WESTERN CAPE GOVERNMENT

INTEGRATED PROVINCIAL VIOLENCE PREVENTION POLICY FRAMEWORK

AUGUST 2013

FINAL DRAFT[1]

CONTENTS

EXECUTIVE SUMMARY

This document provides the overarching policy framework for the Western Cape Government (WCG)'s violence prevention initiatives, and focuses on the key strategies that are to be adopted in preventing violence in the Western Cape.

Every year, the WCG spends up to 80% of its health budget on preventable conditions, including injury-related deaths on our roads, and injuries and deaths from interpersonal violence fuelled by alcohol- and drug use. This places a massive burden on the public healthcare system, and drains precious resources which could otherwise be spent on improving the lives of the people of the province and providing healthcare to patients suffering from illnesses that are not preventable.

The costs of violence are not borne by the state alone. Violence devastates families. It destroys communities. And it rips apart the social fabric. Yet violencecan be prevented if the state and society work together.

We need to take a "whole-of-society" approach to preventing violence. This means that individuals have a duty to prevent violence through the life choices they make, parents through the responsibility they take and the guidance they give, whole communities through the cultural and social norms they establish, and institutions like churches and schools in the leadership they provide. The state, of course, has a critical role to play in shaping the kind of socio-economic environment that discourages violence in the first place. By expanding opportunities to individuals, families and communities so that they can take control of their lives, the state reduces the likelihood of violence occurring.

Globally, evidence-based research and scientific studies show that there are several ways to prevent violence and reduce its impact. Proven and promising prevention strategies have seen the state working in partnership with active and responsible citizens to:

- Develop safe, stable and nurturing relationships between children and their parents and caregivers;
- Develop life skills – for example, social, emotional and behavioural competencies – in children and adolescents;
- Reduce the availability and harmful use of alcohol;
- Reduce access to lethal means, including guns, knives and pesticides;
- Promote gender equality to prevent violence against women;
- Change cultural and social norms that support violence;
- Identify victims and providing care and support programmes.

The integrated provincial violence prevention policy framework recommends the adoption of a comprehensive intersectoral approach that balances short-term evidence-based

interventions, focused on reducing the availability and harmful use of alcohol, with longer-term interventions that require the state and all citizens to take active responsibility in addressing more holistically the complex social norms that support violence.

Interventions by the WCG to reduce the availability and harmful use of alcohol are already well underway. The single largest intervention by the WCG to reduce alcohol abuse and its related harms is the implementation of the Western Cape Liquor Act, passed in 2009, aimed at regulating liquor outlets. Another intervention, the Selected High-Risk Area project, aims to reduce alcohol-related violence in five high-risk pilot communities: Khayelitsha, Nyanga, Elsies River, Hout Bay and Khayamandi. The Selected High-Risk Area project draws on the methodology used by agencies such as Violence Prevention through Urban Upgrading (VPUU), by focusing on situational violence prevention (through the modification of urban environments and public spaces) and social violence prevention (through community involvement in the monitoring of liquor outlets).

The integrated provincial violence prevention policy framework reflects a desire to bring coherence and clarity to the government's objectives in the field of violence prevention across sectors. Historically, society has relied in large part on the traditional criminal justice, or 'law enforcement', approach to respond to violence. This approach is primarily vested in the institutions of criminal justice – the police and prisons – as the main response to violence. Within the law enforcement approach, the main task of the criminal justice system is to "do justice", i.e. to ensure that offenders are properly identified, that the degree of their guilt is ascertained as accurately possible, and that they are punished appropriately. The institutions of the criminal justice system play a vital role in this regard, which is why the WCG is using its legislative powers and influence to improve their functionality and effectiveness --- by monitoring and exercising oversight over the South African Police Service, for example, and strengthening Community Police Forums (CPFs).

Unlike the traditional law enforcement approach to violence, the public health approach focuses on how underlying causes and risk factors - operating at the level of society, community, family, and the individual - interact to produce acts of violence.

The public health approach has a great deal in common with the whole-of-society approach that has been adopted by the WCG in driving its Provincial Strategic Objective 5: Increasing safety. Applied to violence prevention, the whole-of-society approach focuses on the root causes of violence and the situational contexts of violence as the main response to violence. It draws on the resources, capabilities and collective *agency* of every single citizen– working in partnership with one another, and the state – to demotivate potentially violent offenders and remove the opportunities for them to engage in acts of violence. The whole-of-society approach, then, dovetails neatly with the proactive, preventative public health approach. Furthermore, both approaches emphasise the importance of evidence-based interventions.

The successful implementation of this policy will require the co-operation of all role-players in the public health and criminal justice sectors, as well as the active participation and partnership of citizens and civil society more broadly.

The role of state and non-state actors in the educational and social development sectors is also of critical importance. They are centrally and directly involved in working to change the complex social norms that support violence. The role, too, of the private sector is critical: it is in the frontline of employment facilitation, and jobs mitigate against social exclusion and the various social ills – like violence – that it breeds.

One of the main objectives of the integrated provincial violence prevention policy framework, then, is to enhance collaboration between the health, criminal justice, educational and social development sectors – both inside and outside the state – to prevent violence through the adoption of shared strategies. After an overview of violence and the risk factors for violence in the Western Cape in Section 2, these strategies are set out in Section 3.

1. THE CASE FOR AN INTEGRATED VIOLENCE PREVENTION POLICY FRAMEWORK

1.1 Definitions of violence

For the purposes of the integrated provincial violence prevention policy framework, violence is understood in terms of the definition used by the World Health Organisation (WHO). The WHO 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.[2]

The WHO's *World report on violence and health* presents a typology of violence that can help to understand the contexts in which violence occurs and the interactions between different types of violence. This typology distinguishes four ways in which violence may be inflicted: physically; sexually; psychologically; and by deprivation. It further divides the general definition of violence into three sub-types according to the victim-perpetrator relationship.

- **Self-directed violence** refers to violence in which the perpetrator and the victim are the same individual and is subdivided into *self-abuse* and *suicide*.
- **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 the latter is broken down into *acquaintance* and *stranger* violence and includes youth violence; assault by strangers; violence related to property crimes; and violence in workplaces and other institutions.
- **Collective violence** refers to violence committed by larger groups of individuals and can be subdivided into social, political and economic violence.

