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A Journal of Injury and Violence Prevention

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Perspectives

Violent protests and gendered identities

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ABSTRACT

In post-apartheid South Africa there has been a proliferation of public protests occurring in various contexts. While public protests are common globally, in South Africa they appear to be uniquely characterised by extreme forms of violence. The current analysis of public protests suggests that the root causes of public protests are socio-economic and political. However, the role of gendered identities is missing in analyses of violence in public protests. In this perspective, we argue that violent public protests in post-apartheid South Africa are linked to gendered identities in their intersection with race, socio-economic status and social class. First, we contend that public protest violence is due to the gendered division of public and private spaces. In line with this, we claim that, public protests as public phenomena become masculinised such that women are represented as virtually absent or with insignificant contribution to public protests while men tend to be more visible, take the lead, and draw from hypermasculine practices in their approach. Second, we argue that public protests become violent due to the ongoing marginalisation of unemployed and working-class men, which tend to be race based in South Africa. Last, we argue that violence in public protests is due to protection of privilege status by hegemonic groups which invokes radical attempts for inclusion by protesters. This perspective concludes that there needs to be a shift, in both the media and the scholarship on men and masculinities, in how violence of men in public protest is viewed. Much of the work on violence in South Africa is often attributed to problematic aspects of masculinity, yet what is needed is a political project that seeks to dismantle the structure that produces inequalities and, in its resistance to change, provokes frustrations that escalate to violence among protesters.

Keywords: public protests, violence, gender identities, structure, South Africa

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CONTEXTUALISING PUBLIC PROTESTS

Public protests are a global phenomenon occurring in both developed and developing countries, albeit in varying proportions and intensities (Shah, 2011). In a number of commentaries and or opinion pieces, South Africa is dubbed the protest capital of the world (e.g. Rodrigues, 2010). Of concern in post-apartheid South Africa is that protests have become markedly characterised by use of extreme violence by protesters, as evidenced by the violence that erupted during the protest action in Sebokeng in August 2007 (Hough, 2008), and more recently, burning of schools and state property during community protests over municipal boundary demarcation in Vuwani (Kanyane et al., 2016). As was evident in the Marikana mineworkers’ strike in 2012, intimidation, forced participation, display of dangerous weapons and killings are a common feature in public protests (Sorensen, 2012).

The reasons people engage in public protests vary by country and in different localities within countries. For example, in Argentina, between July and August 2001, approximately 100 000 people protested International Monetary Fund-related measures that they felt would lead to large pay cuts; in Papua New Guinea a weeklong protest in June 2001 was held against International Monetary Fund/World Bank austerity measures (Shah, 2011). In post-apartheid South Africa, disputes have commonly revolved around wages at workplaces (Hartford, 2012), service delivery in communities (Hough, 2008), and free, decolonised quality education at institutions of higher learning (Badat, 2016). In summary, available evidence suggests that the root causes of public protests tend to be socio-economic and political (see Shah, 2011).

With some exceptions (Langa & Kiguwa, 2013), the role of gendered identities is sorely missing in analyses of violence in public protests. In this perspective, we attempt to articulate how gendered identities (i.e. masculinities and femininities) are linked to violent public protests in post-apartheid South Africa.

PUBLIC/PRIVATE BINARY AND THE GENDER BINARY

Public protests may be violent because they are gendered as they often appear male dominated with regard to participation and leadership. For example, in media representations (Whittles, 2016), women are either almost absent, or marginally represented in mass protests. Even when women visibly participate in public protests, they tend to be represented as less vocal and radical in their demonstrations and appear to attract much less attention from the media than men (Naicker, 2015). Yet, while few, some studies (Naicker, 2015) have shown that women play significant roles in protest actions, but their contributions are frequently overshadowed by that of men, much like in other social and political struggles where women’s contributions tend to be relegated to the margins of history. This rhetoric of
Perspectives

Public protests may have created an impression of protests being something that only men do and therefore a masculine practice. At the same time, this misrepresentation of public protests as a masculine phenomenon probably stems from what Marxist-feminists identified as gendering of space, with public spaces and activities reserved for men (Connell, 1987; Walby, 1990).

Given that much of the public protest agenda involves engagement with stakeholders and/or state leaders in public institutions, it is not surprising then that men tend to or are made to be more visible and take the lead. Furthermore, considering that dominant masculinities are often framed as the opposite of femininity (Connell, 1987), it is unsurprising that we do not often see peaceful demonstrations and peaceful conflict resolution during public protests, which may be deemed feminine approaches. What we do often see during public protests are demonstrations of hypermasculinity—a kind of masculinity that values aggression, destruction, bravery, dominance, and devalues femininity. It has been argued that hypermasculinity accentuates power and force, is commonly enacted in masculinised contexts (i.e. where women are absent or invisibilised) (Herek, 1986), and commonly develops among socially marginalised men in low-income settings for whom other means of attaining power are not easily available (Gibbs, Jewkes, & Sikweyiya, 2017).

This public/private binary exposes the fundamental lack of progress with gender transformation in South Africa. This is particularly troubling when evident (e.g. in student protests) at institutions of higher learning, contexts where more progressive gender relations are expected as an outcome of exposure to the transformational agenda, intellectual augmentation and accelerated development of student’s cognitive abilities (Garrison, 2001).

VIOLENT PROTESTS AND MASCULINITIES

Public protests may be violent due to the intersectionality (Crenshaw, 1991) of gendered identities of the men who tend to participate in them. Crenshaw (1991) notes that the intersectionality theory is particularly useful in highlighting and addressing differences within what are deemed collective identities. In many of the public protests, those involved tend to be black, unemployed, poor and working class men (Langa & Kiguwa, 2013).

Class and race are significant factors in the hierarchical gender arrangement, with working class, poor and unemployed black men often relegated to the lower end of the hierarchy (Connell, 1987, 1995). In South Africa the apartheid regime created a race-based class system that placed the majority of black men at the lower end of the class hierarchy (Ratele, 2008).

Protesters often occupy marginal masculinities as they often lack access to economic resources; and as such they are hindered from accessing the “traditional masculinity” that
is much valourised in many South African contexts (Gibbs, Sikweyiya, & Jewkes, 2014) and is characterised by establishing a family and being the main breadwinner, amongst other things (Mavungu, 2013). The societal expectation for men to meet the demands of being a provider has implications for the amount of pressure they may feel towards being unable to fulfil this provider role compared to women. In post-apartheid South Africa, black poor men’s frustrations with their inability to provide for their families, dejection about the diminishing prospects of getting jobs, and being increasingly pushed to the margins of the society may be causing them to lash out violently to those around them (Ratele, 2013) and to the state in the context of public protests.

**STRUCTURE AND MASCULINITIES**

Violence in public protests may be due to the power-based structural arrangement of society. And we argue that public protests are thus the result of conscientisation of the marginalised group (Freire, 1970), by the intellectuals and or radical activists within the group, about issues of power in connection with repression and privilege. As Freire (1973) notes, such conscientisation creates awareness among the marginalised group that ‘they will not gain the liberation by chance but through the praxis of their quest for it, through the recognition of the necessity to fight for it’ (p. 45). In line with this, we argue that poor and marginalised black men in South Africa engage in protests having thought critically about their circumstances, reasoning that their situation is unnatural, their oppression and marginalization unjust, and thereby start to devise strategies for altering their situation (Freire, 1973). Inclusion in hegemonies, including that of class (Gramsci, 1971) and gender (Connell & Messerschmidt, 2005), is appealing as occupying a hegemonic position in society represents power, status and privilege (Stern & Buikema, 2013). Hegemonies are also difficult to dismantle because they (are made to) appear natural (Cerulo, 1997). Understandably then, black poor men who are marginalised by these hegemonies, as argued above, are likely to seek to be included in the hegemonic groups, the holders of power.

However, hegemonies by their virtue seek to exclude certain groups from attaining and sharing power (Gramsci, 1971) and, consequently, very little change is effected by protesters since their struggle against marginalisation seeks inclusion in the hegemonies that marginalise them. Rather than relent to the demands of the marginalised and protesting group, agents of hegemony resist change and engage in violence to maintain their power. This is evident in the brutal force the state security is increasingly using to subdue protesters (Farlam, Hemraj, & Tokota, 2015; Shah, 2011), a tactic likened to the apartheid government’s response to mass protests for political liberation of black people in South Africa. Such a response, often identified as a strategy to protect the privilege of an
elite few in society by protesters, may persuade them to engage in more radical strategies, including violence, to further lobby for their inclusion into ruling classes and masculinities.

CONCLUSION

While the value of gender transformative interventions that seek to change men’s violent behaviour and build gender equity cannot be negated as a possible strategy to curb violent protests in South Africa, we argue that it is regrettable that much of the work on violence in South Africa attributes violence to problematic aspects of masculinity. Such an approach puts the emphasis and burden for transformation on poor, unemployed and working class black men whom are themselves marginalised by both the class and gender orders. We argue that what is needed is a political project, spearheaded by civil society groups working in tandem with law-makers and political parties, that seeks to dismantle the structure that produces inequalities. As the structure is resistant to change, it is the very thing that provokes frustrations that escalate to violence among protesters.

REFERENCES


Harnessing the power of South-South partnerships to build capacity for the prevention of sexual and intimate partner violence

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ABSTRACT

Research on primary prevention of violence against women (VAW) and children (VAC) is a rapidly growing priority. The burgeoning evidence base remains small, and is particularly limited in low and middle income settings. More research from low and middle income countries on effectiveness and reliability of prevention efforts and how to sustain them at scale is needed. Limited capacity in the global South for research on VAW and VAC prevention and intervention development and opportunities for South-South partnerships and learning is a potential barrier to the further development of the field. This paper describes a transnational South-South partnership capacity building project in East Africa for primary prevention research and intervention development. It provides important insights and lessons learned for others considering undertaking similar types of projects.

Keywords: Violence against women; violence against children; violence prevention; capacity building; transnational.

INTRODUCTION

Evidence on what works to prevent violence against women (VAW) and children (VAC) is increasing (Ellsberg et al., 2015; Fulu & Heise, 2015; Jama Shai & Sikweyiya, 2015). However, the evidence base remains especially limited in low and middle income countries (LMICs) where the burden is the highest and skewed towards response rather than prevention efforts (Ellsberg et al., 2015; Mikton, 2010). The launch of the Sustainable Development Goals with Goals 5.2 and 16.2 focusing on eliminating all forms of violence against women and girls and ending abuse against children provides a political imperative for this work (UN, 2015).
Some of the most innovative research and intervention trials on the prevention of VAC and VAW has emerged from the global South (Ellsberg et al., 2015). Ground breaking interventions developed and tested in East and Southern Africa include microfinance and gender (Kim et al., 2007); mother-child / parenting (Cooper et al., 2009); community-based (Abramsky et al., 2014; Jewkes et al., 2008; Wagman et al., 2015); multi-component (Jewkes et al., 2014) and school based (Devries et al., 2015; Mathews C. et al., 2015) programmes.

Despite such innovative research being undertaken in the global South, limited capacity for evaluation research, intervention development, and implementation science on VAW and VAC prevention in LMICs is a barrier to effectively and sustainably preventing this violence (Catalano et al., 2012; Dartnall & Gevers, 2015; Jama Shai & Sikweyiya, 2015; Lansang & Dennis, 2004; Whitworth et al., 2008). Transnational capacity building and dialogue programmes on IPV prevention and transforming men and masculinities show promise in building capacity and sharing expertise through North-South initiatives (Airhihenbuwa et al., 2011; Shefer, Hearn, & Ratele, 2015), but can be fraught with inequities, power imbalances and driven by international rather than local research priorities (Campbell & Mannell, 2016; Chu, Jayaraman, Kyamanywa, & Ntakiyiruta, 2014).

