Interpellations and responses to Non-communicable diseases in Uruguay

Update document on the situation of NCDs in Uruguay

December 2018

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AUTHORITIES

MINISTRY OF PUBLIC HEALTH

Dr. Jorge Basso
Minister of Public Health

Dr. Jorge Quian
Undersecretary of Public Health

Dra. Raquel Rosa
Director General of Health

Dr. Gilberto Ríos
Deputy Director of the General Directorate of Health

Mr. Humberto Ruocco
General Director of the Secretariat

Economist Arturo Echeverría
President of the National Board of Health

Dr. Adriana Brescia
Director of the General Directorate of Coordination

PAN AMERICAN HEALTH ORGANIZATION
/ WORLD HEALTH ORGANIZATION

Dr. Giovanni Escalante
PAHO / WHO Representative in Uruguay

Contributions to the document:

Alfonso, Adriana
Asqueta, Miguel
Basso, Jorge
Beron, Analice
Bittar, Griselda
Bove, Ma. Isabel
Brescia, Adriana
Cavalleri, Fiorella
Del Campo, Cecilia
Delgado, Lucía
Escalante, Giovanni
Esteves, Elba
Fenochi, Eduardo
Galicia, Luis
León, Ima
Luongo, Álvaro
Martin, Lilia
Martínez, Joseline
Melgar, Silvia
Mijailidis, Beatriz
Moratorio, Ximena
Noble, Ana
Oreggioni, Ida
Poloni, Ileana
Quian, Jorge
Rios, Gilberto
Rodríguez, Guillermo
Rodríguez, María José
Rosa, Raquel
Soto, Enrique
Villa, Inés
Zelarayan, Mario

Document prepared by: Pablo Anzalone, Wilson Benia
Design and layout: PAHO / WHO Uruguay, Communication Area

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Acronyms

CVA	Cerebrovascular Accident
ANCAP	National Administration of Fuels Alcohol and Portland
ANII	National Research and Innovation Agency
PHC	Primary Health Care
ASSE	State Health Services Administration
DALY	Disability-Adjusted Life Year
HYLL	Healthy Years of Life Lost
YLL	Years of Life Lost
IDB	Inter-American Development Bank
WB	World Bank
GFP	Good Feeding Practices
SSA	Social Security Administration
CRC	Colorectal Cancer
CC	Cervical Cancer
CDC	Center for Disease Control and Prevention
CEIP	Council of Initial and Primary Education
ECLAC	Economic Commission for Latin America and the Caribbean
CHLCC	Honorary Commission for the Fight Against Cancer
CHSCV	Honorary Commission for Cardiovascular Health
ICSID	International Centre for Settlement of Investment Disputes
WHO-FCTC	WHO Framework Convention on Tobacco Control
CHD	National Honorary Disability Commission
PC	Palliative Care
CUDIM	Uruguayan Molecular Imaging Center
AED	Automatic External Defibrillator
SDH	Social Determinants of Health
CCS	PAHO/WHO Country Cooperation Strategy
ENDIS	National Health, Nutrition and Child Development Survey
ENFRENT	National NCD Risk Factors Survey
NCD	Non-Communicable Diseases
COPD	Chronic Obstructive Pulmonary Disease
FAO	Food and Agriculture Organization of the United Nations
NRF	National Resource Fund
SWOT	Strengths, Weaknesses, Opportunities and Threats analysis
FONASA	National Health Fund
FBDG	Food-Based Dietary Guidelines
GENYCO	National Program for the Early Detection and Care of Familial Hypercholesterolemia (Genes and Cholesterol)
HCEN	National Medical Records
HCEO	Oncology Electronic Medical Records
FH	Familial Hypercholesterolemia
HPV	Human Papillomavirus
PAH	Arterial Hypertension
IAM	Medical Assistance Institute

IARC	International Agency for Research on Cancer
GDI	Gender-Related Development Index
HDI	Human Development Index
NCI	National Cancer Institute
NSI	National Statistics Institute
NICE	National Institute for the Care of the Elderly - Ministry of Social Development
JUDESA	Departmental Board of Health
JULOSA	Local Board of Health
JND	National Board of Drugs
JUNASA	National Board of Health
HCM	High Cost Medications
MERCOSUR	The Southern Common Market
MIDES	Ministry of Social Development
MTSS	Ministry of Labor and Social Security
MSP	Ministry of Health
ODH	Obese, Diabetic, Hypertensive
WHO	World Health Organization
OPB	Office of Planning and Budget
PAHO	Pan American Health Organization
CSO	Civil Society Organizations
OSN	National Health Objectives
PAP	Papanicolaou Test
PARLASUR	MERCOSUR Parliament
PARLATINO	Latin American Parliament
GDP	Gross Domestic Product
PET	Positron Emission Tomography
PIAS	Comprehensive Health Care Plan - Service Catalogue
PHC	Primary Health Care
UNDP	United Nations Development Programme
PNPICCU	National Plan for the Comprehensive Prevention of Cervical Cancer
PPENT	Program for the Prevention of Non-communicable Diseases
PRONADIS	National Disability Program
PUP	Ultra Processed Products
ER	Expected Results
RIEPS	Integrated Network of Public Health Suppliers
IHSN	Integrated Health Services Network
NIS	National Information System
SND	National Drugs Secretariat
NIHS	National Integrated Health System
STEPS	Chronic disease Surveillance Methodology
UDELAR	University of the Republic
USAN	Union of South American Nations
UNICEF	United Nations Children´s Fund
UNFPA	United Nations Population Fund

Foreword

We are pleased to present this technical document that systematizes how the Uruguayan State handles a complex global problem, such as Non-communicable Diseases.

We look at the perspective of the State which integrates the government, territory, population and legal constitutional framework.

The Uruguayan State marked a different path which favors development. It was based on a framework of human rights and social protection, health and other social sectors, which have been prioritized consistently during the successive administrations from 2005 until now.

In the case of health and well-being, since 2005 it has been promoting a reformative conception of health policies based on five strategic axes: interstate coordination, decentralization, new operations in the public-private relationship, citizen participation and sustainability.

We are pleased to observe the effects of innovative public policies after three five-year periods of sustainable implementation. As an update, this document takes a balanced view, supported by evidence,instrumental evidence and critical reflection. It considers the integral approach taken to reduce premature mortality, morbidity and disability generated by non-communicable diseases in Uruguay.

Our director, Carissa F. Etienne emphasizes that, "the fight against non-communicable diseases depends of political commitment, particularly from national governments to work in a multi-sectoral manner putting health first before other interests, economic gains or personal promotion ".

We want to highlight three fundamental aspects: First, political and strategic advocacy from the highest level with the involvement of the three powers of the State given that, at present, non-communicable diseases and mental disorders represent one of the greatest threats to health and national development.

Then, the development of a broad intersectoral, intergovernmental strategy with the participation of diverse agents from the health and development sectors based on proven effective interventions and consistent investment in the health sector.

Third, this comprehensive approach involved the three government levels during the implementation through innovation, best practices, critical and reflective anal-

ysis of the actions and an open and inclusive dialogue. Finally, we highlight the contribution of the Uruguayan State in the highest level international forums to promote and advocate the implementation of urgent measures in order to achieve the challenging goal 3.4 of the Sustainable Development Objectives, concerning the prevention and treatment of non-communicable diseases and promotion of mental health and well-being.

In particular, the current president of the republic, Dr. Tabaré Vázquez, formed part of the Independent Commission nominated by the Director General of WHO, Dr. Tedros Ghebreyesus, which has formulated a set of recommendations to be considered by WHO, the Heads of State and Government and other interested parties. In addition, the timely implementation of the Framework Agreement for Tobacco Control marked a milestone in international public health in the face of the claims of the international tobacco industry.

The participation and international contributions of Uruguay in the fight against cancer have led to the country being considered a reference point in the matter. Finally, the action proposed by the Parliament through framework laws that strengthen governance in health matters have led to better health scenarios for the country.

We recommend exhaustive study and generating forums of dialogue and exchange at national and international level as a means of contributing to a universal health strategy.

Giovanni Escalante Guzmán
PAHO / WHO Representative
Uruguay

Executive Summary

The Uruguayan State has taken on the challenge of Non-Communicable Diseases (NCD) as a demo epidemiological problem and has implemented a public policy based on a set of health actions and intersectoral programs, based on the recommendations of international organizations such as PAHO / WHO and the objectives of the Sustainable Development Goals.

I) National NCDs targets for 2020 and 2025

1. National targets for a comprehensive approach to Non-communicable diseases and the problems of mental health defined for 2020 and actions towards its projection to 2025.

2. A Vital Statistics system to systematically obtain reliable data on mortality by specific causes and the consolidation of information from the various data sources.

3. Periodic studies of risk factors for NCDs based on the STEPS methodology (PAHO / WHO) integrated into the systematized information about the epidemiological reality of the country.

II) PMulti-sectoral national policies and plans to achieve the national objectives by 2020 and their projection to 2025

4. Advances in the implementation of mechanisms for coordinating intersectoral actions aimed at the main NCDs and their common risk factors.

III) Reduction of NCD risk factors, on the basis of the guidance contained in the global action plan of WHO on NCDs

5. Implementation of the five measures to reduce tobacco demand identified in the Framework Agreement of WHO for Tobacco Control:

a) Reduction of the affordability of tobacco products by raising excise taxes and prices.

b) Elimination of passive exposure to tobacco smoke in all indoor workplaces, places public and public transport.

c) Application of neutral / standard packaging and/or large graphic health warnings on all tobacco packaging.

d) Promulgation and application of the total prohibition of tobacco advertising, promotion and sponsorship.

e) Carrying out efficient campaigns through different means of communication to educate the public about the damage caused by smoking, tobacco use and passive exposure to tobacco smoke.

6. Application of the following three measures to reduce the harmful use of alcohol, in accordance with WHO Global Strategy:

a) Application of restrictions on the availability of alcoholic beverages (reducing the hours during which it can be sold), with an emphasis on the restriction on selling it to minors.

b) Legislative initiatives on prohibitions or restrictions on the advertising of alcoholic beverages to be discussed in parliament.

c) Increase in the zero tolerance requirements regarding alcohol consumption for drivers of motor vehicles.

7. Implementation of the following four measures to stimulate and facilitate healthy eating:

a) Implementation of national policies to reduce salt/ sodium consumption among the population.

b) Adoption of national policies that limit saturated fatty acids and banning industrially produced trans fat.

c) Promulgation and implementation of legislation health warnings for food and beverages with excess salt, sugar and fats.

d) Consolidation of legislation / regulations for the full application of the International Code of Marketing of Breast-Milk Substitutes.

8. Implementation of the national awareness and public motivation program about physical activity, in particular campaigns in the media to promote a change in behavior in relation with a sedentary lifestyle and physical activity.

9. Preparation of directives, protocols or national clinical guidelines, approved by the competent authorities and academic references, based on the evidence available, for the comprehensive attention of the main NDCs in all NIHS providers.

10. Provision of pharmacological treatments, adequate therapeutic options and advice to people at high risk, in order to decrease the incidence and the complications of diabetes, myocardium and cerebral infarction, with special emphasis on primary health care, through a comprehensive benefit plan (PIAS) that All providers of the NIHS must ensure.

1 - INTRODUCTION

The socio-demographic and epidemiological profile of Uruguay shows a high prevalence of and mortality due to the so-called Non-communicable Diseases (NCDs), which has led to a strong commitment from the natio-nal authorities to influence the social determinants social networks that are the basis of them, as well as the early diagnosis and timely treatment of them.

The Ministry of Health of Uruguay (MSP) has developed a set of comprehensive initiatives, intrasectoral and intersectoral, to deal with NCDs, which need to be systematized as inputs for a future exchange of best practices and experiences among the countries of the Americas.

As of 2015, the MSP began a process to define the National Health Objectives (OSN). This involved a long and prolific exchange with academics, the political sphere and health workers and users. The OSNs were already set in 2016 and later, work was done on the development of strategic lines to achieve the goals and objectives. Within this framework, concomitantly, the Country Cooperation Strategy (CCS) of the Pan Ameri-can Health Organization (PAHO / WHO) was discussed

with the MSP. The CCS has the priorities of the MSP in function of the OSN as its seal of identity. Strategic objective 2 of the OSN 2020 aims to reduce the premature and avoidable burden of morbidity and mortality and disability.

