PROGRAMME SUMMARY	
Implementing Agency	United Nations Population Fund Sub-Regional Office for the Caribbean through the UNFPA Liaison Office in Guyana
Donor Agency	India UN Development Partnership Fund (UNDPF)
Project title	Reducing Adolescent Pregnancy in Guyana
Project Duration	3 years (July -2019 to June-2022)
Relation to SDGs	SDG 3: Good health and well-being SDG 5: Gender Equality SDG 10: Reduced Inequalities
UN classification	Small Island Developing State
Objectives	The goal is to reduce adolescent pregnancy in these two Regions by 10% by the March of 2022
Amount needed	$ 559,496.00 USD
Outcomes and Outputs	**Outcome 1**: Increased use of quality Adolescent Sexual and Reproductive Health services by adolescents of communities of Regions # 1 & # 9. - Output 1.1: Adolescents of Regions # 1 (Barima - Waini) and # 9 (Upper Takutu - Upper Essequibo) have improved access to ASRH information and quality services in their communities - Output 1.2: Strengthened inter-sectoral and intra-sectoral coordination for an enabling environment towards adolescent sexual and reproductive health **Outcome 2**: Adolescents, in particular adolescent girls, in communities of Regions # 1 (Barima - Waini) and # 9 (Upper Takutu - Upper Essequibo) are empowered to prevent adolescent pregnancies. - Output 2.1: Adolescent girls and adolescent boys in Regions # 1 (Barima - Waini) and # 9 (Upper Takutu - Upper Essequibo) have enhanced capacities to make informed decisions about their sexual and reproductive health and to demand for services. - Output 2.2: Accountability mechanisms for local government entities are strengthened for coordination and implementation of prevention and response programmes to end teenage pregnancies
Geographical coverage	Region 1 (Barima - Waini) and Region 9 (Upper Takutu - Upper Essequibo), two rural regions in Guyana.
Implementing partners	The Ministry of Public Health (central and decentralized levels) will be the main implementing partner of the interventions proposed, in partnership with Guyana Responsible Parenthood Association (GRPA) and other key line Ministries.

Agreed by:

For UNFPA	For UN	For Government
Alison Drayton Director & Representative, UNFPA SRO for the Caribbean	Mikiko Tanaka UN Resident Coordinator	Hon. Volda Lawrence Minister of Public Health
Date: 4 June 2019	Date: 7 June 2019	Date: 07-06-2019

REDUCING ADOLESCENT PREGNANCY IN GUYANA

India - UN Funds Project Document

ABSTRACT

Guyana has the highest rate of adolescent pregnancy in the English-speaking Caribbean. The adolescent fertility rate is well above the Latin America and the Caribbean average, especially among Indigenous girls. This proposed programme aims to contribute to reducing adolescent pregnancy in Regions 1 and 9 of Guyana.

Ministry of Public Health (MoPH) in Guyana and the United Nations Population Fund (UNFPA)

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ACRONYMS

AHU	Adolescent Health Unit Adolescent Health Unit
AIDS	Acquired immunodeficiency syndrome
ASRH	Adolescent Sexual and Reproductive Health
CSO	Civil Society Organizations
FBO	Faith Based Organizations
EC	Emergency Contraception
ECLAC	Economic Commission for Latin America and the Caribbean
FACE	Funding Authorization and Certificate of Expenditure
GBV	Gender Based Violence
GDP	Gross domestic product
GII	Gender Inequality Index
GoG	Government of Guyana
GRPA	Guyana Responsible Parenthood Association
HACT	Harmonized Approach to Cash Transfer
HDI	Human Development Index
HF	Health Facility
HIES	Household Income and Expenditure Survey
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
ISF	Integrated Strategic Framework
LAC	Latin America and Caribbean
LTA	Long Term Agreements
MCH	Maternal and Child Health
MICS	Multi Indicator Cluster Survey
mCPR	Modern Contraceptive Prevalence Rate
MoE	Ministry of Education
MoIPA	Ministry of Indigenous People's Affairs
MoPH	Ministry of Public Health
M&E	Monitoring and Evaluation
NGOs	Non- Governmental Organizations
PAHO	Pan American Health Organization
PTA	Parent-Teacher Association
PSB	Procurement and Service Branch
RDC	Regional Democratic Council
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TBD	To be Defined
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UNOSCC	United Nations Office for South-South Cooperation
WAD	Women Across Differences
WHO	World Health Organization
WRA	Women of Reproductive Age

Executive Summary

Guyana has the highest rate of adolescent pregnancy in the English-speaking Caribbean[1]. Persons aged 10-24 account for the largest proportion (31%) of the population. The adolescent fertility rate is estimated at 74 births per 1,000 girls aged 15-19 - well above the Caribbean average of 60.2[2]; with Regions 1,7, 8 and having unacceptable high rates and indigenous girls experiencing the highest rates among all ethnic groups[3]. This proposed programme aims to improve the availability of and access to quality sexual and reproductive health information and services (including commodities) for adolescents. The proposed programme also aims to empower communities, parents and adolescents to prevent adolescent pregnancy in Regions 1 and 9 in Guyana. Region 1 and Region 9 are rural areas in Guyana and home to many Indigenous communities. The goal is to reduce adolescent pregnancy in these two Regions by 10% by March 2022; thereby aiding Guyana's efforts to realise Goals 3 (Good Health & Well-Being), 5 (Gender Equality), and 10 (Reduced Inequalities) of the Sustainable Development Goals (SDGs).

1. Situation Analysis

1.1 Political and socio-economic context

Guyana, the only English-speaking country in South America, shares its history and culture with the Commonwealth Caribbean. Bordered by Suriname, Brazil and Venezuela, Guyana's economy thrives on agriculture (mainly rice and sugar), gold mining and logging. It is classified as an upper-middle income economy and one of the fastest developing countries in the western hemisphere. Guyana has made drastic economic progress over the last few decades with 3.3 % annual GDP growth in 2016 and average annual growth of 4.2 % (World Bank, 2018). The largest gold declaration in the nation's history and higher international prices also contributed to its recent economic growth, which was estimated at 3.8 % in 2017. (ECLAC, 2017).

Guyana is divided into ten administrative regions with 72.4 % of the population concentrated in rural areas, of which 63.6 % of the population lives in rural coastal areas.[4] Most of the

[1] CARICOM. (2014). *CARICOM Integrated Strategic Framework for the Reduction of Adolescent Pregnancy in the Caribbean*; and UNFPA *Sexual & Reproductive Health Thematic Brief*, available on the UNFPA website at <https://caribbean.unfpa.org/en/news/sexual-reproductive-health-thematic-brief>

[2] PAHO/WHO. (2018). *Situation Analysis of Adolescent Pregnancy in Guyana*.

[3] UNICEF. (2017). *Study on Indigenous Women and Children in Guyana*, UNICEF. Available online at: <https://www.unicef.org/guyana/SitAn_on_Ameridian_Woman_and_Children_-_Final-web.pdf>

[4] *Guyana Population and Housing Census 2012.* Available online at: <*http://www.statisticsguyana.gov.gy/census.html*>

population, 89.1 %, is concentrated in coastal areas. People aged 10-24 account for 31 %, the largest proportion, of the population of approximately 764,955 people[5]. There is a high incidence of migration to coastal areas by young adults looking for better economic opportunities.[6] Guyana has a vast forested terrain, much of which is uninhabited or inhabited by Indigenous Peoples. Many of these areas are difficult to access, many are only accessible by small plane or boat, and many lack the facilities and services that exist in more developed areas of the country. This makes it difficult and costly to reach some populations, particularly hinterland communities, with the level and extent of services that they need.

Figure 1: **Administrative and Geographic Map of Guyana**

According to the *Guyana Population and Housing Census 2012*[7] the ethnic composition of the population is 39.8 % East Indians, 29.2 % people of African descent, 19.9 % mixed race people, and 10.5 % Indigenous People. Unlike the East Indian and African populations which are experiencing a decline, the Indigenous population is growing. The three major religions are

[5] *ibid*

[6] *ibid*

[7] *ibid*

Christianity, Hinduism and Islam – almost 64 % of people identify as Christian, approximately 25 % are Hindu, and nearly 7 % are Muslim.

A Partnership for National Unity (APNU) and Alliance for Change (AFC), the coalition of political parties which won the 2015 general elections, comprise the current Government. These parties have expressed a commitment to fighting corruption and improving efficiencies in the political system. The Government focuses heavily on poverty reduction, targeting the most vulnerable and marginalised populations, such as Indigenous people, who mainly reside in hinterland areas, as well as rural and impoverished urban area. Climate change adaptation is one of the Government's areas of focus, with the aim being to reduce the impact on poor households of frequent flooding and other natural disasters associated with rising sea levels (World Bank, 2016).

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

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

Source: Guyana National Bureau of Statistics, 2012 Census

Despite its remarkable economic growth, Guyana is challenged by significant inequality. Guyana's human development index (HDI) value for 2015 was 0.638 - which places the country in the medium human development category - positioning it at 127 out of 188 countries and territories. However, when one discounts the value for inequality, the HDI falls to 0.518 with an overall loss of 18.8 %. According to the 2016 Human Development Report, the inequality in life expectancy at birth was 20.7 %, in education and income it was 10.5 % and 24.4 % respectively in 2015. Moreover, the Human Development Report indicates that almost 7.8 % of the population are multi-dimensionally poor and an additional 18.8 % live near

multidimensional poverty, suffering from overlapping deprivations in health, education and living standards. There are also significant geographical disparities in poverty. Gender disparities persist in the country, with a Gender Inequality Index (GII) value of 0.508, ranking it 117 out of 159 countries in the 2015 index reflecting deep gender-based inequalities in reproductive health, empowerment, and economic activity. In Guyana, 30.4 % parliamentary seats are held by women, and 68.1 % of adult women have reached at least a secondary level of education compared to 53.2 % of their male counterparts. Female participation in labour market is 41.8% compared to 77.2% for men. In 2017, female unemployment rate was 16.5% whilst, male and total unemployment rate is 9.3% and 11.8% respectively.

1.2 Problem analysis

1.2.1 Population dynamics and SRH (focusing on Adolescent SRH)

Guyana has experienced a population growth over the last decade. Among the population, people aged 10-24 account for the largest proportion for 31%. Life expectancy at birth for females and males is 68.9 years and 64.2 years respectively[8]. The country has achieved improvements in child health and sexual and reproductive health. The under-five mortality rate has fallen off to two-thirds and maternal mortality is on a decreasing trend, as part of an effort to ensure universal maternal care coverage. The high skilled birth attendance (at 92.4 % MICS 2014) have contributed to such progress.[9] However, despite the progress, maternal mortality is the second highest within Latin America and Caribbean (LAC) region, at 229 per 100,000 births in 2015 and child mortality rate is also the second highest in the region at 32.4 per 1,000 live births in the same year.[10]

Efforts to improve adolescent sexual and reproductive health (ASRH) are vital in tackling the country's health challenges as young people aged 10-19 account for approximately 20 % of the population. Adolescent pregnancy as a percentage of all pregnancies in Guyana has remained between 19% and 22% from 1997-2016[11]. According to MICS 2014, adolescent fertility rate at 74 births per 1,000 girls aged 15-19 which is well above the Latin America and the Caribbean

[8] UNDP. (2016). Human Development Report, 2016.

[9] UNFPA. (2017). State of the World's Population Report, 2017. Available online at: <https://www.unfpa.org/swop>

[10] WHO. (2015). Trends in Maternal Mortality: 1990 to 2015 – estimates by World Health Organisation, United Nations Children's Fund, United Nations Population Fund, World Bank Group and the United Nations Population Division. Available online at: <http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/>

[11] PAHO/WHO. (2018). Situation Analysis of Adolescents in Guyana.

average of 60.2[12]. There are socio-economic, regional and ethnic differences in the rates of adolescent pregnancy with regions 1,7,8,9 having higher rates than others (187 versus 49 in region 10), as well as rural areas having higher rates that urban areas (81 versus 55)[13]. The Indigenous Peoples have had the highest rates compared to the other ethnic groups, as do girls from the lowest wealth quintile and lower educational background. Underlying and root causes identified for adolescent pregnancy by the 2014 MICS include inequities such as poverty, lack of comprehensive sexuality education, lack of access to contraceptives, early initiation to sex which almost invariably was associated with unprotected sex, sexual violence and abuse, high secondary school dropout rates, living in overcrowded households, and living in female-headed single-parent households.[14] Factors contributing to adolescent pregnancy in Guyana also include lack of economic opportunities, alcohol consumption, the "minibus culture" where adolescents engage in sexual activity with minibus drivers and conductors, and school dropout.