1.2 Background to violence prevention: the global picture

According to the *World report on violence and health*, violence claims an estimated 1.6 million lives annually worldwide.[3] This amounts to 4000 deaths per day. Of those killed by violence, just over 50 percent die by suicide, more than one third die by homicide, and roughly 10 percent die directly as a result of war or other form of collective violence.

Around 90 percent of deaths due to violence occur in low-income and middle-income countries, and males account for 77 percent of all homicides.

Many more people suffer non-fatal injuries and chronic, non-injury-related health consequences as a result of suicide attempts, interpersonal violence, and collective violence.

Beyond deaths and injuries, violence has serious, life-long, and far-reaching consequences. It places a massive burden on national and local economies, costing countries billions each year in health care, law enforcement, and lost productivity. In countries with high levels of violence, economic growth can be slowed down, personal and collective security eroded, and social development impeded.

Violence is linked with high-risk behaviours such as unsafe sex, abuse of alcohol and other addictive substances, physical inactivity, smoking and antisocial behaviour. Due to such behaviours, perpetrators and victims of violence are more likely to suffer from diseases such as cancers, cardiovascular diseases, cirrhosis, depression, emphysema, reproductive health problems, and HIV/AIDS. Adversities in early childhood (such as child maltreatment, itself a form of violence); dysfunctional and conflicted family relationships; and easy access to alcohol and firearms are among the main risk factors for becoming both a victim and perpetrator of violence later in life.

Violence is preventable. Globally, evidence-based research and scientific studies show that there are several ways to prevent violence and reduce its impact. Proven and promising prevention strategies include:

- Developing safe, stable and nurturing relationships between children and their parents and caregivers;
- Developing life skills – for example, social, emotional and behavioural competencies – in children and adolescents;
- Reducing the availability and harmful use of alcohol;
- Reducing access to lethal means including guns, knives and pesticides;
- Promoting gender equality to prevent violence against women;
- Changing cultural and social norms that support violence;
- Identifying victims and providing care and support programmes.

The WHO's *World report on violence and health* and the Global Campaign for Violence Prevention (GCVP) were launched in 2002. They aim to bring the evidence for violence prevention to bear on low- and middle-income countries, where the problem of violence is most acute.

The recommendations of the *World report on violence and health* were endorsed by the 2003 World Health Assembly in Resolution WHA56.24, and since then several other global and regional resolutions have been adopted. Currently, internationally, there are over 100

officially appointed national health ministry focal persons for the prevention of violence. Over 50 countries have had national launches of the *World report on violence and health.* Over 25 countries have established national violence prevention programmes and several municipalities and regional governments have initiated violence prevention activities.

In 2004, the WHO hosted a meeting under the banner of '*Milestones of a global campaign for violence prevention',* or 'Milestones' for short. The Milestones meeting reviewed the progress made in the first year following the 2002 launch of WHO's *World report on violence and health*, and looked to the future to plan activities to be undertaken as part of the GCVP. This included initiatives to advocate for violence prevention, develop technical guidance, provide support for work in different countries, and encourage donors to increase their investments in the prevention of violence.

In September 2011, the Western Cape Government (WCG), through its Department of Health (DOH), and in collaboration with the National Department of Health, hosted the 5th Milestones meeting together with the World Health Organisation and the national DOH.

1.3 Introduction to the integrated provincial violence prevention policy framework

At the 5th Milestones Meeting, under the theme "Joining forces, empowering prevention", almost 300 experts from more than 60 countries discussed progress in the WHO´s Global Campaign for Violence Prevention and strategized the way ahead by:

- Presenting new evidence on effective interventions to prevent interpersonal violence in low-, middle-, and high-income countries;
- Highlighting the need for joint programming to address underlying risk factors for different forms of violence;
- Proposing ways to increase collaboration between role-players in different sectors, particularly those in health, social development, and criminal justice; and
- Agreeing on the need to focus on a set of policy, legal and programme delivery targets for violence prevention.

The 5th Milestones meeting emphasised the need for the WCG to put in place an integrated and intersectoral policy framework that sets out strategies for violence prevention, along with data-driven, evidence-based violence prevention programmes.

This document provides the overarching policy framework for the WCG's violence prevention initiatives, and focuses on the key strategies that are to be implemented in preventing interpersonal and self-directed violence in the Western Cape.

The policy reflects a desire to bring coherence and clarity to the government's objectives in the field of violence prevention across sectors. Historically, society has relied in large part on the traditional criminal justice, or 'law enforcement', approach to respond to violence. This approach is primarily vested in the institutions of criminal justice – the police and prisons – as the main response to violence. Within the law enforcement approach, the main task of criminal justice system is to "do justice", i.e. to ensure that offenders are properly identified, that the degree of their guilt is ascertained as accurately possible, and that they are punished appropriately. One of the main reasons offenders are arrested, prosecuted, and convicted is to prevent further crimes - through deterrence (threatening potential offenders with criminal sanctions if they commit crimes), incapacitation (physically preventing offenders from committing further crimes by locking them up) and through rehabilitation (using time spent under state supervision to develop skills or change one's psychological make-up to reduce the likelihood of future offences).

The public health approach to violence, by contrast, focuses on how underlying causes and risk factors - operating at the level of society, community, family, and the individual - interact to produce acts of violence. In fact, this approach has a great deal in common with the 'whole-of-society' approach that has been adopted by the WCG in driving its Provincial Strategic Objective 5: Increasing safety.

Applied to violence prevention, the whole-of-society approach focuses on the root causes of violence and the situational contexts of violence as the main response to violence. It draws on the resources, capabilities and collective *agency* of every single citizen– working in partnership with one another, and the state – to demotivate potentially violent offenders and remove the opportunities for them to engage in acts of violence.

The whole-of-society approach, then, dovetails neatly with the proactive, preventative public health approach. Furthermore, both approaches emphasise the importance of evidence-based interventions.

In recent times, the provincial Department of Health has driven the development of the integrated provincial violence prevention policy framework, because the prevention of violence was identified as a public health priority and included among the provincial DOH's five focus areas for prevention in their Burden of Disease (BoD) reduction project initiated in 2007.

However, it is clear that the successful implementation of this policy will require the co-operation of all role-players in the public health, criminal justice, educational and social development sectors, as well as and the active participation and partnership of citizens and civil society more broadly.

For that reason, one of the main objectives of the integrated provincial violence prevention policy framework is to enhance collaboration between these sectors to prevent violence through the adoption of shared strategies.

