Mental health in the Plurinational State of Bolivia

Monica Garcia BSc (Hons) Psych MSc Health Psych

Claims Medical Specialist for Swiss Re Europe, UK branch, email Monica_Garcia@swissre.com

Bolivia is a multicultural country located in the heart of South America. Neighbouring countries include Brazil, Peru, Argentina, Paraguay and Chile. It is a large nation, with an area of nearly 1 100 000 km^2, although most of its territory was lost in wars. A particularly damaging loss was the sea coast, which was lost to Chile in the late 1800s. According to the constitution, Sucre is the capital city but La Paz is the seat of government and is often referred to as the capital.

As with most Latin American countries, Bolivia was subject to Spanish colonisation in the 1500s. It became an independent republic in 1825. According to the National Institute of Statistics (http://www.ine.gob.bo), Bolivia has a population of 10 million and the largest proportion of native people in Latin America. In fact, in the 2001 census, 62% of the population over 15 years of age self-identified as native. Bolivia is a multicultural country. The ethnicities most represented are: Quechua (30%), Aymara (25%), Chiquitano (2.2%), Guarani (1.5%) and Mojeno (0.85%), with 36 groups having been identified in all. The main languages spoken in Bolivia include Spanish, Aymara, Quechua and Guarani. In 2009, following the implementation of the new constitution, Bolivia officially became a secular state. However, Roman Catholicism remains, at least nominally, the religion of most of the population.

Bolivia is considered one of the poorest countries in South America, despite recent improvements in financial, social and health areas brought by the first native president, Evo Morales, elected in 2005 and re-elected in 2009. These included, for example, the 'Bono Juana Azurduy de Padilla', which provides free antenatal care for expectant mothers, as well as postnatal care up to the age of 2 years, with a view to reducing mortality rates in infants. Overall, the proportion of the population living on less than US$2 a day was 30.4% in 2005 and 21.9% in 2007 (United Nations Development Programme, 2010). As a result of Bolivia's slight reduction in inequality in recent years, it is no longer considered the most unequal country in Latin America.

The major export industries include gas and soya. There is a long history of mining, dating back to colonial times. Large amounts of lithium, used in many modern batteries, have been found in the south-west. Bolivia is also the third largest producer of coca leaves in the world.

Health

Life expectancy is currently 66.3 years (United Nations Development Programme, 2010). In the decade 2000–09, there were on average 120 doctors per 100 000 people; in 2008, the under-5 mortality rate was 54 per 1000 live births and the proportion of births attended by trained health professionals was 65.8% (United Nations Development Programme, 2010).

Overall, health has improved in the past 20 years, with illnesses such as malaria and polio being now much better controlled (Rivera, 2008*a*). However, access to healthcare is still uneven across the population and is especially difficult in rural and highland areas. A health service reform process started in 2004 but resources for mental health remain scarce (Rivera, 2008*a*,*b*).

Traditional/alternative medical practice is common in Bolivia, with *curanderos* being known as *Kallawayas* (Becht, 1998). Most healers use natural herbs and remedies, as well as general counselling, which involves lengthy discussions with the patient. It is estimated that, when ill, some 40% of Bolivians typically use traditional medicine only.

Mental health services

The first psychiatric hospital was opened in 1933, in Sucre, as an independent hospital, but in 1964 the psychiatric services became part of the national health service, Caja Nacional de Seguridad Social (Rivera, 2008*a*,*b*).

Mental health legislation was formulated in 1978 and revised in 2001. It focuses on promotion, prevention and human rights, and it regulates mental health services. Alongside the mental health strategy, there is a national mental health programme in place, initially put forward in 1972 and revised in 2001. Its objectives include the integration of mental health services in primary care and the development of specialised services. So far, only 10–25% of the programme has been implemented. The specialist programmes in place are directed at children and elderly populations (Rocha, 2008; World Health Organization, 2008).

At present, there are 9 psychiatric hospitals across the country, offering 9.2 beds per 100 000 inhabitants and 29 mental health units for out-patient psychiatric care (World Health Organization, 2008). For every 100 000 inhabitants, working in mental health there are 0.22 general doctors (not trained in mental health), 0.34 nurses, 5 psychologists, 0.25 social workers, 0.20 occupational therapists and 1.43 other professionals, including medical assistants and counsellors (Rivera, 2008*a*; World Health Organization, 2011). The total number of psychiatrists in the country is 95 (Rocha, 2008).

Access to services and adequate management of psychiatric conditions are unfortunately suboptimal, due to financial constraints. Only 0.2% of the national budget is

ring-fenced for mental health services. Typically, most resources are provided to the psychiatric hospitals and outpatient units to cover the costs of medication and staff and so on. Extra funding may, however, come from both non-governmental organisations and charities supported by the Church.

Professional training

Formal academic training involves 5 years of general medicine plus 3 years of specialisation in psychiatry. This involves placements in city-based hospitals as well as in more rural areas of the country. The first stage of training is awarded by the university in which the training was completed; further specialist psychiatric training is awarded by the Sociedad Boliviana de Psychiatria (see http://www.psiquiatriabolivia.org).

Prevalence of psychiatric conditions

The principal conditions for which patients are admitted to specialised psychiatric centres in Bolivia (Rivera, 2008*a*) include: schizophrenia/schizotypal disorders (28.0% of admissions); substance misuse (28.0%); organic mental disorders (including somatic disorders) (17.5%); mood disorders (13.5%); neurotic disorders secondary to stress (6.9%); personality disorders (2.9%); intellectual disability (1.7%); and anorexia nervosa (0.2%). Substance misuse involves alcohol in 88% of cases and drugs (mainly cocaine and marijuana) in 7%; the remaining 5% involves polydrug misuse. Overall, the tenth commonest reason for any doctor's consultation in Bolivia is depression.

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COUNTRY PROFILE

Mental health in Somalia

Rebecca J. Syed Sheriff,[1] Massimiliano Reggi,[2] Abdirizak Mohamed,[3] Farhan Haibe,[4] Susannah Whitwell[5] and Rachel Jenkins[6]

[1]King's College London, Institute of Psychiatry, London, UK, email rebecca_syed@hotmail.com; [2]Gruppo per le Relazioni Transculturali, Milan, Italy; [3]General Assistance and Voluntary Organisation (GAVO), Hargeisa, Somaliland; [4]General Assistance and Voluntary Organisation (GAVO), Hargeisa, Somaliland; [5]South London and Maudsley NHS Foundation Trust, London, UK; [6]King's College London, Institute of Psychiatry, London, UK

Somalia, in the Horn of Africa, suffers violence, political instability and high mortality rates. The recent major drought in Somalia led to what was termed the worst humanitarian disaster in the world. In July 2011 it was reported that nearly 60 000 people had entered into Kenya from Somalia already that year, including 1300 new arrivals every day to the Dadaab refugee camp, described as 'the largest, most congested and one of the most remote refugee camps in the world' (see http://www.unhcr.org/4e204b1e9.html). The drought along with mass migration into such poor conditions are likely to have significant short- and long-term mental health consequences for the populations involved.

Somalia comprises Somaliland, Puntland and South Central Somalia (Somalia-SC). Somaliland, in the north, declared independence from Somalia in 1991, with resulting relative peace, stability and development, but is yet to be internationally recognised. The Puntland State of Somalia, in the centre (including the Horn itself) was established in 1998 by traditional and political leaders (Ministry of Planning and Statistics, 2003). Most of the violence is now concentrated in Somalia-SC, where there is considerable destruction of the infrastructure.

https://doi.org/10.1192/S1749367600002745 Published online by Cambridge University Press