The survey[15] also shows that 11.2 % of girls aged 15-19 have had a live birth and 15.8 % of women aged 20-24 have had a live birth before age 18. The early child bearing is more prominent in rural areas, where 12.1 % of girls aged 15-19 have already had a live birth and 17.2 % of women aged 20-24 have had a live birth before age 18, whilst the percentage for the same indicators are 8.7 % and 12.0 % in urban areas.[16]

[12] PAHO/WHO, UNFPA & UNICEF. (2017). *Accelerating Progress toward the reduction of Adolescent Pregnancy in Latin America and the Caribbean.*

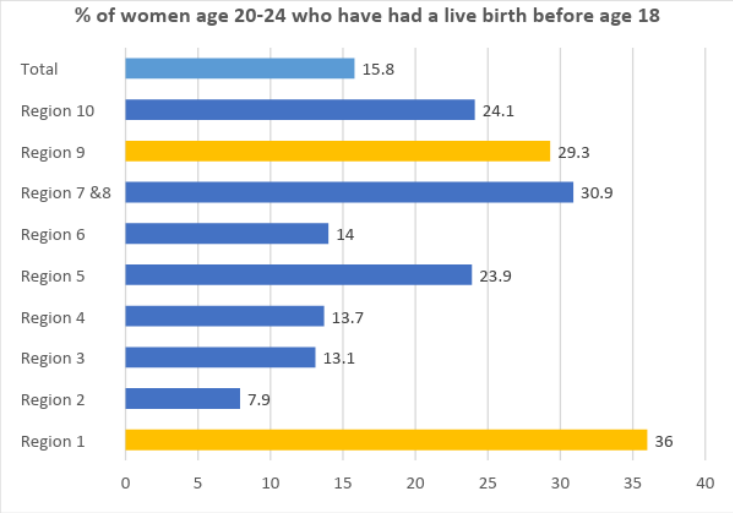
[13] Bureau of Statistics, Ministry of Public Health and UNICEF. (2015). *Guyana Multiple Indicator Cluster Survey 2014*, Final Report. Available online at: <http://mics.unicef.org/news_entries/57/GUYANA-2014-MICS-FINAL-REPORT-&-DATASETS-RELEASED>

[14] UNICEF. (2017). *Study on Indigenous Women and Children in Guyana*. Available online at: <https://www.unicef.org/guyana/SitAn_on_Ameridian_Woman_and_Children_-_Final-web.pdf>

[15] Ibid 11.

[16] *Ibid 11*.

Figure 2: Early childbearing

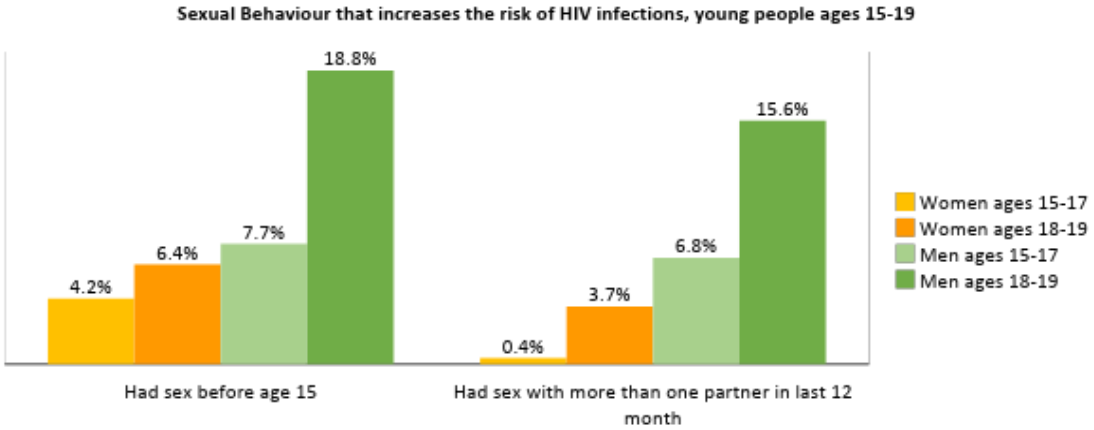


(Source: Bureau of Statistics, Ministry of Public Health and UNICEF. 2015. Guyana Multiple Indicator Cluster Survey

2014, Final Report. Georgetown, Guyana: Bureau of Statistics, Ministry of Public Health and UNICEF) (note: Region 2 based on 25-49 unweighted cases)

To prevent such early childbearing as well as to delay a second pregnancy among adolescents, delaying sexual debut and ensuring the access and use of contraception where and when necessary is essential. However, the trend of early sexual debut reveals a real challenge for adolescent pregnancy reduction as well as HIV and Sexually Transmitted Infections (STI) prevention. More than one third of girls (33.1 %) and boys (37.6 %) aged 15-19 ever had sex[17]. Among them, 5 % of women and 11.9 % of boys had sex before age 15. In addition, the percentage of girls and boys aged 15-19 who had sex with more than one partner in last 12 months is 1.6 % and 10.1 % respectively. The following bar chart brings together two critical behaviours that are known to increase the risk of HIV among adolescents (girls and boys aged 15-19) – sex before age 15, and sex with multiple partners.

Figure 3: Sexual behaviour

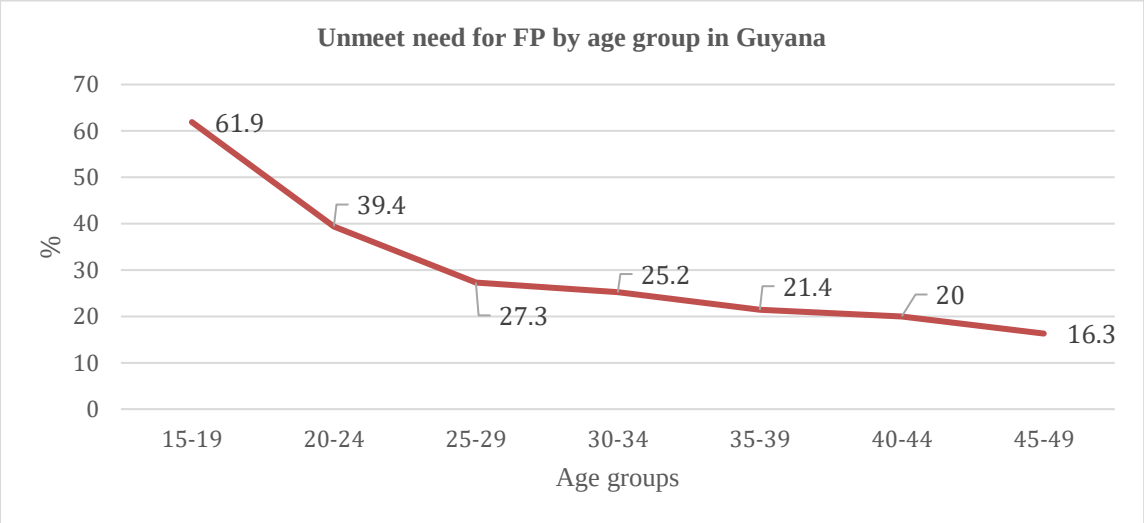


(Source: MICS 2014)

[17] *Ibid 11*

Guyana's Multiple Indicator Cluster Survey (MICS)[18] indicates that use of contraception among girls aged 15-19 is significantly lower than other age groups. Modern contraceptive prevalence rate (mCPR) is 12.4 % among girls aged 15-19. It is not surprising that the percentage of girls aged 15-19 with an unmet need for family planning is 61.9 %, which is more than twice as high as total unmet need for family planning (28 %).

Figure 4: *Unmet need for FP by age group*



(Source: MICS 2014)

Whilst national HIV prevalence is relatively low, 1.6 % in 2016 (UNAIDS, 2018), AIDS remains one of the leading causes of death. In 2014, a total of 751 cases were reported, of which 61.7 % was reported within age group of 25-49 (Guyana Presidential Commission on HIV/AIDS, 2015). Recent data also demonstrates that HIV prevalence among the 15-19 and 20-24 age groups fluctuated between 2.9% and 3.5% in the former age group and 11.5% and 11.9% in the latter group (ibid).

As part of the efforts towards HIV prevention, comprehensive knowledge about HIV and AIDS of the population is required. According to the most recent MICS[19], the percentage of young women and men aged 15-24 with comprehensive knowledge of HIV is 51.5% and 40.2% respectively. It also indicates that adolescents (aged 15-19) have lower comprehensive knowledge of HIV compared with the 20-24 age group. Such a gap is also demonstrated in the HIV testing rate. 68.4 % of females and 50.4 % of males aged 20-24 reported that they have

[18] *Ibid 11*.

[19] Ibid 12

ever been tested, whilst the rate for girls and boys aged 15-19 are 28.8% and 16.8% respectively.

1.2.2 Health system

The *Constitution of the Cooperative Republic of Guyana* 1980 specifically guarantees the right to health of Guyana's population, with Article 40 (1) guaranteeing the economic accessibility of health services by providing that "every citizen has the right to free medical attention". Accordingly, public health care is primarily financed by the government with significant contributions from the donor community. Public health care services in Guyana are offered free of charge to all persons accessing these services without any requirement for the presentation of proof of identification. The 2008 *Regulations made under The Health Facilities Licensing Act 2007,* provides at *section 13* that all persons seeking service at a health facility (public or private) shall be treated equally regardless of age, place of birth, race, creed, nationality, gender and sexual orientation.

The Ministry of Public Health (MoPH) is responsible for stewardship (setting policy, regulation, and standards) and for building and initial furbishing of facilities and financing the employment of health professionals in the public health sector. However, each of the ten administrative regions (under the Ministry of Communities) is responsible for the day-to-day management of the facilities and employment of all other staff working in the health sector in their respective regions. The Ministry of Public Health usually has Service Level Agreements with all public hospitals, ensuring that public health services are developed in line with the central Government's National Health Plan. There are five levels of health care: 1) health post, 2) health centre, 3) district hospital, 4) regional hospital, and 5) national referral hospital. Programmes and interventions for the provision of SRH services are available at all levels of the public health sector, at private healthcare facilities and at some non-governmental organizations.

The Georgetown Public Hospital is the national referral hospital. There are 350 health facilities, of which 344 are public. The private health care sector operates independently but is subject to regulations ensuring standards of care and practice. There is significant involvement of NGOs in service delivery related to HIV/AIDS. A small pharmaceutical industry exists in the country producing a range of medicines, including antiretroviral treatments for HIV. There is no national health insurance, but a national insurance scheme exists which provides some health insurance benefits.

The Ministry of Public Health's *Health Vision 2020: A National Strategy for Guyana, 2012-2020*, in addressing service priorities for improved health outcomes, highlights the need to strengthen facilities and capacities to promote sexual and reproductive health to, among other things, promote behaviour change, increase contraceptive prevalence, develop the evidence base for targeted interventions, promote screening for sexually transmitted infections, promote health education, and enable sexual and reproductive health services to meet the needs of persons living with disabilities. The *Health and Human Resource Action Plan 2011-2016* identified shortages in areas such as registered nurses, midwives and social workers as well as challenges with planning, capacity development, attrition and workforce optimisation. Main priorities identified were the need for a Human Resource Strategy, improving the quality of pre-service training programmes, ensuring qualified staff and incentives for employee.

Health Vision 2020 aptly seeks to engage and support capacity building to Non-Governmental Organisations (NGOs), Faith Based Organisations (FBOs) and other Civil Society Organizations (CSOs) and community organizations in developing and implementing interventions. This continues a strong history of collaboration between government and NGOs. Guyana's local family planning association, for instance, the Guyana Responsible Parenthood Association (an affiliate of the International Planned Parenthood Federation) plays a key role in providing sexual and reproductive health services (including commodities) to the population, with some financial support from the Ministry of Public Health. This is a relationship which has existed for decades and which continues today. The response to HIV is a good example of Government's partnership with NGOs. Through the National AIDS Programme, the Government provides NGOs throughout the ten administrative regions with training and testing supplies to conduct outreaches, and also ensures capacity building, technical and financial support to these NGOs.

Due to the geography of the country, challenges are faced in transportation and communications in all areas of public services. This is particularly challenging for regional health services that are under-financed. In addition, there is a lack of qualified technical personnel in rural interior locations. These factors have a negative impact on the balanced delivery and availability of services. Various social, cultural and economic factors affect the delivery of health services resulting in underserved and marginalised segments of the populations, including women, migrants and adolescents.

