Guyana Drug Information System (GuyanaDin)

Annual National Report 2002 and Network Meeting

January 2003
GUYANA

Map of Guyana with neighbours

The contents of this report represent the proceedings of the 1st Network Meeting held in Guyana which was supported by the United Nations Office on Drugs and Crime (UNODC)/Global Assessment Programme (GAP) under the umbrella of the Drug Epidemiology and Surveillance System Project (DAESSP) and the Ministry of Health.

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For further access to further information and resources on drug information systems visit the United Nations Office on Drugs and Crime (UNODC) Global Assessment Programme on Drug Abuse (GAP) website at *www.undcp.org,* email *gap@undcp.org*, or contact: Demand Reduction Section, UNDCP, P.O. Box 500, A-1400 Vienna, Austria.

Acknowledgements

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Abbreviations

CAREC	Caribbean Epidemiology Centre
CARIDIN	Caribbean Drug Information Network
CARIFORUM	Caribbean Forum (Group of 15 independent Caribbean States)
CICAD	Inter-American Drug Control Commission
DAESSP	Drug Abuse Epidemiological and Surveillance System Project
GAP	Global Assessment Programme
GUYANADIN	Guyana Drug Information Network
NACDER	National Council for Drug Education, Rehabilitation and Treatment
OAS	Organisation of American States
SIDUC	Inter-American System of Uniform Drug-Use Data
UNODC	United Nations Office on Drugs and Crime

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SECTION 1: NETWORK

BACKGROUND

Country information

Guyana covers approximately 214,000 square kilometres with a population of approximately 730,000 persons. Guyana is bordered on the east by Suriname, on the South, South East and South West by Brazil. Additionally, the country also shares a border on the North West with Venezuela, and on the North with the Atlantic Ocean. The ethnic composition of Guyana is: 49.5% East Indian; 35.6% Afro-Guyanese; 6.8% Amerindian: 0.7% Portuguese; 0.4% Chinese and 7.1% mixed.

As a former British colony, the main economic activities have been and continue to be the cultivation of rice and sugar, as well as mining of bauxite, though the latter has been on the decline in recent times. The labour force is around 340,000 and unemployment is about 13%. Mining of minerals has increased considerably, however, all mining takes place in the interior of the country. The interior is populated mainly by indigenous peoples who live in small isolated villages scattered throughout the area, as well as along the borders with Venezuela, Brazil and Suriname. Several other economic activities normally exist to support mining; these include trading through established shops as well as itinerant traders selling clothing, food and other necessities.

Over 80% of the population live along the Atlantic Coast, which leaves the other parts of the country largely uninhabited and the borders unpatrolled. These geographical features have made it possible for illegal drugs to be taken in and out of Guyana with relative ease.

Anecdotal evidence suggests that large quantities of illegal drugs remain in the country and are distributed through a large network to persons throughout the country. This network is comprised primarily of children, adolescents and young adults.

Report of Network Meeting

The collection of data related to trafficking, use and abuse of narcotic substances in Guyana has been done by several agencies. Through the initiative of the Drug Abuse Surveillance System Project (DAESSP) and the Caribbean Drug Information Network (CARIDIN), the National Council for Drug Education, Rehabilitation and Treatment (NACDER) of the Ministry of Health , Guyana convened a meeting to establish a network of agencies who are involved in drug related activities. The Caribbean Drug Information Network (CARIDIN) currently extends to the 15 CARIFORUM countries, the Dutch and British Caribbean Overseas Countries and Territories are encouraged to sign on. Information on both licit and illicit substances is collected from various sources as outlined below. Each island, through its National Drug Council establishes a National Drug Information Network (NDIN), which collects information that feeds into CARIDIN. The network, which is made up of all institutions that collect information on substances, will play a major role in the demand and supply reduction efforts of the Caribbean. A total of 22 agencies attended the network meeting in Guyana (see Appendices)

