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Violence and injuries in South Africa: prioritising an agenda for prevention

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Violence and injuries are the second leading cause of death and lost disability-adjusted life years in South Africa. The overall injury death rate of 157·8 per 100 000 population is nearly twice the global average, and the rate of homicide of women by intimate partners is six times the global average. With a focus on homicide, and violence against women and children, we review the magnitude, contexts of occurrence, and patterns of violence, and refer to traffic-related and other unintentional injuries. The social dynamics that support violence are widespread poverty, unemployment, and income inequality; patriarchal notions of masculinity that valorise toughness, risk-taking, and defence of honour; exposure to abuse in childhood and weak parenting; access to firearms; widespread alcohol misuse; and weaknesses in the mechanisms of law enforcement. Although there have been advances in development of services for victims of violence, innovation from non-governmental organisations, and evidence from research, there has been a conspicuous absence of government stewardship and leadership. Successful prevention of violence and injury is contingent on identification by the government of violence as a strategic priority and development of an intersectoral plan based on empirically driven programmes and policies.

Introduction

South Africa, a country not at war, faces an unprecedented burden of morbidity and mortality arising from violence and injury. In 2000, violence and unintentional injuries combined were the second leading cause of all death and disability-adjusted life years (DALYs) lost in the country, after HIV/AIDS,¹ with interpersonal violence the leading risk factor, after unsafe sex, for loss of DALYs.² Injuries from traffic accidents, fires, and falls are the fourth, 19th, and 20th leading causes of death, respectively.¹ South Africa had 59 935 deaths due to injury in 2000, which is an overall death rate of 157·8 per 100 000 population.^{3,4} This rate is higher than the African continental average of 139·5 per 100 000 population, and is nearly twice the global average of 86·9 per 100 000 population.⁴ These high rates are driven by violence. Nearly half South Africa's deaths due to injury are caused by interpersonal violence,³ four and a half times the proportion worldwide.⁵ Data from death certificates and the National Injury Mortality Surveillance System (NIMSS)^{6,7} show further that more than a quarter of such deaths are due to road traffic injuries, with the remainder attributable to self-inflicted injuries, fires, drowning, and falls (figure).³

An estimated 3·5 million people every year seek health care for non-fatal injuries,⁸ of which half are caused by violence.⁹ Furthermore, 55 000 rapes of women and girls are reported to the police every year,¹⁰ which is estimated to be nine times lower than the actual number.¹¹ Exposure to rape, intimate partner violence, and abuse and neglect in childhood are risk factors for the country's most prevalent and serious health problems, including HIV and sexually transmitted infections, substance misuse, and common mental disorders, such as post-traumatic stress disorder, depression, and suicidality (RJ, unpublished data).^{12–16} Injuries and violence undermine social cohesion and the

nation's social and economic development, and are a substantial burden of preventable mortality and physical and emotional disability.¹⁷ Prevention of such violence and injuries is a national public health priority. We describe the size and nature of these issues and the determinants of the high rate of violence, review the responses made since 1994, and point to what is needed to respond effectively.

Key messages

- Violence and injuries are the second leading cause of death and lost disability-adjusted life years in South Africa.
- South Africa's injury death rate is nearly twice the global average.
- The high injury death rate is driven mainly by interpersonal and gender-based violence, followed by traffic injuries, self-inflicted injuries, and other unintentional injuries arising from fires, drowning, and falls.
- Violence is profoundly gendered, with young men (aged 15–29 years) disproportionately engaged in violence both as victims and perpetrators. Half the female victims of homicide are killed by their intimate male partners and the country has an especially high rate of rape of women and girls.
- The social factors driving the problem include poverty and unemployment, patriarchal notions of masculinity, vulnerabilities of families and exposure to violence in childhood, widespread access to firearms, alcohol and drug misuse, and a weak culture of enforcement and failure to uphold safety as a basic right.
- The government should identify reduction in violence and injuries as a key goal and to develop and implement a comprehensive, national intersectoral, evidence-based action plan.