Harnessing the growing research expertise and skills from the global South and the power of partnerships through South-South transnational capacity building programmes for violence prevention aids researchers from LMICs to lead, fund, develop, test and publish locally relevant VAW and VAC prevention programmes. These partnerships are important and valuable because they promote ownership of the process, findings, and solutions; as well as strengthening and retaining expertise and passion for this work in the region. In this way, the work can truly take root and becomes part of a locally driven and sustained movement.

This paper describes the experiences of a South-South collaboration for building capacity in East Africa on VAW and VAC prevention research and intervention adaptation, development and testing. The overall aim of this collaboration was to build evidence for VAW primary prevention in LMICs, with a particular focus on parenting or school strengthening programmes, through South-South funding and technical assistance.

**SVRI PRIMARY PREVENTION PROJECT**

From 2013 to 2015, the SVRI provided intensive mentoring and technical advice to four multi-sectoral teams based in Kenya, Uganda and Tanzania to develop or adapt and undertake preliminary proof of concept testing of VAW and VAC primary prevention interventions.
Capacity building activities and technical assistance were integrated throughout the three key phases of the project.

- **Phase 1: Team selection and proposal development:** Teams were identified through a competitive open call for partners in East African countries and evaluation according to clear selection criteria (Box 1). All four teams were brought together with technical experts for a week-long workshop on primary prevention concepts, what works to prevent VAC and VAW, and to work with mentors to develop research proposals.

- **Phase 2: Formative Research and Intervention Development:** During this phase the SVRI team provided extensive support and guidance to each of the teams to undertake formative research to identify key risk and protective factors for VAW and VAC in their communities. Teams, with support from SVRI, identified and adapted existing tested or promising interventions to their own settings. Towards the end of this phase, teams developed plans for pilot testing their interventions.

- **Phase 3: Testing for feasibility, acceptability and proof of concept:** The final phase of the project was pilot testing the intervention with a few groups to see whether it is feasible, acceptable, and shows promise of being effective based on objective qualitative or quantitative data collected before and after the intervention.

Sixteen people consistently participated in the programme over the 3 year period: 4 from Tanzania; 7 from Kenya; 3 from Uganda and two technical advisors from South Africa. The lessons learned outlined below were drawn from project and workshop evaluations, feedback received from participants through one on one meetings, and reflections on lessons learned from the technical advisors.

### Box 1.

**Selection Criteria**

Teams must be:

- Multidisciplinary
- Led by a locally based institution;
- A partnership between researchers and practitioners with expertise in: research, intervention development, practice and advocacy;
- Institutionally able to manage complex projects;
- Technically able and professionally empowered to adapt and promote the prevention interventions at country level.
LESSONS LEARNED

This project provides a number of core lessons for building capacity for primary prevention of VAC and VAW intervention development and evaluation from a technical assistance perspective.

ONGOING ASSESSMENTS ARE ESSENTIAL

A comprehensive capacity assessment at the beginning of the project to inform support plans for each team is essential. Capacity assessments with teams identified a number of areas where support was needed, including: how to review and build on existing literature and why it is important; how to develop a clear, evidence informed theoretical framework to guide formative research and intervention development; rigorous methods and tools for formative research; and ethics of doing research on sensitive issues including seeking local IRB approval.

A highly structured approach to delivering training and building capacity is most effective, which includes consistent and on-going, intensive mentoring; revisiting and revising core concepts and skills multiple times and from different angles or perspectives; using templates for reports, proposals, intervention adaptation, monitoring and evaluation strategy, etc. This approach provides space for personal and professional transformation to take place. Such transformation takes time and many team members were in need of development and growth in terms of the principles and values of primary prevention including skills and attitudes consistent with a primary prevention approach, how to adapt and implement a primary prevention programme, and how to rigorously evaluate it.

SELF-TRANSFORMATION IS IMPERATIVE

It is essential that the project teams embrace the skills and attitudes that are promoted in the intervention; therefore, it is strongly recommended that teams go through an intervention as participants first in order to understand and integrate these skills, values, and attitudes.

MENTORSHIP THROUGH PARTNERSHIP

From the outset, a partnership should be set up between technical advisors and project teams that positions these two groups as co-PIs within a grant mechanism with a strong capacity development focus. Such a model is more about partnership and collaboration, and is supportive of more long-term, intensive involvement through mentorship.
FACE-TO-FACE MEETINGS ARE INVALUABLE FOR LEARNING AND INSPIRATION

Face-to-face meetings are incredibly valuable and must form an essential part of the project plan in order to facilitate learning, pool resources where possible, and make significantly faster and deeper progress on capacity strengthening and project advancement. Further, having regular meetings with all project teams and technical advisors promotes a community of practice and builds links between teams who then begin to support one another and collaborate on primary prevention work. On-going, team-specific meetings through virtual technologies is important to build on and maintain learnings and resolutions formed during the in-person meetings.

Working with multiple teams in similar settings was helpful to build motivation to continue with this work that is very demanding and often meets with obstacles. Project teams were inspired by one another and learnt a great deal from one another. Further, they were motivated knowing that their individual projects were part of a larger movement of violence prevention. The multi-sectoral project teams promoted partnerships between researchers and practitioners that offered both partners opportunities for capacity development and innovation; however, such partnerships are not without challenges (Gevers & Namy, 2016).

A SYSTEMATIC APPROACH FOR LONG-TERM INVESTMENT

Teams should be encouraged to adapt existing, evidence-based interventions through formative research rather than developing entirely new primary prevention interventions. This formative research should assess acceptability, feasibility, and promise to understand how an existing intervention does or does not work in local settings and how to change the intervention to be more effective. Only after successful piloting should teams consider conducting a full trial that will inform scale up and policy advocacy.

Issues of sustainability and scale up should be addressed throughout all phases of the project. This may be done through engaging with community and policy maker stakeholders throughout the project. The project teams should ensure that intervention implementation strategies are feasible within their settings and the human resource capacity available. Similarly, as a field, we need to insist researchers publish programme learnings such as the skills and characteristics of good facilitators; how to train and support facilitators; core aspects of the intervention in terms of the content, skills, and concepts, the recommended timing and overall length, and the delivery approach or style; and, potential mechanisms to deliver interventions at scale. Offering teams opportunities to share their work at international conferences is also important to showcase successes and link work across the diverse Global South as well as throughout the global field. Through this project, partners shared lessons and experiences at SVRI Forum 2015.
DEVELOPING SHARED MEASURES AND TOOLS

There are significant challenges in process and outcomes measurement. Understanding how to get good quality data in order to measure intervention process and outcomes including those factors that may influence the scalability of an intervention are a key capacity development area. It is beneficial for the different teams to use some common measures of core concepts and issues to contribute to a larger evidence base.

VALUE OF SOUTH-SOUTH COLLABORATIONS

When asked what they valued most about this project, project partners spoke about the networks they built and working with other colleagues across East Africa and in a South-South partnership; building research capacity within organizations and within the region; improved confidence for conducting a research project including being able to conceptualise research from scratch and doing relevant research with direct programmatic impact.

Partners particularly valued the annual regional meetings where they could learn from and share with each other to continue to push their own projects forward; learning about the availability of and how to access funding opportunities; the opportunities to participate in international forums and online courses; regional and global exposure of the work through wider networks; the fostering of an East African primary prevention collaboration and the creation of a research family all through a South-South partnership.

CONCLUSION

This initiative is unique. It was Southern driven and Southern owned with a focus on supporting local organisations to develop interventions informed by local contexts for the primary prevention of VAW and VAC by building on the existing evidence base. It provided partners with skills and confidence to advocate for the inclusion of primary prevention interventions for VAW and VAC in national violence prevention policies and ongoing programming plans. In this way, leadership, expertise and commitment to VAW prevention is developed within regions which can drive the work forward through continued innovation in research, policy advocacy, and scale up.

Building capacity for research, intervention development, and implementation science on VAW and VAC prevention is a long term commitment and an important one for the ultimate realisation of no more violence against women or children. South – south partnership approaches are a feasible model for producing sustainable prevention efforts in LMICs.
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REFERENCES


Exploring the heuristic value of non-personal data for sexual- and gender-based violence research and prevention in South Africa

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ABSTRACT

Research and media reports indicate that most incidents of sexual and gender-based violence (SGBV) in South Africa, as well as globally, are not reported to the police because of victims’ fears of retaliation, intimidation, stereotyping, secondary abuse and stigmatisation. As a result, there is a lack of accurate data available to the South African public and a certain level of ignorance to the realities of the incidence of SGBV across all sectors of society. The purpose of the study is to explore how non-personal data obtained through mapping the distress calls received on TEARS Foundation’s “Help-at-your-fingertips” service line can be used for SGBV research and prevention purposes. Given that in South Africa the death of women at the hands of an intimate partner has been estimated at six times the global average, the urgent need for alternative SGBV prevention strategies is unquestionable. The study shows how the calls received on the “Help-at-your-fingertips” service line across South African provinces and towns were analysed to identify trends, and visually represent the number of SGBV distress calls over two periods, namely July 2013 to August 2014 and September 2015 to October 2016. The key trends identified include times of year, times of day, highest call volumes in terms of provinces and differences in times of calls in different areas in South Africa as examples of the kinds of information that can be deduced from non-personal data.

The study shows how non-personal data can be used as a powerful tool to make SGBV data visible and to raise public awareness of its incidence in South Africa.

Keywords: Sexual and gender-based violence (SGBV), geographic mapping, crime mapping, communication, SGBV prevention, TEARS Foundation, “Help-at-your-fingertips”
INTRODUCTION

It is generally known, as Sigsworth (2009) shows, that the exact prevalence of SGBV in South Africa is not known because only a very small percentage of incidents are reported to authorities (Jewkes & Abrahams, 2002; Gender Links, n.d.). Current findings suggest that increasing emphasis is being placed on prevention programmes that involve multiple stakeholder participation, among other things (Ellsberg, Arango, Morton, Gennari, Kiplesund, Contreras & Watts, 2014). Several sources such as Seedat, Van Niekerk, Jewkes, Suffla and Ratele (2009) and Gevers, Jama-Shai and Sikweyiya (2013) propose that evidence-based prevention should be advocated among South Africans. In this article, we propose that the analysis of non-personal data and the visual representation of live non-personal data relating to the distress calls made by victims of SGBV can provide useful information that can be used to corroborate or challenge other data sets.

This article therefore focuses on the SGBV distress calls made to a unique service helpline known as “Help-at-your-fingertips”, which is provided by a non-government organisation (NGO) called TEARS (Transforming Education About Rape and Sexual abuse) Foundation. While the non-personal data obtained through analysing these calls do not specify the exact kind of SGBV suffered by the caller, it can be used to: 1) represent the number of SGBV distress calls received; 2) enable communication about SGBV through showing its prevalence in specific areas; 3) compare different data sets, i.e. disclosed and location-based services; 4) identify trends in incidents of SGBV, i.e. changes in times of calls; and 5) present new ideas for further technological innovation and collaboration, i.e. collating different kinds of personal and non-personal data.

