was one male among the 11 parents, and of the persons asked, nine (9) had agreed to act as future guardians for these children. These plans were discussed with eight (8) of the children, but the other three (3) caregivers said they had not disclosed because of fear. These three persons who had made their plans but not discussed them with the children were all HIV positive and one mother from Region 4 had a child who was HIV positive. When speaking about the situation, she became very tearful as she expressed that daily she has to face the emotional pain of what her partner knowingly did to her and the fact that their "four year old child was suffering so much because of it". Up to the time of the interview, the mother had never discussed the child's status with him, but gave reasons of "heart problems" to the child and any one who wondered about the child's failure to thrive and frequent absence from school.

Two (2) of caregivers interviewed had made special preparations for their children to remember them after their death. One has started a picture collection, labeling as best as she

could remember, the memories of family and friends whose pictures she had in a photo album. She would always show the album to her children and tell them that she is doing it for them. The other had a note book in which both she and her children would write about things that were special to them and visits they made to different places. This started as a project one child got in school and was continued as a family activity. Both these parents were widowed and single as one had lost her husband to HIV/AIDS and the other's partner had "disappeared with another woman".

Areas of Concern for caregivers

Caregivers were asked to list their three areas of greatest concerns. The three categories that emerged as highest on their lists of concerns were i) financial, ii) child's education and iii) the health of both the caregiver and child. There were many other concerns expressed by caregivers, many of which were centered on the children and families for which they cared.

The concerns about the children included the need to get help for children's care and upbringing**;** the desire for the child to "become something good in society"; the care and supervision of children while at work; the fear that the child would "become like the father"; the desire for the children to be loved and treated well by others and if they were to become ill.

The concerns about themselves, partners and families included the need for better employment that would allow them to effectively meet all the families' needs; their safety from abusive partner; unfaithfulness of partners and the consequence of such actions; need for basic utility services namely electricity and safe water supply; the procurement of land that should be theirs and greater involvement from faith-based organisations. Caregivers were also concerned that the impact of parent/s' death, whether from HIV, murder or suicide, would have a negative impact on children.

Persons who identified themselves as being HIV positive and or caregivers caring for children who had lost parents due to AIDS also expressed their concerns about the well-being of their children. Their concerns include: 1) the persons who will take care of the children in the event of the caregivers' illness; 2) loosing a job because of frequent bouts of illness and 3) the fear that the children may die of AIDS related illness like their parents.

Most challenging and rewarding aspects of care giving

Then most challenging aspects of care giving were similar to the needs and concerns of the caregivers. Again they listed things surrounding providing care for the children as the priority areas. This is in keeping with the anecdotal information from these caregivers in which it was indicated that the children are always their priority. The areas posing challenges were providing food, education, clothes, adequate health care and good mentorship for the children.

Caregivers reported that they found caring for these children mostly rewarding. There were a lot more positive comments, some with deep expressions of emotions and gratitude as they felt that their involvement as caregivers made a difference to the children. Caregivers felt rewarded when they considered their children's attitude, behaviour and performance of tasks and academics. Many expressed that watching the children grow up was enough of a reward

and they didn't need other factors since many were mannerly, happy, understanding, healthy, well behaved, loving and caring. Some of the caregivers spoke of the helpfulness in the household and with other siblings. Some caregivers shared that the special family times spent with their children were the things they found rewarding. There were eleven some (11) however, who did not find care giving a rewarding experience. Some of these persons who expressed this feeling were also persons who disclosed being HIV positive or dealing with issues of murder, suicide or abuse in the family.

Chapter 4 – Group Discussions

Two Group Discussions were held. One was held in Georgetown, Region Four and the other in Karasabai, Region Nine. The Georgetown group discussion was held with OVC at the Joshua House orphanage with children who live there, while the Karasabai discussion was held with members of the community. These two places were chosen since persons from there were not involved in the Assessment.

Karasabai

This community is located in Region Nine and lies approximately mid way between Lethem and Annai. At the time data was being collected for this Assessment, Karasabai was affected by flooding to the point where crops were destroyed. It is not an unusual occurrence for this comminuty. The situation necessitated the Guyana Red Cross and other relief agencies having to send in various forms of aid and support for residents of this community. While the situation is reported to be generally grim for residents of this community, the flooding worsened it. The responses of participants of the group discussion should therefore be taken within this context.

There were 16 adult participants, five (5) of whom were male. Twenty-eight (28) children were present. Not all the participants present engaged in the discussion.

OVC responses

The children were asked to list three things they wanted/ needed the most. Of the 28 children, fifteen (15) said they wanted food, fourteen (14) said they wanted school supplies including pencils and erasers, thirteen (13) said they wanted school uniforms and twelve (12) wanted shoes.

The children present were also asked what worries them. Their responses varied. Thirteen (13) children responded to this question and some gave more than one response. The table below illustrates the responses.

Table 9: Things that cause children to worry

Worry/Concern	Number Of OVC Responding
Hungry	7
Walking long distances to get to school	3
Poor state of house	1
Parent's death/absence	2
Getting to school late	1
Lack of school supplies	1

Some of the statements made by the children of this community are as follows:

- "*Sometimes I does be hungry*." – 8year old female.
- "*Sometimes I does get hungry and it does hurt*." – 7 year old male.
- "*I worry about my father because he died."* – 16 year old female.
- I worry about "*my mother- that she not here. She die*." – 14 year old male.
- "*I punishing. I don't get enough to eat."* – 12 year old male.
- *I tired walking to school. I want a bicycle*." – 9 year old female (she walks approximately 5 miles to get to school).
- "*I want zinc for our house. I want food cause I does hungry steady*." - 13 year old female.
- "*I want a bicycle for school*." – 7 year old male.
- "*I worry about not having enough pencils*." – 10 year old male.
- "*I don't want to go to school walking cause it far*." -7 year old male who walks approximately three miles to get to school.
- "*Nothing. Only I does hungry*." – 7 year old male.
- "*Shortage of food. Often we don't get enough food*." – 16 year old female.
- "*I want my father to cook for me early. I does come to school late everyday*". – 9 year old female.

Adult Caregivers

Adult caregivers were asked to list three things that worried them the most. Most of them identified food, lack of support to provide for children's needs, the long distances the children have to travel for school, and the absence of one or both parent as their main concerns. Lack of employment opportunities, not being able to provide adequate clothing, and not being able to provide toys for the children were also included in the list of concerns.

Some of the statements made by caregivers include the following:

"*I worried about my grandchildren because they don't get the kind of treatment they should get. The father died and the mother in Lethem working. Sometimes she does send money but not enough*"- 61 year old Grandmother.

"*My husband die in 1994. I belong to a women's group which helps me a lot. My house is falling down. The roof has holes. I working towards getting me house fixed. In 1996 I applied for public assistance. I check with the District Development Officer steady but I ain't hear anything yet.*" – 45 year old mother of five.

"*My wife recently died of cancer of the uterus. I was in Georgetown with her for three months, then I took her to Brazil for treatment. After she died I returned to work and was told that I was fired. I have five children to*

take care of (ages 11 months-15 years old) and no job. I do a little bit of farming when I can. I worry about not working and having the children to take care of." – 35 year old father.

Most of the caregivers who responded to a question about what needs to be put in place to support them, said the following:

1) That families and family members are supported so that children can remain in the home where possible.
2) That children must be supported in a comprehensive way so that they can remain in school.
3) That a home should be established in the community to house the OVC. They suggested that community elders be put in charge of taking care of the children. This arrangement, they said, would then mean that the children would be taken care of and the elders would have an opportunity to earn money and support themselves as well as provide care to the children. They spoke of this arrangement enabling the elders to share traditions, culture, values etc. with the OVC.