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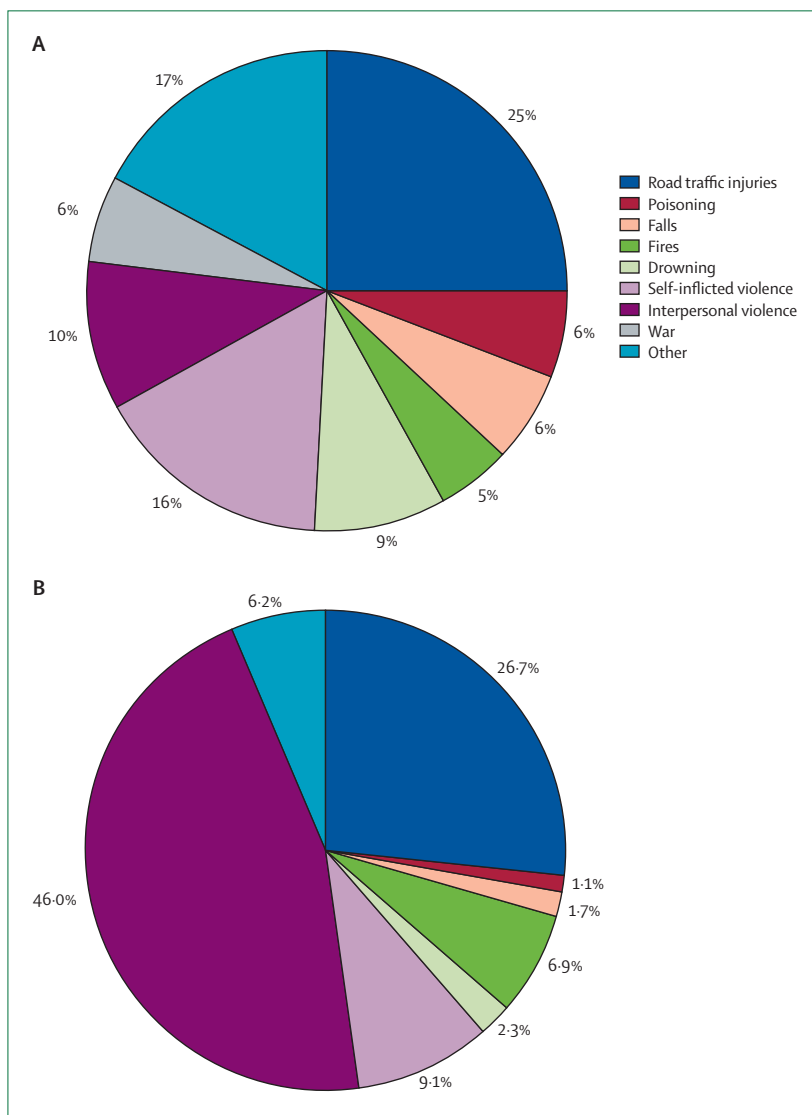


Figure 3: Distribution of injury mortality by cause, 2000
 (A) Worldwide. Data from reference 5. (B) South African. Data from reference 3.

Manifestations of violence

Homicide

In 2007–08, the South African Police Service (SAPS) recorded 18 487 homicides at a rate of 38.6 per 100 000 population—a fall of 42% since 1994, when the rate was 66.9 per 100 000 population (panel 1).¹⁸ SAPS has been criticised for under-reporting of homicide and other violence; for example, in 2000–01, SAPS homicide rate⁶ of 49.8 per 100 000 is by stark contrast with the 64.8 per 100 000 estimated using several data sources, including vital registration and NIMSS information.³ SAPS, however, still provides the most comprehensive and comparable national information on homicide and other violence. SAPS data show an overall fall in the rate of most forms of violent crime; however, despite this decrease, the country's overall

violent death rate is still nearly five times the average worldwide.^{3,20,21}

A dominant feature of violence in South Africa is the disproportionate role of young men as perpetrators and victims. The highest homicide victimisation rates are seen in men aged 15–29 years (184 per 100 000)³ and in some areas, for instance in Cape Town's townships, rates are more than twice this number.²² Deaths of men from homicide outnumber those of women by more than 7:1. The male to female ratio increases further for deaths during the evening: two of every three male violent deaths occur at night. Although most homicide victims are black, the highest rates are reported in men and women who under apartheid were classified as coloured.^{7,19} In South Africa, the terms white, black, coloured (referring to mixed heritage), and Indian or Asian refer to various population groups. These terms were created through apartheid laws, but are still used because they have social significance as a result of the profound effect of apartheid laws on the lives of South Africans.²³ In 2007, NIMSS suggested that nearly 40% of homicides were committed with sharp objects (ie, stabbings) and just over a third resulted from gun shots.²⁰ Up to 57.7% of tested homicide cases had high alcohol concentrations in their blood.^{24,25} Overall, these deaths, which are associated with the use of firearms or sharp objects and fighting between men, occur in the context of entertainment linked to alcohol consumption. Alcohol-related violence frequently occurs in public spaces and peaks over recreational periods, including weekends and festive periods.²⁶

At least half of female victims are killed by their male intimate partners. In 1999, there were an estimated 3797 homicides of women, giving an overall homicide rate (24.7 per 100 000) six times higher than the rate worldwide (4.0 per 100 000).⁷ The highest age-specific mortality rates for murder by an intimate partner are for women aged 14–44 years, whereas those for women killed by others, usually during an incident of other crime, are for age 30 years and older. Many female victims of intimate partners have high blood alcohol concentrations at the time of their deaths, and most of the men who kill them are similarly intoxicated. In one study, nearly two in three women who were murdered in the Western Cape had high blood alcohol at the time of their death, with a median value of 0.11 g/100 mL (which is twice the legal limit for driving).²⁷

In 2000, there were 654 homicides of children younger than 5 years, representing an estimated 0.6% of all child deaths for that year.²⁸ Homicide rates for such children were estimated at 14 per 100 000 for boys and 11.7 per 100 000 for girls, which is more than double the corresponding rates in low-income (6.1) and other middle-income (5.1) countries.³ The sex differentials increase with age, with boys aged 10–14 years the most likely to be killed.²⁸

Intimate partner violence

There are no reliable national data for the prevalence of intimate partner violence, but the best population-based estimates, from 1998, identified a lifetime prevalence of physical violence of 25% and past-year prevalence of 10% in adult women in three provinces.²⁹ Studies undertaken in men, including population-based samples, and subgroups of women suggest that this prevalence might be an underestimate. More than 40% of men disclose having been physically violent to a partner^{30–32} and 40–50% of women have also reported experiencing such violence.^{13,33,34} Intimate partner violence is often sexual and emotional, and many women undergo several forms of violence. 20% of women surveyed in antenatal clinics in Soweto reported sexual violence by an intimate partner and 68% reported psychological abuse, identified by measures such as threats of violence, controlling movement, eviction from home, insults, and humiliation. Intimate partner violence usually occurs within a broader context of relationships marked by controlling behaviours by men and a pervasive sense of fear in women. Furthermore, patriarchal social norms sanction the use of violence by men to discipline and control female partners, and so long as boundaries of severity are not transgressed, violence is viewed as socially acceptable.³⁵

