



4 An overview of gender-based violence in South Africa and South African responses

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Violence against women is a public health problem that accounts for many negative health outcomes for women (Campbell, 2002; Heise & Garcia-Moreno, 2002). It is the most invisible but the most common form of violence and it is distinguished from other forms because it is perpetrated by male intimate partners. It is a universal problem that transcends social, economic and cultural boundaries. Non-governmental organisations (NGOs) and women's organisations have been trying for more than three decades to locate this problem on the international agenda. It only received recognition as a human rights violation in 1993 (United Nations, 1993), and in 1996 the World Health Organisation (WHO) recognised gender violence as a public health priority (World Health Organisation, 1996).

In this chapter we present an overview of gender-based violence in South Africa. The focus is on intimate partner violence and health sector responses. We also present an analysis of how the criminal justice system has performed in its response to the violence. The terms 'gender-based violence' and 'violence against women' are used interchangeably throughout the chapter.

DEFINITIONS

A lack of consistency in definitions has been identified as one of the major flaws in the research on this problem since it prevents adequate comparisons. Definitions vary according to the reason for use, whether for a legal, research or social purpose. Often definitions used in research depend on the disciplinary perspective of the researchers (legal, criminological, social justice, public health, etc.). In addition, the cultural context of the geographical region also influences standardisation of definitions. For example, sexual coercion in one cultural setting may not mean the same thing in another. This has resulted in non-comparability of prevalence data

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between studies. To overcome some of these problems the WHO is currently completing a study on intimate partner violence in seven countries using a standardised instrument and methodology to ensure adequate comparisons (World Health Organisation, 1999).

Gender-based violence

Gender-based violence encompasses a wide range of violations against women and girls, and includes any number of behaviours that serve to undermine the physical, sexual and emotional integrity of women. This is captured in the United Nations (UN) Declaration on the Elimination of Violence Against Women as:

Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life (United Nations, 1995, n.p.).

This definition emphasises that all these acts of violence are rooted in the power imbalances between men and women. For a depiction of the array of violent acts over the lifespan of girl children and women, the reader is referred to Watts and Zimmerman (2002). The Centers for Disease Control (CDC) (1999) and the WHO, for their multi-country study (World Health Organisation, 1999), have developed other useful definitions for research, shown in Box 1.

Box 1. Definitions of intimate partner violence

Centers for Disease Control

Pattern of coercive control of one intimate partner against another that includes physical and sexual violence, threats of physical or sexual violence, and emotional abuse in the context of physical and sexual violence (Centers for Disease Control, 1999).

WHO Multi-country study

Any act or omission by a family member (most often a current or former husband or boyfriend), regardless of the physical location where the act takes place, which negatively effects the well being, physical or psychological, integrity, freedom or right to full development of a woman (World Health Organisation, 1999).

A definition for gender-based violence in South Africa can be found in the Domestic Violence Act 116 of 1998 (1998), which defines domestic violence as:

Physical abuse, sexual abuse, verbal and psychological abuse, economic abuse, intimidation, harassment, stalking, damage to property, entry into complainant's residence without consent where they do not share the same residence or any other controlling or abusive behaviour towards a complainant where such conduct harms or may cause imminent harm to the safety, health or well-being of the complainant (Domestic Violence Act 116 of 1998, 1998, p. 4).





Intimate partner violence is commonly used and refers to violence that occurs between people who are in intimate relations. Most often the perpetrator is a husband, ex-husband, a boyfriend or an ex-boyfriend. Domestic violence and family violence is also not gender-specific, and although it includes violence between intimate partners (where women are overwhelmingly the victims), it also includes violence against children, violence between family members, and violence between people who share households.

Physical violence

Legal definitions

Legal definitions of physical violence can be found in the two legal recourses available to South African women. Firstly, in the Domestic Violence Act 116 of 1998 (1998) described above, and secondly in the crime of assault, which is seen as a crime against bodily integrity (Snyman, 1991).

Sexual abuse

Legal definitions

Legal definitions of sexual violence in South Africa fall under the ambit of crimes against the person and those against the community, and at present are defined in terms of rape, indecent assault, incest and unnatural sexual offences in common law. Rape is defined as intentional, unlawful intercourse with a woman without her consent (Snyman, 1991). Indecent assault is defined as unlawfully and intentionally assaulting another person with the object of committing an indecency. The Act also includes a provision to protect the sexual integrity of young persons by criminalising sexual intercourse below the age of 16 years even with the consent of the persons.

Sexual law reform

The South African Law Commission has published a report on sexual offences that redefines sexual offences and related matters. Rape is defined as any act which causes penetration to any extent whatsoever by the genital organs of the person committing the act into or beyond the anus or genital organs of another person, or any act which causes penetration to any extent whatsoever by the genital organs of another person into or beyond the anus or genital organs of the person committing the act (South African Law Commission, 2002). An act which causes penetration is *prima facie* unlawful if it takes place in any coercive circumstances; under false pretences or by fraudulent means; or in respect of a person who is incapable of appreciating the nature of an act which causes penetration. The Bill is far-reaching in its definition of coercion, including the use of any physical or psychological force, any threat or abuse of power and authority, and situations where a person is detained.

Health sector legal duties

Submissions to the South African Law Commission have recommended the following positive legal duties for health workers. Among others, the health care practitioner must provide the patient with information relating to the legal rights and options available, the examination, pregnancy, sexually transmitted infections (STIs), HIV,

post-exposure prophylaxis (PEP), post-traumatic distress stress disorder and rape trauma syndrome, medications, local resources and available literature, and the outcome of the examination. The health care practitioner must obtain fully informed consent, the examination must be conducted within 2 hours of presentation, a support person is allowed to be present, and the health care practitioner must ensure that it is conducted in a safe and private space. Lastly, the health care practitioner must utilise a standard management protocol, complete the protocol forms (the J88 if a charge is laid), and inform the police of the relevant findings (South African Law Commission, 2002).

In addition, non-legislative recommendations by the South African Law Commission in respect of the Sexual Offences Report have imposed a number of positive duties on health care practitioners, health institutions and Departments of Health. Some of these are listed in Table 1.

Table 1. Some non-legislative recommendations by the South African Law Commission to the Department of Health as contained in the Sexual Offences Report 2002

Category	Recommendations
Forensic medical examination	<ul style="list-style-type: none"> • An appropriately trained health worker (which includes doctors and nurses) should conduct a proper medical examination, which includes treatment and referrals, at the first consultation. • The collection of evidence and treatment of the patient should be done by the same health worker. • The adult patient should be given the option of a full examination with collection of forensic evidence that can be kept at the health care facility for 90 days while the patient decides whether or not to report to the police. • A full and detailed explanation should be given to the patient (or caregiver in the case of a child or mentally disabled person) about the examination, potential pregnancy/STI/HIV, any medication given, and the outcome of the examination. • Patients should be tested for and counselled about HIV, or referred for it. • The results of the examination should be shared with the investigating team, specifically around evidence found for comparison with the scene and the suspect/s. • The SAPS must provide training for health workers in the use of the sexual assault evidence collection kits (SAECK). • The health worker must refer the patient for appropriate counselling.





Category	Recommendations
Training	<ul style="list-style-type: none"> • Specific training should be given to health workers to manage cases of sexual assault, which must be continually monitored and evaluated. • This training should include how to perform medico-legal examinations, how to correctly manage the health care of sexual abuse patients, knowledge about and correct use of the SAECK, how to complete the required documentation (e.g. the J88), police procedure, and legal aspects including the presentation of expert evidence in court. • Training at all levels should include collaborating with the South African Police Service (SAPS). • Social and cultural context concerns with respect to sexual violence should be included in the training. • Gender and gender-based violence should be included in the curricula of undergraduate health workers.
Protocols	<ul style="list-style-type: none"> • A national system of accreditation for health workers in the management of survivors of sexual assault should be established by the Department of Health; thereafter those accredited health workers should be given the designation 'Sexual Assault Care Practitioner'. • Until this system is established health workers should be obligated to manage such patients according to a management protocol. • When a patient presents to a health care worker/facility (including private practitioners) who have not received training, the health worker must refer the patient to a facility or health care worker who has received the accredited training. • Protocols for the management of rape survivors for health care workers should be developed by the Department of Health. • These protocols should include the following minimum standards of care: <ul style="list-style-type: none"> - The physical, emotional and psychological safety, health and well-being of the patient is given precedence; - Standardised evidence collection and documentation procedures must be developed nationally and used in all sexual assault cases; - Patients must receive the same quality of care regardless of where the assault happened; - Health workers must have the ability to recognise, document and appropriately interpret injuries, or the lack thereof; - Health workers must have the ability to collect and package the appropriate forensic specimens as per the new SAECK. • The protocols should contain: <ul style="list-style-type: none"> - Measures to protect the privacy and dignity of patients and measures to expedite the examination and management. - All patients must be examined immediately after presenting to a health facility. - This assessment must include the patient's risk of acquiring HIV infection; patients must be informed and counselled



Category	Recommendations
Health care facilities	<p>about this risk, and given information about PEP, which includes the existence, purpose and possible side-effects of antiretroviral therapy.</p> <ul style="list-style-type: none"> • PEP should be available at all health care facilities. If not, the health worker should assist the patient in obtaining the drugs.
	<ul style="list-style-type: none"> • It is felt that the criminal investigation of sexual offences would be improved if all role players were involved from the outset; hence the provision of 'one-stop centres' should be endorsed and implemented nationally. • That nationally issued health instructions should oblige health workers, when requested to do so, to examine victims and alleged perpetrators of sexual offences, and should regulate the manner in which evidence is collected and disposed of. • The superintendent of the health care facility must establish an adequate complaints mechanism.
Debriefing and complaints mechanisms	<ul style="list-style-type: none"> • Support mechanisms for health workers should be available to deal with vicarious trauma. • A complaints mechanism must be established for patients who feel that health workers have acted inappropriately or have not complied with their designated duties. • In all complaints the superintendent must undertake to register, probe and see to the proper internal disciplinary mechanisms being adhered to.



Emotional, verbal and economic abuse

These three forms of abuse are captured in both the UN definition and the South African Domestic Violence Act 116 of 1998. This type of abuse has not enjoyed the same attention from researchers and therefore no agreement has been reached on definitions for research purposes. The Domestic Violence Act 116 of 1998 defines emotional abuse as a combination of verbal and psychological abuse and describes it as:

A pattern of degrading or humiliating conduct towards a complainant including repeated insults, ridicule, or name calling; repeated threats to cause emotional pain; or the repeated exhibition of possessiveness or jealousy which is such to constitute a serious invasion of the complainant's privacy, liberty, integrity or security (Domestic Violence Act 116 of 1998, 1998, p. 4).

The WHO defines emotional abuse as any act or omission that damages the self-esteem or identity (World Health Organisation, 1996) of a person, while the CDC recommends that emotional abuse only be considered as a type of violence when there has been prior physical or sexual violence (actual or threats). Psychological abuse would therefore not be considered in the absence of physical and sexual violence (Centers for Disease Control, 1999). Researchers should identify specific behaviours as emotional abuse; for example, in a South African study abandonment and issues of infidelity (unfaithfulness and bragging about girlfriends) were included as emotional acts (Jewkes, Penn-Kekana, Levin, Ratsaka & Schrieber, 2001).

Research into economic abuse has been given the least attention. Where it has been measured, it has often been included as a dimension of emotional abuse (Centers for Disease Control, 1999; Ellsberg, Peña, Herrera, Winkvist & Kullgren, 1999; World Health Organisation, 1999). Tactics identified and used by abusers include ensuring that women are persistently short of money, taking away money that the women have earned, and damaging their possessions.

PREVALENCE

Physical violence

Consistently high levels of physical violence have been reported in both developed and developing countries. The Population Report reported on nearly 50 population-based studies (including South Africa) done between 1982 and 1999 (Heise, Ellsberg & Gottemoeller, 1999). Between 10% and 50% of women reported physical abuse on one or more occasions by an intimate partner sometime in their lifetime.