The Chief Medical Officer welcomed the participants and made brief comments. Jennifer Hillebrand, Regional Epidemiology Adviser, UNODC gave two presentations which described the intent of the Caribbean Drug Information Network and the purpose and functions of a local network. The format of the meeting allowed for maximum

participation and the participants utilised this opportunity to discuss their perceptions and views on the constraints and factors that could inhibit the establishment of a surveillance system and a network to monitor substance use, abuse and other drug related activities. The first group discussion required the participants to identify problems and needs related to documentation of drug related activities. The participants acknowledged the paucity of systems to facilitate data collection and the limited skills available to adequately manage and retrieve the data in a timely and efficient manner. The participants also proposed solutions to the problems and needs. (see Appendices).

The second group activity required that the participants identify ways in which the SIDUC instruments could be used as well as suggest possible modifications which would make the instrument culturally appropriate for specific types of agencies in Guyana. (see Appendices).

The last activity of the meeting requested participants to make general comments, among which were the reiteration of the importance and need for improved processes to collect data and improved networking and sharing among agencies involved in drug related activities.

It was highlighted that serious consideration needs to be given to ways of reaching those population groups who do not have access to specialized agencies and to document substance use and abuse among persons who are sent to the juvenile correction centre.

At the end of the meeting, the participants agreed to provide available and relevant information to the National Council for Drug Education, Rehabilitation and Treatment. The CARIDIN data collection forms were distributed and over 50% of the organisations represented at the meeting completed and returned the forms.

Based on the information received, it was recognised that important agencies had not been invited to be a part of the network; these included the Food and Drug Analyst and the National AIDS Programme Secretariat. These agencies have since been contacted and they have expressed their willingness to contribute to the Surveillance System and be a part of the Network. A few of the agencies represented voiced their doubts about the benefits that their organisation could accrue from involvement in the Network.

GUYANADIN – The way Forward

It is proposed to include other agencies from various parts of the country in the Network and to modify the data collection instruments from institutions such as the prison, hospital emergency rooms, health centres and juvenile correction centres to identify substances used by the inmates and clients. At the present time the psychiatric units and one residential facility only collect this information.

The expansion and sustainability of a Drug Information Network requires changes in the legal framework of the country and in the operational procedures of agencies involved in both Drug Demand and Supply activities. The immediate actions required are

- Sensitisation of policy makers of the agencies participating in the Network so that they could make the necessary policy changes that would facilitate the collection of data in their respective agencies;
- Training of persons who will be responsible for the actual data collection process;
- Development of an epidemiological database that facilitates not only storage, but timely retrieval of data and compilation of reports.

In the long term, it will be necessary for the Drug Council (NACDER) to include in its establishment, an officer with specific responsibilities for maintaining the database and

managing the Network. Another critical, but longer term objective would be the formulation of legislation for physicians, psychologists and treatment centres to report new cases of substance abuse, including the substances of abuse and the establishment of norms and standards for drug treatment facilities.

Constraints

The sustainability of the Network is a time consuming task. It requires

1. **Keeping in touch with participating agencies**. Staff in many of these agencies are rotated, as a result, it is necessary to spend time doing orientation of each new person who becomes responsible for collecting the data.
2. **Reviewing existing data collection forms and/or assisting agencies to develop their own data collection instruments**.
3. **Reviewing the forms** as they are submitted and preparing it for data entry.
4. **Development of a database**. This is a major problem since this is a time consuming job. As a result, a computerised data collection and collation system has not yet been put in place, consequently, the collation and storage of the data is still being done manually and stored on hard copies. The establishment of an appropriate database is critical if the data collection process, storage and retrieval of information is to be transformed into a surveillance system.

SECTION 2 – ANNUAL REPORT

Description of all sources

Drug related activities in Guyana come under the umbrella of the National Anti-Narcotic Commission, which is chaired by the President of the Country and managed by a Secretariat, which is located in the Ministry of Home Affairs. The Commission is comprised of several Committees, each of which is responsible for various aspects of drug related activities, viz. law enforcement, legal issues, drug treaties, seizures and one committee that oversees prevention, rehabilitation and treatment.