Unlike rates of other violent crimes, rates of rape have hardly fallen. In 2005–06, the rate was 117 per 100 000—a decrease of only 6% since 1996.¹⁰ In a population-based random sample of men, 27.6% reported that they had ever raped,³² a finding that accorded with results in a subgroup of young men, of whom 21% disclosed perpetration.³¹ Most men who rape (73%) do so for the first time before age 20 years, and half rape more than once.³² Black African women and girls have a much higher risk of rape than do those of other racial groups.³⁶ Rapes of babies and toddlers are not uncommon. In Gauteng province in 2003, about one in 35 victims of rapes who were reported to police (2.8%) were aged 1–3 years.³⁶ Many rapes are especially violent: 9–14% of men disclose having taken part in a gang rape (with one or more other perpetrators);^{31,32} weapons are used in 41% of rapes of women;³⁶ and rape is suspected in 16.3% of homicides in women,³⁷ with 1% of rape victims murdered.³⁸ Men are also raped. In one study, 3.4% of young men disclosed having been raped by a man and the results included an increased risk of alcohol misuse and having HIV (RJ, unpublished data).^{13,38}

Child abuse

Violence against children is ubiquitous. Beatings take place daily or every week. Sticks, belts, or other weapons are used and injury is common. Generally, the frequency and severity of beatings are greater for boys than they are for girls. Research has shown that 39% of girls report having undergone some form of sexual violence (eg, unwanted touching, forced sex, or being exploited by much older men) before they were 18 years old (RJ,

Panel 1: Information sources for injury and violence

Several information sources for injury and violence exist. One of these sources is the National Injury Mortality Surveillance System (NIMSS), which is a sentinel mortuary-based system that provides epidemiological data for mortality. In 2007, NIMSS covered 42–49% of all injury mortality, with full coverage in three provinces and the six largest cities. The South African Police Service (SAPS) supplies information about both fatal and non-fatal violence. Additionally, localised community surveys and studies, hospital-based studies, and national burden of injury analyses were used to establish occurrence of non-fatal violence. Sources of information vary in their methods, comprehensiveness, and reliability of some of their statistics, and there are particular difficulties with some of the routine sources. For example, substantial challenges affecting the SAPS system have been reported and result in undercounting. These challenges include loss of public confidence in police responses after reporting some crimes, too few police, and pressure on police to show crime prevention and improved case closure.¹⁹

No data source exists that can be used to study prevalence trends in intimate partner violence. In the absence of detailed systems for non-fatal injury surveillance, rapid low-cost assessments are used for trauma headcount estimates. The designers of this system recommend that the assessment for trauma headcount be administered every 5 years.⁹ The Department of Transport's National Traffic Information System (eNaTIS) records details of all collisions and their circumstances, which is useful for prevention interventions. However, similarly to the police system, eNaTIS is faulted for under-reporting.

unpublished data). Most of this violence is not reported to the police; however, rape dockets from Gauteng province in 2003 show that 40% of victims who report rape to the police are children younger than 18 years, with 15% younger than age 12 years.³⁶ Most (84%) rapes in the young age group are perpetrated by men who are known to the child, whether relatives, neighbours, friends, or acquaintances, by contrast with adult rapes, of which half (48%) are perpetrated by strangers.³⁶

In schools, teachers are often perpetrators³⁹ and such is the culture of sexual entitlement and impunity in schools that they very often work together to facilitate the sexual exploitation of children.^{40,41} Sexual bullying by schoolboys is also very common and contributes to rampant violation of girl pupils' dignity and human rights.³² Children are also exposed to various forms of emotional violence and neglect. The results of one study showed that 35–45% of children had witnessed their mother being beaten, 15% reported that one or both of their parents had been too drunk to care for them, 30% were moved around between households during their childhood, and 35% were orphans, having lost one or both parents (mostly not from HIV).

Panel 2: Unintentional injuries from causes other than transport

13% of deaths are due to unintentional injuries that are not transport-related. Of these deaths, 39% are caused by burns, 16% drowning, and 10% falls. The National Injury Mortality Surveillance System does not show deaths related to mining injury separately; however, the South African Mine Health and Safety Inspectorate independently reported a death rate of 0.48 per 1000 employees in 2005, compared with 0.65 deaths per 1000 employees in 2003 (US estimate by comparison was 0.285 per 1000 miners for 1988–97).^{49,50} Children are vulnerable to unintentional injury, which is the leading cause of death in 10–14 year olds.²⁸ For children, most deaths due to burns and falls occurred at home, whereas drowning took place in the sea, lakes, and rivers, although a substantial percentage of them also happened at home (eg, in swimming pools).²⁰

