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VIOLENCE AND HEALTH

Violent behavior in the Region of the Americas constitutes both a serious public health problem and a cause of deterioration in the quality of life. Its consequences for community health and well-being, for social harmony, and for economic stability have taken on alarming dimensions.

Violence affects all social strata; however, certain highly vulnerable groups such as women, children, and the elderly suffer its impact disproportionately. The prevention of violence is feasible inasmuch as it is an expression of human behavior, attitudes, and lifestyles, all of which can be modified through activities aimed at health promotion.

The information available in the Region refers mainly to the fatal outcomes of violence, expressed in mortality rates and potential years of life lost. Data on morbidity and the consequences for the victims and for their immediate social groups in the short, medium and long term are more limited and less reliable.

The response of the health sector to the problem has been inadequate. The health services have focused on the immediate care of injuries, but even here, coverage is incomplete and the accessibility of services is limited. To a lesser extent there has been a focus on the psychosocial aspects and on rehabilitation. Actions geared toward prevention have been few, and have generally been limited to isolated cases.

There is urgent need for to change the approach of the health sector to violence by modifying the structure and operation of the health care services and introducing effective measures of primary prevention, jointly with other concerned social sectors. Support for epidemiological and socio-anthropological research, personnel training, and the promotion of legal measures are some of the strategies that should be considered

Health promotion programs, which encourage healthy behaviors, discourage unnecessary risk-taking, and favor rational solutions to conflicts, are the principal instrument within the health field for the prevention of violence.

This document has been prepared for the Executive Committee with the aim of providing a basis for recommendations that the Committee will be formulating on this subject.

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1. Definition of the Problem

The Working Group on the Psychosocial Consequences of Violence, convened in The Hague in 1981[1], agreed to define violence as the imposition between human beings of a significant degree of avoidable pain and suffering. This very broad definition--which says nothing about the intentionality or deliberate perpetration of the violent act, the victim's lack of consent, or the duration of the consequences--allows sufficient room for the concept to embrace the different forms of violence with specific effects on the health of the victims. It also makes it possible to exclude other events that do not qualify as expressions of violence; for example, certain accidents where the human factor plays a minimal role, as well as natural catastrophes and occurrences.

Two aspects of this definition deserve special mention. One is that violence is the product of actions that are carried out by humans and affect other human beings. The other is that the pain and suffering that violence induces are avoidable. A third implicit facet of the definition is the ethical unacceptability of violence, which is seen as an assault on the individual's human rights.

Violent acts are human behaviors with somatic, psychosocial, and ethical consequences, which manifest themselves in the short and long term. They are closely related to the expression of aggressiveness, the presence of conflicts, and the socioeconomic conditions in which these develop, although the relationship is not necessarily one of linear causality. The study of such acts can suggest indicators with regard to risk factors, help to identify vulnerable groups, and guide the formulation of programs geared toward health promotion, treatment, prevention, and rehabilitation.

The Declaration of the International Conference on Health Promotion[2], held in Bogota in 1992, summarizes the principles that undergird the prevention of violence, affirming that the right to and respect for life and peace are the ethical values of the culture of health, and that the strategy of health promotion seeks to promote life, not to degrade it.

2. Rationale for Including Violence in the Agenda of the Health Sector

Violence affects individuals and communities in various aspects of their lives--most significantly, as mentioned above, in aspects related to health. Other factors, such as economic, legal, and political considerations, are also important and should be taken into account in any assessment of the health aspects, with which they overlap.

The health sector constitutes the "end of the line" where most of the consequences of violence for human health and well-being converge. Public health is concerned with the problem of violence to the extent that its effects jeopardize the physical and emotional integrity of the victims. The fact that violence results in deaths, injuries, disabilities, and

suffering justifies its incorporation in the policies, plans, and programs of the health sector. Moreover, the analysis of its causes, the description of its natural history, and the assessment of its impact on the structure and operation of the health system, all provide ample evidence that violence is indeed an important public health concern.

The care that the health sector provides to the victims of violence involves mainly emergency services, specialized care, and rehabilitation centers. The sector has also established systems of classification and registry,[3] and it has taken part in activities concerned with the medical-legal aspects of violence. Only recently has the health sector directed its attention to the psychological and psychosocial aspects of violence, both in terms of the impact on victims and in relation to environmental factors, the characteristics of the victimizers, and the consequences for the latter.

What is needed, then, is to enlarge the spectrum of actions undertaken by the health sector in such a way that the services it offers incorporate or expand the psychosocial dimension in treatment and rehabilitation programs. In addition, the health sector should develop actions aimed at primary prevention, directed especially to high-risk groups, through the execution of interventions that seek to modify those factors within its scope of action.