Seedat et al. (2009) reiterate that collaborative efforts from all stakeholders are imperative. Yet, as is portrayed in the People Opposed to Women Abuse (POWA) campaign of 2014 (Independent Online, 2014), South Africans typically avoid getting involved in domestic and intimate partner violence incidents, arguably because all forms of SGBV remain stigmatised (Jewkes & Dartnall, 2017). The video clip in this campaign shows a white male in a typical apartment complex in a seemingly affluent residential area making a tremendous noise while playing a set of drums to loud music. Several neighbours are seen knocking at his front door and objecting profusely to the noise. The next scene depicts the same man, in the same residential complex at another time playing a recording of a domestic violence scene, with sounds of a woman screaming and objects breaking in the background. The camera, focused on the front door, shows that not one neighbour comes to object to the obviously violent abuse. South Africans’ tendency to resort to silence in response to incidents of SGBV is well captured in this video clip. It supports the premise that silence is also communication and that in the case of SGBV, it communicates apathy and ignorance.
The existing literature on SGBV in South Africa, in particular, has dubbed South Africa the “rape capital of the world” (Gordon & Collins, 2013, p.93). The scope of SGBV in South Africa includes the high prevalence of child sexual abuse (Jewkes, Penn-Kekana & Rose-Junius, 2005), child prostitution and human trafficking (Thelwell & Van der Merwe, 2014), child pornography (SABC News, 2016), and rape on South African university campuses (Corke, 2016). The continuous theme emerging from research reports is one of silence that manifests itself in the low report rate and consequently the low conviction rate of perpetrators of SGBV, i.e. 7% to 13%, according to Jewkes and Abrahams (2002). This silence, which seems to perpetuate and propel SGBV, appears to communicate an almost stoic consent or, even worse, as Jewkes, cited in Capp (2006, p.719), in reference to South Africa states: “A lot of the population, a lot of the time, doesn’t think rape is a problem”.

The necessity for effective SGBV communication and, therefore, for scholarly collaboration is indisputable, as Jewkes and Abrahams (2002) implore when they underscore the need for genuine partnerships and the adoption of a strategic approach to SGBV intervention and the promotion of zero-tolerance approaches to sexual coercion in communities. The sentiment has been echoed by Walby, Towers and Francis (2014), for example, in their case for the adoption of multidisciplinary and interdisciplinary approaches towards SGBV. However, at present, research publications on SGBV are still predominantly found in health journals, addressed as a public health concern with the anonymity of respondents secured through rigorous ethical guidelines. The need to protect victims’ identities is unquestionable. At the same time, it means that SGBV remains invisible, as shown by Russo and Pirlott (2006). It also means that victims remain isolated and excluded because abuse, most often, occurs within marriages, dating relationships and families (Jewkes & Abrahams, 2002) where perpetrators assume power roles and victims feel compelled to conform to these expectations and demands.

Current research findings suggest that SGBV remains more prevalent in low- and middle-income countries (Jewkes & Dartnall, 2017) where victims are more excluded from public health, legal and other support structures (Stauffer, 2015). However, current findings also suggest that more educated and more affluent victims of SGBV are even more isolated, as they are less likely to report incidents of SGBV (Gass, Stein, Williams & Seedat, 2011).

It has been shown in previous studies that the dominating narrative of patriarchy in South Africa (Jewkes, et al., 2005) remains the key driver in the perpetration of SGBV. In terms of SGBV, patriarchy facilitates the trans-cultural construction of masculinities that legitimises the use of violence to control and punish women (Abrahams, Martin, Mathews, Vetten & Lombard, 2009; Mathews, Jewkes & Abrahams, 2014) and that it inadvertently ratifies the use of alcohol, among other factors, that promote such forms of SGBV. We therefore argue
that until patriarchy and its constitutive dimensions, namely subordination, male dominance and sexual entitlement are eradicated, the culture of silence cannot and will not change, since, as Coetzee (2001) shows, patriarchy assumes religious status, views reality in a reductionist way, adversely affects every aspect of society and adjusts norms to suit its purpose.

OVERVIEW OF EXISTING SGBV RESEARCH FINDINGS

South Africa has been characterised by an almost unorthodox sense of sexual entitlement (Jewkes et al., 2005) that has problematised gender equality and has perpetuated a culture of silence. It is the victim, rather than the perpetrator, of SGBV who bears the stigma (Russo & Pirlott, 2006). It seems as though fear of stigma exceeds the fear of SGBV itself. The intersubjective relationship between SGBV and stigma is complex as it includes gender traits, expectations, norms, values, roles, environments and institutions (Russo & Pirlott, 2006) that are intertwined with class, race and gender.

In summary, the key drivers of SGBV in South Africa are patriarchy (Coetzee, 2001; Jewkes et al., 2005), definition of masculinities, religious dogma (Stauffer, 2015), possession of guns, alcohol abuse, poverty, absence or failure of social support structures (Jewkes & Abrahams, 2002; Seedat et al., 2009), cultural dynamics, mistrust of police and legal systems (Stauffer, 2015), and low levels of education (WHO, 2014; Matzopoulos, Bowman, Mathews & Myer, 2010).

Other than the high femicide rate in South Africa (Mathews, Abrahams, Jewkes, Martin, Lombard & Vetten, 2009; Abrahams et al., 2009; Mathews, Abrahams, Jewkes, Martin & Lombard, 2013; Abrahams, Mathews, Martin & Jewkes, 2013; Mathews, Jewkes & Abrahams, 2014), there has not been sufficient information on the actual incidence of intimate partner violence (IPV) to enable successful prevention and intervention programmes (Seedat et al., 2009; Jewkes & Dartnall, 2017). It is generally understood that because these relationships are personal, victims prefer to disclose their experiences anonymously and confidentially, if at all. The shame and stigma associated with SGBV referred to earlier cannot be underestimated. Therefore, as these research reports indicate, in most cases, such disclosures occur retrospectively in surveys or in-depth interviews and are based on what survivors can recall. In the worst cases, the data is obtained from mortuary-based records. We aim to show that non-personal data can indicate more accurately when and where incidents of SGBV occur, assuming that victims typically seek help within hours rather than days, weeks or months of such incidents.

At present, existing research methods such as in-depth interviews and health surveys (Jewkes & Abrahams, 2002; Jewkes et al., 2005) and mortuary-based data (Mathews et
al., 2009; Abrahams et al., 2009; Mathews et al., 2013; Abrahams et al., 2013; Mathews et al., 2014) are based, in many cases, on personal data such as race, gender, age, place of residence and personal experiences of SGBV. However, as Jewkes and Abrahams (2002, p.1240) state: “...national data on rape in South Africa is highly sensitive to the sources of information, the way in which the questions are framed and the definition of rape”. Further, a higher number of studies seem to have been conducted among vulnerable groups such as poor, uneducated or rural communities. Fewer studies such as Jewkes, Sikweyiya, Dunkle and Morrell (2015), Meinck, Cluver, Boyes and Loening-Voysey (2016), and Gass, Stein, Williams and Seedat (2011) indicate nationally representative, randomly selected or natural samples, for example. There is little or no information on the kinds of SGBV that occur in more affluent neighbourhoods and towns.

We aim to show in the section below how the use of non-personal data can provide some information that is not available because of the low reporting rate, and because of some of the obstacles such as recall bias, for example, when dealing with people and their personal data. We aim to show that non-personal data can maintain the anonymity of victims and perpetrators, while informing authorities and other stakeholders, such as communities.

CRIME MAPPING AND THE USEFULNESS OF NON-PERSONAL DATA

Crime mapping was introduced in the United Kingdom in 2014 and it is thus a relatively new concept. It is defined by the Information Commissioner’s Office (ICO) as “the process of producing a geographical representation of crime levels, crime types or the locations of particular incidents” (ICO, 2014, p.3). The rationale is that crime maps can give citizens a readily accessible means of understanding the patterns of crime in their residential areas. In terms of the UK Statistics Authority Code of Practice for Official Statistics, it is a clear requirement that official statistics do not reveal the identity of an individual or any private information relating to them. E.G. Bascerano (personal communication, October 19, 2016) indicates that a similar regulation applies in South Africa under the Protection of Personal Information (POPI) Act, as it probably does in most other democracies. The ICO’s conceptual paper was published in the UK under the umbrella of the Data Protection Act 1998.

By its definition, crime mapping is primarily concerned with the geographical aspects of criminality and its purpose is to raise awareness among the public for many obvious reasons. It is also important to note that crime mapping has implications for the types of crimes shown on the map. In the case of domestic violence (DV), it includes intimate partner violence (IPV) and child sexual abuse (CSA). For example, we argue that information on the location and prevalence of different kinds of SGBV can help members of the public to be more alert and to become more sensitised to the issue. We further argue that the publication
of information about the scale of DV, based on actual data rather than assumptions, can encourage victims to report incidents and to feel less isolated. The ICO (2014) reiterates that crime mapping is a relatively new and innovative area, and states that it may take some time for the exact benefits and privacy risks to emerge. It is therefore clear that a continuous evaluative process is required. In this regard, use of the “Help-at-your-fingertips” service line can contribute to further research and development of this technology.

It is highlighted again that the “Help-at-your-fingertips” service line is the first of its kind in South Africa, and to our knowledge, in the world. At this stage, the POPI Act is the only currently accessible guideline for the processing of this kind of information in South Africa, according to E.G. Bascerano (personal communication, October 19, 2016). TEARS Foundation was established in 2012 by M.E. Glennie who personally experienced IPV and found that victims of SGBV had no knowledge of where to go in the event of IPV or DV when she attempted to seek help from the police on a Friday afternoon in 2002. She was told to return to that particular police station the following Monday morning (Glennie, 2016). This experience of trauma and being unable to find help in a state of despair, inspired the establishment of TEARS Foundation and the “Help-at-your-fingertips” service line. The heuristic value of this service only emerged through the analysis of the data with the use of Microsoft technology and software. In the following section, we describe the process of gathering non-personal data through the TEARS “Help-at-your-fingertips” service line.

METHOD

While it emerged through the collection of non-personal data recorded from calls to the “Help-at-your-fingertips” service line that this data could be analysed and mapped, this was never the initial purpose or objective of the service when it was launched. Therefore, conventional research parameters such as methodological orientation (which is quantitative in this case), population and sampling method, for instance, can be deduced retrospectively since there was no research design from the outset. Under these circumstances, the non-personal data discussed in this article is by no means representative of the South African population, but is clearly confined to victims of some form of SGBV who had in some or other way received the information provided by TEARS and who had access to a mobile device. Calls to this number could not be made from a landline and, initially, not via a computer. Africanews (2016) shows that in terms of the latest AMPS data for South Africa, 37% of South Africans use smartphones, 52% use ordinary mobile phones, while as little as 10% do not use, or do not have access to, mobile phones. Mobile phones are therefore viable instruments for SGBV response purposes.
DATA COLLECTION

The information we present has been developed through the use of Microsoft software. In simple terms, this helpline for victims of SGBV is a mobile phone portal linked to a database of service providers that send information via a mobile phone, using simple prompt-based technology, which tracks the location of the caller within 45 seconds and sends details of the nearest care facility to the caller. Typically, this includes the nearest police station, medical facility, or other emergency support units. The information received from the geographical location of the phone calls is drawn into a Microsoft Excel data model where it is analysed and reworked to fit the criteria required for analytics. Critical Performance Indicators (CPIs) are used to indicate anomalies in patterns. From there it is sent to Power Business Intelligence in the Microsoft Office 365 Enterprise Cloud. These steps have to be followed because information is drawn from different intersections. The use of a combination of technologies enables the identification of exceptionally high numbers of events.

The data processing involves the use of Unstructured Supplementary Service Data (USSD) to place the calls received on a map of South Africa as they occur over the two thirteen-month periods that cannot be accurately displayed in print format.

