Archives of Public Health

RESEARCH Open Access

"The professionals weren't from here": provision of mental health services in the context of the Colombian armed conflict

Diana Carolina Rubio-León[1*], Laura Cano-Sierra[2], María-Juliana Reyes-Rivera[2], Sara Lucia Forero-García[2], Dennys García-Padilla[1], Pablo Abitbol[3] and Wilson López-López[2]

Abstract

Background The provision of mental health care services in different municipalities of Colombia has been significantly affected by the armed conflict, especially in rural areas. From the Social Determinants of Health (SDH) perspective, this study aimed to understand the characteristics of the provision of mental health services in the context of armed conflict from the perspectives of healthcare personnel and administrative staff involved in mental health care in the Montes de María region.

Methods A descriptive qualitative study was carried out with 49 participants from the healthcare and administrative sectors. Data were collected through 15 semi-structured interviews and 7 focus groups held in 2023 and 2024. A content analysis was conducted using NVivo 14.

Results Two main categories were identified: (1) Deficiencies in Service Provision and Access, where professionals reported issues in the provision of mental health services in Montes de María, including shortcomings in public policy, barriers to access and continuity of the services, infrastructure limitations, bureaucratic obstacles, high staff turnover, lack of contextualization, limitations in the conceptualization of mental health, ethical and professional misconduct, and security threats due to the ongoing armed conflict; and (2) Successful Approaches to Mental Health Care, in which participants highlighted effective strategies characterized by implementing context-sensitive interventions, incorporating community involvement in service provision planning, and transcending an individual and psychopathological perspective of mental health.

Conclusions This study highlights how both the provision of health services and armed conflict act as key social determinants of mental health. In Montes de Maria, the complex mental health and psychosocial needs of the population remain unmet due to the absence of adequate, context-sensitive health services. Moreover, existing regulations designed to ensure access to mental health services fail to translate into effective implementation in the region. A potential solution lies in the sustained community engagement, from the initial planning of healthcare services to the direct involvement of community members as health promoters. The proposed SDMH framework,

*Correspondence:
Diana Carolina Rubio-León
rubio.diana@javeriana.edu.co

Full list of author information is available at the end of the article

along with this study's findings, should serve as the foundation for updating Colombia's National Mental Health Policy, ensuring a dedicated section that addresses the specific needs of regions affected by armed conflict.

Keywords Mental health services, Healthcare personnel, Social determinants of mental health, Health care, Armed conflict

Text box 1. Contributions to the literature

- The perspectives of mental health professionals and administrative staff provide a deeper understanding of current challenges and help create contextually relevant solutions.
- Understanding the issues and successful approaches in conflict-affected areas can inform the creation and updating of mental health policies.
- Many mental health care models for conflict-affected communities are developed without involving local professionals, leading to decontextualized and sometimes harmful approaches.

Introduction

The Social Determinants of Mental Health (SDMH) model [1] proposes that mental health, and many mental disorders are determined by social, economic, and physical conditions that shape social inequalities and injustices, especially for those who have experienced oppression, marginalization, and poverty throughout their lives [2, 3]. These factors encompass the circumstances in which people are born, live, work, and age, as well as the health systems they can access [4]. Poor access to health care is a SDMH [5] and represents a complex system of multiple levels dependent on social, cultural and geographical factors that determine the resources, funding, organization of service provision and the guarantee of access, elements that can be modified by political decisions reflected in current mental health plans and programs.

Health care, access to services and the working conditions of health care personnel are current and critical issues in war contexts [6]. In Colombia, mental health care and access to these services have been significantly affected in territories where armed conflict has been more prevalent [7]. The armed conflict in Colombia has spanned more than six decades, involving various perpetrators and resulting in more than 9.8 million registered victims [8]. Regardless of multiple peace negotiations and a peace agreement signed in 2016 with one of the largest guerrilla groups in the country, the conflict is still ongoing, and armed groups continue exerting violence especially in rural populations. In this context, hospitals and health centers have been looted or destroyed, the delivery of supplies has been hindered, and the provision of care to communities has been blocked. As in other war contexts [9], in Colombia, health personnel have been subjected to attacks, threats, torture, arbitrary detentions and other forms of violence, which have affected their mental health and well-being [10, 11].

The armed conflict has also been considered a SDMH in Colombia [12, 13, 14, 15], due to the complex mental health problems it has caused in more than six decades of violence [16]. An example of this is Montes de María, a subregion of the Caribbean composed of 15 municipalities in the departments of Bolívar and Sucre, which has been deeply affected by the armed conflict, becoming an epicenter of violence that has left profound psychological and social consequences on its population [17]. This region has been the scene of massacres, forced displacements, kidnappings and other forms of violence that have had a devastating impact on the mental health of its inhabitants, who experience high levels of mental disorders related to post-traumatic stress disorder, depression and anxiety, just as in other areas of the country affected by the armed conflict [18, 19].

In Colombia, since 1993 the provision of healthcare services has been governed by the General System of Social Security in Health (SGSSS), which is supervised and regulated by the State. The SGSSS operates under the principles of efficiency, universality, comprehensiveness, and solidarity, and is structured into two regimes: the contributory regime, in which affiliates with the ability to pay make contributions, and the subsidized regime, which is financed by the State for low-income individuals [20]. The system's management is overseen by Health Promoting Entities (EPS), which are responsible for ensuring the provision of health, promotion and prevention, primary care, specialized care, emergency services, hospitalization, medication supply, differential approaches, and other health and mental health services [20, 21].

The SGSSS mandates that services must be adapted to geographical and demographic conditions to ensure accessibility [22, 23]. In order to guarantee coverage in rural and remote areas, regulations have established mechanisms such as the provision of infrastructure in regional health centers, the operation of State Social Enterprises (ESE)—autonomous public institutions responsible for delivering and strengthening healthcare services in hard-to-reach regions [20]—and economic and labor incentives for healthcare professionals providing services in remote areas [24]. However, there are significant challenges in the implementation of many of the services proposed by Colombian legislation regarding mental health, particularly community-based services, while resources are predominantly focused on emergency care and hospitalization [25, 26].

In this context, recognizing the impact of armed conflict-related violence on physical and mental health, a regulatory framework was established to ensure access to healthcare as a form of reparation for victims [27]. Within this framework, priority is given to the affiliation of victims to the SGSSS to ensure immediate emergency care, specialized medical services, psychotherapy, medication and prosthesis provision, hospitalization, among others. Additionally, the Psychosocial Care and Comprehensive Health Program for Victims (PAPSIVI) was created to provide interdisciplinary psychosocial care, following a differential and territorial approach, establishing the need for a continuous care and covering expenses for access to mental health services [27].