1.4 Objectives

The integrated provincial violence prevention policy framework aims to promote intersectoral support for, and collaboration on, the key elements of successful violence prevention approaches, namely:

- The balancing of programmatic and policy interventions likely to reduce violence in the short term (such as those that reduce access to lethal means, e.g. firearms, and the use of drugs associated with violence and aggressive behaviour, e.g. alcohol) and interventions that affect sustained long-term change to the social environment and societal norms that support violence (such as programmes for improved early childhood development and positive parenting);
- An intervention approach driven by an accessible evidence base and reliable injury surveillance data;
- The strategic and systematic deployment of prevention resources to target high-risk times, places and groups at-risk; and
- The ongoing monitoring of outcomes and risk factors for refinement and improvement.

In addition, the policy supports:

- The establishment of a review and consultation process across relevant departments to align existing performance priorities and deliverables;
- The provision for ongoing consultation with state and non-state actors as well as community organisations and stakeholders;
- The institutionalisation of an intersectoral framework that supports and sustains multi-dimensional prevention strategies over a long-term period; and
- The design and implementation of programmes and interventions to effect behaviour change – by incentivising socially responsible behaviours that prevent violence, and disincentivising socially irresponsible behaviours that promote violence.

2. AN OVERVIEW OF VIOLENCE IN THE WESTERN CAPE[4]

2.1 Overview of violence in the Western Cape

A total of 9162 deaths were recorded in the Western Cape catchment area from January to December 2010. Some 5466, or 60%, of these deaths were due to non-natural causes. The highest proportion of non-natural deaths were due to homicide (2264 deaths, or 41% of the total) and road deaths (1551 deaths, or 28%).[5]

South Africa's rates of fatal violence are five and eight times higher than the global average for females and males, respectively.[6]

In the Western Cape, violence accounted for 12.9% of premature mortality and was the second leading cause of years of life lost (YLLs) after HIV/AIDS, which accounted for 14.1% of YLLs in 2000.

Western Cape violence mortality rates (i.e. homicides) were higher than national rates for males per hundred thousand (129 vs. 115), and females (25 vs. 21).[7] Homicide mortality rates in the Western Cape are 15% higher than in other provinces, and interpersonal violence is the second leading cause of premature death in the province after HIV/Aids.

Among non-fatal injuries, interpersonal violence accounts for more than half of all injuries presenting to facilities in the state sector across all levels of care.

Children in the Western Cape face a high risk of exposure to violence. There appears to be an upward trend in reports of sexual assaults on children under 13 years as reported to health facilities. Many children are subject to corporal punishment in homes.

According to the 2005 National Youth Victimisation Survey, a fifth of children in the Western Cape between the ages of 12 and 17 years had been exposed to domestic violence of all kinds (not solely intimate partner violence).

The 2005 National Youth Victimisation Survey also found that:

- 23% of children aged 12 – 17 in the Western Cape have been threatened with harm, have been fearful of being harmed, or have actually been hurt in a violent incident while they were at school. Learners are the most likely perpetrators of violence, and bullying at school often manifests in, or leads to, violence.
- 8% of all teenagers in the province have been exposed to domestic violence in which a weapon was used.

- 8% of all teens in the Western Cape reported that the perpetrators of the domestic violence were under the influence of drugs or alcohol at the time of the attack.

According to the Human Sciences Research Council (HSRC), there are currently no administrative data sources that provide reliable statistics on physical abuse of children, and very few research studies have focused specifically on this form of maltreatment.

In 2006, the HSRC sourced research reports based on reviews of hospital records in order to gain an indication of the extent and nature of the problem. One such report[8] found that:

- Most physically abused children needing hospital treatment are under 5 years of age, and more than half are boys.
- The perpetrator of physical abuse is typically male and someone known to the child, often the child's father or mother's partner.
- Most assaults occur in the child's home.
- Most perpetrators use their fists, hands, or feet to assault the child.
- Children caught up in violent events between intimate adults in the home are more likely to suffer injuries of a serious nature than children who are intentionally abused. Partners may even use the child as a shield against the attack.

Finally, gang violence is a manifestation of collective violence that is particularly marked in the Western Cape. Gangsterism is endemic in the province and increasingly affects young people at school-going level. A 2006 survey found that in 22 of the schools in 'at risk' areas 61.6% of schools were affected by gang violence and robbery.

2.2. Risk factors for violence

2.2.1 Biological risk factors

Young males are more likely to be perpetrators and victims of violence worldwide. In the Western Cape, males were disproportionately affected by fatal violence and in 2000 there were 5.2 male deaths due to interpersonal violence for every female death. This ratio was marginally higher than the average in other provinces, but 60% higher than the world average of 3.2 male deaths for every female death. In South Africa, males also account for a greater proportion of non-fatal injury cases presenting to health facilities, although the male to female ratio is not as pronounced as for fatalities, as women are more frequently the targets of other types of violence, such as sexual assaults and domestic abuse that represent a larger proportion of non-fatal outcomes.

The gender distribution of fatal violence in South Africa varies by age. In Cape Town, fatal interpersonal violence for males and females increases sharply from the age of 15 years, peaking in the 25–29-year age category for males and the 35–39-year age category for females. Women 60 years and above are disproportionately represented, but women who are murdered by intimate partners are younger (mean age 30.4 years) than those murdered by others (41.2 years). For younger children, fatal violence is evenly distributed by sex. For non-fatal injuries boys are more frequently victims of physical abuse and girls of sexual abuse, which not only results in physical injuries but also has long-term psychological consequences.

Data from Cape Town's Red Cross Children's Hospital in 2000 revealed that although girls comprised only 37% of non-fatal trauma cases, nearly half (48%) had suffered sexual abuse. Only 3% of boys presenting to the facility had been assaulted sexually . In general, children are disproportionately affected by sexual violence. In 2004 police statistics reported that children younger than 18 years constituted 41% and 47% of South Africa's rape and indecent assault victims respectively, although the high likelihood of under-reporting suggests that the true magnitude of child sexual abuse may be considerably higher.

Mental and physical impairment also constitute important biological risk factors that may increase the risk of being a victim of violence or, in some cases, predispose individuals to violent or aggressive behaviour. For example, an abnormal heart rate can act as either a risk or protective factor. For youths a low heart rate is associated with sensation-seeking and risk-taking behaviour and among younger children high heart rates are associated with anxiety, fear and inhibition, which are believed to be protective factors against aggressive or violent behaviour. Neurological damage that results in psychological or personality disorders predisposing individuals to violent or aggressive behaviour can also be the result of biological factors.

