Cartas / Letters

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VIOLENCE AND HEALTH IN THE AMERICAS: PROJECTIONS TO 2030

In 2002, an estimated 1.6 million people worldwide died as a result of self-inflicted, interpersonal, or collective violence. This number is roughly half the number of deaths due to HIV/AIDS, nearly equal to the number of deaths due to tuberculosis, somewhat greater than the number of deaths due to malaria, and 1.5 times the number of road traffic deaths. Of the total 1.6 million victims of violence, about one-third (560 000) were homicides, a further 870 000 people killed themselves, and an estimated 170 000 died as a direct result of collective violence. A disproportionate share of the burden of violence affects developing countries. In addition to the high annual death toll, each year millions of people suffer nonfatal health consequences of violence including injury and disability, mental health and other behavioral disorders, poor reproductive health, and long-lasting implications including increased risk for chronic diseases.

In the WHO Region of the Americas, an estimated 233 000 persons died as a result of violence in 2005. About 67% of these deaths were the result of interpersonal violence—accounting for 27% of global mortality due to interpersonal violence—and 28% of violence-related deaths in the Region were due to self-directed violence (Table 1). By 2030, the number of deaths due to violence in the Region is estimated to increase > 30%. Similarly, disability-adjusted life years (DALYs) for violence are expected to increase > 30% in the Region by 2030, from 8.9 million DALYs in 2005 (Table 1). Overall, DALYs lost to violence in the Region account for about 18% of global DALYs lost due to violence, and DALYs lost due to interpersonal violence in the Region account for one in three DALYs lost worldwide due to interpersonal violence.

Despite this evidence, violence prevention is largely absent from global lists of priorities such as the millennium development goals and is rarely the focus of governmental, nongovernmental agency, and philanthropic-donor-sponsored fieldwork. When violence is addressed, it is most often in the context of collective violence rather than self-directed or interpersonal violence and often is not integrated into the health sector.

We must continue to remind ourselves that violence is not an inevitable aspect of the human condition (1). In much the same way as communi-

TABLE 1. Projected number of deaths and burden of disease (disability-adjusted life years) for the WHO Region of the Americas and all WHO regions for intentional injuries, injuries due to self-directed violence, and injuries due to interpersonal violence, 2005, 2015, and 2030

Region	2005	2015	2030	% change 2005–2030
WHO Region of the Americas				
Deaths				
Overall intentional	233 348	270 369	320 828	37
Self-directed	66 424	76 297	92 020	39
Interpersonal	156 849	182 830	216 437	38
Disability-adjusted life years				
Overall intentional	8 957 427	10 229 325	11 836 568	32
Self-directed	1 543 782	1 751 732	2 062 709	34
Interpersonal	7 075 165	8 118 269	9 403 614	33
All WHO regions				
Deaths				
Overall intentional	1 702 837	1 930 309	2 292 476	35
Self-directed	911 836	1 004 331	1 144 988	26
Interpersonal	593 084	679 927	808 838	36
Disability-adjusted life years				
Overall intentional	50 499 744	55 886 153	63 776 054	26
Self-directed	21 114 460	22 173 579	23 461 939	11
Interpersonal	22 316 269	25 073 064	28 797 244	29

Source: World Health Organization. Global burden of disease project. Available from: http://www.who.int/healthinfo/bodestimates/en/index.html. Accessed 15 August 2007.

cable diseases and other conditions have been threats to public health in the past, violence can be prevented and its impact can be reduced by applying science-based approaches at the population level as set forth in the *World Report on Violence and Health* (1) and its companion document *Preventing Violence: A Guide to Implementing the Recommendations of the World Report on Violence and Health* (2).

Reducing the global burden of violence will necessitate action on many fronts. In addition to applying a public health approach to violence, a successful response to violence will require a concerted effort to place violence prevention into major development agendas and instruments as well as country-level work, a massive mobilization of additional resources, a multisectoral approach, and a scaling up of evidence-based interventions. The goal must be to improve the on-the-ground response to violence and its consequences to not only achieve reductions in mortality and disability but also to reduce morbidity and long-term consequences and noninjury health outcomes.

The findings and conclusions in this report are those of the author alone.

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