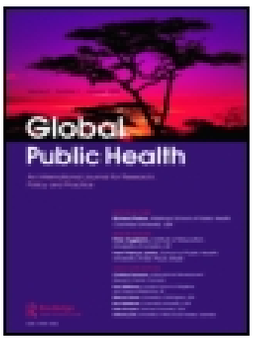

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Community perceptions of risk factors for interpersonal violence in townships in Cape Town, South Africa: A focus group study

Prestige Tatenda Makanga[a,b], Nadine Schuurman[a] and Ellen Randall[c]

[a]Department of Geography, Simon Fraser University, Burnaby, Canada; [b]Surveying and Geomatics Department, Midlands State University, Gweru, Zimbabwe; [c]School of Population and Public Health, University of British Columbia, Vancouver, Canada

ABSTRACT

Interpersonal violence is a major contributor to the burden of disease globally, and in South Africa, it is the leading cause of injury. There is an emerging consensus that the development of actionable policy and effective prevention strategies for interpersonal violence requires an understanding of the contextual matters that elevate risk for interpersonal violence. The objective of this study was to explore community perceptions of risks for interpersonal violence in five townships in Cape Town, South Africa, with high rates of violence. Focus group discussions were conducted with community members to identify key factors in that contributed to being either a perpetrator or victim of interpersonal violence. The ecological framework was used to classify the risk factors as occurring at individual, relationship, community or society levels. Some of the risk factors identified included alcohol abuse, poverty, informality of settlements and cultural norms. Differences in how each of these risk factors are expressed and experienced in the five communities are also elucidated. This approach enabled the collection of contextual community-based data that can complement conventional surveillance data in the development of relevant community-level strategies for interpersonal violence prevention.

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Interpersonal violence; community perceptions of risk; South Africa; Cape Town; focus group discussions

Introduction

Approximately 1.3 million people died in 2010 from injuries that resulted from self-harm and interpersonal violence (Lozano et al., 2012). Roughly 90% of all cases of interpersonal violence occur in low- and middle-income countries (Herbert, Hyder, Butchart, & Norton, 2011), with varying frequencies and risk factors among and within these countries (Andersson, Ho-Foster, Mitchell, Scheepers, & Goldstein, 2007). Globally, the total years of life lost (YLL) attributed to interpersonal violence increased by 31% between the period 1990–2010, and in 2010 interpersonal violence was among the leading causes of death for men aged 15–49 worldwide (Lozano et al., 2012). Understanding the underlying risk factors for interpersonal violence is foundational to the design of effective community-level prevention programmes. This exploratory descriptive study used

CONTACT Prestige Tatenda Makanga pmakanga@sfu.ca

focus groups to gather community-based intelligence from community members in five townships in Cape Town, South Africa, regarding local risk factors for interpersonal violence within their respective townships.

Interpersonal violence in South Africa

Interpersonal violence is the leading cause of injury in South Africa, and in 2000 had associated mortality rates seven times the global average (Norman, Matzopoulos, Groenewald, & Bradshaw, 2007). Mortality data show that most injury-related deaths in South Africa are due to interpersonal violence (Ward et al., 2012). Interpersonal violence results in 30% of injury-related disability adjusted life years (DALYs)[1] in South Africa (Figure 1) (WHO, 2012), and is the second leading cause of YLL among all disease burdens after unsafe sex (Norman et al., 2007, 2010).