However, the provision of mental health services within the context of armed conflict has been characterized by barriers to access [28]. These services are unevenly distributed, suffer from underinvestment, and the effectiveness of the programs remains undetermined [29]. It is also possible that some programs are poorly contextualized and disconnected from the actual needs of the communities. Communities that have been victims of the conflict have pointed out that mental health care, framed within humanitarian assistance, has sometimes contributed to revictimization and abandonment by the State [30]. Additionally, health personnel have reported significant difficulties such as low resource allocation, limited training, insufficient support for their work, limited involvement of administrative staff, and lack of community participation [31]. This problem is further complicated by the actions of illegal groups that, through financing political campaigns, co-opt public officials from different entities, affecting the resources that should be benefiting the communities [32]. This adds to factors such as limited availability of mental health services, lack of specialization, geographical barriers to access, excessive bureaucratic procedures, lack of timely and continuous care, and inadequate care, which leads to the communities having a general perception of abandonment by the State and mental health institutions [33].

In this regard, in Colombia the Ministry of Health and Social Protection is updating the National Mental Health Policy in accordance with the article 166 of the National Development Plan [34]. This update focuses on the SDMH with a territorial focus and for its implementation it is crucial to articulate with primary care and community-based rehabilitation, giving a central role to health personnel who are present in the territory, leaders and members of the communities.

Given the above, this article addresses mental health care in the context of Colombia's armed conflict, considering that mental health and psychosocial support programs are necessary for peacebuilding in post-conflict scenarios [35, 36]. Thus, this article aimed to understand the characteristics of the provision of mental health services in the context of the armed conflict from the perspectives of mental healthcare personnel and administrative staff involved in mental health care in the Montes de María region.

Methodology

Context of the study

This article is part of the study: "Participatory design of a model of psychosocial care in mental health in the communities of Montes de María in the framework of the health emergency by Covid-19" that was developed between 2020 and 2024. This region is in the Colombian Caribbean and is made up of fifteen municipalities from the departments of Bolívar and Sucre. Geographically, the region corresponds to the mountains, hillsides, and savannas of the Serranía de San Jacinto, and it is located between the Magdalena River and the Gulf of Morrosquillo, as well as between the cities of Sincelejo and Cartagena [37]. It has been historically sought after by armed groups due to its fertile soils and water resources, as well as the strategic corridors that connect the areas of Middle Magdalena, Southern Córdoba, Northeastern Antioquia, the savannas of Magdalena and Catatumbo, with ports used for the entry and exit of weapons, drugs and illegal money [32]. Thus, the region has experienced decades of occupation by different armed actors and exposure to victimizing events such as threats, homicides, massacres and forced displacement, which have had important implications for mental health [38].

Currently, this region has a population of 406,265 habitants with 27% identifying as afro-descendants and 7.2% as indigenous population, and it experiences multiple socioeconomic challenges, including a 39.8% of multidimensional poverty and a 91.6% of informal employment [39]. Although 99% of the population are registered in the SGSSS, the community's perception is that healthcare is inadequate, with rural health posts lacking resources, limited medical access due to poor infrastructure, unpaid staff, and transportation issues [39].

Design

This is a descriptive qualitative study [40] based on a grounded theory design [41] that followed the consolidated criteria for reporting qualitative research in the COREQ checklist [42].

Participants

Intentional sampling of 49 participants, 42 women and 7 men, from 25 municipal, departmental and national institutions and organizations involved in the provision of mental health services in Montes de María (see online supplemental file 1). Of these, 35 participants took part in focus groups, while 15 participated in semi-structured

interviews. Notably, one participant was involved in both a focus group and an interview, as her contributions were considered relevant to both settings. The participants were representatives of departmental health secretaries (15), intergovernmental organizations (6), municipal mayor's offices (5), State Social Enterprises providing health services (ESE) (5), Health Service Provider Institutions (IPS) (5), Health Promoting Entities (EPS) (3), Non-Governmental Organizations (NGOs) (3), national government entities (3), community organizations (3) and a national union entity in psychology (1). Their professions were psychology (24), nursing (10), law (4), medicine (3), social work (3), health administration (1), dentistry (1), Bachelor of Education (1), victims' support officer (1), communicator of health services (1). Most of the participants were from the region.

Techniques and instruments

Semi-structured interviews and focus groups were conducted to address the provision of mental health services from the perspective of healthcare personnel and administrative staff involved in mental health care in communities. The questions included were based on the review of background information and the SDMH perspective. They covered topics such as: perspectives on mental health needs in Montes de María, provision of mental health services, experiences in mental health care in Montes de María and pathways to mental health care and access to services. These topics were addressed in both the semi-structured interviews and the focus groups, but the wording of the questions was adjusted, for the focus group they were phrased in a more general way, while for each interview they were specified according to the role and institution of each participant (see online supplemental files 2 and 3).

The focus groups and interviews were conducted by the seven members of the research team, who were professionals in social and basic psychology, public health, and political science. They all had experience working with the population and had received prior training on the research questions and qualitative techniques (see online supplemental file 1).

Procedure

During 2023 and 2024, 15 semi-structured interviews and 7 focus groups were conducted. To contact the participants, invitations were sent to the healthcare institutions that are present in the territory, as well as to departmental and national entities. Direct contact was also made from the references and contacts provided by the participants. The interviews and focus groups were conducted in Montes de María except for two interviews with professionals from the national level that were conducted virtually. The interviews lasted between 29 and 172 min and the focus groups between 62 and 155 min. The audio recordings were transcribed by the research team for further analysis in the NVivo 14 software. This program facilitated the processing of the information as there was a significant volume of data.

Data analysis

Content analysis [43], which began with the preparation of the data by reading the transcripts in detail and identifying relevant fragments. In the first stage the research teams familiarized themselves with the data and inductively defined codes based on the relevant information. Since this study did not have predefined categories, an inductive approach was used for the coding of the transcripts. These codes were included in an initial codebook that was permanently updated according to the coding process. The codes were classified into categories, and each one was defined. The categories and codes were discussed in research team meetings to ensure consistency with the narratives provided by the participants. This enabled an inductive approach to coding the transcripts and achieving consensus throughout the process. The developed codebook was systematized using the NVivo software, where the transcripts of the interviews and focus groups were subsequently included for initial coding. Based on the coding of all the material, the main analysis of the information was carried out, reviewing the codes, identifying the categories in which they could be grouped within the NVivo software and analyzing them in relation to the provision of mental health services in the context of the armed conflict in the Montes de María region. During the analysis, the SDMH perspective was considered.

To ensure the criteria of methodological rigor the categories and codes were continuously reviewed by the team to verify that no new relevant information emerged for data saturation ensuring consistency in the information analysis. To guarantee reflexivity, the researchers held weekly meetings where they planned, evaluated, and adjusted the development of the fieldwork and shared their conceptual lenses, preconceptions, and perspectives.

Ethics approval and consent to participate

As described in the declaration section. The project and the consent form were approved by the Research and Ethics Committee of the School of Psychology of the Pontificia Universidad Javeriana. Participants were asked to read and sign the informed consent form, which was written in accordance with the Colombian normative [44]. All participants were older than 18 years.