When this service line was first publicised in March 2013, with the number *120*7355#, its primary purpose was to provide instant support to victims of rape and sexual abuse; this information was clearly stated in the first TEARS brochure. It is therefore unlikely that calls to this line would be made for any purpose other than some kind of SGBV, such as rape, sexual assault, IPV, DV or some other experience that victims may interpret as fitting within the scope of abuse. In other words, other than perhaps testing the service, people who had been in a car accident or mugged, for example, would have had no reason to call the “Help-at-your-fingertips” service line. Prior to its official launch on 9 August 2013, information on this service line was publicised through media such as Radio 702, M-Net television channel, websites, social media and brochures. Since TEARS is a non-government organisation it did not have the resources to market and publicise the service through mainstream media.

At first, calls to this line were not free, but the primary objective of this privately funded initiative was to provide victims of SGBV with a helpline they could call for information on the nearest support service within their vicinity, at any time of day. Figure 1 below illustrates the sequence of information provided and responses received when a call is made to the service line.
In spite of funding and marketing constraints, and the challenges these present, a toll-free service line *134*7355# was introduced in August 2014. The increase in calls since the introduction of the toll-free line can possibly be attributed to calls to the service being free of charge, although this cannot be concluded with absolute certainty.

DATA ANALYSIS

The analysis of the calls received on this service line revealed that by using Microsoft technology, the calls received could be distinguished in terms of the following criteria:

- Times of calls
- Location of calls
- Frequency of calls from the same number
- Prevalence of calls during certain times of year, such as school holidays or public holidays.
- The data was filtered in terms of completed calls, (calls that received instant messages with information on the nearest support services), the removal of duplication of calls from the same number (for geo-mapping purposes), and a distinction between calls that used location based services (LBS), and those that opted for disclosure of location.
In reference to Figure 1, it should be clarified that if the caller chooses to disclose their location, they would typically indicate “Johannesburg”, for example. The caller will, typically, not indicate from which suburb in Johannesburg the call is being made. This means that such a call cannot be mapped in terms of the actual location of the caller and cannot position the call in an exact location in Johannesburg, for example. It also means the service line, in such cases, provides the location of service providers closest to the centre of Johannesburg and not necessarily closest to the caller. This may explain, for instance, why more than one call from the same number is often recorded within minutes, as the same caller may provide a more exact location in subsequent calls. If the caller indicates that she/he can be located, the LBS can be used. This means the exact position of the individual can be used to identify the closest service provider and gives the exact coordinates of the call. However, within the scope of legislation in South Africa (the POPI Act), the physical addresses and identities of callers may not be traced or disclosed, and callers may not be contacted. At this stage, based on the information provided on the TEARS platforms, the communication to callers is based on the assumption that they do not want their identity known. It was shown earlier that very few cases of IPV, in particular, are reported to the police which explains why so little is known about this form of SGBV and why much more research is required (Jewkes & Dartnall, 2017). The SGBV distress calls recorded on the “Help-at-your-fingertips” service line gives some insight into callers who would probably not report such abuse to the police.

RESULTS

The calls received on the two service lines for the periods July 2013 to August 2014 and September 2015 to October 2016 were recorded for further analysis, as indicated in Table 1 below. It is noted at this point that TEARS could not use or analyse the data recorded between September 2014 and August 2015. Due to a lack of resources, there were insufficient funds to pay the service provider who had initially recorded the incoming calls, since Glennie personally funded the service (Glennie, 2016). As a result, there was no caller information data before September 2015, when the service was reinstated with some aid from AVON Cosmetics. Table 1 provides an instant overview of the call volumes over the two indicated periods.

Table 1: Calls received on TEARS “Help-at-your-fingertips” service lines over the two indicated periods

<table>
<thead>
<tr>
<th>Period</th>
<th>Paid line <em>120</em>7355#</th>
<th>Free line <em>134</em>7355#</th>
<th>SMS messages sent</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2013 to August 2014</td>
<td>8 172</td>
<td>Unknown</td>
<td></td>
</tr>
<tr>
<td>September 2014 to October 2016</td>
<td>695</td>
<td>17 985</td>
<td>10 782</td>
</tr>
</tbody>
</table>
In the 2013 to 2014 period, the software technology had not yet advanced to a point where the SMS messages that were sent (in other words, the completed calls) could be recorded. Therefore, it is unknown how many callers received SMS messages in the first period. It can be seen in Table 1 that 10782 messages were sent to callers, while 7898 calls were not completed. Since 2015, further developments in Microsoft software have enabled far more in-depth data gathering and analyses of which disclosure is prohibited in terms of the previously mentioned legislation.

The analysis of the data enables the representation of non-personal data, such as the calls per province in relation to its population, indicated in Table 2 below.

Table 2: The percentage of calls for each province compared to the percentage of population per province over the two indicated periods of data collection, (Statistics South Africa, 2014)

<table>
<thead>
<tr>
<th>Province</th>
<th>Help Calls %</th>
<th>Population %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Cape</td>
<td>7%</td>
<td>13%</td>
</tr>
<tr>
<td>Western Cape</td>
<td>6%</td>
<td>11%</td>
</tr>
<tr>
<td>Gauteng</td>
<td>28%</td>
<td>24%</td>
</tr>
<tr>
<td>KZN</td>
<td>13%</td>
<td>20%</td>
</tr>
<tr>
<td>Free State</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>North West Province</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>14%</td>
<td>8%</td>
</tr>
<tr>
<td>Limpopo</td>
<td>18%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Table 2 shows the percentage of calls for each province compared to the percentage of population per province over the two indicated periods of data collection, based on the latest data published by Statistics South Africa (2014). While it is obvious that the highest volume of calls would come from Gauteng, the higher call volumes from Mpumalanga and Limpopo, for example, stand out. Figures 2 and 3, based on the same population count, visually represent the different call patterns recorded on the “Help-at-your-fingertips” service line over the two indicated periods referred to in this article.
Figure 2: Calls received per province on the “Help-at-your-fingertips service line from 2013 to 2014

The change in call patterns in the different provinces can be seen in Figure 3, which indicates how the volume of calls to the “Help-at-your-fingertips” service line increased in the second period.
While the precise reasons for this increase cannot be pinpointed, we can indicate that 4 025 calls were received during the 16 Days of Activism for No Violence Against Women and Children from 25 November until 10 December 2015 (personal communication with C. Roberson, 9 January 2017), when the TEARS “Help-at-your-fingertips” service line was publicised on M-Net television channel. Another study that shed some light on the prevalence of SGBV in different provinces was the Gender Links study, referred to as the “War @ home: GBV Indicators research project”. It involved a survey among 5621 South Africans in four provinces that were initially released on the eve of the 16 Days of Activism in 2012 (Gender Links, 2015). The study shows 77% of women in Limpopo reported experiences of SGBV in their lifetime, while only 48% of men admitted to committing such offences. Surprisingly, 78% of men in Gauteng admitted to being perpetrators of SGBV, while only 51% of women in Gauteng reported such experiences (Gender Links, 2015). In the Western Cape 45% of women reported experiences of SGBV and 35% of men admitted to being perpetrators; in KwaZulu-Natal 36% of women reported experiences of SGBV and 41% of men admitted to being perpetrators. While the TEARS data is not representative of the population in different provinces, and can therefore not be correlated with the Gender Links surveys, closer comparison of these data sets could be of value. For example, the high percentage of women in Limpopo who reported experiences of SGBV and the high
volume of “Help-at-your-fingertips” calls received from Limpopo province relative to the size of its population indicates the need for stronger intervention campaigns in this province, among others.

Figure 4 shows the average prevalence of calls received on the “Help-at-your-fingertips” service line over the different months of the year for the two periods.

**Figure 4:** Peak times of year for distress calls received on the “Help-at-your-fingertips” service line

![Graph showing peak times of year for distress calls received on the “Help-at-your-fingertips” service line](image)

Given that these peaks appear to overlap with school holiday periods, a number of questions arise that require further investigation. Current findings suggest, for example, that high levels of alcohol and drug consumption (Seedat et al., 2009) over holiday periods in this case, increase the prevalence of SGBV incidents. Other evidence suggests that in many cases, SGBV acts are committed by learners in secondary school (Meinck, Cluver, Boyes & Loening-Voysey, 2016). Therefore, it cannot be assumed that SGBV incidents increase because parents are at home during school holiday periods, for example. As we show throughout this discussion, it is imperative that there is a comparison between different data sets to get further clarification on this trend in particular.
Figures 5 and 6 provide a summary of the average time of day for all of the provinces over the two periods indicated in this article.

**Figure 5.** Time of day calls peak: July 2013 to August 2014

![Figure 5.](image)

**Figure 6.** Time of day calls peak: September 2015 to October 2016

![Figure 6.](image)

It is immediately apparent that the “Help-at-your-fingertips” service line was used far more frequently at night (between 6pm and 10pm) during the 2013 to 2014 period. Interestingly, this was also the period indicated by Jewkes and Abrahams (2002), who also indicated that a higher number of calls were received on Saturdays. It is also noted that the call centre
Jewkes and Abrahams (2002) refer to involved telephone calls being answered and not non-personal messages being provided on the screen of a mobile device, based on the location of the caller. The software we are using does not show the day of the week as a key variable. However, there is a big change in this pattern during the second period for reasons we can only speculate on and cannot verify at this stage of our analysis. Further cross-correlation with other qualitative and quantitative data will most certainly enable verification and more informed conclusions pertaining to the patterns indicated by the non-personal data we presented.

Figures 7, 8 and 9 show how different call patterns for different times of day can be developed from non-personal data for three provinces in South Africa, namely Eastern Cape, North West Province and Mpumalanga, over a combination of both periods (July 2013 to August 2014 and September 2015 to October 2016).

**Figure 7**: Peak times of day for completed calls in the Eastern Cape over the two periods
Figure 8: Peak times of day for completed calls in the North West province over the two periods

Figure 9: Peak times of day for completed calls in the Mpumalanga over the two periods

Interestingly, all three provinces show similar patterns with particularly high call volumes occurring around 12pm and 6pm. Further investigation is required in this regard as the common pattern has implications for tailoring prevention efforts. Figure 10 below offers a glimpse of the potential for analysis and intervention that mapping live data can offer.
Although we stated earlier that three-dimensional live data cannot be displayed accurately or effectively because the columns on the maps change continuously, Figure 10 provides a snapshot of the calls mapped in the Gauteng area at the end of 2016. This map shows the volumes of calls from towns in Gauteng as it accumulated in the 2015 to 2016 period. In its live format, this map is played as a video clip that shows how the columns develop and increase for each town over the 13 month period. The value of live data such as this would lie in its accessibility for all stakeholders so awareness of incidences of SGBV can be increased. We reiterate that TEARS Foundation’s mapping of live data is unique and cannot be compared to other studies using mapping technology, such as the study conducted by Ernest (2002), for example, that mapped static data.

