BOLIVIA (PLURINATIONAL STATE OF)

The Burden of Mental Disorders in the Americas:
COUNTRY PROFILE

Bolivia is located in central-western South America. Bordering Argentina, Brazil, Chile, Paraguay, and Peru, it has an area of 1,098,581 km^2, with three major geographical areas: Andean, sub- Andean, and plains. It is divided administratively into 9 departments, 112 provinces, and 339 municipalities, with 36 constitutionally recognized nations.

The population in 2019 was 11.5 million.
The evolution of selected basic indicators from 1990 to 2015 reflects general improvement in socioeconomic and health status, with the human development index reaching 0.662 in 2014.

Since 2006, the country's annual economic growth has averaged 4.9%. Key productive sectors include manufacturing, mining and quarrying, agriculture, forestry, hunting, and fishing.

THE DISEASE BURDEN AFFECTING MENTAL HEALTH

Mental, neurological, substance use disorders and suicide (MNSS) cause 14% of all disability- adjusted life years (DALYs) and 33% of all years lived with disability (YLDs).

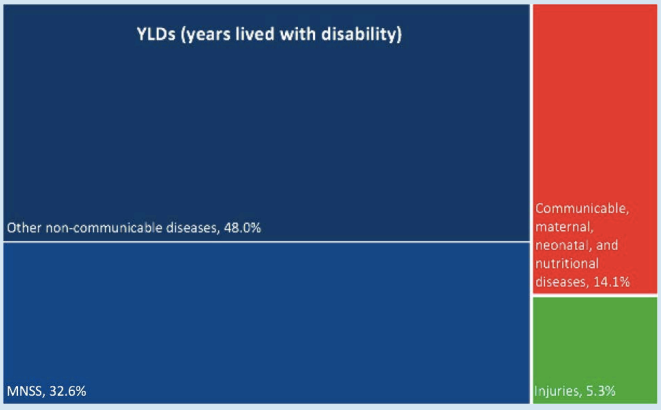


Figure 1. Distribution of YLDs with a focus on mental, neurological, substance use disorders and self harm (MNSS)

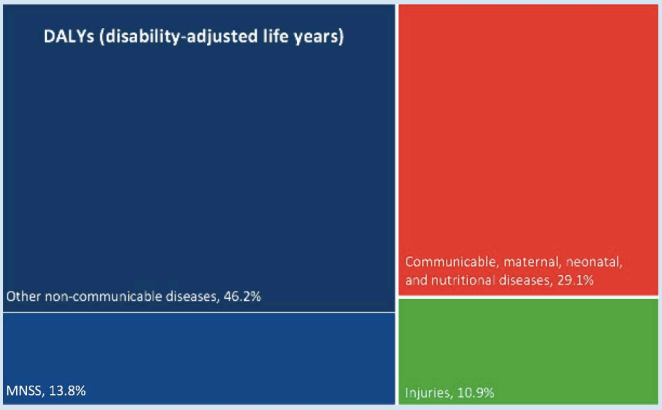


Figure 2. Distribution of DALYs with a focus on mental, neurological, substance use disorders and self harm (MNSS)

THE BURDEN AFFECTING MENTAL HEALTH ACROSS THE LIFETIME

Fig. 3 shows the changes in disease burden across age-groups. NCDs (in shades of blue) reach 50% of the burden at 5 to 9 years old, and will remain the largest burden throughout the lifetime. MNSS account for between nearly a fourth and a third 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 (54%) and autism (39%). Between 5 and 15 years old, the burden of conduct disorders (20%), anxiety disorders (17%), and headaches (17%) –including migraine and tension-type- gain prominence. 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 42%, headaches for 19%, substance use disorders 18% (12% due to alcohol), and severe mental disorders (schizophrenia and bipolar disorders) around 8%. The elderly suffer mostly from neurocognitive disorder due to Alzheimer's disease, which surpasses 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

