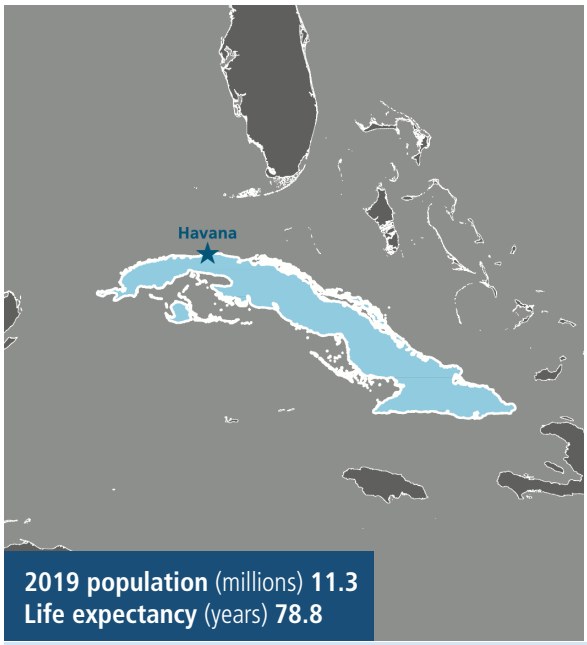
CUBA

The Burden of Mental Disorders in the Americas:
COUNTRY PROFILE



The Republic of Cuba is an archipelago comprising the island of Cuba and more than 1,600 islands, islets, and keys covering an area of 109,884 km^2. It is administratively divided into 15 provinces and 168 municipalities.

Between 1990 and 2015, the population increased by 6.7%, reaching 11,3 million in 2019. In 2019, the urban population was 77% of the population.

In 1990, the population structure was expansive among people over 30, although in 2015, the under-30 population became regressive due to mortality and low fertility. In 2019, life expectancy at birth was 78.8 years (80.8 years in women and 76.8 in men).
In 2015, Cuba obtained a high human development index, ranking 67th among the 188 countries of the world.

THE DISEASE BURDEN AFFECTING MENTAL HEALTH

Mental, neurological, substance use disorders and suicide (MNSS) cause 20% of all disability- adjusted life years (DALYs) and 33% of all years lived with disability (YLDs).

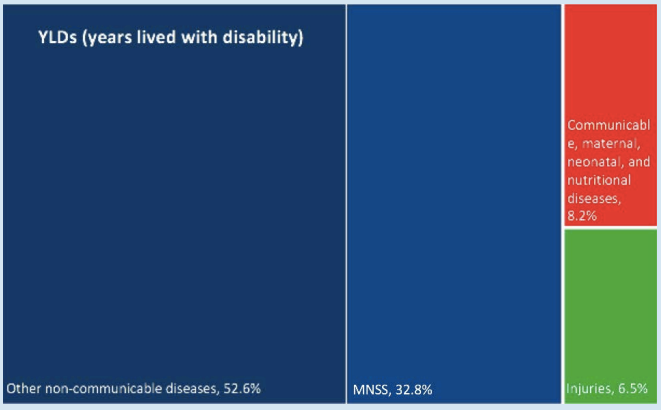


Figure 1. Distribution of YLDs with a focus on mental, neurological, substance use disorders and self harm (MNSS)

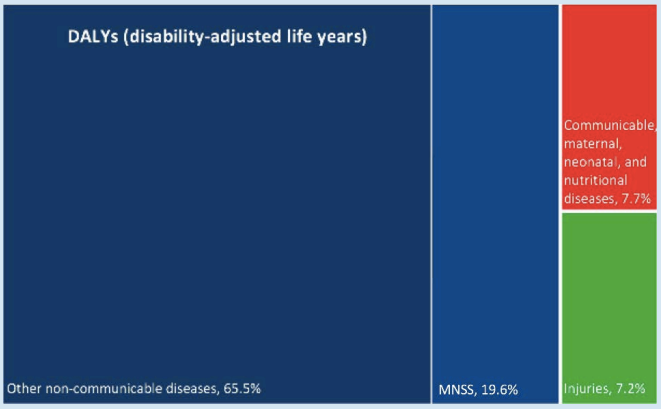


Figure 2. Distribution of DALYs with a focus on mental, neurological, substance use disorders and self harm (MNSS)

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 in the 1 to 4 year old group, and will remain well above 70% of the total burden throughout the lifetime. MNSS account for between nearly 30 and 40% of the total burden between 10 and 45 years of age, by far 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 autism (51%) and epilepsy (41%). Between 5 and 15 years old, the burden of conduct disorders, anxiety disorders, and headaches –including migraine and tension-type- gain prominence, with around 18% 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 45%, headaches for 20%, substance use disorders 16% (12% due to alcohol), and severe mental disorders (schizophrenia and bipolar disorders) 9%. 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
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Figure 3. Burden of disease, by disease group and age