Burns are the main cause of injury death in children aged 1–4 years, with high rates of hospitalisation also reported; for example, the Cape Town mortality rate (158 per 100 000)⁵¹ echoes the high occurrence of infant burn morbidity and mortality reported elsewhere.⁵² These deaths occur most often in boys, in the home, and in the early hours of the morning. Toddlers and infants are at a substantially higher risk of burn injuries than are older children. Male children have an overall excess risk of burn injuries compared with girls. These burn injuries and deaths arise with poor housing conditions in which the child–adult ratio is high and socioeconomic opportunities are scarce—ie, in informal settlements and other areas with underdeveloped or absent infrastructure. Implicated are storage and inappropriate use of paraffin or kerosene, use of portable or inappropriately secured stoves and homemade bottle lamps, hot water cylinders with very high water temperatures, and informal outdoor heating equipment.⁵³ Homes in such areas are also typically tiny with internal divisions made of combustible material such as curtains or tall boards. These congested living spaces augment children's proximity and exposure to domestic equipment and heat sources, placing them at high risk of burns needing hospital treatment.^{53,54}

Traffic and other injuries

South Africa's road traffic mortality rate of 39.7 per 100 000 is estimated to be 26% higher than the aggregate for the African region and nearly double the global rate.³⁴ Vital registration and NIMSS information suggest that almost 16 000 national road traffic deaths happened in 2000.¹ This figure is distinctly higher than the number of traffic deaths reported by the Department of Transport, which noted 11 201 deaths in 2001.⁴² The Department of Transport figures had increased to 15 393 by 2006, the cost of which was estimated to be R10.96 billion (about US\$1.4 billion).⁴² The NIMSS data accord with this trend, because they also show that since 2003, rates of traffic mortality in Johannesburg, Cape Town, and Pretoria have steadily increased.²⁰

In 2007, 40% of traffic deaths were pedestrians.²⁰ In turn, 17% of pedestrian and passenger deaths were children.^{42,43} In 2007, half (56.7%) of the deaths were in people aged between 20 and 44 years.²⁰ In most instances, deaths peaked over weekends across all road user categories. The 30–39 years age group was most at risk in these categories, apart from motorcyclists, for whom those aged 20–29 years were at greatest risk.^{20,24} Notably, roughly three-quarters of traffic deaths were in men.³ Consumption of alcohol is strongly associated with traffic deaths, with blood alcohol concentrations above the legal limit for driving in nearly half (46.5%) the drivers and over half the pedestrians killed.^{3,24} Excessive speed is reported to play a part in 30–50% of heavy commercial and public passenger vehicle-related accidents alone.⁴⁴ Inadequate road and pedestrian infrastructure, poor street lighting, and weak integration of transportation and land-use planning pose major difficulties for pedestrians.⁴⁵ Thus, alcohol misuse, excessive speeding, inadequate accommodation of pedestrians and other non-motorised road users, and driver fatigue play a large part in traffic deaths and injuries.^{43,45–47}

Between 5514 and 7582 suicide-related deaths and between 110 280 and 151 646 non-fatal suicide acts are estimated to occur every year.⁴⁸ Nearly two-thirds of suicide victims are aged between 20 and 39 years. There are 4.6 male suicides for every female suicide. A high proportion of suicides occur in white and Indian populations. Parasuicide peaks in the second decade of life, with a third of cases in adolescents, and with suicidal behaviour more frequent in women than in men.⁴⁸ In 2007, hanging accounted for 58% of fatal events, poisoning for 17%, and firearms for 15%. Most suicides took place in private homes. Victims of suicide are reported to have high blood alcohol concentrations.²¹ Panel 2 shows additional burdens of unintentional injuries from other sources.

Social dynamics of violence

Poverty and inequality

Poverty and inequality are crucial social dynamics that have contributed to South Africa's burden of violent injury. They are inseparably related to other key drivers such as the dominant patriarchal constructions of masculinity, the intergenerational cycling of violence, alcohol, and drug misuse, and the proliferation of firearms. Coovadia and colleagues in this Series²³ describe how apartheid and colonial policies were used to generate great wealth for a small racial elite while most of the population lived in abject poverty. Redistribution of wealth has nominally been national policy since 1994, but income inequality has grown. The Gini coefficient increased from 0.56 in 1995 to 0.73 in 2005,^{55,56} with 60% of the population earning less than R42 000 (US\$5085) per year and 2.2% of the population earning an income exceeding R360 000 (US\$43 572) per year.⁵⁷

A detailed analysis of the relation between socioeconomic inequalities and violence, based on survey data from 63 countries, shows that income inequality (measured by the Gini coefficient), low economic development, and high levels of gender inequity are strong positive predictors of rates of violence, including homicides and major assaults.⁵⁸ South Africa had the worst income inequality and the highest rate of homicide of the 63 countries studied.⁵⁸ After income inequality, unemployment, in particular male youth unemployment (as in the case of South Africa), was the most consistent correlate of homicides and major assaults.^{59,60} Broadly, over a third of South Africa's population is unemployed.⁶¹ Poverty presents barriers to access of traditional sources of wellbeing, status, and respect that can in turn result in feelings of shame, humiliation, and loss of self-respect. Where there is great inequality there is likely to be great anger and frustration, and so violence might be used to gain the resources, power, and influence that others have, or are perceived to have.⁵⁹ This situation might be more acute in urban areas, typified by poor community cohesion, dense populations, rapid urbanisation, and inadequate housing infrastructure.⁶²

