PERU

The Burden of Mental Disorders in the Americas:
COUNTRY PROFILE

Peru is located in west central South America and borders on Ecuador, Colombia, Brazil, Bolivia, Chile, and the Pacific Ocean. Administratively, it is divided into 26 regions, 196 provinces, and 1,854 districts.

Between 1990 and 2019, the population grew by approximately 42.7%, reaching 32.5 million, and its structure shifted from an expansive trend toward a near-stationary one. Overall, 78% of the population lived in urban areas.
A 2006 survey on ethnic self-identification found that 1.6% of the Peruvian population considered themselves black, mulatto, or zambo (of mixed indigenous and African ancestry).

Basic development and health indicators systematically improved between 1990 and 2015.
Peru is an upper-middle-income country, with a per capita gross domestic product (GDP) adjusted for purchasing power parity of US$ 11,960 in 2015.

THE DISEASE BURDEN AFFECTING MENTAL HEALTH

Mental, neurological, substance use disorders and suicide (MNSS) cause 18% of all disability- adjusted life years (DALYs) and 34% of all years lived with disability (YLDs).

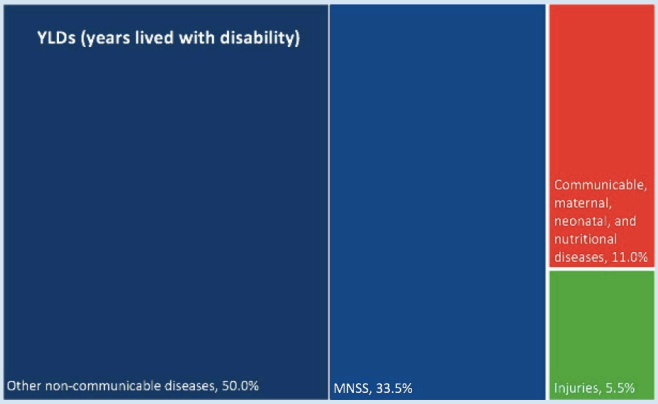

Figure 1. Distribution of YLDs with a focus on mental, neurological, substance use disorders and self harm (MNSS)

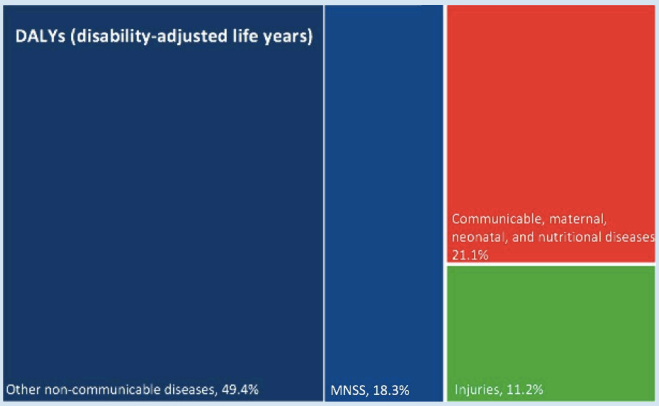

Figure 2. Distribution of DALYs with a focus on mental, neurological, substance use disorders and self harm (MNSS)

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 at 5 years old, and will remain the largest burden throughout the lifetime. MNSS account for between a fourth and a third of the total burden between 10 and 50 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 autism (47%) and epilepsy (46%). Between 5 and 15 years old, the burden of conduct disorders (21%), anxiety disorders (18%), and headaches (18%) –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 38%, headaches for 23%, substance use disorders for 16% (10% due to alcohol), and severe mental disorders (schizophrenia and bipolar disorders) around 10%. 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

