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in the WHO African Region

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CONTENTS

Page

CONTRIBUTORS v
ACKNOWLEDGEMENTS vii
PREFACE ix
ABBREVIATIONS xi
EXECUTIVE SUMMARY: xiii

CHAPTER 1: INTRODUCTION 1
1.1 DEFINITION AND TYPES OF VIOLENCE 1
1.2 RATIONALE FOR THE REPORT 3
1.3 BARRIERS TO PREVENTION 4
1.4 AFRICA'S HISTORICAL CONTEXT 5
1.5 CONTEMPORARY AFRICA 7
1.6 HOW BIG IS THE PROBLEM? 9

REFERENCES 12

CHAPTER 2: FAMILY VIOLENCE 13
2 INTRODUCTION 13
2.1 CHILD MALTREATMENT 13
2.2 INTIMATE PARTNER VIOLENCE 27
2.3 ELDER ABUSE 39
2.4 CONCLUSION AND FUTURE PERSPECTIVES 41

REFERENCES 43

CHAPTER 3: COMMUNITY VIOLENCE 55
3 INTRODUCTION 55
3.1 YOUTH VIOLENCE 55
3.2 SEXUAL VIOLENCE AGAINST WOMEN 66
3.3 CONCLUSIONS AND FUTURE PERSPECTIVES 77

REFERENCES 79

CONTENTS

CHAPTER 4: COLLECTIVE VIOLENCE 89

4 INTRODUCTION 89

4.1 DEFINING COLLECTIVE VIOLENCE 90

4.2 THE DATA CHALLENGE 91

4.3 PATTERNS OF COLLECTIVE VIOLENCE IN AFRICA 93

4.4 PATTERNS OF VIOLENT CRIME AND ORGANIZED VIOLENCE 110

4.5 RECOMMENDATIONS FOR PREVENTING COLLECTIVE VIOLENCE 111

4.6 CONCLUSIONS AND FUTURE PERSPECTIVES 113

REFERENCES 114

CHAPTER 5: SELF-DIRECTED VIOLENCE 119

5 INTRODUCTION 119

5.1 DEFINING SUICIDAL BEHAVIOUR 120

5.2 STATE OF KNOWLEDGE ON THE AFRICAN CONTINENT 121

5.3 EXTENT OF THE PROBLEM 123

5.4 PREVENTING SUICIDAL BEHAVIOUR 137

5.5 SUMMARY OF RESEARCH FINDINGS 148

5.6 RECOMMENDATIONS FOR PREVENTING SELF DIRECTED VIOLENCE 149

5.7 CONCLUSIONS AND FUTURE PERSPECTIVES 153

REFERENCES 154

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS 163

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PREFACE

I am pleased to share with you the first WHO report on Violence and Health in the African Region. The subject is certainly familiar and infinitely complex. A team of more than 25 authors, 22 reviewers and 60 contributors from across the globe undertook a wide consultation to put together this report which constitutes a wealth of information for health professionals, planners, development partners and decision-makers.

We are all familiar with sad stories about people whose lives have been cut short by one form of violence or another. This report provides us with tools for better understanding and prevention of these unnecessary deaths. The consequences of violence - in Africa, as elsewhere in the world - go far beyond fatalities. For every ensuing death, non-fatal injuries due to violence lead to dozens of hospitalization of victims, many left with permanent disabilities, and hundreds of visits to casualty departments and thousands of doctors' appointments. Over and above these deaths and injuries, some highly prevalent forms of violence such as child maltreatment, domestic violence, and sexual violence have numerous non-injury health consequences. These consequences include high-risk behaviours such as alcohol and substance abuse, smoking, unsafe sex and perpetration of violence, contributing to serious diseases such as cardiovascular disorders, depression and HIV/AIDS. Although the negative effects of violence are felt by all, violence disproportionately affects development in low-and middle-income countries. In poor countries, the socioeconomic impact of violence can be very severe in terms of slowing economic growth, undermining personal and collective security, and impeding social development.

While different sectors have acknowledged the need to address violence, action has remained inadequate partly because of scarcity of information on the magnitude of violence, its risk factors and interventions known to prevent it. This report does not answer every question concerning violence. Nonetheless, it goes a long way to give communities, countries and regions the tools they need to start taking systematic and concerted action to reduce the scourge of violence.

Dr Luis G. Sambo
Regional Director

ABBREVIATIONS

CMR	Crude Mortality Rate
DALYs	Disability adjusted life years
ECOMOG	Economic Community of West African States Monitoring Group
FGC	Female genital cutting
FGM	Female genital mutilation
GSHS	Global School-based Student Health Survey
HICs	High income countries
IDPs	Internally displaced persons
LMICs	Low and middle income countries
LRA	Lord's Resistance Army
MDGs	Millennium Development Goals
MoH	Ministry of Health
PRSP	Poverty Reduction Strategy Papers
PTSD	post-traumatic stress disorder
SGBV	Sexual and gender based violence
U5MR	Under five mortality rate
UNHCR	United Nations High Commission for Refugees
UNICEF	The United Nations Children's Fund
UNITA	*União Nacional para a Independência Total de Angola* (The National Union for the Total Independence of Angola)
UNSGVC	United Nations Secretary General's Report on Violence against Children
WHO	World Health Organization
WRVH	World Report on Violence and Health

EXECUTIVE SUMMARY

The World Report on Violence and Health defines violence as *'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation'* (Krug et al., 2002, p. 5).Within this general definition adopted for this report, three types are described based on the perpetrator of the violence.

- Interpersonal violence refers to violence between individuals, and is subdivided into 'family' and 'community' violence. The former category includes child maltreatment; intimate partner violence; and elder abuse, while community violence covers violence between acquaintances or strangers, and includes youth violence, sexual violence, assault by strangers, violence related to property crimes, and violence in workplaces and other institutions. Although this typology is used widely, it is clear that the different categories are not mutually exclusive as, for instance, the experience of child sexual abuse within the home may pre-dispose the victim to the perpetration of sexual assaults in the community.

- Collective violence refers to violence committed by larger groups of individuals and can be subdivided into social, political and economic violence.

- Self-directed violence refers to violence in which the perpetrator and the victim are the same individual and is subdivided into suicidal behavior and self-harm. The latter is not discussed further in this report.

In these categories the violence may be physical; sexual (except in self-directed violence); psychological; or may constitute deprivation.

There is now widespread acceptance that violence is not only a developmental or criminal justice issue, but a public health problem as well. Yet, prevention of violence in Africa has been hampered by a number of challenges, including fragmentation of effort and resources, and the failure to fully exploit the benefits of working across disciplines and sectors. Other barriers to preventing violence include:

- Lack of good data on the nature and magnitude of violence, and on its cost to society.

- Inertia and inaction resulting from the misconception that violence is endemic, part of the social fabric of the continent, and not really preventable.
- Inadequate resources to fund research and programs – partially due to the two points above, and to a global focus on the achievement of Millennium Development Goals (MDGs) that in some ways understate the scale of the threat violence poses to development. Links between violence and the Millennium Development Goals have not been well articulated despite the fact that high levels of violence seriously undermine the possibility of achieving any of the goals (Matzopoulos et al., 2008). For instance the continuing conflicts over resources such as diamonds and oil perpetuate violence in many countries in the region, and have a bearing on the integrity of health and education systems, food security, and child survival, and overall human development.

Clearly, for systematic violence prevention programmes to be implemented in Africa, stakeholders must take cognizance of the above barriers as well as the unique history and current context of the continent.

Nature and magnitude of violence in Africa

Africa has one of the highest rates of interpersonal violence in the world. Among WHO regions mortality rates due to injuries arising from interpersonal violence in 2004 were highest in Africa followed by the Americas and the European Region. Violence was responsible for 35.5% of all injury deaths in the Region, and at 37 deaths per 100 000 population it was considerably higher than the global average rate of 25 violent deaths per 100 000 population. These deaths were dominated by homicide, particularly among males, which accounted for 50% of all violence related deaths in the African Region in 2004.

Homicide rates were almost three times the global average of 9 per 100 000 population. Mortality patterns were markedly different for males and females, and varied across age ranges. The rate among males increased sharply from below 15 years to a peak of 128 homicides per 100 000 population for those aged between 20 and 29 years, and remained high, with a slight decrease after 70 years.

In both males and females suicide caused more deaths than war, and suicide rates for both sexes rose from the twenties to reach low peaks among the elderly. Suicide was the only major violence category whose African rates were lower than the global average.

While mortality data tend to be more available and therefore more quoted than non-fatality data, there are substantial impacts related to non-fatal outcomes. These include trauma and disability, as well as massive social, developmental and economic impacts. In

2004 interpersonal violence alone was the 12th leading cause of morbidity as measured by disability adjusted life years lost (DALYs), a measure that combines the years lost due to premature death and those lived with disability. Because some of the ill health resulting from violence occurs years or decades later, it is often difficult to trace its roots. This is particularly true of violence suffered in childhood.

The introductory chapter of this report discusses definitions of violence, the African context, challenges for violence prevention, and what is known about the size of the problem.

Chapter 2 focuses on child maltreatment, intimate partner violence, and elder abuse, while *Chapter 3* addresses community violence. These closely linked chapters contain several text boxes that explore and expand on phenomena that are either particular to or important drivers of violence in Africa, including harmful traditional practices, vigilantism and mob violence, and corporal punishment in schools. The authors highlight the factors that give rise to the particular violence sub-category and its broader social, economic and developmental consequences, before exploring possible opportunities for cross-cutting and type-specific interpersonal violence prevention.

Chapter 4 describes the intricate relationships between collective violence and population health in sub-Saharan Africa. It discusses the wider public health effects of armed conflict beyond the deaths and disabilities resulting from war injuries, and the overlaps and links between collective and interpersonal violence. The chapter elaborates on the challenges of accurately describing and quantifying collective violence, given the difficulties of data collection and validation in conflict situations. It discusses possible causes of continued collective violence on the continent, and concludes with a number of proposals for the prevention of collective violence in Africa.

Chapter 5 addresses self-directed violence. It examines the extent of suicide and suicide attempts with particular reference to differences across demographic groups, followed by an assessment of the typical methods used in and the risk factors for self-directed violence. Using an interdisciplinary approach, the chapter concludes with recommendations for prevention based on current knowledge.

In its last chapter the report carries cross-cutting recommendations and prevention strategies that apply to all forms of violence. The recommendations are summarised below:

Advance a single shared message that violence can be prevented. The widespread and unshakeable conviction that violence can be prevented is key to overcoming the current

inaction in the face of violence. Prevention means to stop violence from occurring, through direct efforts to remove the underlying causes and risk factors, and by harnessing the indirect effects of other policies and programmes that can contribute to reducing violence. Disseminating this preventability message and advocating for its uptake provides the foundation for all subsequent action.

Prioritize the prevention of violence as an integral part of human, social and economic development agendas. Violence in all its forms devastates human and social capital, diverts immense resources from constructive investments, and traps countless individuals, families, communities and countries in vicious circles of violence and underdevelopment. Violence prevention must therefore be prioritized alongside rather than after other material, environmental and humanitarian challenges such as poverty eradication, food security, or malaria and HIV/AIDS. To do this requires that violence be included in national development planning processes.

Implement and evaluate prevention strategies, giving priority to those that can simultaneously decrease different forms of violence. Primary prevention uses approaches that prevent violence before it occurs. Prevention efforts should therefore prioritize strategies that address common underlying risk factors and so have the potential to simultaneously decrease different forms of violence. These include strategies to increase safe, stable, and nurturing relationships between children and their parents and care givers; reduce availability and misuse of alcohol and access to lethal means (guns, poison, etc); promote gender equality and empower women; change cultural norms that support violence; improve the criminal justice and social welfare systems; reduce social distance between conflicting groups; and reduce economic inequality and concentrated poverty.

Develop national action plans with targets. A national plan should include objectives, priorities, strategies and assigned responsibilities, as well as a timetable and evaluation mechanism. It should be based on input from a wide range of governmental and non-governmental actors, and coordinated by an agency with the capacity to involve multiple sectors in a broad-based implementation strategy.

Initiate and enhance routine data collection. To set violence prevention priorities, design prevention programmes and monitor the effects of those efforts, good data are vital. The commitment of decision-makers at a national and regional level to develop policy and support the establishment of routine data collection systems is thus crucial to the violence prevention endeavour. Key actions include creating systems that routinely obtain descriptive information on a few key indicators that can be accurately and reliably measured, and ensuring appropriate inclusion of violence variables in national and lower level information systems.

Develop in-country violence prevention capacity. The prevention of violence requires knowledgeable and skilled staff, supportive structures and good networks. In every country these areas are critically in need of strengthening, and should be reflected in national action plans. Important actions include the establishment of a national network of individuals and agencies working on violence prevention, and the introduction of violence prevention components in appropriate training.

Strengthen services for victims of violence. The psychological, medical and social consequences of violence have a profoundly negative impact on individuals, families, communities, countries, and the whole region. Investing in health, social and legal support systems for victims of violence can help prevent future acts of violence, reduce disabilities, and help victims cope with the impact of violence on their lives. Strengthening integrated health systems should include strengthening the capacity for violence prevention. Key actions include introducing screening and referral services where these are lacking, and ensuring availability of victim sensitive medico-legal services, as well as institution of child friendly medico-legal services.

CHAPTER -1

INTRODUCTION

INTRODUCTION

CHAPTER -1

Whether in print or electronic media, or through witnessed accounts, reports of violence across Africa are so frequent that to some it has now become accepted as an inevitable part of life. The thread of violence runs through families, schools, communities, and nations. It affects all ages and is reported in rural and urban areas in virtually all societies. But violence is not random nor is it the outcome of inexplicable events. It is not an inescapable reality of African life, but in fact has patterns that can guide its prediction as well as its prevention. Information accurately collected and analyzed systematically across the world has demonstrated that like many other threats to human health and well-being, violence can be prevented.

1.1 Definition and Types of Violence

This report follows the definition of violence put forward in the *World report on violence and health* namely:

> *The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.*[1]

Within this general definition, the report further divides violence into three types according to the perpetrator of the violent act. Each of these broad categories of violence is constituted by more specific forms.

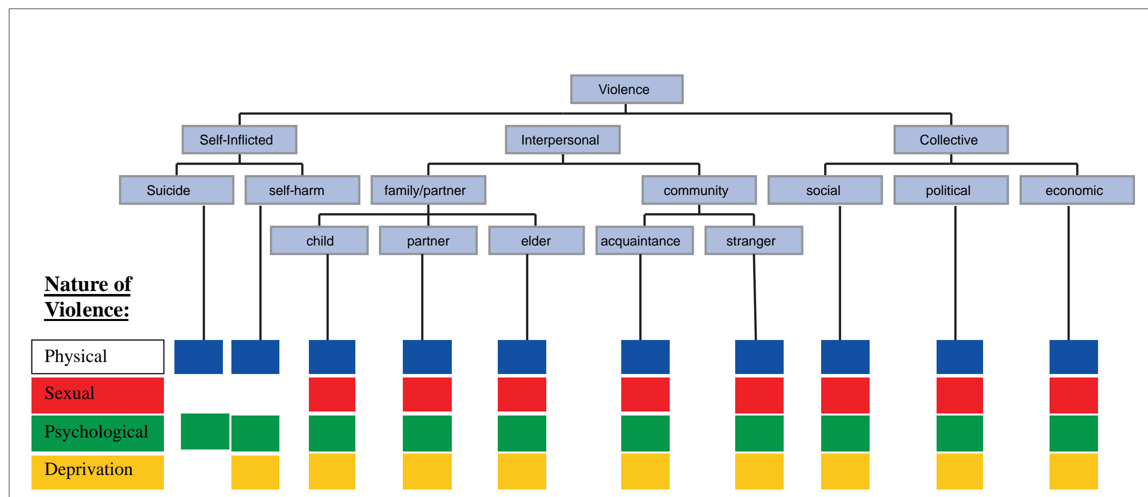
- Interpersonal violence refers to violence between individuals, and is subdivided into 'family and intimate partner violence' and 'community violence'. The former category includes child maltreatment; intimate partner violence; and elder abuse, while community violence covers violence between acquaintances and strangers, and includes youth violence; assault by strangers; violence related to property crimes; and violence in workplaces and other institutions. Although this typology is used widely, it is clear that the different categories are not mutually exclusive as, for instance, the experience of child sexual abuse within the home may pre-dispose the victim to the perpetration of sexual assaults in the community.

- Collective violence refers to violence committed by larger groups of individuals and can be subdivided into social, political and economic violence.

- Self-directed violence (or self inflicted violence) refers to violence in which the perpetrator and the victim are the same individual and is subdivided into suicidal behavior and self-harm. The latter is beyond the scope of this report.

Intersecting each of the above categories are the four ways in which violence may be inflicted, namely: physically; sexually; and psychologically; and through deprivation.

Figure 1.1: Typology of violence.



Source: World Report on Violence and Health (1)

A considerable amount of formal research on the problem of violence has been undertaken in Africa during the last two decades. However, despite the impressive array of findings, no systematic overview and analysis of violence in Africa has been compiled and research recommendations are often reported in ways that are not easily accessible and in places far removed from the study sites themselves.

Seminal publications such as the *World Report on Violence and Health*[(1)] together with an increasing awareness of the need for an inclusive, broad-based approach to violence prevention have demanded that systematic research on violence be disseminated as widely as possible. Because violence impacts negatively on almost everybody in some way or another, all Africans ought to participate as potential resources and agents for its

prevention. The global community also plays a role given that the underlying causes are strongly conditioned by global forces that impact on many of the key risk factors which underlie violence, including, for instance, economic and social inequalities; inadequate investment in social welfare systems; access to lethal means such as firearms, and ease of access to alcohol and illegal drugs.

This report attempts to enhance understanding about the prevalence and risk factors for violence on the continent as well as the numerous prevention opportunities that will stimulate a co-ordinated prevention effort. In so doing, the report uses a public health framework to reflect on what is and is not yet known about violence in Africa and what is required to reduce the scale of violence on the continent, to levels that no longer pose a threat to the public health and development of its people.

1.2 Rationale for the Report

A host of documents and reports have been written on the various forms of violence worldwide, and many have contained proposals for addressing the problem. International, regional, and national meetings have also been held to develop evidence-based prevention strategies. Evidence from elsewhere[1] shows that violence can indeed be prevented, and that the rates of injuries and deaths from violence can be reduced by systematically implementing certain interventions.

In order to institute interventions based on evidence, countries and communities need good information about the types of violence that are prevalent, where violent incidents occur, who is involved and what the outcomes are. Equally important is information on the situations and circumstances that increase the risk of violence, and those that protect against it.

In most countries in Africa the problem of violence is tackled by an array of players, approaching it from different perspectives, such as preventing violence against children, promoting and protecting the rights of the child, preventing gender-based violence, empowering women and girls, creating safer cities and neighborhoods (through policing, crime prevention, public safety, and maintaining the rule of law, among others), and resolving civil conflict through non-violent means. In many instances the sectors that work on these different facets do not consult on cross-cutting or overlapping issues, and information generated in one sector may well remain inaccessible to others that might benefit from it. This fragmentation has hampered a systematic and consultative approach to the prevention of violence in Africa.

In response to this challenge, this report draws attention to as many of the existing data on violence and prevention as possible, and puts in one volume key information that is relevant to multiple sectors in their efforts to prevent different types of violence. By collating and presenting the latest information on the burden of various types of violence in Africa, their risk and protective factors, consequences, and what interventions and strategies are known to be effective in their prevention, this report provides a tool that can be used by countries, communities, and institutions to reduce the toll of violence in Africa. It also highlights the barriers to effective prevention, and important gaps that should drive both the research and prevention agendas. In so doing, it is hoped that the report can inspire multisectoral groups to work together to overcome the obstacles created by the relative fragmentation of information and effort.

1.3 Barriers to Prevention

- That violence is erroneously considered an unchangeable part of the social fabric of the continent is in itself a potential barrier to its prevention. The implicit acceptance of some level of violence in many communities may be responsible for the inadequate mobilization of resources and articulation of strategies for its prevention. As a result, there may be more efforts expended in the containment of the consequences of violence, and less in its primary prevention.

- A further barrier is that effective prevention requires the commitment and intervention of several sectors, some of which do not work together often, making it difficult to agree upon and sustain actions. Depending on the type of violence they wish to address, these sectors could include education, health, social welfare, criminal justice and law enforcement, and urban development.

- Most countries in the region have focused their resources on the achievement of the Millennium Development Goals, none of which mentions violence prevention specifically. This is despite the fact that high levels of violence seriously undermine the possibility of achieving any of the goals.[(2)]

- In many countries, the lack of concrete efforts to address violence is partially attributable to the lack of good data on its nature and magnitude, on its cost to society, as well as what savings can be made from investing in violence prevention. The difficulties of documenting violence are varied. For example, different definitions of violence are used, leading to incomparable data sets. Certain types of violence such as sexual violence, suicide, and violence against children are poorly reported as they are associated with stigma. This results in a poor appreciation of the importance of the problem, and therefore its low prioritization, both by the state and civil society.

- Moreover, most systematic evaluations of the effectiveness of a variety of violence prevention programmes have been conducted in high-income countries, or in countries whose social systems are markedly different from those in Africa, making evidentiary arguments for their replication on the continent difficult. Clearly, for systematic violence prevention programmes to be implemented in Africa, stakeholders must take cognizance of the above barriers as well as the unique history and current context of the continent.

1.4 Africa's Historical Context

Africa is an expansive, diverse and "complex" continent[3] and sources detailing the history of violence in Africa are numerous. The continent is populated by thousands of ethnic groups, all with their own languages and histories. Cognisant of these complexities, this section attempts to provide a brief historical snapshot rather than an exhaustive history of the continent.

A reading of the history of violence in Africa must take two fundamental observations into account. Firstly, the fact that violence has characterised much of Africa's documented history in some way lends credence to what Stevens[4] has called the historical resilience and recalcitrance of violence on the continent. Secondly, as is the case in many other settings, the historic context of violence tends to focus on an account of collective violence rather than on the various types of interpersonal violence that pervade most societies. It is therefore one of the aims of this review to demonstrate the extent to which the full spectrum of violence has been fomented by Africa's repressive and divisive past and how certain types of interpersonal violence, such as intimate partner violence and child abuse and neglect, are endemic across the continent.

Most documented violence in Africa's pre-colonial history was collective and tended to be attributed to territorial wars between tribes.[5] Although these battles presumably resulted in high casualty numbers, very little is known about the nature, prevalence and impacts of violence during this period. However, it was not until the arrival of the Europeans on African soil that firearms capable of inflicting widespread and lethal injuries during periods of war, were available to Africans.

Ushering in the colonial period, the Portuguese took the town of Ceuta from the Moroccans and embarked on a series of explorations of the coastline of the continent that would span several decades.[6] Landing at the Gold Coast (Ghana) in 1471 and beginning with Elmina in 1482, they began setting up forts to protect areas rich in gold from other primarily European seafarers. Although the trading of slaves was seemingly practiced in pre-colonial Africa, it was only in the middle of the sixteenth century that the slave trade began to

dominate European activities on the continent and by the early seventeenth century firearms were being traded for slaves, beginning the arming of Africa.

By 1900 most of Africa had been colonised by a range of European countries. Most national borders were arbitrary with regard to ethnicity, culture, and religion, and the division of similar, or amalgamation of diverse, population groups, might have set the stage for conflicts within and between countries. Resistances to rule and revolts were commonplace in almost every colony, as inhabitants were violently dispossessed of their land and people were displaced.(7) Collective resistance to colonial rule was ongoing, and mainly took the form of revolts against the direct brutality or indirect exploitation of Africans through heavy taxation, labour exploitation and other mainstays of colonisation.(7) East Africa was the site of heavy conflict during the First World War (1914–1918) and the Italian invasion of Abyssinia (Ethiopia) and conflict in Northern Africa represented key areas of conflict in the Second World War (1939–1945).

The end of the Second World War marked a new period in the history of the continent with the newly formed United Nations (UN) redefining the continent's borders. Independence was gained in waves between 1950 and 1990. However, these years were not without their own high levels of collective conflict as Africa became integral to players in the cold war. In this way, a variety of newly liberated African states became heavily militarised, were plagued by civil strife and geographical divides, both of which appear to have laid the foundations for the collective violence that characterises the continent today.

Between 1950 and 1990, rapid population growth[1], a liberation ethos, and the pursuit of political and economic stability within the vacuum of colonial withdrawal represented key features of an independent Africa.(7) The liberation of the continent came with its own set of difficulties. Immediately following World War Two, the continent's economy showed signs of acceleration, yielding development gains such as increases in life expectancy and declines in infant mortality.(8) However this economic forward momentum was curtailed by the 1973 oil crisis, triggered by war in the Middle East which severely undermined Africa's developing industrial infrastructure. Politically, the sense of nationalism that had been fostered as a direct result of the mobilization of various factions against colonial rule began to disintegrate in particular states following decolonization, producing widespread difficulties in consolidating African 'states'.(9) For example, in Uganda, attempts at developing democratic dispensations showed early promise but later escalated into violent conflict. In the Sudan, challenges to the legitimacy of a central government spiralled into civil war contributing to the violence and political instability that continue to define everyday life in parts of the country. A number of conflicts were at least fuelled if not partially caused by attempts by various factions to access and exploit the vast mineral

1. The African population increased by three hundred percent during these years (Iliffe, 2004).

wealth in different countries.[9] For example, long-term conflict in Angola, although seemingly just another key site of vicarious conflict in the Cold War, was also driven by attempts to secure the country's rich oil and diamond deposits. Conflicts of this scale systematically undermined Africa's attempts at securing economic growth and, intersecting with the broader economic dimensions of globalisation, resulted in increasing levels of poverty. Widespread famine further hampered attempts at securing economic and political stability on the continent.

With the mining sector booming in southern Africa, there was an acute need for cheap labour, one of the key drivers of the intersection between capitalism and exploitation in countries such as South Africa. In that country, racism was institutionalized in the form of Apartheid legislation in 1948. Countries in the region began to mobilize military and financial resources in response to the last threat to the complete liberation of Africa. In addition to the perenial and systematic violence that already existed based on race, violent resistance was now met with heightened state brutality until a negotiated settlement was reached in the early 1990s. This made way for the first democratic elections in 1994.

More recently Africa has experienced genocides in Rwanda and Burundi. However, in the wake of a relative recession of collective violence on the continent, the prevalence, causes and consequences of other types of violence that appear to have been historically overshadowed by constant reporting on war and collective violence are becoming increasingly visible. While collective violence continues to ravage areas of the continent, it is becoming evermore apparent that interpersonal violence in its many guises, even outside of conflict zones, is an enduring feature of African life. Indeed, in some high-violence settings where they have been measured (e.g. South African cities) homicide rates among young males reach into the hundreds per 100 000, representing a death toll considerably higher than that manifest in many conflict settings. Violent assaults are becoming more frequent particularly in urban areas, and other forms of abuse directed at children, elders, intimate partners and females in general are pervasive. These types of violence intersect and continue to undermine the safety, security and well-being of Africans, as they do in all other regions and continents.

1.5 Contemporary Africa

Between 2000 and 2030, Africa's urban population will increase from 294 million to 742 million, an increase of 152%.[10] In 2005, Africa had an urbanization level of 38%. In spite of political opposition to urbanization in many countries, rates of urban growth are expected to remain relatively high over the next 25 years, with marked increases in the urban population. The continent is expected to sustain the highest rate of urban growth in the world for several decades. In some parts of the region, the primary influence on

urbanization is the movement of people uprooted by drought, famine, ethnic conflicts, civil strife and war.[10] Unless definite steps are taken to reverse the trend, it can be expected that the increases in population, urbanisation, and urban poverty will result in higher levels of all forms of violence.

Unlike in past decades when violence was not even considered a public health concern, there is now widespread acceptance that it is not only a developmental or criminal justice issue, but a public health problem as well. The *World Report on Violence and Health*[1] crystallised this thinking, and provided a public health approach that has influenced the way in which violence is understood, described, quantified, and tackled. More recently the *World Report on Violence against Children*[11] has provided updated information concerning the magnitude and nature of childhood violence.

This heightened awareness of the problem of violence is gaining impetus against the background of a global focus on the Millennium Development Goals (MDGs) that in some ways understate the scale of the threat violence poses to development. In 2000, most countries ratified the MDGs, with targets for the reduction of poverty and hunger, for gender equity, education, and critical health issues such as malaria and HIV/AIDS. Achievement of these goals would require investment in measures to reduce violence of different types.[2] For instance the continuing conflicts over resources such as diamonds and oil perpetuate violence in many countries in the region, and have a bearing on access to health care, food security, and child survival. As will be seen in the coming chapters, gender based violence has close links with the spread of HIV/AIDS in some communities.

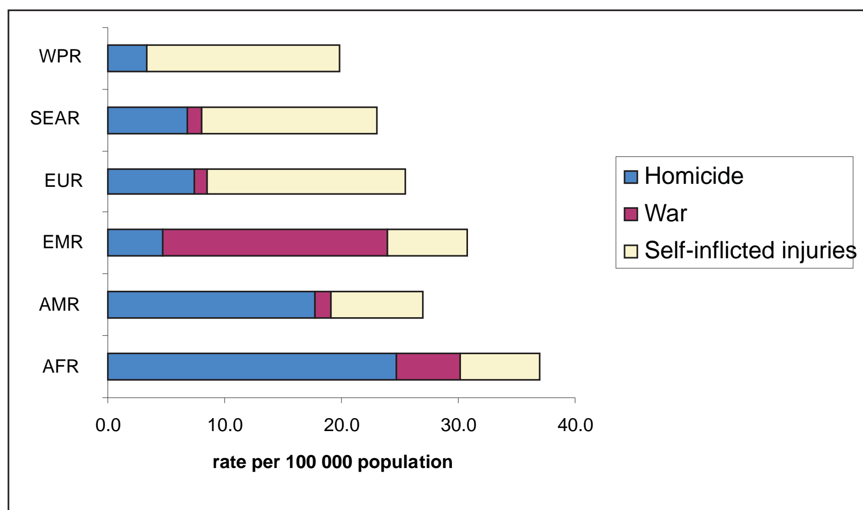
The importance of violence in Africa has not escaped the notice of the continental body politic. In 2003, Heads of Member States of the African Union (AU) passed a resolution endorsing the recommendations of the *World Report on Violence and Health*, and requesting Member States to develop national plans of action for violence prevention, and systems for data collection on violence. In 2005 the World Health Organization's Regional Committee passed a resolution on sexual violence against children; "Child sexual abuse: a silent health emergency" (AFR/RC54/15 Rev.1). The Third Session of the African Union Conference of Ministers of Health meeting (Johannesburg, South Africa, 9–13 April 2007) considered and endorsed a plan of action for the prevention of violence in Africa. At global and continental levels, recent efforts are focused on the reduction of armed violence. This stems in part from the mainly UN-led effort to reduce the trafficking and use of small arms and light weapons, and from African-led initiatives as well. The continent has received significant support towards this goal – for instance, leaders at the 2005 G8 Gleneagles summit pledged to support Africa in tackling conflict, which they acknowledged as 'one of

the greatest barriers to development'.
Violence in Africa therefore needs to be discussed in the context of a globalized economy, where Africa is an integral player in the sourcing and distribution of resources, including key drivers of violence such as economic and social inequalities, firearms, alcohol and drugs.

1.6: How Big is the Problem?

Despite imperfect and fragmented information, violence is known to be a formidable public health and development problem in Africa. Data drawn from health and criminal justice agencies confirm that Africa has one of the highest rates of interpersonal violence in the world. Among WHO regions mortality rates due to injuries arising from interpersonal violence were highest in Africa followed by the Americas and the European Region (Figure 1.2).

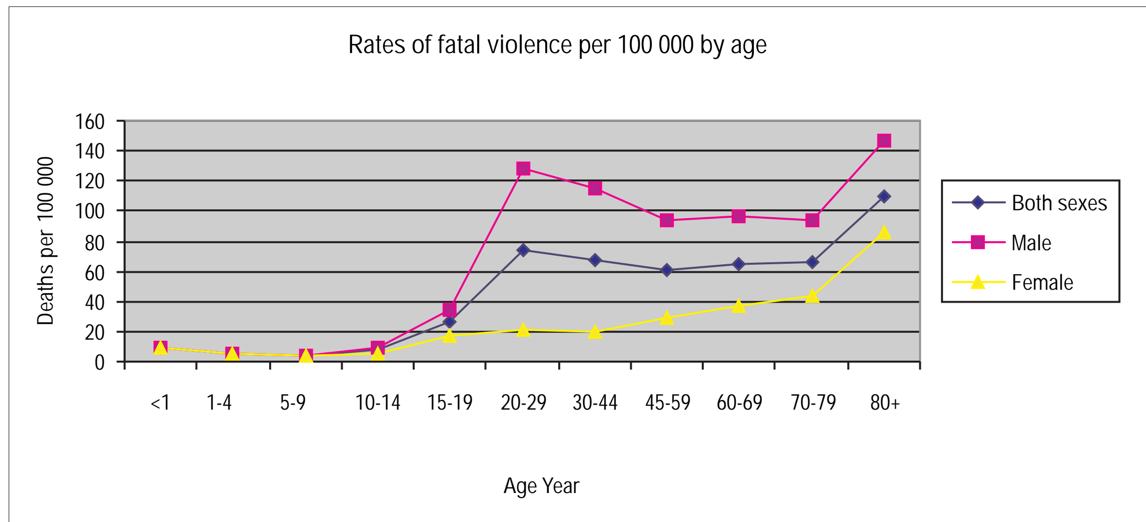
Figure 1.2. Estimated Violence-related mortality rates by WHO region, 2004.



*WPR = Western Pacific Region; SEAR = South East Asian Region; EUR = European Region; EMR = Eastern Meditarranean Region; AMR = American Region, AFR = African Region. Source: Global Burden of Disease, 2004 (12)

In 2004 violence was responsible for 35.5% of all injury deaths in Africa, and at the rate of 37 deaths per 100 000 population it was considerably higher than the global average of 25 deaths per 100 000 population. The pattern of these deaths was dominated by homicide, particularly among males, which accounted for 150 000, or 50% of all violence related deaths in the African region in 2004 (Figure 1.3).

Figure 1.3: Rates of fatal violence by age in the African Region, 2004



Source: Global Burden of Disease, 2004 [12]

Homicide rates (25 homicides per 100 000 population) were almost three times the global average of 9 per 100 000 population. Mortality patterns were characterised by stark contrasts between sexes and across age ranges. The rate among males increased sharply from below 15 years to a peak of 128 homicides per 100 000 population for those aged between 20 and 29 years, and remained high, with a slight decrease after 70 years. In females there was a slow and steady rise from the late teens, the highest rates being recorded in the elderly (Figure 1.3).

In both males and females suicide caused more deaths than war, and suicide rates for both sexes rose from the twenties to reach low peaks among the elderly. While homicide dominated the picture in the African region, the regional suicide rate of 13 suicides per 100 000 population was half that of the global rate, and suicide was the only major category of violence with a higher global rate than in the African region. Both European and Western Pacific regions registered much higher suicide rates and greater absolute numbers than the African region (Figure 1.2).

Although war related deaths had decreased between 2000 and 2004 (5.5 deaths per 100 000 population compared to 32 per 100 000 in 2000) they were still higher than the global average at 2.9 war deaths per 100 000 population.

While mortality data tend to be more available and therefore more quoted than non-fatality data, there are substantial impacts related to non-fatal outcomes. These include trauma and disability, as well as massive social, developmental and economic impacts. In

2004 interpersonal violence alone was the 12th leading cause of morbidity as measured by disability adjusted life years lost (DALYs), a measure that combines the years lost due to premature death and those lived with disability (Table 1.1). Because some of the ill health resulting from violence occurs years or decades later, it is often difficult to trace its roots. This is particularly true of violence suffered in childhood.

