GUYANA

The Burden of Mental Disorders in the Americas:
COUNTRY PROFILE

2019 population (thousands) **783**
Life expectancy (years) **69.9**

Guyana lies on the northeastern coast of South America and borders Suriname, Venezuela, and Brazil. It includes two distinct areas: the coastal area and the interior (or rural interior). It comprises an area of 215,000 km^2 and is divided administratively into 10 regions.
Although the official language is English, at least eight other languages and dialects are also spoken.

Its population is multi-ethnic: Indo-Guyanese (40% of the total population), Afro- Guyanese (26%), Amerindian (11%), and ethnically mixed (20%). The Chinese, Portuguese, and white populations together constitute less than 1% of the total population.

Life expectancy at birth was 69,9 years in 2019.
In 2015, per capita gross domestic product (GDP) was US$ 3,724.
Agriculture, forestry, and the fishing and mining industries accounted for 28% of GDP.

THE DISEASE BURDEN AFFECTING MENTAL HEALTH

Mental, neurological, substance use disorders and suicide (MNSS) cause 16% of all disability- adjusted life years (DALYs) and 33% of all years lived with disability (YLDs).

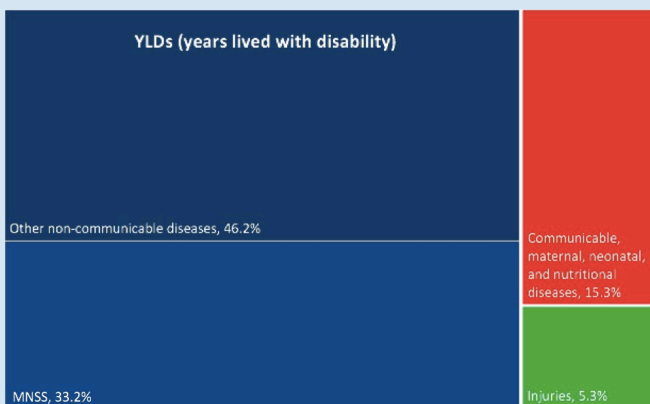


Figure 1. Distribution of YLDs with a focus on mental, neurological, substance use disorders and self harm (MNSS)

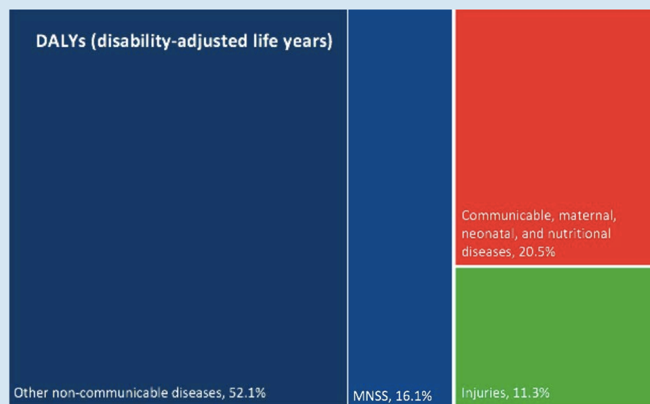


Figure 2. Distribution of DALYs with a focus on mental, neurological, substance use disorders and self harm (MNSS)

THE BURDEN AFFECTING MENTAL HEALTH ACROSS THE LIFETIME

Fig. 3 shows the changes in disease burden across age-groups. NCDs (in shades of blue) surpass 50% of the burden around 5 years old, and will remain the largest burden throughout the lifetime. MNSS account for more than a fourth of the total burden between 10 and 40 years of age, the largest burden of all disease groups during this period.
Fig. 4 focuses exclusively on the burden resulting from MNSS. Until 5 years old, the MNSS burden is mostly due to epilepsy (53%) and autism (40%). Between 5 and 15 years old, the burden of conduct disorders, anxiety disorders, and headaches –including migraine and tension-type– gain prominence, with 16% of the MNSS burden each. Around 20 years of age, a pattern emerges that will remain stable throughout youth and adulthood: common disorders (anxiety, depression, self-harm and somatic symptom disorder) account for 53% of the burden (suicide accounts for a more than a third of the MNSS burden between 15 and 35 years old), substance use disorders for 18% (14% due to alcohol), headaches 13%, and severe mental disorders (schizophrenia and bipolar disorders) 5%. The elderly suffer mostly from neurocognitive disorder due to Alzheimer's disease, which reaches 50% of the burden around 80 years old and remains above 70% after 85 years old.

This is the second installment of the 2018 PAHO report, found here

Pan American Health Organization
World Health Organization
REGIONAL OFFICE FOR THE Americas