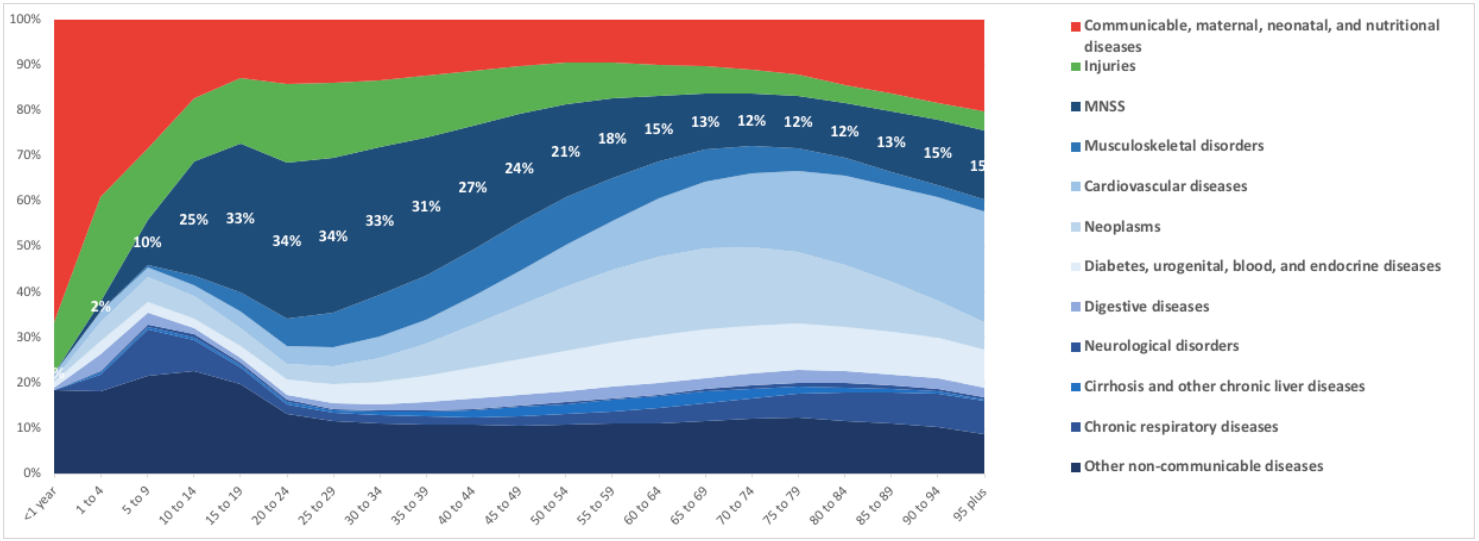
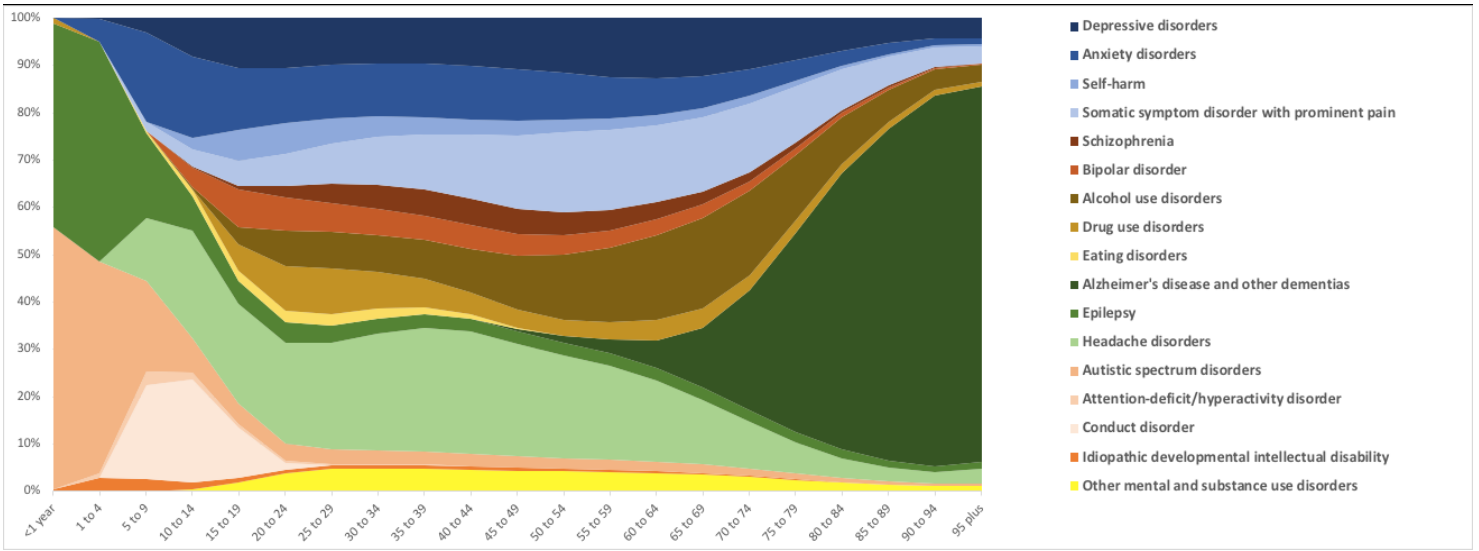


Figure 4. Burden of disease, by MNSS and age



THE BURDEN AFFECTING MENTAL HEALTH IN MEN AND WOMEN

The top three disorders in terms of disability-adjusted life-years –accounting for 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, anxiety and depressive disorders.

Men		Women	
Disorder	DALYs per 100 000	Disorder	DALYs per 100 000
MNSS (all)	3874	MNSS (all)	4026
Alcohol use disorders	559	Headache disorders	1009
Headache disorders	532	Anxiety disorders	506
Somatic symptom disorder with prominent pain	424	Depressive disorders	480
Alzheimer's disease and other dementias	338	Somatic symptom disorder with prominent pain	462
Depressive disorders	311	Alzheimer's disease and other dementias	326

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.