Joshua House Group Discussion

The group discussion held in region 4 was conducted at the Joshua House children's home. Ten children participated. The children were asked a number of questions aimed at getting their perspective on issues affecting OVC. When asked about the causes of orphaning in Guyana, the children listed lack of shelter, child abuse, death of parents from HIV/AIDS, mental illness, murder and domestic violence in the home. The children felt that once children became orphans, they live on the streets, get locked up, go to orphanages, or live with other relatives. These responses were similar to the ones they gave when discussing things that caused children to become vulnerable. In response to the question the children spoke of living on the streets, running away from home, running away from abuse, and being influenced by friends.

The children did not feel that they were deliberately being put at risk, but that circumstances caused this. When asked to define the circumstances, the children said sexual abuse, violence among parents and severe beating. In discussing sexual abuse, the children pointed out that not every child would tell about their experience since some parents or caregivers do not believe the children and they are further punished. They noted that in some cases, some children will put up with the abuse while some would run away from home.

The children also spoke of being "bothered" by people because they live in an orphanage. They said they are teased and called names.

In talking about problems they faced living in an orphanage, the children spoke of not having enough contact with their remaining parent. For some children, they have one or both parents but were placed in the orphanage for a number of reasons. For those children who had at least one parent still alive, they wanted more contact with that parent.

All of the children interviewed said they preferred living in the orphanage to living at home since they got more attention, food and care at the orphanage. The children spoke of being taken care of properly by the caregivers at the orphanage and rated the quality of care as higher than that they received at home.

In responding to what their greatest needs were, the children spoke of the need to be loved and receive attention. They saw the needs of their caregivers as financial and for accommodation. They felt more attention should be paid to OVC and that more attention should be placed on how children are affected by their parents' actions. They were aware of some of their rights and noted that some of the things they needed to assist them in life included counselling, to socialize and interact with other persons, and learning how to deal with peer pressure. For children whose parents are HIV positive, the children said they would need information on understanding HIV/ AIDS and what it does, and learning how to deal with the persons that are ill.

In their parting remarks, the children said that more visits of this nature should be done to other organisations, more attention should be placed on the incidences of teenage pregnancy, peer pressure, child prostitution and alcohol and drug abuse.

Chapter 5 – Discussion of Assessment Findings

The needs of OVC can no longer be overlooked. From both the OVC and caregivers findings, it has become clear that strategies must be put in place to address these needs and the "rights of the children". Already, too many children are in trouble as seen in the number of school absenteeism, street children, crime involving children, children direct and indirect victims of (domestic) violence and abuse including murder, abandonment, drug abuse by both children and parents and early pregnancies.

Children have become orphaned or made vulnerable by many causes. Although HIV has been ranked highest in the causes of OVC in this Assessment, attention must be shown to the cases where children witness suicide/murder of their parents, levels of physical and sexual abuse in the home- which is not just to adults, but also experienced by the children. Of importance also are the reports made by children who wish their fathers were not involved in trafficking and usage of illegal drugs or who wanted their fathers to be better role models for them. When categorized the family is the first safety net for these children, as caregivers who were not parents were mainly grandparents, then aunts/uncles, siblings and cousins. Clearly the extended families, though they may be willing, are finding it more difficult to absorb extra children due to their own financial constraints, levels of poverty, large households and the challenge of caring for HIV positive children in a time when the stigma of HIV/AIDS remain a challenge to be tackled. This was clearly displayed in the response of the children that the persons who were most sensitive, yet also displayed most negative responses to them were persons who were related to them or who they knew well.

Some children in the Assessment also found it difficult to remain happy in their homes because of the abuse and neglect. The children in orphanages clearly delineated this as they expressed that they were happier in the orphanages than in their own homes. Children who were placed there had not only lost a parent or parents, but were placed there for safety and protection from physical and sexual abuse. These children did however indicate missing their parent(s) and wanting to be with their parent(s) in a protective environment.

Most of the children in the Assessment were at the educational level in keeping their age. Commonly, the children were in the 10-14 age group and also pursuing or completing either primary or secondary level education. There are concerns though for those who are not attending school because of the parents/caregivers financial challenges, or who may have run away from home and are not attending school.

There were 26 children in the Assessment who were employed on a full time basis. There were more boys than girls who were employed and most felt that they were being paid fair wages for what they did. More boys being employed is in keeping with the reports of the caregivers and the OVC that the boys were the ones who would help to bring in earnings in the families while the girls were more involved in the domestic activities and caring for parents or other siblings in the home. There were girls who were of the working age, but stayed at home as the main caregiver as the parent present in the home was ill. The children who were employed full time were mainly in the 10-14 age group (15 children) while 11 were employed in the 15-18 age group and many of the employed children were already working for over one year. Most concerning are the numbers of full time employed children in Regions 4 and 6.

The needs expressed by the children were all in keeping with daily survival. They were all concerned about their education and getting their basic needs met. For those who asked for bicycles, some indicated that they needed it to transport themselves to school or to get around and help their families. It was mainly boys who asked for toys but again this is in keeping with the normative behaviour of children.

For children and families suffering from HIV/AIDS, the stigma attached, makes the experience of everyone involved infinitely worse, and effectively prevents many from accessing existing services. Stigma is often propagated in areas or among persons thought to be more aware of the needs of the families.

Children respond well to counselling and mentoring – people in positions of influence should be educated and trained in counselling for HIV and the other factors such as the challenges of dealing with issues of murder, suicide, physical and sexual abuse as they have all contributed to the vulnerability faced by many Guyanese children. Those children who displayed such emotional release during their interviews are obviously in need of a safe place to express their pain and hurt. For these children better counselling services must be provided.

Both the children and the caregivers utilized a variety of means to meet their needs. The health services were often tapped, but participants in the Assessment were also able to find other useful resources such as churches, NGOs and the school attended by the children. Only a few children and caregivers knew of government agencies that could provide assistance for their needs. Available agencies need to be better known to persons in need. The social services provided by NGOs and Government agencies should be made more public and offer greater support so that more caregivers and children can know about and use them. In the long run this will save money and improve lives. No organization can tackle this challenge on its own, many have to collaborate and take ownership of the problem of OVC if it is to be effectively addressed.

Caregivers have an average of 2.9 children who will need alternative care when they die and as seen in this Assessment, fathers play a limited role in providing homes and care for these

children. This was seen from the number of male caregivers in the Assessment as well as the comments made by children about their fathers. Although many of the caregivers had not achieved more than a primary level education, this obviously did not prevent them from caring for their children. The large number of household occupants reflects the willingness of adults to take on and offer care to children who may not even be related to them. The fact that some persons offered to help or found help for OVC, makes it clear that people are willing to be involved, but need to be empowered in order to do so.

Chapter 6 – Findings from Organisations

In addition to the interviews conducted with OVC and their caregivers, and group discussion, researchers also spoke with representatives of organizations that provide services to this group. Interviews were conducted with 31 organisations in Regions 2, 4, 5, 6, 7, 8, and 10. At the time of Data collection, there were no known organizations working with OVC in Regions 1, 3 and 9. As such, it is not possible to do a fair regional comparison of the services available. Of the 31 organisations interviewed, 26 work directly with OVC in a limited way.

The questionnaires contained 38 questions that looked at issues including:

- How many children are assisted through the organizations
- What activities/services are designed for OVC
- Their opinions on what were the important issues for OVC
- Whether the needs of children orphaned or made vulnerable through HIV/AIDS were any different to children who were not.

The organizations reported working with approximately 1148 OVC. Of these children, 147 live in orphanages or the Children's Convalescent Home.

