URUGUAY

The Burden of Mental Disorders in the Americas: COUNTRY PROFILE

2019 population (millions) **3.4**
Life expectancy (years) **77.9**

The Oriental Republic of Uruguay is located east of Argentina and south of Brazil and has a land area of 176,215 km². Uruguay is a unitary state and is territorially divided into 19 departments.

In 2019, 95% of the population resided in urban areas and was concentrated in greater metropolitan Montevideo.
The population pyramid was expansive in 1990 but became regressive by 2015. The proportion of the population over 65 was 14.1% in the 2011 Census.
Afro-descendants are the principal ethnic-racial minority in the country (8.1%), followed by those who claim indigenous ancestry (5.1%).
In 2019, life expectancy at birth was 81.5 years in women and 74.1 in men.

THE DISEASE BURDEN AFFECTING MENTAL HEALTH

Mental, neurological, substance use disorders and suicide (MNSS) cause 19% of all disability- adjusted life years (DALYs) and 35% of all years lived with disability (YLDs).

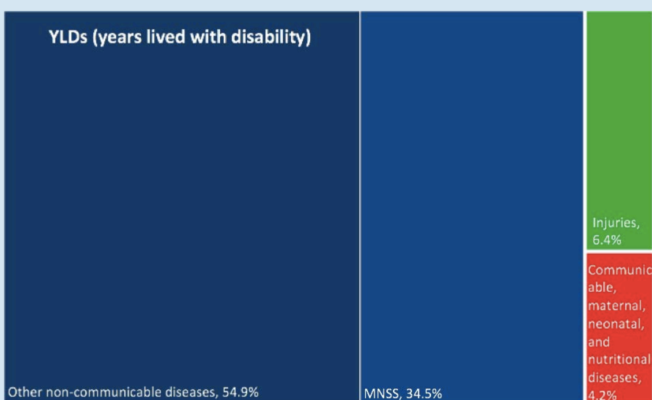


Figure 1. Distribution of YLDs with a focus on mental, neurological, substance use disorders and self harm (MNSS)

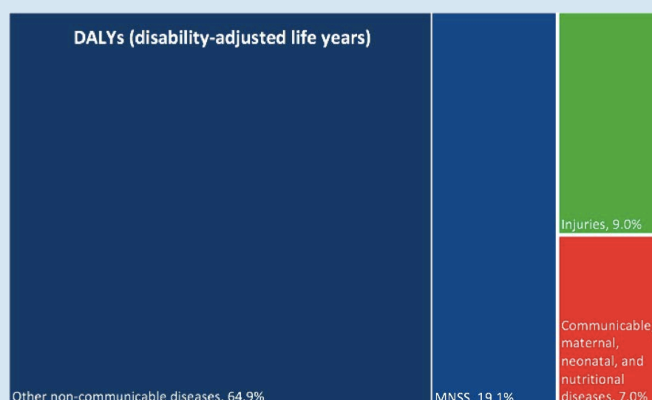


Figure 2. Distribution of DALYs with a focus on mental, neurological, substance use disorders and self harm (MNSS)

THE BURDEN AFFECTING MENTAL HEALTH ACROSS THE LIFETIME

Fig. 3 shows the changes in disease burden across age-groups. NCDs (in shades of blue) surpass 50% of the burden in the 1 to 4 years old group, and will remain the largest burden throughout the lifetime. MNSS account for between 30 and 40% of the total burden between 10 and 45 years of age, the largest burden of all disease groups during this period. Fig. 4 focuses exclusively on the burden resulting from MNSS. Until 5 years old, the MNSS burden is mostly due to epilepsy (52%) and autism (38%). Between 5 and 15 years old, the burden of anxiety disorders (25%), conduct disorders (19%), and headaches (17%) –including migraine and tension-type- gain prominence. Around 20 years of age, a pattern emerges that will remain stable throughout youth and adulthood: common disorders (anxiety, depression, self-harm and somatic symptom disorder) account for 54%, headaches for 17%, substance use disorders 11% (6% due to alcohol), and severe mental disorders (schizophrenia and bipolar disorders) around 7%. The elderly suffer mostly from neurocognitive disorder due to Alzheimer's disease, which surpass 50% of the burden around 80 years old and remains above 70% after 85 years old.

This is the second installment of the 2018 PAHO report, found here

Pan American Health Organization
World Health Organization Regional Office for the Americas