Until 5 years ago no empirical research had been done to answer the question of how big the problem of violence against women was in South Africa. The first South African Demographic and Health Survey (SADHS) was conducted in 1998 and included questions on violence against women. This national and representative study interviewed a total of 11 735 women aged between 15 and 49. The prevalence of women who had been physically abused by an intimate partner at least once ranged between 8.7% and 17.8%, with an average of 12.5% for the whole country. The prevalence for each province is presented in Table 2. The highest levels were reported in Gauteng (17.8%) and the Western Cape (16.9%) (Department of Health, 2002a).

Table 2. Comparison of prevalences of physical abuse by partner and current physical abuse in the SADHS and Three Province study

Province	Ever physically abused by partner (%)		Physically abused by partner in last year (%)	
	SADHS	Three Province study	SADHS	Three Province study
Western Cape	16.9		8	
Eastern Cape	8.7	26.8	5.4	10.9
Northern Cape	13.2		7.2	
Free State	12.4		7.3	
KwaZulu-Natal	10.2		5.4	
North West	6.8		4.2	
Gauteng	17.8		7.3	
Mpumalanga	15.2	28.4	7.6	11.9
Northern Province	8.8	19.1	5.3	4.5
Total	12.5		6.3	

A second major representative study was conducted in 1999 and had a more specific objective than the SADHS: to describe the epidemiology of violence against women in specific areas and to further validate the findings of the national survey (SADHS). A similar sampling frame as the SADHS was used to allow for comparison and 1306 eligible women aged between 18 and 49 years in Mpumalanga, the Eastern Cape and the Northern Province were interviewed (referred to as the Three Province study) (Jewkes *et al.*, 2001). A comparison of the prevalence estimates of physical violence in this study and in the SADHS is shown in Table 2.

A few other studies among particular groups reported higher rates. In a study of municipal male workers in Cape Town, 42% of the men reported using physical violence against female intimate partners of the past 10 years (Abrahams, 2002). In a study of women attending antenatal clinics in Soweto ($N=1395$), 50% of the women reported having experienced physical violence in their lifetime (Dunkle, Jewkes, Brown, McIntyre & Gray, 2002).

Sexual violence

In the 1995 Human Rights Watch report, South Africa was dubbed the “rape capital” of the world (Human Rights Watch, 1995). Two years later a second report highlighted the shortcomings of the medico-legal system with respect to rape survivors (Human Rights Watch, 1997), and in 2001 a third report featured rape and sexual harassment as the main reasons for girls abandoning school (Human Rights Watch, 2001).

Official figures of the SAPS

Official data on sexual violence for South Africa are derived from the narrow legal definitions and captured into three crime categories for reporting purposes. Consequently, the official figures do not give an accurate picture of the extent of violence against women, which is better obtained from empirical research (see below). Table 3 reflects the reported cases for South Africa over the past years. Data from 1996 showed that 240 out of every 100 000 women reported rape and attempted rape to the police (Crime Information Analysis Centre, 2001). This is three times what is reported in the USA (80/100 000) (Ramin, Satin, Stone & Wendel, 1992). Compared to crime ratios from 89 Interpol member states, South Africa has the highest ratio of reported rape cases per 100 000 population (Bollen, Artz, Vetten & Louw, 1999).

Table 3. Official Crime Information Analysis Centre (SAPS) data on sexual crimes in South Africa

Year	Rape (including attempts)	Intercourse with a girl under the prescribed age and/or female ‘imbecile’	Indecent assault	Total
1994	42 429	787	3874	47 090
1995	47 506	666	4873	53 045
1996	50 481	580	5220	56 281
1997	52 159	537	5053	57 749
1998	49 280	474	4851	54 605
1999	51 249	489	5762	57 500
2000	52 860	523	6602	59 985





Survey data

In South Africa huge differences are observed between the number of cases reported to the police and the number reported in studies. A nine-fold difference was reported by Jewkes and Abrahams (2002) in their comparison between the cases reported to police (240/100 000) and those reported in a representative community-based study (2070/ 100 000 women per year in the 17- to 48-year age group).

A number of South African surveys on sexual violence have been conducted. Direct comparison is not easy because of different definitions used. The national study (SADHS) showed that 7% of women reported having ever been 'forced or persuaded to have sex against their will' (Jewkes & Abrahams, 2002). The Three Province study showed similar figures (Mpumalanga 7.2%, Eastern Cape 6.7%, and Northern Province 6.3%) (Jewkes *et al.*, 2001). In a study of ante-natal attendees in Soweto, 20% of the women reported a lifetime prevalence of sexual violence by an intimate partner, while 9.7% reported this happening within the past year (Dunkle *et al.*, 2002). A study among 500 sex workers in Hillbrow in 2000 revealed that 59.7% had experienced some form of violence while working. When clients of sex workers were asked if they had ever been party to a violent act with a sex worker, 10% said they had, while 47% said they had witnessed violence (Naire, 2001). In Cape Town 15.3% of working men reported having forced or tried to force an intimate partner to have sex during the last ten years (Abrahams, 2002).

Studies on adolescents have provided important data on sexual coercion. Buga, Amoko and Ncayiyana (1996) reported that 28% of the Transkei scholars they studied reported forced sexual initiation while Richter (1996), in her random sample of 864 boys and girls aged 20 years and younger at three sites in South Africa, found that 17% of the males reported having forced a woman and 28% of the girls reported having been forced to have sex.

The broad epidemiology of rape has also been described by a surveillance project at three medico-legal clinics in Johannesburg where women who had reported to the SAPS were taken for examination (Swart, Gilchrist, Butchart, Seedat & Martin, 2000). The study reported on 1401 cases and although limitations included a bias in the collection of the data, with the majority of cases (1008) reported from only one of the three clinics, it does highlight important factors for prevention programmes. Some of the findings were that young women were at greater risk of being raped; most rapes were intra-racial (most women raped by men from their own race group); most rapes happened over weekends; and open spaces and homes were the most likely places for rape to occur.

Another aspect of sexual violence in South Africa is gang rape. The rape surveillance undertaken in Johannesburg reported that more than one-third of the women reported being raped by more than one perpetrator (Swart *et al.*, 2000). Gang activity in South Africa includes "jackrolling", which is the forceful abduction and possible sexual abuse of women. "Stream-lining" is another form of gang rape in South Africa. In this case, girls usually know the perpetrators. A young man may arrange for a number of his friends to have forced sex with his girlfriend, usually when he intends to end the relationship or when he wants to teach her a lesson, for example when she has transgressed rules (Wood, 2001).



The only South African study to describe the epidemiology of fatal sexual violence was done by Martin (1999) in Cape Town. She found a 1.2% fatal sexual violence rate, which equates to 12 fatalities per 1000 cases of rape reported to police. This rate was 12 times higher than that reported in the USA (Marchbanks, Kung-Jong & Marcy, 1990).

HEALTH SECTOR RESPONSES

National level

In 1998 the Department of National Health issued the Uniform National Health Guidelines for Dealing with Survivors of Rape and other Sexual Offences as part of national policy guidelines spearheaded by the Department of Justice and Constitutional Development (Department of Justice and Constitutional Development, 1998). These guidelines quite clearly delineated the responsibilities and requirements for and of medical practitioners, as well as for and of provincial and national Departments of Health, especially with regard to training and establishing accredited health care practitioners. In particular, they acknowledge that:

Special skills are required to provide proper health care plus forensic examination of survivors. These skills are only available at certain centres at present and thus extensive training programmes are required throughout the country to increase access for the victims (Department of Justice, 1998, n.p.).

In these guidelines an accredited health care practitioner is further defined as being:

Highly proficient in medico-legal knowledge, credible to the justice system through accreditation of their skills and qualifications, and competent to give evidence in court confidentially (Department of Justice, 1998, n.p.).

Despite these guidelines, the required rollout, implementation and monitoring did not follow.

The 2001 health policy document, The Primary Health Care Package for South Africa (Department of Health, 2001), also very clearly states the norms and standards required for the management of victims of sexual abuse, domestic violence and gender violence, stating the requirement that:

A member of staff of every clinic has received training in the identification and management of sexual, domestic and gender related violence (Department of Health, 2001, p. 57).

Furthermore, following the April 2002 announcement by the National Department of Health regarding the provision of antiretroviral therapy (ART) to sexual violence survivors (Department of Health, 2002b), the HIV/AIDS and TB Cluster of the National Department of Health produced a draft Protocol for Management of Sexual Assault Survivors (Department of Health, 2002c), which is more holistic and all-embracing in the provision of PEP for STIs and HIV following sexual violence. These guidelines list, as one of the medium-term policy objectives, *specialised training for health care*



49



*workers*² in all aspects of rape counselling and care, including the medico-legal and forensic aspects and the provision of PEP.

By mid-2002 existing policy on health services from the National Department of Health for survivors of sexual violence was therefore available in the following documents:

- a) Uniform National Health Guidelines for Dealing with Survivors of Rape and Other Sexual Offences (Department of Justice & Constitutional Development, 1998).
- b) A Comprehensive PHC Service Package for SA (Department of Health, 2001).
- c) Policy guideline for management of transmission of HIV and STI in sexual violence (Department of Health, 2002b).
- d) Draft protocol for management of sexual assault survivors (Department of Health, 2002c).

Attention to the management of sexual violence had gained enormous impetus at ground level with the realisation of the magnitude of the HIV epidemic and the potentially fatal consequences for rape survivors. Many clinicians provided ART to their patients (see Table 4). The introduction of PEP management as national policy, although criminal in its tardiness, has provided the mechanism for the provinces to address the provision of services to sexual violence survivors adequately.

To provide a comprehensive, holistic management package that is patient-centred requires coordination between various programmes and clusters at national and provincial levels, with clearly defined competencies and responsibilities for each. The HIV/AIDS and TB cluster, as well as the Gender Focal Point programme, has acknowledged the need for this coordination, and the process of composing a definitive Sexual Assault Policy document is underway. A draft for comment was released in June 2002 (Department of Health, 2002c). The drafting of this policy has been aided by the efforts of the South African Gender Based Violence and Health Initiative (SAGBVHI), which has provided technical assistance and expertise.

The SAGBVHI is a national specialist partnership of individuals and organisations within the health sector that was established in December 2000 to help develop an appropriate health sector response to gender-based violence. Its focus lies in training, research and advocacy around gender-based violence. To this end, SAGBVHI co-hosted a two-day workshop in March 2001 with the Women's Health and Genetics sub-directorate and the Gender Focal Point programme of the National Department of Health to initiate the development of an appropriate health sector response. The workshop attracted participants from all provinces, as well as national government and NGO stakeholders. Some of the recommendations from the workshop were for the Department of Health to clearly delineate responsibilities with regard to the prevention, management and provision of services and standards for gender-based violence (Jewkes, Jacobs, Penn-Kekana & Webster, 2001).

A more recent collaboration has been the drafting of the Sexual Assault Policy. The content focuses on the transformation of sexual assault services, drawing on the experiences of various provincial projects and initiatives. Training of health care practitioners was recognised as a priority in the provision of adequate services.

² Authors' emphasis.



Provincial level

Medico-legal services are provided at a provincial level. Individual services for survivors of sexual violence are rendered at a variety of institutions in each province. The health care practitioner who sees patients can be either a very inexperienced intern and/or community health officer, or may be a very experienced senior medical officer with many years of District Surgeon practise.

Because of this long and arduous process by national government to define responsibilities and service delivery, many provinces have forged ahead with their own initiatives. However, there are unfortunately many disheartening disparities between provinces. The current status is presented in Table 4 (the Western Cape province has a policy and standardised guidelines for the management of sexual violence survivors).