The purpose of this paper has been to gather information, lessons learnt and perspectives on how progress is made at the level of managing NCDs in Uruguay, that contribute to a deeper understanding and consolidation at the national level.

Structure of the document

In the present paper you will find the following sections:

National context: Presents a summary of the demographic and socio-economic context in which the health system operates, focusing on the social determinants of health (SDH) that have a greater impact on NCDs.

Epidemiological situation with focus on NCDs: Presents a descriptive summary of the state of health of the country and of the epidemiological situation, particularly in the field of non-communicable diseases.

Advances of Public Policies towards NCDs: Describes the main lines of action from the MSP and at the intersectoral level for a comprehensive approach to NCDs and their determinants.

Challenges related to NCDs: Presents a synthesis of the guidelines of international organizations on the subject, as well as proposals of national references linked to the subject, generated within the scope of a discussion organized recently by PAHO / WHO and MSP for such purposes.

Applied methodology

The preparation of this document required combining different methodological tools, generating a synthesis of the data and information from the documentary review with full analysis of the available documents on the health situation and profile of the country's health system, social networks and institutional web pages; interviews with qualified informants in the field of NCDs; systematization of contributions emanating from a discussion on good practices and lessons learned in the field of interventions in NCDs, which took place in November, 2018. Annex 1 details the institutional insertion of those who contributed to the document.

2 - NATIONAL CONTEXT

2.1 - Demographic Analysis

Uruguay began its first demographic transition in the early twentieth century, earlier than most countries in Latin America, and during that century its population growth was slow and its age structure was gradually aging.

After several decades of low mortality and birth rates, Uruguay is in an advanced stage of demographic transition, with an increase in life expectancy, a decrease in mortality at all ages and a reduction in fertility below replacement levels. This means a smaller number of children and an increase in the number of older adults. Migrations have presented a negative balance in the last 40 years, although recently an intra-regional immigration increase has been observed. The population of Uruguay in the year 2017 was 3,493,205 inhabitants (NSI 2018).

The infant mortality rate decreased from 30.1 per thousand live births in 1984 to 13.4 in 2004. The social advances and early childhood care policies of the last decade produced a significant downward trend in infant mortality with slight inter-annual oscillations

Year
2050
The proposal is to reach a life expectancy of
82
years
with significant growth of the population of:

+65 years
825.000
senior citizens (over 65)

-15 years
570.000

reaching its historical low of 6.5 per 1,000 live births in 2017 (MSP 2018).

In a prospective analysis of Uruguay projected to the year 2050, the Office of Planning and Budget (OPB) poses a possible scenario in 2050 with the current trends without major changes, reaching a life expectancy of 82 years, with a significant population growth of those aged 65 years and older, which reaches 22.2% of the total (almost 825,000 senior citizens) in a population of 3.7 million, while the number of those under 15 will be just over 570,000. In another scenario, also plausible, there would be a greater increase in life expectancy (88 years), a population of 3.93 million and a proportion of 65-year-olds of 25.7%. These latter figures would be similar to those of the more developed countries in 2050 but would imply a drop in mortality related to the control of the determinants of NCDs (OPB 2017).

The birth rate had a sustained decrease of 20% between 1996 and 2006, then stabilized for a decade before having a further reduction in the last three years. The projections at the end of 2018 place the births at about 40 thousand, with a very significant pregnancy decline in adolescents, whose fertility rate has been reduced by half in the last 3 years (Cabella 2018). This decrease is the result of a set of social and health factors related to the most vulnerable population, where poverty was historically reproduced through unintentional pregnancies in adolescents.

The demographic trends of the country are clear indicators of social progress and do not merit catastrophic views, although they pose societal challenges at different levels. The Uruguayan population maintains a moderate growth with an unequal distribution in the territory, characterized by a large concentration of inhabitants in the capital (40% of the population) and in the coastal and southern cities of the country.

Healthy aging has become a strategic goal for the whole society. The change of the attention model and the approach of the socio-cultural determinants of health have acquired a decisive importance in this prospective perspective. As PAHO notes, "the aging of the population is forcing us to rethink our health and redesign our health systems" (PAHO 2017).

2.2 – Socioeconomic situation

In 2017, Uruguay reached 15 uninterrupted years of economic growth. Despite a slowdown in the last three years, the growth rate of the economy increased by 2.7% in 2017 and it is estimated that in 2018 growth will remain around 2.5% (1). An increase in consumption and a recovery in investment levels, mainly in the public sector, contributed to this growth. The recovery in the level of activity was also linked to an improvement in external regional and extra-regional demand, an increase in tourism, greater consumer confidence and a reduction in imports (ECLAC 2018). The fiscal deficit was 3.6% of GDP in 2017 and 2.9% in 2018.

Most of the social indicators showed a substantive improvement during 2017. Poverty, indigence and inequality decreased that year, although unemployment and several labor problems increased. In 2016, the number of Uruguayans living in poverty had fallen to 9.4% of the population and in 2017 this figure fell to 7.9% (NSI 2018). The average real salary increased by 55% between 2005 and 2015, ranking first in the region (MTSS 2017), which had an average increase of 20%. The increase in the National Minimum Wage and the decline in labor informality are also noteworthy in the regional context (2).

From a Human Development perspective, Uruguay is in the category of very high human development, ranked number 55 out of 189 countries, with an HDI of 0.8045 (UNDP 2018), which adjusted for inequality drops to 0.689 (14.39%). Countries with very high HDI drop by 10.7% when adjusted for inequality, while in Latin America this decrease is 21.8%. In the Gender-related Development Index (GDI), Uruguay is in the group of countries with the best relative position for women. Although there are significant inequalities due to gender, the Gender Inequality Index places the country in 57th place among 160 countries (UNDP 2018).

In Latin America, poverty and extreme poverty increased after 2015, after a long decade of tailing off in most of the countries (ECLAC 2017).

According to the World Bank, Uruguay is characterized in the region by its high per capita income, low level of poverty, almost complete absence of indigence and low levels of inequality.

It has reached a high level of equal opportunities (World Bank Human Opportunity Index) in terms of access to basic services such as education, clean water, electricity and sanitation.

The distribution of income by quintiles between 2006 and 2016 shows that the appropriation of the quintile of higher income decreases by 8%, while that of the lowest income quintile increases by 33% and that of the second quintile by 26%.

The absolute differences are still very high. In 2006, the highest income quintile took 10.5 times more income than the lowest income quintile, and that ratio was reduced to 7.1 in 2016 (Social Report 2017). The Gini index fell slightly from 0.383 to 0.380 in 2017, the second consecutive year that it fell (3). Child poverty (children from 0 to 5 years old) went from 53% in 2006 to 20% in 2016, which represents a relative decrease of 62% (in the total population it was 71%).

Poverty decreases in all age groups, although it continues to be concentrated in childhood and adolescence. It drops to 6.4% in adults up to 64 years old and is barely 1.3% above 65 years old (Social Report 2017). The World Bank (2015) emphasizes that inclusive social policies have allowed the coverage of programs to be expanded.

About 87% of the population over 65 years old is covered by the pension system, one of the highest coefficients in Latin America and the Caribbean.

In the labor market, unemployment has reached the lowest levels since statistics were kept (6.6% in 2014). The sharp deceleration in growth in subsequent years brought unemployment figures to 8.6% in October 2018. Despite the complex external environment, Uruguay maintains a stable macroeconomic framework.

The report "The state of food security and nutrition in the world" of the Food and Agriculture Organization of the United Nations (FAO 2017) shows that the prevalence of undernourishment in the total population went from 4.3% to less than 2.5% in the period 2004-2016.

The prevalence of acute malnutrition in children was 1.3% in 2016, and that of chronic malnutrition among children under five years of age decreased from 13.9 to 10.7% between 2005 and 2016, while the number that were overweight fell from 9.4% to 7.2% in that period. Obesity among people over 18 years of age increased from 22.9% to 28.6% in the period 2005-2014 (FAO 2017). On the other hand, anemia among pregnant women with more than 20 weeks of gestation showed a decreasing trend between 2010 and 2015 from 19.7% to 15.9% (MSP, 2016c)

1 - The reports of National Accounts of the Central Bank of Uruguay indicate a growth of 2.5% in the second quarter of 2018 compared to the same period of the previous year with a positive performance from most of the sectors of activity. Domestic demand grew in physical volume due to the rise in Gross Capital Formation and Final Consumption Expenditure.

2 - The national minimum wage went from 80 dollars in 2005 to 426 dollars in 2017 (MTSS 2017). The rate of informality in Uruguay fell 17 points from 40.7% in 2004 to 23.5% in 2014 (ECLAC 2016).

3 - The Gini Index measures inequality by income between 0 of minimum and 1 as maximum inequality.

3-EPIDEMIOLOGICAL SITUATION OF NCDs

Non-communicable diseases (NCDs) are the main cause of disease and premature and preventable death in the Americas. They generate three out of every four deaths and 34% of those deaths are premature (they occur in people between 30 and 69 years of age). In particular, four of these diseases: cardiovascular diseases, cancer, diabetes and chronic respiratory diseases, account for the highest morbidity and mortality. Due to its health and social importance, obesity and hypertension should be especially considered. NCDs cause most of the avoidable costs of health care and represent a great social and economic burden for countries, affecting their well-being and future possibilities (PAHO / WHO 2014). The monitoring, prevention and control of non-communicable diseases, mental disorders, malnutrition, violence and injuries, and disabilities has been a priority for PAHO / WHO and the subject of concrete actions in the country.

As has been reported by many international studies, the causes of NCDs refer to risk factors common to all of them, such as smoking, unhealthy eating habits, physical inactivity and the harmful consumption of alcohol. The contamination of the environment is also a relev-

ant cause. The NCD epidemic is deeply related to the current transformations in life styles and conditions, in the socio-cultural processes and the economic and demographic situation.

The association between these diseases and the social determinants of health is strong both in the sense that they affect NCDs, and in that NCDs deepen these determinants and their structure of inequalities. The socio-economic situation, gender, race and ethnic group, urban or rural location, occupation and other socio-environmental characteristics are relevant social factors in NCDs. With a Life Course approach, the problems of maternal health and development in early childhood, persistent childhood diseases and exposure to violence should be considered as causes of these pathologies. The environmental factors and urban life patterns that have grown rapidly are key elements for the emergence and high prevalence of NCDs. Assuming the complexity of the phenomena that are intended to be addressed, biological risk factors for NCDs and their correlation with generating comorbidities are also included, such as hypertension, hyperglycemia, overweight and obesity, mental health disorders, oral diseases and nephropathies. Addressing NCDs in all their dimensions means questioning some characteristics of current society and analyzing them as markers of inequality and inequity.

With a general mortality rate of 9.3 per thousand inhabitants, Uruguay has a high concentration of mortality due to NCDs and specifically to diseases of the circulatory system, neoplastic diseases and diseases of the respiratory system, which account for over 60% of the deaths

These diseases together with external causes account for 70% of deaths in the country. Ten of the first 15 diseases that cause Years of Life Lost (YLL) and also Years of Healthy Life Lost (HYLL) in Uruguay are Non-Communicable Diseases (PPENT-MSP 2015). Three of the NCDs such as COPD, chronic ischemic heart disease and strokes are at the highest positions of the generation of Years of Life Lost by Disability (DALY) (MSP 2016).

Table 1. Selected indicators linked to mortality due to Non-Communicable Diseases. Uruguay. 2014 - 2017.

INDICATOR	2014	2015	2016	2017
Gross mortality rate due to diseases of the circulatory system x 100000 inhabitants	250,8	267,5	269,2	294,5
Gross mortality rate due to diseases of the circulatory sys in those under 70 years x 100000 inhabitants	59,0	60,4	60,4	59,0
Gross mortality rate due to diseases of the respiratory system x 100000 inhabitants	90,4	98,5	109,6	94,5
Gross mortality rate due to diseases of the respiratory system in those under 70 years	19,1	20,4	25,6	20,5

Source: Ministry of Health. General Directorate of Health. Vital statistics

Table 2. Selected indicators linked to mortality due to Non-Communicable Diseases in males and females. Uruguay. 2014 - 2017.