3. Magnitude and Severity of the Problem

The different factors that influence the genesis, course, and outcome of violent acts must be viewed from various angles. The problem should therefore be approached from multiple perspectives, taking into consideration the apparent cause of the violence, its form of expression, the affected groups, and the nature and severity of the injuries inflicted on the individual, the family, and the society. However, the data currently being collected by the health services reflect only the identification and evaluation of physical injuries, the sex and age of the victim, and sometimes also the means used to inflict the violence.

4. Mortality Related to Violence

In the Region of the Americas the most readily available statistics relating to violence are those on mortality from violent causes, although they, too, suffer from obvious underregistration. Despite its importance, this information only hints at the magnitude and gravity of the problem, since it reports only those outcomes which are most extreme. These data refer to deaths; thus they do not reveal the impact of violence on those who survive an assault, on persons close to the victims, or on the aggressors.

In the Region of the Americas, mortality from causes associated with violence is alarmingly high[4]. These causes underlie a substantial percentage of all deaths. In Mexico, for example, violent acts accounted for 5% of total deaths in 1982, and for 8% of the total years of potential life lost (YPLL). In El Salvador violent deaths were 9% of total deaths in 1984 and accounted for 21% of the YPLL (Table 1).

Moreover, mortality from violent acts in Latin America is clearly on the increase, as can be seen in the evolution of mortalities from homicide (not including war-related deaths) in the 1968-1987 period[5]. In general, the highest rates of homicides during that period occurred in men from 25 to 44 years of age (110-125 per 100,000 in El Salvador and 75-125 per 100,000 in Colombia). In Colombia the rates increased by 50% between 1972 and 1982 (Graph 1).

Mortality from suicide, although in general relatively low in the Region, has shown some tendency to increase in certain countries (Graphs 2 and 3). In several countries and territories of the Region, among them Canada, the United States of America, Puerto Rico, and Suriname, suicide is among the five principal causes of death in the age group from 5 to 14 years. Suicide generally constitutes a problem of greater importance in the older age groups. In the United States of America the suicide rate in 1981-1985 was around 12 per 100,000, making it the fifth-ranking cause of YPLL. For the group aged 15-24 years it ranked second as a cause of death, following deaths from traffic accidents[6]. Homicide in the United States of America ranked 12th as a cause of death, and was the leading cause of premature mortality (YPLL)[7]. The problem in this country is especially severe among African American males aged 15-24. In this group mortality from homicide rose from 60.6 per 100,000 in 1984 to 84.7 per 100,000 in 1987.

5. Morbidity Related to Violence

Violent behaviors which do not result in death can, nonetheless, cause physical injuries, mental suffering, and psychological disorders; these in turn may lead to functional limitations, disabilities, and handicaps. Available information on the frequency and severity of violent acts that do not result in death is much less reliable than the data on mortality. Not all the cases in this category come to the attention of the health services or the police; and even when there are obvious injuries, information provided by the victims or their family members is not always complete or reliable. This occurs especially in cases of domestic violence, where the victim is frequently a woman or child who may be incapable or reluctant, for various reasons, to report the abuse.

To these circumstances must be added the relative weakness of record-keeping by emergency rooms and outpatient health services. Most of the available information on morbidity from violent acts is derived from studies of specific population groups and

from estimates based on field observations. For example, a study carried out in Medellín, Colombia, revealed that 28% of the patients undergoing physical rehabilitation suffer from disorders or conditions caused by violence[8]. It has been estimated that 1% of the Central American population in 1985 was physically disabled as a result of the wars in this subregion[9].

It should be noted that deaths from violent causes have secondary effects in terms of their impact on the mental health of the survivors, especially with regard to mourning and its psychopathological aftermath (post-traumatic conditions). This "secondary victimization" is amply supported in the literature, which suggests that some survivors are especially vulnerable to emotional disorders[10] [11]. The situation is rendered even more serious by the fragmentation of the social support network that can occur at the same time, especially in situations in which the violence is associated with war or political persecution. Surviving children are especially vulnerable, and studies have shown that the loss of the parents through violence can lead to behavior disorders present four years later[12]. It can be assumed that when violent death is not an isolated incident, but rather a widespread occurrence--as is the case in wartime--the psychopathological effect is even more extensive and malignant. Added to the consequences of losing one or both parents at an early age are the effects of the violence itself as a self-perpetuating phenomenon, since a person who witnesses violence in the home or in the immediate social surroundings, in a context that rewards violent behavior, may be at higher risk for later engagement in violent acts[13].

6. Vulnerable Groups

6.1 *Children*

Children are a group that is especially vulnerable to violent acts. A high proportion of these acts occur at home, but children are also mistreated frequently at school, in the street, and at recreation sites. Violence against children most commonly takes the forms of physical, psychological abuse, and sexual abuse, economic exploitation, and negligence on the part of caretakers. However, these make up only a small part of a spectrum that ranges from neglect, stemming from emotional detachment and lack of interest and incentives, all the way to abandonment and brutal physical abuse resulting in death.