Needs of OVC

In providing for the needs of this target group, the focus has been primarily on the provision of food and clothing to the children and their caregivers. This was reflected in the responses given by organizations when asked about the services provided. Ten organizations specifically listed the need for assistance with food as a priority for OVC, while clothing was listed by nine of them. Six listed financial assistance. Thirteen mentioned the need for some form of counselling and guidance to be provided to OVC. The organizations interviewed agree that the basic needs of OVC include access to quality education, health care, food, shelter, love and affection. They also included guidance, self esteem building opportunities, recreational activities, support with schoolwork, spiritual guidance, medical assistance and other forms of support. Education was listed by 11 of the organizations, five of which are in Region 4; five in Region 6 and one in Region 2. One organization mentioned the need of OVC to be able to "live a life with hope."

Temporary and Permanent Accommodation

Temporary and permanent accommodation are other services provided, with the Government run Drop-in Centre for street children providing temporary accommodation during the day for children; while a more permanent arrangement is available through the government and

non-government operated orphanages or children's homes in Regions 4 and 6. The orphanages visited are Camal's Children Home, Canaan Children's Home and Alpha Children's Home in Region 6; and the Children's Convalescent Home and the Joshua Children's Home in Region 4. Some persons felt that OVC need to remain within the family structure as much as is possible. Linden Care Foundation, a NGO, has been supporting families with the aim of keeping the children within their environment and is also hoping to implement a foster care system that will see extended family members taking care of OVC once parents are no longer able to do so through illness or death related to HIV/AIDS. There are other organizations that provide community outreach and support services that help to facilitate this.

Counselling

While the need for food and accommodation are of primary importance, it is equally important that the organizations also look at other needs such as the social welfare and psychological needs of the children including those infected/ affected by HIV/AIDS. Few organizations provide counselling to OVC. Organisations providing counselling include Hope for All in Region 2; Guyanese Youth Network, Monique's Helping Hand, Guyana Responsible Parenthood Association, Lifeline Counselling Services, G+, Youth Challenge, Help & Shelter, Varqua Foundation, Silver Lining Association of Region Four; Roadside Baptist, St. Francis Community Developers, Albion Chapel Library and Skills Training Centre of Region 6; Hope Foundation in Region 7; and Linden Care Foundation of Region 10. The need for these kinds of services was reflected in the responses of OVC when interviewed.

The children spoke of the lack of opportunities to examine and discuss their feelings. Research has found that in the absence of this kind of support, "there will be long term developmental impacts on children and the future of these countries."[3] Children served by these organisations include those made vulnerable or orphaned through parents being dead, ill, abroad, imprisoned and those affected/infected by HIV/AIDS. If children are not assisted in overcoming the effects of their trauma it can stay with them for the rest of their lives and most likely contribute to some form of dysfunctional behaviour.

Health

In Region 4, GRPA is the only organization that focuses mainly on reproductive health care services for youth. While their programmes are not designed specifically for OVC, they are included in all aspects. G+, The Guyanese Youth Network and Lifeline Counselling Services of Region 4 also focus on health related issues for persons including OVC. In Region 7, Hope Foundation does the same; and in Region 10, LCF also looks at health related issues. In Region 6, the organizations that listed health related services are St. Francis Community Developers, Youth At Risk Peer Educators and Devine and Destiny Women's Group.

[3] Care for Orphans, Children Affected by HIV/AIDS and other Vulnerable Children: A Strategic Framework. June 2001. FHI/USAID

OVC not assisted by Organisations

The organizations were also asked how many OVC were not assisted by them. Very few numerical answers were given in response to this question. Many of the organizations said the information was not collected because of limited resources within the organizations. For those who gave figures, the Guyanese Youth Network + (GYN+) indicated that approximately 50 OVC in their urban catchment area of Kitty were not assisted. This was the only organization in this region that gave a numerical response to this question. In Region 6, the Roadside Baptist Church Skills Training Centre's response given was, "too many" children are not being assisted. Their representative noted that while some children were reluctant to come out and access their services, there were also funding restraints facing the organization and limiting the scope of their work. This is a common trend in the responses of the organizations interviewed. The lack of adequate resources was stated as one of the main issues affecting their ability to provide support to the target group. The inability of organizations to give numbers of how many children they work with underscores the need for a monitoring and evaluation system to be put in place within these groups.

Other Services

Other services provided by organizations include skills training, life skills building, feeding programmes, counselling and testing, educational programmes, counselling around reproductive health issues and related services, community outreach and advocacy. A directory of the organizations that were interviewed is included as an appendix to this document.

Other research has found that to a lesser extent, the secondary focus of programmes has been to "address the needs for skill transfer and education for children."[4] And to an even lesser degree, is the focus on health care and the emotional /psychosocial needs of OVC.

Networking and Referrals

Many of the organizations noted that they are able to refer persons to other groups that may be more suited to their needs. Of the 31 organisations, 25 indicated that they liaised with other organizations while 6 did not. Of the 6 that gave a negative response, four were from Region 4, while the remaining two were from Region 6. For those who liaise with each other, their experiences have been mixed, with 16 of them saying that their experiences have been good. Others said their experiences have been mixed. This situation is helped by the networking and referral systems in place among the organizations.

[4] Care for Orphans, Children Affected by HIV/AIDS and other Vulnerable Children: A Strategic Framework. June 2001. FHI/USAID

Table 10: Organisations working with OVC and their caregivers[5]

Regions	Organisations –details	Key Services for OVC and their Caregivers
Region 1		
Region 2	**Hope for All (NGO)** Suddie Public Health Building Telephone: 774-4360 Fax: 774-4560 Email: Shutty1@yahoo.com Focus: HIV/AIDS	- Community Outreach - HIV/AIDS education - Voluntary Confidential Counselling and Testing (VCCT) site - Advocacy - Counselling - Referrals
Region 4	**Guyana Red Cross** Eve Leary Georgetown Telephone:226-5174 Fax: 227-7099 Email: redcross@sdnp.org.gy Focus: Humanitarian work	- Advocacy - Youth development - OVC - Care, support and counselling - Community outreach/development-hinterland - Skills training - Health care - Donation boxes including food and clothing - Education programmes - Referrals - Children's convalescent home (see following organistion)
	Guyana Red Cross Children's Convalescent Home (NGO) Durban Backlands Georgetown Telephone: 225-7120 Focus: OVC - children recovering from severe illness (0-6 years old)	- Convalescent facilities and therapeutic care - Housing and care and support for homeless children
	Joshua Children's Home 255 Thomas Street South Cummingsburg Georgetown Telephone: 226-8020 Focus: OVC	- Orphanage for children - Referrals

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Please note that this list is not exhaustive. These agencies are the ones know to work with OVC to the researchers and the children and adults interviewed during the Assessment.

	G+ (NGO) 35 C North Road Lacytown, Georgetown Telephone:223-0931 / 1701 Fax: 223-0930 Focus: PLWHA	- Counselling - Care and support - Advocacy - Education - Community Outreach - Referrals
	Silver Lining Association (NGO) 106 Brickdam Stabroek, Georgetown Focus: PLWHA	- Support groups - Care and support - Empowerment sessions - Referrals
	Youth Challenge Guyana (NGO) 25 Thomas Street Georgetown Telephone: Fax: 223-7885 Focus: Community development through youth development	- Food hampers - Peer education - Life skills - Counselling and support - First Aid classes - Referrals - Outreach -hinterland
	Varqua Foundation (NGO) 120 Parade Street Kingston, Georgetown Telephone: 226-7870 or 227-4623 Email: bjotook9@hotmail.com Web site: www.sdnp.org.gy/varqua Focus: Promotion of an integrated model of development based on spiritual values.	- Training for youth on HIV/AIDS related issues - Production of video educational training programmes and peer education - Community outreach - Counselling - Behaviour change training - Referrals
	Volunteer Youth Corps (NGO) 235 South Road Lacytown, Georgetown Telephone: 223-7404 Fax: 223-7966 Email: vycorg@guyana.net.gy Focus: an holistic approach to youth development.	- Provision of a youth friendly environment - Distribution of hampers to families - Peer education and counselling - Community outreach - Hospital visits - Public education - Sexual and reproductive health education - Youth entrepreneurship - Referrals
	Dec.com (NGO) 292 Lamaha Park East La Penitence Telephone:227-5216 Email: shirleyallen@yahoo.com Focus: OVC	- HIV/AIDS education - Nutrition - Advocacy - Emotional and material support - Referrals
	Ruimveldt Children Aid Centre (NGO) 13 Public Road Riverview, Ruimveldt Telephone: 227-3092 Focus: OVC	- Meals - Assistance with school work - HIV/AIDS education for parents and children - Referrals