DISCUSSION

Given how little is known about incidents of IPV and the prevention of femicide in South Africa, further developments in non-personal data technologies need to be explored. While there is no specific evidence relating to the impact of the “Help-at-your-fingertips” service line, besides the records of the number of victims that received information on support services, it is imperative to recognise its potential to have a significant heuristic value in the future. With more resources, the time patterns in the different provinces can be analysed more closely to establish, for example, if the majority of day-time calls are made from business areas or from residential areas. Further research can be conducted to establish why call patterns change; for example, whether interventions in certain towns or suburbs lead to higher call volumes during the intervention period. Non-personal data and geographic mapping are powerful tools for presenting statistical information in
visual formats that can be easily understood by anybody, should it be made available. Matzopoulos, Bowman, Mathews, and Myer (2010) suggest multiple interventions for violence prevention, some of which can be supported by the use of non-personal data; for instance, through contributing to campaigns to increase awareness of child maltreatment, IPV and DV in particular communities, for example. Even though this service provides no personal information about the callers, it can pinpoint specific areas where more specific victim-focused prevention strategies could be deployed in terms of the LSM specifications for each area. For example, the three-dimensional live data indicates very high call volumes for Sandton in Gauteng. Sandton includes multiple suburbs, but the disclosure of the prevalence of calls from these more affluent areas certainly could be eye opening. Further development of the “Help-at-your-fingertips” service line can distinguish between test calls, indicate time of calls in relation to the occurrence of the incident, specific service required, i.e. physical, psychological or emotional, or even a request for emergency assistance in the event of a life-threatening situation. If victims can be informed about, and encouraged to allow the use of LBS, the geo-mapping component of the service can provide much more detailed information for prevention purposes. On the other hand, as we mentioned earlier, a primary objective of the “Help-at-your-fingertips” service line is to assist victims wherever they are, which may not be near their residence. It is therefore possible that victims who do not have life-threatening injuries may wish to identify support services within the vicinity of their place of work or their place of residence. In such cases, using LBS would not provide them with the correct information.

With regards to Matzopoulos et al.’s (2010) suggestion that IPV offenders should be “named and shamed”, current legislation will in all likelihood continue to constrain the mapping of convicted perpetrators’ places of residence or work, for example. On the other hand, community policing could be encouraged by alerting residents to the occurrence of violence in their neighbourhoods. Such alerts may also caution people about alcohol abuse, as Matzopoulos et al. (2010) also suggest, as it may highlight its consequences within their immediate surrounding areas.

In summary, based on the representation of the actual calls received and the analysis of these calls, we suggest that further software development in non-personal data technology and its geographic mapping can revolutionise SGBV prevention and intervention programmes through its potential to:

- Provide a more accurate picture of actual volumes, locations, timing of SGBV distress calls in South Africa that can inform prevention strategies
- Facilitate communication between victims and support services through sensitisation and awareness pertaining to where and how frequently SGBV data can be made accessible to stakeholders
• Assist police to foster relationships between Family Violence and Sexual Offence Unit officers and community members
• Increase the provision of support services in higher income communities that are identified as particularly vulnerable
• Promote community interventions through developing active bystander approaches that can change norms about SGBV
• Increase support for NGOs such as TEARS Foundation whose capacity to develop life-changing technology is constrained by funding
• Provide data for the continuous monitoring of prevention and intervention strategies
• Support other research initiatives that can correlate personal and non-personal data.

LIMITATIONS

The reach of the “Help-at-your-fingertips” service remains constrained by a shortage of funds, as it is not publicised and advertised frequently enough. It was this shortage of funding that interrupted the data analysis for the period 2014 to 2015. It is also acknowledged that non-personal data probably raises more questions than answers, but as we have aimed to demonstrate, the visualisation of SGBV incident patterns can have a profound effect on public awareness and understanding of its incidence and trends.

It has to be noted that the high cost of data in South Africa, which has been raised in the “#Data-must-fall” campaign seen in social media towards the end of 2016, further limits and constrains the provision of this essential service and excludes victims who reside in rural and less affluent areas from access to mobile phones, technologies and support services (Sitto, 2016). While South Africa has a very high level of access to mobile phones, and the “Help-at-your-fingertips” service provides a toll-free line, follow-up services and access to cloud-based supportive data and information for victims and survivors is still limited by the cost of and access to data.

CONCLUSION

The purpose of this article was to explore how non-personal data obtained through mapping the distress calls received on TEARS Foundation’s “Help-at-your-fingertips” service line can be useful for SGBV research and prevention purposes. The data in this study shows a high number of calls are received in spite of marketing and funding constraints that limited the publicising of this service. The cost of SGBV and its consequences has been estimated at R28.4-R42.4 billion for South Africa in 2014 (Khumalo, Msimang & Bollbach, 2014) or perhaps even as high as R112 billion, at current conversion rates, as suggested by K. Dalal, who is a senior advisor for the World Health Organization and an expert for cost and injury prevention and safety promotion, relating to SGBV (personal communication on
May 4, 2015). The detail of the cost calculation method for SGBV can be seen in Dalal and Dawad (2011). Geo-mapping and other kinds of non-personal data collection do not entail a fraction of those costs and could therefore be funded by both the government and private sector in South Africa, as Seedat et al. (2009, p.1019) suggest when they state: “Successful violence and injury prevention is contingent on the identification by the government of these issues as strategic priorities; … and development and implementation of a prevention and containment plan that is intersectoral, strategic, and evidence based.” We conclude that the non-personal data we have introduced can be further explored and developed to contribute to meeting these requirements.

At a societal level, the publicising of the high prevalence of SGBV in South Africa in a three-dimensional live data format could present reality in an unmistakable format for all South Africans to see. Should such data be made available, it can serve to encourage South Africans to rethink the sentiment of “family” where SGBV is perpetrated, cultivated and perpetuated through silence, stigma and, ultimately, exclusion. Live three-dimensional data can be used as a powerful tool for society to see the magnitude of SGBV not only in South Africa but across the world.

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Mainstreaming road safety in the regional integration of the East African Community to reduce road traffic injuries

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ABSTRACT

The East African Community (EAC) comprising of five states: Burundi, Kenya, Rwanda, Tanzania and Uganda bear a disproportionate burden of the global public health burden for road traffic injuries (RTIs). In response to this, each state has devised its own road safety measures, but not at the EAC level. This paper aims to explore how differing road safety policies could be aligned as part of EAC regional integration so that they become one mainstream policy in the EAC. This is done after exploring the rate of RTIs; the existing road safety initiatives; and the impact of RTIs on the EAC integration in the four EAC states excluding Burundi. A desk-based review of data and information from different sources between 2009 and 2015 for Kenya, Rwanda, Tanzania and Uganda was conducted. This revealed that the rate of RTIs in the four EAC states significantly exceeds the African and global average rates. This is associated with large numbers of fatalities, debilitating injuries and economic costs which hamper the EAC integration—especially its main pillar of a common market. All the four states have independently adopted different road safety laws and policies in line with the United Nations Decade of Action for Road Safety initiative. A

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unified road safety policy and road safety lead agency for the EAC as a whole is urgently needed. This should be based on cooperation and commitment, and take into account the region's geopolitical dynamics.

**Keywords:** Road safety, road traffic injuries, regional integration, East African Community

**INTRODUCTION**

Road traffic injuries (RTIs) continue to receive a great deal of global attention due to the obvious public health burdens they create from deaths, injuries, morbidity and Years of Life Lost (YLL) (Peden et al., 2004, 2008, 2009). RTIs are currently estimated to be the ninth leading cause of death across all the age groups worldwide. According to the World Health Organization (WHO) RTIs are presently the ninth leading cause of deaths and are also predicted to become the fifth leading cause of death by 2030 (WHO, 2015a). The low- and middle-income countries (LMICs) significantly suffer the heaviest burden of the world's RTIs (Khorasani-Zavareh, Mohammadi, Laamme, Naghavi, Zarei, & Haglund, 2008). The LMICs account for an estimated 85% of all the world's fatalities and 90% of YLL as opposed to the high-income countries (HICs) with only 15% of the global average of RTIs.

It is estimated that RTIs claim more than 1.25 million lives each year worldwide as well as having a huge impact on the health and development. They are the leading cause of death among the young people aged between 15 and 29 years, and cost governments especially in the LMICs approximately between 2% and 3% of their total gross domestic product (GDP) (WHO, 2009, 2013a, 2015a). The African (AFRO) and Eastern Mediterranean regions according to the WHO, lead with the highest global distribution of RTIs despite both regions having the lowest rates of the registered motorised vehicles which were estimated at 11% and 12% respectively (WHO, 2013a, 2013b). The East African Community (EAC), a Regional Economic Community (REC) located in the AFRO region suffers particularly from a high burden of RTIs. The EAC is a bloc of five member states: Burundi, Kenya, Rwanda, Tanzania and Uganda and the distribution of RTIs in the five partner countries is worryingly high even when compared to the AFRO region as a whole.

The EAC is an inter-governmental regional organisation established in July 2000 under the Treaty of the East African Community (EAC, 2010a). Its beginning can be traced back to 1967 when Kenya, Tanzania and Uganda set-out to enact a bold vision of unification (Nzioki & Tostensen, 2010). Unfortunately, this early effort was riddled by some political and socio-economic symbiotic conflicts, which subsequently precipitated the collapse of the EAC in 1977. However, the spirit of EAC did not die completely because on the 7th July 2000 the defunct EAC was revived, and Burundi and Rwanda joined it on the 1st July 2007. Thereafter, the EAC was committed to co-operation in the political, economic, social
and cultural arena with the purpose of achieving a customs union, a common market, a monetary union and ultimately the EAC federation (EAC, 2010). Since then the EAC has achieved some of its objectives, albeit facing many common hurdles. Aside from facing similar geopolitical challenges such as porous borders; security problems; transnational crimes; lack of funding; absence of specific sectoral councils for decision making and others (EAC, 2013), RTIs remain a serious public health burden in the five states. This in turn is likely to have a negative impact on the EAC regional integration.

That’s because RTAs contribute to loss of human life, injury, disability and this in turn results in a great deal of economic losses and costs. Evidence shows that the four partner states of EAC from time to time have been experiencing a significant burden of RTIs and their associated impacts. Between 2000 and 2009, estimated deaths due to RTIs in Burundi amounted to 20 per 100,000 (WHO, 2008). Before 2003, over 3,000 people aged between 15 and 44 years were reported to be killed in RTIs annually in Kenya (Peden et al., 2004). In Rwanda, there was an increase in RTIs from 15 433 to 16 407 in 2002 and 2003, and a decline in 2004 and 2005 which was reported at 15 628 and 13 353 respectively (Twagirayezu, Teteli, Bonane, & Rugwizangoga, 2008). Between 1990 and 2000 the number of RTIs in Tanzania was reported to have risen from 10 107 to 14 548 – which was an increase of almost 44% (Museru, Mcharo, & Leshabari, 2002). Similarly, Uganda was reported to experience RTIs at 28.9 per 100 000 population in 2013 (Balikuddembe, Ardalan, Khorasani, Nejati, & Kasiima, 2016). Despite these trends, there is not enough attention at the EAC regional level being directed towards tackling the burden of RTIs. To help address the problem, this paper attempts to explore how road safety could be mainstreamed as a part of EAC regional integration. It also establishes the rate of RTIs in the four EAC states (Burundi excluded); identifies the existing road safety initiatives in the four EAC states and how RTIs impact the EAC regional integration.

METHODS

INFORMATION AND DATA SEARCH

This paper’s findings are based on a desk-based review of both qualitative and quantitative statistical data and information which was drawn from different authentic sources between 2009 and 2015. At first, based on the paper’s keywords the data and information were extracted online using this search strategy: “road safety” OR “road traffic injur*” OR “traffic accident” AND “East African Community” AND (“regional integration” OR “Kenya” OR “Rwanda” OR “Tanzania” OR “Uganda”) AND (“road safety” OR “Kenya” OR “Rwanda” OR “Tanzania” OR “Uganda” AND “laws” OR “regulation”). Similarly, these keywords were also interchanged to search for further data and information which was freely downloaded through the Google search engine. The search results were also corroborated by visiting
and exploring the official websites of relevant institutions which posted and published the data and information related to this paper’s objectives.