The Ministry of Public Health has prioritised adolescent health; leading to the drafting in 2018 of Guyana's Adolescent Health Strategy which aims to ensure that every adolescent realises

his/her right to the highest attainable standard of health, social and economic opportunities, and his/her full participation in shaping prosperous and sustainable societies by 2030. Pursuant to the country's *Health Vision 2020*, the Adolescent Health Unit of the Ministry of Public Health has been engaged in strengthening its efforts to address adolescent health, with the establishment of adolescent and youth-friendly healthcare services across the country as well as the creation of three (3) specific initiatives under the leadership of the Ministry of Public Health. The three (3) initiatives are: a) Adolescent health and wellness clinics: depending on the area, certain days have been established for adolescents to reach the health facilities to access SRH information and services tailored to their age and needs; b) Adolescent Antenatal Clinics: aiming to prevent discrimination while at the same time providing all antenatal care interventions while covering the five pillars of the safe motherhood: preconception care, antenatal care, high risk pregnancy care, clean and safe delivery and postnatal care; and c) Community parenting and support groups for an enabling environment for SRH.

2. Programme Description

2.1 Problem Statement

Complications during pregnancy and childbirth are the leading cause of death for girls aged 15 to 19 globally. Pregnant adolescents face higher risks of eclampsia, prolonged labour, puerperal endometritis, and systemic infections than young women aged 20 to 24, among other complications. Millions of adolescent girls around the world put their lives at risk by undergoing unsafe abortions each year. Early childbearing also increases risks for new-borns, especially in low- and middle-income countries where babies born to mothers under 20 years of age face higher risks of low birthweight, preterm delivery, and severe neonatal conditions. Rapid repeat pregnancy in adolescents is also a concern because it presents further risks for both the mother and child.[20]

In the long term, adolescent pregnancy can also have negative social and economic effects on the girl, her child, her family, her community and country. She is likely to face stigma, rejection and even violence. She may drop out of school or be unable to further her education. Her employment opportunities and earnings are likely to be affected, resulting in the perpetuation of the cycle of poverty and national economic costs as a result of the nation losing out on the

[20] WHO. (February, 2018). Fact Sheet on Adolescent Pregnancy. Available online at: <http://www.who.int/news-room/fact-sheets/detail/adolescent-pregnancy>

annual income that each adolescent girl affected by adolescent pregnancy would have earned over her lifetime.

Globally, Latin America and the Caribbean is the region with the second highest rate of adolescent pregnancy. Guyana and the Dominican Republic have the highest rates of adolescent pregnancy in the Caribbean.

Guyana must address identified barriers for access to quality comprehensive adolescent sexual and reproductive health (ASRH) information and services in order to fight poverty and inequality as well as negative health outcomes for girls and new-borns. Interventions especially need to target Indigenous populations that have the highest rates of adolescent pregnancy when compared to the other ethnic groups in Guyana; the segment of the population who availability of and access to health services, including sexual and reproductive health services, is more limited as a result of this segment of the population inhabiting the far-flung and hard-to-access Hinterland regions of Guyana.

As highlighted in the problem analysis, a full range of complex drivers are at the root of the limited fulfilment of adolescent's sexual and reproductive rights and the concomitant adverse outcomes. This programme aims to reduce the high rates of adolescent pregnancy and of unwanted pregnancies among adolescents, contributing to reduce the large gap in early childbearing between rural and urban areas, by addressing the:

- Limited availability and access to quality sexual and reproductive health (SRH) information, education and services for adolescents
- Insufficient human resources, contraceptives and other commodities for the provision of sexual and reproductive health services for adolescents
- The limited degree of knowledge among young people about the prevention of pregnancies, HIV and STIs
- The limited control adolescent girls and young women have on their sexual and reproductive lives
- The limited support adolescents have in their communities towards the fulfilment of their sexual and reproductive health and rights
- The low level of information that adolescents have on the existence, availability and location of the ASRH services

2.2 Target group and geographic focus

Guyana has ten administrative regions. This programme seeks to target adolescents aged 10 to 19 in Region 1 (Barima - Waini) and Region 9 (Upper Takutu - Upper Essequibo), two rural regions in Guyana. The choice of Regions 1 and 9 allows the programme to cover the two regions in Guyana where women reported the lowest use of contraceptives.

Region 1 (Barima – Waini) is one of Guyana's significantly forested hinterland regions, comprising many Indigenous Peoples' settlements. Logging and gold and diamond mining are the Region's main economic activities. Based on the 2012 census, the population of Region 1 is 26,941. Guyana's last poverty measurement was conducted in 2006 using the Household Income and Expenditure Survey (HIES). It revealed that 80 % of the population of Region 1 lives in poverty – the second highest rate in Guyana. Adolescent pregnancy in Region 1 was 8.7 % in 2016; as a percentage of all adolescent pregnancies in Guyana. This reflects a rate of 105.72 births per 1,000 girls aged 15-19 (routine data). In Region 1, the proposed programme would focus on five (5) facilities at Moruka (District Hospital), Manawarin (Health Post), Warapuka (Health Post), Kubana (Health Post), and Santa Cruz (Health Post) where the Ministry of Public Health already has the three (3) active programmes that target adolescents: Adolescent Health and Wellness Clinic, Antenatal Clinic, and Community Parenting Support Group.

Region 9 (Upper Takutu - Upper Essequibo) encompasses the Kanuku and Kamoa highlands and the vast Rupununi savannahs. The forested Kanuku Mountains divide this Region into two parts. The population of 19,387[21] lives in scattered Indigenous villages and land settlement schemes. Transportation from Region 9 to the other regions of Guyana is very expensive. The people of this region mainly sell beef to Brazil, mine semi-precious stones and produce a wide variety of craft in many of the seventeen Amerindian villages. Guyana's last poverty measurement was conducted in 2006 using the Household Income and Expenditure Survey (HIES). It showed that 74.38 % of the population in Region 9 lives in poverty. Adolescent pregnancy rose from 5.9 % cent in 2015 to 7.3 % in 2016; as a percentage of all adolescent pregnancies in Guyana. This reflects a rate of 106.08 per 1,000. In Region 9, the proposed programme would focus on three (3) health facilities at Aishalton (District Hospital), Lethem (Regional Hospital) and Annai (Health Centre) where the Ministry of Public Health already

[21] *ibid*

has three (3) active programmes that target adolescents: Adolescent Health and Wellness Clinic, Antenatal Clinic, and Community Parenting Support Group.

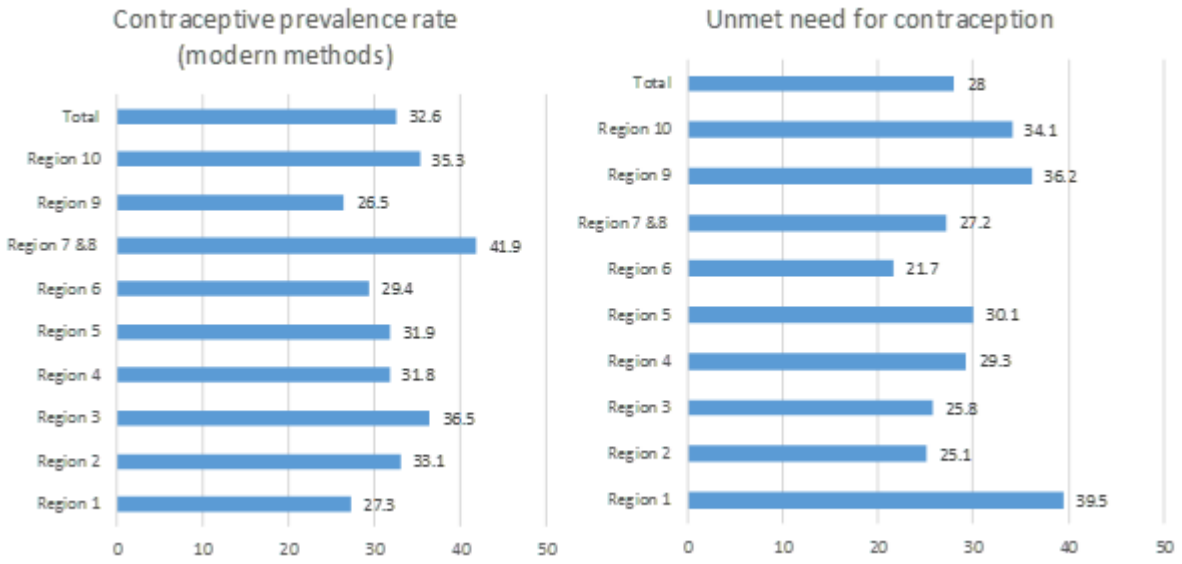
Table 2: Adolescent pregnancies and rates in Guyana by region (2015-2016)

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

Source: Ministry of Public Health Statistical Unit

Women residing in Regions 1 and 9 reported the lowest use of contraceptives, with less than 30% of women reporting using contraceptives:

Figure 5: Percentage of women using modern contraceptive methods and unmet need for contraception (total and by region)



Source: Guyana MICS 2014

It is now critical for Guyana to address the sexual and reproductive health needs of our adolescents who have been left furthest behind if we are to achieve the 2030 Agenda set by the Sustainable Development Goals which Guyana has committed to advancing. The regions 1 and 9, are rural areas, far from the capital, with poor SRH outcomes and were chosen guided by the 2030 Agenda principle of leaving no one behind. It is expected that this Programme will contribute to reducing the existing inequalities between adolescents living in rural and urban areas.

2.3 Partnerships

The Ministry of Public Health will collaborate with its partners in Government and civil society to see this programme to fruition. In order to access the Indigenous communities in a manner that is culturally appropriate and effective, the Ministry of Public Health will collaborate with the Ministry of Indigenous Peoples' Affairs as far as possible in all its endeavours under this programme. It is critical to engage the Ministry of Indigenous Peoples' Affairs to identify as well as to secure access to leaders within these Indigenous communities who can be advocates for ASRH.

It will also be necessary to collaborate with the Ministry of Communities which bears responsibility for the Regional Democratic Council in each target region and under which the mandate for health within the Administrative Region falls.

In order for the Ministry of Public Health (MoPH) and its partners to access in-school adolescents, it will be necessary to engage the Ministry of Education to get permission for activities, and possibly to directly engage key officers of the Ministry of Education in the activities under this programme, such as the School Health Officer and the HIV Focal Point.

MoPH will engage national and local non-governmental organisations involved in ASRH, in particular the Guyana Responsible Parenthood Association (GRPA), Women Across Differences (WAD), and the Peace Corps. GRPA, for instance, has a wealth of experience in executing SRH activities at the behest of and with funding and the provision of other resources by the Ministry of Public Health. GRPA is well positioned to be the Ministry's foremost NGO partner in this endeavour.

MoPH will also receive support from other relevant Government Ministries such as the Ministry of Indigenous People's Affairs as well as from its UN partners (UNFPA, UNICEF, and PAHO/WHO), to ensure the success and sustainability of this programme.

2.4 Methodology

The programme will be implemented in three phases and in all five sub-regions of Region 9 and the three sub-regions of Region 1, simultaneously. The programme will be implemented in an inclusive way (all relevant stakeholders will be included i.e. adolescents, young people, regional village/community leaders, etc.). Implementation will also be integrative i.e. aligned with existing services to ensure sustainability.

Phase 1

Formative assessment and consensus building: This will include meetings with key stakeholders in Georgetown, Central Lethem (Region 9) and Mabaruma (Region 1) and in each sub-region. During this phase all the preparations for trainings and the roll-out of the programme will be in place. Definition of the programme targets will take place as well as any adjustments that might be needed to the approach. In addition, during this phase UNFPA will work with the Implementing Partners in establishing the necessary arrangements; inclusive of micro-assessments and annual work programmes. This phase will also include the recruitment of the Sexual and Reproductive Health Officer and the Monitoring and Evaluation Officer. Duration: 0-6 months after receiving the funds.

Phase 2

In this phase the actual implementation of the project will occur, including training of personnel within each sub region, monitoring of the project, integration with existing services for sustainability and documentation of processes and results. Duration: month 6-33.

Phase 3

Consolidation and preparation for exit will be the focus of this phase. In this phase the Ministry of Public Health (MoPH) will ensure the requisite capacity is in place for continued work of a high quality. Development of the final programmatic and financial report. Duration: month 34-36.