Data for this subject suffer from underregistration, even in the most developed countries of the Region. However, information from the United States of America can provide an approximate idea of the dimensions of the problem. Cases reported in this country in 1991 included 2.7 million cases of negligence, physical abuse, or sexual abuse of minors under 18 years old, yielding an incidence of 2 per cent in this population group[14].

Several studies on child abuse in Latin America illustrate the situation. Research carried out in Colombia[15], for example, found that 41 of every 1,000 children seen by the pediatric services in one city had suffered some form of abuse. Another study from Colombia suggests that the greater a child's initial vulnerability, the higher the risk of abuse. Thus the risk of abuse for children with below-normal mental abilities was 16 times that of a control group of schoolchildren.

In a study carried out in the Dominican Republic on models of child-rearing[16], it was found that 47% of the children in the sample had been physically abused at home, in most cases by the parents; 10% of the abused children required medical attention. Of the children studied, 33% had suffered sexual abuse.

The World Declaration on the Survival, Protection, and Development of Children was approved by the World Summit for Children, held in New York under United Nations auspices in September 1990. The declaration represents a commitment on the part of the participating countries, and prescribes concrete measures for the protection of children[17]. In accordance with the recommendations of this important gathering, a Regional Advisory Group on Child Abuse met under the auspices of UNICEF and PAHO/WHO in São Paulo, Brazil, in June 1992. Participants in that encounter pointed out the scarcity of reliable data on the frequency and distribution of violent acts against children. In the absence of better data it was agreed to accept the estimate, based on data collected by UNICEF, that at least 6 million children in Latin America are subject to severe abuse, with 80,000 per year dying violent deaths at the hands of family members and or other people close to them.

Documents presented at the São Paulo meeting[18] highlight the following[19]:

- In Central America an estimated 1.5 million children have been displaced from their homes by armed conflicts.

- A considerable number of children in Central America, Colombia, and Peru have been used as soldiers, messengers, liaisons, and transporters of war supplies.

- It is estimated that Central America has 2.5 million displaced persons and 316,500 persons officially registered as refugees, a substantial proportion of whom are children. In Nicaragua alone, 7,200 children are believed to have been killed, wounded, or mutilated because of the war.

- It is estimated that more than 100,000 Central American children have been orphaned by the war. Many of them have witnessed the torture, rape, or murder of their parents.

- Statistics from 11 countries of the Region support estimates that between 7 and 8 million children have become "street children." They are often victimized by the types of violence prevalent in the urban environment.

- It is estimated that at least 30 million Latin American children of school age are working full-time and an indeterminate number are working part-time.

- Information from eight Latin American countries suggests that nearly half a million children are confined in closed institutions, which in general are deviating from the purposes for which they were designed.

- In Brazil, homicides accounted for 15% of the deaths from external causes among minors under 19 years of age in 1985. Research in an urban area of Brazil found that 32% of the youths interviewed received physical punishments, especially the youngest age group (11-13 years of age).

6.2 *Women*

Over the last 25 years there has been growing recognition that violence against women of all ages contributes to a deterioration in the quality of life, while hindering their full participation in economic and social development and the achievement of equality and peace. Important statements on the subject include the declaration of the International Convention on the Elimination of All Forms of Discrimination Against Women (United Nations, 1981)[20], and the Nairobi recommendations (1985)[21] set forth in the Nairobi Forward-Looking Strategies for the Advancement of Women.

The United Nations General Assembly and the specialized agencies have dealt with the issue on various occasions, making specific recommendations for the introduction of legal provisions and measures to protect women and children from all types of violence and abuse[22] [23] [24] [25]. Since the end of the 1980s, PAHO[26] and, more recently, WHO have been engaged in research on the problems that affect women who are victims of violence, especially domestic violence. In the technical discussions at PAHO on the subject of women, health, and development (May 1992), it was recommended that steps be taken to intensify the collection of data and information on the health problems of women, including the problem of violence[27]. The XIII Special Subcommittee on Women, Health, and Development of the PAHO Executive Committee recommended in April 1993 that the subject be treated as a major public health problem requiring the health agencies to respond with actions geared toward prevention as well as treatment and rehabilitation[28].

Violence against women and girls affects not only the physical integrity of the victims, but also their emotional, sexual, family, and work lives. The use of violence against women places them at a disadvantage in the exercise of power and authority relations in the various social spheres. It constitutes the most acute expression of the social inequality that exists between the genders, and serves as an instrument of domination aimed at maintaining the subordination of women in society. Violence denies women their autonomy and freedom and undermines their self-determination by preventing women from fully exercising their rights.

Governments in the Region have offered only a limited response to the problem of violence against women. Treatment and prevention programs run by nongovernmental institutions provide most of the coverage. Of 109 programs identified in the Region, 87 were run by nongovernmental organizations, 15 by government entities, 4 by academic institutions, and 3 by regional organizations[29].