Figure 3. Burden of disease, by disease group and age

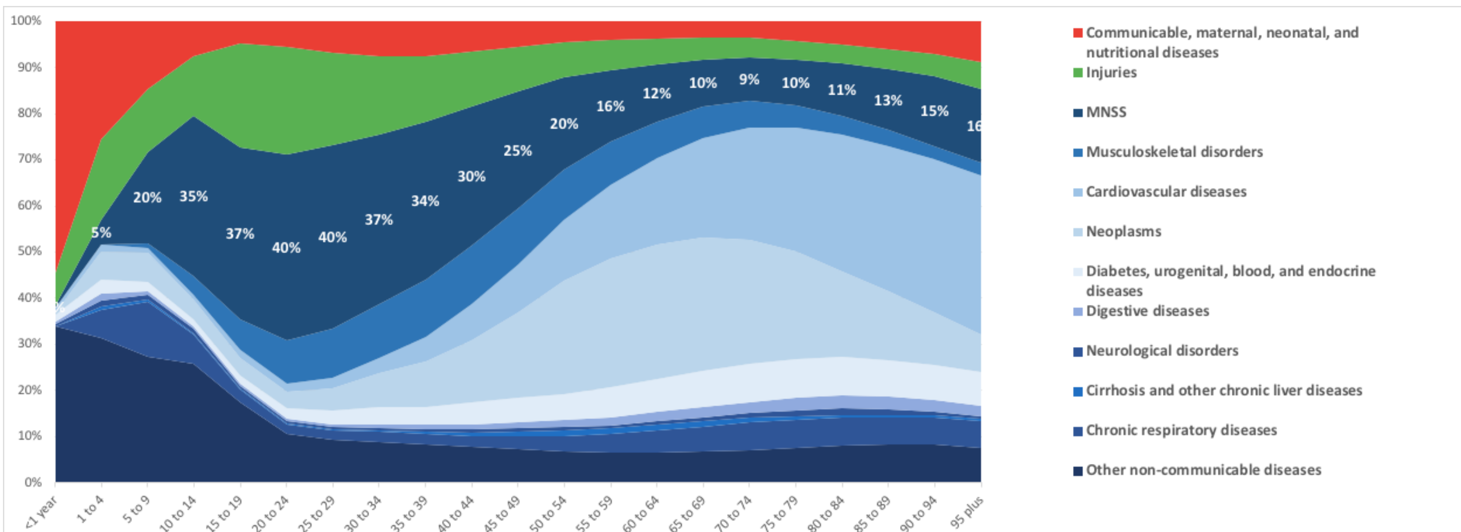
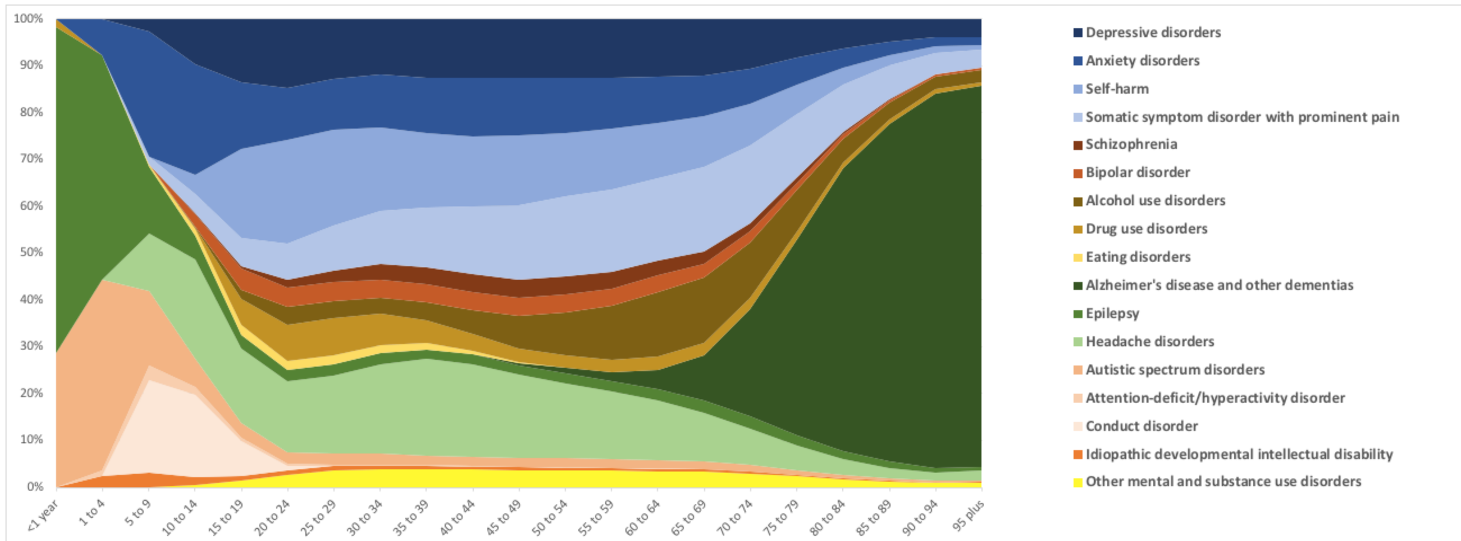


Figure 4. Burden of disease, by MNSS and age



THE BURDEN AFFECTING MENTAL HEALTH IN MEN AND WOMEN

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

Men		Women	
Disorder	DALYs per 100 000	Disorder	DALYs per 100 000
MNSS (all)	5061	MNSS (all)	4846
Self-harm and suicide	1142	Headache disorders	988
Somatic symptom disorder with prominent pain	573	Anxiety disorders	818
Headache disorders	530	Depressive disorders	724
Alcohol use disorders	487	Somatic symptom disorder with prominent pain	612
Depressive disorders	443	Alzheimer's disease and other dementias	335

Conclusions:

Considering these estimates, primary care providers should receive training and tools to prioritize detection and treatment or referral for the common disorders highlighted above for each age-group and sex. For the severe disorders –such as autism, schizophrenia, bipolar disorder and Alzheimer's– as well as for severe, comorbid, or complex presentations of other disorders –e.g. depression during pregnancy, substance use in public service professions, etc.– primary care providers and families need access to adequate supports, such as:

• Referral and/or supervision platforms that allow for continued treatment in the community, including the use of digital technology to increase access to distant geographically concentrated resources.

• Emergency, inpatient, and residential services for the management of high-risk acute situations and high-need patients. These services should be community-based as much as possible, including for crisis management, inpatient treatment in general hospitals, supported housing, and residential services.