

Membro Titular da Academia Mineira de Medicina

Prevenção do suicídio:

Professor Titular de Psiquiatria da UFMG

O que dizem as evidências?

Pesquisador I-A do CNPq

Presidente da ASULAC (Associação de Suicidologia da America Latina e Caribe)

Presidente da ABEPS (Associação Brasileira Para o Estudo e a Prevenção do Suicídio)

Representante Nacional da IASP (International Association for Suicide Prevention)

Presidente da Associação Mineira de Psiquiatria (AMP)

Conflitos de Interesse

Considerando o disposto nas resoluções do Conselho Federal de Medicina (CFM nº 1.595/00 de 18/05/2000) e da Agência Nacional de Vigilância Sanitária (ANVISA nº 102/2000 de 30/11/2000), DECLARAMOS que:

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CNPq

FAPEMIG

Ministério da Saúde

Bolsas

Individuais:

Pesquisador Nível IA
do CNPq

Speaker: Janssen, Servier, Ache, Sanofi

SUICÍDIO E 5-HIAA LIQUÓRICO O LIMÍAR DE UMA NOVA ORDEM?

Humberto C. Silva F.S.

"O FUTURO PODE ENSINAR-NOS A EXERCER INFLUÊNCIA DIRETA, ATRAVÉS DE SUBSTÂNCIAS QUÍMICAS ESPECÍFICAS, NAS QUANTIDADES DE ENERGIA E NA SUA DISTRIBUIÇÃO NO APARELHO MENTAL."
(S. Freud, 1938)

RESUMO

Estudos sobre suicídio iniciaram-se por uma perspectiva sociológica e psicológica. Há cerca de vinte anos atrás uma ação biológica envolvendo o sistema serotoninérgico, possivelmente associado com um fator genético, foi postulada. Em nossa revisão são mostramos que baixos níveis de 5-HIAA, o principal metabólito da serotonina, não são mostrados associado com suicídio e com algumas dimensões psicopatológicas particulares como agressividade e impulsividade. Baixo SHIAA não mostra qualquer associação com distúrbios psiquiátricos. Este fato sugere que uma abordagem nosológica não é muito adequada em pesquisas de psiquiatria biológica, e abre novas perspectivas, no tratamento e classificação psiquiátricos.

UNITERMOS: 5-HIAA, SUICÍDIO, AGRESSIVIDADE, IMPULSIVIDADE

INTRODUÇÃO

O suicídio figura como uma das dez maiores causas de morte na maioria dos países industrializados. Ao contrário de outras causas, que tiveram suas taxas diminuídas, não se observa com relação ao suicídio qualquer diminuição, a despeito dos avanços observados na psiquiatria nas últimas décadas. (23,45,49). Ver gráfico I.

Ao se analisar os dados relativos a determinadas faixas etárias, como os jovens, os achados são mais surpreendentes. Entre o grupo compreendido entre 15 e 24 anos as taxas de suicídio duplicaram ou triplicaram, de acordo com estudos em vários países, nas últimas décadas. (18,34,46,67). Os suicídios correspondem a 10% das mortes de jovens entre 25 e 34 anos e são a segunda causa de morte em adolescentes. (69).