INDICATOR	2014	2015	2016	2017
Gross male mortality rate due to diseases of the circulatory system x 100000 males	242,0	253,7	261,4	240,8
Gross female mortality rate due to diseases of the circulatory system x 100000 females	259,1	280,2	276,4	257,6
Gross male mortality rate due to diseases of the respiratory system x 100000 males	95,2	104,4	114,1	95,9
Gross female mortality rate due to diseases of the respiratory system x 100000 females	85,8	93,0	105,5	93,3

Source: Ministry of Health. General Directorate of Health. Vital statistics

Tables 1 and 2 show the recent trends of the mortality indicators of the main NCDs in the general population and in those under 70 years of age, and their evolution according to sex.

Worldwide, the risk of premature death from any of the four main non-communicable diseases in people aged between 30 and 70 years is measured with a specific indicator called Probability of premature death by NCD; it is the indicator established by WHO in the reduction target for 2025 and by the SDGs for 2030. In 2015, this indicator ranged from 8% to 36%, for both sexes, in the four groups of countries defined according to the income established by the World Bank. (WHO, 2017). In our country, the indicator has fallen in 2017 (Table 3) after a period of persistence in values above 15%.

Table 3. Probability of dying due to any of the four main NCDs between 30 and 70 years of age. Uruguay. 2010 - 2017

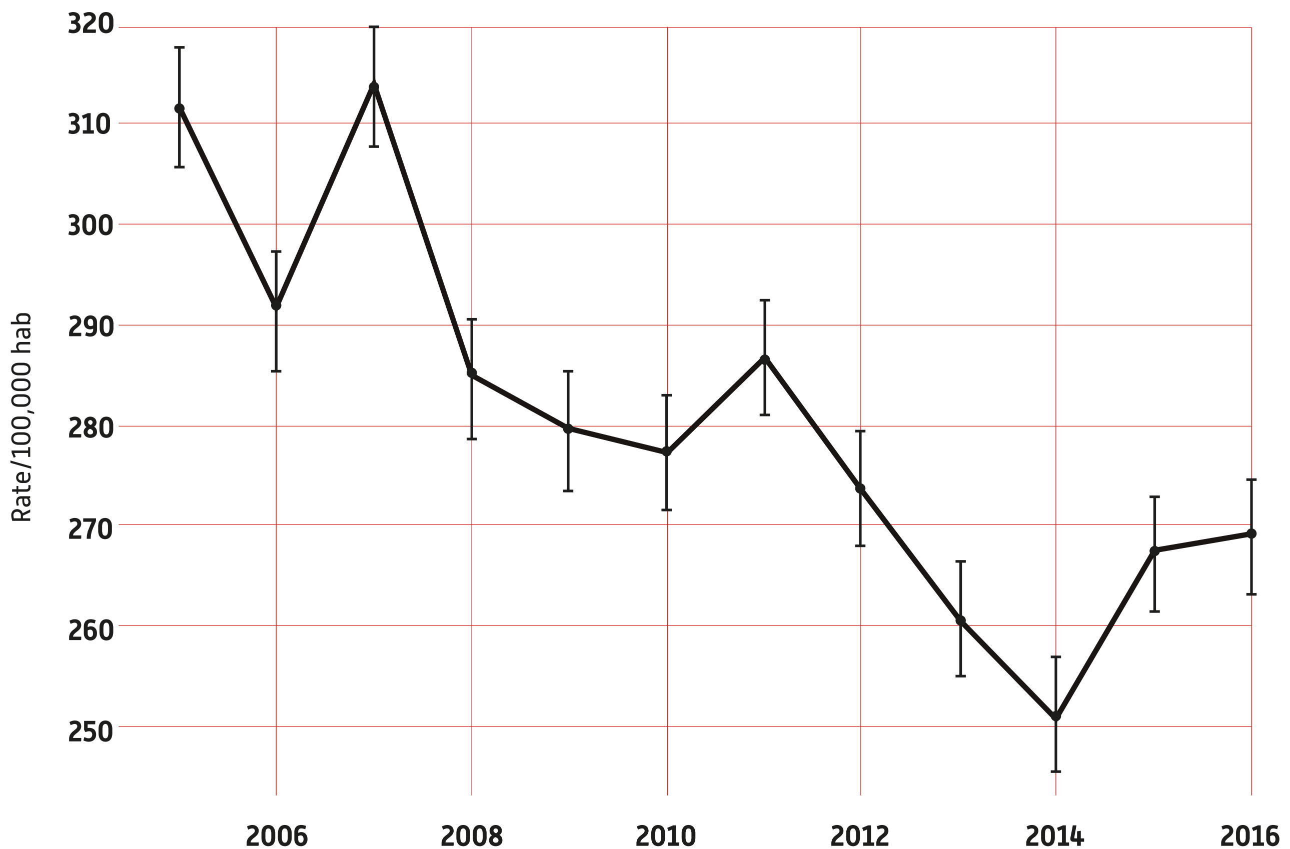
YEAR	Probability of premature mortality due to NCD%
2010	16,33
2012	15,55
2013	15,27
2014	15,28
2015	15,49
2016	15,75
2017	14,61

Source: Ministry of Health. General Directorate of Health. Programmatic Area of NCD. Based on data from Vital statistics MSP and population estimates NSI

3.1 – Cardiovascular diseases

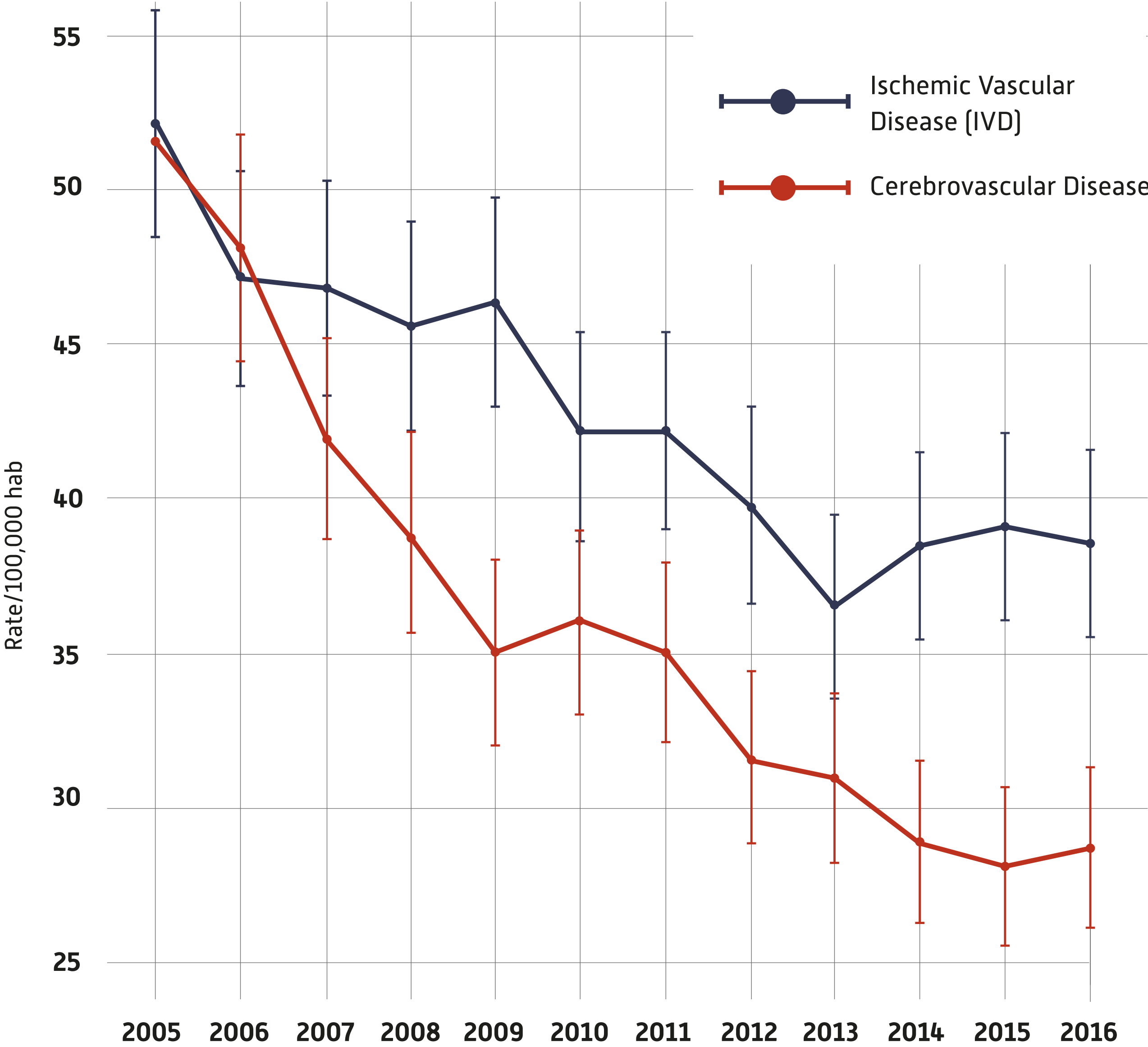
For all age groups, mortality from cardiovascular causes decreased by 13.8% between 2005 and 2016, as can be seen in Figure 1. In this same period, the evolution of mortality from cerebrovascular diseases (I60-I69) for all ages shows a decrease of 29.8%. Mortality from ischemic heart disease (I20-I25) fell by 16.2% between 2005 and 2016 (CHSCV 2018). Between 30 and 69 years, mortality from all cardiovascular causes decreased by 27.5% between 2005 and 2016. In the same period, ischemic heart disease showed a drop in mortality of 26% for this age group and mortality due to cerebrovascular disease decreased by 46%. Graph 2.

Graph 1. Mortality from cardiovascular diseases (ICD 10: I00 - I99). Uruguay. 2005 - 2016



Source: Cardiovascular Health Honorary Commission. 2018

Graph 2. Mortality from ischemic diseases (ICD 10: I20-I25) and cerebrovascular diseases (I60-I69) in the population aged 30 to 69 years. Uruguay. 2005 - 2016.



Source: Cardiovascular Health Honorary Commission. 2018

3.2 - Cancer

Cancer is a significant problem in the epidemiological situation in Uruguay, with almost 16,000 new cases registered annually with a mortality of 8,000 people per year. Cancer deaths are approximately one quarter (24.4%) of the total deaths registered annually in Uruguay. The four most common cancers in Uruguay (with the exception of non-melanoma skin cancer) are breast, prostate, colorectal, and lung cancer, the same as in developed countries (CHLCC 2018).

