Colombia

General Information

Colombia is a country with an approximate area of 1139 thousand sq. km. (UNO, 2001). Its population is 44.914 million, and the sex ratio (men per hundred women) is 98 (UNO, 2004). The proportion of population under the age of 15 years is 31% (UNO, 2004), and the proportion of population above the age of 60 years is 7% (WHO, 2004). The literacy rate is 92.1% for men and 92.2% for women (UNESCO/MoH, 2004).

The country is a lower middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 5.5%. The per capita total expenditure on health is 356 international $, and the per capita government expenditure on health is 234 international $ (WHO, 2004).

The main language(s) used in the country is (are) Spanish. The largest ethnic group(s) is (are) Mestizo (half), and the other ethnic group(s) are (is) European (one-fourth) and native American. The largest religious group(s) is (are) Roman Catholic (95%).

The life expectancy at birth is 67.5 years for males and 76.3 years for females (WHO, 2004). The healthy life expectancy at birth is 58 years for males and 66 years for females (WHO, 2004).

Epidemiology

National surveys on mental health were conducted in 1993 and 2003. In the former study, SRQ (criteria DSM-III) and Zung Scale were applied to a random sample of 25135 adults. The lifetime prevalence for depression was 25.1%, anxiety disorders 9.6%, and alcohol abuse 7.8%. The latter study utilized the World Mental Health Survey methodology and applied CIDI 2000 (criteria DSM-IV) to 4596 adults and 1586 adolescents in a random sample of 5526 urban homes. The lifetime prevalence of mood disorders was 12.9%, anxiety disorders 24.0%, alcohol use disorders 9.2% and drug use disorders 1.7% (Ministry of Health, 2004). Torres de Galvis and Murrelle (1990) evaluated 2800 adults (12-64 years) from four cities and found the use of alcohol (56%), tobacco (29.7%), tranquilizers (6%), marijuana (1.1%), basuco (6%) and cocaine (3%) to be common. Approximately 8.1% of the subjects were dependent on alcohol and 7.3% were at risk of becoming dependent on alcohol. Drug use was associated with male gender (except tranquilizers), medium age groups and unmarried status. Differences in suicide rates between users and non-users were statistically significant in the population aged 15 to 54. Montoya and Chilcoat (1996) reported the integrated findings of a survey carried out in Bolivia, Colombia, Ecuador, Peru and Venezuela to estimate cocaine and coca use prevalence (n=24 108). The lifetime prevalence of cocaine or coca paste use was between 0.8 and 3.0% and it was associated with age (middle-age), class (middle), gender (male), education (high school), income (high) and residence (urban). In a cross-sectional study involving 512 schools, the prevalence of substance use was 59.4% in public schools and 40% in private schools. Alcohol, marijuana, cocaine were the commonly used drugs and family history of mental disorders and personal conflicts were associated with substance use (Bergonzoli et al, 1989). Brook et al (1999) interviewed more than 2800 adolescents and their mothers and found that factors like violence, drug availability, and machismo, family drug use, a distant parent-child relationship and unconventional behaviour are risk factors for adolescent illegal drug use. Jablensky et al (1992) reported the results of the WHO multi-country Determinants of Outcome of Severe Mental Disorders (DOS) that was carried out in a group of patients making their first treatment contact because of symptoms of