The statistics on morbidity and mortality resulting from violence against women do not reflect the true magnitude of the problem, owing to the significant underregistration by both health care and law enforcement institutions. The women who turn to these agencies for help are, in general, those who find themselves in intolerable crisis situations. The rest, the vast majority, never come into contact with either system, or if they do, they do not provide sufficient information to establish violent acts or assault as the cause of their complaints.

According to a Canadian publication[30], gender-specific violence not only is widely accepted, but in some cultures is even expected. In Canada, 1 of every 10 women is beaten by her husband, and in the United States of America 4 women die every day as a result of violence. The same publication notes that in Peru, according to police sources, 70% of the crimes reported to the police involve women beaten by their husbands. Research carried out in Chile[31] in 1992 found that 33.5% of the women interviewed had been psychologically abused and 26.2% had suffered physical violence.

Among the reasons for the underregistration, both of domestic violence and of female morbidity due to violence, is the fact that most victims do not seek assistance from health care institutions. Moreover, health care personnel and even the victims themselves often believe that dealing with violent incidents is beyond the competence of the health sector and falls within the exclusive jurisdiction of the police. Another factor that causes underregistration is the focus of the health services on treating the injury, without recognizing that it resulted from human interactions that could have been avoided. Finally, the greater visibility of violent deaths diverts attention from other less tangible forms of violence that are primarily psychological or social in nature.

The magnitude and importance of the problem of violence against women and children is also obscured by sociocultural patterns and by distortions arising from the structure and operation of the health services. The widespread belief that violence is inherent in the nature of the male, while the nature of the female is to be submissive and peaceful, contributes to the legitimization of aggression by men against women. Within the health services, the sole emphasis on the female reproductive function diverts attention from other psychosocial and health problems of women, particularly those linked to violent acts. The relatively low importance assigned to the problem of unwanted pregnancies adds to the risk of violence against the child and the mother.

6.3 *The Elderly*

Elderly people as a group are particularly vulnerable to violence. Factors contributing to their high risk include the frequency with which the elderly find themselves in situations of physical, psychological, and economic dependence; the diminution of their physical abilities; and their increasing social isolation. Demographic changes currently under way in the Region are leading to a progressive increase in the absolute and relative number of elderly people in the population, with a corresponding increase in public health problems linked to this new situation. The mistreatment of elderly people and, more generally, the perpetration of all types of violent acts against this age group, thus constitutes a growing social and public health problem.

Violence against the elderly is not limited to physical and psychological abuse and negligent care, but may also include financial exploitation, violation of their rights, and sexual abuse. A review of 30 surveys carried out in the United States of America between 1979 and 1985 identified more than 12 categories of abuse[32]. The problem is extensive, especially in countries that have a high proportion of elderly people. A 1985 report by the U.S. House of Representatives Select Committee on Aging[33] estimated that each year 4% of the elderly (more than one million people) are subjected to physical, emotional, or financial abuse by family members or other persons close to them. In a review of research carried out in the United States of America, Wolf[34] suggests that the proportion of the elderly population subject to physical abuse ranges from 4% to 10%. A national study on abuse of the elderly carried out in Canada[35] in 1988 found that 4% of elderly people in that country had suffered one or more forms of abuse in the recent past, with the most frequent forms being financial (2.5%), verbal (1.4%), and physical (0.5%).

7. Environmental Factors Associated with Violent Behavior

Numerous studies have pointed to an association between violence and various environmental factors; however, it was not possible in all of these cases to demonstrate a direct causal relationship. Nonetheless, preventive activities have been proposed to control some of the risk factors identified, among them:

- Firearms. In various countries attention has been drawn to the frequency with which homicides and personal injuries are associated with the possession of easily obtained firearms. In the United States of America, according to the Public Health Service of the U.S. Department of Health and Human Services[36], a majority of the 21,000 homicides in 1987 were committed with a firearm in the course of a dispute between persons who knew each other. In the same country between 1979 and 1986, firearms were used in 60% of the homicides and suicides and in a high proportion of cases involving injury to the spinal cord[37]. Stricter regulation of firearms, howver, is still controversial in the United States.

- Drinking and drug abuse. Another environmental factor frequently linked with violence is the abuse of alcohol and other psychoactive substances by the victim, the victimizer, or both[38]. Research by Wolfgang[39] points to high alcohol consumption by the victims and the perpetuators of homicide. Hotaling and Sugarman[40] found a clear association between male drinking and aggression against women and children. Ladoucer and Temple[41] demonstrate an association between excessive ingestion of alcohol and sexual assault. Violent acts related to the trafficking and consumption of psychoactive substances have reached epidemic proportions in some countries of the Region.