Although the current data already present a bleak picture, future projections present an even less favourable one. In 2002, interpersonal violence ranked 21st as a cause of death globally, and was responsible for only 1% of all deaths in that year. At that time it was projected to rise up to 19th place by 2030. Only two years later, in 2004, interpersonal violence was found to be the 12th leading cause of death and DALYs lost in Africa, responsible for 1.6% of all deaths in the region.[12]

Table 1.1: Leading causes of death and DALYs lost in the African Region, 2004

	Cause of death	*Deaths ('000)*	*%age total*	*Cause of DALYs lost*		*%age total*
	All causes	11 248	100	All causes	376 871	100
1.	**HIV/AIDS**	1 651	14.7	HIV/AIDS	46 655	12.4
2.	**Lower respiratory infections**	1 405	12.5	Lower respiratory infections	41 760	11.1
3.	**Diarrhoeal diseases**	994	8.8	Diarrhoeal diseases	31 816	8.4
4.	**Malaria**	832	7.4	Malaria	31 619	8.4
5.	**Cerebrovascular disease**	425	3.8	Neonatal infections & other*	13 441	3.6
6.	**Tuberculosis**	405	3.6	Birth asphyxia & birth trauma	13 433	3.6
7.	**Neonatal infections & other***	382	3.4	Prematurity & low birth weight	11 317	3.0
8.	**Ischaemic heart disease**	346	3.1	Tuberculosis	10 827	2.9
9.	**Prematurity & low birth weight**	309	2.7	Road traffic accidents	7 151	1.9
10.	**Birth asphyxia & birth trauma**	285	2.5	Protein-energy malnutrition	7 095	1.9
11.	**Road traffic accidents**	205	1.8	Measles	6 361	1.7
12.	**Inter-personal violence**	182	1.6	Inter-personal violence	6 333	1.7
13.	**Measles**	182	1.6	Congenital anomalies	5 797	1.5
14.	**Diabetes mellitus**	172	1.5	Meningitis	5 321	1.4
15.	**Meningitis**	156	1.4	Cerebrovascular disease	4 876	1.3

** comprises severe neonatal infections and other non-infectious causes arising in the neonatal period.*
Source: Global Burden of Disease, 2004 [12]

These projections underscore the need for the urgent application of violence prevention strategies, without which the scourge of violence will exert evermore strain on Africa's already overburdened health and social systems.

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CHAPTER -2

FAMILY VIOLENCE

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2. Introduction

The typology of violence used in the *World Report on Violence and Health* describes interpersonal violence according to two main categories, violence within the family or household, and violence at the community level. This chapter focuses on violence at the family or household level which encompasses three subcategories; child maltreatment, intimate partner violence and elder abuse. These forms of interpersonal violence have previously been considered a social issue, and have only recently been acknowledged as a public health problem. In addition to the more immediately apparent physical injuries and consequent deaths resulting from these forms of interpersonal violence, exposure to non-fatal violence has serious and long lasting consequences for mental and physical health. Child maltreatment, intimate partner violence and elder abuse result in an increased incidence of depression, anxiety disorders, eating disorders, post-traumatic stress disorder, substance abuse as well as sexually transmitted infections, including HIV infection. Given the range of psychological, behavioural and physical health consequences, the burden and cost of exposure to these forms of interpersonal violence can only be substantial.

2.1 Child Maltreatment

While violence against children is not new to Africa, child maltreatment recently gained increased visibility through the process of compiling the UN Secretary-General's Study on Violence against Children.[1] This report, presented to the UN General Assembly in 2006, drew on the work of several subregional networks, and highlighted the magnitude of the problem in Africa. As in other regions, violence against children in the family context by parents and caregivers has often been culturally and legally justified, and viewed as a normal part of childhood.

Defining child maltreatment

WHO defines child maltreatment as "all forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power".[2] The abuse of power and trust by parents and caregivers has significant developmental consequences for the child.

Child maltreatment includes physical, sexual, emotional/psychological abuse and neglect, including such abuse as may be inflicted in the name of discipline or corporal punishment. Developing local legal and operational definitions of child maltreatment for the purposes of prevention and child protection is therefore especially challenging when, as is the case in many African societies, corporal and humiliating punishment is not viewed as violence and regarded as acceptable.[3] Prevailing cultural norms, derived from unwritten laws that emphasize parental obligations to strictly educate children remain strong in much of rural Africa.[4] This is often accompanied by the belief that a certain level of physical or psychological suffering is necessary to prepare children to thrive in a hostile world.[5-7] The Committee on the Rights of the Child however has stated clearly that corporal punishment is degrading and contrary to children's rights (see Box 2.1). Therefore the replacement of beliefs and norms supportive of physical punishment with those that value the avoidance of all physical punishment must be an important goal of prevention programmes.

Box 2.1: The Committee on the Rights of the Child, on corporal punishment

The Convention on the Rights of the Child (8) obligates States Parties to "... take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s) or any other person who has the care of the child" (Article 19.1). The Committee on the Rights of the Child, which monitors implementation of the Convention, adopted General Comment No. 8 in 2006, namely "The right of the child to protection from corporal punishment and other cruel or degrading forms of punishment". The following paragraphs are excerpted from the text of the general comment:

"The Committee defines 'corporal' or 'physical' punishment as any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light. Most involves hitting ('smacking', 'slapping', 'spanking') children, with the hand or with an implement - a whip, stick, belt, shoe, wooden spoon, etc. But it can also involve, for example, kicking, shaking or throwing children, scratching, pinching, biting, pulling hair or boxing ears, forcing children to stay in uncomfortable positions, burning, scalding or forced ingestion (for example, washing children's mouths out with soap or forcing them to swallow hot spices). In the view of the Committee, corporal punishment is invariably degrading. In addition, there are other non-physical forms of punishment that are also cruel and degrading and thus incompatible with the Convention. These include, for example, punishment which belittles, humiliates, denigrates, scapegoats, threatens, scares or ridicules the child.

"In rejecting any justification of violence and humiliation as forms of punishment for children, the Committee is not in any sense rejecting the positive concept of discipline. The healthy development of children depends on parents and other adults for necessary guidance and direction, in line with children's evolving capacities, to assist their growth towards responsible life in society."

Following on from the Convention, the African Charter on the Rights and Welfare of the Child requires member states

- to "take all appropriate measures to ensure that a child who is subjected to school or parental discipline shall be treated with humanity and with respect for the inherent dignity of the child and in conformity with the present Charter" (article 11);
- to "take specific legislative, administrative, social and educational measures to protect the child from all forms of torture, inhuman or degrading treatment and especially physical or mental injury or abuse, neglect or maltreatment including sexual abuse, while in the care of a parent, legal guardian or school authority or any other person who has the care of the child" (article 16); and
- to "ensure that no child who is detained or imprisoned or otherwise deprived of his/her liberty is subjected to torture, inhuman or degrading treatment or punishment" (article 17).

Nature and extent of child maltreatment in Africa

The type of violence a child is exposed to varies according to the child's age and developmental stage. Infants and young children depend completely on adults for their survival and in High Income Countries (HICs) have been shown to be at greater risk of maltreatment by caregivers and family than older children.[9, 10] Despite major research gaps, the evidence available through surveys of reported child abuse cases, and a growing number of population-based studies clearly indicates that physical and sexual abuse constitute a significant threat to the health, development and rights of African children.

Physical abuse

Physical abuse is defined as the intentional use of physical force against a child that results in – or has a high likelihood of resulting in – harm for the child's health, survival, development, or dignity,[11] including in the context of punishment and attempts to correct behaviour. This includes hitting, beating, kicking, shaking, biting, strangling, scalding, burning, poisoning, suffocating, and a range of other harmful acts.

Regional comparisons show that homicide rates for the WHO Africa region among children aged 0 to 14 could be the highest of any UN region by a wide margin[2]. Special studies conducted in high-income countries show that for the age group 0–14 years deaths due to interpersonal violence are most likely as a result of maltreatment (often involving physical abuse) by a family member or another person living in the household.[9] Such studies have yet to be conducted in Africa, but were they to show similar findings, the WHO estimates suggest that rates of fatal child maltreatment in Africa would be among the world's highest. It is unclear to what extent non-fatal physical abuse follows a similar pattern, but a high prevalence of physical abuse among children aged 10–15 years was found in several African studies.[12–14]

Physical child abuse has not yet catalyzed public outcry and political commitment to the same degree as child sexual abuse. This may stem from the widespread acceptance of harsh corporal punishment as non-abusive, with corporal and humiliating punishments still widely used in African schools (see 'Corporal punishment in schools' in Chapter 3) and at home. In the United Nations Secretary General's Report on Violence against Children (UNSGVC), African children speaking-out against violence have confirmed that physical abuse – including corporal punishment - is part of their daily reality and that it has a negative impact on their growth and development.[15–17]

2. These estimates are based on vital registration data and epidemiological research studies. Vital registration coverage in the region is weak, and there are few sound epidemiological studies of deaths due to external causes in the region, so these estimates should be interpreted with caution.

Child sexual abuse

Child sexual abuse is defined as the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violates the laws or social taboos of society[3]. Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility, trust or power over the victim. WHO estimates that 24 million girls and 8.6 million boys under the age of 18 in Africa[4] have experienced forced sexual intercourse or other forms of sexual violence involving physical contact.[(18)]

Public awareness and media attention to child sexual abuse in Africa have grown substantially in the last decade, but systematic research on its magnitude and causes is still lacking.[(19)] Existing research often does not include information about the victim-perpetrator relationship, making it difficult to determine the proportion of sexual abuse occurring in the family context as opposed to other settings. To date much research has focused on describing characteristics of child sexual abuse cases identified in clinical settings.[(20-31)] Such studies have been conducted in Burundi, Cameroon, Ethiopia, Kenya, Malawi, South Africa, Togo and Zimbabwe. They have been helpful for drawing attention to the existence of child sexual abuse, providing evidence that a portion of it occurs within families, and demonstrating that sexual victimization is linked with sexually transmitted infections. For example, Meursing et al.[(23)] collected information on 1025 rape victims seen at seven major police stations in Bulawayo, Zimbabwe, between 1985 and 1991. Among these cases, 38% of victims were younger than the age of 16, with 14% aged eleven or younger. The proportion perpetrated by family members was not reported. A 2003 analysis of 5082 children seen at the Center for Mother and Child Protection in Yaounde, Cameroon between 1992 and 1997 showed that 2%[(104)] had experienced sexual violence. Most of the victims were girls (95%) and the most common form of violence was rape (97%). One-quarter of the sexual violence incidents occurred within families.[(7)]

In a national study of childhood sexual violence in South Africa, 1.6% of 11 735 women aged 15 to 49 reported being forced into or persuaded against their will to have intercourse prior to the age of 15. Most (84%) of these rapes took place between the ages of 10 and 14, with school teachers the most commonly reported perpetrators, followed by relatives.[(31)] WHO's Multi-country study on women's health and domestic violence against women asked women aged 15 to 49 about their exposure to different forms of violence, including child sexual abuse, and included study sites in Tanzania[5] and Namibia[6]. Between 9.5% and

3. The spectrum of sexual violence is defined more fully in Chapter 3 under Sexual Violence.
4. Defined as WHO's Africa region.
5. Dar es Salaam and Mbeya District.
6. Windhoek

12% of women in the Tanzanian study sites, and 21% of women in the Namibian study site, reported childhood sexual abuse (defined as someone touching them sexually or making them do something sexual they did not want to, before the age of 15), with the most commonly reported perpetrators being male family members other than father/stepfather, and boyfriends.[32] According to a national study of childhood sexual violence against females in Swaziland, approximately one-third of respondents reported experiencing some form of sexual violence prior to age 18.[33] Incidents occurred most often in the females' home or at the home of a friend, relative or neighbour - although it was not uncommon to experience sexual violence in public areas or on school grounds - with the most commonly reported perpetrators being husband/boyfriend (36%), man/boy from the victim's neighbourhood (27%), male relative other than father or stepfather (16%), and strangers (10%).

Building on this foundation, several studies asking secondary school and college students about their exposure to child sexual abuse have shown that a high proportion of students have been sexually abused. Madu and Peltzer[34] studied abusive sexual experiences prior to the age of 17, and with a person at least five years older or in a position of power, among 414 secondary school students in Northern Province, South Africa: 56% of males and 53.2% of females had experienced some form of sexual abuse involving physical contact with an adult or person at least five years older, or a person in a position of power, with 13.5% males and 17.6% females reporting oral, anal or vaginal intercourse. The prevalence of sexual violence against males was higher than expected compared to similar North American and European studies.[34, 35]

A study among 323 randomly sampled female secondary school students in southwest Ethiopia asked about the girls' experiences of child sexual abuse: 18% reported sexual intercourse, 17% reported unwelcome kissing, 5% reported genital fondling, and 51% reported verbal sexual harassment. Nearly one-third of the victimized girls reported that the perpetrator was a family member or neighbour.[36] A study among 487 university students in Tanzania investigated the prevalence of unwanted sexual experiences prior to the age of 18, with an age differential of at least five years between the respondent and perpetrator. Thirty-one percent of females and 25% of males reported at least one abusive sexual experience, with 18% of females and 10% of males reporting unwanted kissing, 28% and 13% reporting unwanted fondling, and 11% and 9% reporting unwanted sexual intercourse.[37] Most respondents did not specify the victim-perpetrator relationship. Abusive episodes against females most commonly involved physical force, betrayal of trust, bribes or intimidation. Abusive episodes against males most commonly involved betrayal of trust, bribes, intimidation or threats. The few studies which have looked at sexual abuse of boys suggest it is surprisingly frequent. It is therefore important that future studies of sexual abuse in the region include both girls and boys.

Other forms of abuse: Psychological abuse, deprivation and neglect

Maltreatment is not limited to physical abuse. Although the prevalence of deliberate psychological abuse or neglect remains mostly unstudied in the region, in one Kenyan study abandonment and neglect were the forms of childhood abuse most commonly cited by adults in selected communities.[(38)] In describing a multidimensional approach to child poverty, Noble and colleagues [(39)] explore numerous forms of deprivation that are imposed on South African children, including material, human capital, social capital, living environment, adequate care and physical safety deprivation along with physical and sexual abuse of children. For example, a high level of food insecurity in 30% of South African households is cited as a major cause of stunting due to malnourishment.[(40)] Many of these are likely to be present, or even more pronounced in many other African countries. Children deprived of protection networks often end up abused. Sometimes parents leave their children to people who are masters of a certain art in order to be taught, or to help them deepen their spirituality or faith ("*enfants talibés*").

Child trafficking

The circulation of children within Africa is an old traditional practice. Children entrusted to a third person within a 'poverty reduction' cultural framework often end up abused in many ways. Sometimes, it is not a question of 'entrusting', but that of underage children and adolescents leaving home in search of work, as is the case in Burkina Faso. Indeed, due to lack of activities during the dry season, and the only means of subsistence being farming which is so dependent on climatic conditions, youths go 'in search of money' to the cities and beyond national borders. For some particularly poor families, their departure is a survival strategy. Some fathers have described the departure of their children as follows: "*because of poor rains. It is in order to have money to buy food. Also, it is one less mouth to feed and that reduces the expenses of fathers. Their departure means reduced family expenses*".[7]

This strategy is confirmed by former migrants. Young boys from Benin go or are sent to work in rock quarries in Nigeria,[8] or in plantations in the subregions, in harsh conditions. Elsewhere, boys have more diversified activities such as sheet-metal works, gardening, sale of water, car mechanics, masonry, harvesting or cutting of cotton stems; or they become menial workers for drilling projects or plantations, or work as factory hands. The attitude of parents regarding the departure of these children swings between interested encouragement, concern for minimal safety of the child, and resigned opposition.

7. Land of men, girl-child servants in Burkina Faso: trafficking or migration? Analysis of child labour migration in the Sourou province of Burkina Faso: June 2003.
8. Terre des hommes, Les petites mains des carrières de pierre, Décembre 2005.

Child trafficking has reached worrying proportions in Africa, particularly in the sub-Saharan region, where it is at sub-regional and international scale. The children placed in households and victims of trafficking either within or across borders top the list of victims of violence, including sexual and psychological abuse. Girl-servants or helpers of handicapped or aged people are particularly affected. Often there are no data available. Everywhere, the duty of being helpful and painful experiences with tutors, 'owners', or employers co-exist. Various living and work conditions of children have been observed, ranging from quasi-harmonious relations, where each party is satisfied, to the worst forms of exploitation, accompanied by psychological, physical and sexual abuse, and even deprivation of food, medical care and leisure time.

It is estimated that there are more than two hundred thousand trafficked children per year in West and Central Africa[9]. According to the International Labour Organization, approximately 48 million children aged from five to 14 years in Africa (29% of the child population) engage in an economic activity.

The personal 'advantages' derived from trafficking are of questionable value when compared to the risks and consequences involved. The children bring back material objects (bicycles, radios, tape recorders, 'modern' clothes, kitchen utensils, etc.), life experiences, a sense of emancipation and pride. "You know when they return, the whole village turns out to welcome them, this is what encourages others to leave" declared a village chief in Burkina Faso.[10]

There are consequences though: loss of cultural roots and identity with maladjustment to community norms: "[girls] return with unacceptable behaviours. They no longer want to work the farms, they refuse arranged marriages, and become too 'educated' to listen to or respect their parents". A more detailed discussion of child trafficking is beyond the scope of this report, but it is important that governments and communities wishing to prevent violence against children not ignore the problem.

Factors associated with child maltreatment

The risk of child maltreatment by parents and caregivers is related to a combination of personal, familial, community and societal factors. Research has identified several factors that are associated with child maltreatment, but most of this research was conducted in high-income countries. Identification of risk and protective factors in African societies is therefore important.

9. UNICEF, Le trafic d'enfants, Belgique, opt cit, p 6.
10. Land of men, girl-child servants in Burkina Faso: trafficking or migration? Analysis of child labour migration in the Sourou province of Burkina Faso: June 2003.

Child-related factors

Very young children are especially vulnerable to abuse and neglect because of their dependence on adult carers and their developmental vulnerability, which can result in abusive acts having severe, even life-threatening, consequences. A child's sex influences what types of violence he or she is most at risk for, with some evidence indicating girls are more at risk of sexual abuse and boys more at risk of physical abuse, especially severe corporal punishment. Children with disabilities, children who are unwanted, premature, low birth-weight, part of a multiple birth, or suffering chronic illness or behaviour problems may also be at increased risk.[1, 41, 42]

Parent and family factors

Parents who are young, single, poor, and socially isolated, and parents with a history of victimization or perpetration, are at increased risk of abusing their children. Alcohol and drug misuse, mental health problems, poor impulse control, unreasonable expectations of child development, and partner violence by parents also increases the risk of child maltreatment within a family. Authoritarian parenting, where the parent-child relationship is characterized by control and harsh punishment, increases the risk of abuse. [11] [1, 41].

Community factors

Although the link has not been well-researched, a community's social and cultural norms related to the status of children, child-rearing practices, and family violence can create an environment that either enables child maltreatment to flourish, or acts as a restraining force.

When prevailing norms dictate that physical and psychological suffering are a necessary part of children's growth and development, that children should always submit to their elders without question, that parents have the right to treat their children as they see fit, that child abuse is a private matter and not a matter for state intervention, children's vulnerability to abuse increases. In communities where these are the accepted norms, family members, neighbours and even child protection authorities may be reluctant to break the silence when they know or suspect a child is being victimized. Strong patriarchal norms contribute to child sexual abuse and have been discussed as an important factor by several researchers and activists working on child sexual abuse prevention in Africa.[19, 23, 35, 37, 41, 42] Other factors that influence the risk of child maltreatment include the availability of alcohol, high unemployment levels, poverty and social capital deficits.[1, 41, 42]

11. Authoritarian parenting stands in contrast to authoritative parenting, a healthy and effective parenting style which sets high standards for behaviour and enforces clear limits but balances this with warmth, support and responsiveness to the child's needs (1).

Societal factors

Researchers, advocates and professionals working on child maltreatment in Africa have identified several societal factors as key contributors to the problem, though data regarding these issues is extremely sparse and the direct relationship of these factors to child maltreatment has not yet been studied. These factors include the breakdown of immediate and extended family systems, migrant labour, separated and orphaned children, child-headed households, and the household effects of poverty that can make a child vulnerable to abuse and exploitation, coupled with societal norms that accord a low status to children and normalize harsh physical punishment.[1, 3, 19, 35, 42–46] HIV/AIDS is set to further strain regional parenting capacity. The increasing number of orphans has led to very young children being institutionalised or raised in child headed households, which has further implications for maltreatment.

In addition, weak legal frameworks that do not offer children equal protection under the law may contribute to child maltreatment as they seem to condone, or at least fail to prevent, violence against children. Laws however, are not enough to bring about change unless they are implemented and accompanied by awareness-raising and behaviour change initiatives.

Weak social policies that leave children and families without economic and social safety nets lead to family stress and social isolation, which in turn can lead to higher rates of child maltreatment. Policies related to alcohol availability, maternal and child health services, mental health care, and substance abuse treatment further affect this risk.[1, 41] A social perspective constantly reminds us that there is a link between economic deprivation and physical abuse and neglect of children.[47–52]

Consequences of child maltreatment

Underlying causes and risk factors for child maltreatment may vary from region to region, but international research has shown that the consequences of child maltreatment are universally damaging to a child's health and well-being. Child maltreatment has a variety of acute consequences including physical injury (in severe cases, even death), sexually transmitted infections including HIV/AIDS, unwanted pregnancy, depression, anxiety and post-traumatic stress disorder.[41] Exposure to abuse and neglect can negatively affect the development of a child's brain, resulting in cognitive, psychological and social impairment.[53] Abused children may suffer poor school performance, psychosomatic disorders, difficulty in relationships, and may attempt suicide. Several studies have shown that corporal punishment, including less severe forms, is associated with child aggression, anti-social behaviour, mental health problems, and impaired parent-child relationships.[54]

The psychological and emotional consequences of child sexual abuse and their impact on children's school performances is another focus of current studies.[55–59] One study of young adult and adolescent men in South Africa found that those who had experienced more childhood trauma in the form of emotional abuse and/or neglect, physical abuse and/or neglect, or sexual abuse, were more likely to commit rape later in life.[60]

In addition to acute physical and mental health and social consequences, child abuse has also been linked with an increased vulnerability to health risk behaviours such as smoking, alcohol and drug misuse, and high-risk behaviours associated with HIV infection, and, in turn, to higher risk of HIV/AIDS and chronic diseases later in life.[61–65] For example, a study of adolescents in Zambia found family abuse (physical or sexual) to be a significant predictor of engagement in high-risk HIV/AIDS-related behaviours such as injecting with unclean needles and having sex without using a condom; the more family abuse an adolescent had experienced, the higher their probability of engagement in any high-risk behaviour.[61] There is an extreme paucity of studies exploring the links on the long-term impacts of child maltreatment in Africa, and therefore a need to address this gap in research.

Recommendations for preventing child maltreatment

The visible and invisible scars of past child abuse prevent many people from achieving their potential, thereby draining society of much needed intellectual and social capital. International research indicates that the potential for child maltreatment exists within all societies and all social strata. Preventing the wilful mistreatment of children or mistreatment due to ignorance is an important social policy objective.[46, 66] Effective prevention requires a combination of primary prevention to address child maltreatment before it occurs by targeting potential groups at-risk, secondary prevention to optimize services for victims and families where maltreatment is identified, and tertiary prevention to mitigate the long-term effects following maltreatment or abuse.

Primary prevention strategies to address child maltreatment

Several strategies for reducing the underlying causes and risk factors of child maltreatment have been found effective, and many more show promise but have not been fully evaluated. These strategies must be assessed for feasibility and then adapted for implementation and evaluation in Africa, where to date there are very few programmes directly aimed at the prevention of child maltreatment. There also need to be more deliberate efforts to harness and monitor the indirect effects of those policies and programmes that may contribute to reducing exposure to risk factors and causes on child maltreatment rates. The effects of home-based day care centres in Korogocho slums, Nairobi, Kenya (http://www.anppcan.org/new/projects/daycare.htm), for instance, would

be more instructive were they rigorously evaluated. The overall purpose of the project is to provide affordable and accessible early childhood care and education for children from low-income earners. The centres are housed in homes of mothers who have been selected by the community members. There are approximately 120 centres spread in eight villages. Each centre has a capacity of 10 children. The program therefore cares for some 1000 children aged between 0–6 years old. The project has assisted the community to make initiatives, which they say have contributed a lot to the care and protection of their children against various forms of abuse.

Support for parents and families. When properly supported, families can provide healthy, protective environments that allow children to thrive. Programmes that facilitate infant-parent attachment; educate parents about children's normal physical, emotional, cognitive and sexual development; promote the development of parenting skills for behaviour management and non-violent discipline; and provide access to high-quality childcare when the parent is absent have been shown to have preventive effects for child maltreatment, as well as other positive child health and development outcomes [1, 11, 41, 67–69] These types of interventions can be delivered through home visitation programmes or community-based centres, with the latter, centre-based option of delivering training and support for parents, likely to be the most feasible in many African contexts where professional staff are in short supply. The most effective home visitation programmes focus on families at greatest risk of abuse (rather than involving all families), begin in pregnancy and continue until the child is two years old, promote positive health behaviours and stress management strategies, and address a range of other issues important to the family.[68, 70]

Increased access to reproductive health care, including family planning, pre-natal and post-natal services. Improving access to quality reproductive health services can reduce unwanted pregnancies, improve pregnancy and birth outcomes, and provide entry points for educating parents and identifying parents in need of additional support.[71] Depending on the country context, providing access to legal, safe abortion may be an additional strategy.

Life skills education. Life skills programmes aim to build social, emotional, cognitive and behavioural competencies among children and adolescents. Such programmes can be offered through schools or be community-based. The life skills approach has been applied particularly to child sexual abuse prevention. Programmes targeting child sexual abuse usually focus on giving children the knowledge and skills to protect themselves from abuse, and to ask for help should abuse occur. These programmes have demonstrated some impact on improved knowledge and skills, but it is not clear how long the impact lasts after the intervention, and whether the skills are effective in helping children protect themselves if the perpetrator is someone very close to and trusted by them.[11, 71] While equipping

children to protect themselves and to break the silence is important, preventing child maltreatment is primarily the responsibility of adults. Life skills education should therefore be implemented alongside other interventions.

Changing social and cultural norms. General awareness-raising activities are important for breaking the silence about child maltreatment, but are not consistently linked to changes in child maltreatment rates. Public awareness campaigns should be implemented alongside other prevention strategies to support behaviour change. Communication initiatives can improve knowledge and awareness, and can influence social norms.[11, 71] Sensitization and mobilization work should target parents, child care providers, children, community leaders, professionals who work with children and families, and the general public.

Legal reform and social policy measures. Children must be protected from all forms of violence in all settings, regardless of the sex of the child or perpetrator, and regardless of the victim-perpetrator relationship. Legal reforms are necessary to harmonize laws so that children are afforded equal protection under the law. Legal reforms should be accompanied by measures to promote positive, non-violent relationships in families, particularly through training and education programmes.

In addition, legal and policy measures to reduce the availability of alcohol, access to reproductive health care and mental health and substance abuse treatment may be important societal interventions for reducing child maltreatment. Strong social policy to support families in times of rapid social and economic change is also necessary, including policies in the area of poverty reduction, employment, rural livelihoods, early childhood education and care, and social protection systems.[11, 41, 72]

Secondary and tertiary prevention: Intervening when abuse is detected

Achieving significant reductions in child abuse incidence rates requires systematic primary prevention approaches, but action is also required to assist the millions of children living in situations of family violence. These children need care and appropriate protection from further abuse, and to facilitate their complete recovery. According to the Convention on the Rights of the Child (Article 19), protective measures should include mechanisms for identifying, reporting, referring, investigating family violence against children and for providing treatment, follow-up and judicial involvement as appropriate. A strong legal framework is an essential foundation for child protection systems, but such systems should not be grounded in legislation alone. Public awareness, legislation, community responses and the building of service provider capacity must develop in parallel for an effective child protection system, and alongside primary prevention strategies for a balanced approach.

Caution is advised in the design of formal child protection systems, whose interventions may cause harm when carried out incompetently or in the absence of sufficient resources.[73] Models of child protection systems that are adversarial and punitive in nature are often resource-intensive and rely on skilled professionals, presenting a challenge in settings where there is a shortage of such resources and professionals. Decision-makers in these settings must identify alternate ways to protect children and provide them treatment despite human and financial resource constraints. There is little research to guide this process, but several issues must be considered.

Early detection, reporting systems and intervention. The consequences of child maltreatment worsen with increasing frequency, severity, and time span of abuse. Early detection of abuse, when accompanied by interventions to stop it and facilitate healing, is therefore critical. Any professional group that regularly interacts with children and families (e.g., health workers, teachers, social workers) provides an important entry point for child protection. Standardized guidelines can be helpful for building professionals' capacity to detect and respond appropriately to child abuse. Furthermore, for various reasons, 'frontline' workers who interact frequently with children and families may be reluctant to report cases of suspected abuse to child protection authorities.

Some countries have implemented mandatory reporting requirements for certain categories of professionals (e.g., health workers, social workers) in an attempt to strengthen protection for children. While mandatory reporting can improve reporting rates, it is not clear that this leads to improved outcomes for children and families[74] and in fact may result in further limiting child protection resources without offering further support to families.[73, 74] Reporting structures should be matched with adequate treatment and support mechanisms for children and families, and children and their representatives should have access to confidential services where they can seek assistance without reporting implications unless there is threat of serious injury or death.[1]

Treatment and support. Children and families require a wide range of services to help mitigate the enormous impact of child maltreatment. The child victim needs access to comprehensive and sensitive treatment that includes documentation and treatment of physical injuries, psychosocial support, and when indicated, testing and prophylaxis for sexually transmitted infections, including HIV, pregnancy prevention and collection of forensic evidence. Families may require health, social and legal assistance. Training based on standard protocols and guidelines can improve the quality of care.[12]

12. The WHO Regional Office for Africa is currently developing a clinical guideline for the management of child sexual abuse, modelled on the 2003 WHO Guidelines for medico-legal care for victims of sexual violence.

Intervening in the best interest of the child. When abuse is suspected or confirmed, a range of interventions may be taken to protect the child and support the family. These range from supportive interventions such as respite care, financial assistance, and training in parenting, to more protective interventions including supervision of the home, removal of the perpetrator, and as a last resort, removal of the child from the home.[11] The intervention least detrimental for the child and least intrusive for the family should be prioritized, and the child's wishes should be considered. Alternative care can be formal (e.g. foster care, adoption) or informal (e.g. placing child with extended family). If alternative care is necessary, family-based solutions are preferable to institutional placement; long-term solutions with regular review should take precedence over temporary solutions; and in-country solutions are preferable to those involving another country (e.g. international adoption).[75] Coordinated case management among service providers in the community is an important aspect of successful child protection intervention.[1]

Community involvement. Since formal child protection systems are implemented at the community level, communities should be involved in the design of such systems. In many countries of the region community-based NGOs engage in child protection work as part of the formal system, or as part of an informal system in the absence of state intervention.[73, 76] Efforts to design or improve child protection systems should seek the participation. of these organizations and other civil society organizations such as SOS Children's Villages (see Box 2.2) or Save the Children, who offer child protection services in several countries.

Box 2.2 SOS Children's Villages

SOS Children's Villages is an independent, non-governmental and social development organisation, which has been active in the field of children's needs, concerns and rights since 1949. Its activities focus on neglected and abandoned children and orphans, as well as disadvantaged families. If a child cannot stay with his/her biological family, his/her right to care, protection and equal opportunities should still be guaranteed. Every SOS Children's Village offers a permanent home in a family-style environment to children who have lost their parents or can no longer live with them. Four to 10 boys and girls of different ages live together with their SOS mother in a family house, and eight to 15 SOS Children's Village families form a village community.

In Africa the SOS Children's villages have taken on slightly different forms depending on the communities in which they are based. The large and increasing numbers of orphans as a result of HIV/AIDS has meant more children in need of care. In Zimbabwe for instance, where the collapse of the commercial farming sector and HIV/AIDS have left large numbers of children at risk of becoming destitute, there are efforts to help communities neighbouring the villages to develop child oriented programs, and to reduce the vulnerability of children in those communities. In the Gambia, the programs of the SOS village provide services for children not resident in the village, and family strengthening programs aim to reduce the numbers of children at risk of being homeless and without adult care. While these and similar programs are not primarily designed to prevent violence in children, it is important that this aspect is not missed out in program evaluations, since the need for such settings is set to increase.

Conclusion and future perspectives

Far too many children in Africa, as in other regions, experience abuse at the hands of their parents and caregivers. A growing body of research has demonstrated the prevalence of

abuse and some of the unique dynamics of the problem in the region. Further investment in systematic research efforts are needed to fill the remaining knowledge gaps.

The UN Secretary-General's Study on Violence against children catalyzed interest and action on violence against children across the region.[(1)] In the process of the study, two interdisciplinary subregional networks were created (West and Central Africa, and Eastern and Southern Africa). These networks brought together a diverse group of stakeholders including government representatives, researchers, civil society organizations, UN agencies, and children themselves. Each network identified regional priorities and recommendations, and will assist with implementation of the wider recommendations of the study. The regional momentum generated by the study and its subregional networks must be capitalized on and converted to action.

Despite the availability and widespread ratification of the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child, levels of family violence against children remain high, suggesting that States have not yet matched their commitments to human rights with the requisite investment and action to prevent child maltreatment and provide protection when it does occur. Now is an appropriate time to assess the resources devoted to problem definition and identification of evidence-based solutions in Africa, and to take stock of what measures are being implemented by states in the region to prevent and respond to child maltreatment.

Child maltreatment can be prevented, and assistance can be provided to victims to minimize the consequences of maltreatment. The supporting evidence comes mainly from other regions, but there is every reason to believe that with careful adaptation, implementation and evaluation, many of the measures proven effective elsewhere can work for the children of Africa.

2.2 Intimate Partner Violence

Intimate partner violence is one of the most common but also most hidden forms of family violence. In Africa and other low- and middle-income regions, it is predominantly perpetrated by men against women.[(77–79)] This section therefore focuses on partner violence with men as perpetrators. Our understanding of the nature and extent of this problem in Africa has emerged over the past decade with data only available for some countries. International studies on intimate partner violence have shown that factors associated with partner violence are a complex interplay of personal, situational and socio-cultural factors.[(80, 81)] The WHO multi-country study on domestic violence and women's health estimates that globally between 13% and 61% of ever partnered women have experienced violence in an intimate relationship.[(82)] The burden from intimate partner violence remains

largely hidden but is thought to pose an enormous health problem to most countries. Yet, the recognition of intimate partner violence as a health and human rights issue is recent, with the development of policies to prevent violence against women at international and regional level having emerged only over the past decade.

Defining intimate partner violence

Intimate partner violence refers to violence by the husband or other former or current male intimate partner. This form of violence includes acts that result in physical, psychological or sexual harm to the partner. Such acts include:

- Physical assault which includes hitting, slapping, kicking and beating with or without objects.
- Psychological abuse, such as constant belittling, intimidation, harassment and humiliation.
- Coercive sex and any other forms of sexual degradation.
- Controlling behaviours such as isolating the woman from family and friends, monitoring her movement and restricting her access to resources.[83, 84]

Studies in Africa show that women often perceive wife beating as justified.[85–87] A population-based national survey in Zimbabwe found that 53% of women thought beating was justified when a wife argued with her husband (36%); neglected her children (33%) and went out without telling her spouse (30%).[86] Other studies found attitudes that rationalised the idea that wife beating was justified when the female neglected household chores, disobeyed her husband or elders, refused to have sex or was suspected of infidelity.[88–92] Women and communities explain partner violence based on what is perceived as 'just cause', when the woman is viewed as not fulfilling her role as wife and mother. This suggests that women's justifications for violence are rooted in the notion of traditional gendered roles of women and men.