a possibly schizophrenic illness. Better outcome was reported in patients living in developing countries. Significant differences were found between centres in the incidence of schizophrenia using a broad definition, although the rates ranged only from 1.5 to 4.2 per 100 000 population aged 15-54. In contrast, the incidence of schizophrenia using a narrow definition (category S+ of the CATEGO programme derived from the PSE-9 interview) was not significantly different between centres. Lima et al (1993) assessed 113 adult victims of a major Latin American disaster 1 and 5 years after the catastrophe with the Self-Reporting Questionnaire. The prevalence of emotional distress decreased from 65% in 1986 to 31% in 1990. A study conducted in three countries, Columbia, Ecuador and Venezuela (n=1946), showed that 53.4% of subjects had erectile dysfunction with 19.8% of all men reporting moderate to complete ED. Increasing age, hypertension, benign prostatic hyperplasia and diabetes mellitus were associated with the disorder (Morillo et al, 2002). In a general population sample of 1879 Spanish-speaking university students (mean age=24.0), the prevalence of self-reported stuttering was found to be 2% (Ardila et al, 1994). Giel et al (1981) assessed 925 children attending primary care centres in Columbia, India, Philippines and Sudan using a 2-stage design and found that the rate of psychiatric disorders varied between 12-29%. Pineda et al (1999) used multiple standardized rating scales, clinical interviews and neurological tests on large samples of preschool and school going children and reported the prevalence of ADHD to be more than 16.1%. But, the prevalence of subtypes differed in the two studies. Gender (male), age (school going) and economic status (lower) were significantly related to prevalence. Pinzon-Perez and Perez (2001) found that 21% of school students (n=1692) expressed suicidal ideation, 19% suicidal plans and 16% reported at least one attempt in the 30 days preceding the study.

Mental Health Resources

Mental Health Policy

A mental health policy is present. The policy was initially formulated in 1979.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The policy was reviewed in 1998, but it was not implemented. The policy is being reviewed again to make it consonant with the health system and the priorities emerging from the National Study of Mental Health, 2003.

Substance Abuse Policy

A substance abuse policy is present. The policy was initially formulated in 1979. The policy was reformulated by the National Board of Economic and Social Policy in 2002 (CONPES 3078 of 2002). Currently, the 'Policy for the Reduction of the Demand for Consumption of Psychoactive Substances' is in final phase of consensus-building and implementation, under the leadership of the Ministry of the Social Protection.

National Mental Health Programme

A national mental health programme is absent.

Under the guidelines defined by the Ministry of the Social Protection, each department is formulating plans of action in mental health that should be implemented within a period of 2 years.

National Therapeutic Drug Policy/Essential List of Drugs

A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1993.

Mental Health Legislation

There is no comprehensive national mental health legislation, however, Law 715-2001 includes mental health functions in the regional-local levels, but it has not been enacted. The Ministerial Resolution No.2417 of 1992 allows for a charter of rights for mental health patients. Resolution 2358 of 1998 and Law 30 of 1986 relate to drug statutes.

Details about the year of enactment of the mental health legislation are not available.

Mental Health Financing

There are budget allocations for mental health.

The country spends 0.08% of the total health budget on mental health.

The primary sources of mental health financing in descending order are tax based, social insurance, out of pocket expenditure by the patient or family and private insurances.

The country has disability benefits for persons with mental disorders. There is no mention to the proportion of the population entitled to get these benefits

Mental Health Facilities

Mental health is not a part of primary health care system. Actual treatment of severe mental disorders is not available at the primary level. Despite some pilot projects, mental health services are not provided under the Primary Health Care scheme.

Regular training of primary care professionals is not carried out in the field of mental health.

There are community care facilities for patients with mental disorders. Mental health care is provided with different approaches according to users' affiliation with social security.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	
Psychiatric beds in mental hospitals per 10 000 population	0.45
Psychiatric beds in general hospitals per 10 000 population	
Psychiatric beds in other settings per 10 000 population	
Number of psychiatrists per 100 000 population	2
Number of neurosurgeons per 100 000 population	
Number of psychiatric nurses per 100 000 population	
Number of neurologists per 100 000 population	
Number of psychologists per 100 000 population	
Number of social workers per 100 000 population	

20% of psychiatric beds are dedicated to long-stay patients. There are facilities in prison for offenders with mental disorders.

Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion and prevention. These organizations participate in mental health activities related to displaced populations, women, children and domestic violence.

Information Gathering System

There is mental health reporting system in the country. ICD-10 and DSM-IV criteria are used. Information on ambulatory morbidity, admission and hospital discharge of mental disorders are recorded in the Individual Registries of Delivery of Services, however, this information is still not available with the opportunity, coverage and quality desired, which is in the process of standardization and implementation of the registry.