Biological studies have also shown that abuse and neglect in childhood affects brain development and negatively influences cognitive, psychological and social adjustment increasing the risk for violent and anti-social behaviour. Nevertheless not all children exposed to adverse traumatic experiences become violent. A range of factors, including the presence of the Monoamine oxidase A (MAO-A) genotype, other social support and IQ, serve to moderate the effects of maltreatment, and may provide protection.[1]

[1] Monoamine oxidase A (MAO-A) is the so-called "warrior gene". A dysfunctional MAO-A gene has been correlated with heightened levels of aggression in humans.

2.2.2 Behavioural risk factors

Problems such as hyperactivity, impulsiveness, misconduct, and attention problems experienced in early childhood are important examples of psychological and behavioural factors that may predispose youths and young adults to display violent and aggressive behaviour. There is also evidence that diet and exposure to lead may affect aggressiveness and risk-taking behaviour.

Although alcohol and substance abuse cut across various ecological levels as risk factors, they impact primarily at the behavioural level. Three meta-analyses of the association between alcohol use and violence cited by Parry and Dewing found that **between 27% and 47% of intentional injuries were related to the use of alcohol**. The role of alcohol is three-fold. First, as alcohol lowers inhibition, it is an important situational factor in precipitating aggressive behaviour and violence. Several studies have found a link between alcohol dependence and child abuse and intimate-partner violence across different settings, although causality is still being debated.

Second, due to alcohol's effect of lowering motor-coordination and cognitive perception, intoxicated people are more likely to become victims of violence. In the Western Cape in 1999, 62% of murdered women had elevated blood alcohol concentrations at the time of death with an overall median of 0.11 g/100 ml. In the context of intimate-partner violence it may not necessarily be the perpetrator's drinking, but the ensuing conflict that results in violence. Alcohol thus has a disinhibiting effect which can fuel violent conflicts. There is also evidence to suggest that men may drink to embolden them to be violent towards an intimate partner if this is socially expected.

Third, both victims and perpetrators have an increased likelihood of using alcohol as a coping mechanism, as shown in co-morbidity studies comparing alcohol dependence and abuse with a range of psychiatric disorders, most notably post-traumatic stress disorder (PTSD and depression). This exacerbates the mental-health burden imposed on already-traumatised communities. Among South Africa's three major cities the alcohol-relatedness of homicides was significantly higher in the Western Cape's largest city, Cape Town, than in Johannesburg and Durban.

As drug testing is not performed routinely during post-mortem investigations, information on the use of other substances of abuse in relation to violence is more difficult to obtain. Nevertheless, one local study showed self-reported cannabis use at between 22% and 28% of arrestees who committed violent offences and another conducted among arrestees for violent crimes across eight police stations in Cape Town, Durban and Johannesburg confirmed a high prevalence of drug usage amongst the alleged perpetrators, with nearly half (45%) testing positive for illicit drugs by urinalysis. Arrestees in Cape Town tested

positive for Mandrax, which may be attributed to gang activities in the city. More recently, the use of and trafficking in crystal methamphetamine or 'tik' as it is known in Cape Town has been implicated in heightened gang violence.

2.2.3 Socio-cultural factors

During childhood, family-related factors are influential in fomenting the later onset of violent and aggressive behaviour, whereas peer relationships are more important during adolescence. The risk factors at the family level for a child's development of aggressive or violent behaviour include a family having a large number of children, a mother having a child at a young age, a low level of family cohesion, single parent households, low socioeconomic status, and abusive parental behaviour including harsh physical punishment and parental conflict.

Some South African studies have shown strong linkages between the risk of intimate-partner violence and child abuse. Abrahams et al. found that 23.5% of men from three municipalities in the Western Cape witnessed abuse of their mothers. This was found to be associated with later use of intimate-partner violence, and other forms of violence, i.e., involvement in conflicts in the community and at their workplace and arrest for possession of an illegal firearm.

The risk factors outside the family for violence among adolescents and young people usually relate to having violent friends. This may influence the likelihood of a young person engaging in violence, as well as increasing the risk of engaging in other delinquent and criminally violent behaviours, such as alcohol and substance abuse and rape. Activities relating to gangs, guns, and drugs tend to drive increases in the rate of violence within neighbourhoods and the psychological imprint of these experiences expose children to a range of severe negative mental-health outcomes.

In the Western Cape, these factors are pronounced. While recent national figures indicate that that there are currently 3.7 million guns in personal hands, the Western Cape is also beset with a strong history of street crime and gangs, which comprise an estimated 90,000 members in the province. The Medical Research Council's Youth Risk Behaviour Study revealed that in the Western Cape approximately 38% of male learners and 8% of female learners had carried a weapon in the past 6 months.

Another important contributor to rates of violence is social integration within the community. Reduced social capital (which refers to the protective effects of social networks), manifesting in low social cohesion and interpersonal mistrust, has been linked

with an increase in higher violence rates and economic inequality. Conversely, there is a strong relationship between high levels of civic engagement and low levels of crime.

These factors may be involved in the high levels of community violence in South Africa and the Western Cape; reported rape cases ranged from 197 to 210 per 100,000 population in South Africa from 1996 to 1998 compared to 80 per 100,000 in the United States. Another study in Cape Town reported that 32% of pregnant adolescents and 18% of matched controls had been forced into their first sexual experience. In Cape Town, high-school dropouts were significantly more likely to engage in a range of risk-taking behaviours, including violence.

Socio-cultural factors such as traditional gender and social norms supportive of violence are associated with a man's risk for abusing his partner. Cross-cultural studies indicate that intimate-partner violence is more likely in societies where violence has become an everyday occurrence, such as may be found in conflict areas. Socio-cultural inequality has also been implicated in risks for violence. The Western Cape's Gini index of 61.6 is higher than the national average of 57.8, highlighting the need to consider income inequality as a driver of violence in the province. There are also marked differences between Cape Town sub-districts in terms of other measures of inequality such as the aggregate education level, the percentage of informal dwellings and access to public infrastructure such as piped water and electricity.