- Television. Research has been under way for several decades to determine whether television may be a risk factor that encourages violent acts. There is a general consensus that watching violent television programs may lead to an increase in the physical aggressiveness of children. Canterwall[42] asserts that the homicide rates in the white population of South Africa increased noticeably starting in 1975, when the existing ban on television was lifted in that country. He also points out that annual homicide rates in Canada and the United States of America nearly doubled in the 10-15-year period after television was introduced in both countries. (In the United States of America the rate rose from 3 homicides per 100,000 population in 1945 to 5.8 per 100,000 in 1974; and in Canada, from 1.3 per 100,000 to 2.5 per 100,000 in the same period.) The factors that intervene in the production of violence are numerous and complex, and include demographic, economic, and sociocultural influences. It would be an error to hold television exclusively responsible for the observed increases in the rates of violence in the foregoing examples; however, the accumulated evidence supports the conclusion that a connection can be demonstrated between television and violent or aggressive behavior.

The factors discussed in the preceding paragraphs are only a few of the many variables which have been linked to violence, and which have formed the basis of proposals for preventive actions. A broad spectrum of factors have been identified,

ranging from personality traits and the psychological profiles of victims and victimizers to the histories, sociocultural characteristics, and economies of the communities where they live. Personal characteristics--determined in part by heredity, by early childhood experiences, and by the environment in which the child and adolescent grows up--have been the focus of various interventions. Grouped under the rubrics of education, primary prevention, and health promotion, these interventions seek to encourage peaceful behavior through activities focusing on interpersonal relations, conflict resolution, gender relations, the preservation of identity, and the struggle for survival. Furthermore, the social, political, and cultural factors related to violence--such as poverty, marginality, overcrowding, political persecution, and the lack of opportunities for minority groups--go beyond the immediate capacity of the health sector to respond. Nonetheless, the health sector, jointly with other sectors, can, in addition to pointing out these factors and their consequences, make important contributions to the development of policies, plans, and programs for the prevention and control of violence.

8. Impact of Violence on the Health Care System

Violence in all its forms is placing an ever-increasing burden on the health services, requiring an increasing allocation of resources of all types to cope with the demand. The provision of urgent care to the victims of violence is overloading the emergency services, outpatient clinics, general hospitals, specialized centers, and services of forensic medicine, and has made it necessary to provide them with additional human and material resources.

The consequences of violence in the medium and long term also compromise the structure and operation of the health services. The physical, psychological, and social repercussions of violence place a particular burden on physical and psychological rehabilitation services and those concerned with social welfare.

Violence and its consequences impose enormous costs on society, and on the health services in particular. For society, the most important consideration is the social cost, represented by years of potential life lost, suffering, and a deterioration in the quality of life. The most easily quantifiable element, years of potential life lost, is alarmingly evident in the statistics.

The costs that violence imposes on the health sector are related to the direct and indirect expenditures for the immediate care of victims, follow-up treatment, and rehabilitation. In the United States of America it is estimated that the cost of trauma and personal injury, whether purposely inflicted or not, reached US$158,000 million in 1985[43]. Violence can have a direct effect on the structure and operation of the health services by placing a strain on their facilities and personnel. It also directly affects the personnel and centers that train human resources, causing physical and psychological harm.

9. Basis for Action

The prevention and control of violence demands coordinated action by different social sectors, among them the health sector. An example that illustrates how actions can be coordinated toward this end is the "Peace, Security, and Development" program sponsored by the mayor's office of the city of Cali, Colombia[44]. The program, which is primarily educational, seeks to build relationships between the police and the community; promote social harmony, civility, and democracy; support families; facilitate the cooperation of volunteers; and encourage citizen participation, the modernization of the judicial system, and the involvement of young people. Another example, the Safe Communities Network[45], provides a unique opportunity for the development of programs to control violence.

Efforts to prevent and control violent behavior involve diverse factores, dependent on, among other circumstances, the severity of the problems, the relevant legal issues, and the sociocultural environment. These three factors are distinguished by the following characteristics:

- An understanding of the magnitude and distribution of the problem of violence and of the factors that affect it is an indispensable condition for the development of rationally based actions. Information available on this subject is fragmented and somewhat unreliable or outdated. Hence the importance of promoting epidemiological research that can provide reliable and timely information to serve as a basis for the establishment of policies and strategies and for the development of operational plans and programs. The promotion of research in this field--aimed at the identification of the psychosocial factors, the economic impact, and the social repercussions of violence--together with quality control of the services, and the evaluation of interventions, constitute an important strategy for programs of prevention and control.

- Legal regulations, which provide the legal basis for activities to control violence, frequently suffer from imperfections, owing in part to their vagueness and ambivalence. Despite these difficulties, the law does provide generic mechanisms for protection against violence, applicable to all elements of society; some directly target the violence and its consequences, while others seek to reduce the vulnerability of high-risk groups. Thus, the constitutional provisions of the countries concur in recognizing the right to life and the right to be recognized as a person in the eyes of the law, which are frequently violated by acts of violence. Other provisions create institutions such as special prosecutor's offices for women, the elderly, or children, set up to receive complaints of aggression against these groups and to take the corrective and preventive measures appropriate to each case.