	Guyanese Youth Network + (NGO) 96 Thomas Street Kitty, Georgetown Telephone: 225-1116 Email: gyn@sdnp.org.gy or evervessence@yahoo.com Focus: HIV / AIDS	- Education - Counselling and support - Advocacy - Networking - Referrals
	Guyana Responsible Parenthood Association (NGO) 70 Quamina Street Georgetown Telephone: 225-0736 Email: gilliebutts@yahoo.com Focus: Family Health	- Sexual and reproductive health education and related services - Family life education - Counselling - Information - Clinics - Care and support - Referrals
	Monique's Helping Hand (CPIC) Support Centre (NGO) 18 Norton Street Worthmanville, Georgetown Telephone: 225-9263 Email: cpicincny@aol.com Focus: OVC	- Child friendly space - Literacy and skills building programme - Home visits - Sexual and reproductive health education - Educational materials - Provision of clothing and food - Community outreach - Referrals
	Help & Shelter (NGO) Homestretch Avenue Durban Park, Georgetown Telephone: 227-3454 or 225-4731 Email: hands@sdnp.org.gy Focus: Domestic Violence and Child Abuse	- Counselling - Court support - Advocacy - Public education - Training - Referral
	Lifeline Counseling (NGO) 354 Cummings Street South Cummingsburg Georgetown Telephone: 226-8684 Focus: HIV/AIDS	- Sexual and reproductive health education and related services - Family life education - VCCT - Information - Clinics - Care and support, also to OVC - Referrals
Region 6	**Devine Destiny Women's Group (NG))** Hopetown Village Corentyne, Berbice Status: NGO Focus: HIV/AIDS affected families	- Counselling and support - Community outreach and education - Referrals

	Canaan's Full Gospel Children's Home 11 Area Q Manager's Compound Port Mourant, Berbice Telephone: 336-6606 Focus: OVC	- Provision of a home for children who are orphaned, street children and other vulnerable children until they are 18 yrs old. - Referrals
	Camal International Home Lot 1-3 Chesney/Kilkenny Albion, Berbice Telephone: 322-0374/ 0373 Focus: OVC and battered women	- Residential facility for battered women and their children - Home for OVC - Counselling - Advocacy - Care and support - Education - Referrals
	Roadside Baptist Church Skills Training Centre (NGO) #68 Village Corentyne, Berbice Telephone: 338-2586 Fax: 338-2644 Email: rbccebtre@yahoo.com Focus: Community programmes for youth and adults.	- Counselling - Technical and vocational skills training - Support programmes for disadvantaged children, youth and adults including seniors - Community outreach and advocacy - Nutrition programmes - Micro credit programmes - Desktop publishing - Library - Internet café - Educational programmes including tutoring for CXC and Pitman examinations
	Swing Star Youth and Sports Club (NGO) #58 Village Corentyne Berbice Telephone: 618-6526 or 624-5805 Focus: Youth and community development	- Community outreach - Skills training - Remedial classes - Feeding programmes - Referrals
	Corentyne Community Based Rehabilitation Programme (NGO) Port Mourant CBR Building Berbice Telephone: 337-6559 Focus: Persons living with disabilities	- Advocacy - Therapeutic care - Counselling - Community outreach - Recreational activities for families - Reproductive health education - Referrals

	Albion Library and Skills Training Centre (NGO) Fyrish Village Corentyne, Berbice Telephone: 322-0293 Focus: women and children	- Counselling - Skills training - Food distribution - Community outreach - Referrals
	Turn Your Life Around (NGO) Kildonan Village Corentyne Berbice Telephone: 621-5832 Focus: Community development	- Counselling and support - Community outreach and education - Referrals
	St Francis Community Developers **(Family, Children and Youth at Risk Project") NGO** East Sideline Dam Rosehall Town Corentyne, Berbice Telephone: 337-4090 Focus: Community development, Youth, Children and Families at Risk, HIV/AIDS and Sexually transmitted diseases	- Counselling - Training - Networking - Resource center and Internet café - Voluntary Confidential Counselling and Testing (VCCT) site - Music/drama - Library services - Youth education - Community development - Micro credit and small business enterprise scheme - Women and children empowerment - Skills training programmes - Group capacity building - Advocacy - HIV/AIDS and STIs education, support and care - Family friendly spaces - Referrals
	St. Marks Mother's Union (NGO) Alness Berbice Focus: Community Development Services Offered:	- Education - Skills training - Community outreach - Advocacy - Care and support - Hot meal programme for children - Referrals

	Fair Revival Tabernacle Wesleyan Women's Group (NGO) 22-16 Main & Asylum Street New Amsterdam, Berbice Telephone: 333-2807 Focus: Spiritual enhancement and family life education	- Community outreach - Counselling - Education - Advocacy - Referrals
	Comforting Hearts (NGO) New Amsterdam New Amsterdam, Berbice Telephone 333-4882 Focus: HIV/AIDS	- Education - Counselling and support - Advocacy - Networking - Referrals
Region 7	**Hope Foundation (NGO)** 2nd Avenue Bartica Telephone: 455- Focus: Community support, HIV/AIDS	- Counselling - Community outreach and education - Voluntary Confidential Counselling and Testing (VCCT) site - Advocacy - Care and support - Children at risk summer camps - Parent/child enhancement programmes - Parenting skills education - Education - Resource center - Referrals
Region 8	**Ribbons of Life (NGO)** 111 Miles Mahadia Potaro Focus: Poor families	- Counselling - Aids education and awareness programmes - Parenting skills - Advocacy - Referral
Region 10	**Linden Care Foundation (NGO)** Burnham Drive Christianburg Telephone: 442-0588 Hotline: 444-0142 Fax: 444-2135 Focus: OVC due to HIV/AIDS	- Nutritional Enhancement Programme - Care and support - Peer counselling - Group Counselling - Child counselling - Workplace sensitization - Hotline counselling for youths and persons living with HIV/AIDS (PLWHA) - Mini pharmacy - Capacity building - Summer camps for children - Social welfare services - Advocacy - Community outreach - Voluntary Confidential Counselling and Testing (VCCT) site - Education

Chapter 7 – Social Support Services

State Responsibility

There are a number of Government ministries that are directly responsible for the welfare of OVC. The Ministry of Labour, Human Services and Social Security share responsibility with the Ministries of Health, Education and Culture, Youth and Sport.

Ministry of Labor, Human Services and Social Security

Based on information from the Ministry of Labour, Human Services and Social Security (Min. LHSSS), between 2002 and Sept 2003, 588 OVC received support that included food, education support, health care, protection services including legal support, and psychological support, which included group counselling, and structured support for caregivers.[6]

When contrasted with the estimates of OVC in Guyana, a figure listed as 4000 by UNICEF[7], the implications of the sheer number of OVC who are not receiving support is staggering. Throughout the data collection phase, it was evident that the majority of OVC are living with a parent, elderly grandparents or members of their extended family. Sometimes parents, who are unemployed, living with abuse and poverty, sick and/or dying, care for the children. In the case where there were grandparents taking care of the children, some grandparents are themselves sick, unemployed, and in need of care themselves. The same is true for some relatives who often have children of their own and are already stretching their resources to meet the needs of their own family members before OVC are absorbed into these homes. As families and communities struggle to absorb OVC in Guyana we are seeing an increasing number of street children and street involved children (those who are not living on the street full time) who are more vulnerable to risks that include sexual abuse, prostitution, health and psychosocial problems.