Table 4. Health sector responses to violence against women by province

Western Cape	Western Cape Province in 1999 set up a Reference Group to establish a provincial policy, with standardised guidelines and protocols for the management of survivors of sexual assault (Martin & Denny, 2000). This process was completed in November 2000 with the issuing of these guidelines as Provincial Policy. Two important aspects of this policy included the provision of services at designated health care facilities with the intent to establish centres of excellence, and the provision of PEP. Two specialised centres of excellence were established, one at Groote Schuur Hospital (the largest tertiary care centre in the Western Cape), and the second, the Thuthuzela Clinic at G. F. Jooste Hospital (a secondary level provincial hospital) in Manenberg on the Cape Flats. These centres piloted the examination protocol and treatment guidelines, including the provision of AZT as PEP. The Thuthuzela Clinic was established in conjunction with a Dept. of Justice initiative, which is to provide specialised sexual offences courts through the country. The clinic has a separate specially assigned space in the hospital and is staffed full-time by nurses. There is a medical officer immediately available 24 hours a day. The special feature of the clinic is the presence of a prosecutor from the outset/initial contact with the patient. As part of the formulation of the guidelines and protocol, various experts from the Reference Group compiled a training package and training team. The training package was first piloted in the 4 regions of the Province, culminating in the production of a Training Manual, facilitator notes, pre-course and in-course reading. The training consists of a 2-day in-service workshop, aimed primarily at the medical officers conducting examinations of sexual assault survivors, but does not preclude, and in fact encourages, participation by nurse practitioners, social workers, members of the SAPS, prosecutors and local NGOs. By the end of 2002 approximately 12 such workshops had been completed with approximately 360 attendees. This training is the
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	only formalised Dept. of Health programme for health care workers on the management of sexual assault survivors. It owes its success and sustainability to 'adoption' by the Provincial Dept. of Health as a special project, assigned to the Maternal, Child and Women's Health sub-directorate with a dedicated co-ordinator at the level of Deputy Director, and the stipulation of a budget for its implementation.
Northern Cape	Kimberly in the Northern Cape provided training for approximately 26 nurses in clinical forensic skills. Unfortunately, following that training only 2 nurses were given posts that utilised these skills. Some medical officers in the province hence received didactic training (4-5 hours) from a very experienced clinical forensic examiner (Martin, 2001).
Gauteng	In Gauteng services have been provided at a few 'medico-legal clinics', which were established in Hillbrow, Soweto, Pretoria and Lenasia in the 1990s. Additionally, the private health care group Netcare established a sexual assault survivors' clinic at one of their private hospitals in Sunninghill, Johannesburg. The Sunninghill clinic has also always provided PEP to their patients (Swart <i>et al.</i> , 2000). Gauteng's Dept. of Health has a medico-legal directorate that is responsible for clinical forensic services. They are in the process of creating forensic training for health care providers comprising curriculum development and practical requirements through an accredited institution (National Clinical Forensic Medicine Committee, 2002a).
Mpumalanga	An initiative in Mpumalanga established in 2000 by a group of concerned women provides support and counselling to survivors, as well as offering ART to survivors (Kenyon, 2002). This project has provided doctors in the hospitals in which it works with information and access to ART. A medical officer at the Tintswalo hospital recently formulated protocols specific for the hospital and community resources to guide doctors in the provision of services to sexual assault survivors.
KwaZulu-Natal	KwaZulu-Natal is the other province with a medico-legal directorate in its Dept of Health. It works very closely with the Independent Medico-Legal Unit (IMLU). Part of the province's health policy is to establish Crisis Care Centres at health facilities in various locations to improve services to survivors of sexual violence (Amnesty International, 2002). They have also recognised the importance of specialised postgraduate training for examiners as being integral to implementation of the policy. The directorate, together with IMLU, has developed a generic clinical forensic medicine curriculum and training course comprising 15 modules in 4 blocks of 5 days run over a period of 1 year (McQuoid-Mason, Pillemer, Friedman & Dada, 2002). This curriculum strongly endorses a mentorship programme (National Clinical Forensic Medicine Committee, 2002b).



Other health sector responses

Numerous other localised health sector responses exist and continue to evolve as concerned individuals recognise the need for provision of adequate services. These responses emerge both from individuals in governmental organisations (for instance managers within Provincial Departments of Health and, more frequently, from medical officers working in clinics) and individuals in the NGO sector.

Many of the NGO health sector responses are directed at training. These programmes focus mainly on awareness and sensitisation around gender-based violence and are aimed at health care workers, as well as lay counsellors. Few of them address the provision of clinical skills (Martin, 2002).

Some of these initiatives use the Vezimfihlo package (Jacobs & Jewkes, 2002), which includes training materials developed for primary health care workers on gender-based violence (*Vezimfihlo* is an Nguni word which means “getting things off your chest”). Similar training by the Gender Advocacy Project (Khan, 2002) for primary health care nurses has been conducted with an emphasis on the Domestic Violence Act. Soul City is a health promotion initiative in the form of a prime-time TV drama series. One of its programmes depicted violence against women at the time that the Domestic Violence Act was enacted. It has been repeated since because of its popularity (Soul City, undated). The Centre for the Study of Violence and Reconciliation (undated) and the Women’s Health Project (undated) have both developed training packages for health workers and work mainly with medical personnel in the Gauteng region.



CRIMINAL JUSTICE RESPONSES TO GENDER-BASED VIOLENCE

This section of the chapter will explore how, against the background of constitutional obligations, the criminal justice system (including the Department of Justice and Constitutional Development, the SAPS and the Department of Correctional Services), fared in meeting its mandate to deal with domestic violence and sexual violence. The policies, legislation and specialist structures established to address the problem of violence against women are discussed, followed by an examination of the criminal justice system’s performance in implementing these various initiatives. Given the size and complexity of the criminal justice system, only a brief overview of recent developments can be presented.

Key policy and legislation addressing gender-based violence

National Crime Prevention Strategy (NCPS)

This strategy, finalised in 1996, is the first key document guiding the state’s initial response to violence against women. The document identifies gender-based violence as one of a number of priority crimes³, and recognises that gender inequality is one of a cluster of factors giving rise to this crime. The NCPS proposes a four-pillar approach to crime prevention: criminal justice processes; reducing crime through

³ The other priorities are crimes involving firearms, organised crime, drug-trafficking, gang-related crimes, white collar crime, violence associated with inter-group conflict, vehicle theft and hijacking, corruption within the criminal justice system, illegal immigrants and trade in endangered species.



environmental design; public values and education; and transnational crime prevention. Violence against women and children is cited as a national priority, with the bulk of strategies to address the problem located in pillar one, the criminal justice process, under the section on victim empowerment and support (National Crime Prevention Strategy, 1996).

National Rape Prevention Strategy

This strategy was initiated in March 2000 after Cabinet directed the Ministers of Health and Safety and Security to develop a strategy to reduce rape. An inter-departmental management team, including the Departments of Health, Social Development and Safety and Security, as well as the Sexual Offences and Community Affairs (SOCA) Unit of the National Directorate of Public Prosecutions, was subsequently set up to undertake this task. The aim of this initiative was to investigate what was being done already, to measure the impact of these initiatives and to develop a coherent strategy based on the findings (Vetten & Khan, in press). Although completed by January 2002, the report has never been made public. However, in November 2002 the Mail and Guardian newspaper (Kindra & Gabrielse, 2002) published some of the report's key findings and conclusions after obtaining a leaked copy. Some of these findings are presented in Table 5.



Table 5. Recent empirical research on prosecution of rape cases and implementation of the Domestic Violence Act (116 of 1998)

Sexual violence	<p>According to the November 2002 Mail and Guardian report referred to earlier (Kindra & Gabrielse, 2002), 9% of reported child rapes and 7% of adult reported rapes resulted in convictions in 2000. Mpumalanga province recorded the lowest number of convictions (3% and 4% respectively) followed by Gauteng, which secured convictions in 7% of reported child rape cases and 5% of adult cases. In the same year, perpetrators could not be traced in 30% of cases nationally. The percentage of cases where the suspect could not be traced has been increasing by 10% every year since 1996, with an 11% increase having been recorded between 1999 and 2000. Of reported rape cases, 43% were withdrawn in 2000, with 46% of these withdrawals occurring at the request of the victim. The Director of Public Prosecutions withdrew a further 36% of cases and the police 14%. A reconciliation between the parties involved, or their settling of the matter among themselves accounted for 19% of withdrawals. Victims could not be found in 17% of cases and in a further 15% of cases, inconclusive or contradictory evidence led to the matter being withdrawn. Cases judged as 'false' accounted for 7% of withdrawals (<i>ibid</i>). Unfortunately no further information is available outlining the criteria by which cases were judged as false or not. The article goes on to quote the report as stating that a "longer-term, sustainable anti-rape strategy can only become a reality once the criminal justice system as a whole improves" (Kindra & Gabrielse, 2002, p.3).</p>
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Domestic Violence Act

The clerks, being gatekeepers to the courts, are an important link in the chain of gaining access to a protection order. Importantly, data from the Dept. of Justice (Stack & Soggot, 2001) indicates a decline in administrative officers and clerks from 6897 to 4101 between 1996 and 2000 - a loss of 2796 employees. The Dept. of Justice and Constitutional Development (2002a), in its briefing on Budget 2001 to the Portfolio Committee, states that the implementation of new legislation such as the Domestic Violence Act has placed serious pressure on its offices. The Dept. then goes on to say that since the 2001/2 budget for personnel seems to be less than that required for the number of approved posts, fewer individuals can therefore be employed. The Dept did not appear to consider how the broader definition of domestic violence, as well as the more inclusive understanding of family and domestic relationships, was going to impact upon the courts.

The shortage has led to some organisations setting up services to assist in court functions. These NGOs are thus subsidising the functions of the Dept. of Justice. One such NGO, Mosaic Training Service and Healing Centre for Women, working in the Cape Town area, assisted 15 142 applicants to obtain protection orders during the period April 2000 to February 2001. From January 2001 to November 2001, Mosaic spent a total of R373 364.15 providing this service to women (Vetten & Khan, in press). In addition, two evaluations on the impact of the Act (Mathews & Abrahams, 2001; Parenzee, Artz & Moulton, 2001) highlighted many other barriers experienced by women, including completing the application forms, language limitations and the cost of the sheriff's fee for serving the protection order. The interviews conducted by Parenzee *et al.* (2001) with criminal justice personnel implementing the Act point to further barriers to implementation. These included inconsistent interpretations of the Act; lack of training around the Act; lack of support services outside of the criminal justice system; lack of collaboration between the courts and police, resulting in a fragmentation of services; lack of involvement by the health sector; lack of resources such as vehicles, faxes and photocopiers and personnel; and the burden of the emotional toll exacted by dealing with distressing cases of domestic violence, further exacerbated by working in circumstances for which insufficient resources are available (Parenzee *et al.*, 2001).



National policy guidelines for victims of sexual offences

National policy guidelines have been developed to ensure the provision of an effective and comprehensive service to victims of sexual violence (Department of Justice & Constitutional Development, 1998). These include guidelines for the Department of Justice, the SAPS, the Department of Welfare, the Department of Correctional Services and the Department of Health (discussed in more detail earlier).



The Gender Policy

The Gender Policy issued by the Department of Justice notes violence against women as one of its critical areas of concern and commits itself to undertake all possible measures within its mandate to eliminate violence against women, to facilitate an integrated national response to violence against women as set out in the Southern African Development Community's (SADC) Declaration on the Eradication and Prevention of Violence Against Women (SADC, 1999), and to develop a specific policy framework on violence against women. Strategic areas of intervention include domestic violence, sexual violence, witch-hunting, female genital mutilation, trafficking in women and children, women in armed conflict and refugee women.

Five-Year National Strategy for Transforming the Administration of Justice and State Legal Affairs

Also known as Justice Vision 2000, this asserts that it aims to achieve "a justice system that is responsive to the needs of victims of crime, including vulnerable groups such as women and children" (Department of Justice & Constitutional Development, 1997, p. 79). One strategy for achieving this goal is "developing and implementing training programmes to sensitise court officials to the experiences of victims of crime and to ensure that victims get support and sensitive treatment" (Department of Justice & Constitutional Development, 1997, p. 80).


A premier project put forward by the document is the prevention of violence against women. Activities proposed to achieve this goal include developing a holistic, coordinated and integrated approach to dealing with violence against women through all government departments and NGOs; establishing a high-level task team involving the SAPS, district surgeons' offices, senior prosecutors, court staff, judicial officers, social workers and NGOs to develop a set of standards and practical guidelines on sexual violence against women; reforming the substantive law and prosecutorial matters concerning sexual violence; and establishing gender information desks in every magistrate's court.