2.2.4 Structural factors

Major social changes and demographic shifts resulting from migration, urbanisation or modernisation have been linked with increased rates of violence among youth. The relationship between socioeconomic status and violence has been shown to exist in many high-income countries and violence is more concentrated in areas of poverty and deprivation and has been shown to increase along with income inequality and poverty.

According to research by the Centre for the Study of Violence and Reconciliation (CSVR)[9], there is strong statistical evidence that levels of inequality are important in determining why some communities are more violent than others.

Inequality manifests itself in violence through a variety of mechanisms. The main link is to be found in the psychosocial consequences of inequality and the structural exclusion that propels it.

The CSVR explains:

> Indeed, in a society premised on the ideals of equality — ideals that are themselves constituted in opposition to the gross injustices of the past — inequality at the level

> generated by the South African economy is a kind of broken promise. This is made worse in a materialistic culture where one's level of income plays a very important role in shaping individuals' self-images, with the gap between expectations and reality sometimes feeding into feelings of humiliation, frustration and anger. These, in turn, sometimes manifest in violence.

In Cape Town the highest rates of homicide were recorded in the relatively impoverished sub districts of Nyanga (132 per 100,000 population) and Khayelitsha (120 per 100,000 population) double the citywide average of 66 per 100,000 and three times the rate recorded in the city centre (42 per 100,000). It is likely that these discrepancies would have been more pronounced had small area data been available to disaggregate informal areas from more established residential areas.

Migration and urbanisation are key factors in driving high rates of violent crime and in the Western Cape the substantial variation in the provincial injury profiles is partly explained by these variables. In the last two decades internal and cross-border migration has been the catalyst for South Africa's rapid urbanisation and dramatic expansion in the size of sub-economic and informal housing settlements on the urban periphery.

First, large-scale internal migration from rural to urban areas from the late 1980s coincided with the relaxation of the apartheid-era Group Areas and Influx Control legislation. More recently, cross-border migration has increased with migrants displaced by civil unrest and economic instability in countries to the North of South Africa. This has placed a considerable burden on already stressed social infrastructure and services, particularly in the peri-urban communities that were the primary sites for the xenophobic violence that afflicted the country in May 2008. Between 2001 and 2006, the Western Cape experienced 100% net migration, the highest of all South Africa's nine provinces. This trend is projected to continue into the future.

Provinces with more urban-based populations have higher injury rates and it is understandable that the 20 police stations reporting the most murders comprised a mixture of inner city and township stations with most also being in and around Johannesburg, Cape Town and Durban. The Medical Research Council's provincial estimates of mortality in 2000 also indicated a higher concentration of fatal violence in cities, with the Western Cape and Gauteng – the two most developed provinces – reporting the highest rates of fatal violence.

3. VIOLENCE PREVENTION STRATEGIES

3.1 Introduction: prioritising interventions in the Western Cape

Violence prevention requires a set of strategies that mobilises the resources, knowledge, creativity and concerns of all role-players in government, the private sector and civil society to prevent violence on a partnership basis – or a 'whole-of-society' approach for short.

Globally, evidence-based research and scientific studies show that there are several ways to prevent violence and reduce its impact. In their guide to implementing the recommendations of the *World report on violence and health*, Butchart et al.[10] highlight several key strategies for promoting primary prevention. These are investing in the early development stages of childhood, which shows greater promise than programmes directed at adults; increasing positive adult involvement in the monitoring and supervision of children and adolescents; strengthening communities, for example through reducing the availability of alcohol or improving childcare facilities; changing cultural norms in order to promote such positive norms as equality for women or respect for the elderly, and to challenge negative norms associating violent behaviour with masculinity, or racism, classism, and sexism; reducing income inequality; and improving the efficiency and resource base of the criminal justice and social welfare systems.

Similarly, the WHO's seven violence prevention strategies, as presented in its 2009 series of briefings entitled *Violence prevention: the evidence*, are:

- Developing safe, stable and nurturing relationships between children and their parents and caregivers;
- Developing life skills – for example, social, emotional and behavioural competencies – in children and adolescents;
- Reducing the availability and harmful use of alcohol;
- Reducing access to lethal means including guns, knives and pesticides;
- Promoting gender equality to prevent violence against women;
- Changing cultural and social norms that support violence;
- Identifying victims and providing care and support programmes.

A cursory review of current national violence prevention strategies reveals an over-reliance on downstream interventions to reduce the institutional short-comings of the criminal justice sector. Prevention is focused on a law-enforcement approach to security, which is vested in state policing and imprisonment as the main response to violence. With this approach, the institutions involved operate in silos to some extent, or only work collaboratively to a limited extent, by employing a 'whole-of-government' approach or 'state-on-state' collaboration to the possible exclusion of the private sector, for instance.

For its part, the WCG has attempted to reconceptualise the way in which safety is perceived and managed by adopting Provincial Strategic Objective 5: Increasing Safety. Previously, the focus was on a 'law-enforcement' approach. Now the focus is on an inclusive 'whole-of-society' approach.

The whole-of-society approach is focused on the root causes of crime and the situational contexts of crime as the main response to crime and insecurity. It utilises a system of collaborative governance to achieve its objectives. That is, it is focused on *security* governance rather than purely *state* or *police* governance.

The four policy thrusts of this strategic objective, each of which has been assigned to a working group, are to:

- Maximise the safety contribution of WCG institutions, assets and people;
- Improve the performance of the South African Police Service (SAPS) through effective oversight;
- Reduce accidents and fatalities through road safety, which is driven through SO3; and
- Strengthen 'whole of society' community safety initiatives through public-private partnerships.

Under SO5, the WCG is implementing a strong civilian oversight programme for SAPS to improve accountability of the police in the Western Cape's main centres. For example, the Department of Community Safety has developed a web-based Community Safety Expanded Partnership Programme (CSEPP) to oversee service delivery at police stations, and to make safety information continuously available in order to strengthen decision making.

Another key intervention is the introduction of legislation for stronger oversight mechanisms over the police. If enacted, this legislation will go a long way to professionalizing the police service[2].