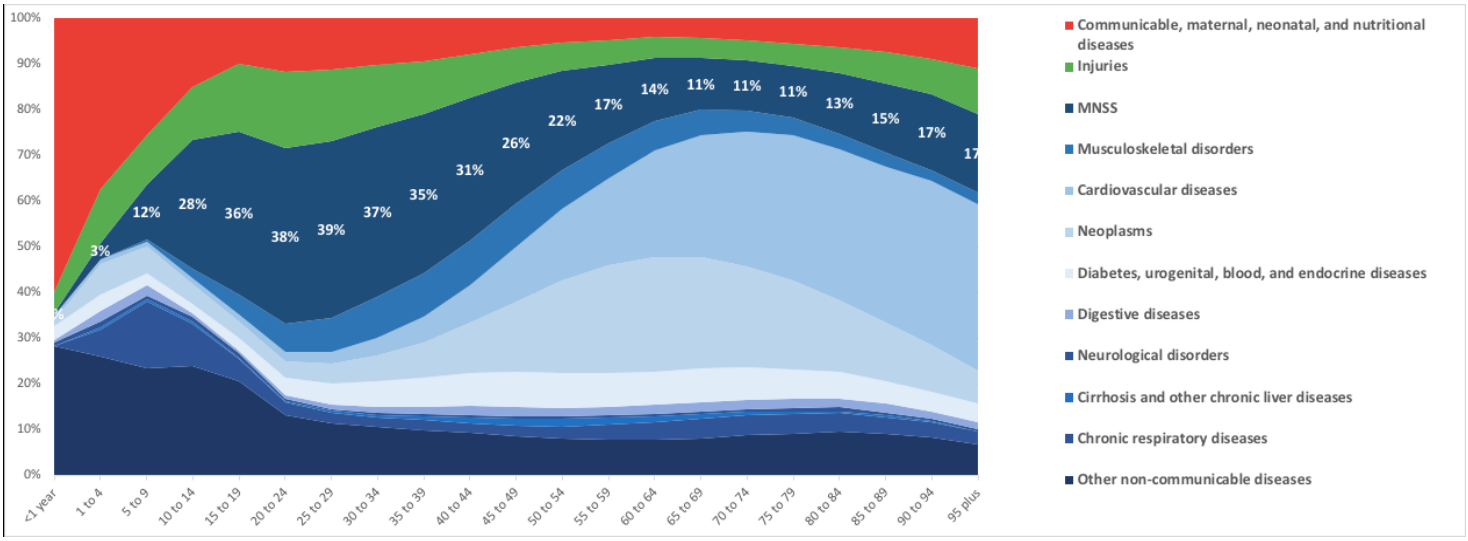
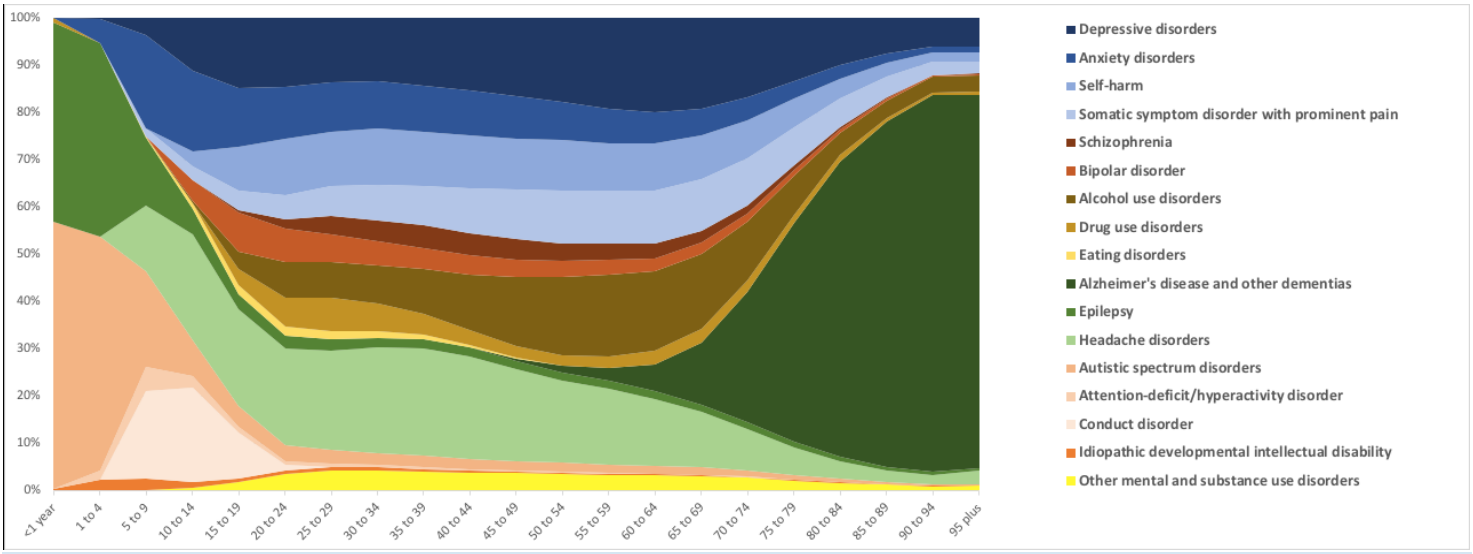


Figure 4. Burden of disease, by MNSS and age



THE BURDEN AFFECTING MENTAL HEALTH IN MEN AND WOMEN

The top three disorders in terms of disability-adjusted life-years –accounting for 40 to 55% of total MNSS burden- are not the same for men and women: While men are mostly affected by alcohol use disorders, self-harm and suicide, and headaches, women are mostly affected by headaches, depressive and anxiety disorders.

Men		Women	
Disorder	DALYs per 100 000	Disorder	DALYs per 100 000
MNSS (all)	4642	MNSS (all)	4332
Alcohol use disorders	732	Headache disorders	1001
Self-harm and suicide	675	Depressive disorders	821
Headache disorders	557	Anxiety disorders	506
Depressive disorders	527	Alzheimer's disease and other dementias	410
Alzheimer's disease and other dementias	388	Somatic symptom disorder with prominent pain	390

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.