Strategic Plan for the SAPS, 2002-2005

The SAPS has been heavily criticised for the manner in which it has traditionally dealt with violence against women - displaying insensitivity, ignorance, indifference and hostility to victims of rape and domestic violence (Human Rights Watch, 1997). The NCPS has however ensured that gender-based violence becomes a priority crime, and over the years strategies to address rape and domestic violence have appeared in the police's strategic plans.

The Strategic Plan outlines a number of activities to address crimes against women and children under the Crime Prevention and Combating Programme (SAPS, 2002). These include improving service delivery by the SAPS to all victims of crime; improving services provided by the Family Violence, Child Protection and Sexual Offences units to all victims of abuse; improving SAPS services around domestic violence and vigorously implementing the Domestic Violence Act; developing an interdepartmental strategy for the prevention of rape and sexual offences; preventing the unauthorised removing of women and minors abroad; implementing the Safer Schools project in priority areas; and implementing Project Women⁴ in priority areas.

⁴We have no information describing what "Project Women" entails.



Partnerships with the National Network on Violence Against Women, the Commission on Gender Equality and Human Rights Commission are mentioned. Best practices such as the intersectoral approach, crisis centres and awareness programmes are also singled out as strategies to be introduced in areas where gender-based violence is widespread. Compiling a DNA database to ensure successful prosecution (presumably of rapists) is also mentioned.

Legal Acts

Domestic Violence Act (No. 116 of 1998)

This Act was implemented on 15 December 1999 and introduces South Africa's first definition of domestic violence, including a broad range of behaviours that were presented earlier (Domestic Violence Act 116 of 1998, 1998). Those applying for protection orders may ask the court to order the abusive party to refrain from committing any of the acts previously mentioned. In addition, applicants may also ask the courts to order the police to remove firearms and/or other dangerous weapon(s); that the police accompany the applicant to collect her belongings; that the abuser be evicted from the house and continue paying the bond/rent; that the abuser provide emergency monetary relief; that the abuser have either no, or structured, contact with any children; and that the court not disclose her whereabouts if she is not living with the abuser.

The protection afforded by the Domestic Violence Act is available to those in heterosexual or same-sex relationships. It also covers adult and child members of both the immediate and extended family.

Another innovation of the Domestic Violence Act is how it has effectively ensured that domestic violence is now the responsibility of the police. The Act compels police officers to intervene in situations of domestic violence and to follow the national instruction, which includes informing women of their rights to lay criminal charges and obtain a protection order; helping women find medical treatment when they are injured or shelter in the event of further risk; and supplying a protective escort to women wishing to collect their belongings. Failure on the part of the police to meet their obligations may result in the officer(s) concerned being charged with misconduct.

Criminal Law Amendment Act (No. 105 of 1997)

This Act makes provision for the setting aside of all sentences of death and also imposes minimum sentences for rape among other categories of crimes (Criminal Law Amendment Act No. 105 of 1997, 1997). Those convicted of raping girls under the age of 16, physically disabled women or mentally ill women should be sentenced to life imprisonment, as should those who rape the same victim more than once, inflict grievous bodily harm on the victim, participate in gang rape, or who rape knowing that they are HIV-positive or have AIDS. Those who have been convicted of two or more rapes should also be sentenced to life imprisonment. Only the presence of "compelling or substantial circumstances" allows for imposition of a lesser sentence (and these circumstances have not been statutorily defined).

According to research investigating the impact of this piece of legislation, the Act has created a distinction in the severity of sentence for child rape which did not exist in the past. Before the amendments were introduced, there was no statistically



significant difference in the length of sentence handed down for the rape of women and girls of different ages. After the Act was introduced, those convicted of raping girls under the age of 12 received significantly more severe sentences than those raping older women and girls. Overall, the effective median years of imprisonment for rape increased from eight to ten years (Paschke & Sherwin, 2000).

The same piece of legislation also imposes life sentences on those who commit planned or premeditated murder. This has had particularly severe consequences for those women who kill abusive partners, a matter we take up in the latter part of this section.

Bail legislation

Bail legislation has undergone numerous amendments since 1994. The interim Constitution confirms the right of an accused person to be released on bail, but because of the apparent leniency with which accused persons were being released, the Criminal Procedure Second Amendment Act 85 of 1997 specified stricter criteria for bail, including provisions for specific offences such as sexual offences. Both the SAPS and the National Prosecuting Authority have been issued with national policy that directs investigators and prosecutors to apply careful consideration in bail applications for sexual violence cases because of the nature of the offence. These include taking cognisance of the close relationship that often exists between the perpetrator and the victim, and the potential of threats to and intimidation of witnesses. They are also instructed to consult with the victim prior to the bail hearing and to inform her of the outcome. However, the recent research report by the Consortium on Gender Equality has identified many constraints in the implementation of this legislation, and recommendations for interventions at various levels are offered (Barday & Combrinck, 2002).

Proposed Bill on Compulsory Testing of Alleged Rapists for HIV

This Bill arose out of research conducted by the South African Law Commission into the question of whether or not it is possible to introduce legislation to provide for compulsory testing of sexual offenders for HIV. Should the Bill come into effect, it will permit a rape victim (or person acting on their behalf) who has reported the attack to the police to apply to a court to have the alleged rapist tested for HIV (South African Law Commission, undated). The application should be brought within fifty days of the rape having taken place. The results of the test may only be made known to the victim and alleged perpetrator and cannot be used as evidence in either civil or criminal matters arising from the rape.

The Commission claims that this process will benefit rape survivors in at least two ways: not only might this knowledge give women some peace of mind about their attackers' HIV status, it should also assist them to make important choices around the use of antiretroviral drugs and safer sex practices.

Sexual Offences Bill

See earlier discussion on Sexual Law Reform.



Specialist structures established to address gender-based violence

Family Courts

Five pilot Family Court centres were established in 1997, one of the premier projects prioritised by Justice Vision 2000. Services offered at all of these courts include divorce, maintenance, domestic violence and a children's court. However, a report notes that at least two of these courts, Johannesburg and Cape Town, are located in unsuitable premises (Department of Justice & Constitutional Development, 2002b). Concerns about safety were also expressed since prisoners and those standing trial were sharing the same entrance to the building as users of the Family Court. The report concludes that most of the pilot family courts were not offering integrated services, nor was their approach to these services identical. At the time of writing, they were being reviewed with a view to strengthening existing services.

Sexual Offences Courts

The first specialised rape court was opened in Wynberg in the Western Cape in 1993. In 1999 it was announced in the *Mail and Guardian* (Smith, 1999) that a further 18 rape courts were to be set up nationally and be fully operational by April 2000. According to the blueprint for Sexual Offences Courts developed by the SOCA Unit, the objectives of establishing such courts are to increase the rate of reporting of rape, to improve conviction rates for rape, to reduce secondary victimisation, and to reduce the turnaround time for finalisation of cases.

Eight criteria need to be met in order to qualify a court as a Sexual Offences Court, including a minimum of two dedicated and experienced prosecutors per court; dedicated magistrates; counselling services, intermediaries and victim assistant services; case managers and administrative support; and special courts which should include closed-circuit television cameras, waiting rooms located away from suspects, private consultation areas and anatomical dolls. Twenty eight courts are in operation around the country at the time of writing, but not all meet blueprint standards and are described instead as dedicated courts, meaning that they meet some but not all of these requirements (P. Smith, personal communication, 3 March 2003). An associated initiative with the Department of Health has been the establishment of the multidisciplinary care centre, Thuthuzela, at the G. F. Jooste Hospital in Manenberg, Western Cape (see Table 4).

Family Violence, Child Protection and Sexual Offences Units

These units evolved out of the Child Protection Units first set up in 1986. By 2000, a total of 15 had been set up nationally. A further 27 Child Protection Units exist, as well as 4 Indecent Crimes Units. In addition, specialised individuals located in 156 smaller towns around the country deal with crimes against children, as well as the localised incidence of sexual crimes (South African Society for the Prevention of Child Abuse and Neglect, undated).

Sexual Offences and Community Affairs Unit

The SOCA Unit is a recent innovation of the Department of Justice and was established to deal with cases of rape, domestic violence, maintenance and child justice. It is responsible for establishing the Sexual Offences Courts and has also provided training around both domestic violence and rape (Department of Justice & Constitutional Development, USAID & BAC, 2002).





Performance of the criminal justice system

The Department of Justice has been candid in describing its shortcomings, stating that it is characterised by "huge bureaucratic inefficiencies, wastefulness, not obtaining value for money for the resources it has deployed" and showing "no urgency and persistent customer dissatisfaction for inferior services" (Department of Justice & Constitutional Development, 2002a, n.p.). Some of the ineffective implementation of programmes and legislation addressing violence against women results from the haphazard functioning of the Department overall. Limited resources have also played a large role. The fate of rape cases in the criminal justice system in 2000 and performance of the implementation of the Domestic Violence Act are described in Table 5.

CONCLUSION

Intimate partner violence is indeed prevalent in South Africa. In the last five years an increase in research has described the scope of the problem, but most studies continue to warn that the true prevalence is likely to be much higher. Although it was not within the scope of this chapter to review risk factors for gender-based violence and its health impact, both of these areas are critical in the development of effective public health intervention. Some critical work has been done in describing the risk factors, but very little has been done on the impact of the violence on the health of South African women. Given the size of the problem, future research agendas should consider this a critical aspect of explaining the impact of this public health problem.

Health sector responses have been sadly lacking, and have only received attention within the last two years. These responses have been led mainly by advocates outside government in response to the HIV epidemic, and as a result sexual violence has received the most attention. In addition, strategies have been focused on treating victims in the aftermath of an assault (mainly sexual violence); a comprehensive national strategy, with health as a key component of addressing violence against women, has not emerged. However, efforts by organisations such as SAGBVHI and the Department of Health to address this gap are a step in the right direction.

The criminal justice system has made the most progress towards meeting its constitutional mandate to address violence against women. However, the preponderance of criminal justice interventions has resulted in gender-based violence being framed as a problem of criminal law and procedure, police investigation, and appropriate counselling programmes for both victims and perpetrators. Again, this approach emphasises amelioration rather than prevention.

The impact of the projects, programmes, policies and legislation developed at various levels were not as expected. Many of these initiatives were set up to fail because proper costing had not been done beforehand or because they were not adequately resourced.

Globally, the health sector is emerging as an important role-player in the multi-sectoral response to the prevention and management of violence against women. This is clearly seen in South Africa as well, with the emergence within the last year of new policies that place duties on the health system and health care practitioners

regarding the management of this problem. The challenge for the South African health sector is to ensure that it does not fail women - it must develop effective responsive partnerships and strategies to meet the needs of women that experience violence.

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5 Gun violence in South Africa

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While people speak of many forms of violence - domestic violence, community violence, communal violence, gang violence - gun violence is the only term in common use that refers to the type of weapon used. This reflects the increasing role that guns have come to play in the different kinds of violence that confront us globally, and the fact that firearms - because of their easy use and lethality - have an extreme impact in situations in which they are used.³

This chapter attempts to provide an overview of recent literature on gun violence, particularly as it occurs in South Africa. It is not intended to be an academic treatise, but a guide to some of the more central data and arguments that are currently shaping debates. It looks at the incidence of gun violence and explores factors that are prompting the increased circulation of firearms. It summarises recent arguments about the cost of gun violence and its impact on development. It then focuses on key issues, including the impact of gun violence on youth and women, and concludes with a call for coordinated programmes by different government departments to address the symptoms and root causes of gun violence.



Gun violence

THE INTERNATIONAL PICTURE

The 2001 Small Arms Survey estimates that globally at least half a million people are killed each year by small arms and light weapons - about one death every minute. It notes that :

[Victims] die in an astonishingly diverse number of ways: as combatants in internal and inter-state wars; as participants in gang fights and criminal battles; as casualties of government-sponsored or -condoned violence and terror; as innocent civilians trapped in deadly wars and social conflicts; and as victims of suicide, homicide, or random acts of violence (Graduate Institute on International Studies, 2001, p.1).