NÚMERO DE VIDAS PERDIDAS POR
SUICÍDIO A CADA ANO NO MUNDO:
mais de

804 000

Um equivalente a

1
MORTE

a cada

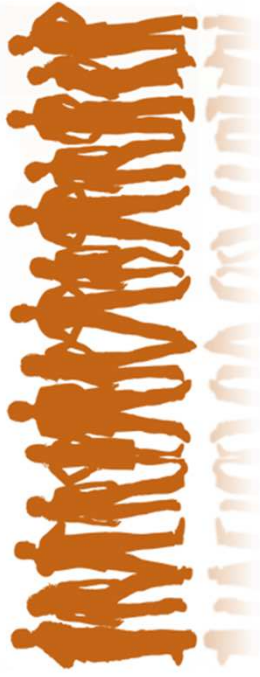


SEGUNDOS



*Maior causa de mortes entre
pessoas na faixa etária de*

15-29



OCORRE EM TODAS AS REGIÕES DO MUNDO

75%

**DAS MORTES
POR SUICÍDIO**

EM 2012 OCORRERAM EM PAÍSES POBRES E EM
PAÍSES EM DESENVOLVIMENTO



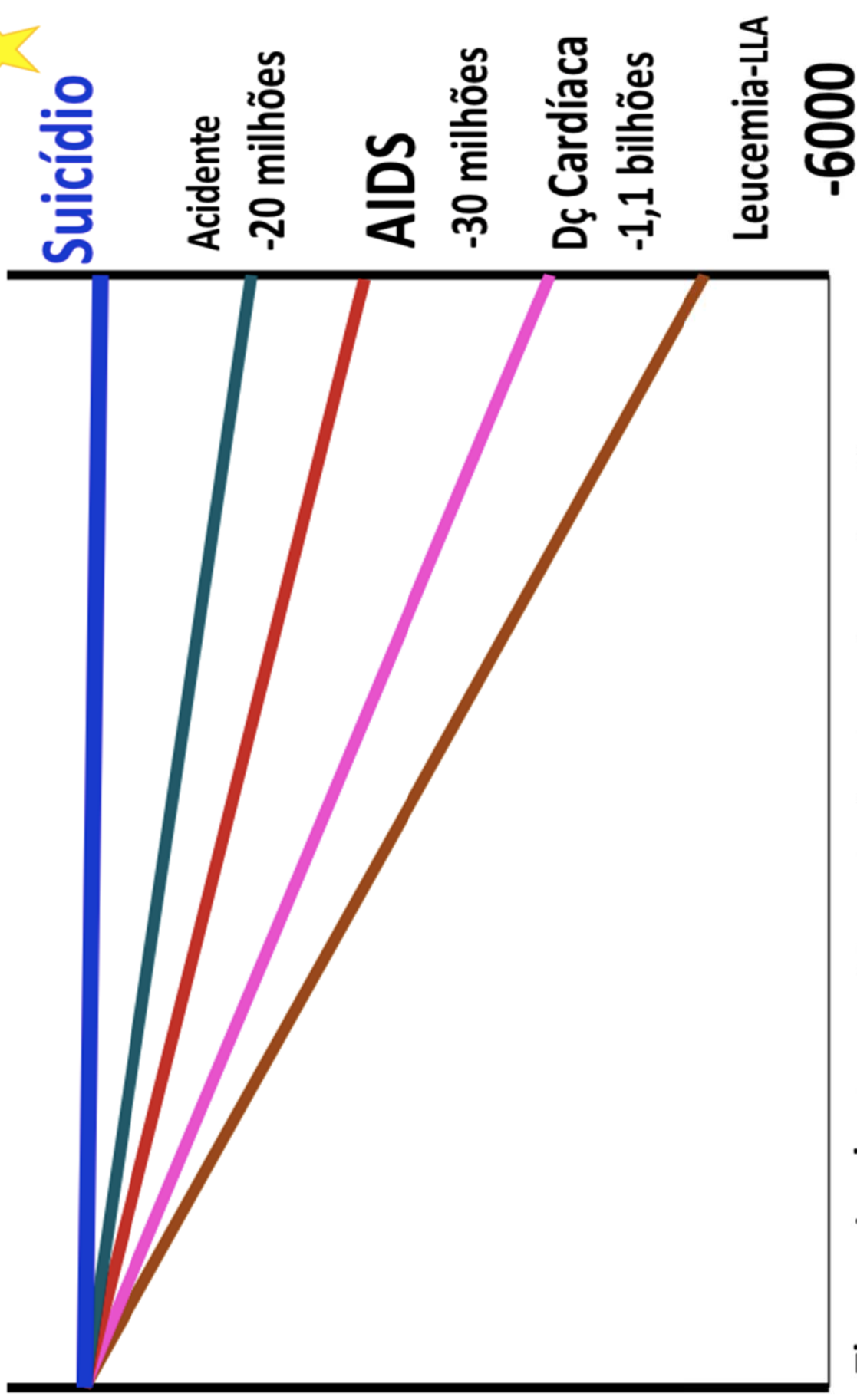
O número
anual de
mortes por
suicídio

Excede o número
de vidas perdidas
por homicídio e guerras juntos



1965-1995

2009-2012



Thomas Insel: Director of the National Institute of Mental Health NIMH,
Neuroscientist and psychiatrist, USA (Insel et al, 2010)

Suicide prevention strategies revisited: 10-year systematic review

Gil Zalsman, Keith Hawton, Danuta Wasserman, Kees van Heeringen, Ella Arensman, Marco Sarchiapone, Vladimir Carli, Cyril Höschl, Ran Barzilay, Judit Balazs, György Purebl, Jean Pierre Kahn, Pilar Alejandra Sáiz, Cendrine Bursztein Lipsicas, Julio Bobes, Doina Cozman, Ulrich Hegerl, Joseph Zohar

Summary

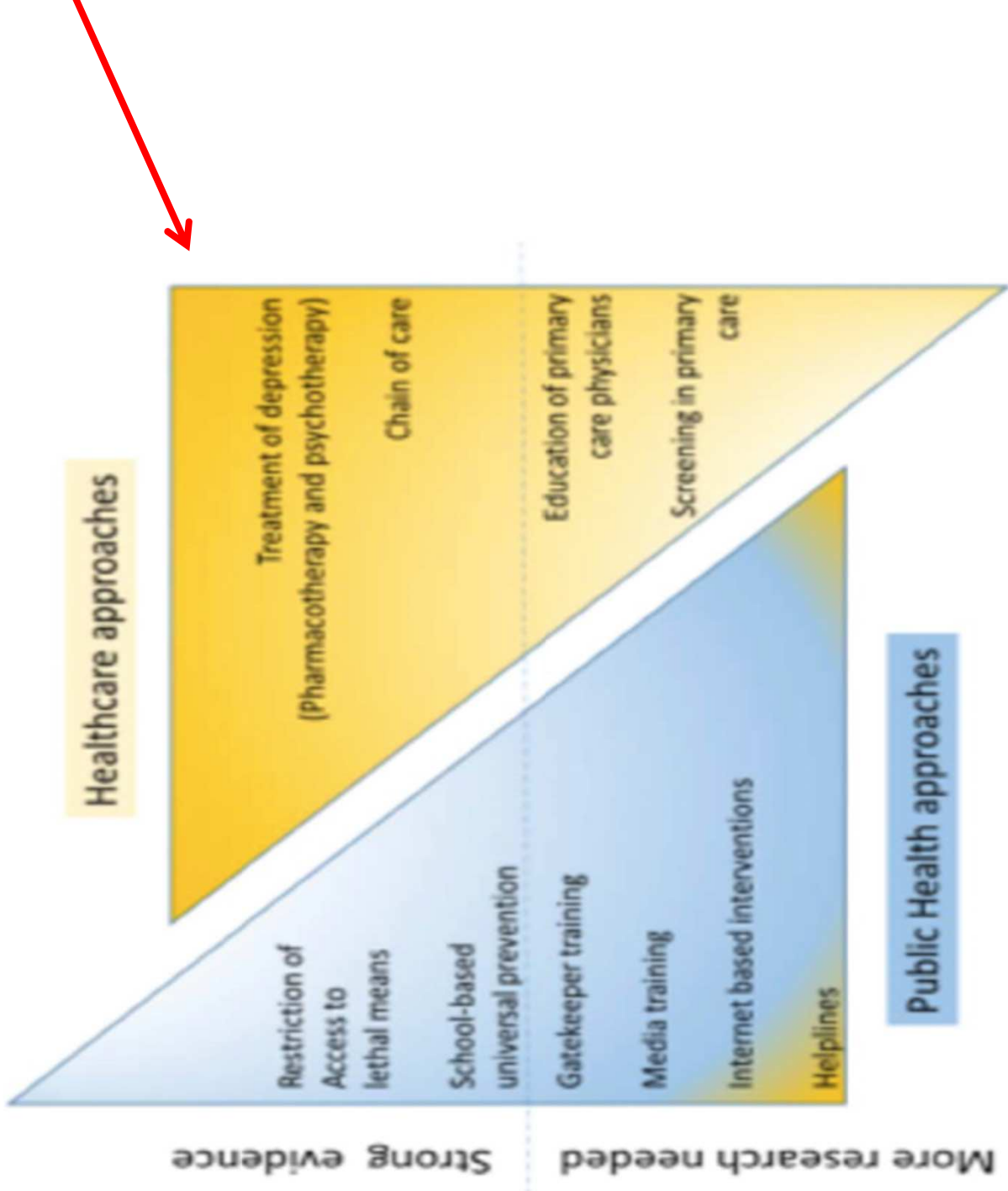
Background Many countries are developing suicide prevention strategies for which up-to-date, high-quality evidence is required. We present updated evidence for the effectiveness of suicide prevention interventions since 2005.