Results

Based on the analysis of interviews and focus groups with healthcare personnel and administrative staff involved in mental health care in the Montes de María region, the following categories were identified:

Deficiencies in service provision and access

Barriers in mental health public policy implementation

A first aspect frequently pointed out was the limitations both at the national and regional levels in the design and implementation of public policies on mental health. The professionals argued that the implementation of these policies is related to a lack of knowledge of mental health and the refusal on the part of some institutions or professionals to follow the regulations. This issue is common around the country; however, it is mentioned how it is even worse for rural communities, where state institutions are rarely present to reinforce public policies.

> *"There is a lack of commitment from the ESE workers, even from the Ministry of Health because many times they are told, it's sent to them in writing, and a follow-up is done, but at the time of implementing it they do not apply it and the moment when, for example, another entity goes and asks them how is the care they say: "no, they haven't come here", but we went the day before yesterday and showed it to them, so there is that refusal, like that fear of attending to the patient and activating the pathway, because it is a route that is known to everyone" (Focus Group 5).*

Another problem in the implementation of public policy is related to the inadequate allocation of public resources, both from the national allocation and due to the misuse of resources by local governments and institutions. It is also mentioned how previous policies, especially those focused on the reparation of victims of the armed conflict, have favored other types of reparation over the psychosocial attention for these communities, thus, the resources allocated for mental health services have been limited. This could even make it difficult to implement the update of the National Mental Health Policy that is being developed in Colombia.

> *"We are going to have a much more efficient scenario in the implementation of public policy, but what is the gap? The rulers. We must create a development plan. Yes, in the development plan they make decisions about how the resources of the municipality, of the territory, are going to be distributed, and if mental health is not within that agenda, there is nothing to do." (Administrative staff, psychologist, interview 14).*

Service gaps in mental health care

The professionals identified specific problems that arise in the services available in Montes de María and that are usually at the root of community dissatisfactions. Programs face limitations such as lack of continuity in the care provided, compliance with quotas in care, geographical barriers that hinder access to services by rural communities, which significantly affects the quality of care.

> *"At the moment mental health campaigns are being carried out, but these campaigns, are today, but they disappear and then reappear in 2 or 3 months, so it is not a continuous process" (Nurse, interview 10).*

Specifically for mental health programs that aimed to support victims of the armed conflict, professionals identified poor-quality care, as most efforts focused solely on meeting required quotas and the number of people assisted, without prioritizing proper care. This is due to governmental pressure to show results, which are often measured mainly by the number of services provided rather than the quality of care.

The professionals also mentioned problem areas in health institutions, which are common in rural areas. They reported aspects such as an inadequate infrastructure that leads to transfers between medical institutions, failures in patient confidentiality, a shortage of staff, particularly in specialized health personnel, and high turnover of professionals, which increases the work of professionals in institutions, as well as limits access, quality, and continuity of care, generating a sense of distrust on the communities. The participants pointed out that part of the responsibility for these shortcomings lies with the resources and attention provided by the State and the governments in power.

Additionally, the professionals commented that working conditions are usually poor. They are assigned tasks that transcend their contractual functions, even performing work that does not correspond to their profession. They also receive salaries that do not reflect the large amount of work and complexity involved in attending to populations that have been, and continue to be, affected by the armed conflict.

> *"The salary is not good for a professional. There are psychologists who work for the minimum wage, and you know what it means carrying the burden of the problems, at least in our case, some of us are in charge of three municipalities, others have four municipalities, and they are not any municipality" (Psychologist, interview 5).*

Role, performance and needs of health professionals

The participants mentioned how institutions are dominated by a medical model focused on illness, relegating prevention and health promotion to a secondary role, as well as overlooking key actors such as the family environment or caregivers. This has led to interventions that overlook the history of armed conflict and the ongoing violence in the region. For this reason, many professionals emphasized the importance of training anyone working in the area to understand the context and the best approaches for caring for victims of the conflict.

> *"I'll give you an example: how many times have we come across a victim, or have you ever known someone, a mother whose son has disappeared? (...) And I always tell this to psychiatrists when I talk to them, I'm not going to tell them how to treat people, but keep in mind that if it's a forced disappearance of someone's child, that event can cause mental health symptoms that aren't necessarily a disorder. They can be a response associated with the body's physiological reaction to that event, because I'm going to see my child in other people's faces, and I'm going to look for them, and when I see them, it's someone else, and I'm not hallucinating." (Focus Group 2).*

They also pointed out the need to receive greater training in care, especially in psychological first aid, prioritization of emergencies in mental health cases, interventions and particular management for some diagnoses, management of situations in which patients become aggressive, reception of cases of domestic violence, comprehensive care, differential care, community care and psychosocial approach.

> *"There is always a new person, and that person needs to be trained, qualified. There is also a high turnover, and staff have to be constantly qualified. So, I think that there should be a strategy at the national and health level where all health personnel are qualified to always provide care with a differential approach." (Administrative staff, psychologist, interview 6).*

Participants identified a problematic area related to healthcare practices that are revictimizing. For instance, it was recognized that some professionals are unaware of the context of armed conflict, especially those from mental health care programs at the national level. This decontextualization has hindered their ability to approach, empathize and express themselves with the communities, as well as has contributed to a pathologizing logic of mental health, prompting participants to emphasize the importance of a psychosocial perspective to understand the complexity of the wounds caused by war.

> *"What happened with the PAPSIVI was that the professionals weren't from here and that affected, they did not know the territory, they did not know where to go, with whom, they were not like really empathetic people, because they did not live through that conflict." (Psychologist, interview 7).*

Other revictimizing practices mentioned include insensitive treatment, driven by stereotypes and prejudices towards victim populations, who are considered violent because of their history of armed conflict, as well as towards people with mental health conditions. Related to this, participants reported dehumanizing and impersonal treatment by medical and psychological staff.

Confusion about available healthcare pathways

One of the challenges with mental health care pathways is the lack of knowledge about which pathways are available for addressing different conditions, seeking care in cases of violence, and accessing reparations for victimizing experiences. This lack of knowledge is more pronounced within rural communities, but some participants pointed out that even healthcare professionals themselves lacked clarity about the pathways, particularly due to high staff turnover and administrative changes. They emphasized the importance of institutional efforts to educate about the pathways and services available to communities, especially in remote rural areas.

The lack of awareness is more evident in mental health care services. In this regard, professionals identified issues such as the limited or non-existent institutional efforts to outline clear care pathways and share them with the communities. They also found that the current pathways do not prioritize cases, presenting significant limitations in properly addressing mental health emergencies.

> *" People who were admitted to hospitals for mental health reasons with seven suicide attempts. As institutions, what are we doing to prevent that person from reaching an eighth or ninth attempt? And to ensure the act doesn't ultimately happen, becoming just another statistic. We need to stop counting tragic statistics and start taking more action. " (Focus Group 1).*

Barriers to accessing mental health services

The professionals identified barriers such as the geographical location of specialized care centers, which are primarily situated in major cities. Communities must undertake long journeys to access certain services and bear the travel expenses despite their economic

limitations. Additionally, people from remote areas are often not given priority for care, and institutions frequently lack the necessary medications or services.

