

Reflections on two decades of violence and unintentional injury prevention: Responses in South Africa

Ashley van Niekerk, Programme Manager with the Violence, Injury and Peace Research Unit and a Professor Extraordinarius with the University of South Africa's Institute for Social and Health Sciences. His recent research interests include childhood safety, burn injury, safety interventions, and the development of safety policy for South Africa. Ashley.vanniekerk@mrc.ac.za.

Mohamed Seedat, community-centred intervention development and violence prevention researcher. He is a vision-making and strategic development facilitator and life-oriented academic coach, mentor and post-graduate student supervisor. Seedama@unisa.ac.za.

Kopano Ratele, Professor at the Institute for Social and Health Sciences, and the co-director of the Violence, Injury and Peace Research Unit. Best known for his work on men and masculinity – specifically in relation to violence, race, sexualities, and tradition – he has published a number of books, scholarly essays, research papers, and shorter pieces on a range of psychological, cultural and social topics. Kopano.Ratele@mrc.ac.za.

Shahnaaz Suffla, senior scientist with the Violence, Injury and Peace Research Unit, trained as a clinical psychologist. Her research interests include issues related to gender, peace, conflict, and violence and injury prevention. Shahnaaz.Suffla@mrc.ac.za.

Violence and unintentional injury make up one of the four major health burdens in South Africa, along with HIV and tuberculosis (TB), chronic illness and mental health, and maternal, neonatal and child health. Despite South Africa's remarkable political transformation, the country has continued to experience staggering levels of morbidity and mortality arising from violence and injury. Annually, as many as 3.5 million people seek health care for non-fatal injuries, of which half are due to violence (1). Over the course of a lifetime, up to 75% of South Africans experience at least one traumatic event, an astounding cumulative burden and drain on the country's human resources (2). In 2000, violence and unintentional injuries combined were the second leading cause of all death and disability adjusted life years lost in the country, after HIV, with just under 60 000 deaths due to injury were reported at a mortality rate of 157.8 per 100 000 population (3). Injury mortality has decreased in the last decade, with approximately 23 200 deaths to interpersonal violence and a further 13 200 traffic crash deaths reported in 2009 (4). This overall decline appears to have started in the 1990s and has been confirmed by the available sentinel indicators of homicide and traffic mortality reported by agencies that include the South African Police Services, Department of Transport and Department of Health. In 1995, the Police Services reported a homicide rate of 66.9 per 100 000 population, which has since significantly declined to 31.1 per 100 000 in 2012 (5,6). The Department of Transport descriptions of traffic mortality have been more mixed, with an increase from 11 201 deaths in 2001 to 15 393 deaths in 2006, to 13 932 in 2011. These national information sources have, however, been plagued by concerns of under-reporting and other inconsistencies, with significant differences highlighted by independent mortality studies (6).

Inequality in the burden of violence

South African society has, therefore, since 1994 continued to carry a substantial, but declining burden of trauma and consequent traumatisation. The disproportionate magnitude of especially violence generates widespread concern across social strata, including political and business decision-makers, media and the general public to more specialised research,

intervention and community safety sectors. The occurrence of violence in South Africa is notable for its pronounced gender, age and socio-economic features, important for the determination of intervention priorities and responses (7). The exposure of girls and women to interpersonal violence is endemic, with a considerable proportion of traumatic events linked to acts of sexual violence, which are grossly under-reported (8).

While the rate of female homicide involving intimate partners is six times the global rate (9), the exposure of men to violence, especially severe and homicidal forms of aggression, is also of considerable concern, with male homicide in South Africa being eight times the global indicator (3). Although the total female homicide rate declined from 24.7 per 100 000 in 1999 to 12.9 per 100 000 in 2009 (10), the current figure remains considerably higher than the estimated global rate of 4.0 per 100 000 female population (11). Age-related vulnerability is reflected in the concentration of violent death of young men and children. The highest rate of homicide is among men aged 15-29 years (184 per 100 000). The homicide rate for boys under 5 years of age is 14 per 100 000 while for girls under 5 the homicide rate is 11.7 per 100 000. These rates are more than twice the corresponding rates for other low- and middle-income countries (12). Furthermore, South Africa's violence continues to be concentrated in its under-resourced communities. For example, the rate of violence perpetrated against young men in Cape Town's townships is more than double the national rate (13). These rates, considered a reflection of the entrenched gang activities in urban centres, have in recent years been further exacerbated by an escalation of community service delivery protests, which have also concentrated in impoverished settings, with an attendant acceleration of collective violence incidents (14).