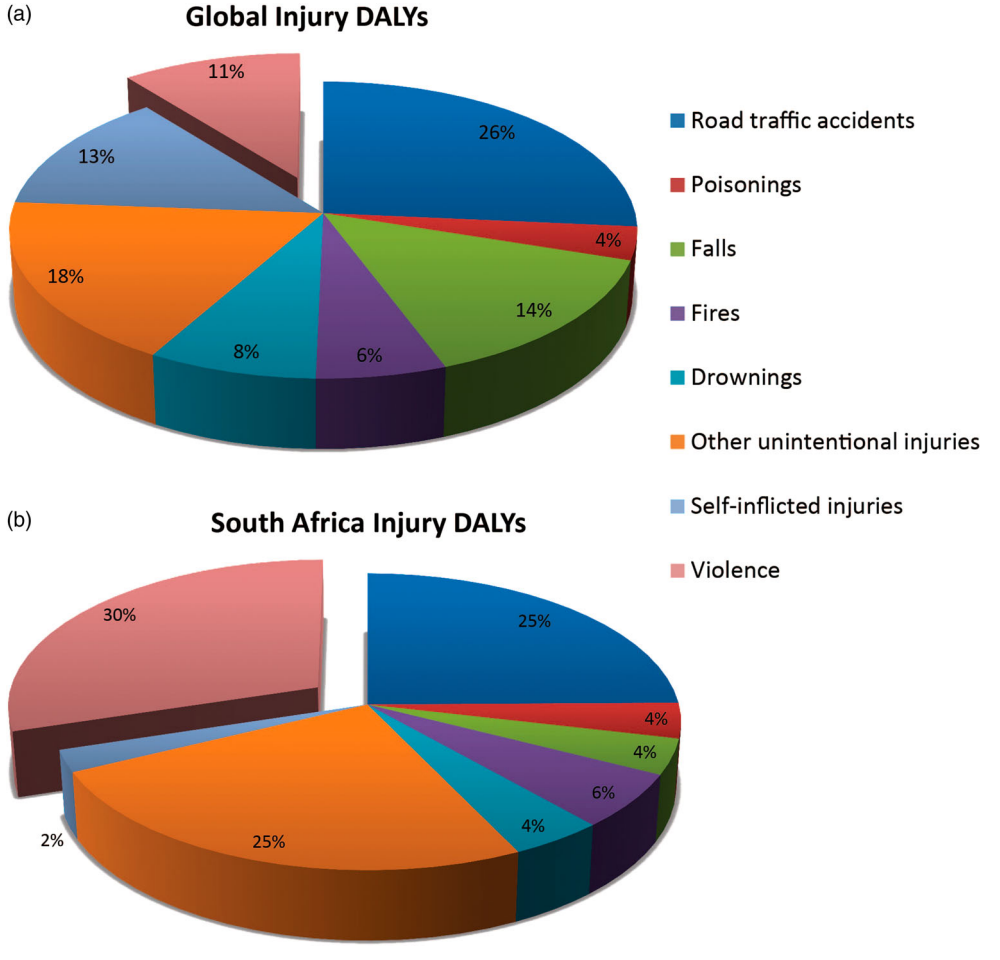

Figure 1. (a) Violence contributes 11% to the global burden of Injury expressed in DALYs; (b) violence contributes 30% to South Africa's burden of injury.
Source: WHO (2012).

The underlying determinants of the high level of violence in South Africa are rooted in an uneven socioeconomic landscape and a history of unequal access to social services and education across people of different incomes and races, particularly in urban South Africa (Doolan, Ehrlich, & Myer, 2007). More directly, violence has been associated with the nationwide ease of access to unlicensed fire arms, which has led to a high level of gun-related deaths (Baker, 2002), with close to 30% of homicides in the five major South African cities involving firearms (Matzopoulos, Thompson, & Myers, 2014). The use of firearms in homicides – while showing a decreasing trend since 2000 as a consequence of gun control efforts – is still high (Matzopoulos et al., 2014). Alcohol is highly implicated in violent assaults; in 2008, 54% of violent deaths among youths aged between 15 and 19 years were associated with high blood alcohol levels (Ramsoomar & Morojele, 2012).

South Africa has high rates of intimate partner violence (IPV), resulting in the death of a woman every six hours (Mathews et al., 2004). Most IPV is enacted by men against their female intimate partners. Patriarchal norms, rooted in male sexual entitlement, low social value of women and ideas of manhood linked to control of women, and a culture of violence linked to witnessing mothers being abused and beaten during childhood, are linked to male perpetration of violence against their intimate partners (Jewkes, Levin, & Penn-Kekana, 2002; Smithson, 2000; Ward et al., 2012). Sixty per cent of all violence experienced by women is attributable to IPV (Norman et al., 2007), and more than 60% of women who are victims of IPV have high blood alcohol content at the time of their deaths, as do the perpetrators (Mathews, Abrahams, Jewkes, Martin, & Lombard, 2009).

The public health approach to violence prevention consists of surveillance, risk definition, development of countermeasures, and implementation of a prevention programme (Krug, Mercy, Dahlberg, & Zwi, 2002). There is an emerging consensus that this approach has had somewhat limited success in translating surveillance data into policy that supports effective prevention of interpersonal violence (Feldbaum, Lee, & Michaud, 2010; Hyder et al., 2009; Shiffman, 2009). In addition, it has been recognised that researchers need to find means to better understand the actual contexts in which these risk factors act and interact to produce instances of interpersonal violence (Latta & Goodman, 2005; McClure et al., 2010; Peek-Asa & Casteel, 2010). This study sought to gain an understanding of how community members in five Cape Town townships experience and perceive risk for interpersonal violence in their communities. This understanding provides a basis for rational, evidence-informed, contextualised violence prevention efforts (Andersson et al., 2007; Baker, 2002).