> *"If we are going to improve the care of mental health illness, we must first consider how we are going to reach those people and not those people reach us. As I was saying, it is easier for me, as a salaried worker, to have access than for a person who lives in a rural area, two or two and a half hours way. They would have to take a boat to get to a psychiatric consultation and then what happens if they need follow-up or medication? (Administrative staff, health administrator, interview 8).*

Additionally, there are security issues in the area related to the current presence of armed groups and threats to victims and health professionals that hinder the efforts of getting mental health services for those in need. Thus, when community members are willing to make the necessary efforts to access services in different cities, they must start their commute early in the morning, which in many cases represents a risk of being targeted by armed groups. This is especially true for victims of the armed conflict who have been threatened, as their transportation options are limited because some drivers refuse to transport them once they learn of their situation. There have also been cases where armed groups have limited the entrance of service providers to the territory, further affecting the community's ability to access necessary care.

> *"We try to be with them, giving them that protection, we try not to put them in high-risk situations, because for them even commuting has also been a delicate subject, because we have found women that after coming, the driver calls them and says 'look, you didn't tell me you were a victim and you had a security problem in the territory, don't call me anymore', I mean, such violent things" (Focus Group 2).*

Moreover, the professionals identified that there is a lack of trust and active rejection of available healthcare options within the community. In many cases, this distrust is related to the experiences of armed conflict that these communities have faced, which have led them to distrust outsiders, even when they are part of state institutions. Another barrier to the provision of mental health services relates to cultural practices and beliefs, which often lead to the normalization of violence, as well as the stigmatization and normalization of mental health issues.

> *"We know that when we mention mental health to someone out there in the community, their automatic thought is madness. Truly, the crazy person. And they think, "Why would I need a psychologist if I'm not crazy?" So, that stigma also, from there exactly, it creates the same barrier, the personal barrier to seeking help." (Focus Group 1).*

> *"I believe it starts from the culture, the need for people to understand the importance of going to a psychologist. Even more so for those towns that still hold the belief that going to a psychologist means being crazy" (Focus Group 4).*

Successful approaches to mental health care in Montes de María

Despite recognizing shortcomings in healthcare provision, professionals also mentioned practices that have been helpful for providing mental health services in Montes de María. One of the most important practices is conducting an adequate analysis of the context and designing specific intervention strategies. They also understand the importance of identifying potential risk factors and the impacts of the family and community context. It was considered important that care is provided without isolating individuals from their context and that it includes comprehensive development, productive processes, and artistic and sports practices.

> *"From the recognition of victimizations, which are super important, to the continuous analysis of the context, in order to give meaning and understand what is happening with the mental health of people in the territory" (Focus Group 1).*

The professionals acknowledged that in many cases, they work together with professionals from different fields and collaborate with other institutions to ensure they address the various needs of the community. This characterization process also helps prioritize municipalities based on their specific issues and facilitates the design and implementation of differentiated strategies for ethnic and age groups.

Another practice that has brought good results is the inclusion of the community in the processes, as they play a crucial role in identifying issues and in the design of public policy. It was highlighted that when the healthcare personnel and institutions are from the territory, there is a greater commitment to the well-being of the community, and they make an effort to do better work.

> *"They are from the territory, it is better because they have a sense of belonging, you value that you are there, you value that your community changes, because you want a new future for your community. So, you put love in it. It is true that people from*

the same community do a better job, they dedicate themselves more." (Psychologist, interview 7).

The health personnel mentioned that there is an appreciation for the knowledge of those who live in the territory, as well as attempts to integrate the community's own practices into the provision of services. In this context, community leaders facilitate access to services, their acceptance, the identification of community needs, and the identification of cases. Therefore, the inclusion of community leaders in the provision of mental health services can contribute to the sustainability of programs once they are completed.

"From our cultures, from our customs, from our traditions. The traditions should guide the process through which we want to approach the healing process" (Focus Group 2).

Moreover, in response to geographic barriers, some entities have developed or are in the process of building alternatives to facilitate care in rural areas, for example, institutional, municipal, and departmental helplines, telemedicine services, home visits, and health outreach campaigns in the territories. Additionally, care centers have been expanded, psychosocial spaces have been created, and victim support centers have been established in some municipalities to make access easier for people. However, professionals argue that this is not enough to meet the high demand for care that is often present.

Finally, they mentioned initiatives to address the issues in the provision of mental health services; for example, promoting humane and respectful treatment, creating safe spaces where people can express their experiences, and striving to simplify access to care pathways, ensuring that people can directly access the professional they need without requiring a referral.

Discussion

The SDMH model [1] highlights how various social, economic, and environmental factors influence mental health outcomes throughout a person's life. Consequently, mental health is no longer considered an individual problem only linked to biological characteristics but is shaped by the conditions surrounding people throughout their lives. Two determinants that have been identified as having a considerable influence on mental health are exposure to armed conflicts and access to health services.

More than 60 years of armed conflict in Colombia have plagued different communities and generated consequences in mental health. According to Charlson et al. [12] in the populations that have been immersed in the conflict, the prevalence of mental disorders such as depression, anxiety, post-traumatic stress disorder, bipolar disorder, schizophrenia, among others, is 22.1%. Additionally, these populations face significant important psychosocial consequences, such as social and family disintegration [45], loss of support networks [46], or the intergenerational transmission of violence, linked to dysfunctional parental dynamics among victims [47]. Thus, the relationship between experiencing armed conflict and the deterioration of mental health is clear [12, 48]. In this context, it is pertinent to study the provision of mental health services in conflict-affected territories from the perspective of the SDH.

In Colombia, the National Mental Health Policy designed by the Ministry of Health and Social Protection [49] identifies that the presence of violent events and the constant exposure to highly stressful situations has led to more than 11% of the child population, 29.3% of adolescents, and about 41% of adults suffering at least one post-traumatic stress event. This evidences a clear relationship between violence and mental health difficulties.

For this reason, the State attempts to implement health models, which have been developed with the goal of being applied to urban populations and tend to be based mainly on physical health care, leading to poorly contextualized programs with a limited psychosocial reparation. In these, several problems with the health professionals have been reported, especially regarding deficient training, as well as the prioritization of attending as many people as possible, at the expense of quality, providing fast and careless care [50]. Thus, this type of model, which is typically developed outside the communities, doesn't usually meet the needs of the population. This shows that cultural, ethnic and contextual adaptation constitutes a barrier to mental health care in these communities [50] and that the effectiveness of these programs has yet to be established [29]. In the same way, these programs should adopt a psychosocial rather than a pathological approach to conceptualizing mental health, as academic and institutional frameworks often rely predominantly on psychiatric classifications [51].

Regarding the barriers that limit access to mental health services, in the same way as reported by the Montes de María's health personnel, previous research have found that the provision of mental health services in the context of the armed conflict is characterized by limited availability, lack of staff specialization, geographical barriers to access, excessive bureaucratic procedures that delay mental health attention, lack of opportune care, lack of continuity in the services, and dehumanized care [33]. Factors to which are added to the stigma related to mental health problems and the distrust on health personnel and institutions, contributing to the community's isolation and the ignorance of the mental health problems that affect the territory.