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² The opinions given in this chapter reflect the author's views and not necessarily those of Gun Free South Africa.

³ The terms firearms and guns are used interchangeably in this chapter. According to Gove (1986) a firearm is a weapon from which a shot is discharged by gun powder. The word gun seems older, dating back to Middle English, and includes various items, including a mounted weapon. It also refers to a portable firearm (as a rifle, shotgun, carbine, pistol) which is the meaning given to the term here. Small arms is slightly broader and refers to both commercial and military firearms up to the size of light machine guns. Light weapons are larger and include heavy machine guns, hand-held under-barrel and mounted grenade launchers, portable anti-tank and anti-aircraft guns, portable launchers of anti-tank and anti-aircraft missile systems and mortars of less than 100 mm calibre (Graduate Institute on International Studies, 2001).



More die annually because of small arms and light weapons, the study adds, than the number of deaths in almost all recent wars. In view of this, it argues that small arms and light weapons are “the real weapons of mass destruction” (Graduate Institute on International Studies, 2001, p. 1).

COMPARATIVE INCIDENCE

South Africa has a high incidence of gun violence compared to the rest of the world. A 1998 United Nations (UN) study of firearm-related violence in 69 countries found that South Africa had the second highest firearm homicide rate, at 26.3 per 100 000, second only to Colombia at 53 per 100 000. This compared very unfavourably, for example, with Germany, where the UN reported a firearm homicide rate of 0.21 per 100 000, or even the more heavily armed United States at 6.24 per 100 000 (1998, pp. 108-9).

Unfortunately, South Africa displays most of the risk factors for gun violence. In terms of global patterns, South Africa is a low- to middle-income country, one of a group of nations whose rate of violent death is more than twice that of high-income countries. It also fits in with the continental patterns. According to the World Health Organisation (WHO), countries in Africa and South America experience far more deaths as a result of homicide than their European and South East Asian counterparts (which, however, experience more deaths by suicide) (2002, p. 10).

South Africa is also a post-conflict society. Conflicts create problems that outlast the signing of peace agreements. Conflict changes socio-cultural behaviour, which cannot simply revert to pre-war patterns after peace has been restored. Moreover, weapons outlive conflict, and their presence creates a continuous risk that they will be used in future political struggles or in crime (Amnesty International and Oxfam, 2003).

Finally, South Africa is a society in transition. Shaw (1998) found that countries in transition to democracy tend to experience increasing crime. This is because as oppressive systems of policing and the ideologies that underpin authoritarian rule give way, gaps are created where criminal activity can flourish. It takes time to establish new practices in the criminal justice system and new social mores that are better suited to democracy.

Even so, South Africa experiences greater gun violence than other countries undergoing similar change. This must be acknowledged if we are to take the kind of long-term and inter-departmental approaches that are required to stem the tide.

RECENT TRENDS IN SOUTH AFRICA

Between 1994/5 and 2001/2, violent crime in South Africa increased by 33% (Masuku, 2003, p. 18) (Table 1). The crime rate rose particularly rapidly between 1997 and 2001, and began to level off or ‘stabilise’ thereafter. Masuku noted that while ‘stabilisation’ is an important trend, “overall crime rates remain very high” (2003, p. 17).



Gun violence



Table 1. Violent crime in South Africa

Year	No. of cases
1994/5:	630 110
1995/6:	654 907
1996/7:	656 195
1997/8:	668 223
1998/9:	702 981
1999/2000:	770 501
2000/1:	830 294
2001/2:	839 641

Source: Masuku (2003)

Police statistics do not disaggregate violent crimes that involved firearms from violent crimes that did not. However, commentators report that firearms are prevalent in most categories of violent crime (Meek, 2002). Masuku (2002, p. 6) found that:

Firearms are used in most violent crimes reported to the police. About 10 854 (49%) of murders recorded by the police in 2000 were committed with a firearm. The trend for attempted murder is quite different. 21 967 of 29 418 attempted murders (75%) recorded by the police involved the use of a firearm, as did 80% of 110 590 serious robberies reported in 2000.

Murder trends differ slightly from those for other violent crimes. The number of murders in South Africa fell steadily from 26 832 in 1994 to 22 030 in 2000. However, murders involving firearms went against the norm and actually rose in number from 11 134 in 1994 to 12 011 in 1999 (Table 2). They only began to fall in 2000 (Gun Free South Africa, 2002).

Table 2. Number of murders with firearms 1994 – 2000

	1994	1995	1996	1997	1998	1999	2000
Total murders	26 832	26 637	25 782	24 588	24 875	24 210	22 030
Murder with firearm	11 134	11 056	11 394	11 224	12 298	12 011	10 854
Firearm murders as a % of the total	41.5%	41.5%	44.2%	45.6%	49.4%	49.6%	49.3%

Source: Gun Free South Africa (2003)

Beneath these statistics an important transition was occurring, as firearms supplanted knives and other objects to become the most common weapon used in murder. This was confirmed by the National Injury Mortality Surveillance System (NIMSS). The NIMSS Second Annual Report found that, in 2000, “among homicides, roughly half the victims died from firearms, one-third from sharp instruments, and a further one-tenth from blunt objects” (Burrows, Bowman, Matzopoulos & Van Niekerk, 2001, p.



Gun violence



12). The NIMSS Third Annual Report reported exactly the same pattern in 2001 (Matzopoulos, 2002). In 2000 NIMSS analysts found that “firearms overshadowed all other external causes [of death due to accident or injury] and accounted for 28% of all cases. The total of 5201 firearm deaths [in the study] was greater than the 4315 deaths due to all motor vehicle collision (MVC) categories combined” (Burrows *et al.*, 2001, p. iii). In 2001 NIMSS reported “for both sexes, gunshots were the major external cause of death,” once again exceeding all categories of motor vehicle collisions combined (Matzopoulos, 2002, p. 15).

Clearly the availability and use of firearms is a significant factor, fuelling the high levels of crime and violence in South Africa.

Underlying factors

The causes of mounting gun violence are complex, linking South Africa's past of violence and racial exploitation to its present of high unemployment and unequal distribution of resources. It is important to look at some of the key factors at work.

Firstly, the ‘new’ South Africa inherited a complex gun culture, steeped in centuries of low-level to openly violent conflict, and linking masculine identity to guns. Gun-related violence reached particular intensity in the early 1990s as the apartheid government unleashed a violent ‘third force’, and many communities responded by forming armed self-defence units (Truth and Reconciliation Commission, 2003). The new government has worked to suppress the more violent facets of this culture. However, deep social anxiety remains, for social identities and traditional values and practices have been disrupted and breached, but not yet fully replaced (Cock, 2001).

Secondly, since 1994 international crime syndicates have set up operations in South Africa (Haefele, 2003; Kinnes, 2000). From the early 1980s the growth of international drug syndicates, linked particularly to the sale of crack cocaine, resulted in a surge of gun violence in countries ranging from the United States to Brazil (Dowdney, 2002). Drug cartels looked to South Africa as an emerging market and, from 1994, began operations in the country, exploiting the new government's relative inexperience in dealing with drug and other international syndicates. A wide range of international syndicates now operates in South Africa, including Nigerian cocaine cartels, Chinese triads, Moroccan protection gangs and others (Kinnes, 2000).

This has resulted in the emergence of particularly vicious forms of criminal violence - whether at the hands of gangs selling Mandrax in the Western Cape or syndicates engaged in hijackings in Gauteng - that uses guns to intimidate and control. Violence in such instances can be purposefully ruthless.

Thirdly, ready access to unlicensed or stolen guns creates opportunities for people to use firearms in other crime (see Box 1). Cock (2001) argues that widespread poverty and the high unemployment rate have contributed to the “commoditisation of violence” as increasing numbers of people come to rely on criminal violence as a means of livelihood. “A hungry stomach,” one informant told her, “knows no law” (Cock, 2001, p. 44). In such instances, firearms become preferred ‘tools of the trade’ - for example in armed robbery.



Gun violence



Box 1: Legal and illegal guns in South Africa

By 1999 the Central Firearms Register had issued 3.5 million firearms licences to private individuals, or 106 firearms for every 1000 people. About 1.4 million people had licences for one gun each, while just under 700 000 had licences for two or more guns (Chetty, 2000, p. 38). About two-thirds of these firearms (or roughly 2.5 million) were pistols, revolvers and shotguns, which may be best suited for self-defence purposes. The remainder were rifles, which might be best suited for sports shooting and hunting (Gun Free South Africa, 2002). Currently, the Central Firearms Register receives about 14 000 applications for new firearm licences each month, the vast majority (73%) for self-defence (Mistri, Minnaar, Redpath & Dhlamini, 2003, p. 46). Current estimates are that there are 500 000 illegal firearms in the country. This is very much a 'working' number. No one knows how many illegal guns there really are, how many of these are used primarily for self-protection, or how many are used in crime.

Ready access to firearms seems to have had a direct impact on rising crime levels by making crime a viable option for youth or others who, in the face of high unemployment, feel that they have few marketable skills. However, this begs the question of why and how individuals ultimately decide to take up violent crime (see 'Youth strategies' below).

Fourthly, more and more ordinary people may be acquiring guns in response to rising levels of crime and violence (see Table 3). It seems that until 1999 only a small fraction of Africans or 'coloureds' owned firearms or believed that a firearm made you safe (see Table 4). However, a groundbreaking study by the Institute for Security Studies (ISS) has shown that this pattern is changing (Jefferson, 2001).



Gun violence

Table 3. Firearm ownership in South Africa by race

	Do you own/have you ever owned a gun?	
	Yes	No
Black	2%	98%
Coloured	3%	97%
Indian	11%	89%
White	37%	63%
Total	7%	93%

Source: Chetty (2000)

Table 4. Perceptions of whether a gun makes one safer or more at risk

	Do you think that having a gun makes you					
	Very safe	Safe	Neither safe nor unsafe	At risk	Very at risk	Don't know
Black	10%	19%	12%	23%	31%	6%
Coloured	6%	16%	21%	25%	26%	7%
Indian	7%	12%	6%	22%	43%	11%
White	10%	32%	13%	20%	23%	4%
Total	10%	20%	12%	23%	29%	6%

Source: Chetty (2000)



The ISS surveyed residents in three communities - KwaMashu in Kwazulu-Natal, Tsolo-Qumbo in the Eastern Cape and Lekoa-Vaal in Gauteng - and found that there was an increasing prevalence of firearms in each. Most attributed this to the youth, who were the group most often seen carrying firearms, particularly those youth who were involved in gangs (Jefferson, 2001). Most of the people interviewed wanted to live in a community without firearms: 88% in the Lekoa-Vaal region, for example, argued that guns cause more violence than they prevent (Meek, 1998). Still, 40% said that they were willing to own a gun because they were worried about rising crime and violence, even though 80% said that they would encourage gun-owning friends to get rid of their firearms if the security situation improved (Jefferson, 2001).

What is happening may resemble what Blumstein calls a community 'arms race', whereby "more guns in the community increase the incentive for the next person to arm himself" (2002, p. 41). Gun Free South Africa's work in communities has picked up this trend (Gun Free South Africa, 2000). While a majority of South Africans may see gun ownership as a risk or even as a great risk, attitudes are softening in the face of perceived increases in levels of crime and violence. However, only additional research can confirm whether and to what extent this is occurring.

Those who advocate gun ownership might see this as a positive development - enhancing the capacity of individuals to protect themselves against criminals. However, no concrete research supports this proposition. In contrast, Altbeker (2000) found that when people carrying guns are the victims of crime, most by far have their guns stolen, and only a small minority succeed in using their firearms to protect themselves. Similarly, international research indicates that the presence of firearms may in fact put people at greater risk - by introducing the possibility of firearm accidents, suicide, or the use of guns in domestic violence in the home (Kellerman, Rivara, Rushforth, Banton, Reay, Francisco *et al.*, 1993; Wintemute, Parham, Beaumont, Wright & Drake, 1999).