Methods We searched PubMed and the Cochrane Library using multiple terms related to suicide prevention for studies published between Jan 1, 2005, and Dec 31, 2014. We assessed seven interventions: public and physician education, media strategies, screening, restricting access to suicide means, treatments, and internet or hotline support. Data were extracted on primary outcomes of interest, namely suicidal behaviour (suicide, attempt, or ideation), and intermediate or secondary outcomes (treatment-seeking, identification of at-risk individuals, antidepressant prescription or use rates, or referrals). 18 suicide prevention experts from 13 European countries reviewed all articles and rated the strength of evidence using the Oxford criteria. Because the heterogeneity of populations and methodology did not permit formal meta-analysis, we present a narrative analysis.

Findings We identified 1797 studies, including 23 systematic reviews, 12 meta-analyses, 40 randomised controlled trials (RCTs), 67 cohort trials, and 22 ecological or population-based investigations. Evidence for restricting access to lethal means in prevention of suicide has strengthened since 2005, especially with regard to control of analgesics (overall decrease of 43% since 2005) and hot-spots for suicide by jumping (reduction of 86% since 2005, 79% to 91%). School-based awareness programmes have been shown to reduce suicide attempts (odds ratio [OR] 0.45, 95% CI 0.24–0.85; $p=0.014$) and suicidal ideation (0.5, 0.27–0.92; $p=0.025$). The anti-suicidal effects of clozapine and lithium have been substantiated, but might be less specific than previously thought. Effective pharmacological and psychological treatments of depression are important in prevention. Insufficient evidence exists to assess the possible benefits for suicide prevention of screening in primary care, in general public education and media guidelines. Other approaches that need further investigation include gatekeeper training, education of physicians, and internet and helpline support. The paucity of RCTs is a major limitation in the evaluation of preventive interventions.

Interpretation In the quest for effective suicide prevention initiatives, no single strategy clearly stands above the others. Combinations of evidence-based strategies at the individual level and the population level should be assessed with robust research designs.

Funding The Expert Platform on Mental Health, Focus on Depression, and the European College of Neuropsychopharmacology.



Evidence-based strategies of suicide prevention in mental health care and in public health approaches. (Zalsman et al., 2017)

Restrição a meios

	Study type	Level of evidence
Firearm restrictions		
General population in USA	Systematic review ¹⁵	2a
Men in USA	Ecological ¹⁶	2a
People with serious mental illness	Systematic review ¹⁷	2a-
General population	Systematic review ¹⁸	2c
General population in Australia	Quasi-experimental ¹⁹	2c
General population in USA	Ecological ²⁰	2c
General population in USA	Ecological ²¹	2c
Men in Norway	Ecological ²²	2c
Adult population in Switzerland	Quasi-experimental ²³	2c
Adolescents in Israel	Quasi-experimental ²⁴	2c
General population in New Zealand	Quasi-experimental ²⁵	2c
General population in Austria	Quasi-experimental ²⁶	2c
Youth in Australia (15–44 years of age)	Ecological ²⁷	2c
Youth in USA (<20 years of age)	Case-control ²⁸	3b
Analgesic withdrawal		
General population in UK	Quasi-experimental ²⁹	2c
General population in UK	Quasi-experimental ³⁰	2c
General population in UK	Quasi-experimental ³¹	2c
Pesticide regulation		
General population in Sri Lanka	Ecological ³²	2c
General population in Taiwan	Ecological ³³	2c
Changes in pesticide content		
General population in Sri Lanka	Quasi-experimental ³⁴	3b
Pesticide storage		
General population in Sri Lanka	Quasi-experimental ³⁵	2c
General population in India	Cohort study ³⁶	2c
Restricting measures on hanging		
Psychiatric inpatients	Ecological ³⁷	2c
General population and population in prison and in psychiatric settings	Systematic review ³⁸	5
Erection of barriers at jumping hot-spots		
General population in New Zealand, UK, USA, Switzerland, and Canada	Meta-analysis ³⁹	2a
General population in Canada	Quasi-experimental ⁴⁰	2c
General population in Australia	Quasi-experimental ⁴¹	2c
Restricting access to charcoal		
General population in Hong Kong	Quasi-experimental ⁴²	2c
Restrictions on barbiturate sales		
General population in Denmark	Ecological ⁴³	2c
Restrictions on caffeine tablet sales		
General population in Sweden	Quasi-experimental ⁴⁴	2c

Oxford criteria from the Oxford Centre for Evidence-based Medicine (March, 2009).¹⁴

Table 1: Level of evidence (Oxford criteria) of suicide prevention by means restriction

Brit. J. prev. soc. Med. (1976), **30**, 86-93

The coal gas story

United Kingdom suicide rates, 1960-71

NORMAN KREITMAN

MRC Unit for Epidemiological Studies in Psychiatry, University Department of Psychiatry, Royal Edinburgh Hospital, Edinburgh

Kreitman, N. (1976). *British Journal of Preventive and Social Medicine*, **30**, 86-93. **The coal gas story: United Kingdom suicide rates, 1960-71.** A detailed analysis of suicide rates between 1960 and 1971 for England and Wales and for Scotland confirms that all age-sex subgroups have shown a marked decline in suicide due to domestic gas, corresponding in time to the fall in the CO content. After considering data on the effects of the *International Classification of Diseases (ICD) Eighth Revision*, accident mortality, some personal characteristics of coal gas suicides, and the use of coal gas in parasuicide it was concluded that a simple causal explanation was likely. Suicide due to non-gas methods has in general increased, markedly so in some groups. It was suggested that neither improved psychiatric services nor voluntary agencies could have produced such changes. The 'compensatory' trend of gas and non-gas suicide rates was indicated for certain age-sex subgroups. The continuing need for suicide research was pointed out, and questions were raised concerning the psychological meaning of the epidemiological data.