The socio-economic and psychological dynamics underlying the combined burdens of violence and unintentional injury have received increasing attention as national intervention priorities (3). These often cross-cutting drivers of violence and injury include: persisting and widespread poverty; chronic unemployment and income inequality (exacerbated by an increase in unemployment to 24.9% at the end 2012 from 21.8% at the end of 2008, and a Gini index, a measurement of income inequality, that increased from 0.68 in 2000 to 0.70 in 2008); gender inequality and patriarchal notions of masculinity (illustrated by the ongoing, often gruesome accounts of femicide, rape and sexual assaults); the exposure to abuse in childhood and fractured families (with perturbing rates of child abuse and maltreatment, with nearly 1000 children under 18 murdered in 2010); the declining but still widespread access to firearms (with up to 3 million firearm owners registered in the South African Central Firearm Registry and undetermined unlicensed guns); the high levels of alcohol misuse; and weaknesses in the systems of law enforcement (with highly publicised leadership failures in the national Police Service and certain metropolitan services, and the disastrous intervention at Marikana) (3,5).

Data for violence and injury prevention

The violence and injury prevention sector has seen the strengthening of national policy frameworks and responses, with an emphasis on criminal-justice enforcement responses to priority injury prevention issues, including violence against women and girls, and male youth violence, with some attention to child and youth safety, and traffic safety. South Africa's national and provincial data systems, such as those by the National Injury Mortality Surveillance System, the South African Police Services, Department of Transport, and the support for various surveys, and community and hospital studies have, despite limitations, contributed to an evidence base focussed on the occurrence, distribution and, in some

instances, the impact of violence and injury. These information systems have been supplemented by smaller hospital and area-specific studies that explore the ecology of violence and injury, key risk factors and some protective influences, with emerging indications of the developmental pathways to violence and injury incidents. However, there is still limited data integration across sectors, with considerable information gaps at all levels, such as on priority injury determinants (e.g. perpetrator motivations and experiences, and individual developmental pathways, and the interactions between key determinants), and still inadequate monitoring and evaluation of existing prevention interventions. Although evaluated prevention solutions across the various sectors exist and have worked elsewhere or in pockets of South Africa, these represent only a partial evidence base of effective, implementable safety interventions. There are exceptions, for example, the significant advances in the research and development of services for victims of violence, with various intervention innovations from the NGO sector (3,6).

Addressing determinants of violence and injury

While sector-specific efforts have intensified, there has also been greater recognition, across the injury specific sectors, of the importance of tackling priority upstream and cross-cutting determinants. This has been especially manifest through efforts to control access to alcohol and firearms. For example, alcohol control policy efforts were strengthened at the Second Biennial Substance Abuse Summit which highlighted strategies to enhance the implementation of the existing legislation, including provincial policy alignment, enforcement on sales restrictions, and a reduction of the current legal alcohol limit for vehicle drivers. Only some recommendations have been implemented, e.g. arrests for driving under the influence of alcohol or drugs increased significantly from 56 165 in 2009/2010 to 66 697 in 2010/2011, reflecting more intense enforcement efforts (6). There has also been further consolidation of firearm control measures, especially around the Firearm Control Act of 2004. The number of illegal firearms has been reduced by at least 24% since the Act was implemented, while there is some evidence of the impact of the legislation on female gun-related homicide, with 1147 such cases in 1999 compared to 461 in 2009 (6).

Furthermore, there has been some strengthening of the institutional systems around priority violence and injury prevention issues. In particular, the Department of Women, Children and Persons with Disability was formed in 2009 and in 2012 it established a National Council Against Gender-Based Violence. In addition, the Directors-General of the Human Development Cluster in 2010 mandated the National Department of Health and other cognate departments to develop an Integrated Strategic Framework for the Prevention of Injury and Violence. This Framework targets the risk factors specific to the priority injuries, but also the common cross-cutting determinants, and the promotion of supportive institutional factors (6).