Mortality rates for cancer have decreased gradually

since 1990 in both sexes, as shown in Figure 3. Based on the adjusted model for the period 1990 - 2016, it can be inferred that the standardized rate* by age of cancer mortality (all the sites collected between 2010 and 2016 decreased by 4.2% in men and 3% in women (CHLCC 2018.) In the case of men, there is a decrease in mortality from lung cancer, but also in cancers of the

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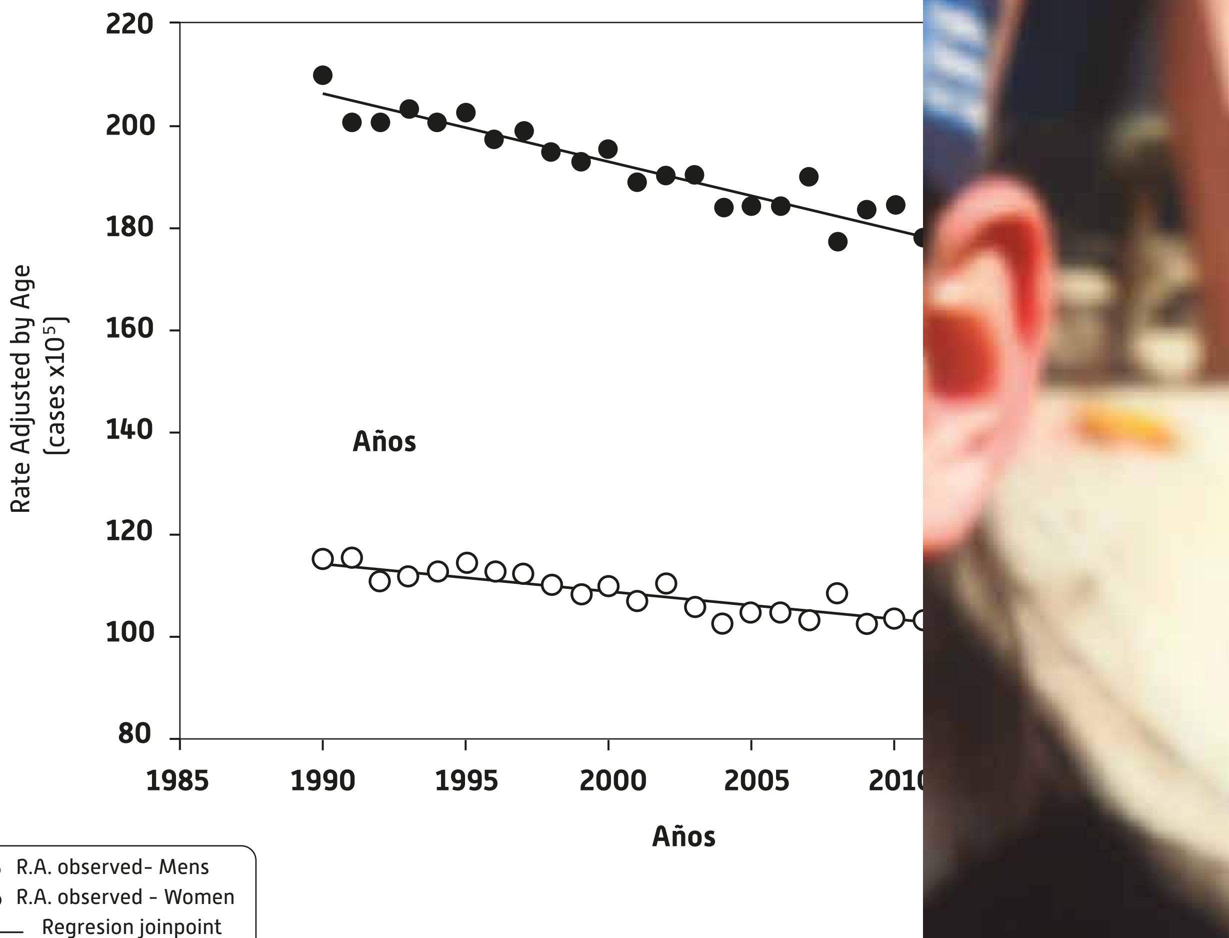
mortality rate decrease

to 21.7 in 2016 (Graph 4

Graph 3. Mortality from cancer in all sites (ICD-O 3rd Ed C00-C80). Uruguay. 1990 - 2016.



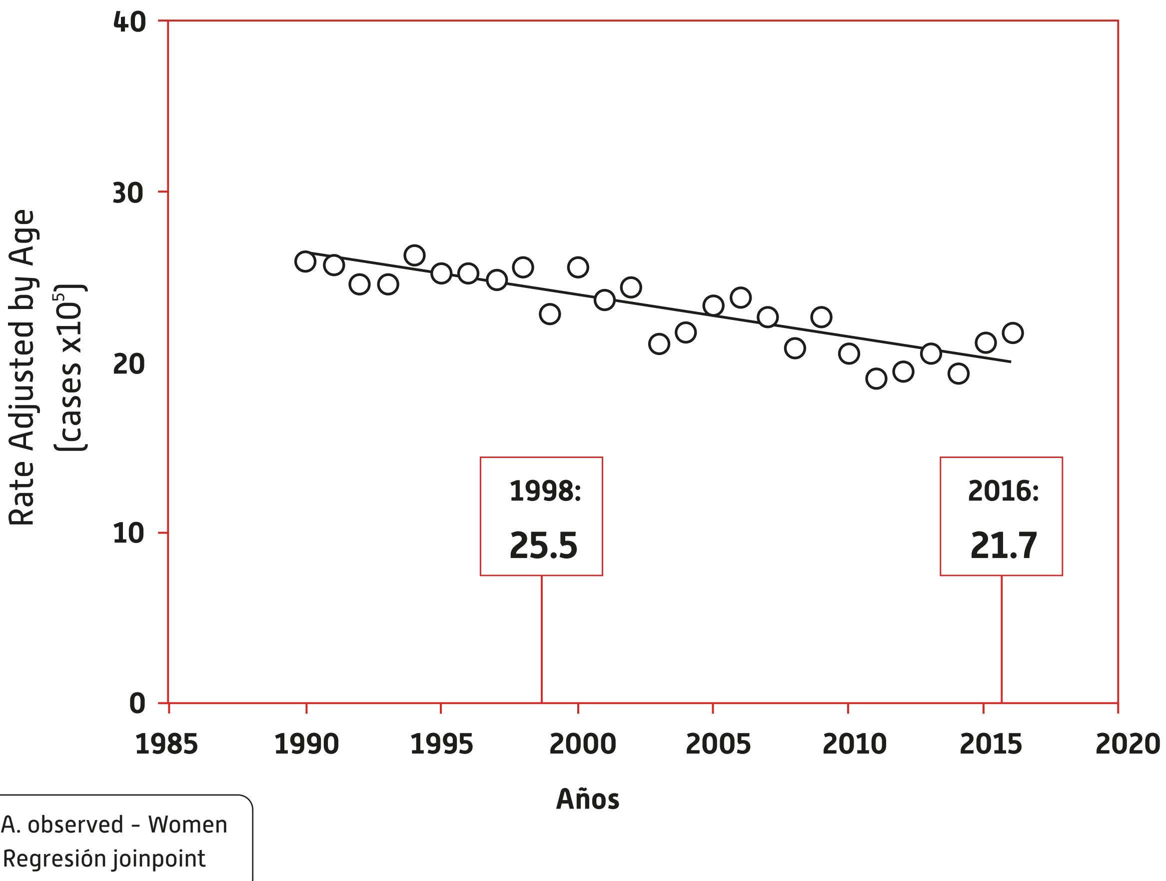
* Rate adjusted for age in the standard world population expressed in cases x 100,000.
Source: National Registry of Cancer - Epidemiological Surveillance Program - Honorary Commission f

On the other hand, there has been a significant rise in lung cancer in women, which has increased by 6% per year and become the third cause of cancer death in women. This phenomenon is the most relevant problem in the epidemiological dynamics of cancer mortality and incidence rates (CHLCC 2018).

The incidence rate standardized by age for all the sites collected (251.0 cases per 100,000) is very close to that exhibited by all the most developed countries (267.2 cases per 100,000). Although the situation is less favorable when considering mortality rates, in the mortality / incidence ratio the value exhibited by Uruguay (0.45) is closer to that exhibited by all the more developed countries (0.41) than to that observed in the group of the least developed (0.67) (Barrios & Garau, 2017).

Regarding comparisons with other countries, it is worth noting the need to take into account the existence or not of screening programs, the presence of which may increase the incidence. On the other hand, and of no less importance, it is necessary to consider the quality of cancer registries. In this regard, it is highlighted that the cancer registry of Uruguay has been classified by the IARC at the highest level (level 1), the best in South America. (IARC, 2015)

Graph 4. Mortality from breast cancer (ICD-O 3rd Ed C50).
Uruguay. 1990 - 2016.



Source: Honorary Commission for the Fight against Cancer. 2018

3.3 - Respiratory diseases

Regarding respiratory diseases, the main causes of mortality are Influenza, Pneumonia and Chronic Obstructive Pulmonary Diseases (COPD). Mortality rates have remained stable with a slight decrease in 2017 compared to 2016, in the general population, in both sexes and in those under 70 years of age.

3.4 - Risk factors

There is a high prevalence of 8 preventable risk factors common to NCDs (MSP 2016). According to the 2nd Chronic Disease Risk Factor Survey (ENFRENT) of 2013, the prevalence in the population aged 25 to 64 was 64.9% for overweight and obesity, 36.6% for hyperten-sion, 90, 9% for fruit / vegetable consumption less than 5 servings per day, 22.8% had a low level of physical activity, 28.8% were daily smokers, 9.5% with excessi-ve episodic alcohol consumption, 7.6% high blood

glucose and 21.5% high blood cholesterol.

Among the risk factors, it should be noted that between 1999 and 2013, the sale of sugary drinks tripled in Uruguay and that sales of other foods with excessive amounts of sugars, salt and fats doubled (PAHO / WHO, 2015). This produced a sharp increase of overweight and obesity in all age groups, which is linked to a higher prevalence of non-communicable diseases at increasingly younger ages. A trend towards greater overweight and obesity has been observed as age increases. In 2013, overweight and obesity of both sexes between 15 and 24 years was 38.5%, increasing to 56.9% between 25 to 34 years, and reaching 78.1% in the population of 55 to 64 years.

The increase of overweight and obesity has been very pronounced and statistically significant in adults from 25 to 64 years, going from 56.6% in 2006 to 64.9% in 2013 (ENFRENT 2013, PPENT-MSP, 2015). It affects 2 out of 3 adults.

The speed of changes in eating habits has been surprising, as has its health effects. Recent studies also identify the weight of health risk factors associated with people's behavior, understanding that they are not always the result of free and informed decisions, but are conditioned by a set of social, cultural and economic factors, including the deliberate strategies of marketing and advertising of economic agents to maximize their profits.

It can be observed that women do less physical activity than men, that smoking in men and women shows a decreasing trend and that obesity and overweight in the population is increasing.

These behaviors show differences by age, with younger people exercising more daily and smoking less than adults.

4 - ADVANCES OF PUBLIC POLICIES TO NCDs

The World Health Assembly adopted, in 2012, the global goal of reducing premature mortality due to NCD by 25% for the year 2025. To that end, it decided to continue working with goals related to the four main risk factors: the consumption of tobacco, the harmful consumption of alcohol, unhealthy food and physical inactivity (PAHO / WHO 2014).

The Regional Strategy for the Prevention and Control of Non-Communicable Diseases and the Plan of Action agreed upon aim to reduce preventable mortality and morbidity, minimize exposure to risk factors, increase the influence of protective factors and reduce the socioeconomic burden of NCDs. To do so, it proposes multi-sectoral approaches that promote well-being and reduce inequity within and between countries (PAHO / WHO 2014).

The PAHO / WHO Plan of Action is based on four key lines: a) Policies and multi-sectoral alliances. b) Reduce the prevalence of the main risk factors of NCDs and strengthen protective factors, with an emphasis on children, adolescents and vulnerable groups. c) Improve the response of health systems to NCDs and their

risk factors, increasing coverage, equitable access and quality of care, with a primary health care strategy. d) Strengthen the capacity of countries to monitor and investigate NCDs, their risk factors and determinants, using the research for the preparation and execution of public policies.

In the last decade, the Uruguayan State and society have begun a process of socio-health transformations in which the policies related to Non-communicable Diseases stand out, with an emphasis on the fight against smoking. The intersectoriality, the social participation, the stewardship of the MSP and the decentralization in the development of these policies have been constitutive elements of this integral health perspective.

The actions that were prioritized in the Discussion organized by PAHO / WHO and MSP with participants from a broad disciplinary, institutional and social spectrum are detailed below.

4.1 - Relevant Actions of Health Promotion in the field of NCDs

There is a high prevalence of 8 preventable risk factors common to NCDs (MSP 2016), according to the 2nd Chronic Disease Risk Factor Survey (ENFRENT) of 2013, whose values were detailed above.

- **The Honorary Cardiovascular Health Commission** is carrying out other initiatives to promote healthy eating and physical activity, including encouraging greater consumption of fish. It has promoted the certification of "Healthy Companies" and the implementation of active pause programs in the working day in public and private companies. In 2017, they certified the first Healthy Company. A first evaluation is that these lines of action led to a clear decrease in medical leave for workers. Annually, Heart Week is a significant activity for the Promotion of Cardiovascular Health with multiple participants, actions and national scope. Awards for the best experiences operates as recognition, encouragement and a form of visibility. Schools, neighborhood communities, health services and very diverse organizations actively participate. Likewise, the **Honorary Commission for the Fight against Cancer** carries out important actions in the field of health promotion and prevention, highlighting its contribution to the incorporation of mammography screening at the national level, to the early detection of cervical cancer, to the information and awareness campaigns of the population, and to the development of the National Cancer Registry.