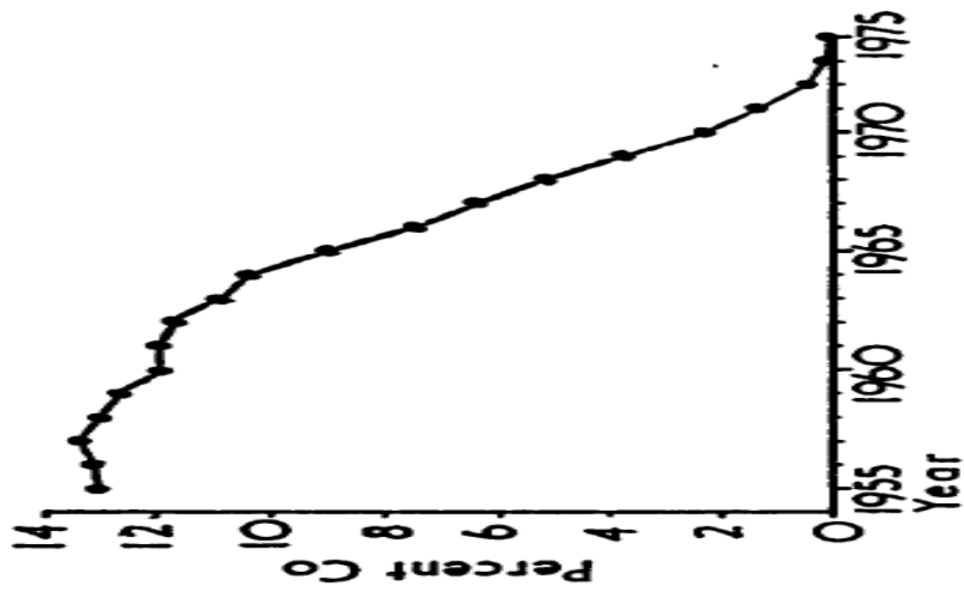


FIG. 3. Percentage of CO in domestic gas, United Kingdom 1955-74.

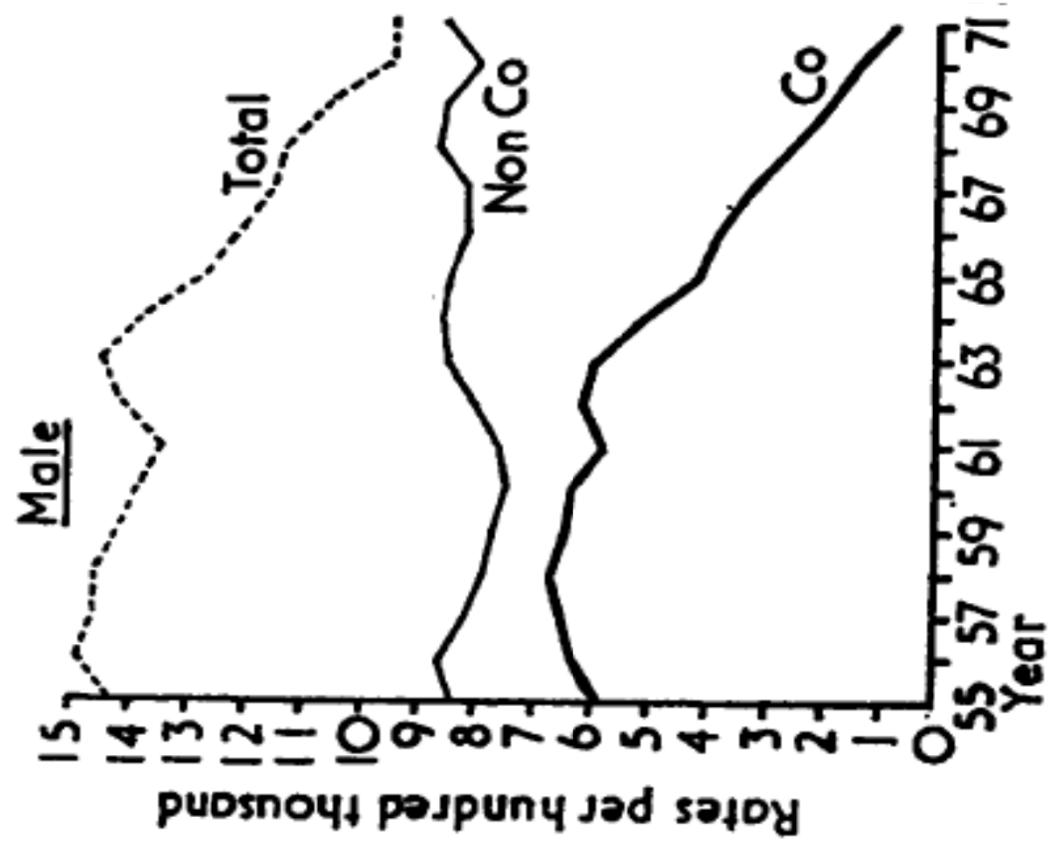


FIG. 4. England and Wales: sex-specific suicide rates by mode of death.

National Suicide Prevention Strategy for England

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Goal 1: To reduce risk in key high risk groups

Many risk factors for suicide have been described. We have therefore identified groups that are at high risk and are targeting them for specific action. We have applied clear criteria to select high risk groups and

Objective **Current situation** **Illustrated impact of 20% reduction in suicides**

• Reduce the number of suicides by people who are currently or have recently been in contact with mental health services

1,200 deaths per year
Latest three year average: 1,238
Male: 826
Female: 412
Source: National Confidential Inquiry

240 fewer deaths

• Reduce the number of suicides in the year following deliberate self-harm

1,180 deaths per year
Latest three year average: 1,176
Male: 672
Female: 504
Source: Centre for Suicide Research, Oxford

236 fewer deaths

• Reduce the number of suicides by young men

1,300 deaths per year
latest three year average: 1,294
Source: ONS

260 fewer deaths

Objectives

1.1 Reduce the number of suicides by prisoners

85 deaths per year
Latest three year average: 85
Male: 80
Female: 5
Source: Home Office

17 fewer deaths

1.2 Reduce the number of suicides by high risk occupational groups

Farmers (and agricultural workers): 52 deaths per year
Nurses: 27 deaths per year
Doctors: 17 deaths per year
Source: ONS

19 fewer deaths

mental

The first ever UK Minister for Suicide Prevention



Conservatives

Jackie Doyle-Price MP



Contents lists available at ScienceDirect

Health Policy

journal homepage: www.elsevier.com/locate/healthpol



Gun control and suicide: The impact of state firearm regulations in the United States, 1995–2004

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NJ 08901-1340, United States

RESEARCH AND PRACTICE

Installation of a Bridge Barrier as a Suicide Prevention Strategy in Montréal, Québec, Canada

Stéphane Perron, MD, MSc, Stéphanie Burrows, PhD, Michel Fournier, MA, Paul-André Perron, PhD, and Frédéric Ouellet, PhD



Conclusões

A escolha de um método depende, ao mesmo tempo, da sua disponibilidade e de sua aceitação sócio-cultural.

Reduções de suicídio acontecem por restrições de acesso a meios quando esse método é frequente em um determinado país/região.