In the past decade, international law has incorporated principles intended specifically for the protection of the most vulnerable groups. The convention on women has already been mentioned; there exist in addition the Convention on the Rights of the Child[46] and the United Nations Principles for Older Persons[47].

- An analysis of the problem of violence from a socio-anthropological perspective constitutes the third pillar which must support actions proposed for the prevention and control of violence. This analysis must take into consideration aspects such as the structure of family relationships, child-rearing practices, the structure and operation of social networks, the use of free time, and the perceptions, attitudes, and beliefs regarding violence, both in general terms and with regard to specific problems such as "machismo," risk-taking, and territoriality, among others. In general, the application of the knowledge and techniques of the behavioral sciences has a relatively short history. It is only in the last two decades that some initiatives have been undertaken with a view to modifying collective behavior related to health.

Health promotion activities, which encourage healthy behaviors, discourage unnecessary risk-taking, and promote tolerance and the rational solution of conflicts, are the principal instrument for the prevention of violence in the field of health. Some of these programs, which seek to bring about changes in lifestyles through interventions during the formative years of the person, have proven to be an effective strategy for the control and prevention of numerous disorders and conditions. Their application to the prevention of violence can open promising avenues of action.

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TABLES AND GRAPHS

TABLE 1

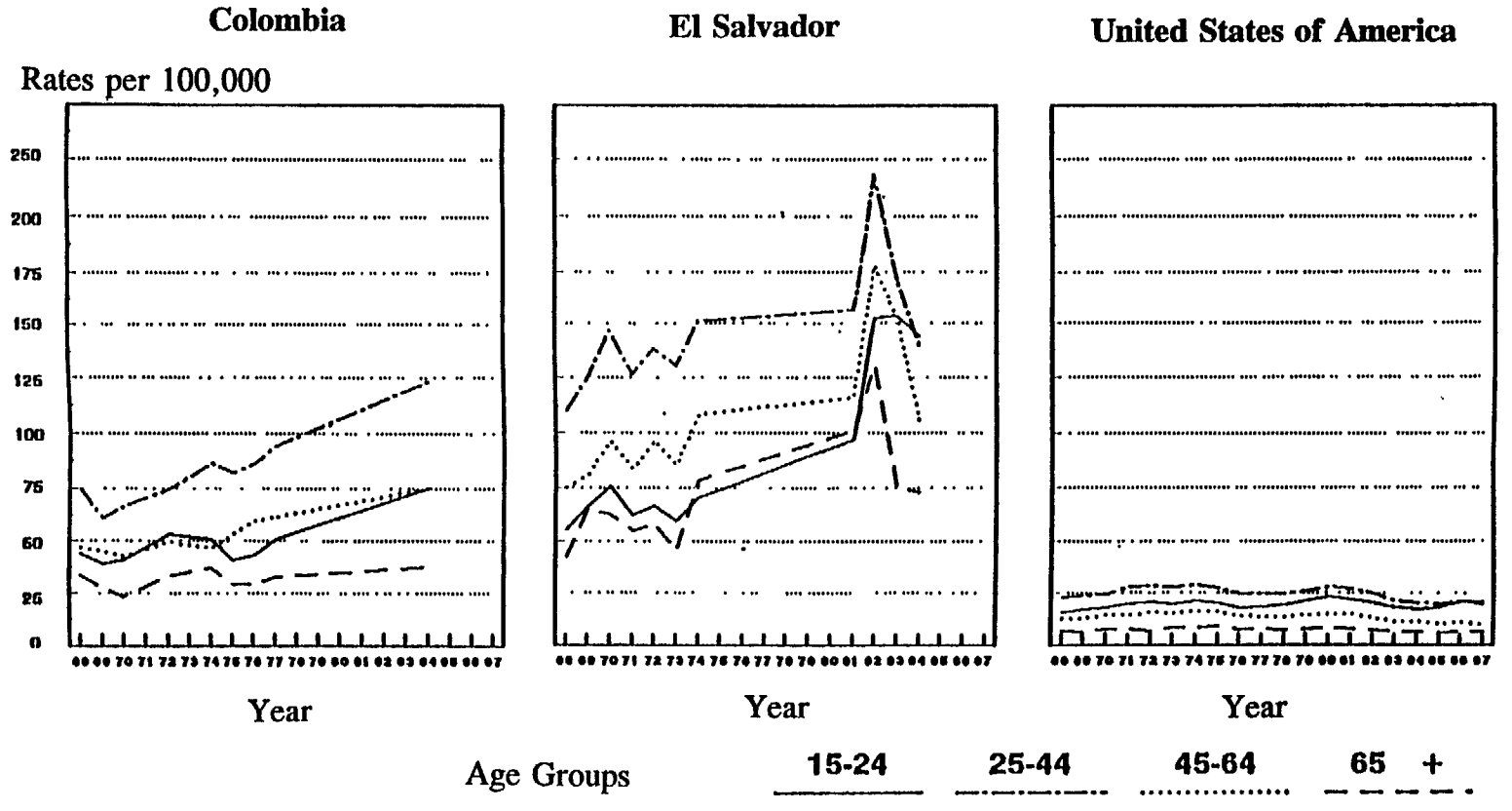
PERCENTAGE OF ALL DEATHS AND OF TOTAL YEARS OF POTENTIAL LIFE LOST DUE TO DEATHS ASSOCIATED WITH VIOLENCE: BOTH SEXES AND MEN ONLY, IN SELECTED COUNTRIES