2.5 Programme Goal

Goal: By 2022, pregnancies among adolescents aged 10-19 in Regions # 1 (Barima - Waini) and # 9 (Upper Takutu - Upper Essequibo) in Guyana, reduced by 10% on an annual basis in each of the two regions.

2.6 Expected outcomes and outputs

OUTCOME 1: Increased use of quality Adolescent Sexual and Reproductive Health services by adolescents of communities of Regions # 1 & # 9.

Output 1.1: Adolescents of Regions # 1 (Barima - Waini) and # 9 (Upper Takutu - Upper Essequibo) have improved access to ASRH information and quality services in their communities

Output 1.2: Strengthened inter-sectoral and intra-sectoral coordination for an enabling environment towards adolescent sexual and reproductive health

OUTCOME 2: Adolescents, in particular adolescent girls, in communities of Regions # 1 (Barima - Waini) and # 9 (Upper Takutu - Upper Essequibo) are empowered to prevent adolescent pregnancies.

Output 2.1: Adolescent girls and adolescent boys in Regions # 1 (Barima - Waini) and # 9 (Upper Takutu - Upper Essequibo) have enhanced capacities to make informed decisions about their sexual and reproductive health and to demand for services.

Output 2.2: Accountability mechanisms for local government entities are strengthened for coordination and implementation of prevention and response programmes to end teenage pregnancies

2.7 Programme strategy

The programme strategy is guided by the following key principles and strategic approaches:

- Government ownership/leadership and alignment with national policies, strategies and plans; ensuring health system strengthening.
- Collaboration with young people through youth-led organizations as well as the involvement of adolescents and youth in planning, implementation, monitoring, reviewing, reporting, communicating and advocating with respect to the “Programme”.

- Working with men and boys in the target regions, as key change agents for the programme.
- Evidence-based.
- Capacity building using the cascade approach and on-the-job mentorship, to guarantee efficiency that is in line with the evidence that knowledge alone does not change the behaviour of health service providers. Mentorship, on the contrary, can help addressing underlying attitudes, values, and cultural norms and provides health workers with skills to manage organizational challenges such as the absence of dedicated staff to conduct counselling.

Evidence

Available evidence has shown that increasing uptake of adolescent sexual and reproductive health services requires implementing four critical and complementary components together: (1) training and sustained support to health care workers to deliver services that are confidential, personalized to the current needs of the adolescent, non-judgmental, non-discriminatory and free of violence and coercion; (2) improving the adolescent-friendliness of health facilities to be welcoming; (3) communication and outreach activities to adolescents to encourage their use of sexual and reproductive health services; and (4) community awareness and support of the importance of these services to adolescents.

- Adequate coordination to ensure that programme activities complement other agencies´ interventions. By sharing information and organizing coordination meetings with relevant actors at regional and national levels, this programme can build upon the existing partnerships and platforms.
- Bringing services (inclusive of the provision of contraceptives) as well as information and education to adolescents in their communities, schools (information only) and health facilities in order to significantly enhance the provision of and access to adolescent sexual and reproductive health information, education and services, especially in rural areas; ensuring that all adolescents in the target areas benefit.
- Promotion of social change at all levels by engaging with community leaders, teachers and parents from the beginning of the initiative as well as by building knowledge and supportive networks for the targeted regions.
- Adaptive/flexible implementation that ensures that the theory of change is regularly assessed and reviewed based on lessons learnt during implementation and that defined activities correctly evolve during implementation, dropping or redefining the ones that become irrelevant, accelerating actions that become more relevant or that have new gaps.

- Sustainability- the programme is aligned with national policies and programmes and it has a strong component on capacity building aiming to enhance local capacities to ensuring continuation of the interventions after the closure of this initiative.

2.8 Key activities per Output

Output 1.1: Adolescents of Regions # 1 (Barima - Waini) and # 9 (Upper Takutu - Upper Essequibo) have access to quality ASRH information, education and services in their communities

Activity 1.1.1: Technical support for the strengthening of the managerial capacities at the central (Adolescent Health Unit, Ministry of Public Health) and district (Regional Health Authorities) levels of the public health system for enhanced implementation as well as monitoring of the adolescent sexual and reproductive health programming; inclusive of the Ministry of Public Health's three (3) active programmes that target adolescents, specifically the Adolescent Health and Wellness Clinic, the Antenatal Clinic, and the Community Parenting Support Group. This includes technical support for the development of the standards for quality health care services for adolescents as per the WHO guidelines and technical support to the implementation (upon approval) of the national adolescent health strategy, 2018-2030.

The technical support will be provided through the SRH Technical Officer and M&E Technical Officer, both to be recruited by the Ministry of Public Health through this project. In addition, technical support will be also be provided by UNFPA and other UN partners.

Activity 1.1.2: **Training** of health care providers, including doctors, nurses, midwives, civil society organizations and community health workers, as appropriate, in the provision of non-discriminatory, non-judgmental, adolescent and youth responsive sexual and reproductive health information, education and services; with particular focus on the provision of contraceptives in the context of free , full and informed choice and in line with the standards for quality health care services for adolescents as per the WHO guidelines. This aims to address barriers adolescents face in accessing sexual and reproductive health services, such as perceived judgemental attitudes, lack of confidentiality and inadequate skills of health care providers aiming to ensure that services are accessible, acceptable, equitable and effective.

Activity 1.1.3: **Equip** five health facilities in Region 1 (Barima - Waini) and three health facilities within Region 9 (Upper Takutu - Upper Essequibo) with the required furniture, medical equipment, and information, education and communication (IEC) materials.

Recognizing that the adolescent population has been identified as a group which rarely visits health facilities to access sexual and reproductive health information, education and services, in addition to the investments in increasing the capacity of the health providers, such investments are aid efforts to make the health facilities more responsive to their needs.

Activity 1.1.4: Support to **contraceptives management** in order to increase the availability of contraceptives in health facilities. This will include at the start an assessment of the availability of contraceptive needs within Region 1 (Barima - Waini) and Region 9 (Upper Takutu - Upper Essequibo). Further, technical and financial support will be provided to the two regional health authorities as well as the Ministry of Public Health in addressing the adequate forecasting, procurement and distribution of contraceptives within the target regions.

Through this project, contraceptives will be procured and will be distributed to Regions 1 and 9, and every year the procurement plan will be revised to make the necessary adjustments. Three methods will be procured through this project: Implants, Medroxiprogesterone (Depo) and emergency contraception. The procurement needs of implants and medroxiprogesterone were estimated taking into consideration the following assumptions: contraceptive prevalence rate annual increase of 0.30% (=1.95% in 5 years) taking into consideration 2006 and 2014 MICS; method mix of the 2014 MICS considering uptake of implants especially in Region 9 where the prevalence use of this method in 2014 was null; no population growth taking into consideration the projections of the United Nations, Department of Economic and Social Affairs, Population Division (2017). World Population Prospects: The 2017 Revision, DVD Edition. In addition, to highlight that procurement needs were estimated taking into consideration all women in reproductive age of both target regions. In the case of Emergency Contraception (EC), the 2014 does not provide any information on the use of this method. It has been considered a maximum need of 600 users (2 doses of Levonorgestrel 0.75 mg, 2 tablets) per year for both regions.

Table 3: procurement plan

	2019			2020			2021		
Methods	**Region 1**	**Region 9**	**Total**	**Region 1**	**Region 9**	**Total**	**Region 1**	**Region 9**	**Total**
Depoprovera (150mg suspension in a 1ml vial)	9,221	7,222	**16,443**	9,341	7,318	**16,659**	9,460	7,415	**16,875**
Implants	155	64	**219**	157	64	**222**	159	65	**225**
EC (Levonorgestrel 0.75 mg)			**600**			**600**			**600**

Activity 1.1.5: As part of this effort, the Ministry of Public Health will also have a twice-yearly **family planning week** in hard to reach communities within the target regions to support increased availability of, access to, and uptake of contraceptives by adolescents.

Output 1.2: Strengthened inter-sectoral and intra-sectoral coordination for an enabling environment towards adolescent sexual and reproductive health

Activity 1.2.1: The Ministry of Public Health, with support of UNFPA, will continue to work within the main structures of dialogue of the health sector and will promote **coordination** among development partners working in the area of adolescent's health at central level and in Regions 1 and 9. This includes multilateral agencies, bilateral agencies and national organizations (such as the Guyana Responsible Parenthood Association-an IPPF Affiliate). Technical support will be provided to conduct annual monitoring of the adolescent sexual and reproductive health indicators and commitments made by the Government of Guyana in the area of ASRH to inform programming. This platform will also aim to ensure that evidence-based advocacy and policy dialogues are conducted.

Activity 1.2.2: The Ministry of Public Health, will strengthen its **collaboration with the Ministry of Education** at national and regional level. With support from the Ministry of Education and the regional health and education authorities, will hold twice yearly information and education sessions for parents at Parent-Teacher Association (PTA) meetings at secondary schools in the target regions. The objective is to enable the environment for the delivery of comprehensive sexuality education through the Health and Family Life Education Programme in the schools of target regions and promote access of adolescents to sexual and reproductive health services.

Output 2.1: Adolescent girls and adolescent boys in Regions # 1 (Barima - Waini) and # 9 (Upper Takutu - Upper Essequibo) have enhanced capacities to make informed decisions about their sexual and reproductive health and demand for services.

Activity 2.1.1: Monthly sexual and reproductive health **information and education sessions** will be conducted in selected secondary[22] schools in the target regions by health providers in line with the Health and Family Life Education Curricula. In addition, capacity strengthening of teachers on comprehensive sexuality education and school-based peer educators will take place. Development partners with peer educators' programmes in place will be engaged on the selection and training of students in secondary schools within the target regions to serve as peer educators in their schools. Many adolescents obtain their information on sex and sexuality from their peers, as most parents do not discuss these matters with them, and therefore to the provision of SRH information through their peers is a complementary action in this programme.

Peer educators should be part of holistic programmes and deployed for sensitization, outreach as well as referrals to expert knowledge and services, rather than serve as the primary strategy for providing information; particularly for services and products to adolescents. Evidence also shows that it allows for stronger linkages between these young motivators with the health system, whilst building accountability to the young people who are to be served. Strengthened recruitment and selection of marginalized adolescents to participate in peer educators is also required.

Activity 2.1.2: Conduct **dialogues in communities** in the target areas focusing on boys and young men; addressing topics such as, Sexual and Reproductive Health and Rights, masculinity, gender equality, gender-based violence, health and human rights, etc. Through strengthened partnerships, the Guyana Responsible Parenthood Association, in coordination with the Ministry of Public Health will execute such participatory community dialogues and community events.

Output 2.2: Accountability mechanisms for local government entities are strengthened for coordination and implementation of prevention and response programmes to end teenage pregnancies

[22] Three secondary schools exists in Region 1; North West Secondary, Port Kaituma Secondary, and Santa Rosa Secondary and will benefit from this intervention. Four secondary schools exist in Region 9; Aishalton Secondary, Annai Secondary, Sand Creek Secondary, and St. Ignatius Secondary and all will be prioritized for Region 9.

Activity 2.2.1: GRPA will be required to partner with various stakeholders, particularly those within the target communities, to ensure strengthened partnerships for **raising awareness** among traditional and religious leaders on adolescent sexual and reproductive health as well as mobilizing them as advocates of adolescent sexual and reproductive health. The Ministry of Public Health will provide adolescent sexual and reproductive health training as well as information, education and communication material to community leaders in target regions so as to strengthen community-based mechanisms which support the delivery of quality adolescent sexual and reproductive health information, education and services; building sustainable capacity within communities to tackle adolescent pregnancy.

Activity 2.2.2: Through strengthened partnerships, the Ministry of Public Health will be required to execute **community events** on adolescent sexual and reproductive health and rights. These activities will be in line/contribute to the existing Community Parenting and Support groups that are in place under the leadership of the Adolescent Health Unit of the Ministry of Public Health; allowing for a strengthening of the existing Community Parenting and Support groups initiative.

2.9 Relevance of the Programme

2.9.1 Policy relevance

The programme meets priority areas and target groups for the Government of Guyana. Guyana's *Health Vision 2020* (Guyana's National Health Strategy), for instance, presents a coherent long-term plan for addressing health determinants and constraints in the health system in order to realise health for all in Guyana. The beneficiaries of *Health Vision 2020* include 'early adolescents who have initiated sexual relations'. The *Health Vision 2020* and its related targets are highly relevant to the objectives of this programme.