Bride price in Africa further compounds the gendered role of women. In a household survey in South Africa it was found that women living in a rural province thought it culturally acceptable that if a man paid 'lobola' (bride price) he owned the wife.[81] Others argue that lobola provides men rights to progeny and labour from the woman after marriage.[93] This exchange of money or goods to seal the marriage therefore impacts on the status of women within society providing men with power in an intimate relationship. Within such societies women are expected to be submissive and sexually available to their partners, and the use of violence is considered as the right and responsibility of the man in order to discipline the woman if she is seen as being disobedient. Intimate partner violence in most parts of Africa is still thought of as a private matter between husband and wife, and the proportion of

women with options such as legal recourse is still very limited.[94] Socioculturally, women are often expected to remain in a marriage. Leaving is seen as a sign of failure for both the woman and her family, while some women leave but do not divorce their partners. Many women also remain in such marriages for fear of losing their means of livelihood.

Nature and extent of intimate partner violence in Africa

Methodological differences in data collection make direct comparisons of estimates from different studies difficult. In response to this lack of comparative data, the WHO conducted a multi-country study on Women's Health and Domestic Violence against Women. Table 2.1 presents data for three African countries from the WHO multi-country study and data from other population based studies. Since data on different forms of violence in intimate relationships are limited, with the majority of studies exploring only physical violence, Table 2.1 only compares prevalence rates for physical violence. Prevalence rates for lifetime experience of physical violence in Africa range from 13% and 66%.

Studies on intimate partner violence suggest that acts of physical violence coexist with other types of violence within that relationship. A study in Soweto, South Africa found that a small proportion (5.5%) of physical violence occurred on its own, with the largest overlap between physical and psychological violence (29.8%) and a 13.4% overlap between physical, psychological and sexual violence.[95] This was substantiated by the WHO multi-country study which also found a substantial overlap between experiences of physical and sexual violence. The study estimates that the lifetime prevalence of combined physical and sexual violence by an intimate partner ranges between 35.9% and 70.9% while estimates of emotionally abusive acts were higher, ranging between 33.8% and 75.1% for African countries.[32] Controlling behaviour of the male intimate partner varied from 51% to 89.5%, with urban Tanzania (Dar-es-Salaam) at the highest end for surveyed countries, with both sexual and physical violence associated with an increased risk of controlling behaviour.

Intimate partner violence can result in death, although only two studies on fatal intimate partner violence in Africa have been published. *Women in Law and Development in Africa* undertook a study on femicide (defined as as the killing of women by men because the women are female) in Southern Africa.[96] This study was conducted in preparation for the United Nations World Conference on Women (Beijing) and reviewed cases from Zambia, Zimbabwe, Swaziland, Botswana and South Africa over a 10 year period. This study used various data sources in the different countries (police, newspaper, court and oral accounts). It found that the majority of perpetrators were current or previous intimate partners. The only national prevalence study on intimate femicide was conducted in South Africa. This study found that 50% of all murdered women were killed by an intimate partner,[97] for an estimated intimate partner femicide rate of 8.8 per 100 000 women aged 14 years and older

- the highest globally reported rate.[97] This study also found that women killed by an intimate partner were more likely to be killed in their home, by blunt force or with a legal firearm, and were often younger than their partner. The ownership of a legal firearm by the perpetrator was found to be strongly associated with such murders.

Table 2.1: Physical Assault on women by an intimate partner, selected population based studies in Africa

Country or area	Year of study	Coverage	Sample size	Age group	Percentage of women assaulted by a partner	
					In past 12 months	ever
WHO Multi-country study (32)						
Ethiopia	2000-2003	Butajira	3016	15-49	29.0	48.7
Namibia	2000-2003	City (Windhoek)	1500	15-49	15.9	
Tanzania 2000-2003		City (Dar es Salaam)	1820	15-49	14.8	32.9
		Mbeya District	1450		18.7	46.7
Other population based studies in Africa						
Zimbabwe (98)	1996	Midlands Province	966	≥18	17	
South Africa (92)	1998	Eastern Cape	396	18-49	11	27
		Mpumalanga	419	18-49	12	28
		Northern Province	464	18-49	5	19
Zambia (99)	2001-2003	National	5029	15-49	26.5	48.4
Sierra Leone (100)	1994	Freetown & Northern Province	144			66.7
Uganda (89)	2000-2001	Rakai District	5109	15-49	20	30
Malawi (101)	2004	National	3546	>18		30
Ghana (102)	1998	National	2069	>18		33
Kenya (103)	2000-2001	6 provinces	1164	17-77		45
Mozambique (101)	2004	National	1927	18-69	18	39.5

Factors associated with intimate partner violence

The risk of intimate partner violence is related to a combination of personal, relationship, community and societal factors. Whereas most research has been conducted in high-income countries, the few risk factor studies that have been conducted in Africa have tended to focus on individual level factors. Limited data are available on community or societal factors associated with partner violence, making this an important area for future research.

Individual factors

It is important to recognise that there are personal behavioural and biological factors that influence either the likelihood of women becoming victims of intimate partner violence, or that predispose men to aggressive and violent behaviour as potential perpetrators of intimate partner violence.

Victim Factors. Most studies in Africa have shown that demographic variables did not increase the risk of partner violence with the exception of victim education. Having a secondary school education or higher has been shown to reduce the risk of becoming a victim of interpersonal violence.[89, 92, 104, 105] Childhood experiences such as witnessing a mother's abuse and being beaten in childhood have also been associated with an increase in risk of being a victim of partner violence.[85, 92] Those who have been exposed to violence in childhood often view it as normal. Sexual debut before 15 years of age was also found to be associated with an increase in risk of partner violence.[89] This association might be confounded by the fact that early sexual debut is often coercive and therefore such women have an increased vulnerability in future relationships. Forced first sex was found to be significantly associated with partner violence in a community based study in South Africa.[106] A study in Tanzania has also shown an association between having problems conceiving and having five or more children with an increase in risk of partner violence.[105] This was supported by a study in Nicaragua that found that women who are infertile may be seen as worthless and beaten, while women might also be "kept" pregnant to disempower them.[107] Women having more than one partner in the past year have also been shown to be at increased risk of partner violence as this might result in jealously by the partner or the victim seeking love from another as a result of being beaten and disempowered.[92]

Perpetrator Factors. In a South African study, the only demographic risk associated with perpetration of partner violence was having no post-school training or education.[108] However, the same study showed that a history of violence, in particular having witnessed his mother being abused, was shown to significantly increase a man's risk of perpetrating partner violence.[108] This would suggest that observing violence as a means of dealing with

conflict is an important predictor of becoming violent later. Conservative ideas about women, for instance parents preferring a boy child,[92] and perceptions that beating a woman is acceptable [108] have also been shown to be associated with an increase in risk. Men who were controlling were also more likely to be violent against an intimate partner.[82] A study on intimate femicide in South Africa has shown that men who are employed as skilled workers, and owning a legal firearm are more likely to kill a partner and continue to commit suicide.[109] HIV risk behaviour such as having casual sexual partners, substance abuse, reporting of sexual assault of non-partner and transactional sex have been shown to be associated with young men's increased risk of being violent towards an intimate partner.[110] In an ethnographic study of young men in the Eastern Cape 'successful masculinities' were determined by dominant beliefs based on number of sexual partners and ability to 'control' one's partner.[111]

An association between alcohol use and increased risk for partner violence has consistently been found.[85, 89-92, 108] While the role alcohol plays in fuelling partner violence is not obvious, there is clear evidence to confirm that it reduces inhibitions, impairs judgement and that its misuse is strongly associated with conflict and violence between partners.[108]

Relationship and interpersonal factors

The following relationship and interpersonal factors increase the risk of a women's risk of victimisation by an intimate partner:

- couples with income, educational or job status disparities;
- dominance and control of the relationship by the male;
- marital conflict and instability.

In addition, the following factors increase the male partner's risk of becoming a perpetrator of violence against his intimate partner:

- marital conflict;
- marital instability—divorce, separation;
- dominance of the male;
- economic stress;
- unhealthy family relationships.[112]

In South Africa studies have shown that conflict over the drinking and infidelity of the potential perpetrator and the victim's drinking, are all factors associated with an increase in risk of intimate partner violence.[92, 108]

Community factors

Research from a range of settings has found an association between poverty and intimate partner violence.[107, 113] Yet this association has not been consistently shown in Africa. In Tanzania, a study has shown an increase in risk when the man did not contribute financially to the household. One South African study showed rape rates increasing with average expenditure levels for the poorer suburbs and decreasing for richer districts.[114]

The involvement of men in fights in settings such as the workplace and in the community has also been shown to increase their risk of being violent in an intimate relationship.[105, 108] The high levels of poverty and unemployment in Africa could perhaps be impacting on this association. Jewkes et al.[92] found that women used support structures, mainly relatives, to assist economically. These family structures could possibly serve as a mechanism to reduce the risk of conflict over resources. An important factor which could explain the high prevalence of partner violence in some parts of Africa is the high levels of violent crimes. In settings where levels of violence are high 'successful' male identity is based on notions of violence and control with hegemonic (violent) forms of masculinity dominating all social practices.

Societal factors

Cross-cultural studies have shown that in places where domestic violence was not considered a private matter it was less common.[115] Such studies have also shown that intimate partner violence is prevalent in societies where there are high levels of violence and conflict.[116] These studies also suggest that levels of violence differ across societies based on the prevailing degree of male dominance related to decision-making and economic power.[77, 115] Sociocultural norms and structures within such societies normalise partner violence. Justifications of men beating their partners are perpetuated by traditional gender roles for women.[88–92] Cultural norms regarding a woman's role and status in society impact on the available resources for women to leave the violent relationship. Factors associated with sexual abuse in an intimate relationship have been shown to be linked to men coming from a less privileged background and having experienced adverse childhood experiences.[60] It is thought that the mix of poverty with ideas of masculinity may lead to sexual violence in an intimate relationship.

Consequences of intimate partner violence

Intimate partner violence has a range of serious health effects with death being the most extreme. The health effects are not always physically visible but can manifest in poor health status and poor quality of life.[117] The WHO multi-country study found an association

between negative health outcomes reported by women and a history of intimate partner violence. At all three African sites women who experienced partner violence were significantly more likely to report poor health.[32] It was also found that of ever-abused women, 19% of women in Ethiopia and 30.5% of women in Namibia reported injuries as a result of the partner violence.[32] The most immediate consequence of violence is undoubtedly injuries, however violence also increases a woman's risk of adverse health outcomes both immediate and in the future. A study among teenagers in South Africa found that first forced sex by a boyfriend was associated with early pregnancy.[118]

In a review of predominantly North American studies it has been shown that a history of intimate partner violence increases the risk for a range of mental health problems from depression, anxiety and post-traumatic stress disorder to suicide.[32, 117] There are limited data on the mental health effects of intimate partner violence in African countries. Studies in South Africa have shown an association between intimate partner violence and suicidal thoughts and post traumatic stress disorder.[81, 119]

Important links between intimate partner violence and HIV have been established in Africa. Studies carried out in Tanzania, Kenya and South Africa have found that HIV positive women were more likely to report having experienced intimate partner violence.[106, 120, 121] There appears to be a connection between male infidelity, intimate partner violence, and women's increased risk for STIs including HIV. This is further compounded by notions of masculinity and male identity. Ethnographic evidence from South Africa suggests that in order for men to attain the 'idealised' masculinity they have to be successful in heterosexual relationships and there is a need to control their partners.[111] One study found that high levels of male control in a woman's current relationship were associated with HIV seropositivity.[106]

Recommendations for preventing intimate partner violence

The prevention of intimate partner violence can be achieved through primary, secondary and tertiary prevention strategies. Primary prevention of intimate partner violence aims to reduce women's risk of victimisation through empowerment programmes, through working with men to change patterns of men's use of violence and aggression in intimate relationships, and through efforts to address other risk factors and situational determinants, such as alcohol misuse and exposure to child maltreatment. Secondary prevention focuses on the training of social and health workers (and other suitable community members as appropriate) to improve the detection of intimate partner violence and to provide appropriate victim services, and tertiary prevention focuses on strengthening institutions to respond to victims thereby mitigating the adverse consequences of intimate partner violence for victims and rehabilitation of perpetrators.

In a review of strategies to address gender-based violence, Guedes[122] found that strategies in low-and middle income countries tended to focus on strengthening the overall response to gender based violence, whereas in high-income countries the focus was predominantly on training and screening policies. Although most intervention strategies to address gender-based violence have not been rigorously evaluated, Guedes[122] recommended the use of multiple strategies to link different levels of intervention and to promote system wide changes.

Primary prevention

Primary prevention means reducing the number of new instances of intimate-partner violence by intervening before any such violence occurs. The impact of primary prevention is measured at a population level by comparing the frequency with which either victimization or perpetration occurs. This approach contrasts with other prevention efforts that seek to reduce the harmful consequences of an act of violence after it has occurred, or to prevent further acts of violence from occurring once violence has been identified. Primary prevention relies on analysis of the underlying, or 'upstream', risk and protective factors for intimate-partner violence and/or sexual violence, and action to address those factors. These factors include individual level factors (e.g. reducing exposure to child maltreatment, reducing rates of adults with foetal alcohol spectrum disorders); relationship-level factors (e.g. working with men and women to enhance non-violent conflict resolution skills); community level factors (e.g., reducing access to and misuse of alcohol; reducing social isolation; promoting positive non-violent role models) and societal factors (e.g., changing cultural norms that condone intimate partner violence; reducing concentrations of poverty; reducing economic inequality).

Among the primary prevention strategies to address intimate partner violence, interventions can be applied at most levels, although for these strategies to be effective from a public health perspective interventions have to take into account the ecological model which suggests that violent behaviour is influenced by the social context in which it occurs.[123] In Africa this would suggest that we need to address the prevailing norms and traditions which perpetuate intimate partner violence, by addressing women's low status, rigid gender roles, and imbalances of power in intimate relationships, with the aim of changing behaviour.

Rights and policy frameworks. The acknowledgement of intimate partner violence as a health and human rights concern has resulted in policy responses by a number of governments through the ratification of international and regional treaties on violence against women. A number of countries in Africa have followed by introducing legal reforms to criminalise intimate partner violence, either by introducing new laws or amending

existing legislation governing domestic violence. Law reform processes should form part of a coordinated response by police and service providers to offer women protection from further violence.[109]

Community mobilisation. Cultural norms that encourage male control and women's subordination have to be challenged. It is important that intimate partner violence be seen not as a problem for women alone, but as a problem for men and the community as well. Community mobilization initiatives have proved promising in engaging multiple community members and organizations to work together in ensuring collective buy-in and establishing issues of concern and potential solutions for that community.[122] A promising example is Raising Voices in Uganda which utilises multiple strategies to change norms on domestic violence.[124]

The process of community mobilisation follows five phases:

1. Community Assessment - gather information on attitudes and beliefs about intimate partner violence and build relationships with community members.
2. Raising Awareness - increase awareness about intimate partner violence within the community and in various sectors.
3. Building Networks – encourage and support community members and various sectors to consider taking action and to strengthen efforts to prevent intimate partner violence and uphold women's right to safety.
4. Integrating Action – integrate actions to address intimate partner as part of everyday life and institutions' policies and practises.
5. Consolidating Efforts – strengthen actions and activities and to ensure their sustainability.

(Adapted from: Preventing Gender Based Violence in the Horn – A Regional Dialogue (124))

Awareness Raising Campaigns. Raising awareness is a critical step in changing behaviour and preventing partner violence. The aim of such campaigns is primarily to challenge prevailing beliefs and norms and contribute to social change at both the individual and community level.[122] The effectiveness of such media campaigns in changing behaviour has not been sufficiently evaluated.[84] A project that has been evaluated is 'Soul City', a multimedia health project in South Africa. In this project entertainment education (edutainment) combined television, radio and print media. Evaluation found an increase in knowledge and awareness with a shift in attitudes and norms away from support for intimate partner violence.[125] However, the evaluation was not able to measure whether these shifts in knowledge and awareness were associated with changes in actual violent behaviour.

Engaging men. Critical to shifting the patterns of intimate partner violence is changing the behaviour and attitudes of men. Most programmes do not have an explicit focus on men but rather include them as part of the strategy to engage communities. In Kenya and South Africa, in response to both the prevention of gender based violence and spread of HIV/AIDs the 'Men as Partners Programme' was implemented. The central element of the programme is education workshops with the aim of addressing the unequal balance of power between men and women.[122]

Building the capacity of women. Empowerment through financial independence shows promise as a strategy to reduce intimate partner violence. An example is the IMAGE Project, a randomised control trial conducted in rural villages in South Africa's Limpopo Province, which focused on women living in poverty.[126] Loans were provided to randomly selected women who were entered into the intervention arm of the study and a participatory learning curriculum training programme called 'Sisters for Life' was offered at bimonthly loan meetings for a 12–15 month period. The intervention also integrated a community mobilisation component involving both youth and men in the intervention communities. Participants were followed up for 2-3 years and showed a 55% reduction in experience of intimate partner violence for women who received the intervention.

Shifting patterns of partner violence through gender training. The effectiveness of sexual health and gender training to reduce intimate partner violence was explored by way of a randomised control trial in the Stepping Stones HIV prevention programme.[127] Participants were recruited from secondary schools in 70 villages in the rural Eastern Cape Province of South Africa. In the intervention arm Stepping Stones was implemented in 35 villages with 20 men and 20 women in each community attending 17 sessions over 3–12 weeks. Participants were followed up at 12 months intervals for two years to assess HIV incidence and changes in knowledge, attitude and intimate behaviour. The evaluation showed a significant reduction in physical and sexual violence used by young men towards their intimate partners 24 months after the intervention. Young men in the intervention arm also reported having fewer partners and correct condom use indicating a change in men's sexual risk taking behaviour.

Secondary and tertiary prevention: Intervening when violence is detected

In their review of international violence prevention efforts, Dahlberg and Butchart[71] noted that most programmes for intimate partner violence were geared towards secondary and tertiary prevention. In sub-Saharan Africa, traditional responses such as counselling services and shelter provision are limited, although secondary prevention initiatives seem to be more common in Africa than primary prevention programmes.

Health Sector Reforms. Health workers are uniquely placed to identify women who are abused as they enter the health system, to provide them with the necessary support and refer to appropriate services. However, over-burdened health services within most communities and the attitudes of health care providers to intimate partner violence present as widespread obstacles to the effective use of health care systems for secondary prevention. Training of health workers to respond appropriately to intimate partner violence is only starting in most African countries. This strategy can only be effective if there are system-wide changes, as training of health workers can only have lasting results if there are support structures.(128)

Increasing women's access to justice. Improving women's access to judicial services is important as it provides women with protection by law. This can only be achieved by addressing the system-wide problems experienced in many African countries such as corruption, procedural delays, and lack of a formal judicial presence in rural and poor urban areas.(129) South Africa has attempted to enhance access through a collaboration of sectors. The success of such initiatives has not been formally evaluated. Training of police officers has also received some attention in the region. Evaluations of such initiatives have shown that unless all levels of police are trained, such interventions yield little impact.(129)

Perpetrator treatment programmes. Perpetrator treatment programmes are in their infancy in many countries of the African region. The only documented programmes are in South Africa, both operating independently from the court system. Internationally there are two existing models; voluntary or court ordered. Evaluation of such programmes in developed countries has shown that they work best when the men continue to participate in these programs for long periods. Men's attitudes are changed enough for them to talk about their behaviour, their participation in the programme is sustained and the work is done in tandem with the criminal justice system should conditions of the court be breached.(84)

Improving Social Services for Survivors. Support services for women in violent relationships are inadequate. Services are mainly provided by NGOs with some countries providing limited counselling services and limited funding available for services such as shelter provision. Social services primarily include the provision of counselling services, psychological care, support groups, legal assistance and income generation programmes. The concept of shelters in Africa has been debated as it is construed as western, and not meeting the needs of African communities.(130) However, there is an emerging need for shelters in Africa as extended families and indigenous support systems often fail women. In Zimbabwe and South Africa the western model of shelters has been adapted to meet the growing need of the communities they serve.(130) The impact of such shelters requires evaluation, particularly in rural settings.

Intimate partner violence poses an immense health burden to most countries in Africa. Tackling this problem effectively requires that we understand the magnitude of the problem for the region as a whole. The current data provide a picture based on only a few countries, implying that the issue remains hidden in many parts of Africa. Strategies to address intimate partner violence have predominantly been spearheaded by development agencies with funding mainly originating from the aid sector. In order to decrease intimate partner violence it is critical that the issue be placed on the public agenda, and that governments acknowledge the health burden it places on all nations. The social context in which intimate partner violence prevails can only be effectively addressed if there is political will from governments to address this form of violence. Community responses can only be effective when the violence is tackled at multiple levels with support from the state.

2.3 Elder Abuse

In most traditional African societies older persons, in particular males, have been highly respected and honoured.(131, 132) Changing social and economic environments have resulted in the elderly no longer being given the respect and reverence that tradition and cultural practices uphold. Shifts in values and practices have influenced how the elderly are viewed and treated in many societies.(131, 133-135) A growing aged population in Africa has meant that many elderly people face a future of neglect and abuse without a social safety net.(136)

Defining elder abuse

Elder abuse is any form of maltreatment that results in harm or distress to an older person.(135, 137–140) Definitions of elder abuse and neglect have been influenced by work in developed countries and include physical, sexual, financial, and psychological dimensions.(141) A focus group study of rural and urban South Africans found that respondents defined elder abuse as including a range of acts:

- Physical abuse – beating and physical mishandling.
- Sexual abuse- incest, rape and other types of sexual coercion.
- Emotional and verbal abuse – insults and hurtful words, denigration, intimidation, false accusations, psychological pain and distress.
- Economic abuse- extortion and control of social assistance grants, theft of property, exploitation of an older person such as forcing them to care for grand children.
- Neglect – no respect for elders, withholding affection, a lack of interest in their wellbeing.
- Accusations of witchcraft – stigmatization which can lead to death.
- Abuse by the system – dehumanizing treatment of older persons by institutions and marginalization by government.(141)

Elder abuse therefore includes forms of gender-based violence such as rape, domestic violence, 'honour' killings and trafficking in older persons. Rooted in cultural and superstitious beliefs in some regions, old age is also associated with witchcraft. Anecdotal evidence suggests that in some areas in rural Africa, elderly women whose relatives meet with some kind of misfortune are blamed as the cause and branded witches resulting in being beaten, ostracized or killed. Elderly women are the main targets of such accusations based on the low status of women in most societies.(141)

Nature and extent of elder abuse

There is a paucity of data on elder abuse in sub-Saharan Africa. The extent of the problem has not been explored systematically and is therefore unknown for the region. In Cameroon a Regional Centre for the Welfare of Ageing with a Legal Department has been established exclusively to protect the rights of the elderly.(142) Examples of human rights abuses are reported to be commonplace; in Ghana there are accounts of several 'witch camps' where older women accused of witchcraft are detained without due process of law.(143) Machera (144) reported that "...when I was growing up in a rural village in Kenya, there was a belief that old women, particularly the poor and ugly, were witches". Financial exploitation is a key challenge faced by many older persons in the region. This is highlighted by the financial and social consequences HIV/AIDS poses for the aged, especially those living in poor rural communities who are left to care for grandchildren.(145–147) Economic hardship and social isolation also endangers their health as this limits access to heath care. Cases of rape of older women by much younger men are on the increase in parts of Africa owing to the mistaken notion that having sex with an older woman can cure one of AIDS.(148)

Causes and consequences of elder abuse

Internationally it has been reported that living arrangements such as overcrowding, lack of privacy and dependency of adult children on elderly parents for housing or financial support are associated with elder abuse.(141) There are limited data on risk factors associated with elder abuse in Africa. A South African study (149) reported that the causes of elder abuse are poverty, lack of respect shown by adult children, alcohol abuse, drug abuse, unemployment, beliefs in witchcraft, and the marginalization of the aged by the government which reflects low status of the elderly. The World Report of Violence and Health reports that at the individual level gender is a defining factor, with older women at increased risk of this form of violence.(141) In Africa strong cultural beliefs and entrenched gender roles enable certain forms of elder abuse, such as inequitable widowhood rights, and accusation of witchcraft which primarily affects women. Very little is known about relationship factors and how they increase the risk for elder abuse in Africa. Research

findings also suggest that the processes of modernization and urbanization, coupled with the impact of the HIV/AIDS pandemic, are eroding the traditional social welfare systems in Africa such as the extended family structure.[131–133] The movement of people, migration and displacements, have also contributed to the disintegration of the family.[134, 147] Consequently, many older persons are left without care or are forced to care for children who are abandoned or separated from parents and home, with resultant economic vulnerability. Given the pandemic proportion of HIV in sub-Saharan Africa the burden of care of both the AIDS patients and their children falls disproportionately on the elderly family members, who also lose the support and care that would be provided by their adult children.

There exists a huge gap in knowledge on the causes and consequences of elder abuse in sub-Saharan Africa. In order to understand this problem in the region it is important to develop a research agenda to provide not only the data but an understanding of the nuances of the problem for the region.

Recommendations for preventing elder abuse

The care and support of most aged persons is provided within the context of the extended family network in most parts of sub-Saharan Africa. Identifying abuse of the elderly and developing strategies to prevent such practices is in its infancy in the region. There are existing policy frameworks such as the United Nations Principles for Older Persons[150] which provides the foundation for a rights-based approach to prevent elder abuse. However, it requires responses at a national level to develop country specific plans of action. Prevention cannot be effectively addressed through legal responses alone but should be coupled with the strengthening of social policies and services for the aged.[141] Training providers of health care and social services to detect elder abuse is an important step in managing this problem. Yet few such programmes have been implemented in low-income countries. Evaluating and sharing best practise models on local responses is important if Africa hopes to tackle this issue effectively.

2.4 Conclusion and Future Perspectives

Interpersonal violence within the family remains severely under-researched in many parts of Africa. Based on the rather limited few available data, it is clear that this form of violence affects large numbers of both children and adults in the region, resulting in long-lasting negative health impacts on current and future generations. Prevention requires innovative responses that extend beyond the health sector. It requires the involvement of multiple

sectors at the local, national and regional levels. It is important that strategies be supported by governments as change can only be achieved if there is substantial, holistic, and sustainable investment in the prevention of violence. National action plans incorporating inter-sectoral collaboration are imperative, given the magnitude of the problem. Research to further our understanding of this form of interpersonal violence is fundamental in developing intervention strategies and evaluating their effectiveness.

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CHAPTER -3

COMMUNITY VIOLENCE

COMMUNITY VIOLENCE

3. Introduction

In addition to violence within the household between intimate partners or family members, much interpersonal violence in Africa occurs in the community (i.e. in the streets, market places, entertainment areas, drinking establishments, transport terminuses and other public spaces), often between acquaintances or strangers. Males are most at risk for acts of violence by other males involving firearms, sharp instruments and other weapons, whereas females are more at risk of being sexually assaulted by males. Where systems are in place to monitor violence-related deaths and non-fatal cases presenting to hospital emergency departments, acts of violence occurring within communities typically show clear patterns with respect to high risk times, places, situational determinants and population subgroups, suggesting the great potential that exists for their prevention. Unfortunately, apart from a reasonably substantial scientific literature on the topic in a few countries, such as South Africa, Kenya, and Nigeria, few other countries in the WHO African region have systematically investigated violence occurring within the community, making it difficult to identify cross-national similarities and differences in the magnitude and characteristics of the problem and underlying causes.

Although the WHO typology subdivides community violence into violence between strangers and violence between acquaintances, few African studies have attempted to document victim-perpetrator relationship patterns. Accordingly, this chapter is organized around two more widely described sub-types of violence occurring in the community, namely youth violence and sexual violence occurring outside the confines of intimate relationships (the latter is addressed in Chapter 2).

3.1. Youth Violence

Youth violence should not be viewed in isolation since it is linked to a history of childhood exposure to other forms of violence within the family, community and at a societal level (1). However, because youth violence frequently occurs outside of close family relationships among friends, acquaintances and strangers within the community, it presents its own specific prevention challenges and opportunities, in addition to those shared with other types of violence.

Defining youth violence

Youth violence is defined as violence that involves adolescents and young adults, both as victims and perpetrators. According to the United Nations, youths are persons aged between 15 and 24 years. However, the definition becomes more complex when psychological and developmental attributes are taken into account. In parts of Africa full adulthood begins when a person, especially a male, becomes self-sufficient through work and is able to support a family. Until then he is viewed as a youth, even if he might be in his thirties. This chapter addresses both the sociocultural and the chronological age definitions of youth, meaning that the age range is wider than might be used in other regions.

Nature, severity and extent of youth violence

In its nature and severity, violence among young people encompasses a wide spectrum of acts, from very severe physical violence that results in death and disability, through moderately severe physical violence resulting in injuries requiring emergency medical treatment followed by discharge, to bullying and emotional violence that may leave no physical traces despite severe and long lasting psychosocial and other health consequences. Sexual violence - including rape - may occur together with these other forms of violence. Despite its importance, the real extent of Africa's youth violence problem is not clear owing to the lack of agreed definitions, reliable data, and capacity to report.

Homicides due to youth violence

Homicides represent the most severe end of the youth violence spectrum. According to the World Report on Violence and Health (WRVH), Africa's youth homicide rate of 17.6/100 000 was second only to the Latin American rate of 36.4/100 000 and nearly double the global average of 9.2/100 000. In contrast, youth homicide rates in high income European countries, parts of Asia and the Pacific were less than 1 per 100 000.[1] However, these regional-level data mask considerable variability between and within different African countries and cities.

Using overall homicide rates as a proxy for youth homicide rates this cross-national variability is illustrated by findings from Mozambique, South Africa, Swaziland and Tanzania. Homicide rates per 100 000 population in South Africa's four major cities in 2005, as measured by the National Injury Mortality Surveillance System, were 60.0 in Cape Town; 53.8 in Durban; 36.4 in Johannesburg and 20.7 in Tshwane/Pretoria.[2] For the year 2002, the Royal Swazi Police reported 184 homicides,[3] equivalent to a rate of 16.3 per 100 000 population. For Maputo City, Mozambique, police data for 2003 indicated a homicide rate of 7.5 per 100 000, although a special study conducted at Maputo Mortuary suggested that

this may be a severe underestimate of the true homicide rate.[4] In Dar es Salaam region, Tanzania, the homicide rate was 12.95 per 100 000 in the year 2005. In all countries and cities, nearly 90% of the homicide victims are male.[5] While some of this inter-city variability in homicide rates is certainly due to differences in definitions and data collection methods, the rates are associated with differences in the proportion of homicides involving firearms, this ranging from approximately 20% in the four South African cities, through 15.8% in Dar es Salaam and 8.8% in Maputo City. In Namibia, however, only 1.7% of police-reported homicides were recorded as involving firearms, a much lower percentage than would be expected from the relatively high national homicide rate of 17.9 per 100 000.[6]

Relatively few African studies have examined the victim–perpetrator relationship and the typical scenarios that underlie youth violence leading to homicide. Those which have been conducted suggest that perpetrators are often friends or acquaintances of the victim, that much of this homicidal violence occurs in neighbourhoods and local hang-outs, and is linked to arguments which develop into fights – over young women, possessions, rivalries, broken loyalties or group codes – and to intoxication with liquor or drugs. The availability of firearms may mean that this violence results in serious injury or death.[7-9]

Box 3.1 Vigilantism, mob violence, and gangs

Mob violence is frequently - but not always - triggered by the perceived need to punish an individual or group. Vigilantism involves a greater degree of organization and structure than the more spontaneously occurring mob violence. Vigilantism and mob violence therefore span the divide between interpersonal and collective violence. This is particularly true of vigilante groups formed with the support and encouragement of governments, as has been the case recently in Tanzania, Zimbabwe and Liberia where groups have been established ostensibly for the protection of the community, and in parts of West Africa, where vigilante-type groups maintain a strong regional presence. In Tanzania, 'SunguSungu' evolved at the behest of a senior government official in response to the government's inability to control increasing levels of petty theft and stock stealing.[10] In Zimbabwe, 'war veterans' of the country's struggle for independence and youth militia were mobilized at the urging of the Presidency to take up the land occupied by white farmers.[11,12] In Liberia, the difficulties of maintaining law and order were compounded by the return of ex-combatants[13]. The Africa Research Bulletin[14] reported that the government had admitted that police were unable to cope with armed robberies in Monrovia, apparently perpetrated by former civil war combatants who had been unable to find work, and that the Minister of Justice had requested that communities form vigilante groups for protection. Yet the very existence of such groups is an indictment of a State's failure to provide a safe and secure environment through the formal security apparatus, and powerful vigilante groups can eventually threaten the host governments that gave them legitimacy. As their actions begin to supplant the law, clashes with police become inevitable[15, 16] and pose unique policing challenges. It is often impractical to arrest perpetrators, as so many are typically involved that a single culprit can rarely be identified, and police may be reluctant or unable to arrest a large group.[17, 18]

Far less structured than vigilante violence, most mob violence occurs when the community takes the law into their hands, physically punishing suspected criminals without trial, without legal procedures, and often without evidence.[19] There is no prior mobilization and no structures, and the mob usually consists of people who happen to be at the scene or within the community.[19] In South Africa mob violence has been documented in conjunction with industrial disputes, political demonstrations, consumer boycotts, and funerals of residents killed by the police[17,20]. Alleged witches, both male and female, have also been targets in Burundi,[21] Democratic Republic of Congo,[22] Kenya,[21,23], South Africa,[24-27] Tanzania,[28-30] and Uganda.[19] In Uganda, the police registered 146 mob killings between January and November 2004,[19,31]. Ng'walali and Kitinya[29] found that 1249 people were killed by mob violence in Dar es Salaam, Tanzania between 2000 and 2004. In 2005, 57% of the 362 homicides in Dar es Salaam were committed by mobs and vigilantes, with 97% of the victims aged 15-39 years and 99% males.[30] In both settings, the overwhelming majority of victims were accused of theft, a finding supported by data from Benin[16], Burundi,[21] Cameroon[18], Ghana,[32,33] Kenya[21] and Nigeria.[21]

Somewhat distinct from vigilantes and mobs, gangs are any durable, street-oriented (youth) group whose own identity includes involvement in illegal activity [34]. Although gangs have not been perceived as an African phenomenon, there is growing evidence to support the need for a more deliberate examination of the problem. Several aspects that supported gang emergence in the Americas such as unfavourable living conditions, family stress and perceptions that the gang members will derive economic benefit, social recognition and easier access to drugs [35] are now prevalent in many parts of Africa.

The majority of the evidence regarding the existence of gang violence in Africa comes from South Africa and in particular the Western Cape Province where their number was estimated at 90 000 in 2002.[36] As noted in other settings, social disorganization provided the favorable circumstances in which gangs could thrive. In the Western Cape these circumstances took the form of growing unemployment, an education crisis, social breakdown and the consequent collapse of civic culture[37] Street gangs are also a common feature in other urban centers in South Africa.[38]

Non-fatal physical injuries due to youth violence

Studies on non-fatal youth violence suggest that, globally, for every youth homicide there are 20–40 victims of non-fatal youth violence receiving hospital treatment. However, few studies in African countries have attempted to establish the number of cases receiving hospital treatment, and it is therefore not possible to better estimate the regional case load.

For example, unpublished Ugandan health facility data from five regions showed that intentional injuries among people ages 13 and 24 years accounted for 47.3% of the intentional injuries in the country's major referral facilities (Injury Control Center – Uganda trauma registry). In a South African hospital-based study youth and young adults aged 15–29 years accounted for more than half (54%) of violence related trauma (Violence and Injury Surveillance Consortium 2000). In Dar es Salaam Region, Tanzania, this age range accounted for one half of all homicides.