Indeed, there is increasing concern that the proliferation of firearms in communities is increasing the number of firearm accidents, suicides and deaths within the contexts of domestic, community and interpersonal violence. Although firearms are only one of a large range of weapons, they are lethal instruments. Blumstein noted that "with guns even transitory violent impulses can have lethal consequences" (2002, p. 8).

This seems to be reflected in police statistics. The SAPS analysed thousands of 2002/3 murder dockets and discovered that in half of the cases the perpetrator was either a partner, family member or friend of the victim. Moreover, "a majority of 56% of murders started as an argument, which degenerated into a fight and then an assault. The assault subsequently went wrong and ended up in murder" (National Commissioner of Police, 2003, Part 6, p. 7). Guns were involved in 54% of these murder cases.

Regional and area differences

There are significant differences between and within regions. The NIMSS Third Annual Report looked at the estimated crude mortality and homicide rates (or deaths per 100 000 people) for five areas and found significant variations (see Table 5). The figures suggest that firearm-related crimes are more of an urban phenomenon than a rural one - although KwaZulu-Natal may be the exception to the rule - and that they are most common in large urban centres.



Gun violence



Table 5. Overall homicide and firearm homicide rates (deaths/100 000) in five centres in 2001

	Overall homicide rate	Firearm homicide rate
Cape Town	80	40
Durban	80	48
East London	100	29
Mpumalanga	17	10
Pretoria	41	25

Source: NIMSS (2002)

This is supported by the ISS rural victim survey (Pelser, Louw & Ntuli, 2000), where researchers interviewed 756 crime victims living in African settlements in over 40 magisterial districts in the Eastern Cape, KwaZulu-Natal, Mpumalanga, Limpopo, North West and Free State. The survey found that property crimes, especially stock theft and burglary, were far more prevalent in rural areas than violent crimes. However, far more research is needed to confirm this pattern.

Finally, there may be significant differences within regions. The Institute of Criminology at the University of Cape Town looked at the kinds and prevalences of crime that occurred between 1994 and 1998 along a single corridor in Cape Town: stretching from the prosperous suburb of Claremont, through the ganglands of Hanover Park and Manenberg, to informal settlements in Phillipi. It found that there was a higher incidence of property and commercial crime in the wealthy suburbs. In the poorer, informal settlements violent crime predominated; at the time of the research these communities were the epicentre of taxi violence, although armed robbery was the fastest growing crime. A slightly higher than normal rate of violent and property crime occurred in the ganglands in the middle, but these areas were more significantly affected by the activities of street gangs and intermittent gang turf wars (Institute of Criminology, 1999).



Gun violence

THE COST OF GUN VIOLENCE

In the past heated public debate over the right to possess firearms has overshadowed discussions about the impact of firearm violence on people and on development. Recently, however, activists have begun to challenge governments to implement effective gun control measures by highlighting the cost of gun violence. This new approach has motivated analysts to look in detail at the impact of gun violence - on human life, on communities and on governments (Muggah & Batchelor, 2002).

Firearm-related deaths

Police statistics indicate that between about 11 000 and 12 000 people in South Africa are murdered with firearms each year, or about 30 each day. We need to add to this the number of suicides committed using firearms and the number of accidental shootings each year, which seem to be far smaller in number, but not insignificant.

This is cause for great concern not only at a humanitarian level, but also because it affects South Africa's potential for development. Of special concern is the fact that the vast majority of victims (over 85%) are young men - potentially key actors in the



labour force and in development. Their deaths impact not only on government and business, but also on families and communities. The death of a breadwinner in a low-income family can cast the remaining family unit into utter poverty, leading in some cases to its break-up. Significantly, this affects not only the family but also the broader community (F. Chatburn, personal communication, 2003).

Non-fatal injuries

No one knows how many firearm-related injuries occur in South Africa. In general, there seem to be far more non-fatal injuries in South Africa than fatal ones. For example, one study estimated that there are 80 non-fatal injuries for every fatal one (Peden, 2000). Yet police and public health statistics seem to indicate that firearms play a far less prominent role in non-fatal injuries than they do in fatal ones.

In terms of police statistics, Hennop, Potgieter and Jefferson (2000) found that firearm-related injuries occur in a range of reported crimes: murder, attempted murder, hijacking, armed and common robbery, and discharging a firearm. They found, however, that although a large number of crimes involve firearms, relatively few result in injury, with the exception of murder and attempted murder. They argued that the injury rate was low because most people complied when confronted by gun-wielding criminals (conversely, one might posit that people shot in criminal incidents are more likely to be killed than injured). They could not project annual or national figures for crime-related gunshot injuries.

In terms of health statistics, South Africa currently lacks the capacity to monitor non-fatal injuries. However, a pilot study (Peden, 2000) tracked non-fatal injuries treated at King Edward VIII Hospital in Durban and G. F. Jooste Hospital in Cape Town over a one-month period in 2000. What it found was surprising.

Firstly, just over half of all patients had been injured as a result of violence. A further 29% had been injured in accidents or mishaps such as falls, burns and drowning; another 17% were injured in traffic-related collisions. The study found variation between the two hospitals. G. F. Jooste, situated on the Cape Flats, registered a significantly higher incidence of violence than King Edward VIII Hospital in Durban.

Secondly, firearms accounted for only 16% of these injuries. Statistically they were dwarfed by the number of injuries involving sharp objects (accounting for 40% of the injuries due to violence) and blunt objects (at 25%) (Peden, 2000). This contrasts with fatal accidents and injuries, roughly half of which, as we have seen, were the result of gunshot wounds. Still, while the number of gunshot injuries may have been small compared to other violence-related injuries, they were not insignificant.

Cost to the health care system

Gun violence impacts on the health care system not only because of the number of gunshot injuries that occur, but also because each one is so difficult to treat. Gunshot wounds require urgent and intense treatment. According to the Centre for Humanitarian Dialogue (CHD), Engelstad, an American facial trauma surgeon said "guns are extremely efficient at damaging soft tissue and causing massive loss of blood" (CHD, 2003, p. 7). They can also splinter bones (Van As, 2003). Moreover, "because a bullet leaves a tract of damage that usually crosses the entire body, these



wounds typically necessitate long and numerous procedures, [and] multiple days in the intensive care unit" (CHD, 2003, p. 7).

We do not know the overall national cost of treating gunshot wounds in South Africa. However, anecdotal evidence would suggest that it is very high. The initial cost of treating gunshot wounds may vary greatly, depending on the injury involved. However, the head of the Johannesburg General Hospital trauma unit reported in 1999 that treatment of gunshot victims admitted to Johannesburg General in 1998 alone may have cost R39 million (Gun Free South Africa, 1999b).

A cost analysis undertaken at Groote Schuur Hospital in Cape Town looked at how much the hospital spent on treating the 969 firearm-injured patients who presented at the hospital in 1993. The study looked at the cost per bed per day, as well as the cost of visits to the outpatient department, and so excluded costs arising from long-term management and rehabilitation. It was calculated that the 969 firearm-injured patients treated in 1993 cost Groote Schuur Hospital R3 858 331 (Peden & Van der Spuy, 1998).

These are simply two hospitals among a whole grid of day hospitals, provincial hospitals and private medical facilities and hospitals that are now treating gunshot wounds. In the light of this, a conservative estimate might be that initial treatment of gunshot injuries alone may cost the health care system tens if not hundreds of millions of rands each year.

To this must be added the cost of rehabilitating gunshot victims after the initial surgery. Engelstad reported that this cost could be very high (CHD, 2003, p. 8):

The rehabilitation of victims includes efforts to deal with amputated limbs, the loss of sensation from severed nerves, permanent physical disabilities, inhibited internal organ functions (such as the loss of the spleen, which necessitates daily antibiotics permanently) and digestion problems arising from the loss of sections of the bowels, amongst other issues.

This impacts not only on government, but also on families, who may go into debt to pay medical expenses. Gun Free South Africa spoke at length with 14 gunshot victims in Soweto in 1999. Their injuries ranged from paralysis (including quadriplegia, paraplegia, or paralysis of the limbs; and hemiplegia, or paralysis of one side of the body) to sensory disability (in this case, blindness) to limb amputation. All were severely challenged by coping with their disability and found this compounded by the high costs of medical care, including the costs of additional surgery, prescriptions, rehabilitation (including long-term physiotherapy) and nursing home care (Motaung & Taylor, 1999).

Any rise in the number of firearm injuries is bound to have a magnified impact on the health care system. There is good evidence that the number of firearm injuries is on the rise. Wigton (1999) looked at firearm-related injuries among children treated at Red Cross Children's Hospital, Groote Schuur Hospital and Tygerberg Hospital in Cape Town between 1992 and 1996. She found that the incidence of firearm injuries among youth under 19 almost trebled during this period, from 20.2 per 100 000 in 1992 to 58.1 per 100 000 in 1996.





Dr Van As, who heads the Trauma Unit at Red Cross Hospital, concurred that the number of children admitted with gunshot wounds rose steeply between 1992 to 1995, and also noted that it has risen continuously albeit more gradually since then (Van As, 2003). Similarly, the head of the Trauma Unit at Johannesburg General Hospital, Professor Bolfard, reported in 1999 that gunshot victims had trebled over five years; 650 were admitted to that hospital in 1998 alone. Gunshot wounds, he said, had become the largest cause of quadriplegia (Gun Free South Africa, 1999b).

Engelstad noted that the treatment of gunshot wounds requires the expenditure of "enormous allotments of cash that could be channelled elsewhere" (CHD, 2003, p. 8). This has had a very negative impact on South Africa. The surge in gunshot injuries coincided with the transformation of the health care system, and in 1999 in particular pushed trauma wards in many city hospitals almost to breaking-point. Although hospitals now seem more able to cope, the growing number of firearm injuries siphons off critical resources that are badly needed elsewhere; for example, to help curb the HIV/AIDS pandemic or to further extend the provision of health care services into rural areas.

We also need to consider the impact of gun violence on health care workers who experience secondary trauma while treating increasing numbers of gunshot victims. At times these workers feel physically under siege because of the gun violence around them.

Psychological impacts of gun violence

Far more pervasive, but far less understood, are the psychological impacts of gun violence and the effect these are having on South African social relationships.

It seems that the fear of violence is very widespread and occurs even in communities where violent crime is not highly prevalent. Masuku reported (2002, p. 1):

Victim surveys generally show that violent crimes are of major concern to the public. The physical and emotional impact of these crimes is devastating for victims, their families and communities. The occurrence of these crimes, coupled with the fact that this subject dominates the news headlines, heightens public fear of crime. This creates misery for individuals and destabilises communities.

The situation is more complex in communities that experience high levels of gun violence. Guns fit into a diverse mix of experiences - in the home, on the street, in school or at work and in the media - where individuals encounter conflict, aggression or even violence on a regular or even daily basis. However, when incidents occur firearms have a different impact than fists, blunt objects or even knives, in that they can easily and quickly - often with a single pull of a trigger - cause death or serious injury. This exceptional lethality can be extremely disempowering for a victim because of the depth of the threat and the lack of opportunity to resist (Reich, Cultross & Behrman, 2002). As one woman put it, "You cannot run from a bullet" (Gun Control Alliance, 1999, n.p.). For survivors, this can deepen trauma and lengthen the time needed for recovery (L. Devoux, personal communication, 2003).



Guns also have the capacity to “project fear” (Cook & Ludwig, 2002, p. 91). Firearms can kill at a distance and stray bullets may find accidental victims. A gun-related incident may traumatise large numbers of passers-by who witness a shooting, even at a distance.

Finally, where people are repeatedly exposed to gun violence the perception of risk - that there is no safe place - can be heightened by the simple sound of gunfire (Cook & Ludwig, 2002). This may be particularly true in informal settlements, where bullets have been known to pass not only through windows, but also through walls and even roofs. In communities where there is chronic violence there is great potential for continuous traumatic stress, which can profoundly affect individuals (Dawes, 2003).