The National Master Plan which was passed in Parliament in 1995 and whose implementation is presently being assessed, had suggested a Joint Information System, however, many of the agencies involved in Supply reduction felt that their information which included some "intelligence" was too sensitive and could not be shared. The possibility exists that some of these agencies continue to hold this view. As a result, data was received from the treatment services, the Police Narcotics Unit and a consolidated report about seizures and arrests from the NANCOM Secretariat. The names of the agencies from which data was received are included in the tables.

Information on drug consumption

Over the years, it has been difficult collecting data related to substance abuse; very few agencies maintained databases specifically for substance abuse. Thus, the data collection form provided through CARIDIN has served as a guide, which was used by some agencies to review their records and extract the relevant information, which is presented below. Despite the data collection form, agencies have expressed the need for simpler

forms to collect data related to substance abuse on a daily basis. This kind of data collection instrument would be particularly useful for the Prison services and the Emergency Rooms of hospitals, where substance users and abusers are seen but no information about their drug using habits are collected or recorded. A review of the Inter-American System of Uniform Drug-Use Data instruments for juvenile offenders and emergency rooms that were developed by OAS/CICAD may provide guidance when developing data collection instruments. Furthermore, although the summary format presented has been useful, it requires some adaptation to make it user-friendlier and there must be sensitization of persons outside the network representatives and training in basic data collection skills for all persons who would routinely collect data in the agencies represented on the Network. With these modifications, it is likely that more agencies will be able to collect data and contribute to the national substance abuse database and information network.

A. Treatment Services

Drug treatment services in Guyana are very limited and since substance use is not a reportable condition, physicians, including psychiatrists, do not provide this information for various reasons. First of all, there is no legislation requiring them to do so, and secondly, no agency has ever requested this information. Additionally, there are no protocols for identification or treatment of conditions that result from substance abuse. No norms and standards for establishment and management of treatment services exist and agencies are not required to register if they are providing drug treatment and rehabilitation services. Thus, the drug treatment industry is unregulated; as a result, the information available is incomplete.

In treatment services, three agencies submitted information, these are the National Psychiatric Hospital, the Psychiatric Clinic of the Georgetown Public Hospital and the Salvation Army Rehabilitation Centre.

- The National Psychiatric Hospital has 2 units that serve as in-patient treatment centres for substance abusers.
- The Psychiatric Clinic of the Georgetown Public Hospital Corporation operates several out-patient clinics through which out-patient treatment is provided to clients who are suffering from drug induced psychoses.
- The Salvation Army Drug Rehabilitation Centre is a Residential Rehabilitation Centre for male substance abusers. This programme is run by an NGO and clients have to pay for treatment.

Table 1: Summary of Data on Treatment Services

Type/Name of institution	**Reporting Cycle**	**# of clients**			**# of person by type of drug used**				**Admission over last month (2001)**
		Total	M	F	1	2	3	4	
National Psychiatric Hospital	Yearly 2001	71	60	11	19	71	35	-	7 (Dec)
Georgetown PHC	Monthly & Yearly 2001	41	40	1	15	27	6	-	19 (Sept)
Salvation Army RC	Quarterly 2001	14	14	-	2	1	-	11	3 (Sept)

1	Alcohol
2	Marijuana
3	Cocaine
4	Crack-Cocaine

B. Arrests

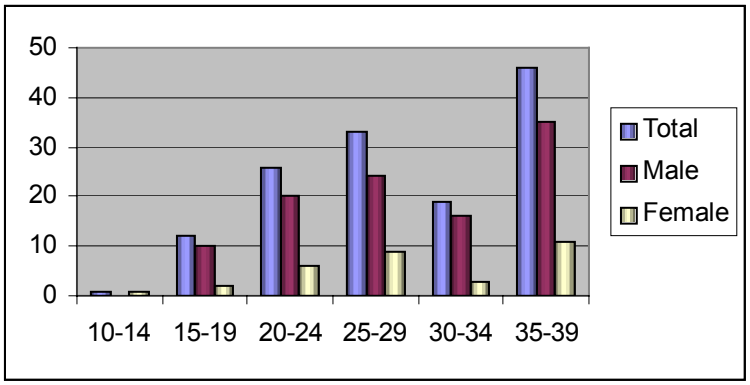
The information on arrests and convictions was submitted by the Guyana Police Force and the Ministry of Home Affairs and represents the major source of information collected and utilised by agencies in the supply section of the National Anti-Narcotic Commission.