Children who live in these situations are at increased risk of losing opportunities to go to school, access health care, grow and develop adequately, have adequate nutrition, and shelter, in other words, "their rights to a decent and fulfilling existence."[8]

Ministry of Health

Guyana provides free health care to all of its citizens**.** This includes OVC and their families. The Government of Guyana, through the Ministry of Health, is responsible for this service. Guyana Strategic Plan of Action for HIV/AIDS is being implemented by the Ministry of Health as part of a larger plan for health care in Guyana.

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[6] Coverage of Essential HIV/AIDS Services, National Questionnaire-Guyana, USAID/WHO/UNAIDS/CDC/WORLD BANK, Oct 2003

[7] State of the World's Children 2002,UNICEF.

[8] Care for orphans, children affected by HIV/AIDS and other vulnerable children: A strategic framework, FHI/USA. June 2001.

A major challenge that the Government of Guyana faces is the ability to provide consistent quality of care throughout Guyana because of the lack of a reliable supply of drugs and other commodities, the high turn over of staff (many of whom migrate), poor wages and working conditions, untrained personnel and inaccessibility for many Guyanese living in the more remote communities, particularly in Regions 1, 2, 7, 8 and 9.

Challenges facing OVC and their families in accessing health care include accessibility in terms of location and transportation to get there; availability of trained personnel to carry out necessary examinations and procedures; the availability of drugs and other necessities; medical supplies and personnel and shortages due to tough economic situation coupled with significant migration of skilled and unskilled persons, particularly nurses, teachers and social workers. One daily newspaper quoted Dr. Manuel Brozco, who in referring to a 1992 report, said that he found that at least 20, 000 people were leaving Guyana annually for the United States of America, the United Kingdom and Canada. The newspaper article went on to further state that a senior immigration official in Guyana put the yearly number at 50 000. This number has since been challenged by various sources. The same article also mentioned that the current USA census at that time had listed between 200,000 and 220,000 Guyanese living in the USA.[9] The United Nations Development Programme has also been quoted by the Guyana Chronicle as saying that Guyana's population exhibits one of the highest net migration rates in the Caribbean. [10]

Ministry of Culture, Youth and Sport

The chief responsibilities of the Ministry of Culture, Youth and Sport are to ensure that children's lives include opportunities for participation in sports and other cultural activities/opportunities. This ministry is also responsible for adolescents and youth between 14-25 year old and the New Opportunity Corp (NOC), a juvenile correction and rehabilitation facility that houses approximately 160 children.

Discussion

The move towards a widespread response from the Ministries of Health, Education, and Labour can only lead to increased access to health and other services that are necessary to keep conditions from getting worse. The issue of PLWHAs and their children should be featured in the plan and clearly linked with strategies for prevention. The introduction and sustaining of community and family support programmes that include psychosocial, organizational and economic interventions will lessen the impact of this social problem as the number of OVC increases.

Institutionalised care has been proven worldwide to be a more expensive option both financially and socially. To some degree, orphanages in Guyana are linked with communities that support them financially and otherwise. While the existence of orphanages is a reality we live with, we should look at a more community-based solution that takes into account and encourages the ability of the child to remain in the home or within the family structure. There are many who argue that "community based approaches are the only viable and sustainable

[9] Guyana Chronicle. Friday November 8th, 2002.
[10] Guyana Chronicle. Friday November 8th, 2002.

alternative for providing care and protection for children who are OVC, especially by the HIV/AIDS epidemic. This is dictated by the number of children affected by the epidemic, limited service availability in the country, and the relative desirability of alternatives in terms of their impact on long term child development and economic development. ", as is seen in Haiti. [11]

[11] FHI/IOMPACT/USAID 2000.

Chapter 8 – Recommendations

Globally recommended guidelines to manage OVC

There are a number of interventions that are widely accepted as necessary when developing programmes to support OVC. They[12] include but are not limited to:

1. "Strengthening the protection and care or OVC within their extended families and communities". During the research project caregivers were adamant that the best place for the children was with their family and community.

2. "Strengthen the economic coping capacities of families and communities." Again, the caregivers said they would be in a significantly better position to care for the children once they were able to access economic and other forms of support. This was particularly obvious in the cases of grandparents caring for children.

3. "Enhance the capacity of families and communities to respond to the psychosocial needs of orphans, vulnerable children and their caregivers." The need for this kind of support was painfully clear as many of the OVC interviewed had not been able to discuss their feelings prior to speaking with researchers. Often, they broke down into tears during the interviews and when asked, said no one had ever attempted to speak to them about what had happened or how they felt about it.

4. "Ensure the full involvement of young people as part of the solution." OVC should be given some say in the decisions that will affect their lives. The research showed that children were rarely consulted on issues including whom they would live with, schooling, and health care. This was poignantly demonstrated in an interview with a teenaged girl who had been taken to have an abortion after being raped by her stepfather. When interviewed, the child said her mother made all of the decisions around what would happen from the time the abuse was discovered. She said no one asked her any questions, including the doctor, around what she wanted to do. She was just taken to the doctor and told to cooperate. She said she was not even sure about what was happening until she got to the doctor's office and was told she was going to have an abortion.

5. "Strengthen schools and ensure access to education…Governments and other stakeholders must address the ways in which HIV/AIDS is weakening the education systems." For the purpose of this Assessment, in addition to the effect of HIV/AIDS, our government needs to include other issues that impact on children's access to education. In the case of the girl mentioned in the previous principle, that child said she was being denied access to education because of her refusal to discuss any of the details surrounding her pregnancy and abortion. She said the Probation and Welfare Officer had instructed the manager of the orphanage to keep her out of school until she revealed what they wanted to know. This added to the vulnerability of this child

[12] Children on the Brink 2002. UNAIDS/UNICEF/USAID

who openly stated that she was prepared to commit suicide should she continue to be denied access to school.

6. "Strengthen partners and partnerships at all levels and build coalitions among key stakeholders." This has been happening to some degree countrywide with the support of the government and especially international funding agencies.

Guidelines for Developing a National Plan of Action

It is of vital importance, that in designing and implementing a National Plan of Action to address the issue of OVC, stakeholders are cognizant of the problems faced by this group, their caregivers and the community at large. The plan will need to address the range of issues, which are not confined to medical, educational, legal, and psychosocial aspects. There are five basic strategies that have been recommended worldwide. These strategies have also come out in the interviews conducted with caregivers throughout the country

1. **Strengthen and support the capacity of families to care and cope.** The children, families, and communities that have been affected are carrying out the first and most important responses to OVC of various causes (HIV, migration, abuse, murder etc). We need to continue to encourage a continuation of this support. Therefore, support should be given to the families to enable them to continue taking a lead role in the support of OVC. This should include parenting education that focuses on fathers.

2. **Mobilize and strengthen community-based responses.**
   For children whose families cannot adequately provide for their basic needs, the community is the next safety net. Supporting community led initiatives to care for children and adolescents should be a priority. The Ministry of Labor and Social Services has already begun looking at ways of managing the OVC situation and has convened a coordinating team. However, guidelines need to be drafted so that each ministry and NGO working with OVC complies with an operational plan and special attention should be paid to the needs of HIV/AIDS OVC.

3. **Strengthen the capacity of children and young people to meet their own needs.** In light of the significant emotional strains, as stated in the assessment, this support can also play a role to incorporate the youth and their families into community-outreach, social support networks, as well as opportunities to participate in community activism.