Evidências mostram não ocorrer substituição por outro método, nessa população.

Maioria dos suicídios é IMPULSIVO!

Sch clus

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3 month follow-up

	n	Cases (%)	OR (95% CI)	p value	n	Cases (%)	OR (95% CI)	p value
Question, persuade, and refer	2209	15 (0.68%)	0.62 (0.32-1.18)	0.147	1978	22 (1.11%)	0.70 (0.39-1.25)	0.229
Youth aware of programme	2166	19 (0.88%)	0.78 (0.42-1.44)	0.422	1987	14 (0.70%)	0.45* (0.24-0.83)	0.014*
Screening by professionals	2203	27 (1.23%)	1.10 (0.61-1.97)	0.752	1961	20 (1.02%)	0.65 (0.36-1.18)	0.158
Controls	2366	27 (1.14%)	Reference	..	2256	34 (1.51%)	Reference	..

ORs and 95% CIs were generated from generalised linear mixed models with a logistic link, adjusted for age, sex, Strengths and Difficulties Questionnaire total score, not being born in the country of residence, parental job loss in the previous year, not living with both biological parents, and country of residence. Missing covariates were included through use of multiple imputation. OR=odds ratio. *Significant at p<0.05.

Table 2: Incident suicide attempts at 3 and 12 month follow-up

3 month follow-up

	n	Cases (%)	OR (95% CI)	p value	n	Cases (%)	OR (95% CI)	p value
Question, persuade, and refer	2210	25 (1.13%)	0.69 (0.40-1.19)	0.182	1977	29 (1.47%)	0.95 (0.55-1.63)	0.856
Youth aware of programme	2172	32 (1.47%)	0.88 (0.52-1.51)	0.629	1991	15 (0.75%)	0.50* (0.27-0.87)	0.025*
Screening by professionals	2203	27 (1.23%)	0.72 (0.42-1.23)	0.229	1962	22 (1.12%)	0.71 (0.40-1.25)	0.234
Controls	2365	35 (1.48%)	Reference	..	2261	31 (1.37%)	Reference	..

ORs and 95% CI were generated from generalised linear mixed models with a logistic link, adjusted for age, sex, baseline Strengths and Difficulties Questionnaire total score, not being born in the country of residence, parental job loss in the previous year, not living with both biological parents, and country of residence. Missing covariates were included through use of multiple imputation. OR=odds ratio. *Significant at p<0.05.

Figure 5
QPR-Qu
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Youth Aware of mental programme (YAM)

Intervenção universal padronizada (manual, instrutores treinados na metodologia)

3hrs de sessão de role play

Workshops interativos

Um manual informativo de 32 paginas que os alunos levam para casa

1hr de aula interativa sobre doença mental, no início e no final da intervenção

06 pôsteres educativos, mantidos em cada sala

Objetivos: manter a discussão sobre fatores de risco e proteção para suicídio, incluindo conhecimentos sobre depressão e ansiedade, aumento das habilidades para lidar com fatores estressores, etc.



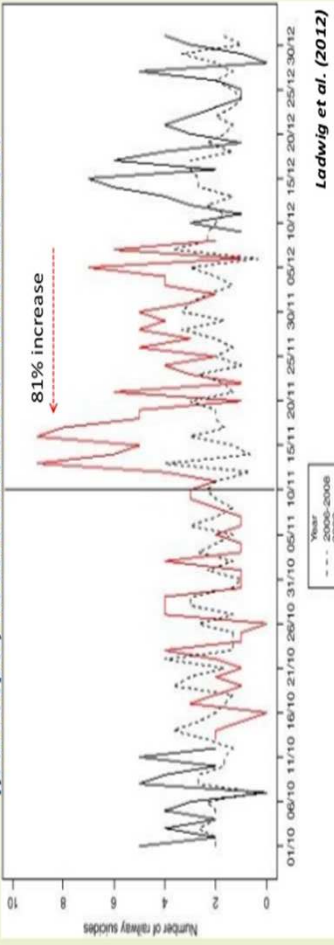
DAILY MIRROR MARILYN MONROE: 'IT LOOKS LIKE SUICIDE'

SAN ANGELES STAR MARILYN MONROE FOUND DEAD

Sleeping Pill Overdose Blamed



Significant increase of railway suicides after the suicide of German goal keeper, Robert Enke on 10th November 2009



In addition to the short term increase in railway suicides, Hegerl et al (2013) identified a long term effect: 100% increase in railway suicides in the time period

Ladwig et al. (2012)

JAMA Psychiatry | Original Investigation

Association of Increased Youth Suicides in the United States With the Release of *13 Reasons Why*

Thomas Niederkrotenthaler, MD, PhD, MMSc; Steven Stack, PhD; Benedikt Till, DSc; Mark Sinyor, MSc, MD; Jane Pirks, PhD; David Garcia, DSc; Ian R. H. Rockett, PhD, MPH; Ulrich S. Tran, DSc

[←](#) Editorial page 891[+](#) Author Audio Interview

IMPORTANCE On March 31, 2017, Netflix released the show *13 Reasons Why*, sparking immediate criticism from suicide prevention organizations for not following media recommendations for responsible suicide portrayal and for possible suicide contagion by media. To date, little research has been conducted into the associations between the show and suicide counts among its young target audience.

OBJECTIVE To analyze the changes in suicide counts after the release of *13 Reasons Why*.

DESIGN, SETTING, AND PARTICIPANTS For this time series analysis, monthly suicide data for the age groups 10 to 19 years, 20 to 29 years, and 30 years or older for both US males and females from January 1, 1999, to December 31, 2017, were extracted from the Centers for Disease Control and Prevention's WONDER (Wide-ranging Online Data for Epidemiologic Research) database. Twitter and Instagram posts were used as a proxy to estimate the amount of attention the show received through social media from April 1, 2017, to June 30, 2017. Autoregressive integrated moving average time series models were fitted to the pre–April 2017 period to estimate suicides among the age groups and to identify changes in specific suicide methods used. The models were fitted to the full time series with dummy variables for (1) April 2017 and (2) April 1, 2017, to June 30, 2017. Data were analyzed in December 2018 and January 2019.

MAIN OUTCOMES AND MEASURES Suicide data before and after the release of the show in 2017.