Insofar as violence prevention is concerned, the Department of Community Safety (which leads SO5) contributes to the intersectoral approach by:

[2] The Community Safety Bill aims to regulate the Civilian Oversight responsibilities of the Western Cape Provincial Executive Council as contemplated in both Chapter 11 of the Constitution of South Africa and Chapter 8 of the Western Cape Constitution; to align the mandate, duties and functions of the Provincial Secretariat with that of the department of Community Safety in support of the Civilian Secretariat for Police Service Act; to regulate the functions of the Department of Community Safety; to regulate the control over and inspections of the affairs of Private Security Service Providers; to provide for directives for the appointment of Community Police Forums (CPFs); to provide for the establishment of partnership with community organisations; to regulate the operations of Neighbourhood Watches; to establish an Office for a Western Cape Provincial Police Ombudsman; to establish and maintain integrated information systems; to regulate the reporting on the state of policing in the Western Cape; to establish a Provincial Safety Advisory Board; and to establish and implement measures to ensure that the Western Cape province will be a safer place for all the people/communities in the Province.

- Evaluating the implementation of the Domestic Violence Act at police precincts;
- Evaluating the implementation of the Child Justice Act at police precincts;
- Advocating mandatory arrest for intimate partner violence.
- Monitoring the SAPS Alcohol Supply Reduction Strategy;
- Monitoring the efficiency of investigations and judicial proceedings during alcohol-related cases;
- Monitoring the readiness and capacity of Victim Support Rooms to provide counselling services, information and the means for further referrals in terms of alcohol-related injuries and crime;
- Monitoring the compliance of SAPS in terms of firearm controls; and
- Sharing information on alcohol-related deaths and injuries, thereby promoting more effective strategies to reduce alcohol-related accidents and road fatalities.

The contribution of DOCS, through PSO5, should be viewed as part of a comprehensive intersectoral approach to violence prevention that balances short-term interventions (focusing on reduction of access to alcohol and firearms, for example) with longer term interventions to address the complex antecedents of violence more holistically.

The integrated provincial violence prevention policy framework will ensure that priority for implementation and funding is accorded to programmes, initiatives and interventions that are evidence-based, and that target high-risk times, places and groups at-risk.

All proposals for interventions should include a justification in terms of their evidence-base either from research already undertaken or as driven by local data. Where such evidence of effectiveness is not available, the implementing agencies will need to provide a justification in terms of the emerging evidence, and also provide an outline of the research that will be undertaken to assess effectiveness of their pilot interventions.

The WCG also undertakes to formalise partnerships with higher educational institutions and research organisations competent in evidence-based research, in order to:

- ensure that the WCG is kept apprised of the most recent scientific evidence relating to violence and injury prevention;
- assist in reviewing initiatives that are potentially targets for WCG funding;
- assist in reviewing initiatives currently underway in the Western Cape that may have a bearing on violence and injury interventions either in the short-term or long-term; and
- provide research support to assess the effectiveness of violence and injury prevention initiatives undertaken in the Western Cape.

3.2 Reducing the availability and harmful use of alcohol

Evidence is emerging that violence may be prevented by reducing the availability of alcohol, through brief interventions and longer-term treatment for problem drinkers and by improving the management of environments where alcohol is served. Currently, evidence for the effectiveness of such interventions comes chiefly from developed countries and some parts of Latin America.

Alcohol availability can be regulated by restricting the hours or days it can be sold and by reducing the number of alcohol retail outlets. Reduced sales hours have generally been found to be associated with reduced violence and higher outlet densities with higher levels of violence. Economic modelling strongly suggests that raising alcohol prices (e.g. through increased taxes, state controlled monopolies and minimum price policies) can lower consumption and, hence, reduce violence. Brief interventions and longer-term treatment for problem drinkers – using, for instance, cognitive behavioural therapy – have been shown in several trials to reduce various forms of violence such as child maltreatment, intimate partner violence and suicide.

Some evidence is beginning to support interventions in and around drinking establishments that target factors such as crowding, comfort levels, physical design, staff training and access to late night transport.

The focus on alcohol reduction is also closely linked to road safety, since injury-related deaths on our roads are driven by alcohol abuse. Since 2009, the WCG has introduced various Safely Home interventions through the Department of Transport and Public Works, the overall aim of which is to reduce the number of people killed on the province's roads by 50% by the end of 2014.

The WCG has achieved an average 29% reduction in road deaths since 2009. In January 2012, 79 lives were lost on our roads, which is the lowest figure of any month since we launched our Safely Home campaign three and half years ago.

While alcohol-reduction is a tried-and-tested strategy for violence prevention, it should be noted that outright restriction has had an unsuccessful history in other parts of the world. This was the case in the USA, for example, when prohibition was introduced after World War I. During this period it was recorded that consumption of alcohol increased dramatically to the extent that it was higher than it had ever been before in the history of the country up until that stage. This also created a space for criminals to enter the sphere and organised crime peaked during this time.

3.2.1 Western Cape Liquor Act (2009) and High Street model

Interventions by the WCG to reduce the availability and harmful use of alcohol are already well underway. The single largest intervention by the WCG to reduce alcohol abuse and its related harms is the implementation of the Western Cape Liquor Act, passed in 2009. Among other things, the Act controls access to alcohol in residential areas. The Act seeks to implement the "high street model" creating zones where alcohol may legally be sold and consumed. These high streets provide secure business environments with increased lighting, policing, pedestrian walkways and partnerships with taxi associations to ensure that people drink more responsibly and get home safely.

In the Namibian town of Kuisebmond, the "high street model" has had encouraging results. For example, the number of criminal cases dropped from around 70 per week to 15 after illegal liquor outlets were closed in residential areas.

This pattern was also seen in Nyanga in 2010, when a major four-day operation resulted in 400 shebeens being closed across seven policing districts over the festive season, leading to a significant drop in serious and violent crime.

The Western Cape Liquor Act seeks to achieve similar sustained outcomes. The implementation plan for the Liquor Act was passed by the WCG Cabinet at the end of August 2011.

3.2.2 Selected high-risk area interventions

The strategic imperative of reducing the availability and harmful use of alcohol has already been programmitised at working group level within the Provincial Transversal Management System (PTMS). The WCG Department of Health has convened an intersectoral working group under Provincial Strategic Objective 4: Increasing wellness, to address the complex antecedents of interpersonal violence fuelled by alcohol. Initial activities arising from the Injury and Violence Prevention Working Group (IPWG) have centred on addressing the linkages between alcohol and injuries, as alcohol was identified during the WCG's Burden of Disease Reduction Project as one of the key cross-cutting risk factor for several priority diseases, particularly for injuries and mental health conditions.