4. **Ensure that government develops appropriate policies, including legal and programmatic frameworks, as well as essential services for the most vulnerable children.** This will help to shape and guide services to be provided. It could include guidelines for the identification, services, and follow-up for each orphan and vulnerable child. This can also include setting a basic package of care (goods and services as mentioned in the assessment: school supplies, school uniforms, school fees, vitamins, transportation to school and medical/counselling appointments, etc. that will be extended by all partners to each of the OVC they are supporting.

5. **Raise awareness within societies to create an environment that enables support for children affected by HIV/AIDS, murder, suicide and physical and sexual abuse.** Public education and community outreach programmes can assist in this area, involving the communities in the devising of strategies to deal with the issue of OVC will also strengthen the process and work towards getting the community to own it.

Chapter 9 – Literature Review

Planning for OVC

There is no comprehensive plan for OVC in Guyana. The Ministry of Labour, Human Services and Social Security is in the process of setting up a Children's Welfare and Protection Unit, within which will be a sub unit that deals specifically with OVC. For those children who are orphaned or made vulnerable through HIV/AIDS, they are somewhat included in the country's National Plan of Action for HIV/AIDS 2002-2006.

Increasing reports are being made of children in Guyana who are being abused and exposed to other forms of violence. They are neglected, abandoned, separated from their parents, and suffer from malnutrition and live in poverty. This is further exacerbated by their lack of access to adequate health care and other social supports; such as an appropriate facility for juveniles who are not committed by the court but need counselling and rehabilitative educational care.

History of HIV/AIDS in Guyana

AIDS was first diagnosed in Guyana in 1987 in a male homosexual. By the end of 2002, there were a total of 3,483 reported cases of HIV/AIDS with 2095 being males. These are the numbers reported by Dr. Navindra Persaud, Director of the Department of Disease Control Services of the Ministry of Health.[13]

Guyana has seen a progressive increase in reported AIDS cases with the majority of the cases being reported in Regions 4, 6 and 10. Based on statistics coming out of the Ministry of Health, between 1991 and 2001, there were 225 persons between the ages of 0-19 who were infected with HIV. Included in this number are 100 children between 0 to 4yrs old. The statistics released by the Ministry of Health does not state how the children contracted the virus. To date, substantial efforts have been made to establish and support Voluntary Confidential Counselling and Testing (VCCT) and Prevention of Mother To Child Transmission (PMTCT) sites by both government and non-governmental groups. Statistics collected from these sites will give a better idea of the HIV/AIDS/OVC situation countrywide.

What is known is that after Haiti, Guyana has the second highest incidence of HIV/AIDS in the Caribbean. AIDS itself is a significant and important cause of death in Guyana; currently ranked as the second leading cause of death. In 2000 it accounted for 14,154 years of potential life lost (YPLL), more than that of acute respiratory infection (ARI), ischaemic heart disease (IHD) and cardiovascular disease (CVD) combined.[14]

Guyana's Plan

Guyana has a National Strategic Plan for HIV/AIDS, which spans from 2002 to 2006. The overall objective of this plan is, "to reduce the social and economic impact of HIV and AIDS on individuals and communities, and ultimately the development of the country." [15] The plan

[13] Guyana Review Vol 12 Nos. 133&134 January & February, 2004
[14] Caring for People with HIV/AIDS in the Caribbean; Tony Fraser: http://www.prb.org (4/29/2004)
[15] Guyana's National Strategic Plan of Action for HIV/AIDS 2002-2006, Government of Guyana

also includes components that look at care and support among other areas. The plan acknowledges the need for an integrated approach among the various government ministries and agencies, as well as non-governmental organizations, community based organizations, persons living with HIV/AIDS (PLWHA) and the religious community. The plan is referred to as "one plan and that it is essential for the components to come together as an integrated whole since the various components are interlinked."

This plan emerged in response to the increasing number of AIDS cases, and continues to work towards reducing the number of HIV cases. The National AIDS Programme Secretariat (NAPS) in collaboration with CAREC-GTZ and UNICEF developed a programme to increase access to VCCT as the key element in the national strategy. The Guyana HIV/AIDS/STI Youth Projects funded by various donors such as USAID (and implemented by Family Health International (FHI)) introduced for example the "Ready Body" outreach campaign while another 25 Governmental and Non-Governmental partners under the "Youth and HIV/AIDS" project funded by UNICEF targeted community-based interventions with children, adolescents and youth between the ages of 8 and25.

HIV/AIDS has become a significant area of NGO involvement and includes Information, education and Communication (IEC) and Care, Treatment and support programming. This development has seen the workplace being targeted through the IEC programme of NAPS and the Min LHSSS. Sensitization of the general public, health care providers, youths, employers, employees, entertainers and female commercial sex workers has been carried out.

There has also been a media initiative for responsible journalism and strong networking with NAPS undertaken. A pilot project for PMTCT was initiated at 8 pilot sites and expanded to include 24 sites in Regions three, four, six and ten**.** The Guyana Pharmaceutical Corporation (GPC) has begun production of antiretroviral drugs (ARVs) and the Ministry of Health's GUM clinic initiated a treatment programme with ARVs.

The issue of OVC in the Guyana Plan

Guyana's National Strategic Plan of Action for HIV/AIDS 2002-2006 also takes into account the issue of OVC, albeit fleetingly. In looking at care, treatment and support, the Expected Results is aimed at addressing the establishment of support services to complement the care and treatment of persons living with HIV/AIDS (PLWHA). One section of the plan projects that "by 2005 at least 50% of PLWHA who cannot provide for themselves and families receiving social assistance." [16] The plan is being implemented by the Ministry of Health as part of a larger plan for health care in Guyana. Within the National Plan of Action for HIV/AIDS, OVC are addressed indirectly in the section that deals with Care, Treatment and support.

The percentage of children absorbed into families and communities is not yet determined in Guyana. The latest Children at the Brink Report[17] estimates that 4,000 children, or 9% of all children in Guyana, are orphaned. More extensive research needs to be carried out to capture

[16] Guyana's National Strategic Plan for HIV/AIDS 2002-2006, Government of Guyana.
[17] Children at the Brink 2004; A joint Report of New Orphan Estimates and a Framework for Action, UNAIDS, UNICEF, USAID

a true representation of the numbers of OVC and where they are. However, increasingly, there are anecdotal stories about the burden of caring for these children being placed on both government owned and privately owned orphanages. The stigma, economic strains and organizational challenges of caring for these children limit the response.

Factors that put Children at Risk of Being Orphaned or Becoming Vulnerable

Children and adolescents who are orphaned by the HIV/AIDS epidemic or other causes are generally from families who have experienced the consequences of poverty, lack of access to services, discrimination and family disruption. These children are most often cared for solely by their mother, with or without the assistance of other family members such as a grandmother. Around the world there are children who lose their parents, either permanently or temporarily, children who experience natural and man made disasters, as well as pandemics and various forms of abuse. This is no different for Guyanese children. The factors that put our children at risk of being orphaned or becoming vulnerable are basically the same.