■ **The Health Promoting Schools Strategy** has been an initiative to promote the healthy development of children impacting the health conditions of school communities, promoted by the MSP, the National Public Education Administration (ANEP) through the Initial and Primary Education Council (CEIP), PAHO / WHO and the National Secretariat of Drugs of the Presidency of the Republic (SND).

■ **The School Feeding Program** of Primary Education provides 280 thousand breakfasts, lunches and snacks daily covering 96% of schools. The Oral Health Program have been developed in educational centers as of 2005 from the Presidency of the Republic and visual and auditory research programs have been added, which will soon be institutionalized in the Primary Education budget.

In Uruguay, a **hearing study** has been carried out on all newborns since 2008. Starting in 2019, the State will perform a new hearing screening test for all schoolchildren to detect acquired hearing loss, and those who need it will receive free hearing aids or implants. Along with adequate nutrition, early diagnosis and timely treatment of visual and hearing deficiencies have a positive impact on childhood educational and social development.

■ Social participation in health promotion policies includes the movements of users integrated to the Local Health Boards (JULOSAS), Departmental Health Boards (JUDESAS), Consultative Boards by institution, Health Networks, The National Health Board (JUNASA) and the ASSE Directorate. **The movements of users** and different alliances of local participants usually carry out Assemblies, Councils and Health Fairs in municipalities and localities. They implement tours and territorial meetings to gather the perceptions of the neighbors, promote their involvement in actions on the SDH and citizen control over health services.

■ There are **Health Networks** by municipality, Early Childhood Networks, Elderly Networks, Environmental Networks, which are a powerful health promotion experience in the communities. They have promoted forms of community participation such as Community Health Agent Courses and Seminars on Social Participation. With local alliances, the **neighborhood organizations** articulate health, culture, physical activity, education, public spaces, where each area is enhanced by synergy and a joint approach, generating innovative experiences.

Another line of work with good results is the runners and walkers groups and Diabetic and Hypertensive Obese Groups in various polyclinics or Health Centers.

The Healthy Municipalities strategy has been a tool for the intersectoral labor approach in the territories. Urban and Rural Health Fairs have been successful in several departments. The joint work of educational centers articulating with other institutions, disciplines and sectors has had good results and includes the Ministry of Labor, the Social Welfare Bank and Departmental Municipalities. There are also projects such as Valor de lo saludable (The value of health), social dialogue for the transit, departmental swimming programs, Environmental Observatory to monitor the environment.

From the **departmental spheres**, worked has been done towards a strategy to promote active aging. In 2016, the Interdepartmental Commission for the Elderly was created and worked with NICE of the Ministry of Social Development to design the strategy. The Friendly Cities with the Elderly project, an Action Plan on the identified weaknesses, a Network and an Advisory Council on Aging were all promoted.

Actions have been developed to raise awareness of the population and training of human resources for the prevention (tobacco dependent, skin, cervix cancers) and early detection of cancer (cervix, colorectal, breast cancers). These are coordinated and developed by an inter-institutional working group (MSP, NCI, CHLCC, Faculty of Medicine) formed and led by the National Cancer Control Program. In this context, it contributed to the conception and programmatic development of the optional subject "Towards better cancer prevention" for undergraduate students of the Faculty of Medicine of UDELAR, which has been developed since 2017 and includes important fieldwork.

4.2 - Policies to reduce the main risk factors

The National Surveys of Risk Factors of Non-Communicable Diseases (ENFRENT) are noteworthy. The first was carried out in 2006 and the second edition in 2013. With these tools, the country has comprehensive and updated information on the evolution of risk factors such as smoking, alcohol, sedentary lifestyle, malnutrition, hypertension, among others.

4.2.1 - Policies to reduce smoking and other drugs

The anti-smoking policy of the last 11 years has been one of the country's major health priorities, which was strongly introduced from the government's agenda and has promoted a cultural change in Uruguayan society. This policy has had strong support among the population, including both smokers and non-smokers. The following measures stand out in this national policy:

- Application of the **WHO Framework Convention on Tobacco Control**. This treaty recognizes the magnitude of the harm caused by smoking by establishing legally binding purposes and principles for countries, regulating both supply and demand.

- Prohibition of smoking in enclosed public spaces, places of work, health and educational centers. As of March 1, 2006, closed spaces for public use have been 100% free of tobacco smoke and there is a compliance of practically 99% of Law No. 18,256, which contains these aspects of tobacco control.

- Increase in the size of the health warnings on cigarette packages as well as generic or plain packaging and a single presentation per brand. The importation, registration as trademark, commercialization and publicity of any electronic device used for smoking, as well as its use in closed places and other prohibitions in force for tobacco products in general, is prohibited (Decree 299/017).

- Application of taxes on tobacco products and increase in the price of cigarettes.

- Ratification of the protocol for the elimination of illicit trade in tobacco products.

- Creation of tobacco cessation clinics, with more than 100 points of attention existing at present.

Free delivery of medicines to support smoking cessation by the National Resources Fund (NRF). The use of smoking cessation drugs among people who know about them increased from 5% in 2008-09 to 17% in 2012. Medical advice to stop smoking provided in professional consultation has been promoted in the

health services. The results of these policies have been the decrease in the number of people who begin to consume tobacco products and an increase in the number of smokers who quit smoking. The increase in the perception of the risk of consumption has been a determining factor. The perception of smokers about the risks of stroke and impotence increased after the introduction of graphic health warnings on cigarette packages.

It is worth highlighting the transformation produced in the habits of the youngest and in the attitude of society as a whole on the issue, which will have a favorable impact on NCDs.

The prevalence in tobacco consumption between 2009 and 2017 went from 25% of the population to 21.6%, while in young people from 15 to 24 years old it went from 24.7 to 14.6% (MSP / NSI / PAHO / CDC 2018).

The increase in the percentage of women who stopped smoking when they found out they were pregnant is also noteworthy.

Uruguay has historically been one of the countries in Latin America with the highest prevalence of smoking and in the last decade the policies developed have achieved a very significant decline. Ongoing concern about a deceleration of the decline and the propaganda and marketing strategies of the industry towards the consumption of other tobacco products should be maintained.

At the same time it should be noted that Uruguay was a pioneer at the international level in this matter. The lawsuit won by the Uruguayan State against the multinational Philip Morris, before the International Center for Settlement of Investment Disputes (ICSID), dependent on the World Bank (WB), has had a global impact of reaffirming the priority of public health against the interests of the tobacco industry and encouraging several countries to follow suit with a strong anti-smoking policy.

4.2.2 - Healthy eating policies

In recent years, Uruguay has begun the construction of a policy towards healthy food and nutrition that integrates a set of actions at different levels. Some refer to early childhood and childhood in general, others promote the change of habits at the level of the entire population.

Among those measures, it is worth mentioning some of them due to their social and health impact:

The prevalence in tobacco consumption between 2009 and 2017 in young people from 15 to 24 years old fell from 24.7% to 14.6%

Actions to promote breastfeeding have been relevant in the context of the prioritization of policies related to Early Childhood, which include the legal obligation to create Breastfeeding Rooms in workplaces.

The importance of controls and adequate nutrition from pregnancy and especially in the first 24 months of life has been stated continually. A draft law on Regulation of the Marketing of Breast-milk Substitutes is under discussion in Parliament. In particular, the **Accreditation Strategy on Good Practices of Infant and Young Child Feeding** of maternity and NIHS clinics, emphasizes the protection of breastfeeding as the most appropriate and healthy way of feeding the child at the beginning of life and the first years.

The updating and training of health teams in the **National Standard for Breastfeeding** is also noteworthy, promoting breastfeeding exclusively in the first six months and complementary up to two years and more, according to the actual reality of each mother and infant, the use of infant formula and **Supplementary Feeding Guide for the child from 6 to 24 months** with a focus on the prevention of overweight and obesity at an early age and with a life course outlook.

Law No. 19.140 on Healthy Eating in Education Centers (regulated in 2014) was a strong political and institutional signal and generated an inter-institutional work platform to problematize poor nutrition in childhood and promote healthy eating. Its objective was to protect the health of children and adolescents who attend the educational system through the promotion of healthy eating habits, preventing overweight and obesity, as well as the diseases associated with them. For this, a list of foods defined by the MSP has been established and advertising in educational centers for products that are not included and the use of salt shakers is prohibited.

The Parliament is currently discussing a Draft Framework Law on the Human Right to Food and Food and Nutrition Safety that includes a broad process of discussion and agreements reached in the Social Dialogue convened in 2016 and is in accordance with the law approved in the PARLATINO.

Law No. 19307 on audiovisual media (2014) incorporates several articles that refer to health, which are in force, although they have not yet been regulated and which have been validated by the Supreme Court of Justice. In particular, article 33 establishes the regulation of food advertising in accordance with WHO standards. Article 95 defines the possibility of free "public welfare campaigns" in all audiovisual media. This last possibility has already begun to be used in relation to prevention and health promotion issues.

It is worth highlighting the completion of the **National Survey of Child Development in Health**. The first version of this survey was carried out in 2013 and the second edition for the follow-up of the first cohort in 2015. The country now has a powerful tool for diagnosing and monitoring the processes related to childhood.

In 2016 the update of the **Food Guide for the Uruguayan population** was published. The production process was coordinated by the MSP and counted on the participation of a broad intersectoral group made up of public sector institutions, academic figures and CSOs. It is an educational instrument that adapts the scientific knowledge about nutrition into a practical tool that facilitates the selection of an adequate and healthy diet for the population. It constitutes a reference for all the figures.

It is also worth mentioning various educational campaigns to promote healthy habits such as eating slowly, appropriate times and places to eat, preference for natural foods instead of ultra processed foods, reduced salt intake, consumption of water over sugary drinks, incorporating fruits and vegetables into the diet and 150 minutes per week of physical activity. The Food Guide has contributed a lot to these actions. There are multiple experiences of Health Education through the training of School Health Promoters in Healthy Eating. It is the children who, after the training process, carry out and bring the educational actions towards the rest of the school, their families and community.

The approval of Decree 114/018 of progressive and mandatory reduction of trans fats of industrial production as an ingredient in food for consumption is important, with this new standard being incorporated in the National Bromatological Regulation.

Decree 272/18 of **Frontal labeling of products with excessive content of fats, saturated fats, sugar and sodium** is a fundamental measure for the prevention of NCDs. Its approval was preceded by a long development process with the participation of several ministries, the University of the Republic, the Municipality of Montevideo and international organizations such as PAHO / WHO, UNICEF and FAO. The decree was also the subject of a broad public consultation in which a large number of opinions were received, the vast majority of which were favorable. Work is currently being carried out in order that the frontal labeling for excess of sodium, fats and sugars becomes a law, for which the Executive has sent a project to the Parliament.

Initiatives have been promoted by the MSP to reduce salt consumption through voluntary agreements with ba king companies. The Municipality of Montevideo has ordered the mandatory removal of salt shakers from restaurant tables. The Interdisciplinary Nucleus of Food and Welfare of the University of the Republic contributed several research papers on consumption to guide the best measures to generate a change in eating habits.

A measure of transparency is being implemented by the Food Regulation Service of the Municipality of Montevideo, which publishes the registration data of different foods on the institutional website and has as a line of work the incorporation of nutritional information through this mechanism.

After Decree 369/018, the **National Honorary Coordinating Council for Policies to Combat Overweight and Obesity** was set up in December 2018. This inter-institutional space will seek to consolidate the articulation of efforts of the different State agencies around a United Intersectoral Action Plan against NCDs. Stop obesity.

4.2.3 - Promotion of Physical Activity

In the 2013 Risk Factors Survey, two indicators are managed with respect to physical activity: the level of physical activity and sedentary behavior. 22.8% of the adult population registered a low level of physical activity (7.1% less than in 2006) with a higher prevalence in women and adults between 55 and 64 years of age. At the same time, the sedentary lifestyle indicator showed an increase of 7.1% during the same period.