Goal 1 of Health Vision 2020 seeks to advanced well-being of all the people of Guyana. The emphasis is on reducing maternal and child mortality. This highlights a synergy with the intent of this proposed project to address the reproductive health, particularly adolescent pregnancy, of adolescents.

Goal 2 of Health Vision 2020 seeks to reduce health inequities. The emphasis is to achieve universal access to health services by targeting vulnerable or marginalised populations, including adolescents, with improved access to the services and information. This highlights a synergy with this proposed project which seeks to address the rights of adolescents to access

quality sexual and reproductive health services regardless of their age, geographic location, gender, and income level.

Goal 3 of Health Vision 2020 seeks to improved management and provision of evidence-based, people-responsive, equitable health services. The emphasis is on improvement of client satisfaction with health facilities and services for young people and universal access to sexual and reproductive health, including contraceptive methods for adolescents. It also aims to address the need for increased health personnel, availability of health facilities and quality data. This highlights a synergy with this proposed project which seeks to address strengthening capacities for implementation, monitoring and evaluation of the adolescent sexual and reproductive health programme.

The importance of SRH and family planning for adolescents is also emphasised in the Guyana's draft *Sexual and Reproductive Health Policy*. The fundamental values and principles address the significance of good-quality and affordable sexual and reproductive health information, education and services for adolescents, inclusive of family planning. The draft SRH Policy recognises adolescent sexual and reproductive health rights as human rights.

The Government of Guyana has committed to: 1) Providing age-appropriate comprehensive sexuality education for all adolescents and young people; 2) Providing the necessary and appropriate teacher training, supervision and performance review mechanisms to ensure the success of sexuality education; 3) Actively involving young people in the design, implementation, monitoring and evaluation of sexuality education programmes; 4) Ensuring universal access to SRH information and services for all adolescents and youth through youth friendly approaches; 5) Developing special programmes and policies for 'high risk' and vulnerable youth populations including those living in poverty, out-of-school, single mothers, migrants, the disabled and those living with HIV; and 6) Establishing norms that guarantee the rights of adolescent mothers to continue their education and that oblige adolescent fathers to share equal responsibility in childcare.

The proposed programme outlined in this project proposal document aligns with the priorities of the Government of Guyana. Importantly, the proposed programme aligns with Pillar 5 (Human Growth and Development) of the Guyana Green State Development Strategy. The proposed programme will therefore contribute to ongoing efforts on the part of the Government of Guyana to fulfil its commitments to ensuring the health and well-being of adolescents and

youths in Guyana; ensuring that adolescents and youths have access to the full range of sexual and reproductive health services.

2.9.2 Links with Regional and International Frameworks

The main objective of the programme is aligned with the key expected outcomes of CARICOM/UNFPA *Integrated Strategic Framework for the Reduction of Adolescent Pregnancy in the Caribbean*. The proposed programme will contribute to the achievement of the following expected outputs under the Integrated Strategic Framework (ISF) outcome areas:

- Output 1.1: Strengthened and increased availability of and access to differentiated youth friendly, non-judgmental and free from discrimination sexual and reproductive health services for adolescents. These services will improve and increase the availability and utilisation of information and counselling for adolescents on sexual and reproductive health issues. Additionally, adolescent health services should follow World Health Organisation (WHO) quality dimensions for adolescent health care: services should be available, accessible, acceptable, appropriate, equitable, and effective.

- Output 1.2: Increased accessibility and the availability of a full range of contraceptives for adolescents, including emergency contraceptives, as well as the removal of financial barriers for accessing contraceptive commodities.

- Output 1.3: Health service facilities ensure that every adolescent pregnancy, particularly those 16 years of age or younger, are managed as a high-risk pregnancy by appropriately trained professionals.

- Output 2.3: Increased capacity of parents to address sexual and reproductive health issues of their children

The programme is also aligned with *Every Caribbean Women Every Caribbean Child Initiative (CariWaC)*, which target critical public health issues, strengthening health system capacity in human resources, engaging community stakeholders and enhancing governance and accountability. The programme will contribute to the achievement of the main objective of the initiative: to promote the health and well-being of adolescents in the Caribbean, including a reduction in adolescent pregnancy by 20% by 2019.

The programme is also linked and will contribute to the current regional efforts for

implementation of the *Montevideo Consensus on Population and Development*, especially with priority action A (Full Integration of Population dynamics into Sustainable Development with Equality and Respect for Human Rights); B (Rights, Needs, Responsibilities and Requirements of Girls, Boys, Adolescents and Youth); and D (Universal Access to Sexual and Reproductive Health Services).

The programme is aligned with the Agenda 2030 for Sustainable Development and especially with the category "People": ending poverty and hunger in all its forms and dimensions, and ensuring dignity and equality with particular contribution to SDG 3 (Good Health) and SDG 5 (Gender Equality). In addition, the programme is fully aligned with The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) and the Global Accelerated Action for the Health of Adolescents (AH-HA!) (WHO. 2017).

The programme aligns with the Alma-Ata Declaration that identified primary health care as the key to the attainment of the goal of Health for All. In keeping with the Alma-Ata Declaration, the programme seeks to address existing gross inequalities in the health status of adolescents and youth, particularly between rural and urban communities in Guyana.

2.9.3 Links with UNFPA Sub-Regional Programme

The proposed programme is aligned with the UNFPA Sub-Regional programme document for English-speaking and Dutch-speaking Caribbean 2017-2021 which speaks to the following four strategic outcome areas: sexual and reproductive health; adolescents and youth; gender equality and women's empowerment; and population dynamics.

More specifically, the programme will contribute to the achievement of the following expected outputs under the country programme strategic outcome areas: 1) Increased national capacity to strengthen the enabling environment for integrated sexual and reproductive health services targeting underserved populations, including in emergencies; and 2) Increased national capacity to advocate for and deliver policies and programmes for access to sexual and reproductive health for adolescents, with focus on vulnerable and marginalized groups.

3. Implementation Arrangements

As referred in section 2.3 (Partnerships), this programme will be implemented through a collaboration between various stakeholders. The **Ministry of Public Health** (MoPH) will be the main implementing agency for the interventions outlined in this proposed programme. The

Ministry of Public Health at central level will also, with UNFPA, provide strategic direction, ensure coordination, oversight and decision making on priority actions. In addition, the **Guyana Responsible Parenthood Association** (GRPA - an Affiliate of the International Planned Parenthood Federation) will also, in collaboration with the Ministry of Public Health, implement community interventions in Regions 1 and 9, given their expertise in working in sexual and reproductive health and especially with adolescents and youth as well as their experience in working with communities. Given the local government mechanisms in Guyana, there will exist a third tier of implementation, with the regional authorities for Regions 1 and 9 being engaged in the implementation so as to enhance the sustainability of the initiative.

The MoPH will be heavily involved in monitoring, quality control, and the provision of technical support to the regional authorities. The MoPH has an Adolescent Health Unit and the Coordinator of the Adolescent Health Unit will be the focal point and key person responsible for the implementation of the activities under this programme, with the support of a Sexual & Reproductive Health Technical Officer and a Monitoring & Evaluation Technical Officer to be recruited by the project.

In Regions 1 and 9, the Regional Democratic Council, the local government bodies, community support officers from the Ministry of Indigenous Peoples' Affairs (MoIPA), adolescents, NGOs, community and faith-based leaders, will be engaged in the implementation to enhance sustainability of the initiative.

It is proposed that a functional inter-agency coordination mechanism for ASRHR be established at national level as well as the regional levels (in Regions 1 and 9) under the leadership of the Ministry of Public Health with participation of UNFPA and GRPA, at the minimum. Within this framework, the implementation of this Programme will be addressed, including development of the annual work plans, progress on implementation and any other programmatic and/or operational issues. The Indian High Commission in Guyana will be invited to serve on the inter-agency coordination mechanism.

Table 4: Responsibilities of programme partners

Partners	Partner Type	Purpose of the Partnership	Partner Role	UNFPA Role
Ministry of Public Health and the Regional Health	Government	Policy development, standard setting, capacity building	Joint planning, implementation, coordination and monitoring	Provision of technical & financial support, leadership, resources, guidance on policy formulation, evidence-based

Partners	Partner Type	Purpose of the Partnership	Partner Role	UNFPA Role
Authority for Region 1 & Region 9				advocacy to improve resource allocations and enhance investments for FP & adolescents and youth, sharing of global learning and best practice
Ministry of Education and the Regional Education Officer for Region 1 & Region 9	Government	Policy development, capacity building, awareness raising.	Joint implementation with MOPH, of the school-based SRH information and services; support for school enrolment of mentored girls	Provision of technical support
Ministry of Finance	Government	*Policy development* and resource allocation to health	Policy dialogue, prioritization	Advocacy on resource allocation for FP and Adolescents and Youth health programmes to harness the Demographic Dividend
Department of Social Cohesion, Youth, Sport & Culture, Ministry of the Presidency	Government	Support NGOs/youth associations involved in the implementation of the mentorship and in related community-level activities	Joint planning and monitoring, support for identification of mentors as well as linkage to youth friendly spaces	Provision of technical support
Ministry of Social Protection	Government	Support NGOs/youth associations involved in the implementation of the mentorship and in related community-level activities	Joint planning and monitoring, support for identification of mentors and girls to be mentored in communities; support for mentored girls and mentors to access social action services	Provision of technical support
Guyana Responsible Parenthood Association	Non-governmental organisation	Social mobilisation for social and behavioural change; demand creation; girls' empowerment	Community-and school level interventions, to enhance adolescent girls and boys to make informed decisions about their SRH and increase demand for services	Provision of technical advice and financial support

4. Programme Management, Accountability, Quality Assurance,

4.1 Management

As the executing agency of the proposed programme, UNFPA will provide project management oversight, with technical and implementation guidance. It will also have a policy and advisory role and support the government in its coordination role among key stakeholders in the area of family planning and ASRH. UNFPA will also be responsible for technical support and monitoring along the course of the implementation, fund management and quality assurance, for developing and submitting donor reports ensuring that all reporting requirements are met and for procurement of commodities through UNFPA PSB (Procurement and Service Branch).

Under the leadership of the UNFPA Representative & Director of the Sub-Regional Office for the Caribbean, the Deputy Director will oversee the overall management and accountability for results of the Programme. The Guyana Liaison Officer and the SRH Advisor for the Caribbean will guarantee technical support and quality monitoring and evaluation of the proposed programme.

4.2 Accountability and operational quality assurance

UNFPA will submit fund requests to the UNOSCC through the submission of a signed annual work plan and annual budget. Once the funds are in UNFPA account, they will be disbursed to the implementing partners (Ministry of Public Health and the Guyana Responsible Parenthood Association) after an agreement is signed between the Minister of the Government of Guyana and the UNFPA representative, and upon request and submission of the annual work plans aligned with the approved programme. The funds will be disbursed to the implementing partners on a quarterly basis into a dedicated bank account. The implementing partner agreement contains all the appropriate clauses with respect to accounting, reporting, termination, subcontractors, indemnities, intellectual property, etc. This agreement also sets out: a duty to report allegations of corrupt, fraudulent, collusive, coercive or obstructive practices; that engagement in such practices is cause for suspension or termination; and that funds engaged in such practices should be refunded.

Flow of funds:

In line with the implementation of the Harmonized Approach to Cash Transfer (HACT), counterparts account for the use of UNFPA funds through simple certifications (i.e. using fund authorization and certification of expenditure forms-FACE). This procedure is intended to reduce transaction costs for national implementing partners and to increase UN Agencies' focus on strengthening national capacities for programme management and accountability. The HACT shifts the focus from controls towards a broader approach of risk management.

In the framework of HACT (a UN/UNFPA procedure), the following assurance activities are undertaken: 1) Micro-assessments; 2); Periodic on-site reviews; 3) Scheduled and special audits.

1) Micro-assessments: they have the following two objectives:

- Capacity development objective: to identify strengths and weaknesses in the Implementing Partner's capacity for financial management and areas for capacity development by the government and others.
- Financial management objective: to assist in the establishment of appropriate cash transfer modalities, procedures, and assurance activities to be applied by the Agencies.

All implementing partners who receive over USD 100,000 are micro-assessed. The assessments are carried out by independent auditing firms and provide an overall evaluation of the Implementing Partner's financial management capacity and review funds flow, staffing, accounting policies and procedures, internal audit, external audit, reporting and monitoring and information systems. It results in a risk rating (low, moderate, significant or high). The risk rating determines the type and frequency of assurance activities, e.g. spot checks and audits. It can be adjusted based on other available information (e.g. materiality, history of engagement, previous assurance results) to increase assurance activities. It can be taken into consideration when selecting the appropriate cash transfer modality for an IP.