Poverty

All children have physical and material needs, intellectual and educational needs, and psychological needs. Children affected by HIV/AIDS are particularly vulnerable in all these areas, as they take on adult household, parenting and caring responsibilities. They face decreased access to adequate nutrition, education, basic health care services, housing and clothing. The impact of HIV/AIDS on children, families, communities and countries are products of many interrelated factors and require responses that vary by family, community and country.[18]

Guyana has its own domestic problems. The country's poverty is a product of constraints on choices at all levels- national, regional, community and individual.[19] In 1999, 36% of the population was said to be living in poverty, while 19% were said to be living in absolute poverty.[20]

Migration

Guyana can be considered socially vulnerable since there is a high level of migration with a reported 20 000 persons leaving Guyana annually. One daily newspaper quoted Dr. Manuel Brozco who in referring to a 1992 report, said that he found that at least 20 000 people were leaving Guyana annually for the United States of America, the United Kingdom and Canada. The newspaper article went on to further state that a senior immigration official in Guyana put the yearly number at 50 000. This number has since been challenged by various sources. The same article also mentioned that the current USA census at that time had listed between 200,000 and 220,000 Guyanese living in the USA.[21] The United Nations Development Programme has also been quoted by the Guyana Chronicle as saying that Guyana's population

[18] Conducting a Situational Analysis of Orphans and Vulnerable Children Affected by HIV/AIDS. Williamson John; Adsianne Cox; Beverly Johnson. February 2004 (USAID)
[19] Report of the Mid-Term Review of the GOG/UNICEF country programme of cooperation 2001-2005
[20] Guyana: Report of the 1999 Living Conditions Survey, UNDP
[21] Guyana Chronicle. Friday November 8th, 2002.

exhibits one of the highest net migration rates in the Caribbean. [22] The Preliminary Report of the 2002 Guyana Population and Housing Census[23] indicates a household population growth of only 3.29% from 1991 to 2002 with the highest percentage of growth in the hinterland regions and low and even a negative household population growth in the urban regions of Guyana

HIV / AIDS

The rising rate of HIV/AIDS within Guyana is now regarded as the single most significant factor that will see almost 9,000 children being orphaned from HIV/AIDS by 2010[24]. This is a projected increase of approximately 5000 children who will lose their parent(s) to the disease. In addition to the children who will lose their parents to HIV/AIDS, are the increasingly number of children who themselves will be born with the virus. In terms of the number of children being born with the HIV virus and who were able to access medication, the Ministry of Health says 12 children got cotrimoxazole prophylaxis in 2001. Five were given between September 2002 and August 2003.[25] So far, between 1992 and 1997, 4-7% of pregnant women tested positive for HIV. In 2001, one percent is reported as having tested positive.[26] Unlike other factors, HIV/AIDS is more likely to cause the death of both parents within five years of each other, according to Mark Connolly, UNICEF Child Protection Advisor in New York[27]. Statistics presented in the Children on the Brink Report[28] states that in the case of double Orphans (children who have lost both parents), the number of non-HIV/AIDS related orphans stayed stable from 1990 to present and is projected to hold this trend into 2010. On the other hand, for those orphaned through HIV/AIDS, no cases were reported from 1990 to 2000. In 2001, there were 100. This figure is expected to increase significantly to 1000 by next year. Based on the report, the figure for 2010 will remain the same as 2005. In the case of children orphaned through reasons other than HIV/AIDS, there are approximately 22,000 OVC.

The loss of one of both parents is one of the single most devastating factors that contribute significantly to children falling into the category of being vulnerable. The death of a parent means that children are often left without the same level of care that was provided by the parent(s). For many children this translates into being deprived of individualized love, affection, attention and care. Other experiences for children include psychological trauma, that often is not acknowledged or dealt with – as was seen with a number of children interviewed; dropping out of school or attending school inconsistently; being targeted for stigma and discrimination (especially where the parents died from HIV/AIDS related illnesses, and to a lesser degree, suicide); increased physical, verbal, emotional and sexual abuse which in some cases has led to an increased risk of HIV infection; and child labour.

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[22] Guyana Chronicle. Friday November 8th, 2002.
[23] Preliminary Report: 2002 Guyana Population and Housing Census, Bureau of Statistics, The Cooperative Republic of Guyana.
[24] UNAIDS/USAID/UNICEF,2002
[25] Coverage of Essential HIV/AIDS Services, National Questionnaire-Guyana, USAID/WHO/UNAIDS/CDC/WORLD BANK, Oct 2003
[26] WAB, 2003
[27] Mark Connolly, OVC Estimate Presentation, March 6, 2004, Georgetown, Guyana
[28] Children on the Brink 2004. A Joint Report on New Orphan Estimates and a Framework for Action, UNAIDS, UNICEF and USAID

Not unlike other parts of the world. The illness, death or absence of a parent means that the family's ability to provide economically for itself is negatively affected. Therefore, the needs of the children are correspondingly affected. Increasingly this means that more and more children are forced to take on the considerable responsibility of supporting their family. During the OVC Assessment, researchers also found a number of homes where children were responsible for taking care of themselves and siblings. In one community, residents were quick to take researchers to a home where an eight- year old girl was the primary caregiver to four-month-old twins.

In an interview, the child related that her mother, whom she described as being drunk, had taught her all of the time, to take care of her four month old siblings. She described her chores as having to bathe, feed and supervise other aspects of their care on a 24- hour basis. Her only relief from this responsibility was when she was instructed to go and assist her ten and eleven year old brothers with selling produce they had gotten from neighbours. The girl also spoke of being regularly raped by her ten- year old brother, often when her mother was passed out drunk on the floor. She said her brother would pull her under the bed in the middle of the night and rape her. When she cried out for her mother, she said, her mother would often be asleep or singing loudly after consuming some amount of alcohol, and not come to her rescue. She asked researchers to have her brother removed from the home and to get help for her mother. When asked about her father she was unable to say where he was. At the time of writing this report, it was reported that the twins were hospitalized and the doctor in charge of their care was trying to assist the mother with dealing with her alcoholism.

Child Labour

In looking a bit closer at the issue of child labour, information presented indicates that 27% of children between the ages of 5-14 years old were currently working. The 2001 Report of Multiple Indicator Cluster Survey (MICS) notes that 16 % of this group worked in family owned and or operated businesses or farms, while 13% were not paid for their work. Boys were reportedly more likely to be working than girls. The report also noted that children who work are less likely to attend school, a factor that "contributes to the child being disadvantaged and trapped in a cycle of impoverishment." [29] There are also very few rules and regulations governing the conditions under which children work, not withstanding the fact that legally, they should be in school. Nineteen percent of children between 5-14 years were involved in child labor activities between 1999 and 2001. [30]

In a 2003 report done by the International Labour Organisation (ILO) on child labour in Guyana, it was reported that, "the worse forms of child labour exist in a widespread way in Guyana.[31] The ILO report found that the number of children who were below 18 years old, and working was more likely double the number quoted by the MICS survey. Using statistics compiled for the Assessment, the ILO's report said 25-40% of children in Charity (Region 2) and its environs were child labourers. Those interviewed at Parika (region 3) estimated that 15-20% of children in that area, and possibly more, were child labourers. For Georgetown, the number given was 30%, while Corriverton (Region 6) was listed as 15-20%, Bartica (Region 7)

[29] Report of Multiple Indicator Cluster Survey Guyana, Bureau of Statistics, July 2001.
[30] The State of the World's Children 2004. UNICEF
[31] Estimates of Child Labour by Community Informants. ILO 2003

as 15-25%, St. Cuthbert's Mission (Region 4) 50%, and Black Bush Polder (Region 6) as 35-75%.