RESULTS Based on social media data, public interest in the show was highest in April 2017 and was negligible after June 2017. For 10- to 19-year-old males and females, increases in the observed values from April to June 2017 were outside the 95% confidence bands of forecasts. Models testing 3-month associated suicide mortality indicated 66 (95% CI, 16.3–115.7) excess suicides among males (12.4% increase; 95% CI, 3.1%–21.8%) and 37 (95% CI, 12.4–61.5) among females (21.7% increase; 95% CI, 7.3%–36.2%). No excess suicide mortality was seen in other age groups. The increase in the hanging suicide method was particularly high (26.9% increase; 95% CI, 15.3%–38.4%).

CONCLUSIONS AND RELEVANCE Caution must be taken in interpreting these findings; however, the suicide increase in youth only and the signal of a potentially larger increase in young females all appear to be consistent with a contagion by media and seem to reinforce the need for collaboration toward improving fictional portrayals of suicide.

Life expectancy after the first suicide attempt


Jokinen J, Talbäck M, Feychting M, Ahlbom A, Ljung R. Life expectancy after the first suicide attempt.

Objective: To assess excess mortality among suicide attempters compared to the general population.

Method: Remaining life expectancy was calculated for a nation wide cohort of all 187 894 persons 18 years or older hospitalised for the first time attempted suicide in Sweden in 1971–2010.

Results: Life expectancy was shortened throughout the lifespan for both men and women debuting with suicide attempt. The reduction in life expectancy for men debuting with a suicide attempt at 20 years of age was 18 years while the reduction for men debuting at 50 years of age was 10 years. For women attempting suicide, the life expectancy was shortened by 11 and 8 years respectively. The gender difference in life expectancy attenuated in patients making their first suicide attempt at age 70 years or older. Suicide deaths explained about 20% of the total mortality within 10 years of the suicide attempt and 5% in those with duration of four decades since the first suicide attempt.

Conclusion: The life expectancy is dramatically reduced in patients attempting suicide. With most excess deaths being due to physical health conditions, public efforts should be directed both towards improving physical health and to prevent suicide.

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Key words: suicide attempt; life expectancy; mortality; suicide; comorbidity

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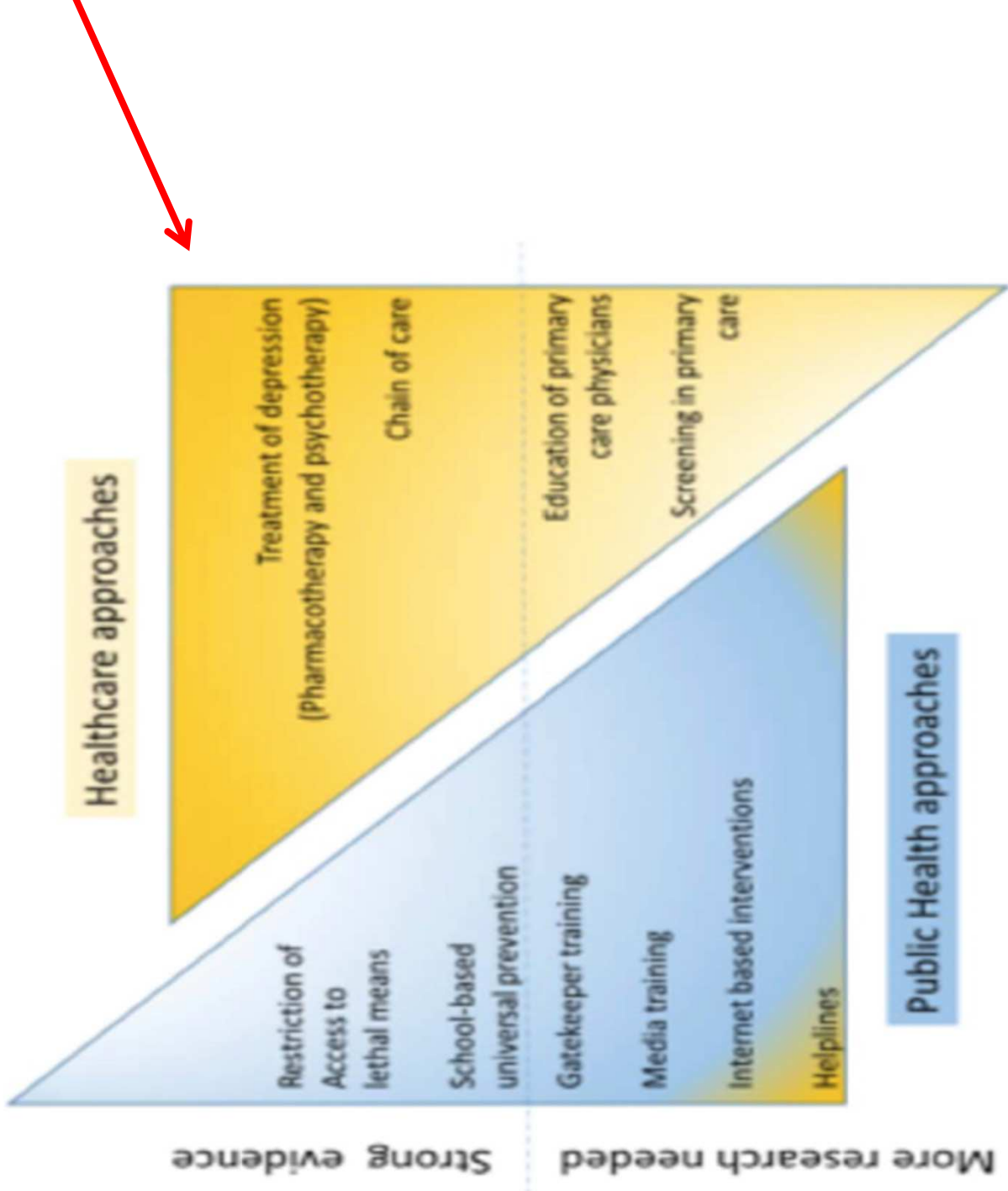
Accepted for publication November 20, 2017

Significant outcomes

- Life expectancy was shortened by up to 18 years for 20-year-old men and 11 years for 20-year-old women who made their first suicide attempt during the study period.
- Suicide deaths and deaths due to undetermined intent explained about 20% of the total mortality for patients 42 years and older who had also made their first attempt in 2001–2010. This is despite the fact that they initially had survived their first suicide attempt and were alive 3 months thereafter.
- The major part of excess mortality in suicide attempt patients is due to somatic comorbidity and not due to suicide.

Limitations

- The cohort included suicide attempters treated in the in-patient wards. Therefore, our results may not apply to suicide attempts not leading to in-patient care.
- We did not stratify for the coexisting psychiatric morbidity. Type of psychiatric disorder coexistent with a suicide attempt influences overall risk for completed suicide.
- We had no information on treatment efforts.