Table 2: Summary of Arrests for drug possession and drug trafficking in 2001

Age Group	Arrests for Trafficking			Arrests for possession			Convictions for trafficking			Convictions for possession		
	T	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**	**T**	**M**	**F**
10-14	**6**	3	3	**2**	1	1	**1**	1	-	**-**	-	-
15-19	**39**	30	9	**10**	9	1	**4**	4	-	**14**	13	1
20-24	**84**	69	15	**92**	82	10	**5**	4	1	**36**	36	-
25-29	**85**	69	16	**134**	128	6	**21**	10	1	**51**	48	3
30-34	**76**	66	10	**88**	82	6	**12**	10	2	**29**	27	2
35-39	**120**	95	25	**106**	96	10	**9**	9	-	**39**	35	4

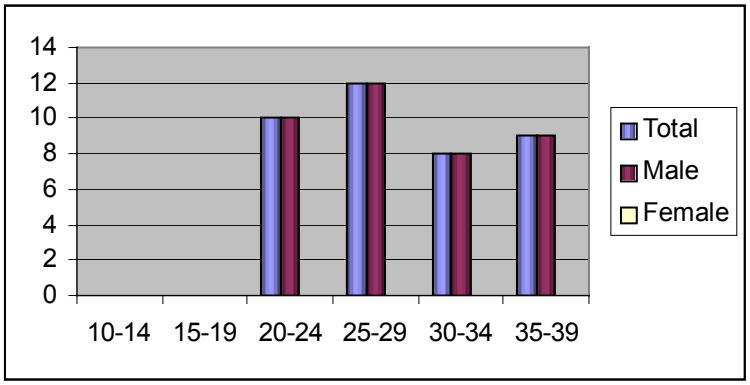
Source: Guyana Police Force and Ministry of Home Affairs

Figure 1: Persons by age group arrested for cocaine trafficking in 2001



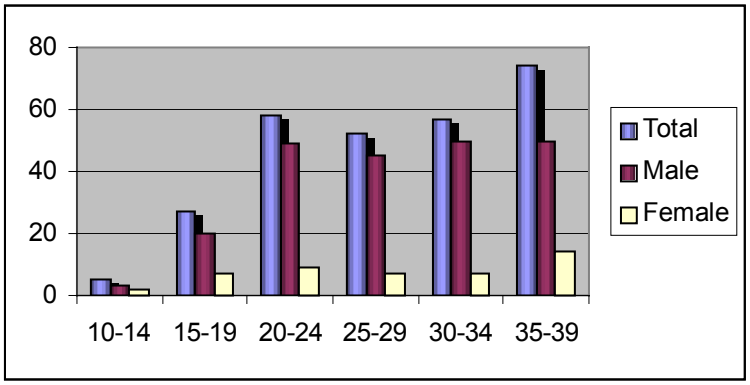
Source: Guyana Police Force and Ministry of Home Affairs