Bullying and harassment in institutional settings

Bullying and harassment of youth in institutional settings, at the hands of both peers and authority figures, has in recent years attracted considerable attention in several African countries. Bullying was reported to be rampant in South African schools, with bullies targeting their victims in taxis on the way to school, or in school toilets and bathrooms.[39] Teachers have been shown to frequently bully pupils verbally, physically, psychologically and even sexually, and both perpetrators and victims have been shown to demonstrate long-term negative consequences of the bullying.[40] In Botswana, up to 67% of secondary school girls report verbal harassment, intimidation or physical sexual abuse at school, with a fifth of them having had sexual requests from teachers. Almost half of them agreed "mainly because of the fear of lower grades if they refused".[41] Studies in refugee camps in Liberia, Guinea and Sierra Leone reported children being sexually exploited by humanitarian workers and teachers. In Chad, some teachers were reported to use promises of better grades to solicit sexual favours from girls, and those who refused faced grave consequences.[42]

Corporal punishment in schools

Although an increasing number of African countries have legally banned corporal punishment in schools, it continues to be practiced in a worryingly large number of settings. In Ethiopia 90% of students are still beaten although corporal punishment is forbidden by the law.[43] A study on the physical punishment of elementary school children in urban and rural communities in Ethiopia found that 21% of school children in urban settings and 64% in rural areas had experienced corporal punishment.[44] Moreover, severe injuries, blindness, and death were reported as a result of corporal punishment in Nigerian schools.[45] Nevertheless, it is important to note that high-level courts in Namibia (Supreme Court, 1991) and South Africa (Constitutional Court, 2000) have condemned corporal punishment in schools and required its prohibition.[46] In addition, Zambia and Zimbabwe have banned corporal punishment from schools since 1979, and Uganda since 2000. In Zimbabwe for example, teachers have perpetuated various forms of physical abuse on children in contradiction to stipulated Public Service (Disciplinary) Regulations. The Public Service (Disciplinary) code has not been found to act as a deterrent against offending teachers, as the majority of violent teachers are merely fined or reprimanded. Only a very small percentage was discharged from the teaching service for violent behaviour.[47]

Box 3.2 Self-reported exposure to violence by school going youth

Studies from around the world show that a large proportion of violent incidents, and especially those that do not result in the victim receiving professional care (either because victim services are unavailable or because they do not wish their victimization to become known to others) are only identified through community-based surveys. In Africa, the Global School-based Student Health Survey (GSHS) provides a unique window onto self-reported involvement in violence by school-going youth aged 13-15 years. This self-administered survey explores exposure to physical and sexual violence in all settings (including the family and community), and health related behaviours such as alcohol and drug use, smoking, sexual activity, diet, sanitation, and physical activity. Results (see table 3.1) showed high prevalence rates for physical violence and being bullied.

Table 3.1: Self-reported violence among youth aged 13-15 years*

	% physically attacked one or more times in past 12 months	% in physical fight one or more times in past 12 months	% bullied one or more times during past 30 days
Botswana	55.7 ± 4.3	47.7 ± 3.4	52.1 ± 3.7
Ghana	59.6 ± 2.9	55.3 ± 3.1	58.7 ± 3.2
Kenya		48.2 ± 4.5	57.1 ± 4.3
Namibia		50.3 ± 2.8	51.8 ± 3.6
Mauritius	55.7 ± 4.3	41.2 ± 6.5	40.3 ± 6.4
Seychelles			50.5
Swaziland		27.8 ± 2.7	39.6 ± 2.4
Tanzania	55.7 ± 4.3	39.9 ± 3.8	27.1 ± 3.6
Uganda		35.5 ± 3.5	45.5 ± 3.9
Zambia		53.0 ± 4.1	65.1 ± 3.7
Zimbabwe		38.8 ± 6.9	59.9 ± 6.3

* The GSHS is a school-based survey conducted among students aged 13-15 years. It uses a standardized scientific sample selection process; common school-based methodology; and core questionnaire modules, core-expanded questions, and country-specific questions that are combined to form a self-administered questionnaire. Missing data show instances where particular questions were not asked in certain countries.

A more detailed study used data from the same GSHS survey on exposure to both physical and sexual violence among youth in Namibia, Swaziland, Uganda, Zambia and Zimbabwe, and explored associations between exposure to such violence and indicators of mental health, suicidal ideation, substance use, and risky sexual behaviour. The prevalence of exposure to physical violence during the 12 months preceding the survey was 42%, and the prevalence of lifetime exposure to sexual violence was 23%. Exposure differed across countries, that for physical violence ranging from 27% to 50% and that for sexual violence from 9% to 33%. After adjustment for age, exposure to physical violence was more likely among boys than girls, and exposure to sexual violence more likely among girls than boys, although differences between genders were not large. Moderate to strong associations were observed between exposure to physical or sexual violence and measures of mental health, suicide ideation, current cigarette use, current alcohol use, lifetime drug use, multiple sex partners, and a history of sexually transmitted infection. Compared to youth who did not experience either physical or sexual violence, those exposed to both forms of violence were more than twice as likely to feel lonely most or all of the time. The likelihood of suicidal ideation was twice as great among youth exposed to sexual violence compared to unexposed youth. Youth physically forced to have sexual intercourse were twice as likely to smoke cigarettes during the 30 days preceding the survey as those who had not been exposed to sexual violence. Compared to those who were not exposed to either physical or sexual violence, youth exposed to both forms of violence were six times more likely to have multiple sexual partners and three times more likely to have a history of sexually transmitted infection. Similarly strong associations were observed between exposure to both forms of violence and current alcohol use, and lifetime drug use.[48]

Factors associated with youth violence

Violence perpetrated by and against young people accounts for a relatively high proportion of all violence worldwide, and there are many common risk factors across different settings. Youth violence in Africa too arises from the array of individual, relationship, community and societal factors that impact on the various stages of a child's growth and development, as described elsewhere in this report (Chapter 2, “Factors associated with child maltreatment”). Rather than revisiting these factors in their entirety, this section explores those factors that are peculiar to, or that are particularly widespread and influential drivers of youth violence in Africa.

Individual factors

Biological, psychological, behavioural, and situational characteristics are among the individual factors that influence young people's risks of violence perpetration and victimization.[1] The effect of age and maturation on behaviour is particularly important, as adolescents and young adults have been shown to be more prone to aggressive behaviours, physical violence, bullying, and weapon carrying than other age groups. Sex is also an important factor, with young males being more willing to take risks than females even in the face of aggressive threats. Risky behaviours may also be more common among youth with behavioural and learning difficulties. This tendency towards aggression is likely to be reinforced by harsh physical punishments, which unfortunately are a common feature of African schools. Other individual level psychological and behavioural factors include substance abuse and history of aggression and abuse.

Relationship factors

Relationship factors include relations within family and other proximal networks that impact on a young person's risk of perpetrating or being a victim of violence. The most important relationships in the lives of young people include those with parents, siblings, peers, intimate partners, other family members and neighbours. These relationships largely define their experiences and influence their predisposition to violence. Several international studies have documented the importance of parental supervision in the lives of young people. They have shown that living with single parents, one biological parent or one step parent is associated with sexual abuse[(49)] in both rural and urban contexts, and witnessing violence in the family or being subjected to abuse or neglect as a child is also predictive of later involvement in violent acts.[(46)] Another study of men in South Africa showed a connection between witnessing a mother being abused and the males' later involvement in public violent behaviour.[(50)] These factors along with poor social support structures and inadequate parental supervision increase the risk for many forms of violence.[(46)]

Community and societal factors

International research shows that lack of social integration within the community is an important contributor to community violence. Children in areas with less social capital are at greater risk of abuse[(51)] and reduced social capital, manifesting in low social cohesion and interpersonal mistrust, has been linked with an increase in higher violence rates and economic inequality.[(52)] On the other hand, there exists a strong relationship between high levels of civic engagement and low levels of crime.[(53)] Migration linked with urbanization threatens social cohesion and is strongly linked with increased rates of violence.[(54, 55)]

In addition, high rates of violence within affected communities reinforce a negative cycle, as being a victim of violence and/or witnessing violence increases the risk of perpetrating violence. In a study of Xhosa-speaking youth in a South African township with high levels of community violence, all of the 60 respondents had been exposed to community violence, while 56% had been victims and 45% had witnessed at least one murder. The psychological imprint of these experiences manifested in 22% of these children fitting the diagnosis for post traumatic stress disorder, 32% for dysthymia and 7% for major depression.[(56)] Another South African cross-sectional study revealed that more than 50% of all boys and girls had experienced violence, either as victims or perpetrators.[(57)] In the Lavender Hill and Steenberg area in Cape Town, over 70% of a sample of primary school children reported exposure to violence.[(58)]

The dislocation and marginalisation of young men is a continental phenomenon and an important driver of violence. Young people, often from broken families with limited prospects or with a poor self image, provide a seemingly inexhaustible pool of new perpetrators and victims, whether of violence occurring in the context of drunken arguments, or of violence associated with vigilante groups, mobs and street gangs. Although there are examples of resilience by migrants in the face of such adversity by, for example, sharing expertise, capital and labour to maximize business opportunities, groups of young men are frequently drawn together for crime, companionship or protection. In the absence of traditional family or community support structures, they develop their own social norms and violence becomes both a source of livelihood, and a means of resolving conflict.

Economic inequality is a particularly important societal level risk factor for youth violence. A global cross-sectional study of the relationship between sex, age and economic inequality suggests that homicide rates in 15–24 year old males are particularly strongly associated with economic inequality, the highest rates occurring in the lowest income groups of societies with the greatest gaps between the rich and the poor.[59] However, owing to a lack of data, this study did not include any African countries. In South Africa, a study of the relationship between community-level economic inequality, crime, and violence showed that whereas residential burglaries and car thefts were most frequent in areas with the highest household expenditures, murder, serious assault and rape were most frequent in areas with low household expenditures.[60]

Poverty exerts its violent effect on individuals and communities by influencing their exposures to, susceptibilities to, and the outcomes of violent encounters. Many people do not have genuine freedom of choice in trade decisions, especially in places with high levels of unemployment and poorly reimbursed employment. Unemployment or marginal employment was shown to be one of the most important variables predicting violent death in Dar es Salaam, Tanzania.[5]

At the societal level, urbanization is an important risk factor for youth violence, with higher rates of violence and crime generally reported in urban areas of both high and low income countries.[61, 62] In Africa, urbanization has steadily increased from 11.2% of the population in 1950 to 35.2% in 2005, an increase which is expected to reach 48.3% of the population in 2030.[63]

The effects of wars, rapid urbanisation and migration in Africa place an extreme burden on the social fabric of communities. Endemic war and civil unrest are important factors in precipitating interpersonal violence at the community level through the erosion of non-

violent value systems and the widespread distribution of firearms and other weaponry among civilian populations.

In addition, a variety of cultural norms exist across Africa that support violence as an acceptable way of 'disciplining' youths. Norms that give priority to institutional rights over child welfare, or community safety over human rights can lead to increased violence against youth (see institutional school violence box).[64-67] Weak governments and institutions may be linked to higher levels of violence,[68] as lack of institutional capacity impacts adversely on the ability of governments to respond effectively to violence. Community violence aimed at youths may also arise along with community perceptions of inadequate or unresponsive policing.

Recommendations for preventing youth violence

Strategies that increase the individual level protective factors through skills, attitudes and beliefs can reduce young people's probabilities of perpetrating or being victims of violence. Strategies can also focus on relationships with parents, peers and friends. At the community and societal levels, environments in which young people interact with the larger society can be modified, for example pursuing criminal justice systems and macro economic conditions that discourage the emergence of violence among young people.

Societal level strategies to prevent youth violence

Maintenance of law and order
The third article of the Universal Declaration of Human Rights (1948) declares that "Everyone has the right to life, liberty and security of person". People have a right to live peacefully. National criminal justice systems should be strengthened to ensure rigorous enforcement of relevant laws in order to maintain order. Community participation in creating safer neighbourhoods needs to be strengthened in ways that do not impinge on individual human rights.

Institutional policies
Many countries are making efforts to decrease institutional violence through policies. This class of interventions can be administered through individual, family or school based programs. Unfortunately, many of these interventions are neither strong enough nor rigorously implemented.

Poverty reduction and employment
Africa may not make significant progress in reducing its current level of youth violence without a genuine commitment to redressing the problem of poverty. An extremely high

youth unemployment rate in sub-Saharan Africa is widely acknowledged. Even the official unemployment rate of approximately 20% "suffers from mis-measurement and does not capture the working poverty and underemployment".[69] South Africa during the most violent years of apartheid reported 40% formal sector unemployment in the economically active population.[70] At the macro level, pro-poor investment policies including input of the poor into government investment decisions and labour-intensive farm and non-farm activities are needed. Establishing job-creation programs with fair reimbursement especially for chronically unemployed males is crucial.

Human capital development through relevant education

There is an urgent need to invest in human potential development. Equipping Africa's young people with requisite competencies for general participation in development and guaranteeing their own livelihoods can go a long way in reducing temptations to resort to violent alternatives.[71] Governments need to enact and guarantee sound educational policies that will assure this and address the existential needs and long-term prospects of youth and young adults. Although many countries now have universalised access to basic education, they still face quality challenges. There is need to urgently address these gaps so that the education given can enable young people to genuinely engage, participate and compete in development processes. Broad-based education, basic skills training for young people, and adult literacy need to be prioritised.

Community, close relationship and individual level strategies to prevent youth violence

The strongest evidence for the prevention of youth violence comes from studies in HICs of the following community, close relationship, and individual level prevention strategies. Although their effect on youth violence in Africa remains to be evaluated, these strategies address risk factors prevalent in Africa, and hence there are good reasons to believe they will be effective in preventing youth violence here too.

- reducing harmful levels of alcohol and illicit drug use during pregnancy (to minimize foetal alcohol spectrum disorders and other neurological damage that could place adolescents born to mothers who abused alcohol and drugs at risk of violence);
- reducing harmful levels of alcohol and illicit drug use by new parents (to reduce child maltreatment, which in turn would reduce youth violence);
- improving access to high quality pre- and post-natal services (to reduce child maltreatment, which in turn would reduce youth violence);
- providing home visitation services by professional nurses and social workers tofamilies where children are at high-risk of maltreatment (to reduce child maltreatment, which in turn would reduce youth violence);

- providing training for parents on child development, non-violent discipline and problem-solving skills (to reduce child maltreatment, which in turn would reduce youth violence);
- pre-school enrichment programmes to give young children an educational head start;
- life skills training;
- assisting high-risk adolescents to complete schooling;
- reducing alcohol availability through the enactment and enforcement of liquor licensing laws, taxation and pricing; and
- restricting access to firearms.

Other prevention efforts are aimed at equipping young people with lifestyles that include conflict analysis and resolution skills. The assumption is that youth can exercise control over their individual responses in situations of provocation. Several such interventions are currently under development and review in Africa.

Box 3.3 The Mato-Oput 5 program

The Mato-Oput 5 is a non-violent conflict resolution educational program which was developed in Northern Uganda, a region that has been afflicted by civil war for over 22 years. The program is values based and aims to produce young people who understand the causes and effects of conflicts, and are skilled to prevent or resolve them non-violently. It is integrated into the children's formal schooling and taught by the teachers who receive prior orientation on the program and its delivery. The concepts covered by the program include conflict, peace, conscience, empathy, anger, self-control/impulse control, fairness, kindness, reconciliation (*mato-oput*), problem solving and non-violence. The program was piloted in a few schools in Northern Uganda and evaluated through a cluster randomized controlled design. Although the evaluation occurred after only a short follow up period, and lacked sufficient power to show effectiveness, it did demonstrate a positive change of attitude regarding violence among the intervention group. The materials have been upgraded after the pilot and the government has now expanded the program to over 1,700 Northern Ugandan elementary schools as part of its post-conflict recovery program. Without a more rigorous evaluation it is not possible to recommend the adoption of this and similar programs for widespread use, but it is commended for having undertaken the type of intervention research which should be done in more countries. The initiative was spearheaded by the Injury Control Center-Uganda (ICC-U), the Uganda National Curriculum Development Center (NCDC) and the Canadian Network for International Surgery (CNIS).

Secondary and tertiary prevention to mitigate the consequences of youth violence

Secodary and tertiary prevention strategies aim at helping youth overcome the negative traumatic effects of violence and equipping them with appropriate coping mechanisms. These include emergency medical and psychosocial services for victims and perpetrators of youth violence and their families. Other interventions include institutionalised and community based rehabilitation services for youths with addictions and dependency problems, victims of torture and other forms of abuse, and juvenile reception centres. Evidence from HICs for the effectivness of such interventions in reducing subsequent violence is limited, and such interventions remain to be evaluated in any African or other LMIC.

3.2 Sexual Violence Against Women

The true extent of sexual violence in Africa is unknown, though various studies highlight its pervasiveness. Data are scant, and comparing figures for sexual violence across studies is difficult due to variations in methodologies employed, questions asked and cultural biases in interpretations of violence. While it is acknowledged that men and boys are also subjected to sexual violence, this section focuses on women, as it is predominantly women who experience sexual violence in Africa.

Defining sexual violence

The *World Report on Violence and Health* (1) defines sexual violence as *"any sexual act, attempt to obtain a sexual act, unwanted sexual comments and advances, or acts to traffic or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim"*. This refers to a wide range of acts, including:

- coerced sex in marriage and dating relationships;
- rape by strangers, including by police;
- systematic rape during armed conflict;[13]
- unwanted sexual attention or sexual harassment including sex in return for favours;
- sexual abuse of children;[14]
- sexual abuse of mentally or physically disabled persons;
- forced marriage which includes child marriage;
- forced prostitution and sexual trafficking; and
- violent acts against the sexual integrity of women including female genital mutilations and virginity testing.(72)

Rape and sexual assault have been used interchangeably to include the physically forced or otherwise coerced penetration of the vulva, anus or mouth, using a penis, other body parts or an object.(72) However, no single definition of rape exists; it differs by country, community and legal context. The lack of cross-cultural applicability of definitions raises concerns for international advocacy, research and implementation surveillance and monitoring.(73)

Nature and extent of sexual violence

Research indicates that sexual violence is a widespread problem facing many women and girls in sub-Saharan Africa. In Africa cultural and customary practices and gendered expectations confer considerable power in sexual decision-making to men. For example, sexual violence by brothers of their dead brother's spouse has been documented in Kenya;

13. See Collective Violence chapter – pg 98.
14. See Child sexual abuse – pg 31.

women in these settings lose their (husband's) property and are often themselves 'inherited'.[74] Studies from South Africa have showed that sexual entitlement as a feature of a 'successful' masculinity reinforced by gender power inequalities perpetuates sexual violence.[75, 76]

The main sources of data about sexual violence in Africa are Demographic Health Surveys (DHS), non governmental agencies, and police data. Comparative studies in the area of gender based violence have shown that DHS studies provide lower estimates particularly for exposure to partner violence, sexual violence and childhood sexual abuse – this is believed to be due to a tendency to under-report sensitive issues when conditions of interviewing are not private.[72, 77] The WHO multi-country study on women's health and domestic violence against women provided the first comparative data across the world and included data from three sub-Saharan African countries; Namibia (the capital city), Tanzania (a rural and urban setting) and Ethiopia (a rural setting) [78] (see Table 3.2). The study estimated that between 21% and 44% of women aged 15–49 in these African countries had ever experienced sexual violence by partners and non-partners.

It was found that women were more likely to be sexually abused by an intimate partner than a non-partner (16%–59%). Anonymous reports of sexual violence before the age of 15 were 7%, 9% and 21% in Ethiopia, Tanzania and Namibia respectively. (For further discussion on the WHO Multi-country Study see 'intimate partner violence' in Chapter 2.)

Other national studies show that in Nigeria 40% of women from a random sample of 1260, had experienced sexual violence at least once in their lifetime,[79] while in Mozambique there was a prevalence of 23%.[80] Demographic Health Survey (DHS) data from Kenya show that 16% of women aged 15–59 years reported that they had been sexually abused in the previous year.[81]

Table 3.2: Percentage of women who reported having ever been sexually assaulted (see also chapter 2 table 2.1)

Country	Study Population % women reported	Year	Sample	Size
WHO Multi-country Study (age 15-49years)				
Ethiopia	Butajira Province	2000-2003	3016	44.2
Namibia	Windhoek City	2000-2003	1496	21.5
Tanzania	Dar-es Salaam	2000-2003	1820	29.8
	Mbeya District	2000-2003	1450	36.1
Other Studies				
Mozambique	National (18-69yrs)	2004	2015	23.0
Zimbabwe	Midlands Province (=18yrs)	1996	966	46.0
*South Africa	National (15-49yrs)	1998	10190	7.0
*Kenya	National (15-59yrs)	2004	3856	16.0

** Using District Health Survey (DHS) sources*

Sexual violence can be indirect, such as sexual violence arising from human trafficking and transactional sex, or overt as in the case of rape perpetrated by strangers, or gang rape as an extreme example. It is also conceivable that this precedent is reinforced by regional norms and beliefs, such as forced sexual initiation, female genital cutting, early and forced marriage and virginity testing. These learned habits, which are passed on from generation to generation, relate to female rites of passage and 'preserving female and family honour' but may in effect perpetuate sexual violence against women.

Sexual Trafficking

A study by the United States Central Intelligence Agency (CIA) estimated that approximately 450 000 out of the 2 000 000 people who are trafficked yearly originate from Africa.[82] Many African countries are source, transit, as well as destination countries for victims of sexual trafficking.[83] The trafficking of women and children from West Africa to Europe is more prevalent than from other parts of Africa, with women lured on the pretence of obtaining work. The majority of women are between 15 and 18 years. Their families are often involved; ignorant of the associated risks, they consent after being promised a better life for their child.[83]

Gang Rape

Data on being raped by more than one perpetrator is sparse, although this phenomenon is reported from most parts of the world. In parts of Africa gang rape is practiced in a systematic manner when used as a weapon of war and terror.[84] (For further discussion on sexual violence during armed conflict see chapter 4 on collective violence). In South Africa surveillance studies of female attendees at sexual assault clinics found that one-third of the cases are gang rapes.[76] An anthropological study in South Africa proposes that group rape as practiced by marginalized men in townships is related to prevailing notions of male entitlement and the control of women.[85]

Forced sexual initiation

There is a growing body of knowledge on forced sexual initiation particularly for the African Region [76]. Surveys on adolescent sexuality show that it is an increasing problem.[86] In a study comparing four African countries it was found that 5% (Burkina Faso), 23% (Uganda), 30% (Ghana) and 38% (Malawi) of adolescents interviewed were "not willing at all" at their first sexual encounter.[86] A South African study found that 32% of pregnant and 18% of non-pregnant girls had been forced or coerced into their first sexual experience.[87] These findings are supported by the WHO multi-country study, which found that when the first sexual experience was before the age of 15 years there was a greater likelihood that the sexual initiation was forced.[88] The exception was found in rural Ethiopia, and is thought to be related to the early age of marriage for this region. The study found the overall prevalence of forced sexual initiation to be 6% in urban Namibia, 14.3% in Tanzania, and 16.6% in Ethiopia. In Tanzania and Ethiopia the study included both rural and urban populations.

Female genital cutting

Female genital cutting (FGC) is practiced widely in the African region and is considered harmful as it violates the woman's human rights and can threaten her health. The number of girls and women who have undergone FGC is estimated to be between 100 and 140 million worldwide; it is estimated that each year, a further two million girls are at risk.[89] The practice is most common in African countries where national prevalence rates range from 99% in Guinea to less than 1% in Cameroon. Many African countries such as Senegal, Burkina Faso, Central African Republic, Djibouti, Ghana and Togo have banned FGC.[90]

Box 3.4 Female genital cutting

FGC comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons.[89] WHO has classified the practice into four types and these include:

- Type I - excision of the prepuce, with or without excision of part or the entire clitoris
- Type II - excision of the clitoris with partial or total excision of the labia minora
- Type III - excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)
- Type IV - pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; incisions to the vaginal wall; scraping (angurya cuts) or cutting (gishiri cuts) of the vagina and surrounding tissues; and introduction of corrosive substances or herbs into the vagina.

Types I and II are believed to account for up to 85% of FGC operations. The most extreme form, infibulation, commonly referred to as female genital mutilation, constitutes about 15% of all procedures. It is believed that in Eritrea 34% of woman have experienced Type III cutting, while fewer than 1% in Mali and Burkino Faso have. In Tanzania, it was observed that there had been a decline in prevalence of FGC in the last decade.[91,92]

FGC is often carried out using special knives, scissors, razors, or pieces of glass.[89] The operation is usually performed by a specially designated woman elder, who may also be a traditional birth attendant. Anaesthesia is rarely used and often the same instrument is used for all the girls thus exposing them to the risk of HIV infection. In its less severe forms FCG is not necessarily harmful to the physical health of a female,[93] although complications, especially in Type III can include severe pain, shock, haemorrhage, urine-retention, ulceration of the genital region, injury to adjacent tissue, and sometimes death.[94]

The procedures are not reversible and their effects last a lifetime,[95] with the immediate and long-term health and psychological consequences often varying according to the type and severity of the procedure performed. Long-term physical effects may include the development of cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, painful sexual intercourse, sexual dysfunction, difficulties with childbirth and chronic pelvic infections.[94]) Other long-term effects include psycho-sexual and psychological health sequelae; women may suffer feelings of incompleteness, anxiety and depression. It has been suggested that FGC may also increase HIV/AIDs infection through (i) use of insufficiently sterilized equipment during the cutting procedure; (ii) sexual intercourse before the wound is healed, and (iii) easy bruising of the genital mucosa afterwards.[96] Research in Tanzania however does not show a clear link between FGC and HIV/AIDs infection.[91]

Early and forced marriage

The practice of forcing young people into early marriages to fulfil sociocultural expectations is common. This practice has been shown to have kept the mean age at first marriage relatively low in some areas; in rural Ethiopia, it is 13.5 years for girls and 19.5 years for boys.[97] Generally it has been rising in several countries and ranges between 16 and 21 years.[98] Although the definition of early marriage includes girls and boys, early marriage mainly affects the girl child.[99] This practice is a form of sexual violence as the child is unable to consent to such a marriage.[72] Based on the Convention of the Rights of the Child (1989) a child is defined as being younger than 18 years of age. The African Region has one of the highest rates of early marriage.[100] Early marriage is generally more prevalent in Central and West Africa – affecting 40% and 49% of girls respectively, compared to 27% in East Africa and 20% in both North and Southern Africa.[101] In Ethiopia and in parts of West Africa, marriage at seven or eight is not uncommon and in some countries girls are betrothed at even younger ages.[101]

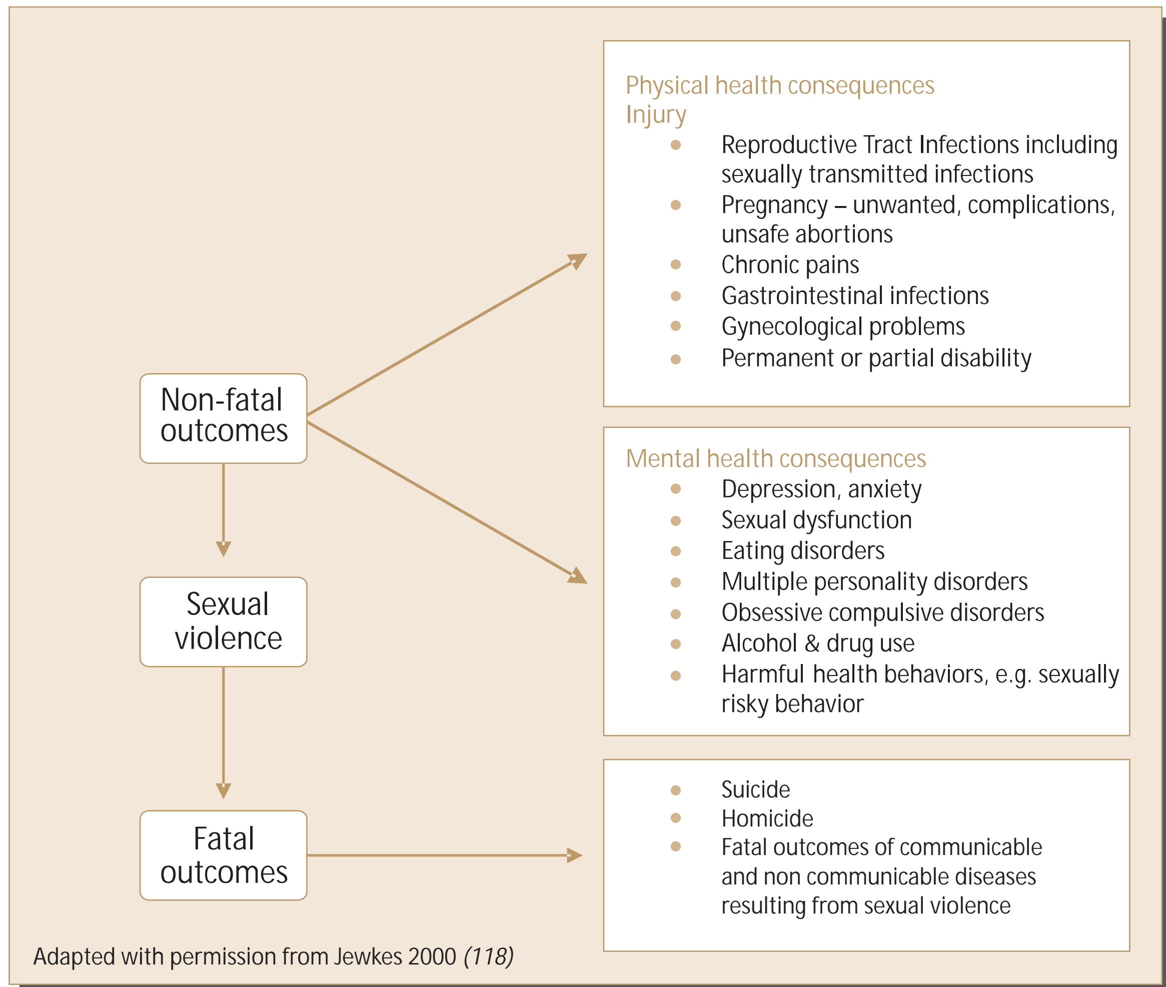
Virginity testing

Virginity testing involves the examination of girls' (and less often boys') genitals to determine if they have had sex. This practice has recently been revived in some parts of Africa.[102] Virginity testing is not well researched; hence the prevalence rate is largely unknown. It is reportedly practiced in southern African countries including Malawi, South Africa, Swaziland and Zimbabwe as a way of to 'preserve beauty, pride, and a valuable asset of the nation' and of combating HIV/AIDs.[103] In South Africa, the phenomenon appears to be centred primarily in the KwaZulu/Natal province where girls are tested by examination of their hymen (which may not be intact for reasons other than sexual intercourse). Since its re-emergence in 1993 it was estimated that one million girls had submitted to the test in Kwa Zulu Natal by 2001.[104] Whereas virginity testing is frequently presented as a cultural right, it is also seen to violate the right to equality (as it is seldom applied to boys) as well as the rights to privacy and to bodily integrity and security.

Consequences of sexual violence

Sexual assault can lead directly to serious injury, disability or death. They can also lead indirectly to a variety of health problems, such as stress-induced physiological changes, substance use and lack of fertility control and personal autonomy as is often seen in abusive relationships (see Figure 3.1). Compared to their non-abused peers, sexually assulated women have higher rates of unintended pregnancies and abortions; sexually transmitted infections, including HIV; and mental disorders such as depression, anxiety, sleep and eating disorders. When this violence occurs during pregnancy, it is associated with adverse pregnancy events – such as miscarriage, pre-term births and stillbirths.[88]

Figure 3.1 Consequences of sexual violence



Adapted with permission from Jewkes 2000 *(118)*

Factors associated with sexual violence

Risk factors associated with sexual violence are complex as the violence incorporates multiple forms which are often influenced by the cultural context in which it occurs. Few risk factor studies on sexual violence have been conducted in the African region with much of the data originating from South Africa. Sexual violence is influenced by factors operating at the individual, relationship/peer, and community levels. Some factors increase the risk of a woman becoming a victim while others increase the risk for a man becoming a perpetrator.

Individual factors

There are several factors that increase the women's vulnerability to sexual violence:

- Age is a risk factor for sexual violence and young women are normally more at risk than older women. [72, 105]
- Research has consistently linked alcohol use to the risk for becoming a victim of sexual violence. In a Nigerian study on 1260 women, 41% of sexual violence occurred while the women were under the influence of alcohol.[79] In South Africa being under the influence of alcohol has been linked to increased women's vulnerability to being raped.[76]
- Experience of child sexual abuse and first forced sex as a risk factor for revictimisation during adulthood is well documented from high income countries.[106, 107] A community based study in South Africa has shown that child sexual abuse (CSA) and first forced sex are associated with an increase in physical and or sexual violence by a partner, while CSA was also associated with increase risk of adult sexual violence by non-partner.[108]

In addition, there are several factors that increase men's risk of being sexually violent as shown in several South African studies.

- A study among young rural South African men showed that at the time of their first assault, most men who raped were younger than 18 years[109]. This finding is in line with studies from the United States[110].
- Adverse childhood experiences were also associated with an increased risk of rape for both partners and non-partners.[49, 109] It has been argued that the impact of childhood trauma can result in feelings of inadequacy which may be masked by anger and a need to control women sexually.[109]
- Alcohol was found to be associated with both partner and non-partner rape.[108] Alcohol clouds judgment and is thought to play a disinhibiting role. In Uganda, alcohol consumption by the male partner before sex was strongly and positively associated to the risk of coercive sex.[111]
- In South Africa rape of a non-partner was also associated with gang membership and peer pressure to engage in sex.[109] Gang membership may define masculine role identity that is linked to the dominant 'successful' masculinity which promotes sexual conquest of women.[109]
- Sexual risk behaviours such as number of sexual partners and transactional sex were also found to be associated with an increased risk for perpetrating sexual violence against both a partner and non-partner.[109] This would suggest that men who place emphasis on sexual conquests may use extreme measures to engage women in intercourse.[75]

Relationship/Peer factors

Forced first sex and coercive sex are well documented in the African region. This is predominantly a feature of young women's experiences, and although young men report coercive sex experiences the nature and consequences differ. A multi-country study on coerced first sex in Burkina-Faso, Ghana, Uganda and Malawi found that 15%–38% of young women had experience of forced first sex.[86] This study found an increase in risk across all countries to be associated with the partner being a casual acquaintance. In-depth focus group discussions with adolescents in Kenya revealed that coercion of female partners was common, where male youth admitted to trying to seduce girls first and if that failed, using force.[112, 113] A South African study on teenage pregnancy and coerced sex suggest that the male dominance and unequal power relations increase the risk for coerced sex.[87]

Transactional sex is a global phenomenon, and Africa is not exempt. An analysis of DHS data from nine sub-Saharan African countries found that 7.4%–42.8% of unmarried men and 3.4%–18.3% of married men had exchanged money or gifts for sexual favours in the 12 months preceding the survey.[114] A survey in rural Ghana found that 70% of mothers had encouraged their young daughters into premarital sexual relationships; many believed that receiving gifts in exchange for sex was evidence of a man's love rather than prostitution.[48] Several African studies have shown that transactional sex is associated with sexual exploitation and other forms of gender based violence [114, 115] and that financial need introduces a power imbalance, with men often expecting and forcing sex if they have given the women money or gifts.[75]

Community and societal factors

The numerous individual and relationship factors that predispose women to the risk of sexual violence are reinforced by prevailing norms and circumstances in society. In addition, their comparatively weak social standing, economic dependence and lack of political rights increase the vulnerability of women and children to sexual violence.[76, 116] However, the relationship between poverty and sexual violence is complex, as women who find themselves in vulnerable economic positions are unable to protect themselves from various forms of sexual exploitation.[76] Poverty increases women's chances of engaging in activities that place them at risk and reduces their ability to protect themselves.[76] It also increases the need for women to engage in sex work or more subtle forms of transactional sex as a means to survive.[115]

It has also been proposed that the HIV/AIDS pandemic is a driver of sexual violence in many parts of Africa. The idea of 'cleansing' oneself of HIV and AIDS by having sex with a virgin or

young girl has anecdotally been linked to reports of sexual violence, particularly among vulnerable groups. Child rape seems to be an increasing phenomenon in Africa;[117] the link between HIV and child rape has, however, not been proven.[105]

Recommendations for preventing sexual abuse

Strategies to address sexual violence are still rather limited, and have largely focused on legislative responses, improving services (enhancing health sector responses for survivors), and training health personnel. They should eventually fall within a prevention, care and rehabilitation continuum, addressing individual, household/relationship, community, and national level factors.