Evidence-based strategies of suicide prevention in mental health care and in public health approaches. (Zalsman et al., 2017)

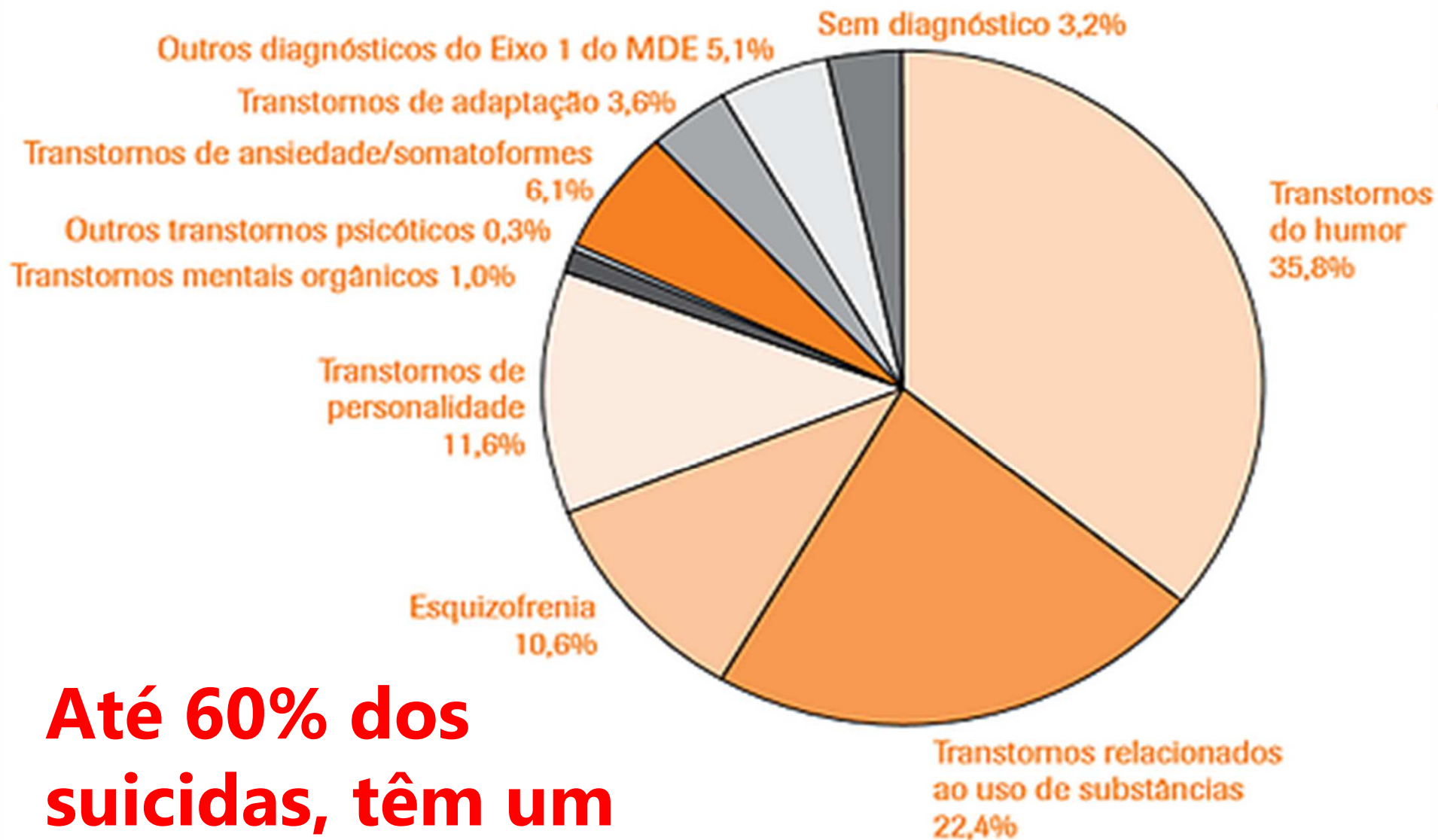
Psychiatric Diagnoses and Suicide: Revisiting the Evidence

José Manoel Bertolote¹, Alexandra Fleischmann¹,
Diego De Leo², and Danuta Wasserman³

¹Department of Mental Health and Substance Abuse, World Health Organization, Geneva, Switzerland, ²Australian Institute for Suicide Research and Prevention, Griffith University, Brisbane, Australia, ³Department of Public Health Sciences, Karolinska Institute and Swedish National Institute of Psychosocial Medicine, and National Center for Suicide Research and Prevention of Mental Ill-Health, Stockholm, Sweden

Abstract: *Background:* The key role of prevention and treatment of mental disorders in the prevention of suicide is widely acknowledged. Which specific disorders need to be targeted remains to be conclusively demonstrated. *Aims:* To re-examine the presence of psychiatric diagnosis in cases of completed suicide from a global perspective. *Method:* A review of studies reporting diagnoses of mental disorders in cases of completed suicide with or without history of admission to mental hospitals. *Results:* Most cases were from Europe and North America (82.2%). The majority (98%) of these had a diagnosis of at least one mental disorder. Among all diagnoses, mood disorders accounted for 30.2%, followed by substance-use related disorders (17.6%), schizophrenia (14.1%), and personality disorders (13.0%). *Conclusions:* The mental health paradigm in suicide prevention covers just a part of the problem. Antisucide strategies focusing exclusively on the identification and treatment of depression need to be reconsidered. In addition to this, other mental disorders should be targeted, in particular alcohol-use disorders and schizophrenia. More emphasis should also be placed on psychosocial and environmental interventions diminishing and counteracting stress.

Keywords: Suicide, prevention, mental disorder, public health.



Até 60% dos suicidas, têm um diagnóstico de depressão.

Fonte: BERTOLETE, J. M.; FLEISCHMANN, A. Suicide and psychiatric diagnosis: a follow-up perspective. *World Psychiatry* 1 (3), p. 181-185, 2002

Representa uma barreira para o desenvolvimento sustentável em todas as regiões.

Lund C et al. Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. *Lancet Psychiatry* 2018; 5: 357–69.