- Through Law No. 18213 (2009) compulsory physical education was established in all primary schools.

Since 2011 there has been a rapid increase in the installation of outdoor gyms, with more than 500 throughout the country, with significant use by the population.

They were installed by a multiplicity of institutional bodies that include the national government, the departmental governments and the municipal governments. There has also been an increase in the use of bicycles as means of transport, in a process where civil society organizations and local governments are playing an important role in promoting the creation of bikeways, presenting proposals in Participatory Budgeting and obtaining support from the majority of the population.

- In 2016 a **Physical Activity Guide** was prepared and distributed by the MSP and the National Sports Secretariat as a reference for various programs and initiatives.

- **The Physical Activity Network** of Uruguay was created in 2010, reaching the 19 departments of the country. In the promotion of physical activity, intersectoral work has been significant in the education system, local governments, the national government, civil society and other bodies.

- The Honorary Commission for Cardiovascular Health has initiated a national registry of physical activities promoted by various bodies.

4.2.4 - Regulation of alcohol

Alcohol consumption in Uruguay is somewhat above the world average (10.8 liters of pure alcohol per capita per year in people over 15 years of age). Alcohol is the drug with the lowest perception of risk in the country (one in four consumers considers that it has zero or almost no risk). According to official data for 2017, there are 261,000 people with dependency and problematic use of alcoholic beverages.

In the young population, 7 out of 10 who consumed alcohol had at least one episode of intoxication in the last 15 days.

In recent years, some initiatives have been taken towards greater regulation of alcohol. The draft law sent to parliament in 2017 by the Executive emphasizes that its "problematic use currently generates more morbidity and mortality than all illegal drugs combined, mainly affecting the nervous, cardiovascular and gastrointestinal systems".

The National Drugs Board has carried out interventions to reduce risks and damage in cultural events with the aim of promoting self-care and responsible consumption.

In order to prevent acute poisoning in young people, the "free pass" program was implemented to reduce alcohol consumption before going out to parties or dance centers, providing free tickets for those who arrive without such consumption. The campaign was complemented with actions aiming for zero consumption of this drug in pregnant women.

4.2.5 - Policies towards the environment

The environment is an important risk factor for NCDs. In environmental matters, it is worth highlighting the elimination of sulfur in nails in 2012. The desulphurization plant of the public fuel company ANCAP eliminates 300 tons of sulfur per day from fuels, reducing emissions by more than 90%.

This means a 20% reduction in carbon dioxide emissions into the atmosphere.

4.3 - Strategies for early detection and timely treatment of NCDs

Uruguay is developing strategies for the early diagnosis of breast, colorectal, cervix, prostate and skin cancer, as well as other NCDs. In this strategy, the following measures stand out:

4.3.1 - Accessibility to Cancer screening tests

Measures were implemented to facilitate access to mammography and pap smears. Law No. 17.242 of the year 2000, promotes the prevention of cervical cancer and breast cancer, ensuring one paid day of leave per year for it to be done, and it is mandatory for public and private companies to grant it when the workers request it.

In 2006, Decree No. 571/006 included a requirement to issue the Basic Health Card to women throughout the national territory, the presentation of the results of Oncological Colpocytology (PAP-Pap smear) and current mammography exams. Recently, the immunochemical test of occult blood in fecal matter (over 50 years old) has been added to the Basic Health Control (former Health Card) (Annex 1 of Decree No. 274/017).

Accessibility to studies and treatments has been one of the central concerns. The three cancer screening studies are within the free health checks. (Ordinance 402 of the MSP, 2006).

4.3.2 - Approach to Familial Hypercholesterolemia

The National Program for the Early Detection and Care of Familial Hypercholesterolemia (FH) called the GENYCO Program (Genes and Cholesterol) arose from Law No. 18,996 (2012), which granted the Honorary Commission for Cardiovascular Health CHSCV authority in the field of the detection and care of familial hypercholesterolemia. The CHSCV promoted the creation of a Family Hypercholesterolemia Registry, a dominant genetic disease of high population frequency, responsible for high morbidity and mortality in young adults and a frequent cause of sudden death, for which there is diagnosis, prevention and effective treatments.

4.3.3 - Clinical Practice Guidelines and Protocols

In terms of quality of care, the development and implementation of various clinical practice guidelines and protocols is noteworthy: a) Reperfusion treatment in acute myocardial infarction with elevation of the ST segment. b) Recommendations for addressing systemic hypertension in the First Level of care. c) Clinical Practice Guidelines for type 2 diabetes mellitus. d) Clinical Practice Guidelines for cervical cancer screening. e) Clinical Practice Guideline for colorectal cancer screening. f) Clinical Practice Guideline for the early detection of breast cancer.

- Preparation and distribution of the Clinical Practice Guidelines for colorectal cancer screening 2018. In Uruguay and worldwide, colorectal cancer (CRC) is the second most frequent cancer in women and the third in men. The incidence and mortality rates are high in Uruguay, it places CRC in second place among the death caused by cancer, with more than 1800 new cases diagnosed per year through fecatest and complementary studies. It causes more than 900 deaths per year (MSP 2018). Early detection allows us to reduce mortality.

The Guide prepared by the MSP is aimed at health teams; it guides the use of the immunochemical test of occult blood in fecal matter that allows for the detection of micro bleeding and is available without cost throughout the National Integrated Health System; if anomalies are detected, complementary studies are available; it promotes periodic control (every two years between 50 and 70 years of age).

In Uruguay and in the world, colorectal cancer (CRC) is the second most frequent cancer in women and the third in men.

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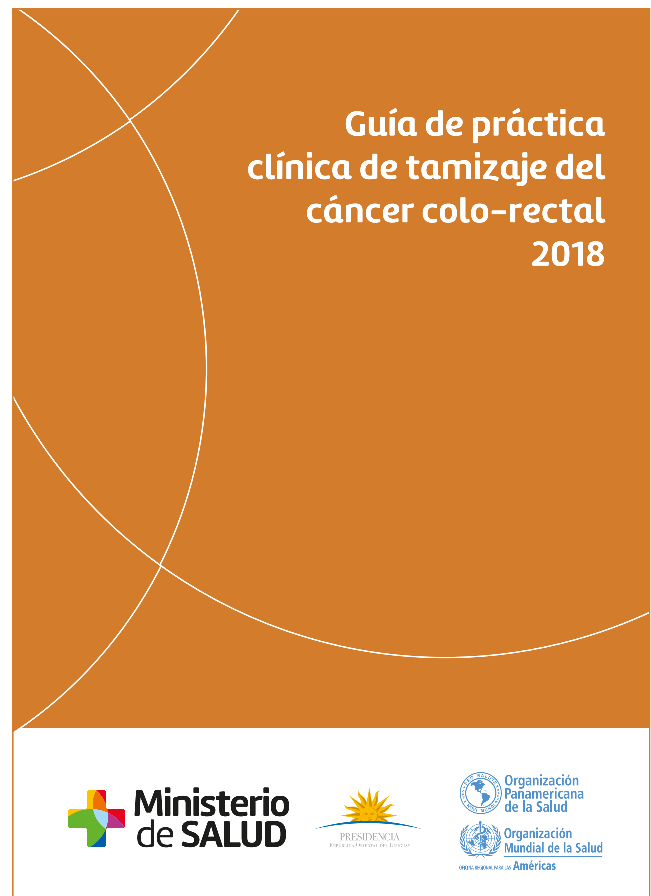
Early detection allows us to reduce mortality



In relation to Uterine Cervical Cancer (CC), the MSP made the implementation of the National Comprehensive Cervical Cancer Prevention Plan (PNPICCU) a priority in conjunction with the CHLCC. To develop it, it carried out a set of actions to:

a)) Know what happens with the disease and detect problems related to the diagnosis and treatment of it.

b) Analyze the prevalence of different types of Human Papillomavirus (HPV) in the country.

c) Analyze the situation of the vaccine against HPV, creating a special commission to study the relevance of the incorporation of the vaccine and its cost in this first stage is the quadrivalent HPV vaccine, which covers the

serotypes of HPV 16, 18 (linked to 75% of the CCU), 6 and 11 (linked to the development of 90% of genital warts). It has been offered free of charge since 2013, to adolescents after the age of 12.

The MSP promotes that information on vaccination is included and other measures to prevent HPV infections and injuries are carried out in the annual health control of adolescents, with the delivery of the adolescent's card.

As a regional action, it is worth noting the participation of the National Cancer Control Program and the CHLCC in the development of the platform for the exchange of experiences and technical assistance for the control of cervical cancer carried out by the National Institutions of Cancer Network of USAN.

- Clinical practice guide for the early detection of breast cancer (2015). Early detection is the mainstay of disease control; recommendations are made for the use of breast self-examination, clinical breast examination and mammography. The systematic application of mammography in asymptomatic women is the only screening study that has been shown to reduce mortality from breast cancer.

Approximately 75% of cases of breast cancer occur from the age of 50 and it is from this age that screening mammography has been shown to have the greatest benefit. In Uruguay, early detection programs promoted by the MSP and the CHLCC, the installed capacity of mammography equipment and current legislation may have contributed to the sustained reduction of the standardized rate of breast cancer mortality. These guidelines take into account the balance between benefits and possible risks, in particular the risk of false positives and over-diagnosis (cases that left to their natural evolution would never have been diagnosed) for each age group.

The second edition includes updated national epidemiological information and the available evidence, which reinforces the recommendations included in it. The risk factors that define the population to be screened are also established (MSP 2015).

4.3.4 - Availability of Cardio-defibrillators

Law No. 18.360 (2008) on the availability of Automated External Defibrillators (AEDs), establishes that public or private spaces where there is an influx of people must have at least one automatic external defibrillator, maintained in suitable operational condition and available for immediate use.

Comprehensive community training programs were launched in cardio-respiratory resuscitation and defibrillator management.

In these ten years

3500

cardio defibrillators have been installed

Training in cardio-respiratory resuscitation has reached 100 thousand people

4.4 - The National Integrated System of Health and NCDs

Public policies regarding NCDs should be placed in the context of the NIHS, which has meant a qualitative leap for health in Uruguay since 2005. The NIHS has defined a renewed PHC strategy and a comprehensive care model with a strong emphasis on prevention and promotion.

The Ministry of Public Health (MSP) has exercised the stewardship in this field, incorporating the Prevention of Diseases and Health Promotion in all the programs prepared since 2005 and in the Comprehensive Plan for Health Care (PIAS). The PIAS is the compulsory benefits plan that health providers must guarantee to their members, with acquired rights of coverage by the National Health Insurance. In recent years, the MSP has taken the definition of the National Health Objectives (OSN 2020) forward, identifying 15 critical health problems, setting goals for 2020 and lines of action in each of them. In this way, the NIHS makes an effort to transcend demand for attention to the disease and develop a proactive approach, with actions on social determinants and defined priorities.

The NIHS created a territorial structure of social participation and inter-institutional coordination with the Departmental Health Boards (JUDESAS) and the Local Boards (JULOSAS). Representatives of the MSP, of the public and private providers, of the Departmental Government, of the users of the public sector and the private sector, of the workers of the public and private sector participate in the JUDESAS and JULOSAS. They are the governing bodies of the NIHS in the territories, whose potential in matters of health promotion plans is important.

In 2017, the MSP and the PAHO carried out a communication campaign called "Healthy Commitment" based on the OSN 2020. A set of audiovisual tools and printed materials were created to raise awareness on the issue of determinants, health promotion, as well as the

timely and quality care of NCDs, with a special emphasis on the prevention of cancer, diabetes, hypertension, overweight and obesity.

Social networks were used as a means to reach citizens with the key messages to promote healthier lifestyles. It was addressed to the general public and had the support of the public and private health providers of the NIHS, who received a set of materials aimed at the population (videos, brochures, posters) and had the possibility to download and customize them with their logo. The 43 health providers signed a "Healthy Commitment" with the NSOs and an innovative process of transforming the care model guided by health goals and targets focused on people throughout the course of their lives.