Figure 3. Burden of disease, by disease group and age

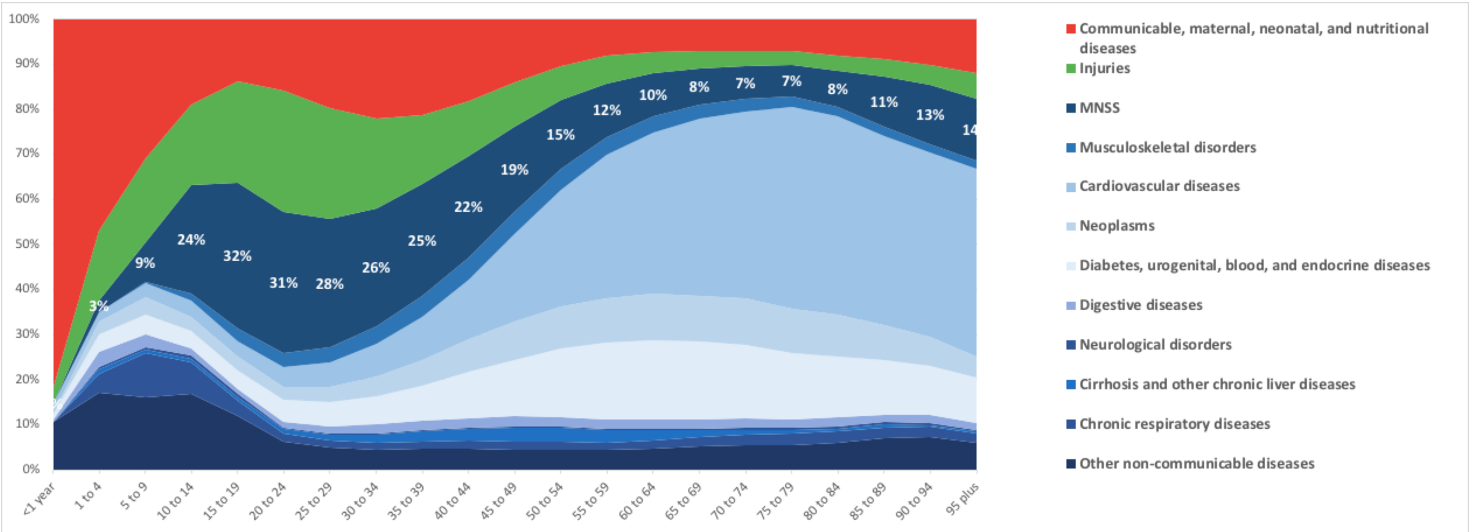
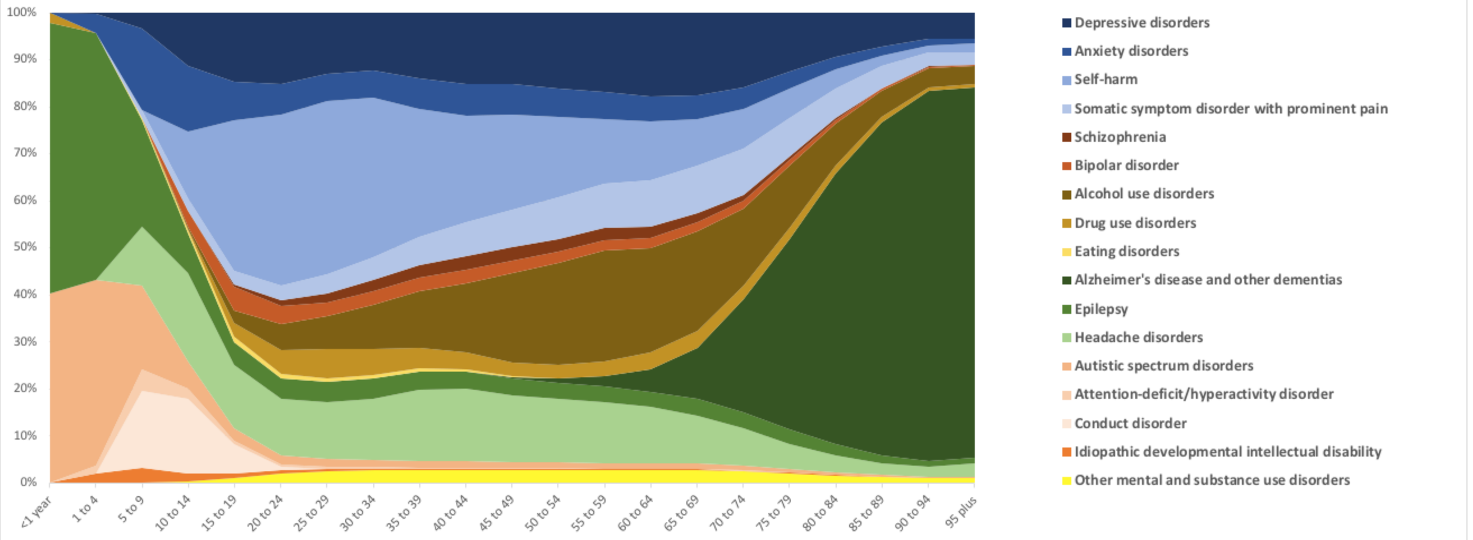


Figure 4. Burden of disease, by MNSS and age



THE BURDEN AFFECTING MENTAL HEALTH IN MEN AND WOMEN

The top three disorders in terms of disability-adjusted life-years –accounting for 50 to 60% of total MNSS burden- are not the same for men and women: While men are mostly affected by self-harm and suicide, alcohol use and depressive disorders, women are mostly affected by depressive disorders, headaches, and self-harm and suicide.

Men		Women	
Disorder	**DALYs per 100 000**	**Disorder**	**DALYs per 100 000**
MNSS (all)	7066	MNSS (all)	5229
Self-harm and suicide	2155	Depressive disorders	1054
Alcohol use disorders	1174	Headache disorders	989
Depressive disorders	688	Self-harm and suicide	623
Headache disorders	549	Anxiety disorders	500
Alzheimer's disease and other dementias	393	Somatic symptom disorder with prominent pain	405

Conclusions:

Considering these estimates, primary care providers should receive training and tools to prioritize detection and treatment or referral for the common disorders highlighted above for each age-group and sex. For the severe disorders –such as autism, schizophrenia, bipolar disorder and Alzheimer's– as well as for severe, comorbid, or complex presentations of other disorders –e.g. depression during pregnancy, substance use in public service professions, etc.– primary care providers and families need access to adequate supports, such as:

- Referral and/or supervision platforms that allow for continued treatment in the community, including the use of digital technology to increase access to distant geographically concentrated resources.
- Emergency, inpatient, and residential services for the management of high-risk acute situations and high-need patients. These services should be community-based as much as possible, including for crisis management, inpatient treatment in general hospitals, supported housing, and residential services.