Soc Psychiatry Psychiatr Epidemiol (2016) 51:1525–1537
DOI 10.1007/s00127-016-1278-4



ORIGINAL PAPER

Global patterns of workplace productivity for people with depression: absenteeism and presenteeism costs across eight diverse countries

S. Evans-Lacko^{1,2} · M. Knapp¹

Evita ou dificulta que as pessoas atinjam todo o seu potencial, reduzindo o capital humano. Além disso é uma das principais causas de morte prematura, devido a várias condições mas, principalmente, **suicídio**.

Patel et al. Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities, 3rd edition. *Lancet* 2016; 387: 1672–85.

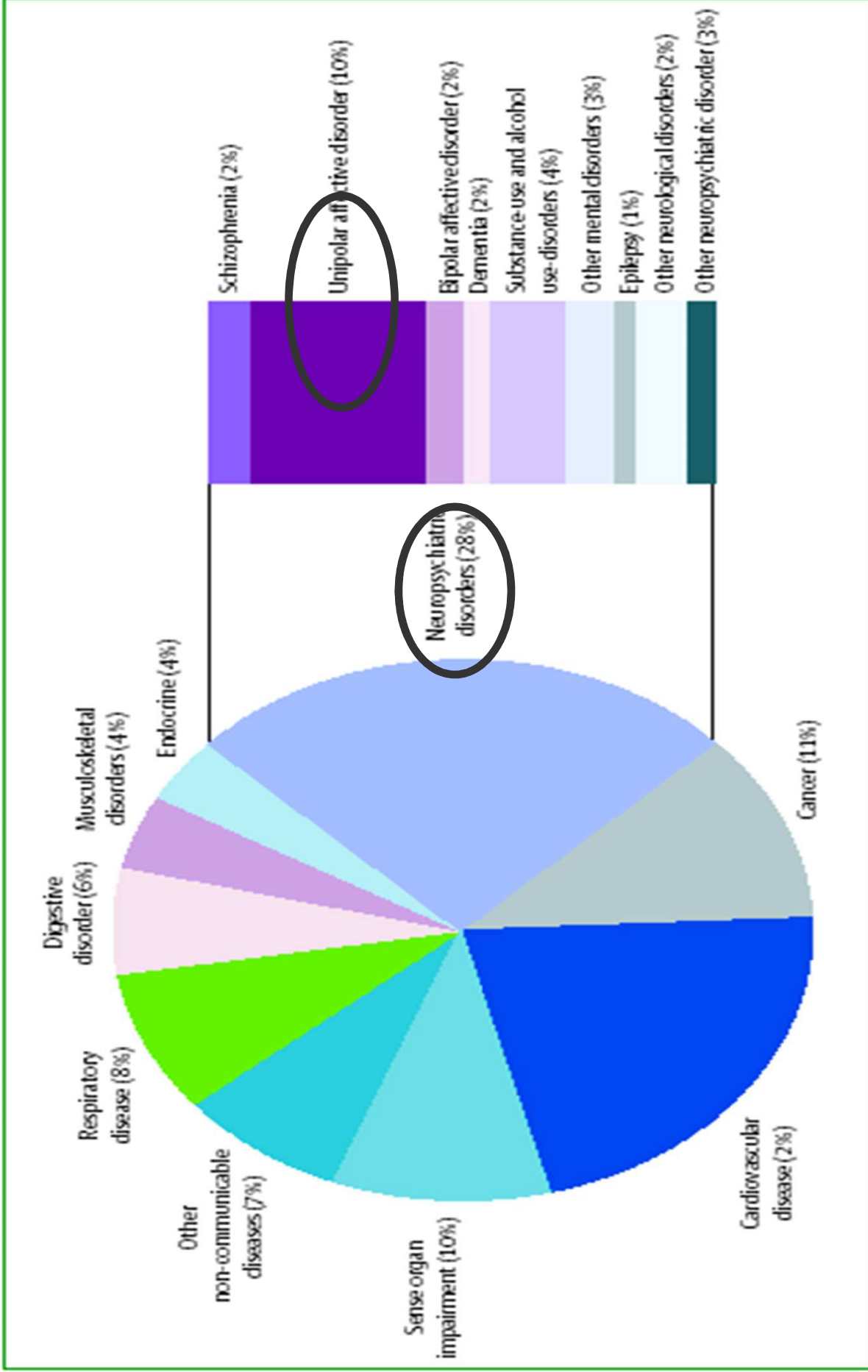


Figure 1: Contribution by different non-communicable diseases to disability-adjusted life-years worldwide in 2005

Data adapted from WHO, with permission.¹


*Epidemiology and Psychiatric
Sciences*

cambridge.org/eps

Original Article

*The WHO World Mental Health Survey
collaborators are Sergio Aguilar-Gaxiola, MD,
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Twelve-month mental health service use in six countries of the Americas: A regional report from the World Mental Health Surveys

G. Borges¹ , S. Aguilar-Gaxiola², L. Andrade³, C. Benjet¹, A. Cia⁴, R. C. Kessler⁵,
R. Orozco¹, N. Sampson⁵, J. C. Stagnaro⁶, Y. Torres⁷, Maria Carmen Viana⁸,
M. E. Medina-Mora¹ and On behalf of the WHO World Mental Health Survey
collaborators*

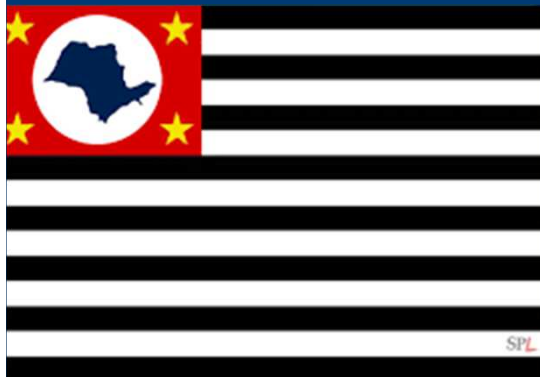
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<https://www.cambridge.org/core/terms>. <https://doi.org/10.1017/S2045796019000477>


Methods. Data come from data collected from 6710 adults with 12 month mental disorder surveys across seven surveys in six countries in North (USA), Central (Mexico) and South (Argentina, Brazil, Colombia, Peru) America who were interviewed 2001–2015 as part of the World Health Organization (WHO) World Mental Health (WMH) Surveys. DSM-IV

22,9% recebeu algum tratamento

34,4% dos quadros graves

38,9% recebeu um tratamento
considerando adequando segundo as
evidências atuais.





Membros de uma população com condições de risco específicas

Sub-populações que podem estar em maior risco.

Universal:
Medidas para a população geral, independentemente do risco

Níveis de prevenção

OBRIGADO!!

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