Masculinity

Patterns of violence show that almost all perpetrators are men. The dominant ideals of masculinity, across racial groups, are predicated on a striking gender hierarchy, with demonstrations of toughness, bravery, and defence of honour, which readily translate into risk-taking behaviours and the high status gained by fighting rather than to resolve differences peacefully.^{23,63,64} Men tend to be highly competitive about power, respect, and status. With high youth unemployment and common carrying of weapons and misuse of substances by young men, fights in defence of honour and for status often occur, resulting in serious injuries and deaths. Some of the road deaths, especially those caused by speeding and drunk driving, can also be viewed as resulting from enactment of toughness and risk-taking.^{63,65,66} The dominant notions of masculinity are predicated on the control of women, and infused with ideas of male sexual entitlement.^{35,67} Physical violence is used to manufacture gender hierarchy (ie, teach women their place) and to enforce this hierarchy through punishment of transgression. Rape is often used as punishment for infidelity, attempts to end a relationship, refusal of sexual advances, or behaviour that is deemed to show insufficient respect for men.^{11,31,68} In some rapes of infants, the motive is to punish the child's mother. Likewise, the raping and killing of homosexual women, which is becoming increasingly common, is often enacted as corrective action.

Childhood and cycling of violence

The widespread abuse of children shows their very low status and power in South African society's age—and gender—hierarchies. The most potent source of power

and protection for children is their parents. However, because of orphaning, poverty, the irregular structure of the country's families, and the social norms around extramarital pregnancy and childrearing,²³ many children are not raised by their parents. This situation leaves children vulnerable to abuse and neglect. Exposure to trauma and violence during childhood can give rise to both revictimisation and intergenerational cycling of violence. Revictimisation is a recognised occurrence in rape; girls exposed to sexual abuse as young children are at increased risk of being raped again in childhood, and of experiencing intimate partner violence as adults.^{33,69} Boys who have been sexually abused in childhood are at increased risk of later becoming sexual abusers;⁷⁰ and whereas women who witness violence directed against their mothers might be placed at risk for violent victimisation, boys are at risk of becoming perpetrators.^{11,71} Both victimisation and perpetration are part of a broader process of socialisation of children into adults who display dysfunctional patterns of behaviour and distorted expectations of power. The results of one study suggested that 27% of intimate partner violence could have been prevented if boys had not witnessed violence against their mothers.⁷²

The experience of trauma and violence in childhood affects brain development and reduces the ability of children to subsequently form strong emotional relationships and to empathise. Exposure to violence can also enhance the likelihood of development of psychopathological disorders, including those that might be manifested initially in teenage delinquent peer associations such as gangs, which often provide the context for early antisocial behaviour and acts of violence.³¹ These pathways do not seem to be restricted to violence against women; boys who have seen abuse of their mother are more likely to become engaged in physical conflict in the community or at their place of work, and to possess an illegal gun.⁷²

Alcohol and drugs

South Africa has one of the highest alcohol consumptions in the world per head for all individuals who drink alcohol.⁷³ Alcohol misuse and, in some parts of the country, drug misuse are major factors underlying homicides, intimate partner violence, rape, abuse of children, road deaths, and other unintentional injuries. Up to two-thirds of patients who presented with injuries to trauma units in Cape Town, Port Elizabeth, and Durban from 1999 to 2001, registered a blood alcohol concentration greater than 0.05 g/100 mL.²⁵ Between 1999 and 2000, in Cape Town, Durban, and Johannesburg, at least 25% of people arrested for weapon-related offences were reported to be drunk.⁷⁴ Thus, victims are frequently drunk, and those who are drunk often become violent or cause death on the roads. In turn, exposure to violence can result in post-traumatic stress disorder, which increases the risk of substance misuse.^{16,27} For

Panel 3: Responding to rape and violence against women**Intimate partner violence**

The 1998 Domestic Violence Act defined domestic violence as psychological, physical, and sexual violence, created an accessible process for granting of protection orders, and made provision for weapon confiscation from men. The act was not promulgated for a year after it was passed, and during this time a concerted non-governmental organisation (NGO) campaign was mounted, led by the Soul City Institute and linked to the television and radio drama series Soul City that focused on domestic violence.

This campaign led to the establishment of the South African Gender-based Violence and Health Initiative, a national collaboration that worked over several years with the Department of Health to strengthen policy and services for rape through research. These organisations also strengthened the NGO sector, including the National Network on Violence Against Women, which contributed to building and support of related NGO sector services.

Rape

Pre-1994: Services for rape victims provided by district surgeons, who were mostly private family doctors with little or no special training. The services were mostly of poor quality and the doctors, like the police and magistrates, unsympathetic and uncaring.⁸⁵

1999: The Minister of Health abolished district surgeons and declared that all doctors could undertake examinations of rape victims. There was no planning, so doctors were untrained and inexperienced.⁸⁶

2000: Rape became a sensitive political issue in the wake of prominence given to it by the media and NGOs and criticism of a presidential decision to restrict the publication of crime statistics. Yet the government did start and promote action, and established an Interdepartmental Management Team to work on rape. The legal form (J88) on which findings of a medical examination are recorded was improved and a sexual assault evidence collection kit introduced. Testing for DNA was started. Ministerial support was given for the use of forensic nurses and they were allowed to undertake examinations and be expert witnesses in court.

2005: 3 years of consultation culminated in the National Sexual Assault Policy and Clinical Management Guidelines. The model of care was changed to a service provided by district hospitals or community health centres (or higher), by appropriately trained staff.

2007: New legislation for rape, which extended the definition to include men and provided a very wide range of coercive circumstances. The legislation included the need for training, and for this training to include understanding of the social context of rape.