4.4.1 - National Health Objectives and Assistance Goals

Special mention should be made of the development of the National Health Objectives 2016-2020, which prioritized 15 critical health problems, among which NCDs occupy a key place.

- **Incorporation of NCDs in the mechanism of Assistance Goals.** The National Integrated Health System has payment for compliance with Health Care Goals as one of the financing instruments for providers by the National Health Fund (FONASA). From the definition of the National Health Objectives, the MSP promoted the implementation of one of the Assistance Goals, orienting it towards NCDs. This Assistance Goal was structured based on two components, one of which is four expected results (ER), two common to all providers defined by the MSP and two specific for each provider in agreement with the MSP.

The second component is the report of indicators that consisted of sending monitoring indicators, considered as tracers of compliance with the lines of action of OSN 2020. The common ER defined by the MSP were the reduction of complications due to hypertension and the reduction of early mortality due to cardiovascular diseases.

Baselines were built for each institution and the preparation and delivery of an Institutional Reorganization Plan from each provider to meet the expected results was required (MSP 2016).

The ER referring to hypertension has the following indicators:

- Percentage of users from 25 to 64 years of age in treatment for hypertension according to clinical care protocol. -Percentage of hypertensive patients recruited, from 25 to 64 years old, with current laboratory routine. - Performance of the audit of the PAH care guide application audit. It is noteworthy that the percentage of hypertensive patients recruited in the second semester that the healthcare target was applied increased by 34% with respect to the baseline. Likewise, the percentage of hypertensive patients with a current laboratory routine increased by 83%.

The ER referring to the reduction of cardiovascular mortality has the following indicators: -Percentage of physicians of the services involved who are trained in the early and timely detection of acute coronary syndrome with high ST. -Audit review of cases with acute coronary syndrome with ST. -Percentage of medicinal or mechanical reperfusions of outflows due to IAM with elevated ST.

Among the eligible goals for each provider, more than half (24 institutions) chose the goal referring to the reduction of cancer mortality. This resulted in an improvement in the coverage of screening studies for cervical cancer (CC) and colorectal cancer (CRC) and access to diagnoses within the established periods through the linking of variable payment with improved coverage of the PAP and the occult blood test in fecal matter, and of the colposcopy and colonoscopy performed within the established periods. In effect, the evaluation after the first two semesters showed a significant increase in screening coverage (19% and 73% with respect to the baseline for CC and for CRC respectively) and diagnoses within the semester for CC (31 % with respect to the baseline) and for CRC (100% with respect to the baseline).

Goals were also defined related to the reduction of mortality due to COPD, reduction of the percentage of smokers and reduction of chronic complications of diabetes, with their respective indicators. The percentage of diabetics with a glycosylated hemoglobin control performed increased by 27% in the second semester with respect to the baseline.

This new content of the Assistance Goal was implemented during 2016 and its evaluation is scheduled for 2019.

These Assistance Goals generated an interpellation to the providers: which are their hypertensive or diabetic patients and how many are there?

It required them to identify who those patients were in their list of affiliates, which became a population to

care for proactively. It is a step to transform the logic of the list of affiliates where the health institution receives contact from the person when they are ill and requests assistance, towards a conception of managing proactively.

4.4.2 - Improvements in the quality of care

Regarding quality of care, the registry of the activities carried out, the National Electronic Health Record (HCEN) and the Oncological Clinical Record (HCEO), which is already operating in the State Health Services Administration (ASSE) and is advancing in private providers, are fundamental factors. Its general implementation will allow for the identification and inclusion of indicators of quality of care in order to evaluate and monitor it.

- The experiences of Programmed Hospital Discharges through the **Liaison Units** with the First Level of Care are also significant advances of quality of care in ASSE.

- **Maternities in Movement:** Good Practices at the Maternity level in the Administration of Health Services of the ASSE State were highlighted by the MSP through the "Maternity in Movement Day" in 2018. This promotes humanization, the non-medicalization of childbirth and the complementation of services to optimize resources and ensure professional experience.

- **Recognition of Good Practices in the First Level of Care.** . The Ministry of Public Health and the Pan American Health Organization convened the presentation of experiences of Good Practices in the First Level of Care of the entire NIHS. 101 experiences were presented, of which 15 were awarded and 54 acknowledgments were made. The objective of this initiative was to move towards a greater capacity of the First Level of Care to resolve health problems by avoiding unnecessary transfers or overuse of consultations with specialists or in hospital services.

4.4.3 - Incorporation of appropriate technologies

The creation of the SALUD.UY program in 2012 has allowed for the development of a medium and long-term strategy for the incorporation of technology and, in particular, towards the National Electronic Clinical Record and the Electronic Oncological Clinical Record, a field where Uruguay is a pioneer in the region. Decree No. 242/2017 of 2017 established the mandatory use of the Electronic Health Record and the HCEN platform for all public and private health providers. This decree initiated the construction of a normative framework for medical informatics in the context of the Salud.uy Program. The purpose of this program is to promote and improve the continuity of the healthcare

process for the users of the Uruguayan health system, through a mechanism that unifies and makes all the clinical information of the health user available before care is provided. In this way, the health teams in each health center will be able to access the information of each user in real time and in any part of the country.

The inter-institutional collaboration, the articulated operability between the different effectors, the legal framework, the leadership of the MSP, the professional training and a conception of information centered on the patient are fundamental axes of this process.

- Progress has also been made in the development of telemedicine experiences with emphasis on the field of imaging, optimizing human resources and installed capacity. It is worth noting the increase in diagnostic capacity in relation to mammograms through centralized reports at the National Cancer Institute (NCI - ASSE), within the framework of an Integrated Diagnostic Imaging Network, which allows remote reporting of digital mammograms carried out in other centers.

- Uruguay has made significant advances in digital technologies. The country stands out for the reduction of the digital divide, the Plan Ceibal and advances in the digitalization of different government services. For this reason, in 2018 Uruguay was invited to join the group of the most advanced digital governments in the world, the only country from to Latin America and the Caribbean to do so.

- The country has enough radiotherapy equipment: 16 linear accelerators (4 per million inhabitants) It is worth noting the incorporation of Positron Tomography (PET) technology and the creation of the Uruguayan Center for Molecular Imaging (CUDIM) for the realization of research, training and diagnostics in the areas of oncology and neurology. It has recently expanded through complementation agreements with the Maciel Hospital of ASSE.

4.4.4 - Accessibility to medications and treatments.

Decree 562/005 establishes the exemption from the payment of the moderating fee for blood glucose regulating drugs. Decree 164/009, approved the payment of drugs which mutual and / or hospital presentations consider the minimum monthly requirements for regulatory treatments of blood glucose and arterial hypertension.

The incorporation of high-priced medicines into universal health coverage through the National Resource Fund using technical criteria on therapeutic efficacy and cost / efficiency, is a notable
the NIHS. In the area of oncology there are
15 high-priced drugs with demonstrabl
significant benefits in terms of survival / qu
and added clinical value.

Recently, 11 new drugs were incorpora
the Therapeutic Formula for Medicines f
by the NRF, linked to seven oncological
to-oncological, dermatological and res
diseases.

The installation of joint regional neg
high-priced medicines has been an import
ensure coverage, unifying the demand of se
tries. In 2016, MERCOSUR member countrie
ciated states negotiated with pharmaceuti
nies to purchase high-cost medicines for the
of cancer, hepatitis C and HIV; the initiative
vated successfully in 2018. The results of t
strategies to buy medicines and share inforr
been positive (IDB 2018). The judicializatio
for high-priced medicines not yet inclu
national vade mecum and without cost-ef
analysis is a growing problem in the country.

From 2010 the following were also established; free treatment of cancer; elimination of co-payments for treatment with conventional chemotherapy and radio-

its implementation it was necessary to define reference

prices for the different services and a common payment mechanism among the institutions through the JUNASA.

4.4.7 - Access to health services for People with disabilities.

Law 18.651 establishes the comprehensive protection of people with disabilities. According to MSP estimates, between 10 and 15% of the Uruguayan population has some type of disability. These figures have been increasing as a result of improvements in care and assistance that prolong survival. Among the rehabilitation services are those of the Hospital de Clínicas, the Pereira Rossell Hospital, the ASSE center "Casa de Gardel", the congenital defects centers of the Social Security Bank, the technical assistance services of the MIDES and those provided by the Teleton Foundation. The Ministry of Public Health seeks to optimize coordination among these services and improve access to treatments.

With Inter Agency support of the United Nations System (UNFPA, UN Women and PAHO / WHO), the "Right to Equality and Non-Discrimination of Persons with Disability" Project was initiated in 2018, which has among other national counterparts the MSP, ASSE , BPS and MIDES. Its first component refers to Universal Access to Health, and involves the active participation of organizations of people with disabilities.

4.4.8 - Improvements in palliative care coverage

Palliative Care is a compulsory integral service of the Comprehensive Health Care Plan (PIAS) since 2008. However, since 2013 the Ministerial Policy of Palliative Care began to acquire further development, establishing the following as guidelines:

a) Universal coverage for patients of all ages and pathologies; b) assistance by interdisciplinary teams with training in Palliative Care; c) continuous assistance to the inpatient, at home or in clinic, with a Telephone On Call Doctor 24 hours, 7 days a week and d) assistance in accordance with the level of complexity, working in the Network between the different levels of assistance (MSP 2016b).

With the integration of Palliative Care in the Health System, Uruguay is well positioned at the international level (among category 4-b countries). It is the country with the highest development of Palliative Care in Latin America. It is estimated that around 16,250 people require palliative care in Uruguay. While in 2012 the effective coverage was 18% of that population, in 2018, 50% of it had access to Palliative Care (MSP 2018). All the departments of the country have some type of Palliative Assistance. There are three collective evaluations of Palliative Care: The National Survey of Palliative Care 2016 carried out on all providers, the Analysis of the National Workshops of Institutional Referees of Palliative Care (2017) and the SWOT Analysis on professionals from all over the country about the situation of Palliative Care in Uruguay (2018). The MSP plans to move towards universal coverage in 2020 based on four objectives: humanizing the service, increasing coverage, training human resources and monitoring the quality of care.

4.4.9 - National Care System

Currently, Uruguay is beginning to implement the creation of a National System of Care whose priorities are early childhood, the elderly and people with disabilities. The problem of care deeply overlaps with comprehensive care and with the promotion of health. Building a National System on this since is an ambitious project that requires a strong alliance with the NIHS and more in general with health policies.

4.5 - International projection

The actions implemented and their results, particularly those aimed at the control of smoking which have been promoted since 2005, have enabled the country to position itself as a key player in the responses to smoking and NCDs worldwide. Uruguay has participated in numerous international events promoting the fight against NCDs:

- co-chair of the High Level Independent Commission of the World Health Organization (WHO) on Non-communicable Diseases,
- The Bloomberg Task Force on Fiscal Policy for Health
- and the organization of the Montevideo World Conference on NCDs, prelude to the 3rd UN High Level Meeting on NCDs.

Likewise, Uruguay has actively participated together with the International Union Against Cancer in the Program C / CAN 2025: Cities against Cancer. In 2018 it led the High Level Regional Forum "Financing Sustainable Solutions for Cancer Control in Latin America", which promoted the involvement of local governments (provincial, municipal, etc.) of Latin American countries in the fight against NCDs and the search for sustainable financial solutions for that goal. Several lines of action developed by Uruguay have had precisely this intersectoral and intergovernmental character, involving different sectors of the State and different levels of government. In this sense, the Report of the WHO High Level Independent Commission on Non-communicable Diseases: "It is Time to Act" urges States to provide the greatest possible political support for the fight against these diseases. It goes even further in that line by extending that responsibility not only to the ministries of health, but also to the highest possible level: Heads of State and Government.

The awards to the Uruguayan president as Hero of Public Health of the Americas of the Pan American Health Organization and the Champions Award for Campaign for Tobacco Free Kids for his contribution to the fight against tobacco, are recognitions of State Policy on the matter. The projection of the actions has reached the levels of MERCOSUR and PARLASUR, generating spaces for the exchange of good practices at the level of public policies, public financing of initiatives and specific legislation.