The IPWG has initiated a Selected High-Risk Area project to reduce alcohol-related violence in five high-risk pilot communities. On 29 February 2012, the Western Cape Provincial Cabinet approved the Selected High-Risk Area approach and the selection of five communities in which the intervention approach will be piloted, namely: Khayelitsha,

Nyanga, Elsies River, Hout Bay and Khayamandi (provisionally[3]).

The Selected High-Risk Area intervention approach includes:

- Surveillance of injury cases presenting to health facilities serving these areas to inform prevention efforts;
- A situational analysis to assess current violence prevention and specifically alcohol-related violence prevention activities and to explore opportunities for enhancement of these activities; and
- Collaborative alcohol-related violence prevention activities between government and non-governmental agencies in these five areas.

The injury surveillance in the Selected High-Risk Areas is part of a broader consolidation of violence and injury data collection efforts by the WCG DOH. Already the Provincial Injury Mortality Surveillance System provides full coverage of all injury deaths in the province and the measurement of non-fatal injuries is the next priority. In the Selected High-Risk Areas there will be intermittent violence and injury studies to identify groups and sub-areas at-risk and to monitor the effectiveness of interventions.

The situational analysis of relevant current and planned government activities to reduce alcohol-related violence in the Selected High-Risk Areas is currently underway (in 2012) after which a stakeholder consultation process will explore the feasibility and capacity for further programmatic implementation. These activities will be drawn from a selection of locally appropriate evidence-based violence prevention interventions identified as part of the review of risk factors and interventions conducted by the working groups on Injury and Violence Prevention and Mental Health under PSO4.

The recommended violence prevention activities in the selected high risk areas will also draw on the methodology used by agencies such as Violence Prevention through Urban Upgrading (VPUU), which identifies three categories of intervention:

- situational violence prevention (through the modification of urban environments and public spaces, for example);
- social violence prevention (through community involvement in the monitoring of liquor outlets, for example); and
- institutional violence prevention (as demonstrated by the provincial mortality

[3] Khayamandi was chosen with the option for revision once the VPUU task team (consisting of members of the VPUU, Western Cape Government and CoCT) has selected two rural sites. The areas currently being considered for selection include: Khayamandi, Mbekweni, Zwelethemba, Rooidake-Pineview, Wesbank-Lingelethu, Hawston-Zwelihle-Mount Pleasant. The task team will only have completed selection of their rural sites within the next year. The selection of a site is strongly linked to inclusion of a site as a Selected High-Risk Area.

and Selected High-Risk Area facility-based surveillance activities outlined above).

3.3 Developing safe, stable and nurturing relationships between children and their parents and caregivers

Some interventions that encourage nurturing relationships between parents (or caregivers) and children in their early years have been shown to prevent child maltreatment and reduce childhood aggression. These types of interventions also have the potential to prevent the life-long negative consequences of child maltreatment for mental and physical health, social and occupational functioning, human capital and security and, ultimately, for social and economic development. There is also emerging evidence that they reduce convictions and violent acts in adolescence and early adulthood, and probably help decrease intimate partner violence and self-directed violence in later life.

High-quality trials in the United States of America and other developed countries have shown that both the Nurse Family Partnership home-visiting programme and the Positive Parenting Programme (Triple P) reduce child maltreatment. In homevisiting programmes, trained personnel visit parents and children in their homes and provide health advice, support, child development education and life coaching for parents to improve child health, foster parental care-giving abilities and prevent child maltreatment. Parenting education programmes, such as the Triple P, are usually centre-based and delivered in groups and aim to prevent child maltreatment by improving parents' child-rearing skills, increasing parental knowledge of child development and encouraging positive child management strategies. Evidence also suggests that parent and child programmes – which typically incorporate parenting education along with child education, social support and other services – may prevent child maltreatment and youth violence later in life.

Services to families should be rooted w*i*thin the 'family strengthening approach' - a framework which recognises families as the most fundamental factor influencing the lives and outcomes of children; which recognises that functional and bonded families are made possible by teaching people parenting skills; and which recognises that families are strong when safe and thriving neighbourhoods and communities support them.

More broadly, the WCG should also design and implement programmes and interventions that incentivise socially responsible behaviours and disincentivise socially irresponsible behaviours.

3.4 Developing life skills in children and adolescents

Evidence shows that life-skills acquired in social development programmes (which are aimed at building social, emotional and behavioural competencies) can prevent youth violence, while preschool enrichment programmes (which provide children with academic and social skills at an early age) appear promising.

Life skills programmes need to be seen as one aspect of a child's complete socialisation. What this means is that the standard of behavioural change will have to be introduced to facets of the child's life in order for it to have a lasting positive effect and outcome. Any and all programmes will have to include a behavioural change aspect for the parents as well; teachers at school should have to undergo similar skills and behaviour training as they are, as the parents, a strong social model for children.

Life skills help children and adolescents effectively deal with the challenges of everyday life. Such programmes that target children early in life can prevent aggression, reduce involvement in violence, improve social skills, boost educational achievement and improve job prospects.

The WCG's Mass Participation and Opportunity and Development (MOD) Centres, which give children in predominantly poorer areas opportunities for development after school hours through cultural and sporting activities, could also play a critical role in the implementation of this strategic thrust.

The beneficial effects of life-skills programmes are most pronounced in children from poor families and neighbourhoods. The benefits of high-quality programmes which invest early in an individual's life have the potential to last into adulthood. Most of the research on life skills programmes has been conducted in high-income countries, particularly the United States. More evidence is needed on the impacts of preschool enrichment and social development programmes in low-income and middle-income countries.

In 2012, the WCG adopted an integrated provincial Early Childhood Development (ECD) strategy, which supports the five approaches to developing children as proposed by the World Bank:

- delivery of quality services to all children;
- training of caregivers and educating parents;
- promoting community development;
- strengthening institutional resources and capacity;

- building public awareness.

3.5 Promoting gender equality to prevent violence against women and changing cultural and social norms that support violence

Though further research is needed, some evidence shows that school and community interventions can promote gender equality and prevent violence against women by challenging stereotypes and cultural norms that give men power and control over women.

School-based programmes can address gender norms and attitudes before they become deeply engrained in children and youth. Trials of the Safe Dates programme in the United States and the Youth Relationship Project in Canada, which also addresses dating violence, have reported positive results. Outcome evaluation studies are beginning to support community interventions that aim to prevent violence against women by promoting gender equality.