Previous studies have highlighted that in Colombia there is a significant disparity in access to mental health services [28, 52]. Even though it is an issue experienced in many regions within the country and around the world, this inequity is particularly pronounced among populations affected by armed conflict [53], like Montes de María. It is reported that the armed conflict hinders the search for health care by community members, limits its access to health services, affects health professionals, and obstructs the provision of medical supplies [53]. Furthermore, health professionals have stated that there is insufficient allocation of resources, low compliance, little support for health personnel [32], as well as failures in the training on care routes, current regulations, the health needs and the population's resources, having to learn while carrying out their work [33, 54]. Given the above, it is evident that exposure to armed conflict is a critical determinant of mental health, as it significantly limits victims' access to mental health services.

In addition, the standardization of the intervention process is a barrier to the quality of care since it leaves a short margin of action on the part of professionals to address specific events [50]. The professionals also report low training on the administrative requirements involved in working in these programs, which hinder the quality care for victims since priority is given to achievement indicators, the completion of forms and compliance with deadlines, in detriment of effectiveness, contact and humanity in the direct relationship with people [55]. Specifically, the professionals argue that in the guidelines they must follow, there is no differentiation of the types of violence in armed conflict, which overlooks the psychosocial effects and differential care needs of the victims [56].

Thus, it is evident there is a structural disconnection between the regulatory framework regarding healthcare services and the reality of its implementation in Montes de María. While legislation establishes strategies to ensure healthcare coverage in hard-to-reach areas [20, 22], mandates timely access to mental health services [21], emphasizes a differential, territorial, and context-specific approach, as well as dictates continuous and immediate care for victims as part of the reparation process [27], our findings indicate widespread non-compliance with these requirements. The reports obtained from healthcare professionals highlight the urgent need to ensure consistency between legal mandates and their practical application in the territory through concrete actions that address the population's needs effectively.

Considering the above, it is important that these health programs are developed from community models of mental health, through which cultural integration is allowed to achieve the psychosocial reparation of the victims. It must be considered that the community's health is affected by social factors, and that these social determinants of health, joined with the social and armed conflicts in the territory, not only have an impact on the individual's wellbeing, but also the collective, cultural and institutional reproduction of violence, preventing the reduction of victimizing processes at the social level.

For instance, the successful interventions reported, particularly the group ones, share a common axis of enabling the development and strengthening of quality social relationships, with functions such as social support and the bonding with one another. The literature evidence that these characteristics of social connection are associated with benefits in people's health, particularly in mental health it is identified as a protective factor [57, 58, 59]; however, the importance of making visible the role of social relations as a determinant of health that must be promoted within the framework of public health is raised [59]. In the case of the Montes de María communities, there is a recognition of the value of social connection that has already been reported when talking about community health care practices and their effects at the individual (e.g., decreased perception of loneliness and hopelessness) and collective level (e.g., reconstruction of the social fabric) [60].

In this context, the recommendations of some healthcare professionals regarding the importance of closely collaborating with the community leaders become even more relevant. Not only this collaboration could contribute to a better contextualization and sustainability of the programs, but it also could serve as a protective factor for mental health, benefiting both the community and the healthcare professionals working in the region. In this regard, previous research on cultural competence indicates that incorporating local knowledge facilitates collaboration with community members to understand how their experiences, values, beliefs, and context may either promote or hinder their emotional wellbeing. This approach is grounded in transformational dialogues that integrate the perspectives and needs of the community, emphasizing the importance of community-driven mental health and primary care services [61].

Another successful approach mentioned was the articulated work with community leaders, which has been reported in previous studies as a facilitator of the implementation of mental health programs aimed at communities that have been victims of the conflict. It has been reported that one of the barriers to providing mental health services to conflict victims is the communities' resistance to the changes applied by the intervention. In this context, the role of the community promoter has proved to be crucial in minimizing the impact of this barrier by facilitating contact with healthcare personnel [38]. Furthermore, it has been reported that health professionals who reside in the same community where the

program is implemented and possess in-depth knowledge of the community can encourage individuals to seek mental health services [50].

Finally, within the framework of the results of this study, the recurrent mentions of the high turnover of health and administrative staff reveal a significant problem that operates in two dimensions: rotation between successive government administrations and rotation within the same government period. These dynamics, coupled with the lack of suitability of staff, are rooted in deep-seated clientelist practices [50]. This phenomenon is aligned with institutional remnants of the armed conflict in Montes de María, such as the capture of the State by clientelist, corrupt and extractive political structures [32]. From a perspective of the SDMH, it is pertinent to ask whether these dynamics not only affect the stability of the health system, but also directly contribute to the deterioration of the mental health of affected communities. The need expressed by the participants to improve the information and training of health officials and personnel, in conjunction with strategies that allow them to reduce their turnover rates, points towards a broader horizon of institutional design and public policies that could be key to the implementation of sustainable and contextualized strategies for mental health care in the territory. These findings highlight the challenges in peacebuilding in Colombia in relation to the SDGs [62], which coincides with the WHO's call to strengthen the health care response to mental health needs [63].

Conclusions

This study shows that both armed conflict and the provision of mental health services are key determinants of mental health in the Montes de María region. The healthcare and administrative staff involved in the provision of mental health services in this region reported significant deficiencies and barriers to the delivery and guarantee of access to available services; they also reported successful approachesthey have developed to overcome these limitations, where the recognition of the specific context, coordinated work with community leaders, and community belonging have proven to be supporters of their work.

The lack of development of specific mental health care models for communities affected by the armed conflict leads healthcare personnel to identify difficulties when providing care to people from these communities. Rural areas have been historically abandoned by the State, which has led them to a higher vulnerability to armed conflict and has been linked with precarious living conditions that worsen mental health issues and limit access to mental health services. Although numerous laws and government programs have been introduced in these regions, their poor implementation, combined with the ongoing presence of armed groups, highlights the urgent need for greater State presence. However, this intervention should go beyond decontextualized solutions; it must be informed by the experiences of the communities and the insights of mental health professionals who work with them to develop effective and sustainable solutions.

In this context, understanding mental health limited to the individual and psychopathological perspective is insufficient and inadequate in ensuring the right to health. An approach based on recognizing mental health from a community perspective and the full enjoyment of health beyond illness is required. These perspectives must be urgently implemented in mental health actions carried out in this territory, which has been historically affected by armed conflict and multiple forms of structural violence.

Limitations

This study presents valuable insights into the provision of mental health services in areas affected by armed conflict. However, several limitations should be acknowledged. As is common in qualitative research, and due to logistical challenges in accessing healthcare professionals in the region, the study relies on a limited sample size, which restricts the generalizability of the findings, particularly to conflict-affected contexts beyond the Montes de María. Nevertheless, the participants narratives align with previous research on mental health service provision in similar settings, reinforcing the validity of the findings. Additionally, this study aimed to explore the characteristics of service provision from the perspective of healthcare professionals. However, the absence of direct accounts from victims of the armed conflict limits the understanding of how affected populations perceive and experience health care, as well as additional insights into the challenges they face when accessing services. Future research should seek to integrate the perspectives of both professionals and service users to provide a more complete understanding of the healthcare services landscape in conflict-affected contexts.