5 - CHALLENGES RELATED to NCDs

Various international organizations and also national references have contributed to reflect on the future challenges for public policies for dealing with NCDs.

- The WHO World Conference on Non-communicable Diseases was held from October 18 to 20, 2017 in Montevideo, with the participation of heads of states, ministers and representatives of civil organizations from 94 countries of the world. It culminated with a Montevideo Road Map 2018-2030 on NCDs that establishes that countries commit to promote the following actions: Reinvigorate political action; provide health systems with the capacity to respond more effectively to NCDs; significantly increase the funding of national responses to non-communicable diseases and international cooperation; increase efforts to involve sectors beyond the health sector; strengthen the role of non-state agents; seek measures to address the negative impact of environmental products and agents which are harmful to health and strengthen the contribution and accountability of the private sector and other non-state agents, among others.

The World Bank has indicated that stimulating healthy population aging will cushion the consequences of the epidemiological transition on health spending through NCD prevention programs (WB 2015). The prevention and control of NCDs is the main health challenge for the country, which is reinforced by the demographic and socio-economic processes under way (BM 2015). The situation is a challenge for the strategy, quality and sustainability of health policies.

Studies of various agencies emphasize that health services are exposed to rapid technological change, both in terms of equipment and medications and in recommended procedures for different pathologies. All these studies conclude that, more so than the epidemiological demo change, technological progress and variation in medical practice were the main determining factors in the increase of health spending. This generates the challenge of continuing to strengthen the leadership capacities of the health authority.

The IDB has recently highlighted that "the main source of allocative inefficiency is related to investments in services and interventions that do not maximize health improvements, such as spending more on curative care for chronic diseases than on preventive measures" (IDB 2018).

The IDB reminds that in 2010 the WHO "World Health Report" estimated that between 20% and 40% of all resources spent on health are wasted (WHO, 2010), due to high prices, irrational use of medicines, overuse of health products and services and poor quality or suboptimal healthcare quality, among other factors. The low use of generic drugs is another reason for inefficiency, as they cost less, despite having the same effect (bioequivalence) as branded products. Irrational use includes prescribing multiple medications per patient ("polypharmacy"), without following clinical guidelines or protocols. In this context, it is becoming increasingly important to develop a national policy for the management of technology and medication.

As PAHO / WHO have repeatedly stated, this recent IDB report (IDB 2018) reaffirms that "the provision of timely and high quality diagnosis and treatment services in primary care prevents acute deterioration, progression or complications in sick people. " It advocates the proactive management of diseases in primary care in order to contain health spending and improve results. It gives as examples that "some of the most efficient health systems in the region, including Costa Rica and Uruguay, have offered comprehensive primary health care coverage to citizens since the beginning of the implementation of reforms"

(IDB 2018). According to this report, efficiency and quality in health mean reconfiguring health services so that primary care can be hierarchized, integrating it adequately into the other levels of the health care system.

- Only five countries in the Region have a Public Health Expenditure greater than the 6% of the GDP recommended by PAHO / WHO: Canada, Costa Rica, Cuba, the United States of America and Uruguay (PAHO 2018). The amount of investment in health and its priorities, but also National Health Insurance with the financing modality (tripartite with contributions proportional to income), universal coverage, reduction of out-of-pocket expenses, the creation of a single mandatory Public Fund led to positive results on inequalities linked to segmented access to health care services.

- The financing of insurance through the capita system, generates opportunities at this stage to propose challenges based around advancing towards greater efficiency in health spending. Strengthening the systemic components to reduce fragmentation involves a more intensive use of instruments such as management contracts, health goals, the calculation of an efficient capita, among others.

- The development of the National Health Accounts between the MSP and the Ministry of Economy and Finance allows for systematic, comprehensive and consistent monitoring of the flow of resources in the country's health system, a tool to provide necessary information in the design and instrumentation of policies, monitoring and evaluation of the different interventions. In this regard, Uruguay has made progress in estimating health spending for the purposes of Sustainable Development Goal 3, "Health and Wellbeing" (Presidency of the Republic, 2018).

- The issue of NCDs being put on the public agenda by the State was key to triggering different synergies. Together with the commitment of the national government, the importance and potential of the departmental and municipal governments, the social movements and the alliances of various sectors and institutions joining forces are highlighted.

- The continued strengthening of the leadership of the MSP is an essential element for the development of policies for dealing with NCDs, with the components of budget, personnel, training, technology and material resources. It is essential to carry out a Third National Survey of Risk Factors of Non-Communicable Diseases, to evaluate the OSN 2020 and the Expected Results linked to them.

Intersectoriality is a necessity and a challenge, which can be assumed through the creation of national and local coordinating mechanisms. It is necessary to create a space to centralize all actions and policies at the national level towards NCDs and also to establish coordination at the local level. Actions towards NCDs should be conceived jointly since there are programmatic and logistical reasons (September and October concentrate many activities) that support this common action. The recently installed Honorary National Council Coordinator of Policies to Combat Overweight and Obesity is an advance in that regard.

It is necessary to start working towards the OSN 2030. The Health Reform produced transcendent changes, but new transformations are needed to strengthen health policies and the NIHS. The involvement of society and the hierarchization of the work in of social and inter-institutional work participation networks are factors to be further strengthened in the next period. As has been analyzed, there are policies that have had important developments, such as tobacco control, and today we are trying to keep moving forward to avoid stagnation or setbacks. In other cases, the measures are recent and the objective is for the concern regarding the front labeling of food to be deployed in all its amplitude, with the commitment of their protagonists and a fluid communication with the population.

But there are also measures that have had a period of preparation and will begin to be implemented in the coming years, facing the resistances that every change generates.

It is important to document successful experiences, highlighting good practices at all levels of care in order to learn from the different agents involved and society as a whole and stimulate health teams and responsible institutions. There are many promotional activities from many areas of society, so it is necessary to incorporate them into the action plan on NCDs. It involves articulating and mainstreaming resources, strengthening the information systems available to the population, measuring the impacts and allowing us to continue advancing in this enormous challenge.

La incorporación de nuevas tecnologías es un capítulo relevante para las políticas hacia las ENT. Pero también debe estar claro que el cambio tecnológico puede venir con intereses de lucro y sistemas de presión que distorsionen las políticas en sus costos, su efectividad y su sustentabilidad en el tiempo.

The continuity of assistance is an important aspect. To avoid healthcare fragmentation, it is necessary to innovate by experimenting with new clinical management programs. It is also necessary to advance in the definition of good practices in the field of healthcare processes that are incorporated into the logic of quality indicators that stimulate healthy competition in health management. It is essential to have the necessary information to make decisions at all levels. Consolidating the National Electronic Health Record is a transcendent step that allows us to have relevant information.

Thinking in the articulation with the education system to work on NCD prevention and health promotion involves developing an adequate curriculum but also involving the entire educational community, teachers, students and families. That is why it is important to develop continuous training plans to and from those agents. Education alone is not enough. There is an environment that determines people´s habits, beyond individual responsibilities. It is necessary to publicly and continually problematize unhealthy habits, without medicalizing daily life, and without authoritarianism or paternalism, in order to promote a profound cultural change.

- It is important to continuously train health teams, increasing the existing supply from UDELAR and NIHS, and focusing on health priorities. The experience of training in virtual environments for health workers is unprecedented nationally and internationally. Since 2016, practically all medical and non-medical workers in the private and public health care systems participate annually in interactive training on a computer platform, the completion of which leads to receiving a payment agreed upon in the Salary Councils. In 2018, 68 thousand workers were registered for these courses and 52,500 have already finished. The contents of the training have been the subject of consultations from the health authority with social and academic organizations, prioritizing the problems defined within the National Health Objectives and the NCDs within them.

- The contributions made in terms of NCDs from international organizations are valid instruments to adapt to the national reality, using the 25 indicators proposed by WHO, integrating the experiences in the national strategy.

Of the 16 interventions recommended by WHO, nine of them are common to the three main risk factors. They are related to taxes, regulation of advertising and labeling in tobacco, alcohol and unhealthy foods. This is a central path for policies towards NCDs. To implement taxes, which is the most cost-effective measure, we need to continue working to generate the political, economic and social conditions for its progressive implementation.

- Addressing problems such as smoking or malnutrition involves contrasting the profit seeking interests associated with certain industries related to the development of products harmful to health, with the general interest of promoting health policies that promote healthy habits in the population.

The judicial litigation to which Uruguay was submitted by Philip Morris, its development and outcome are irrefutable evidence of the scope of the interests at play.

There are conflicts between public policies and powerful economic interests and the State must defend the greater good, regulating all the aspects linked to them, including tax measures within the framework of existing regulations or by creating new ones.

Research is a critical point if it is articulated with the construction of public policies in mind and alliances are built between the academy, the health system, the health authority and social movements. Since 2016, an MSP-ANII agreement has promoted a Sectoral Fund for Health Research, focused on clinical research and aligned with the National Health Objectives. One line of work is to investigate the economic impacts of NCDs. Qualitative research in Health is relevant because this topic is strongly influenced by the perceptions of the different actors, collective subjectivities and emotions, as well as social and cultural factors.

The defense of the front labeling of foods with excess sodium, sugars and fats is a central line for the next period. For this reason, it is important to consolidate a solid base of support for the measure, ensure the greatest impact in changing the habits of the population, overcome any resistance and be able to monitor / evaluate the process.

In the field of Mental Health, the NIHS should advance in the reformulation of benefits and health structures to strengthen comprehensive care mechanisms aimed at the various forms of mental suffering of people, centered on a rights perspective. Likewise, from the governing perspective, mechanisms for health promotion and prevention of mental illnesses should continue to be generated intersectorially. The National Mental Health Plan being developed will be a relevant tool in this process.

PAHO / WHO in particular, and the United Nations System in general, can support in various ways what the Uruguayan State decides to promote. NCDs are on the agenda of all UN agencies. International cooperation can contribute to the processes of sharing, systematization, reflection and generation of learning in health promotion. It can also facilitate intersectoral coordination through periodic meetings and a common agenda, as well as contribute to the training of personnel and promote research-training-action processes based around the major health problems prioritized.

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Annex 1

Authorities and professionals who made contributions to this document:

Alfonso, Adriana / PAHO Consultant / Uruguay

Asqueta, Miguel /Research Center for the Epidemic of Smoking (CIET)

Basso, Jorge / Minister of Public Health

Berón, Analice / Director of the Health Division, Municipality of Montevideo

Bittar, Griselda / PAHO Consultant / Uruguay

Bove, Ma. Isabel / Health Officer. UNICEF Uruguay

Brescia, Adriana / General Director of Coordination. MSP

Cavalleri, Fiorella / Analysis Unit. MSP

Del Campo, Cecilia / Honorary Commission of Cardiovascular Health

Delgado, Lucía / Nat. Prog. Cancer Control MSP / Chair of Clinical Oncology UDELAR

Escalante, Giovanni / PAHO / WHO Representative Uruguay

Esteves, Elba / National Resource Fund

Fenochi, Eduardo / National Cancer Institute. ASSE

Galicia, Luis / MSP Consultant

León, Ima / Information Systems Directorate. MSP

Luongo, Álvaro / Honorary Commission for the Fight against Cancer

Martin, Lilia / Metropolitan RAP. ASSE

Martínez, Joseline / National Food Institute

Melgar, Silvia / Salud.uy. Coordinator AGESIC

Mijailidis, Beatriz / Municipality B Health Network

Moratorio, Ximena / Nutrition Program Area. MSP

Noble, Ana / Metropolitan RAP. ASSE

Oreggioni, Ida / Health Economics Division. MSP

Poloni, Ileana / Unidad Nacional de Seguridad Vial

Quian, Jorge / Undersecretary of Public Health

Rios, Gilberto / Deputy Director of the General Directorate of Health

Rodríguez, Guillermo / Cervical Cancer Prevention Program

Rodríguez, Maria José / Programmatic Area of Non-communicable Diseases. MSP

Rosa, Raquel / General Director of Health. MSP

Soto, Enrique / National Program for Tobacco Control. MSP

Villa, Inés / Municipality of Montevideo

Zelarayan, Mario / Honorary Commission for Cardiovascular Health

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