Way forward for research and implementation of interventions

Despite the value and merits of the kind of initiatives already implemented, the injury prevention and safety promotion sectors face competing social and health interests; opposing commercial interests (e.g. in the alcohol, firearm, motor vehicle sectors); persisting departmental and sectoral silos; limitations to capacity in research, intervention implementation (whether prevention or curative) and policy decision-making; the consequences of changes in national, provincial and local leadership and management; the still restrained support for evidence-led solutions; and the increasing but still relatively limited research and intervention funding (3,6,15). The existing research on violence and

injury has and still tends to be fragmented and limited in scale, and located within disciplinary and institutional silos, thereby reducing its influence on policy, financing and intervention decisions. While violence and injury prevention solutions do exist, much more is required to influence the country's developmental trajectory. An integrated policy or strategic framework with intersectoral, evidence-based action plans to guide injury prevention priorities and responses has been developed; there are numerous departmental collaborations; in some settings provincial efforts to promote data system integration; and a recognition of the significance of the contribution of upstream and cross cutting prevention issues and action areas (3,15). The existing initiatives are to be welcomed, and would be supplemented by the implementation of the integrated strategic framework; support to enable the required human resources and management capacities; an intensification of intervention research sensitive to the complexity and multi-factorial nature of violence and unintentional forms of injury; and the systematic roll-out of interventions of proven effectiveness (3,6,15). The biggest challenge in reducing the burden of violence and injury lies in its prevention and the concerted development of the science to inform it.

Note that the views expressed in this article are those of the author and do not necessarily represent the views of PHASA.

References:

1. Peden MM, Butchart A. Trauma and injury. In: Crisp N, Ntuli A. South African Health Review 1999. Durban: Health Systems Trust, 1999: 331–344.
2. Williams SL, Williams DR, Stein DJ, Seedat S, Jackson PB, Moomal H. Multiple traumatic events and psychological distress: The South Africa Stress and Health Study. *Journal of Traumatic Stress* 2007; 20(5): 845–855.
3. Seedat M, Van Niekerk A, Jewkes R, Suffla S, Ratele K. Violence and injuries in South Africa: Prioritising an agenda for prevention. *The Lancet* 2009; 374: 68–79.
4. Debbie Bradshaw, Medical Research Council, Burden of Disease Unit.
5. South African Police Service. An Analysis of the National Crime Statistics 2012/2013. Pretoria: SAPS; 2013.
6. Mayosi B, Lawn J, Van Niekerk A, Bradshaw D, Karim S, Coovadia H. Health in South Africa: Changes and challenges since 2009. *The Lancet* 2012; 380, 1881–1966.
7. Seedat M, Van Niekerk A, Suffla S, Ratele K. Psychology's and the South African violence prevention agenda. *South African Journal of Psychology*. In press.
8. Jewkes R, Abrahams N. The epidemiology of rape and sexual coercion in South Africa: an overview. *Soc Sci Med* 2002; 55: 153–166.
9. Abrahams N, Jewkes R, Martin LJ, Mathews S, Lombard C, Vetten L. Mortality of women from intimate partner violence in South Africa: A national epidemiological study. *Violence and Victims* 2009; 24, 546–556.
10. Abrahams N, Mathews S, Martin LJ, Lombard C, Jewkes R. Intimate Partner Femicide in South Africa in 1999 and 2009. *PLoS Med* 2013; 10(4): e1001412.
11. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, eds. World health report on violence and health. Geneva: World Health Organization, 2002.
12. Mathews S, Abrahams N, Jewkes R, Martin L, Lombard C. The epidemiology of child homicides in South Africa. *Bulletin of the World Health Organization* 2013; 91, 562–568.
13. Groenewald P, Bradshaw D, Daniels J, et al. Cause of death and premature mortality in Cape Town, 2001–2006. Cape Town, South Africa: Medical Research Council, 2008.
14. Lau U, Seedat M. Towards relationality: Interposing the dichotomy between peace and violence. *South African Journal of Psychology* 2013; 43, 482–493.
15. Van Niekerk A. An analysis of research into violence and injury prevention in South Africa. Presentation to the National Department of Health, National Health Research Summit, Johannesburg, 2011.