INFORMATION AND DATA SELECTION

Using the above search strategy, the searched data and information had to have at least one context-specific keyword (synonym of) or have one topic related word. It had also to be published by an authentic source. Burundi was excluded because it perennially had missing data and its participation in the activities of EAC was rare. This is why we only focused on four EAC states. A period between 2009 and 2015 was considered to be the most appropriate timeframe to establish the rate of RTIs and assess the progress of the existing road safety initiatives within the four EAC countries. This is because the preparations and onset of the United Nations Decade of Action of Road Safety 2010–2020 happened in 2009, whereas its mid-point ever since its promulgation in 2010 took place in 2015. All the information and data had to be officially published and documented in English despite the EAC being a multilingual REC where both local and international languages like French, Swahili, Arabic and others are spoken.

DATA EXTRACTION

A combination of 40 reports, strategic and working papers, statistical documents as well as 15 road safety documents related to laws, policies or charters were retrieved in the first initial search. They were obtained from the EAC secretariat documents; the road safety lead agencies in the four partner states; police departments and different ministries/departments within the four EAC states like transport and infrastructure and road traffic. Other external sources utilised included: the African Development Bank (AfDB, 2013), World Health Organization reports (WHO, 2008 -2015) and the United Nation Decade of Action for Road Safety (UN, 2010) and African Union (AU, 2010). The search process took three months in 2015. Within the references of some publications that were considered, additional information and data sources were also identified for further search and extraction. The titles and abstracts of the reports, strategic and working papers, statistical documents as well as the road safety laws or policies were screened and read first by two reviewers to determine whether they were relevant to the paper’s objectives. Thereafter only 15 reports and related documents, and 10 road safety laws or policies (Figure 1) were considered to be relevant and their complete/ full texts were retrieved for a detailed review.

This review was entirely desk-based and inspired by authors’ philanthropic motivation. It therefore did not warrant an ethical sanctioning from any institution.
Figure 1: A flow diagram indicating how the data and information search for this study’s review was conducted in 2015

Online search (Google search engine and different websites) was launched using a predetermined search strategy

Total of initial results= 40 reports, strategic and working papers, statistical documents AND 15 road safety – related laws, policies and charters

Title and abstract of reports, strategic and working papers, statistical documents as well as the road safety laws or policies were screened. (This is aimed at identifying whether they were relevant to the paper topic)

25 reports and related documents as well as 5 road safety related laws or policy documents were excluded

A combination of 15 reports, strategic and working papers, statistical documents as well as 10 documents on road safety laws or policies were considered. Thereafter their full texts were retrieved for review

RESULTS

The statistical data about the four EAC states is presented as follows:

Table 1 presents the total number of RTIs and fatalities in 2009 and 2015

(1) Table 2 presents the ranking of RTIs as the leading cause of deaths and YLL
(2) Table 3 classifies the victims according to their vulnerability to RTIs
(3) Table 4 presents the road safety lead agencies and denotes whether they have a road safety budget
(4) Table 5 presents the existing road safety laws and related initiatives

INJURY DISTRIBUTION

Both minor and life-threatening injuries were reported to be sustained by the victims involved in RTIs in the four EAC states. They included: head, neck, thorax, spinal, abdominal, limbs and soft tissue injuries.
AGE AND GENDER

Although road users of all ages are prone to RTIs, the victims aged between 18 and 35 years suffer most from RTIs. Males also suffer far more RTIs than females.

ECONOMIC COST

Only the official estimate of the economic cost of RTIs in terms of GDP was reported in Tanzania and Uganda respectively at 3.4% and 2.9% in 2015. The estimated annual cost expenditure for the whole of the EAC (Burundi excluded) due to RTIs was U.S $1.7-billion which equates to 3% of Gross National Income (GNI). This total cost in U.S $ million is made up of 765 million for Kenya, 93 million for Rwanda, 499 million for Tanzania and 315 million for Uganda.

Table 1: Distribution of the total number of road traffic injuries and fatalities in the four East African Community states between 2009 and 2015

<table>
<thead>
<tr>
<th>Country</th>
<th>Total number of RTIs (90% C.I)</th>
<th>Fatalities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009</td>
<td>2015</td>
</tr>
<tr>
<td></td>
<td>Per 100,000 population</td>
<td>%</td>
</tr>
<tr>
<td>Kenya</td>
<td>12,369</td>
<td>12,891</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Per 100,000 population</td>
<td>%</td>
</tr>
<tr>
<td>Rwanda</td>
<td>2,766</td>
<td>3,782</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tanzania</td>
<td>22,748</td>
<td>16,211</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uganda</td>
<td>22,699</td>
<td>10,280</td>
</tr>
</tbody>
</table>

C.I–Confidence Interval, NB: RTI deaths were calculated from the death registration and population data that was reported by WHO (Source: WHO, 2009; WHO, 2015)

Tanzania records the highest number of RTIs compared to other three EAC countries in 2009 and 2015. Apart from Rwanda where the total number of RTIs increased, the other three countries saw their RTIs decline between 2009 and 2015. This can be attributed to the measures which were adopted from the Decade of Action for road safety. On the other hand, apart from Kenya, fatalities per 100 000 of the population in other countries increased from 2009 to 2015.
Table 2: Ranking of road traffic injuries as the leading cause of death and Years of Life Lost in the four East African Community states between 2009 and 2015

<table>
<thead>
<tr>
<th>Leading cause of death</th>
<th>YLL per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009</td>
</tr>
<tr>
<td>Kenya</td>
<td>10th</td>
</tr>
<tr>
<td>Rwanda</td>
<td>10th</td>
</tr>
<tr>
<td>Tanzania</td>
<td>9th</td>
</tr>
<tr>
<td>Uganda</td>
<td>10th</td>
</tr>
</tbody>
</table>

YLL refers to an estimated average years a person would have lived if he or she had not died prematurely. Only data for RTIs as the leading cause of deaths for 2009 and 2014 was obtained as was 2015 data for YLL. (Source: Kavi et al, 2014; WHO, 2015).

Apart from Kenya, RTIs dropped out of the rankings of the top ten leading cause of deaths in the other states. This was a positive sign in terms of reducing the avoidable deaths caused by RTIs. However, YLL per 100,000 of the population was still high and this showed how the four countries were losing valuable labour force contributors.

Table 3: Classification of victims according to their vulnerability to road traffic injuries in the four East African Community states between 2009 and 2015

<table>
<thead>
<tr>
<th>Category of victim</th>
<th>Kenya 2009 (%)</th>
<th>2015 (%)</th>
<th>Rwanda 2009 (%)</th>
<th>2015 (%)</th>
<th>Tanzania 2009 (%)</th>
<th>2015 (%)</th>
<th>Uganda 2009 (%)</th>
<th>2015 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pedestrians</td>
<td>47</td>
<td>47</td>
<td>40</td>
<td>37</td>
<td>31</td>
<td>35</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Passengers a</td>
<td>33</td>
<td>34</td>
<td>12</td>
<td>33</td>
<td>28</td>
<td>43</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Drivers b</td>
<td>9</td>
<td>–</td>
<td>4</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Cyclists c</td>
<td>9</td>
<td>14</td>
<td>18</td>
<td>17</td>
<td>11</td>
<td>10</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>2/3 wheeler riders d</td>
<td>1</td>
<td>5</td>
<td>16</td>
<td>7</td>
<td>22</td>
<td>7</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Others e</td>
<td>–</td>
<td>–</td>
<td>10</td>
<td>–</td>
<td>1</td>
<td>–</td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

a Combines all passengers in the 2-wheeled, light and heavy truck vehicles; b Combines drivers of all vehicles – 4 wheeled, light and heavy trucks; c Cyclists refers to users of 2 – or 3 – wheeled pedal cycles but does not include motorcycles or E-bikes; d Combines riders of motorized 2 or 3 wheelers and includes the victims whose details of RTI were not clearly established (Source: WHO, 2009, 2015) NB: Only 2009 data for Rwanda was available.

The pedestrians and passengers were the most vulnerable road users to RTIs in the four EAC states. However, apart from Rwanda the victims of 2/3 wheeler riders who were involved in the RTIs increased in the three other EAC countries from 2009 to 2015.
Table 4: Road safety lead agencies and the existing road safety budget in the four East African Community states between 2009 and 2015

<table>
<thead>
<tr>
<th>Country</th>
<th>Road Safety Lead Agency</th>
<th>Road Safety Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009</td>
<td>2015</td>
</tr>
<tr>
<td>Kenya</td>
<td>Ministry of Transport</td>
<td>National Road Safety Council</td>
</tr>
<tr>
<td>Rwanda</td>
<td>National Road Safety Commission</td>
<td>National Road Safety Committee</td>
</tr>
<tr>
<td>Tanzania</td>
<td>National Road Safety Council</td>
<td>–</td>
</tr>
<tr>
<td>Uganda</td>
<td>National Road Safety Council</td>
<td>National Road Safety Council</td>
</tr>
</tbody>
</table>

NB: The paper also established whether the road safety lead agencies in each specific country had in place a road safety budget (*Source*: WHO, 2009, 2015)

With the exception of Tanzania, the four EAC states in 2015 had designated their own lead agencies with budgets to oversee the implementation of road safety.
### Table 5: Existing road safety Laws and initiatives in the four East African Community between 2009 and 2015

<table>
<thead>
<tr>
<th>Road Safety Laws or Policies</th>
<th>Kenya</th>
<th>Rwanda</th>
<th>Tanzania</th>
<th>Uganda</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Speed Limit</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Subnational</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Drink-drive</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Seat-belt</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Motorcycle helmet use</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Child restraints</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Mobile use while driving</td>
<td>–</td>
<td>Yes</td>
<td>–</td>
<td>No</td>
<td>–</td>
<td>No</td>
<td>Subnational</td>
<td>Yes</td>
</tr>
<tr>
<td>National drug-driving law</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**NB:** Subnational indicates that some initiatives were not implemented national-wide in a given country. *(Source: National Road Safety Councils in the four EAC; WHO, 2009, 2015)*

Various road safety laws and initiatives were enacted and adopted in different years within the four states although they all lacked child restraint measures between 2009 and 2015.
DISCUSSION

ROAD TRAFFIC INCIDENTS IN THE EAST AFRICAN COMMUNITY

Firstly, the average 2015 rate of RTIs among the four EAC states (30.3% per 100 000 population) is far above the global average rate of 17.4% per 100 000 population in 2015. It is also well above the WHO–Africa region average rate of 24.1% per 100 000 population. Apart from Rwanda the total number of RTIs in Kenya, Tanzania and Uganda remained worryingly far too high when the period between 2009 and 2015 was compared. This fact, is largely corroborated by other evidence that estimated that Kenya, Tanzania, Uganda, The Democratic Republic of Congo, Ethiopia and South Africa contributed to 64% (two-thirds) of all the road deaths occurring in Africa (WHO, 2013a, 2013b). In Kenya RTIs has been one of the ten leading causes of deaths in the three EAC states between 2009 and 2015. This indicates that much more concerted road safety efforts are needed not only in Kenya but also in all four of the EAC states in order to avoid RTIs becoming ranked as the second and seventh leading cause of death in 2020 and 2030 respectively as was predicted in most LMICs (Khorasani-Zavareh 2009; WHO, 2009, 2015b).

It should be noted that the needless loss of lives due to RTIs will cost the four EAC states dearly—especially economically. This is because the lives lost often represent a loss of considerable talent, knowledge, skills, experience and physical manpower that add up to a significant economic productive capability. Due to RTIs, it is evident that the four EAC states are not only needlessly robbed of human lives, but also valuable productive manpower which represents a fundamental driver of the EAC regional integration pillar of the common market that is meant to enhance the free flow of factors of production, labour and capital (EAC, 2010). It has been argued that the people lost to RTIs occurring all over the EAC would more than likely have lived long lives which could have resulted in an estimated $5 billion USD worth of lifetime productivity from each year’s RTI fatalities (Ross & Mandler, 2016).