Primary prevention strategies to address sexual abuse

The risk factors for sexual violence have shown that sexual violence against women is rooted in the prevailing gender power inequalities, defined by the low status of women and notions of male sexual entitlement.[76] Part of the challenge to primary prevention efforts is to improve the status of women and change ideas about masculinity that emphasize control of women.

Rights and policy frameworks

There are a number of international treaties that set standards for national legislation, as well as setting frameworks for national legal reforms. Many countries in the African region are still in the process of developing legislation consistent with existing definitions of sexual violence, thereby improving women's access to justice. South Africa has introduced a new Sexual Offences Act (2007) which broadens the legal definition of sexual assault to be gender neutral.

A challenge in the region is defining the age of consent and legislating statutory rape. A number of African countries have made progress in enacting laws that directly address sexual offenses against minors and age at which young people are protected against rape (the age of consent). It currently varies from under 13 years in Nigeria, under 16 years in Zimbabwe to under 18 in Uganda. In Kenya both physical and verbal sexual harassment is criminalized.[63] However most African countries need to undertake urgent legal reviews to address some of the contextual issues that currently favor the perpetuation of violence. There is also need to create or strengthen the regional/continental legal frameworks to effectively deal with cross border practices like human trafficking, which promote sexual violence.

While laws banning harmful practices are seen as important, there is a general consensus that legal initiatives alone are not enough. Grassroots, community-level approaches are thought to be more effective in changing people's attitudes, and ultimately behaviours.

Advocacy

There is increasing convergence of a global movement against sexual violence. Attempts at developing cross-cultural conceptualization seem to be located in the legal (human rights) and health sectors. WHO has developed a conceptual definition, research strategies, operational frameworks including guidelines and service delivery protocols for addressing sexual violence.(119) The Sexual Violence Research Initiative (www.svri.org) was set up by the Global Forum for Health Research and WHO to promote sexual violence research and to generate empirical data to ensure that sexual violence is recognised as a priority public health concern.

Improving women's status

Integral to the prevention of sexual violence is developing strategies to improve the status of women in communities.(72, 116) This would need government action through the introduction of specific policies and programmes to reduce women's vulnerability. At a local level, mobilization initiatives have to be successful in engaging multiple community partners to develop strategies.(120) In Senegal a broad-based community empowerment programme, Tostan, provided educational programmes on hygiene, democracy and human rights, literacy, women's health (including FGC) and problem solving.(121) Evaluation of the programme showed a decrease in support for FGC in the targeted communities. Women's access to resources has to be promoted through, among others, community-based finance programmes in order to reduce their vulnerability to sexual violence. IMAGE programme from South Africa is an example of a microfinance programme that decreased violence against women (122) (for further discussion see 'Intimate Partner Violence' in Chapter 2).

Engaging men

Critical to changing patterns of sexual violence is addressing the prevailing notions of masculinity, which at their core perpetuate the idea of male sexual entitlement. Programmes need to challenge the socially constructed gendered roles of men and women by promoting gender equity.(123) There are promising programmes that have been shown to shift existing norms (for further discussion see section on 'Intimate Partner Violence' page 42).

Secondary and tertiary prevention: Intervening when abuse is detected

The health care needs of survivors of sexual violence are complex and have in the past been largely unmet. The challenge is to move from a medico-legal response, to a holistic

response that takes into account the range of health consequences faced by the survivor. Some countries are beginning to rise to the challenge. For example, the Kenyan Ministry of Health has recently developed national and standardized health sector guidelines for the care of survivors that include a capacity building plan for service providers with the requisite training materials and tools.[(124)] The aim of the guidelines is to strengthen medico-legal linkages at policy and practice levels and to set indicators for delivery of sexual violence care services with specified and targeted financing for services. For example, the national standard of care for the management of rape includes:

(i) clinical evaluation and legal documentation: forensic/physical examination, collection of evidence, analysis of specimen, legal documentation and development of an evidence chain that has integrity;
(ii) clinical management: treatment of physical trauma, prevention of STIs, prevention of HIV, pregnancy prevention, post abortal care;
(iii) counselling: trauma counselling for survivors and family/partner, HIV pre and post test support, adherence to HIV post exposure prophylaxis (PEP), preparation for the criminal justice system;
(iv) linkages and referrals: for justice, protection, and on-going social support.[(125)]

The need to develop appropriate interventions to deal with the psycho-social impact of sexual violence is critical for the healing of survivors. Igreja [(126)] in her assessment of posttraumatic stress symptoms and psychosocial indicators of ill-health among women who experienced war in Mozambique notes the need for further research on specific problems and needs of women in post war contexts and the systematic examination of the effectiveness of available resources for trauma recovery support.[(126)] The challenge is therefore for services to integrate such a holistic approach to deal with not only their medico-legal obligations but also to take into account the need for healing at the physical and psychological level while obtaining justice for the victim.

3.3 Conclusions and Future Perspectives

The full magnitude of community level violence is still unknown in Africa, yet evidence suggests that it places a large health and social burden on most countries. Attempts at highlighting the importance of violence prevention on the regional and international health and development agenda is fraught with challenges related to the pace and scope of social change typical of economies and societies in transition. For example, urbanisation, which in itself may be an important structural risk-factor for community level violence, is simultaneously an important driver of economic growth and development.

Many socioeconomic, cultural and political contexts in Africa actively contribute to community violence. While there may be existing local interventions that could be used or adapted, these initiatives need rigorous reviews for possible use. In the interim, there is an urgent need to invest in intervention research, as well as to improve national data collection and management systems in order to capture and present the exact magnitude of the problem, define the determinants and to inform interventions. There is need for a wider policy framework to regulate access to small arms and drugs, and ultimately, an obvious need for increased investment into social capital development on the continent.

There have been varying responses in African countries towards preventing community violence and treating its victims. Most of these responses have been indirect through the health care system and based on data collection and the health care needs of survivors. Interventions to reduce and prevent violence are most effective when they integrate responses from other sectors (including but not limited to government, media, arts, business, labour, education, engineering, environment, religion, criminal justice, and public health). These are summarized in *Chapter 6: Recommendations*.

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CHAPTER -4

COLLECTIVE VIOLENCE

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4. Introduction

Africa is widely perceived to suffer from chronic levels of collective violence. Such violence is frequently linked to 'new wars' in the wake of the continent's anti-colonial struggles of the 1960s and 1970s. These armed conflicts frequently occur within rather than between states, involve civilians as the primary perpetrators and victims and reportedly contribute to epidemic levels of urban criminality. But in spite of growing alarm over the burden of collective violence, surprisingly little is actually known about its dimensions. In fact, the relationships between collective violence and negative health outcomes are woefully under-reported and under-researched. The true costs of collective violence in sub-Saharan Africa, much less ways to prevent and reduce it, therefore go largely under-diagnosed.

The complex relationships between collective violence and population health in WHO's African Region are reviewed. The chapter first discusses the definition of collective violence, described as the instrumental use of violence by members of a group against another group. The opening section highlights the specific forms of collective violence in Africa, including armed conflicts, organized criminal activity and related banditry and communal violence and vigilantism. The chapter detects several 'grey areas' in each of the above-mentioned contexts wherein 'collective' and 'inter-personal' violence converge. Owing to the manner in which data is collected and recorded within the health and crime sectors, it is frequently difficult to discern whether violence arising during armed conflict, post-conflict, crime or communal situations is perpetrated and experienced exclusively by 'groups' or 'individuals'. It is likely that violence perpetrated in all the above-mentioned situations involves a combination of the two – as the chapter on interpersonal violence reveals.

The second section considers a number of reasons why the scale and distribution of collective violence remains so poorly understood and measured. One is semantic: collective violence itself is not easily defined and its characteristics and impacts are frequently highly variable across time and space. The section considers the challenges of surveying collective violence using indicators such as fatal and non-fatal injuries, rape, physical and psychological disability, deprivation associated with reduced access to livelihoods, displacement, and other negative effects due to denial of access to essential services. While there is a robust association between collective violence and mortality due to all causes, the section observes that evidence is difficult to mobilize and interpret. The section considers other structural obstacles to reliable surveillance and monitoring of vital

registration statistics such as trade-offs rendered due to structural adjustment, fragile governance and competing priorities. More optimistically, the chapter observes that a growing coalition of African public health specialists are contributing to the growth of a culture of evidence and contributing to advocacy on the burden of collective violence and the value attached to early investment in preventive measures.

The third section considers the specific contribution of collective violence arising from socio-political conflict. Armed conflict has pervasive, highly negative implications for the population health and resilience of sub-Saharan African societies. Though focusing in large part on death arising directly from armed conflict, it notes that the larger share of mortality and morbidity often arises from preventable illnesses associated with malnutrition and infectious disease – particularly amongst displaced populations. The section observes that the incidence of civilian mortality and so-called 'excess deaths' during war (and in its aftermath) appear to be influenced as much by pre-existing societal and household vulnerability as by conflict intensity.[1] In other words, pre-existing conditions are strong predictors of both collective violence itself and the nature and magnitude of its consequences.

The chapter concludes by signaling the need for sustained and sizeable investment in effective national and municipal surveillance and monitoring systems in order to begin identifying, prioritising and costing options for collective violence prevention and reduction. African governments must take stock of the many efforts underway to mitigate collective violence – from preventive strategies to keep 'at risk' youth from joining gangs and being forcibly recruited to formal multilateral and bilateral mechanisms to contain the flow of arms. From a public health perspective, there are real and long-term dividends that arise from concerted investments in strengthening community structures to resist and withstand collective violence. Renewed investment in supporting health infrastructure and legitimate security structures can reduce excess mortality.

4.1 Defining Collective Violence

Collective violence is defined as: *the instrumental use of violence by people who identify themselves as members of a group — whether this group is transitory or has a more permanent identity — against another group or set of individuals, in order to achieve political, economic or social objectives.*[2] As with self-inflicted and interpersonal violence, collective violence exhibits a wide range of causes and consequences that depend on the setting, relationships between perpetrators and victims and the motivations guiding action. Crucially, though, unlike other forms of violence, collective violence is perpetrated by people operating as collectivities, and not as individuals.

It is useful to disaggregate collective violence according to its political, economic and social motivations. For example, *politically-motivated* collective violence often arises from armed conflict and widespread/systematic human rights violations. In this way it is often purposefully deployed by comparatively well-defined state and non-state armed groups in response to relatively clearly delineated political grievances. *Economically-motivated* collective violence refers primarily to criminal activity and organised violence related banditry, motivated by economic gain. While technically autonomous from state institutions, it can operate in collusion with them. *Socially-motivated* collective violence includes a combination of youth gangs, vigilantism, and communal tensions, and appears most prevalent in areas where the state exerts comparatively limited (formal or legitimate) authority.

Collective violence is a multi-faceted and complex phenomenon – even more so when occurring in highly diverse and heterogeneous societies. In the case of sub-Saharan Africa, various forms of political, economic and social collective violence come together in an insidious way. A legacy of systemic inequality during the colonial period, coupled with the tumultuous independence period (1960-1970s) and macroeconomic instability (1980s-1990s) and regressive governance has created conditions favouring the onset of collective violence. The functions of collective violence are in many cases driven as much by grievances over real and perceived political inequality or identity politics as greed – even though these primary motivations transform over time.[3,4]

The causes and outcomes of collective violence presented in the general typology above are not mutually-exclusive. For example, ostensibly political armed conflicts – particularly in areas where profitable resources are readily exploited (e.g. minerals, timbre and narcotics) – are often closely linked to organized crime and banditry. The alarming escalation of collective violence among militant groups in Nigeria's Ongoni region (Niger delta) is a good example of this. The persistence of 'rebel groups' operating throughout the Great Lakes Region is another. The corresponding increase in (economically-driven) collective violence in resource-rich areas may subsequently trigger the growth of self-defense and vigilante activities and an escalation in (social) collective violence as the cases of Angola, Uganda, Sudan and Somalia also demonstrate. Correctly interpreting the associations between different forms of collective violence and the socio-cultural contexts in which they are embedded is critical in the design of effective preventive and reduction strategies.

4.2 The Data Challenge

Measuring and comparing the scale and distribution of different categories of collective violence in sub-Saharan Africa is a challenging task. Part of the challenge is linked to the

very terms of the debate: there are persistent disagreements over the definitions of 'war', 'armed conflict' and 'violent crime', the indicators used to measure them and the temporal thresholds applied. Armed conflict, conflict and war are used interchangeably in this chapter.

In addition to definitional difficulties, there are varied approaches to measuring collective violence relying alternately on national and municipal public health surveillance, periodic cross-sectional mortality and morbidity surveys, incident monitoring of media reports, and even the gathering of interview-based evidence. Because collective violence is manifest in a variety of ways, there are also multiple indicators to measure it: 'direct' and 'excess' deaths; child mortality rates; mortality and morbidity owing to intentional injury; rape and other forms of sexual and gender-based violence; and human-trafficking and cross-border and internal displacement. The use of multiple methods, measurements, and data-sources can generate contradictions in the quality and scope of data and inhibits comparative analysis between and even within countries. For example, it is widely recognized that national surveillance, incident-monitoring and testimonials can undercount collective violence.

Other constraints are deeply political in nature: most estimates of conflict deaths, human rights violations and criminal violence are speculative and politicized. For example, the tipping of countries from 'conflict' to 'war' carries with it significant legal, economic and moral implications – not least of which are the application of international humanitarian law and implications for foreign and domestic investor-level confidence. Governments in Africa and elsewhere often feel they have legitimate reasons to shield the true magnitude of collective violence from public scrutiny. Accurate data are thus one of the first casualties of collective violence

Among the most significant challenges to accurately measuring collective violence in Africa are weak or non-existent population health surveillance capacities (and subsequently vital registration statistics). With few exceptions, African states lack the institutions and resources to systematically collect, analyze and report demographic and spatial distributions of collective violence – particularly in countries emerging from war. Nurses, physicians and surgeons alike are frequently overwhelmed by the enormity of the task and are often themselves facing acute pressures associated with violence. Clinics, hospitals and mortuaries may not be functioning, much less collecting and storing data. In such circumstances, victims and survivors may themselves be less likely to report incidents for fear of inaction from health officials, stigma from their neighbours or even reprisal by specific perpetrators.

African health professionals are acutely conscious of the importance of documenting the nature and extent of collective violence in areas where they operate. Such information is

essential in informing national policy decisions, guiding regional and domestic relief efforts, planning and financing treatment and prevention for survivors and ultimately holding perpetrators accountable for their actions. It also serves an extremely important advocacy function. But even where such data are collected, they seldom filter up to decision-makers in senior positions or find their way into published journals. As noted above, in certain cases the collation and dissemination of data on collective violence is wilfully obstructed by politicians and bureaucrats alike out of a concern with how it might affect perceptions of foreign investors and tourists or for signalling systemic weaknesses in government policy and practice.

As a result of the above factors, the dimensions, causes and consequences of collective violence are not yet fully understood. Even less is known about how zones of relative safety and security persist, are created and maintained.[5]

4.3 Patterns of Collective Violence in Africa

sub-Saharan Africa has experienced high levels of armed conflict and corresponding collective violence during the latter half of the twentieth century and beginning of the twenty-first. Since the independence wars of the 1960s and 1970s, more than three quarters of all countries on the continent have experienced violence on a massive and sustained scale. Many of these endured for decades while a smaller number were short and extraordinarily intense. Although the actual numbers of armed conflicts on the continent appear to be declining over the past two decades, outbreaks of collective violence such as those in Sudan, the Democratic Republic of Congo (DRC) and Cote d'Ivoire continue to draw international and regional condemnation.

Despite evidence that the number of armed conflicts is in fact declining (see Table 4.1), the current state of knowledge on armed conflict, collective violence and population health in Africa is based largely on descriptive and qualitative research.[6] Even so, the contemporary literature concurs that warfare is changing in sub-Saharan Africa as in other parts of the world.[6, 7 ,8] While fewer in number, these so-called 'new wars' are characterized by a multiplicity of (non-state) armed groups, the purposive targeting of civilians, the use of rape and other forms of sexual violence as instruments of warfare, the involvement of child soldiers and ultimately state fragility or even collapse – distinguishing them from the more clearly defined independence and proxy wars of a previous eras.

Table 4.1 Number of armed conflicts in sub-Saharan Africa: 2002-2005

Inter-state conflicts				
	Conflicts	Battle-deaths (best estimate)	Battle-deaths (low)	Battle-deaths (high)
2002	13	4741	2585	9256
2003	7	3427	3416	5222
2004	8	2914	2777	3986
2005	5	1851	1851	2254
Intra-state conflicts				
2002	24	4465	4281	6919
2003	23	3155	2617	5197
2004	17	2942	2558	3541
2005	14	909	878	1153

Data source: (9)

The human costs of these armed conflicts – measured as a function of the overall health and well-being of societies in which they occur – are reportedly dramatic. But data emerging from the front is often piece-meal and anecdotal. Media and advocacy accounts describe how civilians are used as protective shields or are specifically targeted and thus exposed to proportionately higher rates of victimization, recruited into state and non-state forces, abducted and enslaved, tortured and summarily executed. Discouraging reports that civilians – including children – are regularly caught-up in collective violence and bear witness to shootings, killings, rape and the loss of family members abound.

The following sections consider specific outcomes of collective violence in both conflict and post-conflict contexts and their impacts on population health in sub-Saharan Africa. The chapter examines the dynamics of direct and indirect deaths during warfare and its aftermath; the manner in which systemic armed violence contributes to population displacement – with internal displacement flows now far exceeding refugee movements in sub-Saharan Africa; and the concomitant implications for the health and wellbeing of civilians. The chapter also reflects debates on the relationships between collective violence and contagion of preventable and communicable diseases – including HIV/AIDS.

Direct and Indirect Deaths

For the purposes of this chapter, a distinction is made between direct conflict deaths, which occur as a direct consequence of fighting, often due to physical injuries caused by artillery, ordnance and predatory activity, and indirect conflict deaths that arise from related phenomena such as mortality from disease or starvation that would not have occurred to the same degree in the absence of the conflict. Direct deaths are mostly among the young and adult male combatants, while indirect deaths affect both males and females, although they tend to be especially high in the vulnerable very young, or elderly. Indirect conflict deaths are closely associated with the displacement of civilian populations in conflict-affected areas or disruption of access to food, potable water and health services, but are also connected with acute depression and suicide following an outbreak of extreme collective violence. The sum of direct and indirect deaths can be described as 'excess mortality' due to collective violence: the additional mortality in a population beyond the level that would normally be expected in the absence of war.

Direct and indirect death rates can change over the duration of a given conflict and during the post-conflict phase. When acute collective violence breaks-out, direct mortality rates can increase rapidly as people are killed; they are then often soon followed by an increase in indirect mortality rates unless timely preventive interventions are undertaken. As conflict subsides and violence is ostensibly brought under control, direct mortality rates tend to also decline rapidly. Indirect mortality rates may also decline, although somewhat more gradually, but can also remain elevated for sustained periods of time.[1, 10, 11] For example, small-scale household surveys administered in refugee camps in Guinea-Bissau support the hypothesis that sustained levels of excess mortality persist among certain population groups well after conflict has formally come to an end.[12] This is because conflict and post-conflict periods may reproduce complex and fragile policy environments owing to a high degree of political uncertainty, weak civil institutions, economic collapse, disruption of services, destruction of infrastructure and the high burden of ill-health. This in turn limits the capacity of governments to adopt and implement effective policing strategies or adequate development plans thus contributing to continued vulnerability to collective violence.

The incidence of collective violence during conflict and post-conflict periods varies according to the place of occurrence and the demographic make up the affected population. For example, mortality surveys conducted in DRC between 1998 and 2004 recorded an overall death toll of 3.9 million though this was highly concentrated in specific geographic regions. The vast majority of the excess death rates were attributed to preventable and treatable illness in unstable eastern provinces such as Ituri and Kivu as

opposed to other areas of the country.[13, 14] Reductions in collective violence were also strongly associated with reductions in crude mortality rates (CMR): CMR in 'health zones' with high levels of documented collective violence were more than 75% higher than CMR in areas where collective violence was rare.[15]

Table 4.2. One-sided violence (structural) in sub-Saharan Africa: 1989-2005

	Conflicts	Deaths (best)	Deaths (low)	Deaths (high)
1989	3	1186	1186	6000
1990	9	1283	1154	1601
1991	5	844	844	944
1992	7	576	559	775
1993	9	1303	1235	3563
1994	11	500996*	59296	802690
1995	8	2328	1615	5034
1996	12	3709	3732	10743
1997	8	9357	6827	53166
1998	10	3774	3584	5233
1999	10	1890	1859	2954
2000	9	941	917	1772
2001	4	1269	1252	1425
2002	14	2987	2802	3977
2003	7	972	946	1671
2004	11	1887	1581	3165
2005	6	588	579	649

Data source: (9)/Human Security Centre dataset
**This includes a large number of direct deaths arising from the Rwandan genocide*

Box 4.1 Collective Violence: The Case of Post-Conflict Mozambique

Mozambique was severely affected by protracted armed conflict between 1982 and 1988. The low-intensity conflict was particularly destructive from a public health perspective and included the targeting of rural health care units, health workers, schools and teachers and the closure of half (48%) of the primary health care network [1]. The war contributed to widespread displacement – particularly from rural to urban areas. An estimated 2-3 million of the total population of just over 16 million were internally displaced and a further one million left the country as refugees. The conflict also contributed to declines in children and women's health and wellbeing. Moreover, extrapolations from existing surveys suggested that more than 200 000 children were abandoned, orphaned, or separated from their parents [1, 1].

Recent studies in Mozambique reveal that collective violence has diminished dramatically since the early 1990s. Existing surveillance data suggest that while Maputo city and province report the highest indices of armed violence in the country, the number and rate of firearm related deaths are very low. In Maputo city from 1994 to 2003 the total of 1028 firearm-related deaths represented just 8.8% of all external causes of death, second to road traffic crashes. Even so, firearm-related deaths in Maputo city were not constant over time. They decreased by 26% from 1997 to 2003 with the highest rate recorded in 2001 (14.19/100 000 population).

By way of comparison, most cities and rural areas report comparatively fewer incidents of armed violence. The relatively low incidence of armed organized and criminal violence should nevertheless be offset against low reporting rates: only an estimated 10% is reported to the police (see Table 4.3). There appears to be low confidence in the policing services. A national victimization survey supported by the Small Arms Survey and the UNDP revealed that crime rates and weapons misuse are comparatively low in both urban and rural areas. Even so, over 40% of the population continues to perceive robbery as the most important security risk facing their community.

Table 4.3 Distribution of crime by type of weapon used and whether crime was reported to police (%) in Mozambique

Type of weapon	Crimes reported to police (%)	
	No	Yes
Firearm	38.6	61.4
Sharp instrument	68.6	31.4
Blunt object	62.6	37.4
No weapon used	89.5	10.5
Not sure	91.8	8.2
All crimes (committed with or without a weapon)	90.2	9.8

Source: [1]

The considerable variations in ratios of direct and indirect deaths observed in sub-Saharan Africa highlight the need to develop enhanced surveillance and estimation techniques that consider factors of public and emergency health care provision and socio-economic resilience in conjunction with conflict intensity. For example, it might be particularly useful for early warning systems to adopt more sophisticated monitoring techniques to alert development and humanitarian actors about the relative severity of a humanitarian crisis. It is essential to move beyond anecdotal information conveyed by media accounts and simplistic incident reporting mechanisms. More robust modelling is imperative if the human costs of collective violence are to be adequately prevented and reduced.

Displacement

Armed conflict and other forms of collective violence can generate vast numbers of refugees and internally displaced persons (IDPs). For example, in 2005 the UNHCR estimated that there were 9.5 million refugees worldwide, while the Global IDP Project (now IDP Monitoring Centre) calculated over 23 million IDPs. Owing in large part to past and ongoing armed conflicts, but also to a growing intolerance among industrialized countries to promote asylum, the vast majority of refugees and IDPs are in Africa. In total, there are an estimated 2.7 million refugees and 12.1 million IDPs in Africa – with many millions more African refugees living in Europe, North America and the Middle East (see Table 4.4).

At least three quarters of all sub-Saharan African countries were affected profoundly by forced migration - as either sites of origin or destination – in the 1990s with trends remaining constant in the early twenty-first century.[20, 21] Although the number of African countries affected by major cross-border conflicts has steadily decreased since the late 1990s, the persistence of collective violence has to varying degrees perpetuated internal displacement, in some cases by inhibiting return and other durable solutions such as resettlement to a third country or local integration.

Table 4.4 Fleeing from Violence: Refugee and IDP Estimates by Region

Region	Countries	Refugee (millions)*	IDP (millions)**
Africa	20	2.7	12.1
Americas	4	0.5	4
Asia	11	0.8	2.8
Europe	10	2.3	2.7
Middle East	5	5	2.1
Total	50	9.5	23.7

*Figures from IDMC [20] for year 2005; **Figures from UNHCR [22] for end-year 2005

Despite recent efforts to promote the conditions for so-called *durable solutions* for refugees and IDPs, Africa remains the site of the most acute concentrations of displacement in the world.[20, 21, 23, 24] In 2005 and 2006, the Sudan, DRC and Uganda together accounted for more than nine million IDPs and the majority of the continent's refugee flows. More positively, recent peace processes and ceasefire agreements across the continent have yielded positive dividends, allowing for the return of more than three million African IDPs in 2005 and 2006. As is well known by health practitioners in conflict areas, the wellbeing of refugees and IDPs involved in repatriation and resettlement is frequently obstructed by persistent insecurity and meager absorption capacities in areas of return.

There are numerous contributing factors that together induce cross-border and internal displacement in Africa. The primary causes are attributed to real and perceived collective violence, including systemic violations of human rights. Other causes arise from more entrenched structural factors, such as endemic poverty, inequitable distribution of resources, corruption and ineffective or unaccountable governance and the inability of states to protect their citizens. The forced displacement of civilians rarely occurs by chance: it is frequently employed as a strategy by both government and rebel forces to achieve specific political and economic ends. For example, in Angola, displacement in the 1980s and 1990s served to bolster the government's reserve workforce while also building up the reserve of the principle rebel group, UNITA. The Zimbabwean government's 2005 'clean-up' operation in urban areas – allegedly carried-out in the interest of promoting public order – led to the forcible eviction of hundreds of thousands of people from their homes with dire implications for the health of those affected.[25] In Burundi, the government 'regrouped' Hutu populations into camps for their 'protection' – even as these led to spiraling impacts on population health. As Box 4.2 and Table 4.5 show, a similar strategy was pursued in Uganda to perverse effect.

Box 4.2 Conflict and Internal Displacement in northern Uganda

In northern Uganda, nearly two decades of conflict have resulted in the internal displacement of up to two million persons. In Gulu, Kitgum and Pader Districts, the most affected by violence, nearly 90% of the population had relocated to camps as of 2005. The Ministry of Health of Uganda and the United Nations Children's Fund (UNICEF) requested assistance from WHO to assess the health status of IDPs in the three districts. The study was led by the Ministry of Health and WHO, in partnership with the offices of the District Directors of Health Services of Gulu, Kitgum, and Pader, UNICEF, the UN World Food Program, the UN Population Fund, and the International Rescue Committee. The primary study objective was to estimate crude mortality rate (CMR) and under-5 mortality rate (U5MR) in the period between 1 January 2005 and July 2005 among populations living in IDP camps at the time of the survey, in Gulu, Kitgum, and Pader districts. A secondary objective was to measure other demographic indicators, including age / sex structure, monthly mortality, causes and circumstances of death, total excess mortality, violent deaths and abductions, vaccination coverage, and availability of bed nets and drinking water. Four separate surveys were designated to be representative of all IDPs in the camps in the three districts as well as Gulu Municipality.

The main findings were as follows:

- Both CMR and U5MR were well above respective emergency thresholds (1 per 10 000 per day and 2 per 10 000 per day) in all four surveyed populations, and were four times higher than non-crisis levels in Kitgum and Pader Districts (Table 4.5)
- Malaria / fever and AIDS were the top (self-reported) death causes; among children under 5, top causes were malaria/fever, and two lango, a local illness concept encompassing oral thrush, malnutrition and diarrhea.
- Less than half of all deaths and 54.2% among children under 5 occurred in a health facilities. A total excess mortality of 25 694 (of which 10,054 children under 5) can be projected for the entire Acholi region between January and July 2005, namely, 1000 excess deaths per week.
- Violence was the third most frequent cause of death (9.4%) occurring mostly outside the camps (68.8%) and health facilities (93.5%). Persons killed were mostly adult males (70.1%), but 16.9% were children under 15. It was estimated that 3971 persons were killed in the study population between January and July 2005.
- Age and sex population pyramids in Gulu, Kitgum, and Pader districts display an apparent deficit of males 20 to 30 years old.

Table 4.5: Internally displaced persons' health and mortality in northen Uganda

	Gulu District	Gulu Municipality	Kitgum District	Pader District	Acholi Region Total
Survey Profile					
Estimated IDP population	462 590	99 535	310 111	319 506	1 191 732
Household sampled	952	960	959	959	3830
Persons present on survey date (%under 5)	6310 (22.6%)	6658 (19.5%)	5920 (21.2%)	6098 (21.1%)	24,986 (21.2%)
Persons present on survey date (%under 5)	6310 (22.6%)	6658 (19.5%)	5920 (21.2%)	6098 (21.1%)	24,986 (21.2%)
Mortality					
Crude mortality rate (deaths per 10,000 per day) (95% CI)	1.22 (1.00 – 1.44)	1.29 (1.04-1.53)	1.91 (1.45-2.37)	1.86 (1.53-2.19)	1.54 (1.38-1.71)
Under-5 mortality rate (under-5 deaths per 10,000 children under-5 per day)	2.31 (1.76-2.86)	2.49 (1.79-3.18)	4.04 (3.17-4.91)	4.24 (3.40-5.08)	3.18 (2.81-3.56)
Top causes of death (%)	Malaria / fever (25.3%)	Malaria / fever (22.5%)	Malaria / fever (34.7%)	Malaria / fever (28.9%)	Malaria / fever (28.5%)
	AIDS (15.6%)	AIDS (19.7%)	AIDS (15.1%)	Cough (11.4%)	AIDS (13.5%)
	Violence (11.7%)	Cough (4.5%)	Violence (10.5%)	Violence (11.4%)	Violence (9.4%)

	Gulu District	Gulu Municipality	Kitgum District	Pader District	Acholi Region Total
Mortality					
Estimated excess mortality (Jan-July 2005)	6783 (4870-8697)	1667 (1177-2137)	8935 (6139-11.731)	9119 (7000-11,239)	25,694 (21,956-29,665)
Estimate of persons killed (Jan-July 2005)	1218 (522-1913)	78 (1-176)	1216 (486-1945)	1349 (771-1927)	3971 (2803-4905)
Estimate of persons abducted (Jan-July 2005)	174 (17-435)	39 (4-98)	304 (61-486)	771 (321-1220)	1168 (701-1869)

Source: Health and Mortality Survey among internally displaced persons in Gulu, Kitgum, and Pader districts in Northern Uganda. 2005. MOH, Uganda.

The implications of displacement on short-term population health outcomes are widely studied by epidemiologists and public health practitioners in and outside sub-Saharan Africa.[26] There is general consensus that the effects of forced migration on kilo-caloric intake and child health are sharp and immediately felt: African refugees and IDPs have registered crude mortality rates (CMR) as high as 80 times baseline rates.[27] CMR rates may escalate depending on the size and lay-out of camps – environments often characterized by poor sanitation, limited and contaminated food and water and overcrowding – all factors that contribute to diarrheal-related diseases, measles, acute respiratory infections and malaria. There is also evidence that the nutritional status of children and women in both camps and host populations deteriorates and that CMR rates rise faster than expected during mass displacement crises.[28] High rates of malnutrition are also directly linked with high case fatality rates, as are increased rates of communicable disease and neonatal health problems.

Ultimately, population displacement contributes to global and child mortality rates that greatly exceed otherwise 'normal' levels in either the pre-conflict or early post-conflict period.[29] As in the case of armed conflict, these mortality rates are not necessarily attributed directly to violence. For example, a recent retrospective survey examining the situation of displaced Angolan families following the 2002 ceasefire revealed that malnutrition, fever and malaria were the leading causes of death, followed by war and other forms of violence.[30] It should also be noted that the effects of displacement on overall health vary from context to context, depending on the resilience of the displaced

and host community population, the extent and consistency of humanitarian assistance and the dynamics of the armed conflict itself.[26, 31]

One of the reasons why above-average mortality persists in camps and settlements is because refugees and IDPs are unable to leave – with many staying for generations in 'protracted situations'. Literally hundreds of thousands of Africans languish in camps and settlements with uncertain futures: UNHCR reported more than 6.2 million refugees living in 38 camps in 2004. The high levels of uncertainty in such situations, coupled with limited opportunity and externally-imposed constraints on mobility are believed to contribute to dependency and various pathologies. In such circumstances, camps are susceptible to 'militarization'. Militarized camps and settlements can obstruct the mandates and operations of international humanitarian and development agencies as well as domestic health services while also leading to national and regional instability.

Refugee and IDP militarization is thus both a cause and outcome of collective violence. Such militarization in Guinea, Rwanda, Tanzania and Uganda have demonstrated heightened risks to refugees, IDPs and hosting communities of fatal and non-fatal gunshot injuries as well as deterioration in social welfare and physical protection.[23] Because the disease burden associated with fatal injuries is greater amongst adult males the lost productivity and corollary strains on social and cultural networks are especially severe.[32] Long-term displacement and the collapse of social structures also put people at greater risk of HIV, tuberculosis, other infectious diseases, and malnutrition. What is more, the perception of refugees and IDPs as a 'source' of insecurity –rightly or wrongly – has increased threats to cherished principles of asylum and a growing public hostility to displaced populations.

Far from being passive recipients of assistance, refugees and IDPs are frequently amongst the most entrepreneurial and enterprising members of their communities. In many cases, displaced African populations and their host communities adopt a range of innovative coping strategies to enhance their livelihoods – including income-smoothing with relief assistance, informal labour in the informal sector and other forms of seasonal migration. Where such resilience is proactively harnessed by international and domestic relief agencies – including public health providers – it is possible to reduce the negative effects of collective violence on population health and wellbeing. Where strategies are narrowly dependent on providing assistance and treating refugees and IDPs as passive beneficiaries, dependency and related pathologies are more likely to set in.[33] Drawing on the Ugandan case, Harrell-Bond[34] has documented the importance of 'integrating' refugees and IDPs into host communities and encouraging unified health services (as opposed to parallel systems) as a means of enhancing resilience and avoiding duplication and dependency.

The spread of HIV-AIDS and sexual violence as a weapon of war

Africa remains one of the regions most affected by HIV/AIDS and many other forms of acute communicable disease. Approximately two thirds of the 38 million people infected with HIV globally are living in sub-Saharan Africa – many in situations of prolonged collective violence.[35, 36] The overall burden of HIV/AIDS is also growing: in 2003, an estimated three million Africans were newly-infected with HIV and some 2.9 million died contributing to an estimated global burden of 84.5 million disability adjusted life years.[37, 38]

The relationships between collective violence and the distribution and incidence of HIV/AIDS and other infectious disease are complex. While many countries affected by, or emerging from internal conflict, exhibit higher-than-average HIV prevalence rates, there are also several countries exhibiting high infection rates (e.g. Botswana, Namibia, South Africa) that are not at war. There is insufficient evidence to demonstrate that armed conflicts necessarily contribute to the intensification of HIV/AIDS prevalence and other forms of disease within and between states, though this assumption is prevalent.[39] The presumed relationships between HIV/AIDS and conflict were placed firmly on the international agenda by the UN Security Council January 2000 Resolution 1308,[40] stating that HIV/AIDS represented a security issue which constitutes a threat to political, economic and strategic interests of states, as well as to human security'.[41]

Increased vulnerability to HIV/AIDS may result from sexual and gender based violence perpetuated as part of the war, but may also result from “sexual favours” in exchange for food or other essential commodities, adopted for survival. In some cases, the vulnerability to HIV/AIDS and communicable illnesses are increased due to the erosion of public health institutions and preventive services, as well as transformations in social capital and interpersonal relationships and intensification of civil-military interactions.[42] Indeed, there is widespread (if unproven) contention that HIV/AIDS increases due not just to sexual violence and sexual slavery during wartime, but also exposure to higher than average HIV-infection-rates amongst soldiers.