Country	Year	Percentage of deaths associated with violence		Percentage of total years of potential life lost due to violent acts	
		Both sexes	Men	Both sexes	Men
Paraguay	1985	1.8	3.0	5.9	8.5
Colombia	1981	6.5	10.6	14.3	21.2
Brazil	1983	2.9	4.2	9.8	13.2
El Salvador	1984	8.7	12.6	21.4	26.3
Mexico	1982	3.5	5.5	8.1	11.2
Puerto Rico	1985	3.5	5.4	16.8	20.9
Barbados	1984	1.0	1.5	6.9	9.4
United States	1985	2.4	3.4	13.8	16.2

Source: PAHO, 1989

GRAPH 1

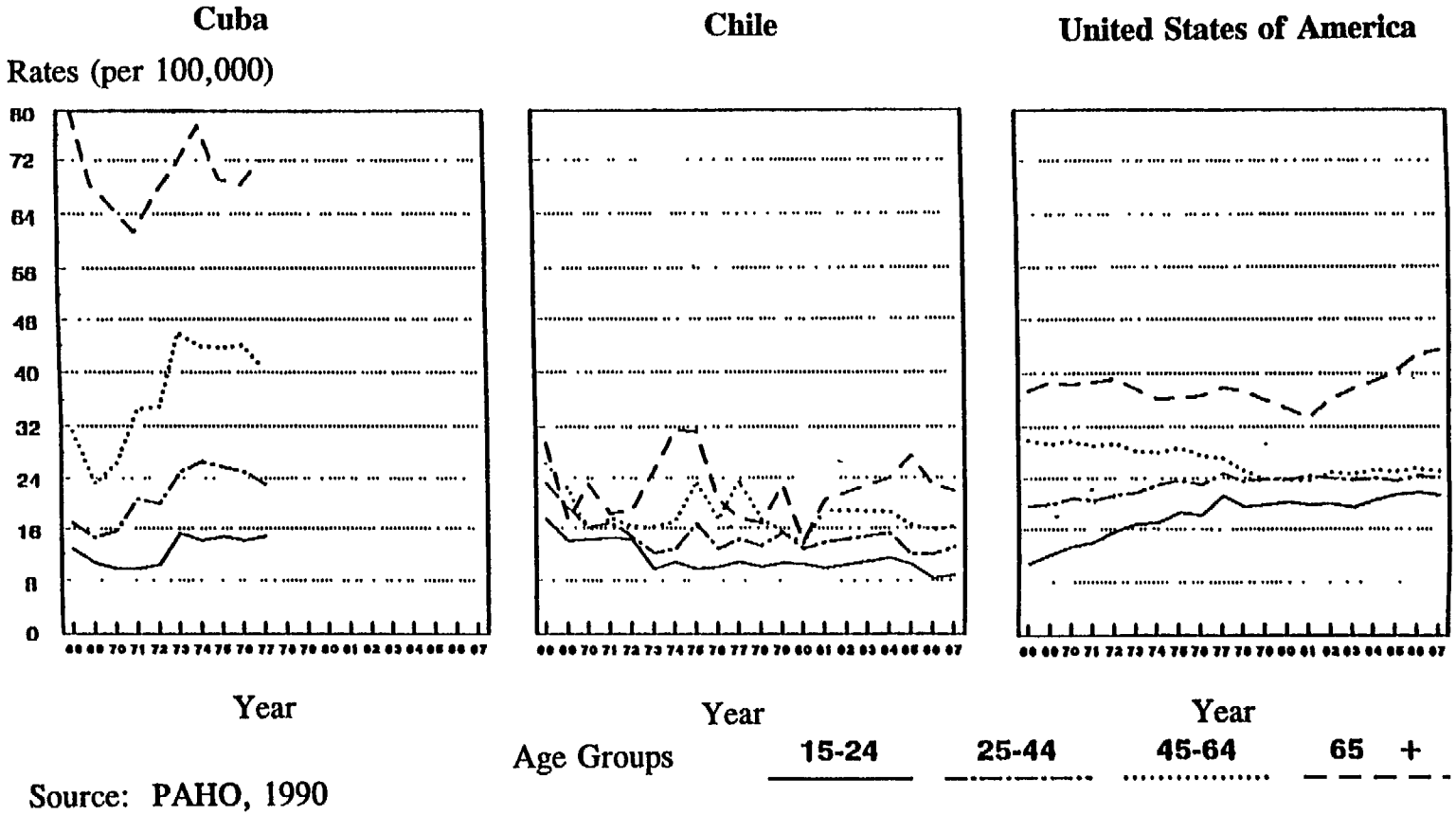
AGE-ADJUSTED MORTALITY RATES FOR HOMICIDES IN MEN
COLOMBIA, EL SALVADOR AND THE UNITED STATES OF AMERICA, 1968-1987