Children falling into the categories of "street children", child victims of prostitutions and children from remote Amerindian communities were among those said to suffer the worse forms of abuse. It was also reported that 64% of the children interviewed worked between 7-18 hours per day. The children were also said to suffer a range of abuses including verbal abuse (22%), harassment (14%), and being injured on the job (22%). Seventy-seven percent of the children reported being sexually active with more than one sexual partner.[32]

The Impact of HIV/AIDS on OVC

The social and economic impact of AIDS threatens the well-being and security of millions of children. Many children face the harsh realities of being on the streets trying to provide for other members of the family. Usually, these children are traumatized, as they try to help, only to witness one parent, then often the other, grow ill and die. These children impacted by HIV/AIDS are also at serious risk of exploitation, including physical and sexual abuse, some engage in risky sexual behaviour and feel isolated from emotional connections with their families.[33] This is compounded by their exposure to malnutrition, child labour and stigma and discrimination.[34]

UNICEF has identified eight key characteristics of the profound impact AIDS has on the lives of affected children. They are as follows:

1. Children suffer profoundly as their parents fall sick or die
2. Psychological distress. Their parents' illness and death cause extreme psychological distress, worsened by the pervasive stigma and shame attached to HIV/AIDS
3. Economic Hardship. With parents unable to work, savings are spent on care and children are forced to take on frightening adult responsibilities of supporting the family.
4. Withdrawal from school. The pressures of earning for and caring for parents and siblings can lead children to withdraw from school, even while their parents are living. There are pressures to abandon schooling when one or both parents die.
5. Malnutrition and illness. Orphans and other affected children are more likely to be mal nourished of fall ill, and less likely to get medical treatment. Poverty is the root cause, but neglect and discrimination by adults in whose care they have been left are also important factors.
6. Loss of inheritance. Orphans are regularly cheated out of their inheritance.
7. Fear and isolation. Dispossessed orphans are often forced out to unfamiliar and hostile places.
8. Increased abuse and risk of HIV infection. Impoverished and without parents to educate and protect them, orphans and affected children face every kind of abuse and

[32] Report of the Mid-Term Review of the Government of Guyana/UNICEF Country Programme of Cooperation 2001-2005

[33] National Plan of Action for Orphans and Other Children made Vulnerable by HIV/AIDS in Jamaica 2003-2006. Child Development Agency (Ministry of Health)

[34] Young People and HIV/AIDS: Opportunity in Crisis 2002. UNICEF, UNAIDS and WHO

risk including HIV infection. Many are forced into exploitative and dangerous work-including exchanging sex for money, food, "protection" or shelter.

Children are affected by HIV/AIDS in ways that can diminish their childhood and as a result, limit choices and opportunities for successful survival throughout their lives. These children experience challenges in their lives in various ways. They have to make adjustments and become adults at a very young age, as well as recognize the need to provide for their families and other siblings. Instead of receiving special care and assistance, their childhood is spent providing care and assistance. They become the decision makers, responsible for the economic and social future of their families. They are forced to fill these roles without sufficient emotional and physical protection they should receive as a child.

As is pointed out in the final draft of the report titled "A framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS 2004, [35] "with so much against them, orphans and other children affected by HIV/AIDS are frequently marginalised and may quickly become the most vulnerable members of society". The presence of HIV/AIDS in family members, particularly caregivers, increases the risk of children becoming vulnerable to a number of situations.

Other Factors

Outside of HIV/AIDS there are other indicators that should be mentioned. The latest UNICEF report that examines the realities of children around the world noted that for every 16 births in Guyana, one child under five dies. Twelve percent of infants are born with low birth weight and 14% of children under five are underweight. Eleven percent suffers from moderate to severe stunting (caused mostly by malnutrition), while in excess of 90% have been immunized. Over 85 % of children go to Primary school, with at least 80 percent of this number enrolling for secondary school. There is also the issue of street youth and street-involved youth but there are no statistics available for this group on a country- wide level.

[35] "A Framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS" – final draft, UNICEF, Feb 2004.

Reference

3. Care for Orphans, Children Affected by HIV/AIDS and other Vulnerable Children: A Strategic Framework. June 2001. FHI/USAID
4. Care for Orphans, Children Affected by HIV/AIDS and other Vulnerable Children: A Strategic Framework. June 2001. FHI/USAID
6 Coverage of Essential HIV/AIDS Services, National Questionnaire-Guyana, USAID/WHO/UNAIDS/CDC/WORLD BANK, Oct 2003
7 State of the World's Children 2002,UNICEF.
8 Care for orphans, children affected by HIV/AIDS and other vulnerable children: A strategic framework, FHI/USA. June 2001.
9 Guyana Chronicle. Friday November 8th, 2002.
10 Guyana Chronicle. Friday November 8th, 2002
11 FHI/IOMPACT/USAID 2000
12 Children at the Brink 2004; A joint Report of New Orphan Estimates and a Framework for Action, UNAIDS, UNICEF, USAID
13 Guyana Review Vol 12 Nos. 133&134 January & February, 2004
14 Caring for People with HIV/AIDS in the Caribbean; Tony Fraser: http://www.prb.org (4/29/2004)
15 Guyana's National Strategic Plan of Action for HIV/AIDS 2002-2006, Government of Guyana
16 Guyana's National Strategic Plan of Action for HIV/AIDS 2002-2006, Government of Guyana.
17 Children at the Brink 2004; A joint Report of New Orphan Estimates and a Framework for Action, UNAIDS, UNICEF, USAID
18 Conducting a Situational Analysis of Orphans and Vulnerable Children Affected by HIV/AIDS. Williamson John; Adsianne Cox; Beverly Johnson; February 2004 USAID)
19 Report of the Mid-Term Review of the GOG/UNICEF Country Programme of Cooperation 2001-2005
20 Guyana: Report of the 1999 Living Conditions Survey, UNDP
21 Guyana Chronicle. Friday November 8th, 2002.
22 Guyana Chronicle. Friday November 8th, 2002.
23 Preliminary Report: 2002 Guyana Population and Housing Census, Bureau of Statistics, the Cooperative Republic of Guyana.
24 Children at the Brink 2004; A joint Report of New Orphan Estimates and a Framework for Action, UNAIDS, UNICEF, USAID
25 Coverage of Essential HIV/AIDS Services, National Questionnaire-Guyana, USAID/WHO/UNAIDS/CDC/WORLD BANK, Oct 2003
26 WAB, 2003
27 Mark Connolly, OVC Estimate Presentation, March 6, 2004, Georgetown, Guyana
28 Children on the Brink 2004. A Joint Report on New Orphan Estimates and a Framework for Action, UNAIDS, UNICEF and USAID
29 Report of Multiple Indicator Cluster Survey Guyana, Bureau of Statistics, July 2001.
30 The State of the World's Children 2004. UNICEF
31 Estimates of Child Labour by Community Informants. ILO 2003

32 Report of the Mid-Term Review of the Government of Guyana/UNICEF Country Programme of Cooperation 2001-2005
33 National Plan of Action for Orphans and Other Children made Vulnerable by HIV/AIDS in Jamaica 2003-2006. Child Development Agency (Ministry of Health)
34 Young People and HIV/AIDS: Opportunity in Crisis 2002, UNICEF, UNAIDS and WHO
35 "A Framework for the protection, care and support of orphans and vulnerable children living in a world with HIV and AIDS" – final draft, UNICEF, Feb 2004Glossary

Glossary

AIDS	Acquired Immune Deficiency syndrome
ARV	Anti Retro Viral
CAREC	Caribbean Epidemiology Centre
CBO	Community Based Organization
CVD	Cardio Vascular Disease
FBO	Faith Based Organization
FHI	Family Health International
G+	Guyanese Network of Persons Living with HIV/AIDS
GPC	Guyana Pharmaceutical Corporation
GPRA	Guyana Responsible Parenthood Association
GTZ	German Technical Agency
GUM	Genito Urinary Medicine Clinic
GYN+	Guyanese Youth Network Plus
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
IHD	Ischaemic Heart Disease
ILO	International Labour Organization
LCF	Linden Care Foundation
Min. LHSSS	Ministry of Labour, Human Services and Social Security
NAPS	National AIDS Programme Secretariat
NGO	Non-Governmental Organization
NOC	New Opportunity Corps
OVC	Orphans and Vulnerable Children
PLWHA	Persons living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Disease
UNICEF	United Nations' Children Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
YPLL	Years of Potential Life Loss

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