The impact can be multiple and complex - people exposed to gun violence can display a wide range of symptoms, including anxiety, sleeplessness, hyper-vigilance, avoidance, and marginalisation. These can result in lost motivation, lost capacity, illness, alcohol and drug abuse and involvement in other risk behaviour, including violence and crime.

Gun Free South Africa's work in communities - for example, through its Youth and Guns workshops in Western Cape schools - has found that gun violence has a far wider and far deeper psychological impact than is commonly acknowledged, especially in communities with high rates of crime and interpersonal violence. Moreover, most people, especially in the poorest communities, go untreated. This creates the potential for a generational spiral of violence, with violence perpetuated by one generation stimulating violence in the next, particularly in communities where there already is poverty, unemployment and high levels of crime and violence (Dawes, 2003).

Indirect costs

Cook and Ludwig (2002) argue that most people are not really concerned about statistics - about how many people are killed or injured or the cost of gun violence. Most people are concerned about safety - about preventing gun violence from affecting them or their families, from damaging their businesses or intruding into their places of work. The authors note cynically that the concern is not with value of life, but with risk of death.

Preventing gun violence, they note, is a costly exercise both for government and for private citizens. However, both are willing to pay if it means reducing the threat. For government this includes the cost of securing premises - fencing schools, providing bullet-proof glass for clinics and hospitals, installing metal detectors and employing private security personnel to guard government buildings.

For private individuals and businesses this involves building high walls, installing burglar bars and anti-car theft devices, and hiring private security firms. In some areas there are even 'walled communities' where automatic gates or booms and full-time security guards restrict entry and exit. Significantly, the private security industry in South Africa is booming. The value of the industry grew from R1.2 billion in 1990 to R13 billion in 2000. By 2001 it already employed more personnel (with 190 000 active security officers) than the South African Police Service (with 112 000 personnel) (Security Officers Interim Board, 2001).



Gun violence



Cook and Ludwig (2002) argue that we can look even further, to the 'flight to the suburbs' and the impact on property prices. This is reflected in the depression of housing prices in 'dangerous' communities and the inflation of housing prices in 'safe' ones.

This, the Graduate Institute on International Studies argues, is a matter for great concern - "money spent on private security is diverted from productive or productivity-enhancing activities. Unproductive spending drains household (and corporate) savings, resulting in fewer resources for local investment" (Graduate Institute on International Studies, 2003, p. 139). Seen altogether, these costs are staggering.

Cost to development

The Graduate Institute on International Studies (2003, p. 128) argues that "small arms availability is a predisposing rather than a fundamental cause of underdevelopment. The misuse of small arms affects human capacities, such as health or education, and people's ability to use their capacity in conditions of safety and security".

This can be seen in a multiplicity of ways. Firstly, the increased use of guns in crime and interpersonal conflict increases the violence and lethality of these incidents. There are far-reaching consequences:

- a) In the case of death, the cost of lost labour and lost earning power (which can have devastating consequences for families and communities).
- b) In the case of injury, the cost to government, businesses and families of working hours lost to emergency and long-term rehabilitative treatment, and lost productive potential where there is permanent disablement or severe psychological distress.

In addition, there are further costs:


- c) To health services of treating victims of gun violence.
- d) To welfare services of supporting those who are permanently disabled.
- e) To the police of upgrading capacity to respond to and investigate gun-related crimes.
- f) To the courts of prosecuting the growing number of cases involving serious, violent crime.
- g) To the prisons of maintaining increasing numbers of criminals for longer sentences.

Secondly, gun violence can lead to the potential decline in and even withdrawal of government services. As noted earlier, the increasing number of gun injuries drains urgently needed resources from the health care system. Gun violence also affects education, for gun-related incidents regularly occur in schools across the country, forcing at least temporary closure of the affected schools and disrupting education there. Other services can also be disrupted. In Cape Town in 2003, for example, gun incidents forced the closure of clinics, libraries and even community centres in various communities across the Cape Peninsula (P. Naidoo, personal communication, 2003). Gun violence, then, is threatening key services that South Africa needs to develop and to enhance the quality of its people's lives.



Gun violence





Moreover, it diverts resources away from development. Over the last few years, government spending on law and order has grown more rapidly than its spending on social services, despite the government's commitment to reconstruction and development. In 2000/1, for example, the South African police budget was significantly higher than the health budget. In addition, "lower levels of [government] spending on social services," the Small Arms Survey (Graduate Institute on International Studies, 2003, p. 145) stresses, "force people to spend their own savings. Lower levels of domestic savings reduce investment and ultimately affect national productivity".

Thirdly, gun violence has direct economic effects. The Small Arms Survey (Graduate Institute on International Studies, 2003) could not establish a clear link between gun violence and international investment. Yet it did find that gun violence can threaten the activities of formal businesses and lead to the collapse of informal businesses in cities and rural areas. Of great concern too is the diversion of economic and human resources out of the legitimate economy and into crime.⁴

Fourthly, gun violence impacts in complex ways on "social capital," or "the features of social organisation, such as trust, norms and networks that can improve the efficiency of society by facilitating coordinated action" (Graduate Institute on International Studies, 2003, p. 146; see also White, 2003). Firearms can lead to the misuse of social capital through membership in armed gangs, for example, or a surge in the incidence of domestic violence. More subtle is the impact on popular confidence in local conflict-resolution techniques, which can lead to deterioration in neighbourhood relations, to faction fighting and to community violence.

While part of this may be visible - for instance, the impact on health care or the impact on schools - far more "invidious and potentially of greater concern" are the limitations that gun violence puts on the choices available to people (Graduate Institute on International Studies, 2003, p. 156). These range from impaired trust, to decreased mobility, to the narrowing of economic opportunities. Clearly, gun violence negatively affects development in multiple and complex ways.



Gun violence

YOUTH AND GUNS

Death and injury

One of the most compelling issues for policy makers and the public overall is the impact that gun violence is having on youth. Each year between 1997 and 2001 about 800 children under 17 years old died in South Africa because of gunshot injuries. Gun violence is the ninth major cause of death due to accident or injury for infants under 1 year old. From there the ranking of firearms tragically climbs: to eighth position for children between 1 and 4; to sixth position for children between 5 and 9; to third position for children between 10 and 14; and to first position for people from 15 until 64 (Matzopoulos, 2002). Although even infants are at risk, it

⁴A recent report found that gangsterism is an 'economy' with a basic workforce in Cape Town of over 100 000. Entire communities on the Cape Flats are dependent on gangs. Of great concern, too, is the blurring of legitimate and criminal activities, with profits from the drug trade, the sex industry and loan-sharking, for example, being invested (or laundered) in legal business operations (Graduate Institute on International Studies, 2003; Haeefe, 2003).



would seem that the more mobile and independent that children become, the more exposed they are to gun violence.

Van As (2003) looked at cases seen at Cape Town's Red Cross Children's Hospital over ten years. He found that children were shot most frequently in their own homes or in their yards. Second in frequency were children who were shot in the road or in a public place. A smaller number were shot in another person's house or yard, and an even smaller number were shot at school or on a sports field. Upon reflection, it would seem that children are most at risk at home, in their yard or on the street where they play. Thus, places that should be safe for children to grow and learn in become places of great danger.

Van As found that most of the young gunshot victims came from Gugulethu, Hanover Park, Khayelitsha, Philippi and Bonteheuwel, areas with significant gang activity or high rates of violent crime. Most, Van As noted, were shot in crossfire. Second in frequency were children who were deliberately shot by adults (this moved up from sixth or seventh position to second place in 2002). Third were children shot while playing with guns; fourth and fifth were children shot in taxi wars or by gangsters; and sixth (and relatively infrequent) were children shot by another child or friend.

Children who witness gun violence

Children who witness gun violence or hear of incidents involving family or neighbours are also directly affected. This phenomenon may be far more widespread than is commonly acknowledged. Soul City (2000) interviewed 50 groups of children between 8 and 12 years old, from urban and rural backgrounds across the country, as well as across the race and cultural spectrum. Researchers were very disturbed to discover how widespread children's experience of guns was and that most of the fears expressed by the children related to guns. The difference then may not be the fact but the extent of exposure.

Garbarino, Bradshaw and Vorrasi (2002) note that simply living in communities where gun violence is common can affect children's development negatively, even if they do not directly witness the gun violence. However, direct exposure to gun violence can scar young people emotionally as well as physically. When children are exposed to gun violence in shared spaces such as neighbourhoods or schools, they are reminded of the trauma every time they pass the spot or enter the building where the shooting occurred. However, children exposed to gun violence in their own homes are at special risk of post-traumatic stress disorder, especially if the victim is a family member.

This is compounded when children are exposed to multiple incidents of violence:

The greater the intensity and frequency [of exposure], the more likely that the brain will form an 'indelible internal representation' of the trauma. Recurrent exposure to the trauma strengthens this response and lowers the child's ability to deal with any type of trauma. The child's brain becomes highly sensitive to threat and trauma-related cues, which in turn can affect his emotional and psychological wellbeing. Several studies have documented that children with a history of trauma develop a persistent, low-level fear, and respond to threats either with dissociation (separating certain ideas or



Gun violence





emotions from the rest of their mental activity to avoid stress or anxiety) or with an unusually heightened state of arousal (Garbarino *et al.*, 2002, pp. 78-79).

Exposure to gun violence can lead to a wide range of effects, including intrusive thoughts about violence, sleep disturbance, hyper-vigilance, withdrawal from significant relationships and survivor guilt. If left untreated, these can evolve into post-traumatic stress disorder, which in younger children can affect brain development. Young people may also experience pathological adaptations, including hopelessness, fatalistic thoughts, desensitisation to violence, truncated moral development, and high-risk behaviour such as alcohol or drug use, promiscuous sex or association with dangerous people.

Garbarino *et al.* (2002) believe that the psychological impact of gun violence can be particularly severe if it occurs during early childhood or early adolescence. Studies in the United States have found that when children under the age of 11 are exposed to gun violence, they are three times more likely to experience post-traumatic stress disorder than children over the age of 12. However, teenagers may feel another range of emotions, including survivor guilt, anger and desire for revenge.

Adolescents may also create protective barriers by joining gangs or arming themselves with knives or guns. Some youth may perceive gun violence as attractive and emulate or copy crimes (Garbarino *et al.*, 2002). This begins to explain what might otherwise seem a paradox: that while youth and young adults (especially from the age of 15 onwards) are the main victims of gun violence, they are also the main perpetrators.

Youth as perpetrators of gun violence

Youth play a prominent role in gun violence (Hennop *et al.*, 2001) for a complex mix of reasons. These factors play out differently in each youth's life.

Firearm technology

One set of considerations is the nature and availability of firearms. "For much of the 20th century," McIntyre and Weiss argue (2003, p. 13), "weaponry was either too expensive and/or too heavy for children to handle". Technology changed that, and firearm manufacturers can now produce guns that are simple, light and easy for youth to use - and with the potential to maim or kill easily. Moreover, the "wholesale flooding of redundant, cheap, but efficient weapons" on the market has given youth easy access to firearms (McIntyre & Weiss, 2003, p. 16).

Economic factors

There is a further, more complex set of economic, social and cultural factors which play out in subtle patterns in each youth's life. Perhaps the easiest to understand are the economic factors. Youth interviewed at the Ekupholeni Mental Health Centre pointed to poverty and unemployment as major factors that lead young people to take up crime:

Tsotsis [criminals] like us started talking about having old shoes and no money and they just said agh! Forget it, let's take a gun and do crime (Clacherty & Kistner, 2001, p. 7).



Gun violence



It is not only poverty but also the social stigma attached to poverty that often marginalises youth, leaving them feeling isolated and ashamed, and convincing them to begin robbing people for money. There may be a progression from using a gun to alleviate immediate poverty to using it to get luxuries or substances such as alcohol and drugs. One Ekupholeni youth said:

They start by using a gun for groceries but then they get used to the money and then they buy clothes for them and their girlfriends. They also buy alcohol and dagga. They buy this because they want to forget their life and what they do with their gun (Clacherty & Kistner, 2001, p. 9).