Figure 2: Persons by age group arrested for possession of cocaine in 2001



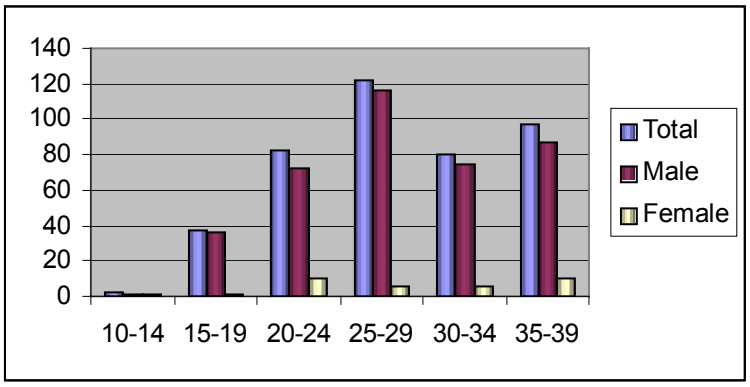
Source: Guyana Police Force and Ministry of Home Affairs

Figure 3: Persons by age group arrested for marijuana trafficking in 2001



Source: Guyana Police Force and Ministry of Home Affairs

Figure 4: Persons by age group arrested for possession of marijuana in 2001



C. Seizures

The highest quantity of drugs seized in Guyana in 2002 was marijuana, followed by cocaine.

Table 1: Quantities of seizures in 2002 and 2001

Name of drug	Quantity (kg) in 2002	Quantity (kg) in 2001
Cocaine	**38.288**	**79.208**
Marijuana	**40,749.251**	**10574.924**
Heroin	**-**	**-**
Marijuana eradication efforts (kg)	**38,535**	**10,332**

Source: Police Headquarters, Georgetown, Guyana

D. Surveys

Data collection for a school survey was conducted in 2002. This survey was only conducted in one of the ten administrative regions of Guyana. This survey is a part of the Drug Abuse Surveillance System Project and spearheaded by OAS (CICAD). The survey instrument presented by CICAD was modified to include questions that would provide data to inform the development of educational interventions that are relevant to the national situation. The survey report is not yet completed.

Prior to this, the last school survey was conducted in 1997. The survey examined attitudes, practices and behaviour in relation to Substance Abuse among high school children in the entire country. This survey was funded through the health desk of the CARICOM Secretariat and the Ministry of Health. A total of 2800 school children aged 11-19years of age were interviewed. The results, revealed that 60% of the respondents smoked cigarettes, 2.5% admitted to using marijuana, and 1% admitted to having used cocaine at some point in their life. However, the majority of students (54%) of the

students said that they would not admit to using drugs, even if they were using drugs. No other surveys have been conducted on drug related issues in the past 3 years.

Overview of drug situation and trends

Due to the limited data collection activity, the information provided in this section is mainly anecdotal.(perhaps a few sources could be mentioned; i.e. verbal reports from staff working at hospitals etc).

Main drug of choice

Alcohol is the most widely used/abused drug in Guyana. It is readily available in most regions from both legal and illegal sources (i.e.). In many rural areas, drinking alcohol is accepted as the main form of recreation.

The effects of alcohol use are quite visible among East Indians and Amerindians of both sexes, including adolescents. Alcohol use is prevalent among sugar workers, farmers and youths in the rural areas.

In recent times, in those areas where alcohol was the main drug of abuse, cocaine and marijuana are infiltrating those communities resulting in multiple drug use, especially among youths.

Second most important drug (and subsequent drugs)

Cocaine abuse has become increasingly prevalent over the past few years. The fact that payment for transhipping cocaine is made with cocaine leaves has resulted in large quantities of cocaine reaching the local markets. Consequently an increase in cocaine use in several administrative regions has been observed..

The effect of cocaine use is more visible in depressed areas, but is also known to be prevalent among high-income families.

Other factors affecting trends

As mentioned earlier in the report, Guyana shares many miles of borders with Brazil, Venezuela and Suriname. In addition, the fourth border is the Atlantic Ocean, which is largely unpatrolled and gives boats of various sizes unlimited access. There are also many small isolated airstrips, which are used for various purposes, both legitimate and illegal. These geographical features and close proximity to major cocaine producing countries makes it easy for drugs to be transhipped into and out of the country. Thus, in areas which border Venezuela, there is evidence of increased availability. A visible increase in the number of abusers and rapid financial growth is also being demonstrated by some members of the area.