Source: PAHO, 1990

GRAPH 2

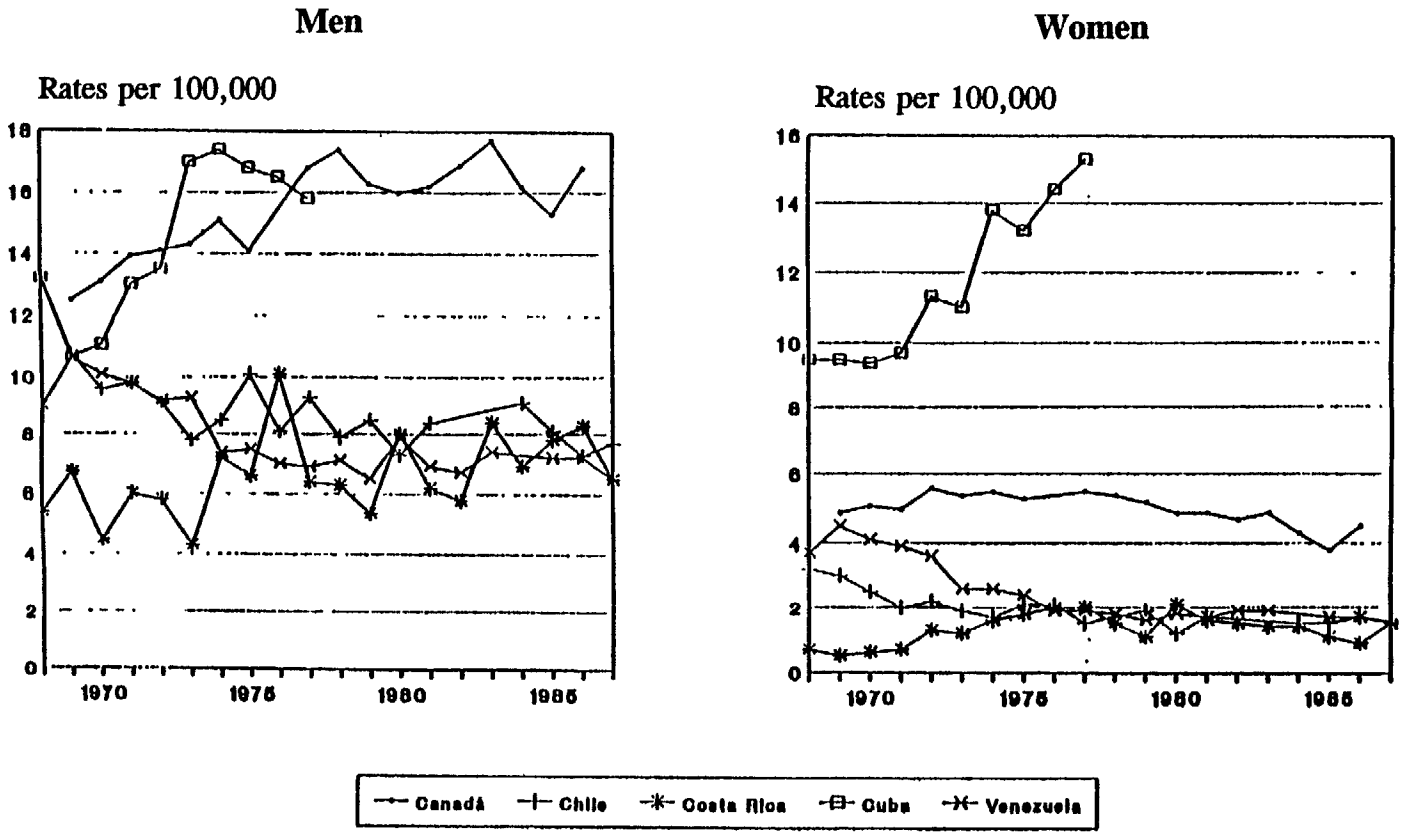
AGE-ADJUSTED MORTALITY RATES FOR SUICIDES IN MEN
CUBA, CHILE AND THE UNITED STATES OF AMERICA, 1968-1987



Source: PAHO, 1990

GRAPH 3

AGE-ADJUSTED MORTALITY RATES, BY SEX, FOR SUICIDES
IN SELECTED COUNTRIES OF THE REGION OF THE AMERICAS, 1968 - 1987



Source: PAHO, 1990