The differentiated impacts of collective violence on specific groups can result in some being more vulnerable than others to HIV/AIDS. Clusters that are especially at risk include refugees, IDPs, sex workers, soldiers, and women and children that head households – including those whose partners and parents are at war. The UNHCR reports disproportionately high incidence of rape and sexual violence in refugee and IDP camps from West to East Africa.[43] Referring to Rwandan refugee camps in Tanzania (1994 and 1996), Benjamin[44] claims that 'the structural design of the camps led to gender violence when latrines and water taps were situated a distance from the dwellings. Women and girls were raped when they visited the latrine or fetched water. Self-appointed guards at water

taps demanded sex from women seeking water.' In some cases, self-appointed 'guards' and male food distributors have reportedly used food as a means of extracting sexual favours in exchange for food entitlements.[45]

Another established pathway for the transmission of HIV/AIDS and other diseases in sub-Saharan Africa includes sexual violence perpetrated during armed conflicts and communal attacks. Women and girls are frequently targeted as a form of ethnic cleansing and ritual humiliation. International legal and humanitarian norms currently define such gender-based violence as a deliberate means of demoralizing communities, undertaking genocide and as a crime against humanity when systematically directed against civilians or widespread. In the context of a collapse in legal and social infrastructure, erstwhile social controls also begin to lose their hold and sexual violence persists. As noted by Garcia-Moreno and Reis[46] 'the violence and the inequalities that women also face in crises do not exist in a vacuum. Rather, they are the direct results and reflections of the violence, discrimination and marginalization that women face in times of relative peace.'

Sexual violence has long accompanied war. From Rwanda and DRC to Sierra Leone and Liberia, sexual violence has been used to advance the objectives of particular groups – whether ethnic cleansing or the demoralization of the 'enemy'. During the Rwandan genocide an estimated 200-500 000 women were raped by groups of armed men. Hutu extremists are reported to have assaulted young girls and women in a systematic attempt to exterminate the Tutsis and their supporters – with threat of HIV/AIDS deployed as a critical weapon of war. According to Cohen and colleagues[47] 'marauders carrying the virus described their intentions to their victims: they were going to rape and infect them as an ultimate punishment that would guarantee long-suffering and tormented deaths'. In DRC, combatants allegedly abducted women and girls and held them for periods up to a year and a half, forcing them during that time to provide both sexual services and domestic work.[48] Likewise, violence against women during wars in the Sierra Leone, Republic of Congo and Liberia revealed high rates of rape, beatings and sexual coercion.[49, 50]

Box 4.3 Dealing with the trauma of sexual violence: A surgeon's view from DRC

Even after working in the Great Lakes region for several years as a surgeon, few experiences can prepare one for the horrors and complexities of treating women violated by sexual violence in the eastern regions of the DRC. Treatment of these patients is complicated by extensive delays in seeking care, serious malnutrition and infections and the psychological and social consequences of rape itself.

My experience was restricted to DOCS hospital in Goma where a steady stream of thousands of women come seeking medical care after being brutally raped, most often by combatants invading their villages (Table 4.6). Over 55% of these women take longer than seven months after the rape event to seek medical treatment and close to 30% of them have suffered chronic Sexually Transmitted Infections (STI) over this time. Their ages range from three to over 80 years (Institut Inter-culturel dans la Region des Grand Lacs. 82-06, avenue de la Corniche, Goma, RD Congo).

The majority of these women were raped by several men at once and 15–20% of them are in need of surgical repair of vesico-vaginal fistula (VVF), a condition that involves the tissues surrounding the pelvic organs being destroyed, which forms connections between the vagina, urinary system and sometimes the rectum, resulting in uncontrollable urine and feces running from their wounds. Globally, this is usually a consequence of obstetrical complications. I was shocked to learn that at DOCS hospital over 60% of the VVF cases are directly due to brutal gang rape with insertion of foreign objects such as sticks and firearm butts.

Successful surgical treatment of VVF is difficult under even the most ideal circumstances. The level of brutality determines whether the repair can be achieved externally or whether the pelvis needs to be approached through an abdominal incision. At DOCS hospital, only a minority of cases require only one surgery. Some require more than eight operative procedures, and many are so damaged as to render repair impossible. At least 90 days is required between each surgery, so women have to be away from their families and villages for long periods of time, often with nothing to go back to when they do return. The majority of raped women present with infectious complications and malnutrition which, when compounded with the long delay in coming to hospital, results in an elevated risk of complications, inadequate healing, or even death following the surgery.

Table 4.6 Number of Identified Rape victims in Southern North Kivu: March – December 2003

	'Gueris mon Peuple' (Heal my People), Goma	'Synergie des Femmes' (Synergy of Women), Goma	Total
Identified through health care system	1177	956	2133
Received first aid after rape	455	486	941 (44%)
Received HIV test	208	54	262 (12%)
Had Surgery for VVF at DOCS	90	16	106 (5%)

Data provided by Gueris mon Peuple (Heal My People) and Synergie des Femmes (Synergy of Women), both in Goma.

Only a fraction of women thought to require this type of care are actually being treated at DOCs. Some women are not willing to publicly acknowledge their violation and others are afraid to negotiate the dangerous terrain to get to the hospital. As the combat situation begins to improve, we can expect a rapid increase in the number of women presenting with these problems.

Physical and emotional challenges are expected by surgeons in areas affected by conflict. What makes treating the women violated by sexual violence in this region unique is the realization that treating their physical injuries barely scrapes the surface of their unseen wounds. Working through the anger sparked by these intentional and senseless attacks, and looking in the eyes of a patient whose hope for mental and physical health is long gone, is a frustration that few clinical experiences can compare to.

While there are still disagreements over the extent to which increased population vulnerability increases HIV/AIDS-related illness on a population level, there is compelling evidence that conflict and post-conflict contexts contribute to the spread of this and other diseases.[52, 53] This is because collective violence can undermine availability and capacity of

human resources and the functioning of health services with implications for prevention, treatment and care. The specific pathways are wide-ranging. Conversely, as observed by Smallman-Raynor, there appears to be a positive correlation between the spread of HIV infections in the 1980s with ethnic patterns of recruitment into and demobilization of the Ugandan armed forces.[36] Others have confirmed how rates of cholera, tuberculosis and even sleeping sickness appear to be spatially and temporally linked to the intensity of armed conflicts in Rwanda, Sierra Leone, Liberia and Côte D'Ivoire.

Other health consequences

It is increasingly clear to economists and social scientists that the costs of these new wars in sub-Saharan Africa extend well beyond death, physical injury and disability, and the spread of infectious disease. The increased participation of civilians both as perpetrators and victims of protracted collective violence has led, in certain instances, to 'collective trauma'. In such situations social capital is severely, even permanently, eroded and traditional ideas of 'community' fractured, potentially contributing to new variations of social and criminal violence. Trauma specialists in sub-Sahara Africa are increasingly preoccupied by the long-term consequences of post-traumatic stress disorder (PTSD) on civilians (see Box 4.5). While the literature on collective trauma and PTSD reiterate the importance of understanding symptoms and treatment in the cultural and social context in which they are manifest, it also highlights the ways in which (psychological) trauma goes largely undiagnosed and under-treated.

Child Soldiers and Post-Traumatic Stress Disorder

PTSD emerged as a major preoccupation of public health and psycho-social experts in the 1990s.[54] Owing to changing dynamics of conflict in which civilians – frequently children – were increasingly exposed to war, there were mounting concerns about the social and health-related consequences on individuals, households and societies. The stigmatization of children involved with rebel groups often contributed to the fracturing of families and households. Two recent studies in Uganda and Rwanda consider the scale of PTSD from different perspectives - child soldiers and victims of acute violence.

Table 4.7 Responses of Ugandan former child soldiers to a PTSD survey

Event	Number (and Percentage) of Respondents (n: 301)
Witnessed somebody being killed	233 (77)
Was forced into military training	195 (65)
Had to fight	193 (64)
Had to loot properties and burn houses of civilians	189 (63)
Had to stay in difficult circumstances in Sudan	184 (61)*
Had to carry heavy loads	166 (55)
Was seriously beaten	156 (52)
Got injured	143 (48)
Personally killed another person	118 (39)
Had to abduct other children	116 (39)
Was sexually abused	21 (35)**
Had to drink urine	49 (27)**
Gave Birth to one or more children during captivity	11 (18)

*Percentage of those who stayed in Sudan: none of the children who did not spend time in Sudan reported this experience. ** Percentage of girls: very few boys responded to this question.

The Lord's Resistance Army (LRA) has waged a conflict against the Ugandan government since the National Resistance Movement came to power in 1986. The LRA itself is composed largely of child soldiers. A structured survey of more than 300 randomly-selected former Ugandan child soldiers abducted by the LRA in the 1990s revealed a number of disturbing patterns with broad implications for treatment and rehabilitation. The survey found that most children were abducted at an extremely young age (12 years or younger) and for extended periods of time (on average 744 days). Almost all children personally experienced severe traumatic events, with more than three quarters of all respondents having witnessed a killing and almost forty per cent killing someone themselves. Well over nine in ten recorded post-traumatic stress reactions of clinical importance.

Table 4.8 Responses from Rwandan children affected by armed conflict to a PTSD survey

Event	Percentage (%)of Respondents Answering Affirmatively (n: 3,003)
Have you seen or witnessed any violence during the recent war	96
Did you believe you would die	90
Did you witness dead bodies/parts of bodies	87
Did you hear someone being injured or killed	80
Have you experienced death in your family	78
Have you ever been threatened to be killed	61
Did you witness killings with machete	58
Did you witness massacres	52
Did you witness someone being shot	43
Did you witness rape or sexual assault	31
Did you ever hide under dead bodies	16
Have you been physically injured during the war	13

The Rwandan genocide resulted in the violent deaths of more than 800 000 Tutsis and a smaller number of Hutus in mid-1994. Thirteen months after the genocide, more than 3000 children between the ages of 8–19 were interviewed in eleven prefectures in Rwanda. The survey found that Rwandan children were exposed to extreme levels of violence (Table 4.8). A shortened form of the Impact of Event Scale from a sub-sample of 1830 children reported high levels of intrusion and avoidance, with reactions associated with numbness, loss, violence exposure and lingering feelings that their lives were in danger.[55, 56]

Destruction of Health Systems

While comprehensive data on the impact of collective violence on population health are limited, the macroeconomic consequences of armed conflict are increasingly well recognized. Recurrent defense expenditures during war and investment in reconstruction and recovery can lead to drastic shifts in 'development' spending – including reduced expenditures on health and health services – at a time when demand for these services may be rising. African countries are thus doubly exposed: their under-development renders them susceptible not only to conflict onset, but also to severely diminished access to basic health care during and after episodes of war.[57] Not surprisingly, conflict-affected countries registering the highest mortality rates are also those located in the bottom tenth percentile of the World Bank's development index.[58] Conflicts are thus not only waged primarily by

poorer and under-developed countries, but the structural economic consequences of armed conflicts ensure that such countries remain stunted for generations.[59, 60]

One of the reasons for the long-term negative impacts of collective violence on households and community wellbeing lies in the destruction of health systems infrastructure and related services. In addition to a generalized break-down in governance and payment of salaries, a combination of deliberate raids on medical clinics and deteriorating security along transport routes disrupts critical supply chains and service provision.

The abuse of health professionals by opposing armed groups can result in the evacuation of personnel and reduced incentives to work in areas most badly affected. In the aftermath of Cote D'Ivoire's recent conflict, for example, there were dramatic decreases in the total number of available health personnel. According to some estimates, over 90% of all medical doctors left rebel-controlled areas. When the number of functioning health facilities in 2004 was compared with those operating in 2001, it emerged that over 70% of all clinics had closed during the conflict.[61] The lack of equipment, diagnostic kits, essential drugs, condoms and human and financial resources constituted major impediments to preventing and treating HIV/AIDS.

In Burundi, while overall rates of collective violence appear to have declined somewhat in comparison to peak periods of the 1993–2006 war, civilian populations are nevertheless still in the cross-fire. A household survey found that one out of 10 households surveyed claimed a victim of violence in the previous six months. Victimisation rates were higher in Bujumbura City and Bujumbura Rural than in the other four provinces covered in the study. The types of violence most frequently cited by respondents included, in decreasing order, armed robberies, gang-related violence, fights due to alcohol and assassinations. Armed robberies appeared to be particularly common in Bujumbura City, while assassinations were strikingly frequent in Bujumbura Rural.

Collective violence often occurs in the context of severely under-funded public health infrastructures, leaving populations especially vulnerable to the indirect impacts of collective violence. For instance, less than 2.5% of Burundi's national budget was allocated to the health sector.[62] Owing to the relatively small size of the country, approximately 80% of the civilian population lives within five kilometers of the country's 42 hospitals and 547 health clinics. Nevertheless, in 13 of the 17 provinces, the number of inhabitants per facility is well below the WHO standards of one facility for every 10 000 people. Moreover, there are considerable shortages of personnel and supplies, as Table 4.9 below demonstrates. As a result, the Burundian government estimates that fewer than three per cent of those requiring attention actually receive services owing to lack of infrastructure but also an

inability of patients to pay for services. A major constraint appears to be the high costs associated with access.[63] When patients are unable to pay their bills, they can be de facto 'imprisoned' within health facilities until their relatives can bail them out.

Table 4.9 Availability and needs of public health personnel

Personnel Category	Needs	Available	Deficit
Doctors	260	95	166
Generalists	224	112	112
Paramedics/Nurses	3 939	2 503	1 376
Support staff	1 889	1 845	44
Other	407	103	304

Source: [64,65]

An end to armed conflict can offer critical opportunities to improve overall population health. For example, in addition to a surge of capital and resources arising from a 'peace dividend', there are often new opportunities to enhance the health infrastructure and services for affected populations. Specifically, improved diarrhea control can be achieved through specific investment in bore-hold drilling and immunization campaigns. As new doctors, nurses and health extension workers are trained and others return, there are enhanced opportunities to control epidemics and to address disability. In certain cases – including Rwanda and Liberia - important gains are currently being made in investing in critical health structures.

4.4 Patterns of Violent Crime and Organized Violence

Another major contributor to collective violence and negative population health in sub-Saharan Africa includes violent crime perpetrated by groups with varying levels of organisation. In certain instances this may include crime perpetrated or supported by formal security structures, while in others it refers to militia, bandits and gangs. It is important to emphasize that such violence is not always exclusively committed by 'collectives' but can also include transient and itinerant violence perpetrated by individuals. As such, there is a 'grey' area in economic and social forms of collective violence that potentially involves interpersonal violence as previous chapters in this report amply demonstrate. One example of this intersection between collective and community violence are the intense armed conflicts involving pastoralist groups in Karamoja region in the north eastern Uganda. These conflicts have claimed thousands of lives and recent attempts at forcible disarmament by the national army have resulted in further death and injury.

Though an appreciation of the scale and distribution of criminality is still evolving, there are convergent views on the types of risk factors contributing to the onset of collective violence in sub-Saharan Africa. These factors are subdivided here into structural and proximate causes. Structural causes relate to limited education, under- and unemployment, inequality, unrealized aspirations, the presence of exploitable mineral resources and rapid urbanization. Proximate causes include segregation and urban density, cultures of paternalism and dominant masculinity, a lack of faith in public security, risk-taking behaviours that are socially reproduced, and arms availability.[5] A combination of structural and proximate causes is most commonly associated with the onset of both armed conflict and violent crime.[66] Specifically, the combination of rapid and unregulated urbanization, visible and pronounced inequality and unregulated arms availability are increasingly acknowledged as primary risk factors for escalating criminal and collective violence in sub-Saharan Africa.[67,68]

The dynamics of criminal violence in sub-Saharan Africa demonstrate some features that are common to trends registered in Latin America and the Caribbean as well as Western Europe. In surveyed African cities, the use of firearms was more likely in the case of property crimes than in violent assault. For example, armed robbery was reportedly committed most often by young male strangers in approximately two-thirds of the cases in sub-Saharan Africa.[69] In many cases the offender was not alone and operated in groups of three or more. In the case of assaults and sexual violence, in over half of all reported incidents, the offender and the victim reportedly knew one another, at least by sight.[70] Across all reported cases, women victims were reportedly less frequently attacked with firearms than their male counterparts.

For a detailed discussion of organized and criminal violence see Chapter 3 on community violence.

4.5 Recommendations for Preventing Collective Violence

Enhance and strengthen population health and crime surveillance capacities and coverage. Enhancing knowledge and awareness of collective violence and its associated burden represents an urgent priority for sub-Saharan African governments, nongovernmental agencies, research institutes and agencies that fund development in Africa. More consistent and reliable data - particularly in under-represented rural areas – are required to prioritize and target interventions to prevent and reduce collective violence and to better understand its relationships with inter-personal violence. Although there continues to be some aversion to investing in surveillance, victim surveys or robust incident reporting, it is nevertheless imperative and mandated in the Programme of Action for Africa 2006–2010, in view of securing sustainable development in the region.

Focus on urgent and targeted preventive measures to reduce mortality and morbidity in conflict and post-conflict situations. It is crucial to address population health in such circumstances because these situations present the most acute forms of vulnerability and highest incidences of direct and indirect death. Preventive interventions should emphasize protection of vulnerable populations – notably the displaced and children. Core priorities of such initiatives should be on the provision of adequate food rations (ensuring good practice in targeting and delivery such as inclusion of women in distribution), clean water and sanitation, diarrheal disease control, measles immunization, maternal and child health care and case management of endemic communicable diseases. Investments in the reconstruction of health infrastructure, human resources and training should follow immediately.

Acknowledge and avert the challenges associated with designing and effectively delivering health services in contexts of extreme collective violence. In some cases humanitarian and development aid can exacerbate vulnerability to violence by unintentionally supporting particular groups over others. A growing number of agencies are introducing standards and guidelines to reduce "unintentional and avoidable" harm - including the so-called 'sphere' standards and sexual and gender-based guidelines.

Promote physical protection and security to reduce collective violence and its associated negative health outcomes contributing to excess mortality. Innovative interventions that require additional investigation include so-called 'safe havens' and 'safe zones'. Safe havens are described as 'circumscribed areas' where the displaced can seek protection and support close to their homes, but not necessarily in them. The model was invoked in six areas in Bosnia-Herzegovina in 1993 and in Liberia to mixed effect.(71) The safe zone concept is designed to protect populations where they normally live and was invoked in the context of Iraq in 1991.

Enhance long-term victim assistance in national planning mechanisms. Many of the casualties of collective violence are not recorded in official statistics, and even fewer of those affected are able to access health systems. It is vital that national and international stakeholders provide sustained investment in equitable rehabilitation and integration programmes, including awareness and sensitization, so that survivors of collective violence are provided with long-term treatment and care for physical and psychological effects.

Ensure inclusion of collective violence prevention measures in national planning mechanism. As important is the creation of enabling mechanisms within responsible ministries and departments to elaborate inter-sector and responsive programmes to prevent and respond to collective violence.

Ensure protection for health staff and facilities during incidents of collective armed violence, including in post-conflict contexts. The density and quality of human resources in the health sector is a crucial factor in determining variations in mortality and morbidity rates. Strong health systems are crucial for achieving universal coverage with critical interventions, including preventive and curative health care and reductions in the contagion effects of armed violence. Humanitarian actors and donors should augment their efforts in conflict and post-conflict zones, particularly with a focus on supporting critical investments in equitable and sustainable health infrastructure, investment in human resources, support for payment of consultation and purchase treatments, prevention of spread of infectious disease, and support for physical security.

4.6 Conclusions and Future Perspectives

Collective violence adopts various forms in sub-Saharan Africa. It is motivated by a combination of political (conflict), economic (crime) and social (gangs and vigilantes) factors. While the diverse outcomes of collective violence are felt most acutely during situations of war, the 'post-conflict' period does not necessarily come with improvements in population health. Collective violence may well continue in the aftermath of declared conflict: the introduction of a ceasefire, peace agreement or primary and curative health care initiatives does not guarantee tangible improvements in the wellbeing of civilians. In fact, many so-called post-conflict environments in recent years yielded even more direct and indirect threats to civilians than the armed conflicts that preceded them. Nevertheless, there is an emerging consensus that collective violence presents a major impediment to national and community development, and that investments in prevention and reduction could enhance growth and improved quality of life.[72,73]

This chapter observes that robust security and support for public health delivery is critical to prevent and reduce collective armed violence before, during and after armed conflicts. Collective violence begets more violence and states that have been weakened by protracted conflicts frequently lack the resources and capacity to address the underlying risk factors that gave rise to collective violence in the first place. The persistence of high levels of indirect conflict deaths following the acute phase of a conflict presents a challenge to policy-makers and practitioners alike.

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CHAPTER -5

SELF-DIRECTED VIOLENCE

SELF-DIRECTED VIOLENCE

5. Introduction

The previous four chapters have shown that high levels of interpersonal and collective violence on the African continent are major causes of premature death and ill-health and exert considerable pressure on national economies. Increasingly, self-directed violence (suicidal behaviour) also contributes to this health and economic burden. The incidence of suicide is a sensitive indicator of the quality of life in a country or area. It reflects the socioeconomic and political situation, public health (psychiatric and somatic) and the population's stress tolerance, as well as the availability of support and the rehabilitation capacity of public health services.(1)

Across the globe, suicidal behaviour is an increasingly serious public health problem. Almost one million people worldwide died from suicide in 2004,(2) with an estimated 10-20 times more individuals engaging in non-fatal suicidal behaviours.(3) Such figures alone do not begin to describe the psychological pain of the suicide victims themselves. Nor do they convey the emotional and social impact that these deaths and attempts have on the family and friends left behind.

Although early reports suggested that suicide was rare on the African continent, recent research from a number of countries indicates that suicidal behaviour is an increasingly important public health problem that deserves greater priority in health systems.(4,5,6,7) As most suicides in Africa are of young and middle-aged people, suicide robs the continent of a big source of human potential. Typically, the majority of deaths from suicide in Africa are among males, who are the traditional bread winners in many African societies.

Using an interdisciplinary approach, this chapter presents what is known of suicidal behaviour on the African continent and proposes several recommendations for preventive action. The chapter begins by describing what is meant by the term suicidal behaviour and providing an overview of the state of knowledge in Africa. Then, the extent of fatal and non-fatal suicidal behaviour is examined with particular reference to differences across demographic groups, followed by an assessment of the typical methods used. The next section discusses the known individual-, familial- and societal level risk factors for suicidal behaviour. Based on both international and local research, preventive strategies on various levels are proposed, followed by specific recommendations.

5.1 Defining Suicidal Behaviour

Suicidal behaviour is a complex and multi-dimensional form of self-directed violence. Its use, interpretation and profile is heavily influenced by the cultural, religious and socio-political context in which it occurs and the characteristics of the person (e.g. gender, age, socio-economic status, occupation, mental state) and/or population involved.[7] If the understanding, assessment, treatment and prevention of suicidal behaviour are to be improved, the different presentations, types and subtypes need to be clearly defined and categorized.[5, 8, 9] Yet, despite extensive international literature on the issue, commonly accepted terminology, classification and unequivocal definitions remain elusive goals, as the phenomenon is not free from ambiguity.[7,9,10,11,12,13,14,15]

Suicidal behaviour is part of a process that ranges in degree of severity from merely thinking about ending one's life to actually killing oneself.[16] It can be associated with psychopathological conditions such as depression, schizophrenia, and substance abuse, as well as with biological, biochemical, neuropsychological, psychological, social, cultural, interpersonal, existential and philosophical factors. According to the stress-diathesis model,[17] some factors such as genetic make-up may increase an individual's long-term vulnerability to suicidal behaviour (diathesis) and others such as life experiences may increase risk at a particular time (stressors). Whether suicidal behaviour emerges under the influence of stress will depend on this diathesis. A stress vulnerability model has been proposed to supplement the stress-diathesis model. This is a broader model of development of the suicidal process that views suicide as an act stemming from the interplay between cognitive, affective and communicative aspects.[18] Recognition and assessment of these interacting biological, psychosocial and environmental factors are important when determining suicide risk.

Four aspects are important to consider when defining suicidal behaviour: (i) consciousness (awareness) of the possible outcome; (ii) intention, or taking the risk, to die in order to achieve a different status; (iii) agency of the act (self-inflicted – done by oneself and to oneself); and (iv) outcome of the behaviour (fatal or non-fatal).[9, 19] These key aspects have been incorporated into a recently proposed nomenclature for suicidology[20] that is based on earlier efforts [13] and extensive discussions among an international group of suicidologists. Under what is termed 'suicide-related behaviours' a suicide attempt is defined as "a self-inflicted, potentially injurious behaviour with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die" (13, p.273). Such behaviour is also called 'non-fatal suicidal behaviour', 'parasuicide', and 'deliberate self-harm', and these terms are often used interchangeably in the literature. The term suicide denotes "a self-inflicted death with evidence (either explicit or implicit) of intent to die".[13]

Intention is difficult to establish as a suicidal person is typically ambivalent; may deny, minimise or exaggerate his/her suicidal intent; or may misjudge the lethality of the method used or the availability of help. Yet, it is key to a definition, primarily as it permits a distinction between unintended and suicidal behaviour.

If there is no intent, the revised nomenclature refers to this behaviour as 'self-harm', or in the case of a fatality 'self-inflicted unintentional death'[13] These behaviours differ in many ways from suicidal behaviour and will not be discussed further here. Suicide-related ideations (i.e. thoughts about killing oneself) and suicide-related communications (i.e. suicide threats and plans) are also discrete and complex phenomena that form part of the suicidal process. They are beyond the scope of this chapter, but readers are referred to several researchers who have examined these issues within the African context (for example see.[6, 21, 22]

The aim of developing the proposed nomenclature is to increase the ability of clinicians, epidemiologists, researchers and policy-makers to better communicate with each other and study similar populations at risk for suicide-related ideations, communications and behaviours.[23] It is too early to tell whether this newly proposed nomenclature will be broadly adopted. In the research reviewed in this chapter, it is often unclear what definitions were used by authors and whether definitions were comparable across studies. For the sake of consistency throughout this chapter and in line with the newly proposed nomenclature, the term 'suicide' is used for suicidal behaviour that results in death and the terms 'suicide attempt' or 'attempted suicide' for suicidal behaviour that does not result in death.

5.2 State of Knowledge on the African Continent

Few African countries have data or studies on suicidal behaviour available. Reasons for the absence of data are frequently socio-political, religious or cultural in nature. Decades of political and socioeconomic instability in large areas of the continent affected the systematic collection of accurate statistics on suicidal behaviour. For example, in South Africa, vital statistics on suicidal behaviour from the apartheid era (legalized segregation by ethnicity) have been shown to be questionable given the reported poor quality of mortality and population data for the groups and regions discriminated against during that time.[24, 25] Also, following the overthrow of the 'Derg' regime in Ethiopia, when the entire police force of Addis Ababa was replaced by one less experienced, an increase in the percentage of suicides without any method specified or with 'undetermined' method was noted.[26]

In addition to their influence on death registers, political and socio-economic factors have complicated investigations of suicide trends in many parts of Africa through a lack of research infra-structure and funds, with research and prevention programmes often given a low priority; a lack of expertise in suicide research; an absence of follow-up studies; inadequate inter-African research collaboration; and a paucity of multi-centre studies. Available studies are typically small-scale and descriptive in nature, often do not cover rural areas and have not always employed standardised research designs and assessment instruments. This makes it difficult to compare study results both regionally and internationally.[5]

Suicidal behaviour in most of the continent still carries negative cultural or religious sanctions [21,27], and in some countries still remains a crime, thereby helping to perpetuate secrecy and non-reporting.[22, 28, 29] In Uganda (see Box 5.1), some reports indicate that suicide victims do not receive a decent burial; their families, and the survivors of suicide attempts are shunned; and those who are employed do not have their terminal benefits paid to the surviving family members.[5,6] There is some evidence though that these views are changing. Ongoing work in Adjumani district of Uganda indicates a reduction in the stigma toward suicide probably as a result of the involvement of communities in the provision of mental health services, and because the police and courts in that district no longer prosecute suicide attempters.[6] In Ethiopia, suicidal behaviour is now recognised as having psychological causes,[26] while in Kenya the courts take a more liberal attitude towards people who engage in suicidal behaviour, often placing them on probation.[30]

Given the stigma and possible financial and legal ramifications associated with suicidal behaviour, there may be a reluctance, on the part of any one of the many informants who know the person or find the body (family members, doctors, police, coroners, statisticians) to call it such.[16] The person committing the act may also make deliberate attempts to disguise their death, or their injuries, as for example, unintentional. It is a challenge to trace these 'disguised' suicides, particularly those where there may be a low index of suspicion on the part of police and medical officers (such as poisonings, drowning, single vehicle crashes or pedestrian injuries).[31] For example, experience in Ethiopia indicates that suicidal behaviour by poisoning (fatal and non-fatal) is recorded as 'accidental poisoning'.[26] The uncertainty surrounding many of these cases means that suicides are also frequently misclassified as an undetermined cause of death.

The consequence of the above actions is that rates of suicidal behaviour are underestimated. For attempted suicide, an additional data limitation is that information is often hospital-based. Many of these cases are not seen in hospitals or clinics if the consequences are not perceived as life-threatening. While the possible sources of under-

reporting are well-recognised, few African studies have attempted to assess the extent to which suicidal behaviour is underestimated. As exceptions, two studies from South Africa found the statistics to be fairly accurate in one city despite the fact that medical practitioners had to base their suicide certifications on limited and fluctuating information.[32,33]

Box 5.1 Cultural attitudes towards suicidal behaviour: an example from Uganda

Traditionally, the Baganda (tribe) found in central and southern Uganda considered suicide a most terrible act.[1] *They believed that chronic illness (such as epilepsy and leprosy) and becoming very angry (as after a quarrel) could lead one to suicide. It was further thought that some form of spirit (kitambo) must be responsible for making a person kill him/herself. They regarded the body of a suicide person with fear, treating suicide in a sense as contagious.*[34]

The body of the suicide used to be beaten, a custom said to have been introduced by the English police in the colonial era. This practice is still carried out to date in some parts of the country[1] *Formerly, no one inherited from the suicide person for fear that he or she could be tempted to commit suicide. A banana tree would instead be planted in front of the house, left there over night, and then taken the next day and thrown into the bush. This tree would then be said to have symbolically inherited from the deceased. Mourners would then cut their hair signifying the end of mourning.*[34]

Anecdotal evidence from clinical practice in urban Buganda (Kampala) and evidence from the recently undertaken study in parts of rural northern and eastern Uganda as well as Mubende, a rural district in Buganda, seem to suggest that the attitude to suicide among the Baganda today is much more varied depending on one's religious beliefs, educational attainment and whether one stays in an urban or rural area.[35] *There is less ostracization among the more educated and those who have embraced Islam and Christianity. Recent data from a number of largely rural districts of Uganda that cut across the main tribal groupings of Bantu, Luo and Nilo-Hamite still indicate prevalent negative attitudes to suicide and the suicide victim and his/her family.*[35]

"It is a norm here that once a person commits suicide, prayers are not held during the burial and the deceased is regarded as an outcast."
(Focus group discussion by elderly females in Katakwi district in North- Eastern Uganda - Nilo-Hamite ethnic group).

"The deceased from suicide is not buried normally ... no prayers take place, the corpse is just dumped."
(Focus group discussion by young females Bugiri district in central Uganda – Bantu ethnic group).

"A person who commits suicide is buried like a dog, few people attend his burial, there are no prayers."
(Focus group discussion of young females in Apac district in Northern Uganda – Luo ethnic group).

The attitude to suicide in Adjumani, a district in North-Western Uganda mainly inhabited by the Madi from the Nilotic tribal grouping, was the exception among the 14 districts in that study.[35] *The attitude of the community in that district as elicited from focus group discussions of various age groups was generally more tolerant and understanding of suicidal behaviour. The more supportive attitude to suicide victims and their families could not be explained by the ethnic group to which respondents belonged but may be due to a greater prevalence of these two problems in this community and the involvement of trained members of communities in the provision of counselling services in this district.*[6,35]

5.3 Extent of the problem

Suicide and attempted suicide are two distinct phenomena and often have different attributes. However they are often linked and sometimes the distinction is blurred, especially among the lay public. In the sections that follow, the estimates of the size of the problem and the distribution across demographic groups of each are dealt with separately. Thereafter, methods used in both forms of behaviour are examined.

Efforts are made to refer to the most recent data available. However, in the interests of better coverage, earlier data from the 1980s are quoted when more current figures are absent. Wherever possible, figures for suicidal behaviour relative to their population size are used rather than absolute numbers. Yet, rates are not always available, particularly for attempted suicide, and in these instances, absolute numbers are used.

The majority of research comes from South Africa. Although it is a country with unique characteristics compared with many others in the region, being relatively prosperous with well-established research infrastructures and a long history on suicidal research,[7] from a socio-economic perspective the majority of the population have to grapple with similar challenges of poverty and underdevelopment as elsewhere on the continent.

Suicide

Estimates of the size of the problem

The WHO reports country-level figures for four countries (Mauritius, Sao Tome and Principe, Seychelles and Zimbabwe). The latest figures (since 1985) for these countries are shown in Table 5.1. For Zimbabwe, where official information on suicide is only available for 1990, the overall rate is 7.9 per 100 000. For the other countries, where multiple years of data are available, the rates tend to vary substantially across time. Although not shown here, Mauritius has data available since 1955. The trends show that after an initial decline from 1955–1970, suicide rates underwent an 11-fold increase, from an overall rate of 1.7 per 100 000 in 1970 to 19.2 per 100 000 in 1999.[3, 16] There is evidence of a decline after this date to 7.4 per 100 000 in the latest 2003 figures.

As a few more (or less) suicides can greatly modify overall rates in countries with small populations,[3] caution needs to be exercised with regards to rates for Sao Tome and Principe and Seychelles. In both countries, rates are provided for only a few specific years. In Sao Tome and Principe, low suicide rates are recorded (0.9–1.9 per 100 000), while rates in Seychelles are considerably higher and increase across time to 13.2 per 100 000 in 1998.

Table 5.1 Suicide rates for countries reporting to WHO (36)

Rate per 100 000 population				
Country	Year	Both sexes	Females	Males
Mauritius	2003	7.4	4.0	10.9
	2000	11.9	5.2	18.8
	1995	13.5	5.5	21.1
	1990	14.1	10.8	17.6
Sao Tome and Principe	1985	10.6	7.3	13.8
	1987	0.9	1.8	0.0
	1985	1.9	0.0	3.7
Seychelles	1998	13.2		
	1995	0.8		
	1985	12.3	3.1	21.3
Zimbabwe	1990	7.9	5.2	10.6

The Burden of Disease Study [37] provides estimates of suicide rates for every country in the WHO African Region. Caution should be exercised when using these figures as the level of evidence is generally rated as low.[38, 39]

Some countries have suicide rates available for smaller areas, usually at the city-level. Figures available from South African studies tend to be higher than elsewhere. For four of the largest cities in the country, rates range between 11 and 25 per 100 000, covering different years between 1997 and 2004.[40, 41, 42, 43] The rates have remained relatively stable from 2001–2004 for these cities [42]. In Ethiopia (Addis Ababa), suicide rates ranged between 3.2 and 11.7 per 100 000 between 1985/6 and 1995/6, with an average rate of 8.1 per 100 000. Suicide in Ile-Ife, Nigeria, was found to 0.4 per 100 000 during 1979–1988.[44] A rate of 4.7 per 100 000 was reported in Maputo, Mozambique for 2000.[45]

Distribution across demographic groups

Suicide rates are not distributed equally across demographic and social groups in the general population. Sex, age and ethnicity are important markers for suicide, although few African countries other than South Africa have focused on ethnic differences (see Box 5.2). Those that do examine ethnic or cultural differences, typically focus on attitudes toward suicidal behaviour [5, 46, 47] rather than differences in the suicidal behaviour itself.