2008: A national curriculum to standardise training of providers in post-rape care was launched. This curriculum established a norm for a 2-week course, which emphasises meeting the mental and physical health needs of survivors, as well as training in evidence collection.⁸⁷

women in violent relationships, misuse of substances reduces ability to cope and perception of their ability to leave the relationship.

Firearms

South Africa's rate of firearm deaths is among the highest in the world, along with those of countries such as the USA, Mexico, Colombia, Estonia, and Brazil.⁷⁵⁻⁷⁸ A third of all homicides of women⁷ and 39% of those of men are committed with guns.⁷⁶ South Africa's violent history²³ has resulted in an entrenched gun culture. Widespread access to unlicensed or stolen guns, the increasing acquisition of handguns by citizens for self-defence

against escalating crime and violence, and the loss of about 3700 SAPS and Metropolitan Police firearms per year has exacerbated the problem.⁷⁹⁻⁸¹ Legal guns kept at home are often used to threaten and intimidate women. Overall, 19% of men who kill their partners commit suicide within a week of the murder, usually with a gun.⁸¹ Examination of the population-attributable fractions shows that an estimated 91.5% of deaths of the victims of these legal gun owners could have been prevented if there had been no gun ownership.⁸²

Culture of enforcement and safety

The historical focus of policing in black areas was on the enforcement of apartheid laws and apprehension of those engaged in crime against white people. As a result there was very little common-law policing in townships. In the context of grinding poverty and unemployment, crime flourished. Some forms of crime against property were justified as redistribution of wealth, although often victims were not rich people, but neighbours, and in general people resisted abiding by laws. Consequently, lines between criminal and community were blurred, and an ambiguity about enforcement emerged, with much doubt about whether communities wanted enforcement.⁸³ This situation has been linked to the underdevelopment of parts of the criminal justice system needed for successful apprehension and prosecution, and partly explains the failure of the state to combat violent crime.¹⁹ These difficulties, manifested in and compounded by widespread corruption within the police force, often work to undermine efforts by sectors of the community that do want to reduce crime and violence.

On the roads, a similar ambiguity is seen about enforcement of safety measures, especially when so doing would encroach on the terrain of the powerful bus and taxi industry. Unroadworthy vehicles remain on roads, and drivers and owners are often not penalised. The failure to effectively regulate the long-distance bus industry and to prioritise safety over commercial considerations has meant that overnight long-distance travel is the norm, despite the high death toll caused by driver fatigue, which is aggravated by overnight driving.

Similarly, there is little regulation of the manufacture and sale of products most often used by poor people for cooking and heating. Promotion of affordable products and expansion of the economy have been placed above safety. The state has failed to remove unsafe cooking devices such as stoves and to reduce the use of fossil fuels for cooking and heating. In essence, despite the injury burden South Africa has not managed to prioritise and to build a culture of safety as a human right. Such a culture, which positions safety as an inalienable right alongside other rights, can be built through legislation, policies, and structures that render the prevention of injuries mandatory and institutionalise safety practices.

A culture of safety is predicated on recognition of the right to bodily integrity and the right to access socioeconomic justice and optimum material conditions necessary for safety.⁸⁴

Responses to violence and injury

Despite the very high rates of injury and violence, responses from state and civil society have been highly variable. Among the most conspicuous is mobilisation to address violence against women, for which there has been at least a decade of concerted action by civil society organisations, including non-governmental organisations (NGOs) and researchers, and sustained collaborative work with several statutory sectors—notably, the health sector, justice system, and police, with stewardship in government at a high level. These efforts, which have focused mainly on services for victims and criminal justice measures, rather than on primary prevention, have resulted in substantial achievements (panel 3). Yet, although there are now good policies and guidelines related to health and criminal justice sector responses, and areas of excellent practice, overall implementation remains a challenge. Some agendas remain incomplete—for instance, the national roll out, monitoring, and assessment of standardised training for rape service providers need further impetus from the national Department of Health. In other areas advances are under threat; for example, the sexual offences courts have greatly increased the chance of successful prosecution in rape cases, but are under threat of closure because they do not have the support of the judiciary and are seen as undermining that body's independence.

Primary prevention has been visible in efforts of NGOs to change attitudes towards gender-based violence and to shape the tradition of the dominance of men in ways that are more gender equitable.⁸⁸ Actions have included campaigns in the media to raise awareness and shift gender norms, community-based workshops with men, and efforts to engage traditional leaders on issues of gender-based violence and masculinity. Sustained reduction in women's experience of victimisation by partners and intervention with men to reduce their use of violence can be achieved (panel 4).^{89,90} Despite such local innovation around prevention and a growing evidence base, and policy initiatives from government to promote greater gender equity, the South African Government has not engaged concertedly in primary prevention. A predominant focus on development of service responses remains. In 2007, the Deputy-President, Phumzile Mlambo-Ngcuka, launched the 365 Day National Action Plan to end violence against women.⁹² This plan was an intersectoral prevention scheme intended to be a blueprint for prevention across government and civil society, but there has been very little evidence of any implementation. Thus, although the value of prevention is nominally recognised, there is

Panel 4: Primary prevention of violence against women

The IMAGE study⁸⁹ assessed a complex intervention that combined small loans given through a microfinance revolving credit scheme—in which loans had to be repaid fortnightly and another loan could be taken out on repayment—with a participatory learning and action curriculum for gender and violence for women in loan meetings, which took place every 2 weeks. The intervention had ten sessions, during about 6 months. There was then a process of identification of natural leaders from among the women, further training of them in violence against their sex and community action, and support of community activism during 6–9 months. This approach was assessed in rural Limpopo province. 2 years after the start of the intervention, experience of physical or sexual intimate partner violence in the past 12 months was reduced by 55% in women in the intervention group. This project is now being rolled out to 15 000 women in Limpopo province.