Abbreviations

COREQ	Consolidated Criteria for Reporting Qualitative Research
ESE	Empresas Sociales del Estado (State Social Enterprises)
EPS	Entidad Promotora de Salud (Health Promoting Entities)
IPS	Institución Prestadora de Salud (Health Service Provider Institutions)
NGO	Non-Governmental Organizations
PAPSIVI	Programa de Atención Psicosocial y Salud Integral a Víctimas (Psychosocial and Comprehensive Health Care Program for Victims)
SDH	Social Determinants of Health
SDMH	Social Determinants of Mental Health
SGSSS	Sistema General de Seguridad Social en Salud (General System of Social Security in Health)

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s13690-025-01561-z.

Supplementary Material 1: Details of the focus groups and semi-structured interviews.

Supplementary Material 2: Semi-structured Interview Guide.

Supplementary Material 3: Focus Group Guide.

Supplementary Material 4: Dissemination of results.

Acknowledgements

We express our gratitude to the health personnel and administrative staff in charge of health and mental health care in the communities of Montes de María, who accompanied us in these years of project. We also appreciate the participation of the administrative staff in mental health at the national level, who complemented our overview of the challenges and needs of mental health care in the Colombian regions.

Author contributions

Given the participatory nature of the project, the authors played various roles in the writing of this article. These are listed below. DCRL: Conceptualization, methodology, data collection, writing of the manuscript and review of the writing process. LCS: Administrative aspects of the project, data collection, information analysis and writing of the manuscript. MJRR: Data collection, information analysis and writing of the manuscript. SLFG: Analysis of information and writing of the manuscript. DGP: Conceptualization, writing of the manuscript and revision of the writing process. PA: Conceptualization, writing of the manuscript and revision of the writing process. WLL: Conceptualization, data collection, analysis of the information and review of the manuscript writing process.

Funding

This manuscript is part of the project "Participatory design of a psychosocial mental health care model in the communities of Montes de María in the framework of the COVID-19 health emergency.", funded by the Ministry of Science, Technology and Innovation of Colombia (MinCiencias), with resources from the Autonomous Heritage National Science Fund, Technology and Innovation Francisco José de Caldas, through the call "Building peace, resilience and mental health: binational call for research to improve support and understanding of Colombia's current challenges in times of pandemic – No. 884–2020". The funder had no role in the interpretation of data or views presented in this article.

Data availability

Given the conflict situation and security concerns in the Montes de María region as well as ethical and participant confidentiality restrictions, the qualitative data generated and analyzed during this study are not publicly available. However, the transcripts and other qualitative materials used in this study are available upon reasonable request. Interested parties may contact the corresponding author to discuss access conditions, subject to ethical and privacy restrictions.

Declarations

Ethics approval and consent to participate

The project was approved by the Research and Ethics Committee of the School of Psychology of the Pontificia Universidad Javeriana during their meeting on August 18, 2020, as stated in Minute No. 125 of said meeting and in certificate PSI-DEC-080-2020. Participants were asked to read and sign an informed consent form, which was written in accordance with the Colombian normative [44], and approved by the Research and Ethics Committee of the School of Psychology of Pontificia Universidad Javeriana. All participants were older than 18 years.

Consent for publication

The authors declare their consent for publication.

Competing interests

The authors declare no competing interests.

Author details

[1]Psychology and Health Research Group, School of Psychology, Pontificia Universidad Javeriana, Bogotá, Colombia
[2]Social Ties and Cultures of Peace Research Group, School of Psychology, Pontificia Universidad Javeriana, Bogotá, Colombia
[3]Regional Group of Historic Memory, Universidad Tecnológica de Bolívar, Cartagena, Colombia

Received: 6 December 2024 / Accepted: 3 March 2025
Published online: 07 May 2025

References

1. World Health Organization, Fundação Calouste Gulbenkian. Social determinants of mental health. 2014. Available from: https://www.who.int/publications/i/item/9789241506809
2. Lund C. Global mental health and its social determinants: how should we intervene? Behav Res Ther. 2023;169:104402. https://doi.org/10.1016/j.brat.2023.104402
3. Kirkbride JB, Anglin DM, Colman I, Dykxhoorn J, Jones PB, Patalay P, et al. The social determinants of mental health and disorder: evidence, prevention and recommendations. World Psychiatry. 2024;23(1):58–90. https://doi.org/10.1002/wps.21160
4. Allen J, Balfour R, Bell R, Marmot M. Social determinants of mental health. Int Rev Psychiatry. 2014;26(4):392–407. https://doi.org/10.3109/09540261.2014.928270
5. Compton MT, Shim RS. The social determinants of mental health. Clin Synthesis. 2015;13(4):419–25. https://doi.org/10.1176/appi.focus.20150017
6. Tunaligil V. Sometimes there is no easy answer: health care protection in conflict zones. Turkish J Public Health. 2024;22(2):238–42. https://doi.org/10.20518/tjph.1471137
7. National Institute of Health, National Health Observatory. Consequences of the armed conflict on health in Colombia. Ninth Technical Report. 2017. Available from: https://www.ins.gov.co/Direcciones/ONS/Resumenes Ejecutivos/9. Consecuencias del Conflicto Armado en Salud en Colombia.pdf
8. Unit for the Assistance and Comprehensive Reparation of Victims. Infographic: official statistics on victims in Colombia. Bogotá: Unit for the Assistance and Comprehensive Reparation of Victims. 2024. Available from: https://cifras.unidadvictimas.gov.co/Cifras/#!/infografia
9. Tarnas MC, Hamze M, Tajaldin B, et al. Exploring relationships between conflict intensity, forced displacement, and healthcare attacks: a retrospective analysis from Syria, 2016–2022. Confl Health. 2024;18:70. https://doi.org/10.1186/s13031-024-00630-4
10. Crawford K, Florez T, Rodriguez M, Cirado L, Read R, Haar R. There is a fear that you will be attacked just for the act of working in health: a survey of experiences of violence against healthcare in Colombia. Confl Health. 2023;17:51. https://doi.org/10.1186/s13031-023-00548-3
11. Echeverry-López ME, Marín-Uribe A, Garcés-Palacio IC, Borrero-Ramírez Y, Hernández-Holguin DM, Pacheco-Sánchez CI, et al. Impacts of attacks to female health care workers in three territories of Colombia. Confl Health. 2024;18:25. https://doi.org/10.1186/s13031-024-00582-9
12. Charlson F, van Ommeren M, Flaxman A, Cornett J, Whiteford H, Saxena S. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. Lancet. 2019;394(10194):240–8. https://doi.org/10.1016/S0140-6736(19)30934-1
13. Ministry of Health and Social Protection. Ten-year public health, plan PDSP. 2012–2031 You build health in Colombia. Ministry of Health and Social Protection. 2022. Available from: https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/ED/PSP/documento-plan-decenal-salud-publica-2022-2031.pdf
14. Piñeros-Ortíz SE, Urrego-Mendoza ZC, Garzón-Orjuela N, Eslava-Schmalbach J. Social determinants, symptoms and mental problems in adults internally displaced by armed conflict. Soacha Colombia 2019 Rev Colomb Psiquiatr. 2024;53(1):8–16. https://doi.org/10.1016/j.rcpeng.2022.08.011
15. Rubio-León D, Cano-Sierra L, Reyes-Rivera M, Abitbol P, García-Padilla D, Forero-García S, López-López W. With mental health and land, we have enough to live. Social determinants of mental health in fifteen conflict-affected municipalities of Montes de María, Colombia: a mixed methods