VULNERABILITY OF ROAD USERS TO ROAD TRAFFIC INCIDENTS

Similar to the prior findings of Balikuddembe et al (2016), Museru et al. (2002), Peden et al (2004), Twagirayezu et al, (2008), WHO (2009, 2015) and others, the pedestrians and passengers are found to be the most vulnerable groups at risk of RTIs in the four EAC states. This can be largely attributed to the inadequate attention, planning and resources that has been devoted to the construction of pedestrian road infrastructure. In fact, this problem was identified as exposing both the pedestrians and passengers to RTIs in many LIMCs including some of the EAC states (Balikuddembe et al., 2016; Khorasani-Zavareh, Mohammadi, et al., 2009; Ogendi et al., 2013).
This highlights a vital need for urgently prioritising the design of non-motorised and pedestrian road infrastructure. Similarly, the enforcement of the use of vehicle occupant protective equipment has been inadequate and noted still to be a serious problem in road safety implementation in EAC states and other LIMCs (Khorasani-Zavareh, Khankeh, et al., 2009; Small & Runji, 2014; Tanzania Police Fore [TPF], 2014; Uganda Police Force [UPF], 2013). Enforcing road safety regulation and building adequate safety considerations into the road infrastructure sector which is accelerating at a considerable pace all over the EAC (EAC, 2010a; EAC, 2013) is vital. Otherwise the four EAC states will continue to lose salvageable lives due to RTIs as well as the invaluable contribution they could have made to economic growth and the full realisation of the EAC political federation.

As noted above, the victims aged between 18 and 35 years are more prone to die or be injured in the RTIs (Peden et al., 2004; WHO, 2009, 2015b). This is also the case with the EAC where the distribution of ages between 15 and 59 makes up 53.6% of the populations of Kenya, 54.4% of Rwanda, 50% of Tanzania and 48.1% of Uganda (UN, 2015). Given that the majority of victims involved in RTIs in the EAC states were aged between 18 and 35 years, the EAC stands to lose more of its economically productive population which was recently reported to consist of 11,275,483 (males) and 11, 046,441 (females) in 2014 (EAC, 2015). Similar findings were reported in some studies whose scope also involved some EAC states (Balikuddembe et al. 2016; Chalya et al., 2012; Tumwesigye, Atuyambe, & Kobusingye, 2015; Twagirayezu et al., 2008). In the same regard, the male exposure to RTIs is far greater than the exposure of females to RTIs which can be attributed to the fact that women drive less compared to men and are thus less exposed to RTIs (Khorasani-Zavareh, Khankeh, et al., 2009; Peden et al., 2004). It can therefore be reasonably deduced that unless some urgent actions are taken the EAC is at risk of continuing to lose some of its most valuable economic components of productive manpower, whose potential contribution to EAC integration pillar of the labour market cannot be replaced.

ECONOMIC IMPACT OF ROAD TRAFFIC INCIDENTS

RTIs are associated with both the direct and indirect losses which are summed-up in the GDP or GNI per capita. The injuries reported to be sustained due to RTIs (head, neck, thorax, abdominal, spinal and limbs) are life threatening and can cause a long-term malady and permanent disability or physiological morbidity (Chalya et al., 2012; WHO, 2009, 2015a). This combined with other socioeconomic effects of RTIs contribute to often unforeseen public health costs and expenditures (Kavi et al., 2014). The costs may include: the costs of administrative, legal, insurance claims; road safety promotion; vehicle and property damages; medical, emergency care services and the treatment of victims especially when that involves long periods of rehabilitation and disability (Peden et al., 2004).
It should also be noted that a sizeable proportion of RTI survivors become economically unproductive (WHO, 2013). That means that survivors will often become dependent on the financial support from their immediate families, friends, government agencies or insurance compensation. This in turn creates a socioeconomic dependence syndrome. This is what adds-up to the significant GDP losses as observed in Tanzania and Uganda. As a consequence, the progress of vital economic sectors like agriculture, trade, transport, education and others is likely to be hampered. This is because vital and limited financial resources that would normally be expended on the productive sectors that play an important role in the EAC integration are instead diverted to pay for emergency costs and other costs incurred due to RTIs.

ROAD SAFETY IMPLEMENTATION IN THE EAST AFRICAN COMMUNITY

The establishment of a lead agency is an important factor that can improve road safety in LMICs (WHO 2013, 2015). The lead agencies undertake multi-sectoral measures which are stipulated in the existing road safety laws and policies, with the ultimate goal of halving RTIs by 50% in their respective states. This work is done in unison with the regional and international road safety frameworks enshrined in The African Road Safety Charter 2014, The African Road Safety Action Plan 2011-2020, and above all, with five pillars of the UN Decade of Action for Road Safety (AU, 2014; UN, 2010). Even though the three EAC states apart from Tanzania have road safety budgets, their financial support for effective implementation of road safety is still inadequate (Kavi et al., 2014; UPF, 2011). This needs to be urgently addressed if the road safety programmes are to be purposeful and capable of ushering in tangible interventions that make significant progress towards reducing the RTIs and their socio-economic costs.

Above all, there's also a great need for establishing a well-funded road safety lead agency for the EAC as a whole in order to meet the common road safety needs and challenges for all the four EAC states (EAC, 2011). This can take into account the existing road safety laws and policies in the four EAC states and streamline them. If this approach were adopted, in the long-run it would enhance the long-awaited idea of the political federation of the EAC (EAC, 2010). One of the EAC's ultimate goals is to have unified institutions for all the EAC partner states rather than for individual states. That would also help to address the often complicated and unnecessary task of understanding and complying with different road safety rules for different road users as they move between different EAC states.

Although different road safety laws and policies exist in the four EAC states, many are often not understood and enforced properly. This is often attributed to some laws being outmoded so they bear less relevancy to the present road safety conditions. Other reasons for this problem include corruption; lack of public awareness and sensitisation and inadequately
trained personnel (TPF, 2014; UPF, 2009, 2011). In Uganda, for instance, several calls have been made for the amendment of The Traffic and Road Safety Act of 1998 so that it can address and improve the road safety standards and support its effective enforcement (UPF, 2013). The EAC states being signatories to the Decade of Action for Road Safety have at least tailored road safety laws and policies in-line with the five pillars of the Decade of Action. These are: road safety management; safer roads and mobility; safer vehicles; safer road users and post-crash management (UN, 2010). This meant that after 2010 some partner states adopted road safety budgets and new laws like legislation outlawing driving under the influence of alcohol and drugs, setting speed limits and requiring helmet use. This is commendable in as much as it saves the EAC states from losing salvageable and productive lives which have a role to play in their quest of EAC integration.

However, there exists considerable divergences in some road safety initiatives adopted by the four EAC states. Speed limit laws in particular standout in this regard. In Rwanda, the speed limits are regulated at 40 Km/h and 80 Km/h in urban and rural settings respectively, while in Kenya they have been set at 50 Km/h and 100 Km/h in urban and rural settings respectively. Drink driving laws are also another road safety concern. In Kenya, there is no limit on the level of Blood Alcohol Consumption (BAC) unlike Rwanda, Tanzania and Uganda which have a BAC limit of 0.08 g/dl for all drivers (WHO, 2009, 2015a). EAC regional integration has led to extensive cross-border transport activities, especially in terms of the haulage of exports and imports across partner states. Variances in the above laws only serve to hinder enforcing speed limits and discipline among the cross-border drivers—not only in their respective states but also across the entire EAC. It should be noted that these factors and others were noted to be exacerbating the risk of RTIs (Balikuddembe et al., 2016; Chalya et al., 2012; Ogendi et al., 2013; Twagirayezu et al., 2008).

Despite the fact that the mid-period for implementing the Decade of Action for Road Safety has passed, it’s worth reporting that unfortunately some vital road safety initiatives such as requiring child restraints are still much needed. In fact, no single EAC state has child restraints laws in place (WHO, 2009, 2015a). Similarly, laws on mobile use while driving and drug-driving laws are still urgently needed in the majority of EAC states. Unless these road safety shortcomings are urgently remedied collectively then a priceless opportunity to significantly reduce EAC RTIs in unison with the ultimate vision of having the EAC political federation with common laws might be missed.

**STUDY LIMITATIONS**

Every research study has shortcomings, and the present one was no exception. It was limited by a lack of information due to the lack of data uniformity within the different EAC...
states, and the fact that often some of the available statistical data and information was recorded in French and Swahili. Therefore, some findings in this paper might either have been over or under reported and contextualised. Also, the information and data presented herein was not representative of all the five EAC states because Burundi was excluded as previously mentioned. Despite these limitations, this study should still offer invaluable insights necessary for successfully devising the remedies to reduce RTIs among EAC states. Above all, it should also make clear the urgent need for harmonising policies for the prospective EAC political federation.

CONCLUSION AND PREVENTION IMPLICATIONS

The path of regional integration, which was embarked on by the EAC states, is applauded since it offers new opportunities to optimise the economic growth and development among the partner states. EAC integration should also offer the opportunity to improve and optimise road safety effectively throughout the EAC. It is vital that this opportunity is not wasted as the rate at which the four states experience RTIs is alarming when compared to the global and AFRO levels. This matters economically and socially because the EAC as a whole presently has to pay a high price from the consequences of RTI related fatalities, injuries, morbidity, disability and YLL as do each of its member states. To respond to this, most efficiently and effectively a road safety lead agency for the EAC is urgently needed, that can create a unified road safety policy not only to save lives, but to aid the quest of ushering the EAC integration goals. This is especially important for the common market if it is to be served by a free flow of production resources, labour and capital as well as the anticipated political federation of EAC. The EAC stands to achieve all of this given the similar geopolitical dynamics of its partner states if it can thrive on continued cooperation and commitment which is vital to any successful regional integration.

REFERENCES


*The Presidential Decree Regulating Traffic Police and Road Traffic 2012.* Government of Rwanda


The conference was co-hosted by the South African Phoenix Rehabilitation and Prevention group and the European Burn Association at the Red Cross War Memorial Children’s Hospital and brought together an inter-disciplinary team of experts and practitioners in the field of paediatric burn trauma. The main theme of this joint workshop was centred on learning exchanges and sharing of experiences and best practices in the prevention and rehabilitation of burn injuries. The conference was initiated with an orientation visit of conference delegates to surrounding Cape Town townships to illustrate, first-hand, the particular resource and safety challenges faced by South Africans. The tour also included visits to the Red Cross Burns Unit and St Joseph’s Home for Children to showcase the medical and long-term care provided for paediatric burn victims.