2) Periodic on-site reviews

Periodic on-site reviews (spot-checks) of the implementing partner's financial records are conducted by UN staff with the aim of ensuring that financial records are consistent with the financial certifications submitted to UN agencies and to verify that accurate financial monitoring records related to supported activities are kept by the partner. In addition, when there is a need, UNFPA hires third party service providers to carry out spot checks - audit firms are engaged under a corporate long-term agreement (LTA).

The frequency of periodic on-site reviews is based on two factors: the amount of funds advanced to each implementing partner and the results of the assessment of each implementing partner's financial management capacity resulting in a rating of low or high risk.

Periodic On-Site Reviews will be undertaken once expenditure amount above US$50,000 from UN agencies within a 12- month period unless they are audited.

In addition, the spot check terms include the clause that: "In consultation with OAIS (the Office of Audit and Investigation Services), the UNFPA office determines to commission of a special audit in order to determine if there are fraudulent expenditures reported. The office determines to suspend any planned direct cash transfer until the audit report is received."

Implications of micro-assessment and on-site review ratings

- Low risk: the Partner has very strong financial management systems and therefore is eligible for the Direct Cash Transfer Modality.
- Moderate risk: the Partner has good financial management systems; however, there are some issues that need follow-up and close monitoring.
- Significant risk: the Partner has weak financial management systems. An action plan must be drawn urgently and the correct funding modality (e.g. reimbursement) should be identified and at least quarterly assurance visits will be conducted.

3) Scheduled and special audits

They are carried out by independent auditing firms and conducted to assess the existence and functioning of the implementing partners' internal controls for the receipt, recording, and disbursement of cash transfers and the fairness of a sample of expenditures reported in all of the FACE forms issued by the implementing partner during the period under audit. Two types of audits are used for the assurance of cash transfers:

- Scheduled Audits: conducted at least once in a programme cycle, for implementing partners who have or are expected to receive more than US$ 150,000 combined from

all UN agencies during the programme cycle. The Scheduled Audits are part of the annual Audit Plan to be developed by the UN system.

- Special Audits: In addition to the Scheduled Audit, if the on-site reviews and/or the assessment of the FACE forms submitted by a specific partner, reveal poor financial management capacity, Special (or ad-hoc) Audits can be commissioned by the UN system to address specific suspected weaknesses and can be implemented at short notice. Special audits are consistent in scope with scheduled audits but are triggered as a result of specific issues and concerns arising during the programme cycle. The special audit may focus on financial or internal control, depending on the nature of the potential or identified issues.

5. Monitoring & Evaluation and Reporting

Planning meetings: each year there will be a planning meeting at central level and a planning meeting in Regions 1 and 9, with participation/technical support from UNFPA. These will be essential for effective planning and to ensure programme supported activities are included/in line with central level and regional level Health priorities. Implementing partners will also prepare annual work plans against which funds will be disbursed on a quarterly basis and based on the submission of progress and financial reports.

Quality control ex-ante through support to Adolescent Health Unit technical support will be provided to develop quality standards for the provision and monitoring of ASRH services; review/develop training materials for all capacity building activities and quality assurance of TOR for each activity.

In order to sharpen the programme strategy, a programme **inception phase** (first 6 months of programme implementation) will be held to finalize programme design (ex. revision/adjustments of baseline and targets for the programme) and adjust the programme theory of change accordingly.

Regular programme monitoring will be undertaken, to supervise activities in progress and ensure they are on- course and on-schedule to meet the objectives and planned targets. Progress will be documented, and corrective measures promptly taken based on monitoring data, where needed.

Monitoring will include both distance monitoring through daily communication with and reporting by implementing partners and programme monitoring visits by UNFPA and the

Ministry of Public Health technical staff. Field mission reports for each visit will be developed and shared.

The collection of information and data for the monitoring of indicators will be mainly based on existing routine systems (collection and regular processing of data by the Adolescent Health Unit). The MICS survey planned for 2019, and the reproductive health services and commodities surveys currently being conducted under the maternal health project of the Ministry of Public Health and the Inter-American Development Bank, will be of great importance to inform the Programme.

Reviews meetings: UNFPA, the MOPH and civil society-implementing partners will carry out annual reviews where achievements against the planned results, activities, inputs, and outputs as described in the implementation plan will be compared and analysed. Success and failures will be identified and discussed; lessons learnt from district level implementation will be brought to the central level and vice-versa. The reviews will also be opportunities to ensure the Theory of Change of the programme is regularly discussed and its assumptions checked. The reviews can lead to adjustments in the program if deemed necessary, including in its theory of change. Documenting the lessons learnt will be important for the scaling up of the programme approach at the end of the programme.

Evaluations: A final review will be undertaken at the end of the project. The review will follow United Nations Evaluation Group's quality standards and will particularly focus on the effectiveness and sustainability of the programme and it will include a cost-benefit analysis component. A final report will be developed by an independent consultant, and discussed and disseminated with main project stakeholders; a copy will be shared with UNOSSC.

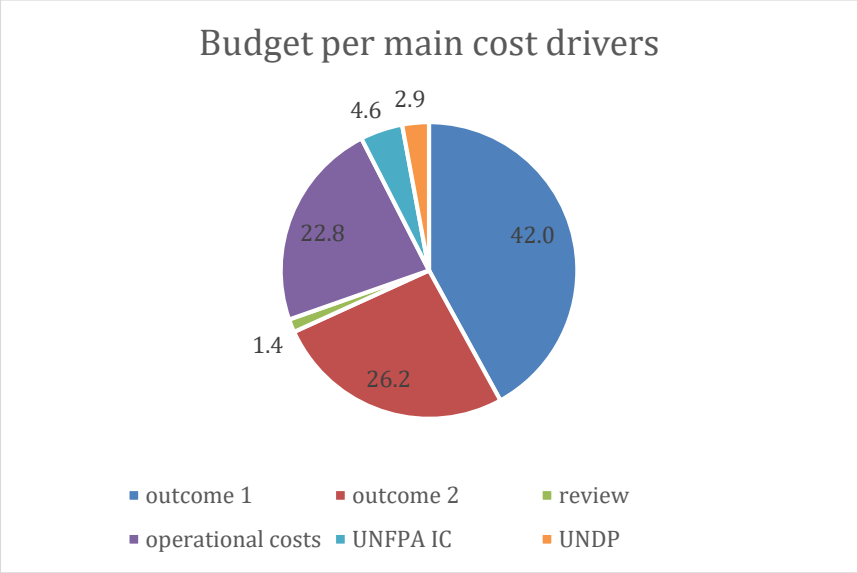
Table 4: Summary of key Planning, programme quality assurance, monitoring and evaluation

Activity	Frequency	Main responsible Entity
Establishment/Adjustments of the baseline and definition of targets	Once, inception phase	UNFPA, MoPH
Annual Work Plan (with budget)	Annually	UNFPA
Joint monitoring field visits	Quarterly	UNFPA, MoPH
Annual Review and Planning Meeting	Bi-annual	UNFPA with MOPH and GRPA and partners
Programme Evaluation	Q 1 2022	UNFPA and partners

6. Budget

The budget proposes to have a grant amount of US$559,496 to be spent over a three (3) year period. 42% of the budget will be used to implement activities under outcome 1, 26.2% for activities under outcome 2, operational costs represent 22.8% of the total budget and UNFPA IC 4.6% and UNDP/UNOSSC IC 2.9% of the total budget. (See Annex 5: Work Plan with Budget).

Figure 6: Budget



7. Reporting

Each implementing partner will be requested to document and share progress reports with UNFPA, both in terms of progress towards results and in terms of financial expenditure. These reports will be submitted to UNFPA on a quarterly basis. Programmatic progress report and financial expenditure report will be compiled by UNFPA and made available to UNOSSC. Monthly updates via email will be submitted to UNOSSC, Secretariat and Trust Fund Manager of the India-UN Fund, and may include available financing delivery figures, description of progress and challenges in project implementation, pictures and any other relevant materials. UNFPA will submit to UNOSSC annual programmatic and certified financial reports as well as biannual narrative and quarterly financial reports.

The deadlines for the submission of the reports and any other required document will be set forth in the signed co-financing agreement between the two parties. UNOSSC will provide guidelines on the outline and length of the annual progress reports.

The implementing partners will provide UNFPA with the quarterly and annual reporting of activity progress and expenditures guided by the Letter of Understanding to be signed between UNFPA and the implementing partners and therefore, prepared in accordance with the implementing partner's financial regulations, rules, policies, procedures, and administrative instructions. UNFPA will be responsible for submitting:

- One annual financial statement certified by an authorized official of UNFPA (Finance Branch, Division for Management Services) as of 31st December of the year in question, to be submitted no later than 30th June of the following year; and
- One final financial statement certified by an authorized official of UNFPA (Finance Branch, Division for Management Services) to be submitted no later than 30th June following the year in which the Programme was operationally completed.

Table 5: Summary of reporting timelines

Activity	Frequency	Main responsible Entity
Regular updates via email	Monthly	UNFPA to UNOSSC
Progress and financial reports	Quarterly	Implementing Partners to UNFPA UNFPA to UNOSSC
Annual Report (building on progress report to identify key achievements, bottlenecks, lessons learnt, indicator status)	Annually (March n+1)	UNFPA to UNOSSC
Annual Certified Financial Report	Annually (June n+1)	UNFPA to UNOSSC
Final Certified Financial Report	Once	UNFPA to UNOSSC
Final report	6 months following the date of operational completion of the Programme[23]	UNFPA with MOPH and GRPA and partners

[23] in the event of termination of this Agreement, following such termination.

8. Risks

RISK	RISK RATING (Likelihood x Impact)	MITIGATION STRATEGY
Socio-political instability/conflict in one or more intervention areas or at national level.	Low	Contingency plan for an appropriate revision of interventions.
Influx of Venezuelan migrants in particular in Region 1 and the strain that this is likely to place on the public health infrastructure	Medium	Emergency contingency plans are being developed and in place with support of international partners
Lack of commitment from the Government	Low	Adolescents Health Programmes are priority programmes and target groups for the Government
Environmental risks (especially floods)	Medium	Support target districts in development of resilience plans on SRH and GBV in close collaboration with partners working in the area of SRH and GBV.
Resistance to change due to social norms and cultural factors.	Medium	Integrated inclusive approach, with specific interventions targeting girls, as well as men and boys, active involvement of religious and community leaders, meetings with school councils and parents.
Lack of capable implementing partners for one or more activities and/or for one or all targeted districts.	Medium	Institutional support and training/capacity building of implementing partners.
Weak capacity by implementing partners to absorb programme funds.	Medium	Differentiate implementing partners: not too much funds for one organization. UNFPA has in place the *implementing partner planning capacity assessment tool*. The relevant UNFPA corporate policy outlines that the implementing partner assessment must be undertaken prior to working with an implementing partner.
Risk of funds not being used as intended by partners and sub-contractors.	Medium	Sound M&E and reporting system in place at all levels; partner assessment before establishing partnerships; establishing and controlling on clear procedures; linking payment schedules for sub-contractors to deliverables; reporting plan and regular reporting by implementing partners on programmes progress; regular field M&E visits. Sound assurance activities and systems in place in order to ensure funds are used for the intended purposes (see section 5)
Inadequate coordination among partners, resulting in delays of implementation, or duplication of efforts.	Medium	Conduct regular field monitoring visits. Conduct programme review meetings twice a year, with the participation of all partners from the target regions

9. Visibility and Communications

9.1 Visibility

Visibility during the course of the implementation of this programme will ensure that the government of India will be provided with due credit for its role in supporting the initiative, including at all public and media engagements, as well as through prominent display of the flag, logo or relevant partnership signage at all relevant occasions and opportunities. All

information, education and communication material produced under this programme, press releases in relation to this programme, and activities under this programme will highlight the funding and support provided by the India-UN Development Partnership Fund. “India-UN Development Partnership Fund Support” will be affixed on all information, education and communication material, goods and equipment purchased and produced under this programme.

The “India-UN Development Partnership Fund Support” branding activities will include the strategic production and placement of banners, posters and project fact-sheets.

9.2 Communication plan

Effective communication will require planning as well as innovative and engaging ways of communicating. Specific communication goals and objectives will be aligned with the project outcomes at the start of the project. Creative community messaging on the prevention of adolescent pregnancy in Guyana will also be crafted to match the internal and external audiences involved in this project.