The same trend of sudden wealth has appeared in the fishing villages that are located along the border with Suriname. The situation has deteriorated to the point where parents have been requesting assistance for their sons, particularly, who are abusing drugs.

The fact that these substances are coming into the country through the borders was verified in the School Survey in 1997. It revealed, that most of the children living along the border areas admitted that they had seen cocaine and that it was easy for them to get marijuana or cocaine if they desired.

Despite the absence of data, there have been reports about a significant increase of persons using and abusing drugs on the streets, and a greater number of parents acknowledging that they are experiencing considerable difficulty with a child who may

be using illegal substances and stealing from the family to maintain their habit and are asking for assistance.

Over the past year, there has been a significant upsurge in criminal activity and violence. Many sources, including the police have indicated publicly that this violence is directly related to the Narco-Trade, but no evidence has been given to verify these statements.

Concerns have also been voiced about the high incidence of HIV/AIDS among the drug using population and the possible relationship between the high incidence of HIV/AIDS and substance use and abuse among adolescents and young adults.

According to estimates from United Nations Programme on HIV/AIDS for 2001, 18,000 people are infected in Guyana. There has also been a large number of road traffic accidents involving minibuses with high mortality rates. Minibus drivers are young males and many of these accidents have been the result of drug or alcohol use. Though there has been no study to establish the relationships, many minibus drivers and conductors have been diagnosed with HIV/AIDS.

Conclusion

Data Collection on drug related issues in Guyana is still in its infancy, as a result, it is not appropriate at this time to draw any conclusions or predict any trends from the limited data available. There needs to be considerably more capacity building for the coordinators, especially in relation to the development of a computerised database and data management. There is also the need for advocacy to ensure that decision makers at the national level understand the importance of the networks and put systems in place so that reports are statistically accurate and useful.

Appendices

1. List of participants at Network Meeting with* marking those who submitted forms
2. Report of Group Discussion 1 at Network meeting
3. Report of Discussion 2 at Network Meeting

Ministry of Health, Guyana
National Council for Drug education, Rehabilitation and Treatment
1st National Drug Information Network Meeting.

List of Persons

No.	Name	Organisation	Occupation
1.	Barbara R. Freso	National Recovery Challenge	Facilitator
2.	Gladson Alert	Habitat for Humanity Guyana Ltd	National Chairman
3.	Venus Wayne	Guyana Responsible Parenthood Association	Programme Officer
4.	Clarence Young	Ministry of Health	Counsellor
5.	Matthew Thomas	Guyana Prison Service	Prison Officer
6.	Royston Adams*	Guyana Police Force	Police Officer
7.	Collin Martin	Guyana Defence Force	Army Officer
8.	Godfrey George	Guyana Defence Force	Coast Guard Officer
9.	Bibi Jaffarally *	National Psychiatric Hospital	Nurse
10.	Sydney Scott *	Ministry of culture Youth and Sport	Social Worker
11.	Ricardo Yearwood	CARICOM/UNDCP	Technical Service Officer
12.	Yvonne Arthur	Ministry of Education	Coordinator Schools Welfare
13.	Surujbans Persaud	Customs Anti Narcotic Unit	Intelligence Officer
14.	Leendert Woodruff	Probation and Family Welfare Service	Asst. Chief Probation Officer
15.	Doneth Mingo	Ministry of Health	
16.	Colin Howard	Guyana Prison Service	Prison Officer
17.	Desiree Crawford	Ministry of Health	Health Education Officer
18.	Steve Callender *	Salvation Army	Counsellor
19.	Joseph Quamina *	Ministry of Home Affairs	Head Public Sector Security
20.	Lakshmi Shiwnandan	Ministry of Legal Affairs	State Counsel
21.	Gordon Payne	University of Guyana	University Lecturer
22.	Roland Holder	Ministry of Health	Drug Education Officer
23.	Joseph Anthony	West End Management Organisation	Community Leader
24.	S. Granger-Ba	Guyana Defence Force	Military Officer
25.	Nellie Gordon	West End Management Organisation	Community Leader
26.	Voyons Morancy *	Salvation Army	Minister of Religion
27.	Rev. Fay Clarke	Guyana Prison Service	Ass. Supt. Of Prison
28.	Shradhanand Hariprashad	Ministry of Health	Health Research Officer
29.	Gloria DeFlorimonte *	Psychiatric Clinic	Health Visitor