The second day was opened with a keynote address that provided an overview of the current epidemiology of burns in South Africa. The second day was dedicated to an exchange of best practices related to burn prevention, treatment, and rehabilitation (e.g., occupational therapy, physiotherapy, art therapy, and reflexology). Lessons were also shared about current medications and treatments that have demonstrated efficacy in wound care, burn scar management, itching, and pain management approaches used by nursing practitioners, occupational therapists, and physiotherapists. Focus was also placed on the support provided for the psychological and social aspects of burn aftercare through art therapy and reflexology. The third and final day of the conference was opened by a very powerful personal experience recounted by an individual who had suffered a burn injury.
as a toddler. He shared some of the challenges he had faced growing up, especially as an adolescent and young adult. The survivor reflected on how he yearned to learn about and be connected to the rest of the world, and through his collection of maps and atlases from around the world -, expressed a need to break through his social isolation. The final part of the day provided an opportunity for more direct engagement through practical skills stations and group discussions on the work that had been presented during the conference. The practical work stations allowed the opportunity for practitioners to showcase work in their respective fields. It was also a platform for giving hands-on demonstrations of the different approaches used in burn prevention, care, and rehabilitation, followed by a questions and answers session at each station. Of especial note is the increased use of technology and gaming such as Wii and Xbox by physiotherapists for physical rehabilitation, improvement of range of movement, etc. The proceedings were concluded with a closing address focusing on the importance of collaboration across different fields of expertise and practice. It is our opinion that the conference was successful in its purpose of bringing together an eclectic group of volunteers, burn victims, and cross-disciplinary practitioners from various parts of the world presenting an opportunity for learning exchange towards a common goal of ensuring the best possible outcomes, both physical and psychological, for children who have experienced a burn trauma.
Injury Control and Traffic Safety Training Course

Venue: Sunnyside Hotel, Johannesburg
Date: 2 - 4 October 2017

The promotion of road safety in South Africa and Africa remains an imperative considering the disproportionately large public health and developmental burden from road traffic crashes across the continent. Extensive and well-intentioned collaborative traffic campaigns held predominantly over the holiday periods have reflected commendable success; however, injury statistics in South Africa and elsewhere remain unacceptably high. It is imperative that both professionals and civil society become more aware of the importance and the basic principles of injury control and traffic safety. The Violence, Injury and Peace Research Unit (VIPRU, co-directed by the South African Medical Research Council and University of South Africa) and the Institute for Social and Health Sciences, University of South Africa will be hosting a training course on injury control and traffic safety in collaboration with the Indian Institute of Technology, Delhi (IITDelhi). The training course will be held from the 2 - 4 October 2017 in Johannesburg.

COURSE OBJECTIVES

This 3 day course will bring together professionals and other social actors working in the area of injury control, research, transportation planning, pedestrian and road safety, trauma, and traffic and law enforcement to acquaint themselves with the state-of-the-art information in the field. The contents of the course have been focused to give a local, national, and global perspective to the road safety problem. By the end of the course the participants should:

- Know about the latest findings and methodologies for the prevention of traffic accidents and injuries, transportation planning and enforcement;
- Be aware of perspectives, policies and practices which have been shown to be successful or have not worked in the past; and
- Be able to develop, improve or initiate their own programmes in traffic injury planning and control.
TARGET SECTORS

The course will be conducted in English, and will accommodate about 30 participants. The course has been designed for an interdisciplinary audience including law enforcers, police officers, urban and traffic planners, road engineers, researchers, behavioural scientists, medical professionals, emergency services, biomedical engineers and civil society activists.

COURSE TRAINERS

The 2017 training course will include the following international trainers:

Prof. Dinesh Mohan

Professor Mohan is currently Distinguished Professor, Shiv Nadar University, and Honorary Professor, Indian Institute of Technology Delhi. He was Coordinator of the Transportation Research and Injury Prevention Programme (TRIPP), Head of the WHO Collaborating Centre for Research and Training in Safety Technology from 1998 to 2010, and Head Centre for Biomedical Engineering 1991 to 1996 at the Indian Institute of Technology, Delhi, India. Prof Mohan is one of the world’s leading experts on traffic safety issues and human tolerance to injury and has been involved in injury control research for the past 30 years.

Prof. Geetam Tiwari

Professor Tiwari is currently MoUD Chair Professor, Department of Civil Engineering, at the Indian Institute of Technology in Delhi. She has about 30 years of professional experience in the areas of Transport Planning and Traffic Engineering in India and USA. Professor Tiwari has worked with a number of research institutes and clients viz., the World Bank, Asian Institute of Transport Development, IFSTTAR (French Research Institute), International Transport Forum (ITF, Paris), Shakti Sustainable Energy Foundation, India, International Association for Traffic Safety Science, Japan (IATSS), Delhi traffic police, and the Central Road Research Institute on various transportation projects.

COURSE FEE

- The conference package will be ZAR2 500, including registration, course materials, teas and lunch.
- Delegates are provided with information on suitable accommodation, but will need to ensure their own arrangements.
• The course registration form is available at the following website: http://www.mrc.ac.za/crime/crime.htm, or may be requested from Ms Kasia Venter, see contact details below. To secure your place, please forward your proof of payment to the address indicated below. **Delegates without proof of payment will unfortunately not be eligible for the course.**
• Seats are limited, so please RSVP early.
• This is a **certified course.**

**CONTACT PERSON**

Ms. Kasia Venter  
Institute for Social and Health Sciences  
Tel: 011 857 1142 /3  
Fax: 0866 569 838 / 011 857 1770  
Email: venterkasia@gmail.com
7th African Regional Safe Communities and Peace Promotion Conference

Strengthening Community Prevention and Promotive Responses

23 - 26 July 2018
Universidade Eduardo Mondlane, Maputo, Mozambique

Co-hosted by:
Universidade Eduardo Mondlane, University of South Africa, and South African Medical Research Council

Co-Chairs:
Mohamed Seedat (South Africa) and Mohsin Sidat (Mozambique)

You are invited to submit abstracts for oral and poster presentations at the 7th African Regional Safe Communities and Peace Promotion Conference

The Conference will be held at the Faculty of Medicine at the Universidade Eduardo Mondlane, in Maputo, Mozambique. The Conference will provide a platform for research, intervention programmes, policy initiatives and community experiences on the good practices in violence and injury research and prevention, and safety and peace promotion. A wide range of key topics are encouraged, especially on child injury and safety, interpersonal and gender violence, the safety of vulnerable road users, community safety interventions, safety policy interventions, and violence and injury prevention capacities. The Conference will bring together a wide range of professionals, including decision-makers in local, regional and national governments, researchers, practitioners, professionals working in the private sector, faculty, students, and community members.

Thematic Tracks

- Africa-centered examples of injury prevention and safety and peace promotion
- Child health, safety and peace
- Gender violence and social inequality
- Community conflict and peace
- Road safety in African contexts
• Social determinants of injuries, injury prevention, and safety and peace promotion
• Innovations in strengthening institutional and community capacities

IMPORTANT DATES

• Deadline for abstract submission: 1 November 2017
• Notification regarding abstract submission: 15 December 2017
• Conference: 23-26 July 2018

ABSTRACT SUBMISSION INFORMATION AND GUIDELINES

Abstracts should be no longer than 250 words and must be based on one of the following formats:

RESEARCH
• Background and Aims
• Methods
• Results
• Discussion and Key Conclusions
• Keywords (5)

POLICY, PRACTICE AND PROGRAMMES
• Background and Conceptual Framework
• Objectives
• Implementation
• Discussion and Key Conclusions
• Keywords (5)

ABSTRACT SUBMISSION

If in English, please submit your abstract to Ghouwa Ismail at Ghouwa.Ismail@mrc.ac.za by no later than 1 November 2017.

If in Portuguese, please submit your abstract to Lidia Maungue at lidiamaugue@gmail.com by no later than 1 November 2017.

REGISTRATION FEE

• African delegates: US$ 50
• Foreign delegates: US$ 75
• Student delegates: US$ 20 (proof of student registration required)
WHO SHOULD ATTEND

- Violence and injury prevention and safety and peace promotion scholars, practitioners and activists
- Graduate and post-graduate students
- Policy-makers and programme planners

ORGANISING AND SCIENTIFIC COMMITTEE

Mohamed Seedat, South Africa
Mohsin Sidat, Mozambique
Esperanca Sevene, Mozambique
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Khatia Munguambe, Mozambique
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TRAVEL AND ACCOMMODATION

Participants are expected to make their own local arrangements, including travel and accommodation reservations. The Secretariat can assist international participants in identifying suitable accommodation or making accommodation reservations.

VISA

You are encouraged to check with your local Embassy/Consulate for information about visa and other documents necessary for travel to Mozambique. Should you require an invitation letter, please email Ghouwa Ismail at Ghouwa.Ismail@mrc.ac.za or Lidia Maungue at lidiamaungue@gmail.com to request one. Visa letters will be issued to those delegates who are registered for the conference, or whose abstracts have been approved.

CONTACT

For more information, please contact Ghouwa Ismail at Ghouwa.Ismail@mrc.ac.za or Lidia Maungue at lidiamaungue@gmail.com.

The course registration form is available at: https://goo.gl/forms/TuxociPOqWXEq5rC3
Submission Guidelines

African Safety Promotion: A Journal of Injury and Violence Prevention (ASP) is published twice a year. Submissions within the following guidelines are welcome. Please submit your contributions or queries to the Editor-in-Chief, African Safety Promotion: A Journal of Injury and Violence Prevention, at the Violence, Injury and Peace Research Unit, Medical Research Council, PO Box 19070, Tygerberg, 7505, South Africa, or via e-mail to nancy.hornsby@mrc.ac.za. Scientific contributions are to be prepared and submitted as indicated below.

MANUSCRIPT PREPARATION

The manuscript must be accompanied by a letter indicating that the article has not been published elsewhere. This letter must be signed by all listed authors to indicate their agreement with the submission. All manuscripts should be typed in 1.5 spacing with a margin of 3.5 cm on the left and right sides of the page. The manuscripts should be in 12 point Times New Roman font, with the main headings in capitals and bold, and sub-headings in capitals. No enumerations and section numbering should be included, and all graphs and tables should be inserted at the end of the document. There are five categories of submissions accepted for publication in ASP, as detailed below.

ORIGINAL CONTRIBUTIONS

Full scientific manuscripts submitted for this category should not exceed 6 000 words in length excluding the title, abstract, references, figures and tables.

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Manuscripts submitted as a literature review should not exceed 6 000 words in total.

BOOK REVIEWS

Copies of books may be sent to the Editor-in-Chief.
SHORT COMMUNICATIONS/PERSPECTIVES

These communications include commentaries on events in the injury prevention sector, and organisation or programme reports. These should not exceed 2 000 words, inclusive of references. Perspectives should offer informed, critical commentary on especially emerging theoretical, research, programmatic or policy issues in the injury prevention, safety and peace promotion sectors. There should be some theoretical or research basis for the interrogation of these conceptual, research or policy issues and the perspective conclusions should have clear relevance for the prevention domain.

All original contributions should have the following sections:

1. **Title Page:** This page should include the title of the manuscript, all authors and their affiliations. Full contact details should be included for the corresponding author. The category in which the manuscript is to be submitted should be indicated at the top of the page.

2. **Abstract:** All manuscripts, except short communications and book reviews, should include an abstract placed before the main text of the article. This abstract should not exceed 250 words in length. Abstracts must be accompanied by a minimum of 5 keywords. While all abstracts need to be submitted in English, authors are also allowed to submit translations of these abstracts in French or Swahili.

3. **Main Text:** The main text of the article should, as far as is appropriate, be divided into the following sections: Introduction, Methods, Results, Discussion, and Prevention Implications.

STYLE AND REFERENCES

All contributions should follow the American Psychological Association style. This format can be found in:


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The manuscript must be submitted to the Editor-in-Chief. Contributors may submit the names and contact details of two referees competent to review their manuscript. Authors will be asked to respond to the editors and reviewers’ comments within four to six weeks. Upon acceptance of the revised manuscript for publication, an electronic copy in Microsoft Word will be requested. If you have any queries please contact The Editor-in-Chief: African Safety Promotion: A Journal of Injury and Violence Prevention, at Violence, Injury and Peace Research Unit, Medical Research Council, PO Box 19070, Tygerberg, 7505, South Africa; Tel. +27 +21 938 0441; Fax: +27 +21 938 0381; E-mail: nancy.hornsby@mrc.ac.za

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