Stepping Stones⁹⁰ is a participatory HIV prevention programme that aims to improve sexual health by building stronger, more gender-equitable relationships and through this process seeks to reduce gender-based violence. It was originally developed for use in Uganda in 1995 and has been used in more than 40 countries.⁹¹ Stepping Stones uses participatory learning approaches consisting of critical reflection, role play, and drama, draws the everyday reality of participants' lives into the sessions, and is delivered to single-sex groups. The programme runs for about 50 h, provided for 6–8 weeks, with sessions on: reflections of how we act and what shapes it; sex and love; contraception; unwanted pregnancy; sexually transmitted diseases and HIV; gender-based violence; motivations for sexual behaviour; and communication skills. The effect of Stepping Stones was assessed in the rural Eastern Cape in a trial of 2776 men and women aged 15–26 years, who were followed up for 2 years after the intervention. The programme significantly improved several reported risk behaviours in men, with 38% fewer men in the intervention group than in the control group reporting perpetration of intimate partner violence at 2 years of follow-up ($p=0.05$), and reduced transactional sex (mainly motivated by material gain) and problem drinking at 12 months. Fewer men reported to have raped or attempted to rape at 12 months than did men who did not participate in the programme.⁹⁰

little evidence of resource allocation, no coordinated roll out of interventions of proven effectiveness, and no evidence of best practice-based processes to develop cross-sectoral approaches.

Other responses to the burden of injuries and violence have been much less concerted and more fragmented. There have been some successes in relation to gun control (panel 5) through very effective NGO-led alliances and lobbying of government, but rates of gun

Panel 5: Efforts to reduce firearms

Efforts to reduce gun violence have been spearheaded by Gun Free South Africa (GFSA), a non-governmental organisation established in 1995. GFSA has had three campaigns and has built alliances with civil society organisations and engaged the state to influence policy, change public attitudes to guns, and effectively manage and control the factors that fuelled the supply and demand for firearms. In the first campaign (gun hand-in) members of the public handed in 900 firearms and explosives and over 7000 rounds of ammunition to the police in 24 h.⁵¹ After this campaign the Minister of Safety and Security declared a 24-h amnesty and police staffed hand-in points. The second campaign encouraged communities to become gun-free zones. For example, in Mapela, a rural village in Limpopo province, the public carrying and misuse of guns are restricted through consensus-driven mechanisms. Last, the Firearms Control Act was passed in 2001 after lobbying from GFSA and its partners, in the face of massive opposition from the firearms industry and gun owners.

ownership and gun-related crime remain very high. Of particular concern is that gun control seems to have dropped from the political agenda—it was not mentioned in the 365 Day Action Plan and there are no policy initiatives directed at either further restriction of firearm ownership, or enforcement of existing laws, including those regulating care of firearms carried by police. The government has developed policy to enhance safety for road users, but apart from sporadic and festive season-related campaigns sparse evidence of implementation exists. In 2008, a pilot of a demerit points system on driver licences was introduced in Pretoria and it is intended to be extended nationally in 2009. There has been remarkably little evidence of attempts to introduce sustainable, upstream, road safety interventions, such as those that restructure the road and adjacent environment, rather than targeting road-user behaviour alone.⁹³

The health and social costs of alcohol misuse are estimated to be R9 billion (roughly US\$1.2 billion) per year, which is roughly twice the amount received in excise duties on alcohol.⁹⁴ There have been some restrictions on alcohol advertising and sponsorship, modest efforts to apprehend drunk drivers, and increased taxation on alcohol products, but beyond these efforts the government has shown little concrete evidence of reduction of national alcohol consumption, which is not yet a prominent policy goal. This lack of activity is perhaps because drinking alcohol remains a primary form of recreation for many, and its accessibility is driven by a massive alcohol industry. The government's own legislation on control of alcohol outlets is conspicuously flouted by the industry and there is little evidence of willingness from the government to enforce existing laws.

To develop a coordinated and coherent national strategy focused on implementation, legislation, and regulation, a multisectoral group was established in South Africa in 2000 to manage the execution of the National Drug Master Plan,^{95,96} but funds have not been made available for implementation. Interventions to address the burden of alcohol misuse have generally failed to combine individual-based and population-based approaches directed at reduction of consumption per head and aimed at high-risk groups,⁹⁷ and many programmes do not subscribe to minimum norms and standards for prevention.⁹⁸ The availability of treatment and rehabilitation services for substance misuse is inconsistent with the increase in demand for these services. Services remain poorly distributed geographically, disjointed between the health and social welfare sectors, and generally offer treatment programmes that are not evidence-based, with obvious gaps in the provision of after-care services.⁹⁶ However, recent initiatives have focused on development of norms and standards for inpatient treatment, and protocols for management of detoxification at secondary hospitals.⁹⁷

Infrastructural interventions have indirectly addressed violence and injuries. Several of these interventions have focused on the home environment, with some including improved housing provision, subsidised electrification, and promotion of safe cooking appliances. The more than 2 million houses allocated to poor people since 1994 have, however, been poorly built and are tiny. Nonetheless, recent policy prioritises development of minimum standards for entry level housing, the increase of state housing expenditure to 5%, promotion of rental housing, and the upgrade of present settlements (rather than resettlement projects). Additionally, there is a policy to implement strategies and projects to build neighbourhood cohesion.^{99,100} The government has also committed to universal energy access by 2014, with strategies for the provision of accessible, affordable, and reliable energy, especially to poor people. It has also published two standards for paraffin appliances, which are a major contributor to burn injuries.⁵²