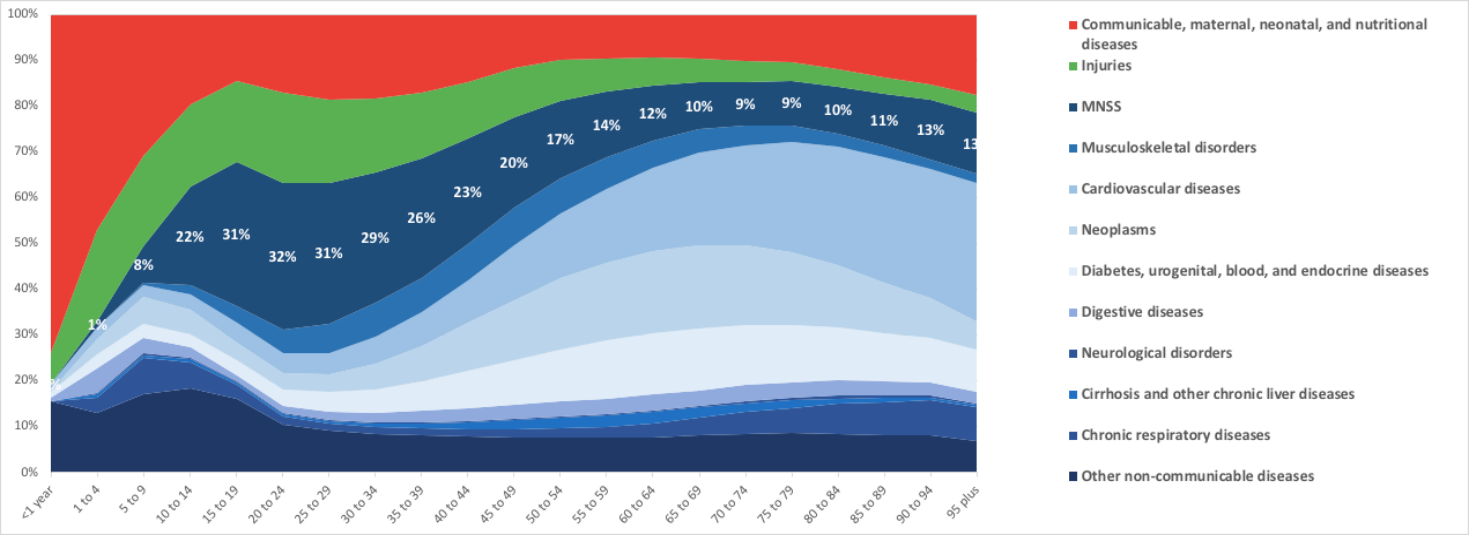
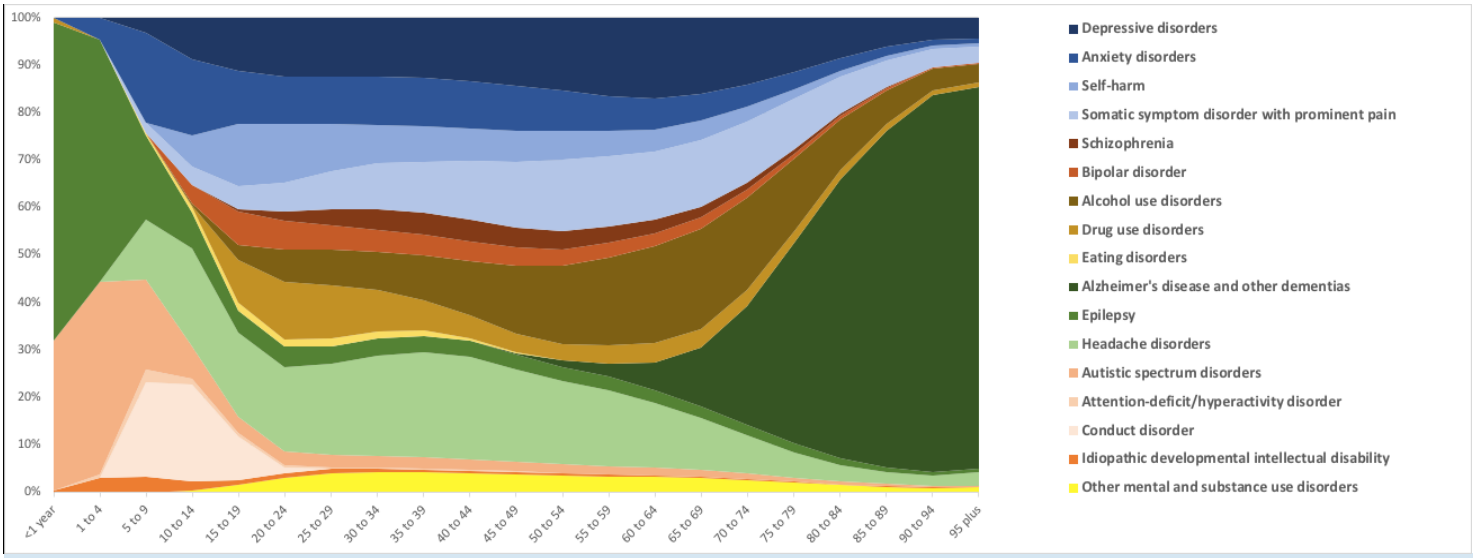


Figure 4. Burden of disease, by MNSS and age



THE BURDEN AFFECTING MENTAL HEALTH IN MEN AND WOMEN

The top three disorders in terms of disability-adjusted life-years –accounting for 35 to 50% of total MNSS burden- are not the same for men and women: While men are mostly affected by alcohol use disorders, headaches, and somatic symptom disorder with prominent pain, women are mostly affected by headaches, depressive and anxiety disorders.

Men		Women	
Disorder	DALYs per 100 000	Disorder	DALYs per 100 000
MNSS (all)	4468	MNSS (all)	4575
Alcohol use disorders	688	Headache disorders	948
Headache disorders	530	Depressive disorders	725
Somatic symptom disorder with prominent pain	440	Anxiety disorders	503
Depressive disorders	430	Somatic symptom disorder with prominent pain	482
Self-harm and suicide	400	Alzheimer's disease and other dementias	381

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.