Evidence suggests that programmes that combine microfinance with gender equity training can reduce intimate partner violence. Some of the strongest evidence is for the national IMAGE initiative which combines microloans and gender equity training. Another intervention for which evidence of effectiveness is building up is the Stepping Stones programme in Africa and Asia which is a life-skills training programme which addresses gender-based violence, relationship skills, assertiveness training and communication about HIV.

Rules or expectations of behaviour – norms – within a cultural or social group can encourage violence. Interventions that challenge cultural and social norms supportive of violence can prevent acts of violence and have been widely used, but the evidence base for their effectiveness is currently weak. Further rigorous evaluations of such interventions are required. The effectiveness of interventions addressing dating violence and sexual abuse among teenagers and young adults by challenging social and cultural norms related to gender is supported by some evidence. Other interventions appear promising, including those targeting youth violence and education through entertainment ("edutainment") aimed at reducing intimate partner violence.

To give effect to this strategic thrust, the WCG provides integrated services for the victims of social fabric crimes such as gender-based violence and child abuse. This is known as the Victim Empowerment Programme. It aims to empower the victims of social fabric crimes by ensuring access to a continuum of services.

The WCG will also design and implement programmes that seek to change the mindsets of abusers and potential abusers, in order to deal with the root causes of gender-based violence and child abuse. To this end, violence prevention programmes need to be designed

across departments and mechanisms integrated between agencies and departments to maximise the impact of resources. This would include linking victim support systems and referral services between SAPS and Social Services agencies to alleviate social fabric crimes such as domestic violence. Frontline staff need to be capacitated to implement formal referral systems between policing agencies and social and health agencies.

4. MONITORING AND EVALUATION

In the longer term, there are six actions that should guide the development of a monitoring and evaluation (M&E) system for violence prevention:

1. Determine the purposes of the monitoring and evaluation mechanisms and assess information needs.
2. Ensure prevention and response interventions have clearly defined objectives, outputs and indicators.
3. Establish co-ordinated and common reporting tools.
4. Determine methods for obtaining information on indicators.
5. Assign responsibilities for information gathering, determine timeframes and frequency of data collection, and allocate resources.
6. Establish mechanisms for sharing information and incorporating results into prevention and response planning.

The Selected High-Risk Area intervention approach provides the basis of M&E for violence prevention in the Western Cape. This includes surveillance of injury cases presenting to health facilities. The injury surveillance in these areas is part of a broader consolidation of violence and injury data collection efforts by the WCG DOH.

Already the Provincial Injury Mortality Surveillance System provides full coverage of all injury deaths in the province and the measurement of non-fatal injuries is the next priority. In the Selected High-Risk Areas there will be intermittent violence and injury studies to identify groups and sub-areas at-risk and to monitor the effectiveness of interventions.

An M&E protocol for the other violence prevention strategies put forward in this policy will be designed and refined during 2013.

5. CONCLUSION

In summary, the integrated provincial violence prevention policy framework recommends the adoption of a comprehensive intersectoral approach that balances short-term evidence-based interventions (focused primarily on reducing the availability and harmful use of alcohol) with interventions that affect sustained long-term change to the social environment and societal norms that support violence.

The strategies guiding these longer-term interventions have been identified here as:

- Developing safe, stable and nurturing relationships between children and their parents and caregivers;
- Developing life skills – for example, social, emotional and behavioural competencies – in children and adolescents; Promoting gender equality to prevent violence against women, and changing cultural and social norms that support violence.

Furthermore, the integrated provincial violence prevention policy framework supports:

- An intervention approach driven by an accessible evidence base and reliable injury surveillance data;
- The strategic and systematic deployment of prevention resources to target high-risk times, places and groups at-risk; and
- The ongoing monitoring of outcomes and risk factors for refinement and improvement.

Finally, it is clear that the successful implementation of all of these strategies, and their associated interventions – both short-term and long-term – requires the co-operation of all role-players in the public health and criminal justice sectors (and the social development sector, as well as and the active participation and partnership of citizens and civil society more broadly).

The role of active, responsible citizens, families and communities partnering with the state in a “whole-of-society” drive to prevent violence is critical. Violence prevention is not the sole preserve of the state. Nor does it serve the interests of social justice for the state to use its strained resources to mop up the consequences of violence – in the public healthcare system and elsewhere – when that violence could have been prevented in the first place through citizens behaving in socially responsible ways.

REFERENCES

[1] This version is based substantially on an earlier draft prepared by Richard Matzopoulos, a Specialist Scientist at the Medical Research Council's Burden of Disease Research Unit. Matzopoulos advises the Western Cape Government on its violence and injury prevention and surveillance activities through the Burden of Disease Reduction Project, which seeks to reduce the burden of disease in the Province by focussing on interventions targeting upstream determinants of health.

[2] World Health Organisation. Global constitution on violence and health. Violence: a public health priority; 1996.

[3] Mathers CD, Inoue M, Guigoz Y, Lozano R, Tomaskovic L. Statistical annex. In: Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health. Geneva: World Health Organization; 2002. p. 255–325.

[4] This section is drawn directly from Matzopoulos R, Bowman B, Mathews S, Myers J. Applying upstream interventions for interpersonal violence: An uphill struggle in low- to middle-income contexts. Health Policy 97 (2010), 62-70.

[5] Medical Research Council Burden of Disease Research Unit, Injury Mortality Report for Western Cape, 2010

[6] Norman R, Matzopoulos R, Groenewald P, Bradshaw D. The high burden of injuries in South Africa. WHO Bulletin 2007;85(9):695–701.

[7] Bradshaw D, Nannan N, Laubscher R, Groenewald P, Joubert J, Nojilana B, et al. South African National Burden of Disease Study 2000: estimates of provincial mortality; 2004.

[8] Dawes, A., Long, W., Alexander, L. & Ward, C. A situation analysis of children affected by maltreatment and violence in the Western Cape. (Commissioned by the Research Directorate, Department of Social Services & Poverty Alleviation: Provincial Government of the Western Cape, Cape Town, South Africa); 2006.

[9] Centre for the Study of Violence and Reconciliation. 2008. Adding injury to insult – how exclusion and inequality drive South Africa's problem of violence', At: http://www.csvr.org.za/docs/study/4.Book_SocioEconomic_20_03_2009.pdf

[10] Butchart A, Phinney A, Check P, Villaveces A. Preventing violence: a guide to implementing the recommendations of the world report on violence and health; 2004.