Overall, although there are many NGOs providing secondary prevention services, the government has not acted in concert with its recognition of violence and injury as public health challenges. There is no visible, coordinated, and inclusive intersectoral government-facilitated management team to develop policy and stimulate responses. The Department of Health has delegated responsibility for violence and injury prevention to a very low level in the hierarchy, with the result that there is an absence of leadership, engagement with service and research-based agencies, and empirically-based planning, implementation, or assessment frameworks, sometimes leading to the inappropriate use of scarce resources.

The way forward

Over the past 15 years there has been much success in strengthening responses once violence has occurred, but the biggest challenge in reduction of the burden of violence and injury lies in prevention. There has been a conspicuous absence of government-promoted stewardship and leadership, which is essential for the development of an effective national response. The government has failed to develop an effective way of working with civil society, and civil society has not developed mechanisms to provide effective oversight of government. Successful violence and injury prevention is contingent on identification by the government of these issues as strategic priorities; a high-level strategic and urgent review of the magnitude, causes, and results of violence and injuries; review of evidence of effectiveness and best practice; and development and implementation of a prevention and containment plan that is intersectoral, strategic, and evidence-based. The plan should be driven by a programme of action that is supported by the requisite political will, adequate infrastructural arrangements, capacities, and allocation of resources that appropriately relate to the massive economic effect of violence and injuries.

Within the programme of action for violence and injury prevention, interventions should target the identified contributory factors of poverty, youth unemployment, gender and other social inequity, intergenerational cycling of violence, excessive alcohol consumption, and uncontrolled access to firearms. The poverty and unemployment reduction agenda has to include strengthening of the education system and reduction of drop out during adolescence, so that more young people complete school with relevant skills; encouragement of the development of labour-intensive and less skills-intensive methods of working; and encouragement of self-employment and small business development—eg, through microcredit schemes targeted at women. Initiatives to change issues related to notions of masculinity to build foundations of gender equity should include, for example, government support for programmes to change social norms; development and implementation of life orientation lessons in schools that address gender and violence issues; engagement with the new National Youth Service and Pioneer Programme in care work and activities that aim to change gender norms; government support for roll out of effective interventions such as IMAGE⁸⁹ and Stepping Stones⁹⁰ in communities; and work with traditional leaders on gender issues.

Interventions to strengthen families and parenting should consist of promotion of men's engagement and caring in families through introduction of meaningful paid paternity leave, strengthening of access to maintenance, role modelling of responsible and engaged fatherhood, and parenting as part of the school curriculum for life orientation. More resources for social services would equip them to undertake their child protection functions, such as identification and active

support of vulnerable children and families, and auxiliary social workers and community health workers should partake in child protection activities. Psychological services for support and counselling of victims of violence need to be strengthened, with particular attention to provision of a national service that is accessible for abused children.

New initiatives to reduce alcohol consumption could be community engagement in action against unlicensed liquor outlets, those flouting regulations, and those operating near schools. The government should challenge the alcohol industry and hold it accountable for responsible and legal distribution of its products and social harms caused by alcohol misuse, and develop a concerted national programme to shift social norms of alcohol consumption. Apprehension of drunk drivers should be strengthened. New initiatives in relation to gun control would be, in particular, the enforcement of laws related to weapons' handling by the police and military, with individuals to be held accountable for the loss of firearms. Access to gun licences should be further restricted, and measures that allow for confiscation of guns from men who have been violent have to be more rigorously enforced. Furthermore, new initiatives should be tested, such as schemes to buy back firearms.

Training of police, prosecutors, and judges in legislation related to sexual offences, protection of children, and domestic violence should be enhanced. Monitoring and assessment of process and outcomes should be improved in policing to ensure that new developments in the organisation of the police services, such as those that led to disbandment of the special units on child and family violence, show benefit, rather than detriment, to the protection of women and children and outcomes of cases, and that the new emphasis on performance indicators does not lead to methods of working that are to the detriment of victims of crime. Investigation and monitoring of cases by the police has to be strengthened to ensure that there is no needless loss from the justice system due to poor basic police work. An amendment of law is necessary to ensure the retention of specialist courts and the operation of these courts is dependent on the efficiency of work within the Department of Justice. Continued efforts to strengthen responses of the health and social service sectors to victims of violence are needed. Additional priority recommendations are the development of safe educational, work, and recreational spaces (eg, through promotion of school, work, and home safety standards); infrastructural access to vulnerable road users (eg, through development of pedestrian pathways, especially in dense traffic environments); and affordable and safer technology (eg, subsidised hot water cylinders and paraffin stoves), especially for low-income homes.^{45,53,101}

A national strategy to address violence and injuries should be based on evidence of effectiveness and good

practice. Therefore, we call for urgent investment in research to deepen our understanding of the magnitude and nature of the problem, development of assessment and monitoring methods to support empirically-based violence and injury prevention interventions, and expansion of systems to monitor effects, including the NIMSS.

Contributors

All authors participated in the search of published work and writing of the report and approved the final version.

Conflicts of interest

We declare that we have no conflicts of interest.

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