Social environment

Far more complex is the child's social environment. The causes of interpersonal violence have individual, familial, community and cultural components. The power of each in shaping young lives changes as young people grow and develop (Dawes, 2003).

Of particular importance during infancy and early childhood (birth to 6 years of age) is a child's home environment, including relationships with caregivers, parenting and possible exposure to violence or abuse.

While this undoubtedly continues during middle childhood (7 to 12 years of age), the child's circle of peer and adult relationships expands, and experiences in school and relationships with friends and others outside the home become increasingly important. New issues arise, including the overall school experience, parental supervision, access to recreational facilities and possible exposure to anti-social behaviour, drugs and alcohol.

In young adolescence (13 to 17 years of age) family and school experiences continue to play an important role, but peers and peer pressure become highly influential. Peer group pressure can lead to a sense of inclusion or to withdrawal from accepted social interactions, marginalisation and exclusion (Clacherty & Kistner, 2001). Peer groups can oppose or encourage violent behaviour or participation in criminal activities. In addition, peer groups can open up access to high-risk activities like alcohol or drug use, or membership in gangs (Dawes, 2003).

It is important to remember that all of these relationships are played out in the real world, and structures that should be supporting the child can be compromised. For example, Dawes (2003) found that in some communities there is a preponderance of single-parent families, where stress factors can be high and where, because the parent works long hours, there are long periods without parental supervision. This situation is being exacerbated by the high preponderance of deaths due to AIDS (Palmary & Moat, 2003). Moreover, the presence of other factors can also undermine the capacity of a family to support the child, including severe poverty, alcoholism or drug abuse in the home, and domestic violence or child abuse.

Schools can also be compromised. "Schools worst affected by violence are likely to be in such a state of dysfunction, and the staff so traumatised by violence themselves, that sophisticated interventions simply won't get off first base" (Dawes, 2003, p. 8). Moreover, the capacity of a school to provide support is curtailed when circumstances



Gun violence



force the child to leave school. On the one hand, domestic violence and child abuse can lead to frequent truancy. On the other, there can be a high dropout rate because of poverty, pregnancy, the illness of parents or the need to provide childcare for younger siblings (Palmary & Moat, 2003).

All of these factors play out in the broader community, where a child might be regularly exposed to violence. A key risk factor here is the presence of gangs. Recent studies argue that children living in areas where there is significant gang activity are exposed to a level of organised armed violence that approaches war (Dowdney, 2003). "Crime and banditry, urban gang-related violence and terrorism create environments in which youth are exposed to instability and physical danger and where communities face long-term consequences similar to those in wartime" (McIntyre & Weiss, 2003, p. 5). Moreover, gangs can be predatory in recruiting youth, mixing strategies of economic enticement with terror (McIntyre & Weiss, 2003).

In these circumstances guns can have a dramatic impact:

They can be used to threaten, coerce, or offer a sense of empowerment. More importantly, they can fuel the conflicts that keep violent groups in business, spur widespread displacement that can leave children vulnerable to recruitment and sustain local civilian demands for guns valued as hard currency (McIntyre & Weiss 2003, p. 5).

Cultural factors

Finally, we need seriously to consider the cultural factors that prompt youth to take up firearms; not only the messages conveyed on television and in arcade games, for example, but also those conveyed in our homes and on our streets. It is important to note that gun violence is highly gendered. Young men are the key perpetrators of gun violence. Moreover, although gun violence is most commonly perpetrated against other young men, it also spills over, intensifying the existing systemic violence against girls and women (Palmary & Moat, 2003).

Far more research needs to be done on the cultural messages being sent out about masculinity, indeed a complex issue given the diversity of South Africa culture and the variety of urban and rural settings in which different cultural messages are transmitted (Morrell, 2001). Still, messages must be sent out that challenge the perception that "when you carry a gun you feel like you are a human being" (Clacherty & Kistner, 2001, p. 13).

Youth strategies

Youth take up guns for a number of reasons. They obtain guns to engage in crime "to force people to give them money" (Clacherty & Kistner, 2001, p. 7). They obtain guns to solve problems, especially conflict. They obtain guns for self-defence, so that "people will listen to you and be scared of you" (Clacherty & Kister, 2001, pp. 11-12). Moreover, they obtain guns for status: not only for clothes or wealth, but also to win dignity and respect.





If we are to develop effective programmes, McIntyre and Weiss argue, we must stop seeing youth simply as victims, but also as “actors and decision makers in violent environments, responding to the pressures, opportunities, norms and values of their societies”(2003, p.3). We need to acknowledge that “children and youth, in their resourcefulness, develop survival strategies that make use of violence in accordance with the social, economic and political pressures and opportunities presented in their environments”(McIntyre & Weiss, 2003, p.3).

Both Masuku (2002) of the ISS, and Palmary and Moat (2002) of the Centre for the Study of Violence and Reconciliation offer excellent, comprehensive recommendations for preventing and combating violence and criminality among youth. These merit serious consideration. Of special note, Palmary and Moat raise the need to address the “demand triggers” - or why youth want guns. Gun Free South Africa’s work with youth - for example, through its Firearm Free Zones School Pilot Project and its ‘Youth and Guns’ workshops in schools - has indeed found that by recognising that young people are active decision makers, we can effectively challenge and change their behaviour.

WOMEN AND GUNS

Very little is known about the impact of gun violence on women. The Medical Research Council is due to publish a seminal work on femicide in 2004, which may bring us far closer to understanding this. However, while we await that publication, three points are worth raising here.

First, while guns kill far fewer women than men, firearms are the most significant weapon used in femicide. In 2001, for example, guns were used in 42% of the cases of femicide reviewed by the NIMSS (Matzopoulos, 2002).

Second, media reports indicate that firearms are commonly used in domestic violence. However, research is urgently needed to identify the incidence and the impact of firearms in domestic conflicts and domestic violence.

In 1999 the Medical Research Council surveyed women in three provinces in an investigation of violence against women (Jewkes & Abrahams, 2000). It found that one in ten of the women surveyed had experienced physical violence or had been threatened with a weapon within the 12-month period before the survey. The study concluded that there were 74 firearm-related incidents of domestic violence per 100 000 women aged 18-49 in the Eastern Cape, and 47 firearm-related incidents of domestic violence per 100 000 women aged 18-49 in Mpumalanga. It found that a quarter of all the weapons used in violent incidents were guns. This is ten times the incidence reported in the United States (Jewkes & Abrahams, 2000).

Unfortunately, it is not clear whether these findings reflect broader trends. Moreover, we need to look at not only the use of firearms in domestic violence, but also their impact on domestic violence. The simple presence of a gun in a home, for example, can generate fear and intimidation when there is conflict in domestic relationships. Discussions with community workers in Cape Town found that at least some women



whose partners threaten them with guns held back from seeking protection orders or reporting this to the police, until they were certain that the relationship could no longer be salvaged. It is not clear why - whether this is due to fear or concern for the partner. It would be ironic if silence in such cases was a survival strategy (Ashby, 2003). This illustrates the complexity of the issue and the need for specific research on the impact of guns on domestic violence.

Third, urgent attention needs to be given to the impact that gun-related deaths have on women survivors. Women, like everyone else, are exposed to gun violence in their communities and suffer similar symptoms. However, the most profound suffering is caused by the loss of a family member as a result of gun violence or by actually witnessing the death of a family member, especially a child. This, arguably, is unique in the depth of psychological stress it produces (see Box 2).

There are few long-term, public support services to help women recover from such incidents. This leads to long-term private suffering, which impairs the ability of the family and the surrounding community to cope with the rigours of daily life and survival. In many communities the number of women living with trauma is very high, and increases each time there is another shooting incident, compounding conflict and compromising the ability of the family to function as a supportive structure.

Box 2: Bereavement

Masnoena Isaacs lost her husband when he was shot in his shop in Valhalla Park in 1995. In 1996 her sister's daughter, to whom she was very close, was also murdered. "From being a fun-loving social person, she became listless and wouldn't go out. She left the creche she worked at because she was scared she would hurt the children there. She shouted a lot at her own children. 'It was as if a mountain had fallen around me,' she said. 'I lost my will. I just wanted to die.' In all this time she couldn't talk to anyone. It felt too overwhelming. 'I kept everything in for three years,' she said. She entertained thoughts of suicide. 'I wanted to throw myself under a train, but every time something stopped me. I just had to think about my children and what would happen to them.' However, unlike many other women, Mrs Isaacs had access to bereavement counselling at the Trauma Centre in Cape Town, which allowed her to heal" (Viall, 21 March 2000, p.6). In the experience of Gun Free South Africa, many hundreds if not thousands of women suffer similar trauma but do not have access to any long-term counselling or support .

This poses two urgent challenges. First, we need to know far more about how this kind of bereavement impacts on the social fabric of communities - particularly communities experiencing high levels of violence. Second, we need to look creatively at ways to address this problem - particularly given the central role that women play in supporting families and in community transformation. Programmes such as Family and Marriage Society of South Africa's (FAMSA) lay counsellor programme may begin to point the way.





CONCLUSION

The abuse of guns in South Africa has led to very high levels of violent crime and large numbers of deaths and injuries, as well as dysfunction at the family and community levels. It has diverted key resources from development and compromised service delivery. As a result, it constitutes a crisis area in any crime prevention strategy.

Urgent intervention is needed on at least three levels. First, there is a need to step up police interventions and to curb gun-related crime, as well as gang and interpersonal violence. Second, there is a need to implement the stricter licensing procedures required under the Firearms Control Act. This will reduce the possibility of guns being used negligently or in domestic violence. Third, there is an urgent need for effective public awareness campaigns:

- a) To convince gun-owning parents to abide by the law⁵ and handle guns responsibly;
- b) To explain to children and youth the real dangers that firearms pose; and
- c) To inform the victims and potential victims of gun violence about their rights under the law.

Public awareness campaigns should be run on the scale of Arrive Alive to ensure that the message seeps into the public consciousness.

However, while we need programmes that address gun violence, we also need programmes to address its root causes. In terms of this, we need to view programmes relating to gun violence as part of a more general response to crime and violence in South Africa. Ideally, these would consist of the kind of long-term, integrated, inter-departmental approaches prescribed by the National Crime Prevention Strategy.

The only department actively engaged in this issue at present is the police. The SAPS prioritises the reduction of illegal firearms in communities and has run important programmes to this end. These have included, for example, Operation Sethunya, implemented this year to bring in illegal guns and promote responsible gun ownership, and, since May 2001, the regular destruction of surplus, redundant and obsolete weapons. Since May 2001 the SAPS and the South African National Defence Force (SANDF) have destroyed 400 000 firearms, permanently removing them from circulation. The police are currently considering other options as well, such as amnesties.

The police also have the potential to improve gun control quite dramatically by strictly implementing the provisions of the new Firearms Control Act. The Act will require people who wish to apply for firearm licences to pass tests on how much they know about using firearms and how much they know about the law. This may reduce negligent firearm use and accidents that result from improper storage of firearms. It will also require the police to do background checks. If properly implemented, this might curtail the use of firearms in community and domestic violence.

⁵ A study by the SAPS Crime Information Analysis Centre on firearm theft between 1996 and 1998 found that of the case dockets studied, only 27% of the guns had been stored in a safe and 13% were being carried in a holster. The rest were stored, for example, in cupboards or cabinets, on beds, in drawers, in briefcases and in cars. The study is discussed in Chetty (2000).



However, while the police must be encouraged in these important efforts, we need to acknowledge that their operations deal with the immediate problem and cannot address the root causes of crime and violence (Masuku, 2002). This chapter has shown that gun violence is complex and pervasive, and requires a holistic approach on the part of government and civil society.

It is imperative that diverse government departments (especially the Departments of Health, Education and Welfare) adopt sectoral strategies for addressing gun violence - including broad public awareness campaigns and more narrowly targeted projects - and that these strategies be geared towards national, provincial and local action.

Moreover, they must be run in close partnership with civil society organisations, not only to achieve local buy-in, but also to ensure that we change mindsets which fuel the escalation of gun ownership and gun violence in our communities. This is critical if we are to respond effectively to the challenge that guns pose in our society.

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