As found in most countries in the world, suicide in Africa is more common in males than in females. Rates for males are usually between two and four times higher than those for

females, although a considerably higher male to female ratio of 6.9:1 was recorded in Seychelles in 1985 (see Table 5.2). Within a country, the male to female ratio can vary over time and across regions. For example, in Tanzania (1992–1998), almost equal rates for males (4.1 per 100 000) and females (3.6 per 100 000) were reported in Dar es Salaam; but in two rural communities, Hai District and Morogoro, male rates were twice and three times higher than those among females, respectively.[48] In Hai, suicides among females were the leading cause of injury deaths (12.1 per 100 000), and for males the second leading cause (22.1 per 100 000).

Table 5.2 Male: female ratios for suicide

Country	Region	Year/s	Male:Female ratio
Malawi (49)	Blantyre	2000-2003	3.4:1
Mauritius (36)	Whole country	1985-2003	Ranges between 1.6:1 and 3.8:1 depending on year
Nigeria (44)	Ile-Ife	1979-1988	3.6:1
Seychelles (36)	Whole country	1985	6.9:1
South Africa (50,51,52,53)	Whole country Buffalo City, Cape Town, Durban, Johannesburg, Nelson Mandela, Tshwan	1984-1990 2000-2003	Ranges between 3.1:1 and 5.7:1 depending on location
Tanzania (48)	Dar es Salaam	1992-1998	1.1:1
	Hai District	1992-1998	1.8:1
	Morogoro	1992-1998	2.7:1
Uganda (35)	14 districts	2004	1.4:1
Zimbabwe (36)	Whole country	1990	2.0:1

Globally suicide rates tend to increase with age, with rates among those aged 75 years and older approximately three times that of those aged 15–24 years.[16] This trend is visible for both sexes but is less consistent among females. However, in the last 50 years there has been an increase in the number of suicides among younger people, and in several countries the rates for those aged below 45 years is already higher than that for those aged over 45 years.

In Africa, no clear pattern of suicide rates across age emerges. In some countries, rates are highest among the elderly while in other places rates are higher in the younger age groups. Furthermore, the profile varies by the time period, area, sex and ethnic group covered (for example see Box 5.2). Typically rates are low before age 15 years, but increase dramatically in older adolescents and young adults.

Box 5.2. Suicide among ethnic groups in South Africa

Since ethnicity has in the past been one of the major bases of division of South African life, it has frequently been considered a crucial socio-demographic variable in suicide research, with study results often presented in ethnic-specific groups: Asian, black, coloured (of mixed racial origin) and white.[4,7] These ethnic groups have no anthropological or scientific validity [1,1] and, as gross proxy measures of social groupings in South Africa, give no indication of intra-group diversity. Indeed, an increasingly multiracial upper class has meant that while differences between ethnic groups are on the decrease, differences within ethnic groups are on the increase.[1]

However, there remain important differences between ethnically-defined groups in the share of suicide. Study results [50,51,52,53] have shown, for example, that rates for whites are often substantially higher than those of other ethnic groups for both males and females, and where tested, for most age groups. High rates among young Asian females aged 15–24 years make this group an exception. Suicide rates are higher among males than females for all ethnic groups, with the size of the difference between male and female rates typically greatest for blacks. Suicides among whites tend to peak in older age groups, particularly for males. In contrast, the other ethnic groups, particularly females, tend to have a concentration of suicides in those aged 15–34 years with fewer among the elderly. Blacks and coloureds typically use hanging as a method while whites more often use firearms and are the only ethnic group for which gassing (carbon monoxide poisoning) is in the top causes of death.[40,43,50,1,1] Suicides among young Asian females are usually a result of poison ingestion.

Examination of group differences allows for the generation and testing of hypotheses regarding possible mechanisms underlying these differences, which in turn is important for prevention. For example, in relation to the different age distributions across ethnic groups, the following factors have been proposed.[1,1,1] First, in traditional black and Asian cultures the elderly are respected and remain an integral part of the family and community and this is thought to be an important protective factor against self-destructive acts. Second, young people from traditional backgrounds in a multicultural South Africa, stressed by the conflict between traditional social roles and new roles offered by a more western-orientated culture, could be more likely to engage in suicidal behaviour. Third, it is likely that in the younger age groups a higher proportion of whites are attending secondary or tertiary educational institutions and are employed than of the other ethnic groups, and therefore may be less inclined to commit suicide.

These differences are mediated by social and economic factors, and better collection of data on these factors would enhance the measurement of group differences in future research. Until better socio-economic data are available, moving away from past apartheid-based discrimination and monitoring progress over time involves measuring differences in life circumstances by ethnic group. Consideration of ethnicity is also important in that the black population which was discriminated against and impoverished, and is now experiencing social and economic gains, could be a valuable indicator for trends that may emerge in the rest of Africa where democratic and economic advances are being made.

Attempted suicide

Estimates of the size of the problem

Figures for attempted suicide vary considerably both across and within countries. Figures (per 100 000) range from 48.9 for Addis Ababa in Ethiopia (1981/1982–1995/1996) to 7.0 for Benin City (1978–1981)[62] and 2.6 for Ibadan (1984/1985)[63] in Nigeria. The percentage of individuals who report having attempted suicide at some point in their lives (the lifetime prevalence rate) was found to be 15.5% in a war torn area of Uganda (), 3.2% in the Ethiopian rural and semi-urban community of Butajira,[64] 0.9% in Addis Ababa,[65] and 0.7% in a recent survey (2002-2003) covering five of the six geopolitical regions of Nigeria (representing approximately 57% of the national population).[66]

Research in South Africa has shown an increase in the number of patients admitted to hospital with suicidal behaviour over a 10-year period from 1988, with the proportion of black patients growing dramatically in some centres.[59] It is argued that this increase should be viewed as a genuine escalation of the problem, rather than simply as a reflection of improved recording practices over recent years in post-apartheid South Africa. A

combination of factors may explain the increase including the changing social role expectations and high expectations which are not always realised following political and other transformation; unchecked rural to urban migration; rapid urbanization; high crime and violence levels; socio-economic difficulties including high unemployment levels; and the HIV/AIDS epidemic.[59] These are discussed further under 'risk factors' below.

Distribution across socio-demographic groups

As for suicides, suicide attempts in Africa vary considerably across sex and age in absolute numbers. For some countries a profile similar to that of Western countries is evident, where young females predominate.[16] For example, in Gabon and South Africa generally three times as many females engage in attempted suicide compared to males;[7, 67] while studies from other countries (Ethiopia, Zimbabwe, Tanzania) have found the ratio to be closer to 2:1.[29, 65, 68] Yet some studies from Ethiopia [65, 69] and Nigeria [62,63] show no marked gender differences and in others, male suicide attempters even outnumber females by 1.7 in Kampala [28] and 2.9:1 in Addis Ababa.[26] To explain the unusual male preponderance, it has been suggested that the stigma attached to suicide attempts is greater for a female as it would severely damage her own and her sibling's marriage prospects; with the result that women's suicidal behaviour goes unreported.[5]

All age groups are affected but various hospital-based and community studies from Ethiopia,[64, 65] Nigeria,[62, 63, 66] South Africa, [7,59] Uganda [28] and Zimbabwe [70] show that most suicide attempts involve those under 30 years. Those aged between 15 and 19 years tend to be at particular risk. In a study in Benin City 15–19 year olds constituted 39% of the sample [62] and in a hospital-based study in South Africa 25% of the total sample of suicidal behaviour patients admitted were youths aged 18 years and younger.[59] In secondary schools in Addis Ababa [69] and a South African province,[71, 72] one or two students out of every 10 reported attempting suicide.

Methods used in suicidal behaviour

The leading causes of suicide by country and sex are shown in Table 5.3. The figures reflect different kinds of data based on availability: data for Mauritius are at the country-level, while those for the other countries come from one or several mostly urban areas. In most countries, poison ingestion is the most frequently used method of suicide. Exceptions include Ethiopia [26] and South Africa [40, 41, 42, 53, 57, 58] where hanging is the leading cause. Suicides involving firearms also contribute a high proportion of deaths in Nigeria and South Africa. Across four South African cities (Tshwane/Pretoria, Johannesburg, Cape Town, eThekwini/Durban), the hanging suicide rate ranges from 3.6 to 7.2 per 100 000, while the firearm suicide rate ranges from 2.0 to 6.4 per 100 000.[42]

Table 5.3 Leading causes of suicide by country and sex

Rank	Ethiopia (26)	Malawi (49)	Mauritius (3)	Nigeria (44)	South Africa (40,41,43,50,58)	Tanzania (73)
1	Hanging/ strangulation Males 66% Females 59%	Poison ingestion Males 75% Females 89%	Poison ingestion Males 64% Females 55%	Poison ingestion Males 33% Females 50%	Hanging Males 31-47% Females 11-27%	Poison ingestion Males 43% Females 98%
2	Drowning Males 12% Females 10%	Hanging Males 22% Females 11%	Hanging Males 23% Females 11%	Firearms Males 41% Females 0%	Firearms Males 31-44% Females 18-37%	Hanging Males 51% Females 0%
3	Poison ingestion Males 11% Females 7%	Firearms Males 3% Females 0%	Burns Males 7% Females 26%	Hanging Males 16% Females 36%	Poison ingestion Males 6-9% Females 21-36%	Firearms Males 4% Females 0%

Where examined, the methods used differ across demographic groups (also see Box 5.2). As found internationally, males tend to use more lethal methods for which there are lower chances of recovery – such as shooting and hanging. It has been suggested that males choose more lethal methods because they have less concern about bodily disfigurement, higher levels of aggression, more knowledge regarding violent methods and, although disproved by some research, a greater desire and intention to die.(74) Only females in South Africa appear to use firearms as a means of suicide, while females in other settings are more likely to use poison. Hanging features as the most common method for females only in Ethiopia. In South Africa, hanging predominates until middle age, after which firearms become the leading method.

For suicide attempts poison ingestion is also the most common method used in the majority of countries. An exception is found in Ethiopia where hanging exceeds poisoning as the leading method of attempted suicide, but only for men.(64, 65) Typically, around 80–90% of suicide attempters ingest poisons. Poisons predominantly involve pesticides (mainly organophosphates) but over-the-counter painkillers, antimalarials, benzodiazepines and antidepressants are also used.(7, 8, 28, 29, 43, 68, 70, 75, 76) Other findings point to the frequent ingestion of household poisons such as paraffin, kerosene and turpentine, and cleaning fluids,(43,59) particularly among females.(28) The public health impact of poison ingestion in Zimbabwe is highlighted in Box 5.3.

A method found in several countries is self-immolation by fire, a method with very high mortality. A study conducted in north-eastern Nigeria found that among young burn patients, 1.4% were suicide attempts by pregnant females (aged 11–15 years) protesting forced marriages.[77] Self-inflicted burns constituted 11% of suicidal behaviour (fatal and non-fatal) admitted to a hospital in Harare, Zimbabwe [68] and nearly 10% of all suicides in Durban, South Africa.[78] Both studies report on the preponderance of female cases, with the typical patient being a young female and dousing herself with paraffin or petrol..

Box 5.3 Attempted suicide by poisoning in Zimbabwe

Attempted suicide by poisoning (ASP) continues to be of importance in Zimbabwe accounting for almost half of all poisoning admissions to eight major urban referral hospitals in the country and an overall case fatality rate of 4% according to a recent study.[1] This rate is for only those cases admitted to the hospitals; it is likely that the actual rate is much higher as many cases do not reach hospital alive. In contrast to unintentional poisoning admissions that show similar male to female ratios, twice as many females were admitted with ASP compared to their male counterparts. This has been attributed to the observation that males generally choose more lethal means to kill themselves such as hanging.

Data from Zimbabwe show that over 60% of all admissions due to ASP occur in the 16–25 year age range.[79] Most of the reasons leading to ASP are related to domestic quarrels and teenage pregnancies. ASP is rare in children aged below 12 years and, unlike in some developed countries, there is a relative absence of ASP cases in people aged 40 years and above.

Pesticides and pharmaceuticals have continued to be the most commonly used chemicals in ASP in Zimbabwe.[79,1] Of the pesticides, organophosphates, especially dimethoate, are used commonly, although in the past decade or so, there has been an increase in ASP admissions resulting from ingestion of illegal aldicarb containing rodenticides sold in street corners in the major cities and towns.[1] Chloroquine also continues to be the major culprit when it comes to ASP from pharmaceuticals, largely due to its ready availability. From hospital data, chloroquine poisoning occurs mainly in females with a male to female ratio of almost one to three.[1] However, although hospital records indicate most cases of chloroquine poisoning as ASP cases, it has been speculated that some young females take the drug in an attempt to induce abortion. Other identified pharmaceuticals involved in ASP are aspirin and paracetamol, which are also readily available without limit or prescription.[80,82]

It would appear the proportion of ASP admissions to major referral hospitals has increased. In 1992, it was reported that approximately 20% of all poisoning admissions resulted from ASP [80] while 10 years later this figure has increased to over 40% [79]. In addition, whereas traditional medicines were an important cause of ASP admissions in the past,[80] they do not appear to be so in recent times.[79] Not withstanding the above-mentioned, the pattern of ASP in Zimbabwe has remained fairly constant, especially with respect to gender and age distribution.

Risk factors for suicidal behaviour

It is internationally recognised that risk factors for suicidal behaviour are multi-dimensional. They result from a complex interplay of psychiatric, biological, familial, psychological, social, and cultural factors. These factors are addressed below especially as they relate to the African context.

Individual level factors

Psychopathology

Psychopathology refers to the pathology of the mind of an individual causing abnormal thought processes, which often leads to outwardly abnormal behaviour or emotional state,

manifesting as a mental illness. Using a "psychological autopsy" approach, researchers have interviewed surviving relatives or friends to identify specific life events or psychiatric symptoms experienced by the suicide victim in the weeks or months preceding death. International and African evidence shows that for the majority of suicides, a diagnosable and potentially treatable mental illness or abnormal mental state is often present at the time of the suicide act.[83] A South African investigation reports that the diagnosis of mood disorders was applicable in nearly two-thirds of patients who attempted suicide, with other diagnoses including substance abuse, schizophrenia, and substance-induced psychosis.[59] Mental illness was a predisposing factor in 32% of attempted suicides in Benin City.[62] In Butajira, mental distress and problem drinking were reported to be significant risk factors.[64] Among Addis Ababa high school adolescents, suicide attempts were strongly associated with hopelessness, school grade, and alcohol intake.[69]

Mood (Affective) Disorders

Affective disorder, especially depression, is the psychiatric diagnosis most strongly linked with suicide. Most patients who commit suicide show several symptoms of depression and up to 60% have fully diagnosable affective disorders.[84] Lifetime risk of suicide in those with major and bipolar depression was previously estimated at approximately 15% but more recent data suggest that the risk may be much lower and may depend on the characteristics of the patient groups examined.[85,86] It should be noted though that suicide risk can be high if the depression remains untreated, especially if other psychiatric illnesses are concurrent and negative life events are present.[84]

The many faces of depression, especially when physical symptoms are reported, can mislead even experienced clinicians and cause misunderstandings between patients and their doctors. Different cultural understandings and expressions of depression have particular relevance in an African setting. In Uganda for example, people participating in a study had no specific word for depression as an illness or disorder.[87] Once thought to be rare in Africa, depressive disorders are now recognised as fairly common, sometimes presenting a subtle form with physical complaints.[44]

Among hospitalised depressed patients, international and African studies have shown that the risk of suicidal behaviour is particularly high in the first weeks following discharge.[7] Severely depressed patients tend to have very low energy levels and slow functioning and cannot reach the cognitive or physical levels required for suicide. A danger period can occur in the early stages of treatment when there is an increase in motivation as the depression begins to lift.

Substance abuse

Alcohol and drug abuse/dependence, though a potentially reversible condition, characterises a high proportion (15–50%) of those who take their own lives.[29, 88, 89] It is argued to rank second, after affective disorders, as a risk factor for suicide. However, estimating the importance of substance abuse as a single factor in suicidal behaviour is difficult, since substance abusers frequently have concurrent affective disorders, anxiety disorders and personality disorders.[89]

Suicide usually does not occur in the early years of substance abuse. The negative consequences of abuse accumulate and increase the risk of suicide across time: personal care and health suffers, work performance is typically affected, and social relationships are often damaged resulting in poor social integration.[88] Suicide risk may not necessarily occur as a result of severe dependence, but on occasions of high consumption when impulsivity increases and the capacity to think clearly decreases. People with a tendency towards anxiety and depression are at high risk of suicide when the effect of alcohol wears off, since these symptoms are exacerbated in conjunction with a hangover.[89]

Schizophrenia

It is estimated that up to 10% of individuals with schizophrenia die by committing suicide.[90,91] The risk is highest for socially isolated male patients without a partner or job. A familial history of suicide, past suicidal and impulsive behaviour, adverse life events, negative attitudes towards treatment, higher intelligence quotient and better functioning before the onset of the illness further increase the risk.[90,91] Few patients kill themselves because of hallucinated instructions or to escape persecutory delusions.[91] Most persons with schizophrenia who commit suicide do so during the first few years of their illness, and often when depression is concurrent. They therefore tend to be relatively young. However, suicide is not uncommon among people with schizophrenia who have been sick for a long time and suddenly have lost social support.[91] The course of illness is characterised by frequent relapse and (usually short) hospitalisations. Up to one-third of suicides among schizophrenic patients occur while the patient is in hospital while another one-third occur during the first few weeks and months after discharge.[90,91]

Personality disorder

Findings show that 31-62% of suicides and up to 77% of attempted suicides have suffered from personality disorders, such as borderline, antisocial, histrionic and narcissistic personality disorders.[92, 93] There is a decreasing prevalence of personality disorders among suicides across the life span that parallels the decreasing incidence of these disorders with age.[94] Frequently, individuals with personality disorders who attempt or commit suicide also suffer from other co-occurring psychiatric disorders (especially affective and substance abuse disorders), a situation that may markedly elevate suicide risk.[92, 93]

People with personality disorders who commit suicide have, to a significantly greater extent than others, experienced a range of highly adverse life events such as troubles at work, unemployment, financial problems, family discord, lack of a permanent home, court convictions and separations.[95] Suicidal behaviour is often triggered by a primitive anger or a sense of hopelessness, or a combination, when self-esteem is severely threatened and the usual self-image cannot be maintained. Without new circumstances or therapeutic help that can provide the support and security that suicidal people are, for the time being, unable to generate for themselves, there is a major risk of suicide. This applies particularly if there have been examples and models of suicidal behaviour in the family.[95]

Biological factors

Evidence, predominantly from Europe and the United States, indicates that suicidal behaviour is influenced by biological and genetic factors. For example, studies of neurobiological processes that underlie psychiatric conditions, including those that predispose a person to suicidal behaviour, have found links between altered serotonergic activity and both suicide attempts and suicide.[16, 96] Serotonin plays an important role as a neurotransmitter in the regulation of mood and aggression. Furthermore, it is well recognised that a family history of suicide increases the risk of both suicides and attempts. Studies have shown that monozygotic twins, who share 100% of their genes, have a higher rate of concordance for suicide and attempted suicide than dizygotic twins who share 50% of their genes. This genetic contribution seems to be independent of the genetic predisposition to psychiatric disorders.[96,97,98]

Little or no work has been conducted in Africa on this area. While biological and genetic explanations add to our understanding of suicidal behaviour, this area of research is likely to offer little in the way of preventive strategies that are of current practical use in an African setting.

Physical illness

The role of somatic illnesses and suicidal risk has received relatively little research attention in Africa, despite the fact that international research has found such a link, especially in relation to cancer, Human Immuno-deficiency Virus (HIV) infection and AIDS, stroke, juvenile diabetes mellitus, delirium, epilepsy, Parkinson's disease, traumatic brain damage, spinal cord injury, multiple sclerosis, Huntington's disease and amyotrophic lateral sclerosis.[99,100] Chronic states, disability and negative prognosis are correlated with suicide.

The HIV/AIDS pandemic continues to have devastating effects not only the physical but also the psychological health of millions of Africans. The disease has been associated with increasing rates of psychiatric disorders,[101] and studies from Kenya,[102] Nigeria,[103] South Africa [7,104] and Tanzania [29] have shown a link with suicidal behaviour. The person's socio-

cultural context plays an important role in coping with the disease. For example, HIV/AIDS in partners and family members can produce relational problems that can trigger suicidal behaviour [104] and in certain communities, infected individuals are still discriminated against socially, in the workplace and even by health professionals. HIV/AIDS is conceptualised as a mystical force in some cultural groups and viewed as creating conditions of 'misfortune', 'disagreeableness' and 'repulsiveness', resulting in a dislike of the person by others. Consequent psychosocial stressors include social stigma, discrimination and isolation, lack of support from family and friends, and social devaluation, all of which contribute to an increased risk of suicidal behaviour.[105]

Familial factors and life events

Research has linked certain negative life events and chronic and acute stresses to suicidal behaviour. Negative life events impact on one's self-esteem and feelings of self-efficacy and thwart the realization of the fundamental human needs of feeling loved, needed and respected by others. Some people, who have no means of regaining what they have lost and who perceive indifference, rejection or aggression among the people around them, may be brought close to suicide.[106]

What matters most is not the occurrence of a negative life event as such, but how a person perceives it.[106,107] Some people react with feelings of guilt, hopelessness, shame, hurt and anger. A limited problem-solving capacity combined with fatigue or exhaustion, insomnia, or hunger or malnutrition, can accelerate the onset of the suicidal process. A relatively minor additional negative event may then be sufficient to precipitate suicidal behaviour.[106]

Life events as risk factors for suicidal behaviour can be grouped into three broad categories, namely, financial and work- or school-related difficulties, interpersonal problems and illness factors (see Table 5.4). [5, 7, 29, 30, 60, 63, 64, 108, 109, 110, 111, 112, 113, 114]

Table 5.4 Life events as risk factors for suicidal behaviour

Financial and work or school-related	Interpersonal problems	Illness factors
▪ Financial difficulties ▪ Dissatisfaction or problems at work ▪ Academic problems at school ▪ Unemployment ▪ Poor economic conditions ▪ Poverty ▪ Legal problems	▪ Social isolation ▪ Death in family ▪ Conflict between parents and adolescents ▪ Conflict in intimate relationships ▪ Physical, sexual or emotional abuse ▪ Loss of relationship through death, separation or divorce ▪ Acculturative pressures ▪ Gender identity issues ▪ Peer group conflict	▪ Disclosure of fatal or chronic illness, e.g. HIV ▪ Chronic ill health ▪ Disfiguring chronic illness ▪ Unrelieved pain in chronic illness ▪ Stigmatized neuro psychiatric illnesses like epilepsy and sexual dysfunctions

African research shows that for adolescents, the most significant factors precipitating self-destructive behaviours include relationship problems with parents, boyfriend/girlfriend problems and teenage pregnancy, and school and academic problems especially the frustration and shame resulting from failure in examination.[29,35,62,63,108,109,115] An early study in Harare, Zimbabwe noted that the background of adolescents with suicidal behaviour was characterized by a high degree of turmoil, rejection and inconsistence.[116] A case-control study in South Africa comparing adolescent attempted suicide cases with non-suicidal medical patient controls, observed that significantly more suicidal subjects than controls experienced family conflict, problems at school and problems with boyfriends/girlfriends during the preceding six months.[115] It was also observed that suicidal subjects expressed significantly lower levels of family satisfaction than controls supporting the hypothesis that suicidal adolescents are dissatisfied with their family functioning and use suicidal behaviour as a means of communicating their distress.

Relationship difficulties are similarly associated with suicidal behaviour in adulthood. Marital violence, poor levels of communication, infidelity, sexual problems, loss of partner, and quarrels with spouse or in-laws are among the factors recorded.[29, 30, 62, 109, 113, 116] Failure to change the relationship and inability to leave because of financial and emotional dependence may lead women to perceive suicidal behaviour as their only escape route.[117]

Community and societal level factors

Several factors related to the broader community, cultural, social and economic contexts in which people are located have been associated suicidal behaviour. The physical and psychological health effects of war or some form of mass violence or trauma, including the implications for suicidal behaviour, has already been elucidated in Chapter 2. Studies done in northern Uganda show that areas with sustained conflict have markedly higher rates of suicidal behaviour, both fatal and non-fatal, than relatively war free areas.[22] Other relevant factors are discussed below.

Cultural and religious factors

Culture and perhaps its main constituent – religion – provide the collective ideas guiding the individual's behaviour.[118] Norms and values are shaped by the social context, become internalized and tend to persist, even in new environments. Community norms play an important role in the likelihood that suicide will be chosen as an option or the degree to which an individual attempts to disguise the suicide. This may not be clearly visible at the individual level, but it becomes evident at the collective level, where differing rates and distributions of suicide and differing ways of and motives for committing the act, reflect

diverse cultural underpinnings.[118] For example, there is a remarkable stability in the rank order of suicide rates in different countries and areas even when suicide in general increases or decreases.

More insight into the role of cultural factors in suicide has been provided by research findings emerging from China. Unlike the rest of the world, China has higher suicide rates in females than in males and higher rural rates than urban rates.[119] This pattern has been attributed to the even stronger influence of culture than gender on the suicide rates. The traditional patriarchal and feudal beliefs and practices still exert a strong influence particularly in the rural areas. This is also true in Africa where the gender identity of many women is deeply embedded in a cultural context of male dominance and bride wealth serves as a justification for control and violence. That the traditional patriarchal system is still strong in the rural areas of most of Africa contrasting with the urban areas where it is fast giving way to western concepts of gender equality is bound to affect the distribution of suicide rates in the rural and urban areas of Africa.

Traditionally, religion was considered to be the 'matrix' of culture. Durkheim highlighted the link between religion and suicide when he claimed that Roman Catholics consistently had lower suicide rates than Protestants.[120] This is a research topic not much covered in Africa, despite the fact that Africa represents most of the world's religions in addition to traditional African beliefs. From a traditional African perspective, religion forms part of the cultural heritage of the people, and has had a powerful impact on shaping social, political and economic activities.[121] While contemporary religious views are often more tolerant than the traditional ones, strong condemnation of suicidal behaviour is still evident in many instances. For example, a study in Butajira, Ethiopia [27] found that the attitudes of Muslim and Christian key respondents towards suicidal behaviour were generally punitive and disapproving.

Socioeconomic factors

The link between social status and health has been realized throughout history and, in recent years, increasing attention has been paid to the role of social status in suicidal behaviour. Typically, those belonging to the more advantaged groups or living in more advantaged areas, whether this is expressed in terms of income, education, social class or race/ethnicity, tend to have better health than the other members of their societies. For example, studies in the US and Canada show higher rates of suicide on the poor Native Indian reserves and in the poor urban black ghettoes compared to affluent white neighbourhoods. Several African studies have emphasized the role played by socio-economic factors (e.g. poverty, unemployment) in suicidal patterns.[4, 5, 29, 65, 122]

5.4 Preventing Suicidal Behaviour

Research has shown that several approaches can be taken at the individual, community and national levels to prevent suicidal behaviour. While only a few countries worldwide have included prevention of suicide among their priorities, there is extensive literature on the management of suicidal behaviour and there are many excellent treatment and prevention guidelines.[7, 10, 15, 123, 124, 125] However, with a few exceptions e.g. [7, 126] research on suicide prevention in Africa has languished as a relatively minor endeavour. Although there are some local/regionalised suicide prevention programmes, no national suicide prevention programmes are in place at present. There is an obvious, urgent need for such programmes.

Suicidal behaviour is a highly complex phenomenon that cannot readily be attributed to a single cause. Recognition of risk factors at all levels is an essential feature in planning prevention initiatives. While the public, national, provincial and local health services ought to share responsibility for the development of prevention programmes,[7] it is clear the involvement of only the health sector is insufficient. Suicide prevention calls for an innovative, comprehensive multisectoral approach, including both health and non-health sectors, such as education, labour, police, justice, religion, law, politics, the media, and nongovernmental and community organisations.[127] In other words, the problem of prevention concerns society as a whole.

Individual-level and relationship approaches

Therapeutic and treatment approaches

Given the links between psychiatric illnesses and substance dependence or misuse, and increased suicidal behaviour risk, it is important that more attention is given to their detection.[66] There is compelling evidence indicating that timely diagnosis and effective treatment of mental illness (particularly depression) and alcohol and substance abuse can reduce suicide rates. It might be beneficial for research attention to be directed toward involving and training members of local communities in the detection, management and prevention of suicide in resource poor areas of Africa. This approach could reach high risk individuals who might otherwise not come in contact with health care providers because the individuals and their families do not believe their situation fits within the paradigm of modern health care practice.

Yet, a key issue in culturally sensitive psychiatric epidemiology is selecting research and/or clinical instruments that are valid and can detect cases with a high degree of accuracy.[6] In several African countries, further work is required to examine the nature of depression, as many communities do not have a specific word for depression as an illness or disorder.[87]

Some people view suicidal behaviour as a cultural/spiritual problem. For example, 'ngozi' means bad spirit in Zimbabwe, and appeasing the 'ngozi' deals with the problem in the family. The poor recognition of the illness may explain the low prevalence rates of depression seen in several samples, and the lack of referral of subjects to health facilities.[70] Poor treatment compliance is evident in several African settings.[29] Accordingly, attempts to maximise initial consultations once suicidal patients are medically stabilised is essential [7]. It is also important to address risk factors in repeat suicidal behaviours.[5, 128, 129, 130]

Almost all African countries have some kind of psychiatric service. However, the quality and accessibility of these services falls far below what would be expected for the huge burden of psychiatric disorders in these countries.[131] This is clearly shown in the latest results from Project Atlas, launched by the WHO in 2000 to address the information gap on existing infrastructure and resources available for mental health.[132] Key results for African WHO Member States are shown in Table 5.5. Definitions, data limitations and country-specific details are beyond the scope of this chapter but are outlined in the full report.[132]

Table 5.5 Existing infrastructure and resources for mental health in Africa

Item	Countries (%)
Presence of:	
Mental health policies	50.0
National mental health programme	76.1
Substance abuse policy	50.0
Law in the field of mental health	79.1
Disability benefits	45.5
Therapeutic drug policy/essential list of drugs	93.5
Community care for mental health	56.1
Mental health care facilities in primary care	82.6
Training facilities for primary care personnel in mental health	58.7
NGO activity in mental health	89.1
Mental health reporting systems	57.8
Epidemiological study or data collection system in mental health	46.7
Specified budget for mental health care	62.2
Primary methods of financing mental health care:	
Out-of-pocket payment	38.6
Tax based	54.5
Social insurance	0
Private insurance	4.5
External grants	2.3
External grants	2.3
Number of:	Median per 100 000 population
Psychiatric beds	0.03
Psychiatrists	0.04
Psychiatric nurses	0.20
Psychologists working in mental health	0.05
Social workers working in mental health	0.05

Half the African countries do not have a specific mental health policy. Indeed, in much of Africa, burdened by infectious diseases, mental health is usually given low priority in the planning and budgetary process. Over 70% of African countries spend less than 1% of their health budget on mental health care.[5] Those few governments which have formulated a policy for mental health care, have problems with its implementation including ongoing high levels of stigma to mental illness by the community, a lack of skills in the management of mental illness for many health workers, low stocks and an irregular supply and access to medication, and a paucity of mental health specialists [5, 87]. In more than half of the African

countries, there is not even one psychiatrist, with other cadres of mental health personnel also rare. The average Psychiatrist:Population ratio is 1:1 000 000 to 1:2 000 000.[133, 134]

Given these difficulties, disseminating treatments is problematic and other means of accessing and mobilizing populations need to be considered.[87] Any treatment strategy needs to adopt a holistic and culturally relevant approach with appropriate modifications made for individual patient demographics and characteristics, cultural influences, health and other belief systems in any suicide prevention programme.[7] Otherwise patients are unlikely to pursue and comply with treatment. Traditional healers and traditional beliefs, as integral parts of many African communities, play a key role in dealing with disease and mental health issues in Africa (including an understanding suicide) and need to be involved in research, management and prevention.[6,135,136] The aim should be to create uniquely African strategies, not simply to transplant knowledge on suicide prevention into Africa from the Western world.[7, 134]

Patients presenting with global psychological distress, hopelessness and anger, particularly together with unresolved interpersonal conflict, should be assessed for suicide risk and these factors should be the target of clinical intervention.[5] People with suicidal behaviour almost always have to be treated in an in-patient setting for a period of time until the risk of self harm has passed (see Box 5.4). The treatments vary and may include medication and psychotherapy. In most cases, psychotherapy should be done to address the issues surrounding the cause of the suicidal behaviour. Encouraging results from a randomised controlled trial conducted in a village in south western Uganda suggests that Group Interpersonal Psychotherapy is efficacious in reducing depression and dysfunction.[137, 138]

Box 5.4 Indications for mandatory in-patient treatment in suicide

Patient is so suicidal that they cannot trust themselves
Patient cannot assure their physician and family about their safety
Patient has no family or other social support
Patient has psychotic features
Patient has attempted suicide in last 72 hours
Patient is suicidal and alcohol-dependent

Practically all suicidal behaviours stem from the person's self-perceived sense of isolation and from feelings of hopelessness and some intolerable emotional pain which, if addressed early, can prevent a suicidal act. Suicidal individuals frequently have limited ways of dealing with their problems; and tend to slip into a cognitive rut, from which it is difficult for them to perceive appropriate alternatives to any intended suicidal act.[7, 139] Interventions aimed at psychological self-empowerment need to enhance coping skills of suicidal patients and shift dysfunctional perceptions, especially that of psychological entrapment.[5, 107]

Medications given depend on the underlying psychopathology and would be the decision of the treating physician. Family involvement or the involvement of significant others, with the consent of the patient, may be necessary to provide the patient with the often greatly needed social support. At all times, issues of confidentiality should be kept in mind and always weighed against the patient's or other's safety.

Training of health care professionals

Only a small number of suicides happen without warning; most people who kill themselves give definite warnings of their intentions and many consult health-care workers in the days, weeks or months preceding the suicidal act. These patients may not necessarily present with psychological issues, but may instead complain of physical symptoms. Particularly in countries where mental health services are not well developed, individuals in a suicidal crisis are more likely to visit a general practitioner than a psychiatrist. Therefore, family practitioners and other primary health-care workers who usually have ongoing contact with patients can play a critical role in the prevention of suicidal behaviour.[6, 7, 140] These professionals need to know the risk factors for suicidal behaviour, be aware of suicidal intent, and be able to provide an astute diagnosis of underlying psychopathology and its appropriate treatment, including medication and, where necessary, hospitalisation or referral for psychological/psychiatric help. International experience suggests that training aimed at better recognition and monitoring of mental illness in primary health-care helps to prevent suicide.[141] In Africa, this training should be tailored to specific local conditions.