The country has data collection system or epidemiological study on mental health. The 'Asociación de Hospitales Mentales' (Psychiatric Hospitals Association) conducts specific surveys on mental health from time to time. There are 'Mental Health Groups' in charge of the data collection system for mental disorders both at regional and national levels. There are, in addition, records of data on injuries due to external cause such as accidents, homicides, domestic violence and other type of assaults, in routine registries of Forensic Medicine and through Observatories of Violence that operate in some departments.

Programmes for Special Population

The country has specific programmes for mental health for minorities, refugees, disaster affected population, indigenous population, elderly and children.

Also, there are programmes for women and victims of domestic violence. Although specific programmes for indigenous populations are not present, they are provided comprehensive

care through the Compulsory Plan of Health. Programmes for persons with mental disorders who are 'not criminally responsible' and psychological immaturity care have more than 250 places available.

Therapeutic Drugs

The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, haloperidol, lithium, biperiden, carbidopa, levodopa.

The national therapeutic drug policy was revised in 2002 and the essential drug list was revised in 2002. Medicines are supplied as part of the benefits from compulsory health plan (POS) within the social security system.

Other Information

Methods for assessing quality of care at primary, secondary and tertiary levels are available.

Additional Sources of Information

•Ardila, A., Bateman, J. R., Nino, C. R., et al (1994) An epidemiologic study of stuttering. Journal of Communication Disorders, 27, 37-48.

•Bergonzoli, P. G., Rico, O., Ramirez, A., et al (1989) Drug use among students in Cali, Colombia. Boletin de la Oficina Sanitaria Panamericana, 106, 22-31.

•Brook, J. S., Brook, D. W., De La Rosa, M., et al (1999) The role of parents in protecting Colombian adolescents from delinquency and marijuana use. Archives of Pediatrics & Adolescent Medicine, 153, 457-464.

•Giel, R., De Arango, M. V., Climent, C. E., et al (1981) Childhood mental disorders in primary health care: results of observations in four developing countries. A report from the WHO collaborative Study on Strategies for Extending Mental Health Care. Pediatrics, 68, 677-683.

•Jablensky, A., Sartorius, N., Ernberg, G., et al (1992) Schizophrenia manifestations, incidence and course in different cultures. A World Health Organization ten-country study. Source Psychological Medicine, 22(Suppl. 20), 1-97.

•Lima, B. R., Pai, S., Toledo, V., et al (1993) Emotional distress in disaster victims. A follow-up study. Journal of Nervous & Mental Disease, 181, 388-393.

•Ministerio de Salud (1998) Politica Nacional de Salud Mental. Direccion General de Promocion y Prevencion Subdireccion de Promocion.

•Ministerio de Salud (1998) Politica Nacional de Salud Mental, Resolucion Numero 2358.

•Ministerio de Salud (1996) Resolucion Numero 4288.

•Ministerio de Salud (1994) Decreto Numero 1292.

•Ministerio de Salud (1986) Por la cual se adopta el Estatuto Nacional dfe Estupefacientes y se dictan otras disposiciones.

•Montoya, I. D., Chilcoat, H. D., et al (1996) Epidemiology of coca derivatives use in the Andean region: a tale of five countries. Substance Use & Misuse, 31, 1227-1240.

•Morillo, L. E., Diaz, J., Estevez, E., et al (2002) Prevalence of erectile dysfunction in Colombia, Ecuador, and Venezuela: a population-based study (DENSA). International Journal of Impotence Research, 14 (Suppl. 2), 10-18.

•Pineda, D., Ardila, A., Rosselli, M., et al (1999) Prevalence of attention-deficit/hyperactivity disorder symptoms in 4- to 17-year-old children in the general population. Journal of Abnormal Child Psychology, 27, 455-462.

•Pinzon-Perez, H., Perez, M. A., et al (2001) A study of suicide-related behaviors among Colombian youth: reflections on prevention and implications for health education. Journal of Health Education, 32, 288-292.

•Torres de Galvis, Y., Murrelle, L., et al (1990) Consumption of dependence-producing substances in Colombia. SO - Bulletin of the Pan American Health Organization, 24, 12-21.