Results of 1st Group Discussion

What are the problems and needs in regard to data collection on drug use in Guyana	How can these problems be solved
Need for a centralized data collection point/Secretariat	NACDER Surveillance Unit Established and functioning
Absence of awareness of the process of information sharing and dissemination - Needs to be raised – HOWS? Ignorance (of drugs/implications) Short-sightedness	- Develop Surveillance and info sharing system. E.g. newsletters, advocacy strategy etc.
Reluctance to share information Lack of trust "Red Tape"	- Sensitization of policy makers and senior personnel in agencies represented.
Absence of documented information Information available not necessarily documented. Inadequate legal and administrative mechanisms Absence of financial resources/transport facilities/human resources Lack of follow-up/monitoring Lack of skilled technical personnel/lack of knowledge to interpret data Lack of equipment	Forms to be developed for use by all agencies.
Absence of systems within agencies in order to collect information	Data collection form (above) institutionalised and used.
Retrieval of information needs to be simplified	Need to develop standardized questionnaires
Need to determine time period for submission of data from agencies (monthly?)	Monthly submission of forms to NACDER
Need for incentives to data collection	Formalisation of arrangements
Confidentiality (Counselor/Client Confidentiality)	
We cannot assess the "true" magnitude of the drug problem because: Information can be gathered. Pervasiveness of drug/drug users do not seek help Late detection	Survey will be implemented targeting various groups
Need to establish focal points (central and agency focal point)	This network will consist of focal point
Need to include community activists and field personnel for data collection	Yes – this has been considered and is being implemented
Need to visit another region/country in order to share data collection strategies.	Many countries in the region are at the same level as Guyana.
Need to avoid "double counting"	Put a system of coding into place

2.2nd Group Presentations

A. How should the SIDUC instrument for – treatment institutions be modified in order to be applicable to the context in Guyana?
* Inclusion of Ethnic origin
* Inclusion of region instead of city
* Inclusion of Homemakers
* Questionnaire should distinguish between general/private governmental institutions
* Inclusion of graduate/above
* Inclusion of single/(never married or divorced/living together)
* Inclusion of indigenous illegal substances: Banana leaves/Bells of death

B. How is data collected at the prison?
Upon submission of the inmate, all relevant information is already available. The committal warrant would state all information that was gathered about the person.
Information is shared with the Ministry of Home Affairs and C.O Police on a monthly basis.
Information about drug use that is not related to the offence is not documented.

C. Salvation Army
The use of questionnaires is possible. At admission an in-depth face-to-face interaction with the clients takes place and the information gathered is kept within the agency only. No information is passed to the police. Currently there are no resources to collate the information.

D. NOC ("New Opportunity Corps")
Information is usually extracted from committal warrant. A face to face interaction takes place and the information gathered is not handed to any other agency.

E. Police
Data is gathered according to offence and reports are transferred into alphabetical listing (names) and regularly sent to the Commissioner of Police.

F. Ministry of Health/Education/NGO's
* Use of Questionnaires
*Ministry of Health utilizes intersectoral collaboration
*Reporting is done regularly (does not apply to NGO)
*Need to see the purpose of data collection and analysis
*Urgent need for professional secretariat to gather and collate information.

General Comments

*Improvement of collection of data needed
*Standardized methods for gathering information will need to be considered
*Improved networking among agencies
*Information gathered to be forwarded to the National Drug Information Centre using coding symbols to protect client identity

*How to reach other populations other than the one that appears at specialized agencies?
Army
Churches – Counselling
Prison
Mining Area (Ministry of Regional)