Periodic meetings will be held with representatives of the Indian High Commission in Guyana, representatives of the Government of India. Representatives of the India High Commission will be invited to participate in major events organized with programme funds.

Table 5: Communications and advocacy plan

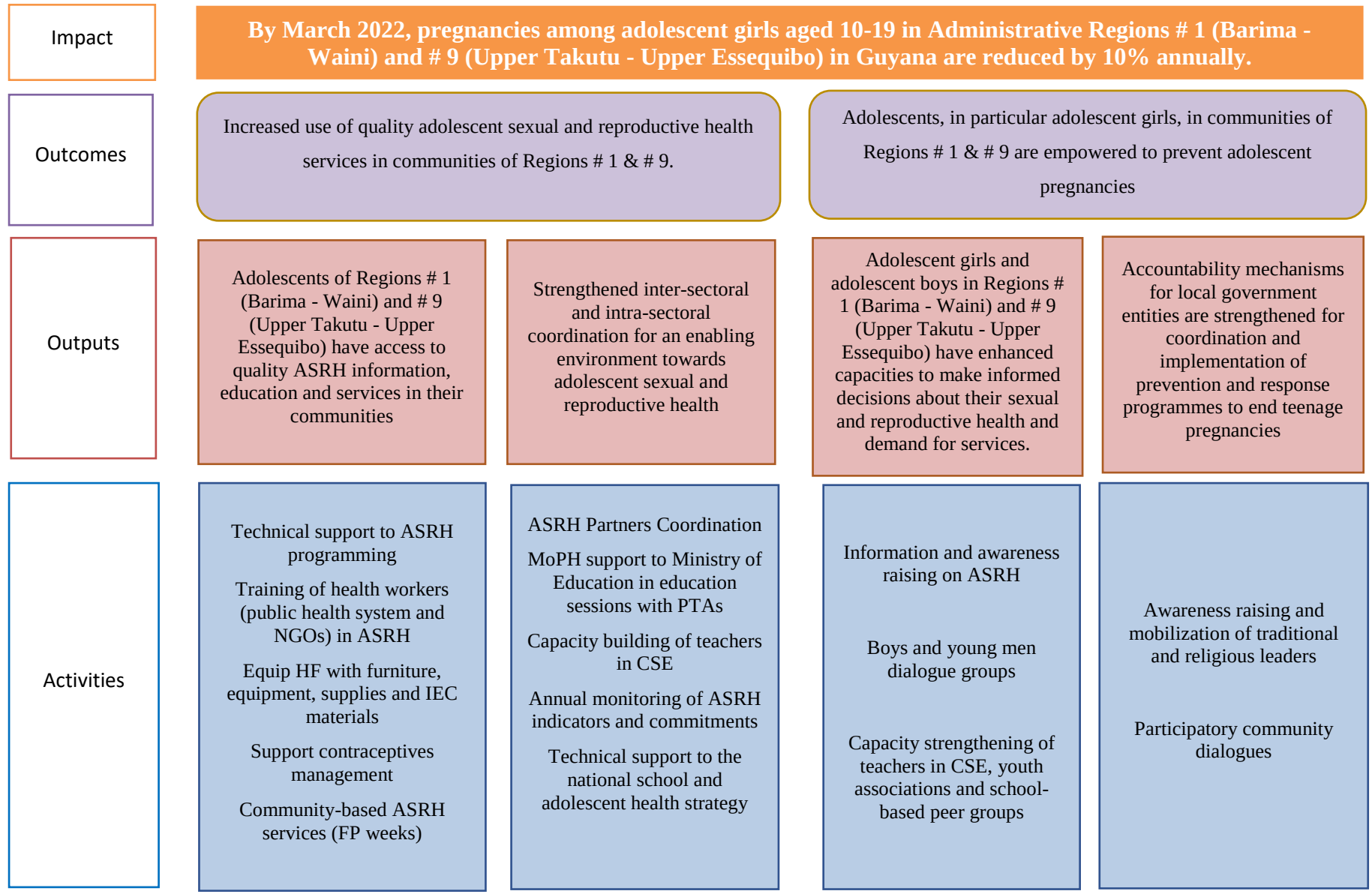
Strategy	Communication Channels	Target Audience
Internal		
Communication and knowledge management at CO, with UNFPA SRO and HQs, using data and information collected during field missions, data and reports, regular communication with UNFPA programme staff and IPs based in Region 1 and Region 9.	i-Docs platform for document sharing and repository, Yammer collaboration platform, Live video conferencing, regular face-to-face contact; internal meetings; internal/coordination meetings among implementers; programme meetings.	UNFPA staff, IPs, contractors, granters.
External - Advocacy and Visibility		
Evidence-based advocacy, using data and reports from the programme, Census data, data from the national database system for SDGs; use human-interest stories, partnerships, community mobilization, media engagement; using national and international commemorative days; involvement of project staff in discussion platforms and national conferences; promotion of national investments into adolescents; synergies with UNFPA programme under current CPD; partnering with existent multi-sectorial structures from district to national level to invite more stakeholders to the discussion table to address the reduction of adolescent pregnancy; actively involve MoPH, GRPA and other relevant stakeholders (inclusive of Civil Society Organisations) in advocacy efforts and political dialogue.	Combination of traditional media (print, radio. TV) and online media (website, social media platforms, infographics etc) FP and Health groups; international partnership platforms; Websites and reports from UNFPA CO/RO/HQs; UNFPA Facebook and Twitter; IPs Facebook pages; national and international media; radios and TV; champions; public events by youth groups and NGOs; technical working group meetings; promotional advocacy material; final document/ video on lessons learnt; press releases; videos; media interviews; electronic newsletters; visual storytelling and infographics	MoPH, GRPA, donors, government, private sector, NGOs, INGOs, youth organizations, IOs, policy makers, community and religious leaders; teachers, health providers; general public.

Strategy	Communication Channels	Target Audience
External – Behavioural Change Communication (BCC)		
Adolescent-friendly language and communications tools; adapt to contexts; use local indigenous languages (where appropriate), oral communication and images to reach the illiterate population; partnerships; community mobilization; media engagement; engage community gatekeepers and teachers; engage young people; use community health workers; using data and reports.	Radio & community radio; theatre; local dance groups; peer-to-peer communication; mentors; group discussions; community events; IEC printed materials;	Adolescents and youth; women and men of reproductive age, parents and partners of target population.

Annex 1: Inception Phase Work Plan

Inception Phase Work Plan – June – December 2019		Q3	Q4
1	Capacity assessment of GRPA (new partner)	x	
2	Micro-assessment of GRPA	x	
3	Work planning with partners	x	
4	Signing of agreements with IPs	x	
5	Recruitment of project team: SRH Technical Officer & M&E Technical Officer	x	
6	Establishment of the coordination mechanism	x	
7	Review/Adjustments of the targets and theory of change		x
8	Selection of target schools, community groups, and key individuals, within Regions 1 & 9, to form part of project implementation		x
9	Assessment of the availability of contraceptives in target Health Facilities		x
10	Procurement of contraceptives		x
11	Procurement of laptops for the SRH and M&E officers	x	
12	Review/develop training materials		x

Annex 2: Theory of Change



Annex 3: Logical Framework

Results	Objectively Verifiable Indicators	Indicator description	Baseline	Target 2020	Target 2021	Target March 2022	Source/ Means of Verification	Frequency of collection / reporting	Assumptions
By March 2022, pregnancies among adolescent girls aged 10-19 in Administrative Regions # 1 (Barima - Waini) and # 9 (Upper Takutu - Upper Essequibo) in Guyana are reduced by 10% (on an annual basis)	Adolescent birth rate	Number of births per 1000 girls aged 15-19	Region 1 and 9: 187 per 1000 girls aged 15-19 (MICS 2014)	Not Applicable	Not Applicable	136 per 1000 girls aged 15-19	Survey	Endline surveys	Provided that National Household surveys will be undertaken.
Outcome 1: Increased use of quality Adolescent sexual and reproductive health services by adolescents of communities of Regions # 1 & # 9.	Modern contraceptive prevalence rate among women aged 15-19	% of women aged 15 to 19 using (or whose partner is using) a modern contraceptive method at a given point in time out of the total number of girls and young women of the region	Region 1: 29.3% (all WRA) Region 9: 27.6% For age 15-19 baseline will be defined through secondary analysis of MICS data	Not Applicable	Not Applicable	TBD	Survey		Provided it is possible to do a secondary analysis of MICS data
Output 1.1 Adolescents of Regions # 1 (Barima - Waini) and # 9 (Upper	# of health facilities with no stock-out of any contraceptive method at any given time in Regions # 1 & # 9	# of HF with at least 3 contraceptive methods available in the last 3 months out of the total	Not available (2018 report yet not released)	TBD	TBD	15	Commodities survey	Annually	Provided that timely results of the Essential Obstetric and Neonatal Care Network

Takutu - Upper Essequibo) have access to quality ASRH information, education and services in their communities	(district health centres, district hospitals, regional hospitals and target health post of region 1	number of HF offering contraceptives in Regions # 1 and # 9 (district health centres, district hospitals, regional hospitals and target health post of region 1)							Assessment, Operational Status Survey. Otherwise field supervision reports
	Proportion of public health facilities that provide quality integrated adolescent-friendly SRH services in Regions # 1 & # 9 (cumulative)	# of public health facilities that provide quality integrated adolescent-friendly SRH services in Regions # 1 & # 9 out of the total public health facilities (cumulative)	Not available	5	10	15		Annually	Project reports
Output 1.2: Strengthened inter-sectorial and intra-sectorial coordination for FP and ASRHR	Stakeholders action plan in support to Adolescent Pregnancy reduction for Guyana and Regions# 1 & # 9	A costed action plan in support to Adolescent Pregnancy reduction at national level and regions 1 and 9	NA	Yes	Yes	Yes	Action Plan document	Annually	
Outcome 2: Adolescents, in particular adolescent girls, in communities of Regions # 1 (Barima - Waini)	Unmet need for FP	The number or % of girls with unmet need for FP is the sum of the number or % of girls with an unmet need for	Region 1: 39.5% (all WRA) Region 9: 36.2% For age 15-19 baseline will	Not Applicable	Not Applicable	TBD	Survey	Endline surveys	Provided it is possible to do a secondary analysis of MICS data

and # 9 (Upper Takutu - Upper Essequibo) are empowered to prevent adolescent pregnancies.		limiting; and the number or % of girls with an unmet need for spacing.	be defined through secondary analysis of MICS data						
Output 2.1: Adolescent girls and adolescent boys in Regions # 1 & # 9 have enhanced capacities to make informed decisions about their SRH and demand for services.	# of adolescents receiving integrated SRH information in Regions # 1 & # 9 (cumulative)	# of adolescents receiving integrated SRH information in Regions # 1 & # 9 (cumulative)	N/A	450 (region 1) 360 (region 9)	900 (region 1) 720 (region 9)	1,350 (region 1) 1,080 (region 9)	Project activity reports	Annually	Provided that timely reports are submitted by Regional Health Authorities
	# of sectors (other than Public Health) that have strategies on adolescent and youth-friendly SRH issues in their sectoral plans, with respect to Regions # 1 & # 9	# of sectors (other than Public Health) that reflect strategies on adolescent and youth-friendly SRH issues in their sectoral plans, with respect to regions # 1 & # 9	Not available	TBD	TBD	TBD	Annual Sectoral Reports	Annually	Provided that timely reports are submitted by the various sectors
Output 2.2: Accountability mechanisms for local government entities are strengthened for coordination and implementation of prevention and response programmes to end teenage pregnancies	A functional inter-agency coordination mechanism for ASRHR in place at district levels.	Numerator: number of functional inter-agency coordination mechanisms for ASRHR out of the total target districts	Does not exist	Yes	Yes	Yes	Regional Health Department Reports	Annual	Provided that timely reports are submitted by Regional Health Authorities