study. 2025. Available from: https://www.researchsquare.com/article/rs-4831513/v1
16. Médecins Sans Frontières. The least visible wounds: mental health, violence, and armed conflict in Southern Colombia. 2013. Available from: https://www.msf.es/sites/default/files/legacy/adjuntos/Informe-Colombia_Junio-2013.pdf
17. Abitbol P. The complex intersection of legacies of violence and legacies of resistance in Montes de María, Colombia. In: Chase AT, Mahdavi P, Banai H, & Gruskin S, editors. Human rights at the intersections.Transformation through Local, Global, and Cosmopolitan Challenges. Bloomsbury Academic; 2022. p. 127–34. https://doi.org/10.5040/9781350268692.0023 class="oxedel_1" id="oxe_del_1_1741352096943_40011762489586866" user="Diana Carolina Rubio-León" deletedat="03-07-2025 07:54:56">>
18. Restrepo M, Padilla-Medina D. Armed conflict exposure and mental health: examining the role of imperceptible violence. Med Confl Surviv. 2023;39(3):199–221. https://doi.org/10.1080/13623699.2023.2222360
19. Zamora-Moncayo E, Burgess RA, Fonseca L, González-Gort M, Kakuma R. Gender, mental health and resilience in armed conflict: listening to life stories of internally displaced women in Colombia. BMJ Glob Health. 2021;6(10):e005770. https://doi.org/10.1136/bmjgh-2021-005770
20. Colombia. Congress of the Republic. Law 100 of 1993. Bogotá: Official Gazette; 2011. Available from: https://www.funcionpublica.gov.co/eva/gestornormativo/norma.php?i=5248
21. Ministry of Health and Social Protection. Resolution 5592 of 2015. Bogotá: Ministry of Health and Social Protection. 2015. Available from: https://www.icbf.gov.co/cargues/avance/compilacion/docs/resolucion_minsaludps_5592_2015.htm
22. Ministry of Health and Social Protection. Resolution 0429 of 2016. Bogotá: Ministry of Health and Social Protection. 2016. Available from: https://www.minsalud.gov.co/Normatividad_Nuevo/Resoluci%C3%B3n 0429 de 2016.pdf
23. Colombia. Congress of the Republic. Law 1438 of 2011. Bogotá: Official Gazette; 2011. Available from: https://www.funcionpublica.gov.co/eva/gestornormativo/norma.php?i=41355
24. Ministry of Health and Social Protection. Incentives for human talent in health. Bogotá: Ministry of Health and Social Protection. 2016. Available from: https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/TH/1.estrategia-tarea-todos-incentivos-minsalud.pdf
25. Agudelo-Hernández F, Plata-Casas LI, Vélez-Botero H. Paradoxes in the implementation of public policies in mental health: a case study of the Colombian context. SSM - Health Syst. 2025;4:100048. https://doi.org/10.1016/j.ssmhs.2024.100048
26. Agudelo-Hernández F, Rojas-Andrade R. Mental health services in Colombia: a national implementation study. Int J Soc Determ Health Health Serv. 2023;53(4):424–33. https://doi.org/10.1177/27551938231156023
27. Colombia. Congress of the Republic. Law 1448 of 2011. Bogotá: Official Gazette; 2011. Available from: https://www.unidadvictimas.gov.co/documentos_bibliotec/ley-1448-de-2011-2/
28. Monroy-Sánchez DC. Nature of access to mental health services for adult victims of the armed conflict in Colombia. Salud Bosque. 2020;10(1):91–105. https://doi.org/10.18270/rsb.v10i1.3053
29. Tamayo-Agudelo W, Bell V. Armed conflict and mental health in Colombia. BJPsych Int. 2018;16(2):40–2. https://doi.org/10.1192/bji.2018.4
30. Sarmiento-Marulanda L, Aguilera-Char A, González-Gil C, López-López W. Psychosocial rehabilitation experiences of women victims of armed conflict in Montes de María. Colombia Archives Public Health. 2021;79:1–12. https://doi.org/10.1186/s13690-021-00548-w
31. Agudelo-Hernández F, Plata-Casas L, Vélez Botero H, Salazar Vieira LM, Moreno Mayorga B. Action program to overcome gaps in mental health: a theoretical model of implementation barriers from health personnel in Chocó, Colombia. Pan Am J Public Health. 2024;2148:e49. https://doi.org/10.26633/RPSP.2024.49
32. Democratic Culture Foundation (FUCUDE), Consultancy for Human Rights and Displacement (CODHES), Legal Option Corporation, Technological University of Bolívar, Regional Group of Historical Memory, Table of Organizations of the Displaced Population of Los Montes de María OPDS Montes de María. The Montes de María Under Fire. 2020. Available from: https://codhes.wordpress.com/wp-content/uploads/2021/01/montes-de-maria-bajo-fuego.pdf
33. Casanova-Burbano MI. Meaning of the health care process for a group of victims of the armed conflict in the municipality of Pasto. Revista Criterios. 2021;28(1):142–64. Available from: https://dialnet.unirioja.es/servlet/articulo?codigo=8736399
34. National Planning Department (DNP). National Development Plan 2022–2026: Colombia, World Power of Life. 2023. Available from: https://colaboracion.dnp.gov.co/CDT/Prensa/Publicaciones/plan-nacional-de-desarrollo-2022-2026-colombia-potencia-mundial-de-la-vida.pdf
35. United Nations Development Programme (UNDP). Guidance Note Integrating Mental Health and Psychosocial Support into Peacebuilding. 2022. Available from: https://www.undp.org/publications/integrating-mental-health-and-psychosocial-support-peacebuilding
36. IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. Integrating MHPSS and Peacebuilding: A Mapping and Recommendations for Practitioners IASC. 2024. Available from: https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-guidance-integrating-mhpss-and-peacebuilding-mapping-and-recommendations-practitioners
37. National Center for Historical Memory. Journeys through the landscapes of violence in Colombia. Montes de María. Bogotá: National Center for Historical Memory. 2018. Available from: https://www.centrodememoriahistorica.gov.co/micrositios/recorridos-por-paisajes-de-la-violencia/montes-maria.html
38. Ramírez-Giraldo A, Hernández-Bustamante O, Romero-Acosta K, Porras-Mendoza E. Estado de salud mental de personas víctimas del conflicto armado en Chengue. Psicología desde el Caribe. 2017;34(1):49–70. Available from: http://www.scielo.org.co/scielo.php?script=sci_arttextamp;pid=S0123-417X2017000100049amp;lng=enamp;tlng=es
39. Agency for Territorial Renewal. Montes de María - subregional document 2023. Bogotá: Agency for Territorial Renewal. 2023. Available from: https://centralpdet.renovacionterritorio.gov.co/wp-content/uploads/2024/02/Montes de Mari%CC%81a - Documento subregional 2023.pdf
40. Sandelowski M. What's in a name? Qualitative description revisited. Res Nurs Health. 2010;33(1):77–84. https://doi.org/10.1002/nur.20362
41. Creswell JW, Hanson WE, Clark Plano VL. Qualitative research designs: selection and implementation. Couns Psychol. 2007;35:236–64. https://doi.org/10.1177/0011000006287390
42. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349–57. https://doi.org/10.1093/intqhc/mzm042
43. Schreier M. Qualitative content analysis. In: Flick U, editor. The SAGE handbook of qualitative data analysis. SAGE; 2014. p. 170–83. https://doi.org/10.4135/9781446282243.n12
44. Ministry of Health and Social Protection. Resolution 8430 of 1993: establishing scientific, technical, and administrative standards for health research. Bogotá: National Printing Office. 1993. Available from: https://minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/DIJ/RESOLUCION-8430-DE-1993.pdf
45. Moreno-Murcia LM, Gómez MA, Bustos Marín T. Mental health and armed conflict in Colombia: a documentary review. IyD. 2021;8(2):26–41. https://doi.org/10.26620/uniminuto.inclusion.8.2.2021.26-41
46. Andrade Salazar JA, Sicachá MA. Indicators of individual and community mental health in women-headed households in situations of forced displacement in the state of Quindío. *El Ágora USB*. 2012;12(1):61–75. Available from: http://www.scielo.org.co/scielo.php?script=sci_arttextamp;pid=S1657-80312012000100004
47. Moreno-Chaparro J, Piñeros-Ortiz S, Rodríguez-Ramírez L, Urrego-Mendoza Z, Garzón-Orjuela N, Eslava-Schmalbach J. Mental health consequences of armed conflicts in adults: an overview. Actas Esp Psiquiatr. 2022;50(2):68–91.
48. World Health Organization. Closing the gap in a generation: health equity through action on the social determinants of health - Final report of the commission on social determinants of health. 2008. Available from: https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1
49. Ministry of Health and Social Protection. National mental health policy: guidelines for its implementation. Ministry of Health and Social Protection. 2018. Available from: https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/PP/politica-nacional-salud-mental.pdf
50. Ramos-Vidal I, Palacio J, Villamil I, Uribe A, Domínguez E, Wehdeking I. Barreras en la implementación de programas centrados en comunidad desplazada: tensiones entre teoría y praxis en el modelo PAPSIVI. En: Bustos VA, Mayor DP. Desplazamiento, perspectivas y estrategias de intervención desde el Caribe colombiano. Editorial Uninorte;2022. pp. 101–140. https://doi.org/10.2307/j.ctv2wk71q9.8
51. López-López W, Rubio-León DC, García-Padilla D, Cakal H, Abitbol P, Pineda C, Rocha D, Reyes-Rivera MJ, Guzmán-Duarte AF. Measuring mental health indicators of armed conflict population in Colombia: scoping review. Univ Psychol. 2022;21:1–22. https://doi.org/10.11144/Javeriana.upsy21.mism