Training also is essential for those practitioners dealing with other physical illnesses that are linked to depression and suicidal behaviour. For example, with increasing numbers and the changing geographic distribution of persons infected with HIV/AIDS in sub-Saharan Africa,[142] primary care physicians play an increasingly important role in the caring for these patients. Health-care providers need to be aware of the impact of disease processes on behaviour (e.g. the neuropsychiatric and neuropsychological complications that can occur in a significant percentage of HIV/AIDS-infected individuals);[7, 143] and be able to screen, identify and treat depression. Pre- and post-test counselling is necessary and it is imperative that health professionals are able to identify and minimise the risk of suicidal behaviour experienced during periods of crisis.(104) However, many health professionals lack sufficient training to deal with the psychosocial issues and may not feel comfortable in discussing sexual practices with their patients. Encouragement in joining support groups can help in this regard. Counselling for people infected with HIV/AIDS has been identified as an important suicide prevention strategy in Namibia.[8]

Community-based approaches

Awareness-raising and advocacy
Ultimately, prevention of suicidal behaviour involves awareness, that is, knowing about and paying attention to the warning signs, and taking active steps to dealing with them in the early stages (including treatment of underlying psychological/psychiatric conditions). Community groups can work to raise awareness about mental illness and suicide in their communities and communicate with their local and state policy makers to advocate for better psychiatric care and suicide prevention. Existing local/village counselling services for conflict resolutions should be encouraged and strengthened. Programmes to increase knowledge of mental illness and suicidal behaviour, and of health-promoting measures, try to remove the fears and misunderstandings surrounding suicide. It is extremely important that these efforts provide well devised information that does not provoke suicidal behaviour among vulnerable individuals.[84]

The activities of World Suicide Prevention Day, held annually on 10th September, and World Mental Health Day, held annually on the 10th October, aim to draw attention to and call for action on the problems of suicidal behaviour and mental illness. Countries are encouraged to use these global awareness days to increase public awareness, reduce stigma and discrimination, and promote service and policy advocacy. The involvement of the media and different partners, such as NGOs, youth groups, researchers, and representatives and decision makers from both health and non-health sectors, is important in this process.

Education and training
In addition to the training of health care workers mentioned above, education, training and promoting skills development of all those who come into contact with suicidal individuals – including educators, the police, the legal profession, the clergy and so on - are important parts of prevention programmes. Such training is important to address social attitudes by increasing knowledge of suicidal behaviour and its causes in order to reduce stigma and discrimination. It should disseminate information about the clues to suicidal behaviour to facilitate early recognition thereof; aim to eliminate myths surrounding suicidal behaviour; and improve knowledge of how to provide suicidal patients and their families with support and assist them in obtaining help.

Suicide prevention centres
The majority of the population in African countries have limited access to mental health services. This is particularly true in rural areas where fewer health professionals are located, and poverty does not easily allow people to travel from rural to urban areas.[144] Community mental health centres therefore can play an essential role in the prevention of suicidal behaviour. Suicide crisis centres provide much needed immediate emotional

support to people when they are suicidal. Depending on the needs of the communities they serve, these centres also provide specific help in dealing with many of the factors associated with suicidal behaviour such as mental illnesses, HIV/AIDS, rape, abuse and trauma. Confidential telephonic counselling is usually the main focus, but particular centres may also have face-to-face counselling and a referral service to community-based services. Additionally, suicide prevention centres may provide information and educational materials, conduct outreach work, and run media campaigns to de-stigmatise mental illness and to encourage people to come forward for treatment. Partnerships with the public, schools, universities, churches, youth groups, prisons, corporations and government are key to their goals. Although not widespread, helplines such as Lifeline Southern Africa and Samaritans/Befrienders Worldwide operate in several African countries such as Botswana, Ghana, Mauritius, Namibia, South Africa and Zimbabwe.

The evaluation of the effectiveness of community mental health centres is limited in Africa, with only two known studies coming from South Africa. One of these studies assessed a national suicide toll free crisis line established in 2003, run by a NGO (South African Depression and Anxiety Group) in conjunction with the Department of Health.[144] Media advertising and reporting and outreach work done by the NGO was important to advertise the existence of the crisis line. The overwhelming majority of callers found the service helpful and obtained the necessary help and/or information.

The other study assessed the value of a Mental Health Information Centre in providing the public with information about the symptoms of, and treatments for, common psychiatric disorders.[145] The rationale was to create awareness of and knowledge about psychiatric disorders, to help destigmatize them, and encourage people and their families to seek treatment. These goals are achieved through a telephone information service to the public, providing the media, medical and other professionals with facts about mental disorders, distributing the Mental Health Resource Guide (a comprehensive list of mental health professionals, and consumer organisations and institutions offering mental health services) and other mental health publications, conducting and collaborating research efforts on consumer related mental health issues and creating projects like clinical services open to the public. The significant satisfaction with the service that most callers experienced suggests that psycho-education is an important part of psychiatric care.

Self-help support groups

Suicide prevention efforts often focus on the suicidal person yet programmes to help families following their bereavement after a suicide are also essential. Experiencing the loss of someone through suicide can be intensely painful, devastating and traumatic. Evidence shows that people grieve in a different and more intense way following a suicide as compared to a death from natural causes.[146] In addition to the grief, the taboo associated

with suicide means that there are feelings of shame, guilt and stigmatization; and less opportunity to talk about these feelings. Psychological help provided to the survivors of suicide not only assists them through their intensively painful experience of loss and reduces prejudice, but can also facilitate research and help with investigations into the effectiveness of prevention programmes. Help to families bereaved by suicide can come through traditional therapeutic approaches, but a growing global trend is for survivors themselves to create and run their own self-help support groups. Such groups are a powerful and constructive way for people to help themselves and others, and may be supported by government funds, as well as religious groups, donations and the members themselves. Few such groups exist in Africa (e.g. Survivors of Loved Ones' Suicide operates in Durban, South Africa), yet they would appear to be an appropriate, inexpensive approach to caring and supporting those who have lost loved ones to suicide. The WHO has produced a resource guide on how to start a survivor's group.[146]

School-based programmes

Childhood experiences of adversities are risk factors for suicidal behaviour in adulthood. While identifying and treating persons at risk because of negative childhood experiences is important to reduce the likelihood of suicidal behaviour, measures to promote the establishment of a stable, nurturing and emotionally healthy family environment for children are important primary prevention strategies to reduce the occurrence of these adversities.[5, 66]

Preventing suicidal behaviour should start early in life and the school environment offers an opportunity to educate and assist pupils, as well as school staff and parents. Given the high levels of suicidal behaviour among youth in Africa, school-based programmes are essential. This is especially true where there are high rates of orphanhood as in communities heavily affected by the HIV/AIDS epidemic and also war.[147] However, educational strategies to increase suicide awareness among the pupils themselves have not been adequately tested and may not have the desired outcomes.[148] Rather, it is recommended that mature adults assume responsibility for managing suicidal behaviour and associated mental health issues. The education of parents should be a priority; school personnel should receive in-service training; and suicide prevention awareness should be promoted amongst schools' policy-makers, community leaders, health-care personnel and the general public.[7, 71]

Teachers need to be aware of family background factors, relationships patterns, changes in living conditions, and potential psychopathology such as depression and stress when assessing suicide risk factors in pupils. There should also be liaison between the various clinical services and education departments so that referral for appropriate professional help can be implemented for at-risk pupils. It may be most efficient to incorporate these strategies for suicide prevention and mental health promotion in more general school

health programmes, given that schools especially, but all communities in general, are struggling to fit in sensitization for all kinds of health problems – for example, HIV/AIDS, malaria, sanitation, prevention of unintentional injuries, alcohol and substance abuse. School-based interventions involving crisis management, self-esteem enhancement and the development of coping skills, psychosocial skills and healthy decision-making have not only reduced the risk of suicidal behaviour among youth, but also other at-risk behaviours such as aggressiveness, depression, anxiety and alcohol and drug dependence.[149]

Societal approaches

Restricting access to methods of suicide

The choice of method used in suicidal behaviour is strongly influenced by factors such as accessibility to the method; knowledge or the lack of knowledge of the lethality of the method; experience and familiarity with the method; meaning, symbolism and cultural influence associated with the method; and the suicidal person's mental status (including the presence of a mental disorder) and the level of intent at the time.[7]

Suicidal behaviour is often impulsive and acute suicide risk is brief, but at the point when a person feels hopeless and potentially suicidal, availability of a particular method may be the key factor in translating suicidal thoughts into action and, depending on the lethality of the method, in determining whether the outcome is fatal or not.[150]

Internationally, there is evidence that controlling the availability of suicide methods can be effective in suicide prevention. Examples include the detoxification of domestic gas, detoxification of car emissions, control of availability of toxic substances including pesticides and pharmaceutical drugs, gun possession control, and fencing high buildings and bridges.[150,151] The common counter-argument that restricting the availability of a particular suicide method will merely result in method substitution has on the whole not been borne out in research.[150]

Little work has been done in this area in Africa. Given the high levels of suicidal behaviour by poisoning – agricultural and pharmaceutical – on the continent, it is likely that suicide rates could be substantially reduced by controlling access to these toxic substances. In many African countries, pesticides can be bought in lethal doses from markets and street vendors without any restrictions.[75] Recently the WHO, in a joint agreement with the International Association for Suicide Prevention, announced a global public health initiative to address the problem of pesticide poisoning in developing countries.[152] Primary objectives of this initiative are to review and recommend improved pesticide regulatory policies (e.g. production, sales and pesticide substitution); improve medical management of pesticide ingestion; implement surveillance and monitoring of cases in clinical and community

settings; promote safer storage of pesticides in communities; implement psychosocial interventions; and to educate pesticide users, key resource personnel/opinion leaders, retailers, school children and the local media.

There is also the possibility of changing legislation with regards to medications sold over the counter. For example, in England paracetamol and aspirin pack sizes were reduced with strict enforcement of the maximum amount of tablets that could be bought per purchase, with warnings on the packs about the danger of overdose. It is estimated that this change in legislation may have prevented approximately 200 deaths in the three years since it was implemented.[153] A change in legislation may not be sufficient without enforcement. In Tanzania, the Pharmaceutical and Poison Act was regularly disregarded because of inadequate supervision over dispensation of treatment drugs (Ndosi et al., 2004). As in many African countries, sufficient doses of medication for overdose can be easily procured over the counter without formal prescriptions.

Firearms are commonly used in suicides in several African countries. Prevention approaches usually focus on legislation for firearm sales and ownership, and gun safety. Gun safety measures can include education and training, safe storage of firearms and ammunition in the home (e.g. storing guns and ammunition separately, keeping guns unloaded and in locked places) and trigger-blocking devices.[16] There is some encouraging evidence from studies carried out in North America and Australia to indicate that introducing restrictive legislation (e.g. background checks on applicants, 'cooling off' period before purchasing a gun, safety tests for applicants) can result in a reduction of firearm suicides.[16,150] In Cameroon, where ownership of firearms is restricted to registered hunters, no suicides by firearms were reported in the two largest cities over a five-year period.[154]

Working with the media

Evidence shows that the portrayal of suicidal behaviour in the media can encourage copycat and cluster suicides and attempts if the approach used in the reporting is inappropriate. Inappropriate approaches include sensationalizing or glorifying the suicidal act; prominent and/or repetitive news coverage; reporting of celebrity suicides; specifying the methods used; or including photographs and suicide notes.[155] Youth appear to be more vulnerable to media effects. Reports and portrayals of suicidal behaviour frequently oversimplify the causes and do not make the important link between potentially treatable mental health problems and suicidal behaviour. The media can play a proactive role in helping to prevent suicidal behaviour by providing information on helplines and community resources, risk factors and warning signs, and alternatives to suicide. There is preliminary evidence showing that toning down reports in the media in this way may counteract suicide imitation and result in fewer suicides by specific methods.

The issue of media influence on suicidal behaviour calls for close collaboration with media professionals to ensure that suicidal behaviour is dealt with responsibly while respecting and protecting media freedoms, that the media is informed about the research findings, and that appropriate guidelines are developed.[155] Changing the curricula of media and journalism studies to include a section on suicidal behaviour may also be an option. Various governments and organisations, including WHO,[156] have produced guidelines for responsible reporting of suicidal behaviour.

Prevention and ethical/legal considerations

Globally, ethical and legal issues in the field of suicidology are complex. These issues also raise controversial points in the prevention of suicide in Africa. A basic conceptual debate between promoting individual freedom and autonomy versus protecting individuals from self-harm underlies the ethical/legal aspects of suicidal behaviour and its management and prevention. Some universal principles have been outlined, but no single standard of care applies globally. Safety of community practices and available resources tend to define standards of care. Moral, religious or ethical disagreements also centre around particular acts, namely, euthanasia/mercy killing and withholding or withdrawing life-saving treatment or support systems.[7] Related issues such as standards of care, responsibility and failure of care, failure to diagnose appropriately, malpractice, euthanasia and assisted suicide have been examined by an international group of experts on suicidology.[157, 158] Other international work has focused on providing a framework for a better understanding of assisted suicide (especially physician-assisted suicide) and its legal and ethical implications.[159] While a detailed discussion of these ethical/legal issues is beyond the scope of this chapter, it is important that they be discussed with attention to the African context.

Policy approaches

The United Nations [160] and WHO [3] have identified suicide as an increasingly important area for public health action, and have made calls for national strategies to be developed. In 1999, WHO launched a global initiative for the prevention of suicide that aims to:

- bring about a lasting reduction in the number of suicides and suicide attempts, with emphasis on developing countries and countries in social and economic transition;
- identify, assess and eliminate at early stages, as far as possible, factors that may result in young people taking their own lives;
- raise the general awareness about suicide;
- provide psychosocial support to people with suicidal thoughts or experiences of attempted suicide, to their relatives and close friends, as well as to those of people who committed suicide.

Strategies to organize global, regional and national multisectoral activities for increased awareness about suicidal behaviours and their effective prevention; and to strengthen countries' capability to develop and evaluate national policies and plans for suicide prevention include the following activities:

- support and treatment of populations at risk (e.g. people with depression, youth);
- reduction of availability of and access to means of suicide (e.g. toxic substances, handguns);
- support/strengthening of networks of survivors of suicide;
- training of primary health care workers and other sectors.

In Africa, it is important to put into perspective suicide prevention programmes alongside other priorities such as infectious diseases and poverty alleviation. As part of the global initiative, the Suicide Prevention – Multisite Intervention Study on Suicidal Behaviours includes a community survey of suicidal ideation and behaviour, the identification of reliable and valid variables for determining suicidal behaviour risk factors, the identification of variables that determine the presentation or not at health facilities following attempted suicide, and the evaluation of treatment strategies for suicide attempters.[161] Participating sites represent all six WHO regions, with Durban, South Africa as one of the study sites.

In addition to the resource books for media professionals and survivors of suicide, WHO has also produced a series of resource books for general physicians, primary health care workers, teachers and other school staff, prison officers, counsellors, and as a resource at work.[162,163,164,165,166,167] These are available in several languages and are highly relevant to African settings.

5.5 Summary of Research Findings

Suicide research findings in Africa are rich and varied. Below is the summary as reviewed in this chapter:

(i) Suicidal behaviour is believed to constitute a relatively high burden for African households and communities. Data on suicide and attempted suicide in Africa is comparatively limited, a function of weak surveillance, diagnosis and a strong bias/stigma against reporting.

(ii) It is therefore difficult to discern concrete regional or socio-demographic trends. As in other parts of the world, males are most at risk. Suicide distributions vary across age groups, depending on location, time period and demographic group covered. Reported levels of attempted suicide among secondary school students seem alarmingly high.

(iii) Suicidal behaviour appears to be commonly perpetrated by hangings and poisoning, with firearms featuring less often.

(iv) Vulnerability to suicidal behaviour appears to be associated with biological factors (e.g. affective disorders, schizophrenia, risk-taking behaviour induced by other diseases like alcoholism, and physical illnesses such as HIV-AIDS), life events (e.g. livelihood/work-related, interpersonal, and illness-related) and societal-level factors (e.g. collective violence, religious affiliation and social status). The role of poverty in suicidal behaviour needs further research.

(v) Preventing and reducing suicidal behaviour can be pursued at different levels: the individual, (e.g. therapeutic and treatment, training of health care professional); community, (e.g. awareness-raising, advocacy, education and training, suicide prevention centres, self-support groups, school-based programmes); and community/societal (e.g. restricting access to methods, media).

(vi) There is a need to enhance African research output in the area of suicidal behaviour as more information is needed to flesh out the picture of suicide in Africa in such a way that culturally appropriate interventions can be designed. An area that needs attention is collaboration between social scientists and biomedical researchers aimed at fostering comprehensive understanding of suicide behaviours and their management and prevention.

5.6 Recommendations for Preventing Self-directed Violence

A number of recommendations for reducing both suicide and attempted suicide can be drawn from this chapter. Many of them overlap with the recommendations made at an international level,[16] but they require adaptation to countries' particular needs.

Recognise of suicidal behaviour as a public health issue

The prevention of suicide has not been adequately addressed primarily because there is a lack of awareness of suicidal behaviour as a major problem. Suicidal behaviour as a taboo subject, or even a crime in some countries, does not permit open discussions of the phenomenon.[127] The decriminalization of suicidal behaviour in countries where it remains a crime is an important step in reducing the stigma surrounding it. Despite overwhelming evidence for its existence, the link between mental illness and suicidal behaviour is often not made, nor is it emphasized that mental illness is treatable. The stigma around mental illness discourages help-seeking and limits the availability of support. Likewise, the negative attitudes toward suicide (shame, discomfort, guilt) and the social, and sometimes legal, consequences following suicidal behaviour are major obstacles to its prevention. A suicidal person may be discouraged from discussing his or her thoughts and emotions openly with a professional, or even a friend or family member. As a result, suicidal acts are concealed and the view of suicide as being predestined or impossible to prevent or treat is

reinforced.[168] Strategies to promote open discussions of suicidal behaviour and the associated risk factors might change the perception of the phenomenon in Africa. It is also important that these discussions consider what constitutes suicidal behaviour since the concealment of suicidal behaviours also may have to do with the confusion surrounding globally accepted definitions.

Yet, dealing with the issue of stigma is not straightforward. It has been argued that the stigma also reduces the ease with which a person will contemplate suicide.[73, 83] Suicidal behaviour needs to be regarded as an appropriate and legitimate area for public health preventive intervention, and suicidal people to be able to feel they can seek and obtain help, but at the same time suicide must not be portrayed as a reasonable course of action. The general issue of stigma surrounding mental illness is then the preferred focus rather than the specific stigma of suicide.[83]

Improve psychiatric treatment

Improving treatment (pharmaceutical and psychotherapy/counselling) for those with psychiatric disturbances is important in preventing suicide.[16] Given the associations between several other health conditions (e.g. HIV/AIDS, trauma), psychiatric problems and suicidal behaviour, all health professionals need to be trained to recognize, treat or refer those with psychiatric disorders. The involvement of traditional healers in this process will be important.

Local government and hospital policies on how to treat people with mental illness and suicidal behaviour would help to provide clear directions for personnel for dealing with these patients and may help reduce the number of the people who fall through the gaps and repeat suicidal behaviour. Mental health issues are a concern for everyone and not only for health care providers.

Develop data collection systems

There is an urgent need for systematic data collection so that the magnitude, scope and characteristics of suicidal behaviour on the African continent can be better understood. It is important that information on both suicide and attempted suicide be collected. Hospitals and other social and medical systems should be encouraged to keep records of suicide attempts in the same way they do other health data. WHO, in collaboration with the US Centers for Disease Control and Prevention, has developed the Injury Surveillance Guidelines [169] to guide practitioners on how to develop information systems in health care facilities. And as hospital-based surveillance systems need to be complemented by other tools to capture all injury events and deaths in a population (e.g. those treated outside the formal health sector or those with minor injuries which do not necessarily require hospital

attention), WHO has, in collaboration with an expert panel experienced in this field, developed guidelines for conducting community surveys on injury and violence.[170] The establishment of a WHO African centre for undertaking suicide research and prevention work is recommended to turn these statements of need into practical and implementable action strategy. A center of this nature has been set up in China.

Ideally, data linkage across a variety of agencies, such as hospitals and other medical facilities, courts, police and coroner departments should be a target to provide a richer and more complete picture of suicidal behaviour in a country. To prevent suicidal behaviour we need to examine its aetiology and co-morbid factors. The data collected should be relevant to prevention and should include such aspects as demographic variables of the deceased, spatial and temporal details of the actual suicidal behaviour, the method used, involvement of alcohol or other substances, and specification of the presence and diagnosis of a mental illness. In addition, simultaneous collection of data on social indicators, for example, the divorce rate, socioeconomic status, social and demographic changes, are also important to enhance understanding.

Part of this data collection process would be to have clear classification systems and definitions of suicidal behaviour. Participation of African countries in the international discussions on nomenclature for suicidal behaviour is important. Reliability of suicide certification and reporting is an issue in great need of improvement.

Enhance research capacity, outputs and collaborative networks

The importance of developing and expanding research efforts on suicidal behaviour in Africa cannot be overstressed. Patterns of suicidal behaviour in different population groups need to be clarified and the underlying factors that contribute to these patterns need to be investigated so that appropriate preventive interventions can be designed. Governments, educational and other departments need to be encouraged to make research and research infrastructure a priority. There should be wide dissemination and exchange of data, research tools, and methods; and the multidimensional nature of suicidal behaviour calls for a multidisciplinary approach. A greater understanding of the problem will be enhanced with inter-African collaborative research and networking; as well as global co-operation and access to the latest information about suicide prevention.

In South Africa, the Durban Parasuicide Study (DPS) originated in 1978, and is an ongoing study with suicide prevention as one of its primary aims [7]. The establishment of the DPS has resulted in many publications and has drawn its work and the work of other researchers on suicidal behaviour in Southern Africa together through the convening of several conferences on suicidology. The International Association for Suicide Prevention held its

23rd World Congress in Africa (Durban, South Africa) for the first time in September 2005. A primary aim of the Congress was to highlight African issues regarding suicidal behaviour and its prevention, and to provide a platform for experts from the continent to add their perspectives.[4]

Develop community-based efforts

Given limited numbers of health professionals with psychiatric training in Africa, community-based initiatives such as mental health centres, self-help support groups and education/training programmes play an essential role in the prevention of suicidal behaviour. In several African countries, current projections are that urbanisation will increase dramatically, leading to further breakdown of extended family kinship. Community approaches with psychosocial interventions to cushion and support new urban arrivals need to be developed.[5] Strategies should include locally relevant life or social skills components, education programmes for adults and the youth on the various risks associated with suicide, and a special focus on high-risk individuals and their families. Partnerships and collaborations between relevant agencies would assist in making best use of the limited funding available.

Reduce access to suicidal means

There is a need to fully document the methods of suicide used so that ways to restrict access to them can be developed. In the African context, modifying policies to restrict the production, distribution and sales of pesticides and promoting their safer storage may have dramatic effects on reducing the risk of suicidal behaviour. Patterns of prescribing medications will also influence trends in substances used in overdose, and these need to be strictly enforced.

Develop national suicide prevention programmes

As available evidence suggests that suicidal behaviour is becoming an increasing significant public health concern on the African continent, there is an obvious need to prioritise suicide prevention in the health agenda. The preventive strategies discussed above would be most effective if integrated into national suicide prevention programmes for each country. Such programmes should provide a strategic framework for action at all levels – national, provincial, and local – to prevent suicidal behaviour and promote mental health. They should be concerned with suicidal behaviour in all groups of the population, with a particular focus on high risk groups, as identified by locally based research. A framework for such a national programme for suicide prevention has been proposed in South Africa.[126]

Important principles can be borrowed and adapted from other national initiatives for suicide prevention, such as in Australia,[171] Sweden[172] and Scotland.[173] These include:

- Creating partnerships and alliances with the community, professional groups, NGOs and government sectors;
- A wide-ranging approach, targeting the whole population, specific population subgroups and individuals at risk;
- An evidence-based and outcome-focused programme, with evaluation as an integral part;
- Appropriate activities, responsive to the social and cultural needs of the groups or populations they serve;
- Building on strengths, capacities and capabilities of individuals, families, and communities.

5.7 Conclusions and Future Perspectives

The prevalence of suicide and suicidal behaviour in the African Region is not well known. Available figures in some parts of Africa indicate that the situation has reached more serious proportions than generally thought, and even more alarming is that they most likely do not reflect the true extent of the problem. With some notable exceptions, good quality research and therefore, appropriately targeted preventive efforts are limited on the African continent for several reasons, including a lack of funding, infrastructure, expertise, cultural, sociopolitical, and legal factors.

Although there are some local and regionalised suicide prevention initiatives, no national prevention programmes exist. The complexity of the phenomenon requires a comprehensive multisectoral approach, including both health and non-health sectors. Key prevention strategies of relevance in the African setting include the recognition of suicidal behaviour as a public health concern rather than a criminal act, improved data collection and collaborative research, better psychiatric treatment by well-trained health-care practitioners, the development and enhancement of community-based efforts and restricting access to the methods of suicide. All strategies must be appropriate and responsive to the social and cultural needs of the populations they serve.

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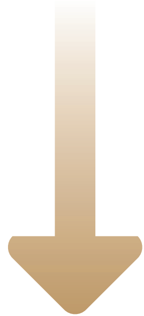
CHAPTER -6

CONCLUSION AND RECOMMENDATIONS



CONCLUSION AND RECOMMENDATIONS

CHAPTER -6

While the different forms of violence addressed in the previous chapters require some specific recommendations and prevention strategies, there are also a number of cross-cutting recommendations and prevention strategies that apply to all these forms of violence. This concluding chapter discusses overarching themes, and presents cross-cutting recommendations with a focus on formulating violence prevention strategies within the diverse country contexts across Africa.

Equitable development

The challenge for Africa – as for all other low income regions – is that development requires progress in many spheres all at once, yet the sectors and agencies working on this development tend to work in silos. Decreasing violence means increasing the well-being of the community as a whole. Many of the actions that might reduce violence rates will not be done primarily to prevent violence, and some interventions directed at promoting development might actually increase violence in certain sections of society, especially if they increase income and opportunity inequalities.

As seen in earlier chapters, endemic or escalating violence threatens the development gains made by society, and it is increasingly difficult for communities to insulate themselves from the effects of such violence. It is imperative therefore, that development planning take into consideration the need to prevent violence at every level. For instance making sure that women live free from the fear of sexual violence is not something to be tackled once all girls are literate – it is a prerequisite for girls' meaningful participation in education. While certain categorical recommendations can be made, the prevention of violence is a priority that must underpin all development planning. This requires that national (and regional) planning processes such as the Poverty Reduction Strategy Papers explicitly state what the various sectors will do to reduce violence, in order to ensure resource allocation, monitoring, and evaluation.

Research

Research on violence in Africa has not been a priority, although it clearly poses a huge public health burden. The ability to create effective policies and programmes for the prevention of violence and treatment of victims, survivors and perpetrators is dependent on an understanding of the root causes of violence in specific social contexts. There is need to invest in data collection and intervention research to evaluate existing best practices including the indigenous approaches.

To design sound and culturally appropriate interventions, more qualitative and quantitative research is needed to understand the many questions posed in the preceding chapters, including:

- the psychosocial needs of survivors of sexual violence especially in the context of a high prevalence of HIV/AIDS;
- why teachers persist in using violence against students even after policies have changed;
- community mediated responses;
- cultural, economic and political factors associated with violent death in various regions and countries;
- the economic, social and environmental differences and similarities of violent enclaves within otherwise relatively peaceful communities. Future comparisons should include rural and urban areas with high and low rates of violence;
- the motives of the perpetrators of community violence;
- ways for community participation in creating safety and security within their neighborhoods, without impinging on individual human rights;
- programmatically important questions such as: What work can the high risk group of unemployed males do?;
- the mechanisms through which exposures to violence translate into violent behaviors;
- the costs of service delivery.

Recommendation 1

Advance a single shared message: Violence can be prevented

The widespread and unshakeable conviction that violence can be prevented is key to overcoming the current apathy and inaction in the face of violence. Prevention means to stop violence from occurring in the first place through direct efforts to remove the underlying causes and risk factors, and by harnessing the indirect effects of other policies and programmes that can contribute to reducing violence. Widely disseminating this preventability message and advocating for its uptake provides the foundation for all subsequent action.

Recommendation 2

Prioritize the prevention of violence as an integral part of human, social and economic development agendas

Unwavering commitment to the prevention of violence to improve the health and safety of all individuals, communities and societies in Africa is vital if human, social and economic development is to thrive. Violence in all its forms devastates human and social capital, diverts hundreds of billions of dollars from constructive investments, and traps countless individuals, families, communities and countries in vicious circles of violence and underdevelopment. Violence prevention must therefore be prioritized alongside rather than after addressing other material, environmental and humanitarian challenges in communities where basic needs for food, shelter and human security are unmet.

Action points:

- Include prevention of violence in all disease prevention programs.
- Include violence prevention in programs for all populations at risk, even if the situation that puts them at risk seems temporary. This includes displaced persons, refugees, and all victims of natural and man made disasters.
- Include violence prevention in all major development projects.
- Unclude violence prevention in national development planning processes.

Recommendation 3

Implement and evaluate prevention strategies, giving priority to those that can simultaneously decrease different forms of violence

Interpersonal, self-directed, and collective violence share common risk factors that often occur together, and one type of violence may cause the other. Primary prevention uses approaches that prevent violence before it occurs. Prevention efforts should therefore prioritize the following strategies that address common underlying risk factors and so have the potential to simultaneously decrease different forms of violence:

- Increase safe, stable, and nurturing relationships between children and their parents and care givers;
- Reduce availability and misuse of alcohol;
- Reduce access to lethal means (firearms, poisons, etc);
- Promote gender equality and empower women;

- Change cultural norms that support violence;
- Improve the criminal justice and social welfare systems;
- Reduce social distance between conflicting groups;
- Reduce economic inequality and concentrated poverty.

Applied prevention efforts derived from these strategies must be carefully evaluated to ensure that they are working and to build the prevention knowledge base.

Recommendation 4

Develop national action plans with targets

In its strong endorsement of the *World report on violence and health* the African Union highlighted the recommendation that Member States develop national action plans for the prevention of violence. Developing a national plan is a key step towards effective violence prevention. A national plan should include objectives, priorities, strategies and assigned responsibilities, and a timetable and evaluation mechanism. It should be based on input from a wide range of governmental and nongovernmental actors, and coordinated by an agency with the capacity to involve multiple sectors in a broad-based implementation strategy.

Action points:

- Conduct a situation analysis on violence prevention that includes the extent of the problem, available resources, and stakeholder mapping;
- Set priorities;
- Set targets and evaluation indicators;
- Establish an annual forum to review progress.

Recommendation 5

Initiate and enhance routine data collection

To set violence prevention priorities, design prevention programmes and monitor the effects of those efforts, good data are vital. The commitment of decision-makers at a national and regional level to develop policy and support the establishment of routine data collection systems is thus crucial to the violence prevention endeavour. The contributions of violence to other public health problems (e.g., HIV/AIDS, mental health) should be documented and baseline measurements for violence and its consequences routinely recorded along with other health problems. Data sources include death certificates, vital

statistics registries, mortuary reports; hospital, clinic and other medical facility records; police and judiciary records, information from crime laboratories, and household surveys. Resources spent on collecting data must be matched by resources to ensure that mechanisms are in place for data analysis, reporting, and prevention programming. Setting up surveillance systems in as many mortuaries as possible would increase the understanding of trends, as well as solidifying the forensic data base for medico-legal responses. Even a passive surveillance system embedded into daily practice may add significantly to the understanding of violence. For example, many mortuaries in Africa use hand-written registration books which include important variables such as age and sex of the victim, and date, place, type and cause of injury. These registration books can be adapted and attendants trained to be more precise with data that they already collect. A *code* for community violence could be added to the surveillance systems.

Action points

- Create systems that routinely obtain descriptive information on a few key indicators that can be accurately and reliably measured.
- Review national and lower level information systems (including but not limited to the health management information systems and Integrated Disease Surveillance systems) to ensure appropriate inclusion of variables on violence.

Recommendation 6

Develop in-country violence prevention capacity

The prevention of violence requires knowledgeable and skilled staff, supportive structures and good networks. In every country these areas are critically in need of strengthening. National action plans must therefore provide for in-country capacity development that includes training on violence prevention; technical and professional skills development, and the establishment of collaborative networks. Training in violence prevention should routinely take place, both in academic institutions and as in-service training for medical personnel, law enforcement personnel, teachers, and relevant staff in other government departments. Relevant technical and professional skills include carrying out research, setting up data collection systems, designing prevention programmes, fundraising, communications, advocacy, and leadership. Collaborative networks within countries are crucial because violence prevention efforts are likely to be distributed across a range of public and private sectors and so require good coordination. Between countries, technical exchanges can speed the implementation of best practices in the field and help formulate policy agendas.

Action points:

- Establish a national network of individuals and agencies working on violence prevention.
- Introduce violence prevention components in appropriate training.

Recommendation 7

Strengthen services for victims of violence

The psychological, medical and social consequences of violence have a profoundly negative impact on individuals, families, communities, countries, and the whole region. Health, social and legal support systems for victims of violence are critical for treating and mitigating these consequences and must be strengthened. Investing in strengthened services can help prevent future acts of violence, reduce disabilities, and help victims cope with the impact of violence on their lives. Violence prevention efforts should be integrated into existing health systems developed for the diagnosis and treatment programs of other health problems, and for the evaluation of the effectiveness of these programs. Strengthening integrated health systems should include strengthening the capacity for violence prevention.

Action points:

- If lacking, introduce screening and referral services for victims of violence in all emergency rooms.
- Review medico-legal services to ensure that the reception and care of victims of violence is respectful and sensitive to their immediate and long term health and legal needs.
- Institute child friendly medico-legal services.

Roles and responsibilities:

The role of governments

In many countries the responsibility for the primary prevention of violence is unclear. As discussed earlier, this is because the problem has many facets. Yet, if a country commits to the reduction of violence, it must identify definite sectors (ministries, departments, agencies) and charge them with clear and measurable responsibilities. The identification of a responsible office, the clear definition of the mandate of the office, and the provision of

resources commensurate with the task is therefore the first and non-negotiable role of the government. Governmental contributions at this level are crucial because while there are many things that NGOs, communities, and research networks can do, there are others which only governments can do, such as passing laws, and ensuring adequate and equitable enforcement of these laws.

The role of the Health Sector

Health sector involvement in preventing violence will vary from country to country based on what other sectors are mandated to address the above recommendations, and what resources (human, organisational, financial) exist. The health sector could undertake the following functions:

- Advocacy.
- Data collection, interpretation, reporting, and dissemination (much data related to violence will come from other sectors, and the health sector can play the role of a clearing house to ensure the most comprehensive use of all data).
- Strengthening the health component of the care for victims of violence.

Most ministries of health routinely report the causes and outcomes of ill health, and they should ensure the inclusion of the various forms of violence to the extent possible.

The role of science and research

One of the most important prerequisites for violence prevention is the development of an easily accessible evidence base on the epidemiology of violence. Primary prevention is difficult without such data. Collecting, collating, and analysing information on violence therefore forms the most pressing task for scientists and researchers in Africa. The availability of such an evidence-base is crucial in identifying priority areas and populations for violence prevention when setting country and regional level research agendas. The setting of these agendas is therefore the non-negotiable task of African researchers and scientists.

The role of Nongovernmental and Community-based Organisations

In addition to the need for nongovernmental organizations (NGOs) and Community-based Organisations (CBOs) to disseminate the understanding that violence is preventable as widely as possible, these stakeholders should actively mobilize resources to build violence prevention advocacy platforms based on evidence. In particular, NGOs should be seen as violence prevention information hubs, from which different actors can get information, join

violence prevention networks and obtain primary, secondary and tertiary violence prevention referrals and resources. In order to raise the profile of this problem to the national level, NGO networks and practitioners in government departments could establish an annual violence prevention forum to which new evidence or programs can be presented, and at which the various players can expect accountability for progress towards the achievement of set goals. Intense and sustained violence prevention advocacy is the primary task of NGOs, CBOs and other community-based actors.

The role of the media

The media serve an especially important information dissemination function across Africa. Although consumption of digital media is increasing across the continent, many countries still rely on print and radio broadcasting media for news and general information. As such radio broadcasting represents a valuable means to social messaging and evidence-based violence prevention information. Drawing on evidence rather than taking recourse to sensationalised, tabloid styles of writing to contextualise acts and causes of violence is the hallmark of responsible reporting. Through assuming a proactive, socially responsible position, African media can act accordingly as relays for prevention messaging and action.

World Health Organization

Regional Office for Africa