Annex 4: Process Indicators

KEY ACTIVITIES	PROCESS INDICATORS	MEANS OF VERIFICATION	FREQUENCY	RESPONSIBLE UNIT/PERSON	RISKS AND ASSUMPTIONS
Technical support to ASRH programming	Standards for quality health care services for adolescents approved	Approved document	2020	MCH/AHU MOPH	Risks: • It might be a lengthy process as it needs substantial technical support and coordination. Assumptions: • Guyana standards will follow the WHO Standards for quality health care services for adolescents with adaptations to the local context • Through the project, an SRH technical Officer will be hired and will lead the development with support from UNFPA, PAHO among others
	Completed annual monitoring of ASRH indicators and commitments made to ASRH by GoG	Adolescent health Unit reports	Annual	MCH/AHU MOPH	Risks: • Failure by the target regions to make adequate or timely reports. • Inadequate skills on the part of health care workers to collect/record the necessary information and data. Assumptions: • Train staff in the collection and reporting of information and data.
Training of health workers in ASRH	# of additional health workers trained in Regions # 1 & # 9 [Baseline: - 272 health workers trained nationally (2017)]	Report of training	Annual	MCH/AHU MOPH	Risks: • High staff turnover in remote hinterland target regions • Attitudes and values of health care workers that may negatively affect the proposal Assumptions: • Government will provide the health workers with a stipend for working in remote locations • Health care workers will be recognised and rewarded for meeting and reporting on ASRH targets

KEY ACTIVITIES	PROCESS INDICATORS	MEANS OF VERIFICATION	FREQUENCY	RESPONSIBLE UNIT/PERSON	RISKS AND ASSUMPTIONS
	# of NGO representatives in communities of Region # 1 & # 9 trained in ASRH	Adolescent health reports	Monthly	MCH/ANU MOPH	Risks: ● Lack of NGOs in target regions that are interested in engaging in ASHR. Assumptions: ● MoPH will work to garner buy-in for and desire on the part of NGOs to work in ASRH
Establishment and support for the provision of ASRH at health facilities	At least 8 additional sites established by 2021; 5 in Regions # 9 and 3 in Region # 1 [Baseline: - 32 sites nationally]	Adolescent health reports	Annual	MCH/AHU MOPH	Risks: ● Difficulty in transporting equipment to health facilities in these remote hinterland target regions. Assumptions: ● Weather must be taken into account ● Local skills and resources will be relied on as much as possible
Support to contraceptives management	Completed training to regional health authorities on contraceptive forecasting, procurement and distribution in Regions # 1 & # 9	Regional Health Authority Reports Adolescent health reports	Annual	RDC, Region # 1 RDC, Region # 9 MCH/AHU MOPH	Risks: ● Competing priorities between Ministry of Public Health and Regional Health Authority. Assumptions: ● Ensure regional health authority participates in both planning and execution phases. ● The Minister of Public Health will engage the Minister of Communities to ensure high-level buy-in and support for the programme.
	Completed availability assessment of contraceptives in Regions # 1 & # 9	Adolescent health reports	Annual	MCH/ANU MOPH	
Coordination with Ministry of Education	Conduct of twice yearly information and education sessions for parents at PTA meetings at targeted	Adolescent health reports Regional Health Authority Reports	Semi-Annual	RDC, Region # 1 RDC, Region # 9 MOPH	Risks: ● Poor PTA meeting attendance. Assumptions:

KEY ACTIVITIES	PROCESS INDICATORS	MEANS OF VERIFICATION	FREQUENCY	RESPONSIBLE UNIT/PERSON	RISKS AND ASSUMPTIONS
	secondary schools in Regions # 1 & # 9	Regional Education Authority Reports		MOE	• Notice of PTA meetings distributed early to parents and the meetings included in the calendar of events for the school term or school year
Information and education in secondary schools and capacity building of teachers in CSE	At least one ASRH information and education session conducted per month in each of the targeted secondary schools in Regions # 1 & 9	Adolescent health reports	Monthly	MCH/AHU MOPH	Risks: • Difficulty convincing Regional Education Officer to include ASRH sessions on timetable. Assumptions: • The Minister of Public Health will engage the Minister of Education to ensure high-level buy-in and support for the programme in the target regions. • The programme will target peer educators and health clubs which will meet during lunch or after school in order to increase access to ASRH information during school hours.
	# of teachers exposed to capacity building training in CSE in Regions # 1 & # 9 [Baseline: - at least 1 teacher per target school in Regions # 1 & 9]	Report of training	Annual	MCH/AHU MOPH HFLE Unit, MOE	Risks: • High staff turnover in remote hinterland target regions • Attitudes and values of teachers that may negatively affect the proposal Assumptions: • Government, through the HFLE Unit within the Ministry of Education, will provide teachers with materials support for the delivery of CSE • Teachers will be recognised and rewarded for meeting and reporting on ASRH targets
	At least one peer educator to be trained per targeted secondary school in Regions # 1 & # 9	Adolescent health reports	Monthly	MCH/AHU MOPH	Risks: • Student's lack of interest/reluctance to engage in SRH issues Assumptions: • Head teachers will be engaged to identify the most capable and willing students to be peer educators

KEY ACTIVITIES	PROCESS INDICATORS	MEANS OF VERIFICATION	FREQUENCY	RESPONSIBLE UNIT/PERSON	RISKS AND ASSUMPTIONS
					• Peer educators will be given recognition and awards as an incentive for dedicated performance.
	# of school-based peer groups established	Adolescent health reports	Monthly	MCH/AHU MOPH MOPH Partners	Risks: • Unwillingness of education personnel (head teachers, teachers) to support initiative. Assumptions: • Include personnel from MOE in planning process and teacher's/head teachers through consultations.
Boys and young men dialogue groups	# of boys and young men dialogue groups established in Regions # 1 & # 9	Adolescent health reports	Monthly	MCH/AHU MOPH MOPH Partners	Risks: • Availability of men and boys for dialogue (may be working or at school)/Competing priorities. Assumptions: • Target community groups and community workers to recruit men and boys.
Community-based ASRH services	# of ASRH training and # of IEC materials provided to community leaders in Regions # 1 & # 9	Adolescent health reports Regional Health Authority Reports Regional Education Authority Reports	Monthly	RDC, Region # 1 RDC, Region # 9 MOPH MOE	Risks • Unwillingness of community leaders to participate in training sessions. Assumptions: • Engage community organisations in planning process so they can appreciate the importance of the activity.
	# of ASRH community dialogues conducted with traditional and religious leaders of communities in Regions # 1 & # 9	Adolescent health Unit reports	Monthly	MCH/AHU MOPH MOPH Partners	Risks: • Lack of will on the part of traditional and religious leaders to engage with ASHR issues Assumptions: • Conduct stakeholder consultations and engage them a part of the planning process.

Annex 5 (a): Work Plan

Expected Results/Activities	Implementing Partners	Years			
		2019 July-Dec,	2020	2021	2022 Jan-Jun
OUTCOME 1: Increased use of quality adolescent sexual and reproductive health services in communities of Regions # 1 & # 9					
Output 1.1: Adolescents of Regions # 1 (Barima - Waini) and # 9 (Upper Takutu - Upper Essequibo) have access to quality ASRH information, education and services in their communities					
Activity 1.1.1: ASRH programming including annual monitoring of ASRH indicators and commitments, planning meetings and supervision visits and development and implementation of the standards for quality health care for adolescents	MCH/AHU – MOPH, UNFPA, PAHO		X	X	X
Activity 1.1.2: Training of health workers and NGOs in ASRH	MCH/AHU – MOPH		X	X	X
Activity 1.1.3: Equip health facilities	MCH/AHU - MOPH		X		
Activity 1.1.4: Contraceptives management and procurement	MCH/AHU – MOPH, UNFPA,	X	X	X	
Activity 1.1.5: Family Planning weeks	MCH/ANU – MOPH, Regional Authorities (1 and 9)		X	X	X
Output 1.2: Strengthened inter-sectoral and intra-sectoral coordination for an enabling environment towards adolescent sexual and reproductive health					
Activity 1.2.1: Health sector coordination around ASRH	MCH/AHU – MOPH, UNFPA, PAHO		X	X	X
Activity 1.2.2: Coordination with the education sector at central and at regional level (1 and 9)	MCH/AHU – MOPH, UNFPA, PAHO		X	X	X
OUTCOME 2: Adolescents, in particular adolescent girls, in communities of Regions # 1 & # 9 are empowered to prevent adolescent pregnancies					
Output 2.1: Adolescent girls and adolescent boys in Regions # 1 & # 9 have enhanced capacities to make informed decisions about their SRH and demand for services.					
Activity 2.1.1: Information and education sessions and capacity strengthening of teachers and school-based peer educators	GRPA, MCH/AHU – MOPH,		X	X	X
Activity 2.1.2: Boys and young men dialogue groups	GRPA, MOSP, MCH/AHU – MOPH, MOPH		X	X	X
Output 2.2: Accountability mechanisms for local government entities are strengthened for coordination and implementation of prevention and response programmes to end teenage pregnancies					
Activity 2.2.1: Awareness raising and mobilization of traditional and religious leaders	GRPA, MOSP, MCH/AHU – MOPH, MOPH		X	X	X
Activity 2.2.2: Support to the community parenting and support groups.	MCH/AHU – MOPH, MOPH Partners		X	X	X

Annex 5 (b): Work Plan with Budget

Expected Results/Activities	Budget				Total (USD)
	2019 (July–Dec.)	2020	2021	2022 (Jan.-June)	
OUTCOME 1: Increased use of quality adolescent sexual and reproductive health services in communities of Regions # 1 & # 9					
Output 1.1: Adolescents of Regions # 1 (Barima - Waini) and # 9 (Upper Takutu - Upper Essequibo) have access to quality ASRH information, education and services in their communities					
Activity 1.1.1: ASRH programming including annual monitoring of ASRH indicators and commitments, planning meetings and supervision visits and development and implementation of the standards for quality health care for adolescents		28,353	22,076	6,000	56,429
Activity 1.1.2: Training of health workers and NGOs in ASRH		16,250	18,250	9,000	43,500
Activity 1.1.3: Equip health facilities		31,820	0		31,820
Activity 1.1.4: Contraceptives management and procurement	18,508	14,696	14,885		48,089
Activity 1.1.5: Family Planning weeks		10,000	10,000	6,000	26,000
Output 1.2: Strengthened inter-sectoral and intra-sectoral coordination for an enabling environment towards adolescent sexual and reproductive health					
Activity 1.2.1: Health sector coordination around ASRH		500	500	400	1,400
Activity 1.2.2: Coordination with the education sector at central and at regional level (1 and 9)		10,600	10,600	6,600	27,800
Sub-total Outcome 1	**18,508**	**112,219**	**76,311**	**28,000**	**235,038**
OUTCOME 2: Adolescents, in particular adolescent girls, in communities of Regions # 1 & # 9 are empowered to prevent adolescent pregnancies					
Output 2.1: Adolescent girls and adolescent boys in Regions # 1 & # 9 have enhanced capacities to make informed decisions about their SRH and demand for services.					
Activity 2.1.1: Information and education sessions and capacity strengthening of teachers and school-based peer educators		36,000	26,000	12,250	74,250
Activity 2.1.2: Boys and young men dialogue groups		9,286	9,286	5,714	24,286
Output 2.2: Accountability mechanisms for local government entities are strengthened for coordination and implementation of prevention and response programmes to end teenage pregnancies					

Expected Results/Activities	Budget				Total (USD)
	2019 (July–Dec.)	2020	2021	2022 (Jan.-June)	
Activity 2.2.1: Awareness raising and mobilization of traditional and religious leaders		8,000	6,000	4,000	18,000
Activity 2.2.2: Support to the community parenting and support groups.		12,000	12,000	6,000	30,000
Sub-total Outcome 2	**0**	**65,286**	**53,286**	**27,964**	**146,536**
Final review	0	0	0	8,000	8,000
TOTAL PROGRAMME COSTS (outcome 1 and 2 and review)	**18,508**	**177,505**	**129,597**	**63,964**	**389,574**
M&E Officer	3,648	14,592	15,322	7,296	40,858
SRH Officer	4,402	17,608	18,488	8,804	49,302
Salary costs (SRH and M&E Officers)	**8,050**	**32,200**	**33,810**	**16,100**	**90,160**
UNFPA operational costs	7,038	12,899	13,286	4,377	37,600
Sub-total Operational cost	**15,088**	**45,099**	**47,096**	**20,477**	**127,760**
Total Direct Costs	**33,596**	**222,604**	**176,693**	**84,441**	**517,334**
Agency Implementation (UNFPA) Cost/Rate (5%)	**1,680**	**11,130**	**8,835**	**4,222**	**25,867**
Total Direct Costs + UNFPA IC	**32,276**	**233,734**	**185,527**	**88,663**	**543,200**
UNDPs GMS Rate (3%)	**1,058**	**7,012**	**5,566**	**2,660**	**16,296**
Total Budget	**36,334**	**240,746**	**191,093**	**91,323**	**559,496**