52. González LM, Peñaloza RE, Matallana MA, Gil F, Gómez-Restrepo C, Landaeta APV. Factors that determine access to mental health services for the adult population in Colombia. Rev Colomb Psiquiatr. 2016;45:89–95. https://doi.org/10.1016/j.rcp.2016.10.004
53. Bernal O, Garcia-Betancourt T, León-Giraldo S, Rodríguez LM, González-Uribe C. Impact of the armed conflict in Colombia: consequences in the health system, response and challenges. Confl Health. 2024;18(4). https://doi.org/10.1186/s13031-023-00561-6
54. Shultz JM, Verdeli H, Gómez Ceballos Á, Hernandez LJ, Espinel Z, Helpman L, et al. A pilot study of a stepped-care brief intervention to help psychologically-distressed women displaced by conflict in Bogotá, Colombia. Glob Ment Health (Camb). 2019;6:e28. https://doi.org/10.1017/gmh.2019.26
55. Moreno Camacho MA, Díaz Rico ME. Positions in psychosocial care for victims of the armed conflict in Colombia. The USB Agora. 2016;16(1):193–213. Available from: https://www.redalyc.org/pdf/4077/407755353010.pdf
56. Pizarro DA, Lopera Mazo JE, Palacios WT. Perception of the psychosocial intervention of the reparation program for victims of the armed conflict in Colombia from the perspective of three professionals in psychology [Undergraduate thesis]. [Bello]: Corporación Universitaria Minuto de Dios; 2020.
57. Holt-Lunstad J. The major health implications of social connection. Curr Dir Psychol Sci. 2021;30(3):251–9. https://doi.org/10.1177/0963721421999
58. Wickramaratne PJ, Yangchen T, Lepow L, Patra BG, Glicksburg B, Talati A, et al. Social connectedness as a determinant of mental health: A scoping review. PLoS ONE. 2022;17(10):e0275004. https://doi.org/10.1371/journal.pone.0275004
59. Holt-Lunstad J. The potential public health relevance of social isolation and loneliness: prevalence, epidemiology, and risk factors. Public Policy Aging Rep. 2017;27(4):127–30. https://doi.org/10.1093/ppar/prx030
60. García-Padilla D, Reyes-Rivera MJ, Rubio-Leon DC, Abitbol P, Cano-Sierra L, Lopez-Lopez W, et al. Cultural practices of mental health care and their relationship with peacebuilding in Montes de María. Colombian J Psychol. 2025;34. In press.
61. Sanguineti MCD, Fonseca L, Burgess RA, Concha N, González M, San Juan NV, et al. Resisting epistemic violence in global mental health: listening to local understandings of mental health and emotional distress among victims and ex-guerrilla members in Southern Colombia. SSM Ment Health. 2025;7:100385. https://doi.org/10.1016/j.ssmmh.2024.100385
62. Oswald TK, Nguyen MT, Mirza L, Lund C, Jones HG, Crowley G, et al. Interventions targeting social determinants of mental disorders and the sustainable development goals: a systematic review of reviews. Psychol Med. 2024;54(8):1475–99. https://doi.org/10.1017/S0033291724000333
63. World Health Organization. Mental health: strengthening our response. 2022. Available from: https://www.who.int/es/news-room/fact-sheets/detail/mental-health-strengthening-our-response

Publisher's note