Risk factors associated with interpersonal violence in Cape Town, South Africa

Alcohol and drugs have been clearly linked to violence in Cape Town, with victims of interpersonal violence more likely to test positive for alcohol than other injury victims (Kapp, 2008; Pitpitan et al., 2013; Plüddemann, Parry, Donson, & Sukhai, 2004; Watt et al., 2012). Govender, Matzopoulos, Makanga, and Corrigall (2012) found that 47% of trauma patients admitted to a Community Health Centre in Cape Town were under the influence of alcohol, and 87% of these patients were victims of interpersonal violence. Alcohol's effect in 'suppressing cognitive function' may leave people under its influence at higher risk of being victims of interpersonal violence (Matzopoulos, Bowman, Mathews, & Myers, 2010), as they may be less able to defend themselves or

recognise the perpetrators. Women who consume alcohol are at higher risk of being victims of IPV (Abrahams, Jewkes, Laubscher, & Hoffman, 2006), while men who abuse alcohol are more likely to be perpetrators of IPV than those who do not (Abrahams, Jewkes, Hoffman, & Laubsher, 2004; Dunkle et al., 2006). Alcohol use is further implicated in perpetration of violence. One study revealed that at least 25% of arrests for weapon-related offences in Cape Town were reported to involve alcohol (Parry, Plüddemann, Louw, & Leggett, 2004).

Victims of interpersonal violence in Cape Town are also more likely to test positive for drugs, either cannabis or crystal methamphetamine, than patients with other types of injuries (Parry et al., 2005). A cross-sectional study of women, married or cohabitating with male partners, revealed that physically abused women were 48 times more likely to have used cannabis in the year prior to their reported abuse than those who had not been physically abused (Gass, Stein, Williams, & Seedat, 2010). The use of methaqualone and cannabis has also been associated with gang violence in Cape Town (Kapp, 2008).

Childhood exposure to violence is an important predictor for violent behaviour (Narayan, Englund, Carlson, & Egeland, 2014). In 2004, 33% of children sampled from high schools in Cape Town had at some point witnessed family members being injured, beaten, or killed (Seedat, Nyamai, Njenga, Vythilingum, & Stein, 2004). Witnessing parental violence at home can lead to greater acceptance of violence in adulthood (Abrahams & Jewkes, 2005; Gupta et al., 2008; Pillay, Naidoo, & Lockhat, 1999). This normalisation may perpetuate violence between intimate partners (Gupta et al., 2008; Kerley, Xu, Sirisunyaluck, & Alley, 2010). Experiencing violence in schools has been shown as a risk factor for continuing to engage in violent behaviour during one's life-course, unless intervention is implemented to break this trajectory (Souverein, Ward, Visser, & Burton, in press). Sexual abuse during childhood and adolescence has been linked to violent behaviour and suicidal tendencies in later years (Brown et al., 2009; Krug et al., 2002).

South Africa is the most unequal country in the world (measured by the GINI index) based on 2011 statistics (Hodgson, 2012; Ortiz & Cummins, 2011). This is a legacy of the apartheid government which systematically excluded populations from economic opportunities, as well as spatially confining activity and place of residence based on race (Van Der Berg, 2011). Socioeconomic status in Cape Town follows a similar pattern of separation and the economic and geographic gaps are exceptionally great (Romanovsky & Gie, 2006). It has been shown that violence is strongly associated with socioeconomic status (Butchart, Phinney, Check, & Villaveces, 2004; Krug et al., 2002); the lower the household socioeconomic status, the higher the risk of violent crime (Norman et al., 2007). However, a more recent study suggests that the correlates for homicides are the average level of expenditure and the degree of inequality in expenditure, and maybe not poverty per se (Harris & Vermaak, 2015).

Social stressors that may elevate the risk of violence are often inter-related. Increase in cross-border immigration, for example, has been an important catalyst for xenophobic violence in South Africa (Matzopoulos et al., 2010). Immigrants living in particularly low-income neighbourhoods are at high risk of being victims of violence, especially if they appear to have better access to economic opportunities than local residents (Dodson, 2010). Community assaults are often a consequence of lack of community cohesion based on either socioeconomic or tribal differences (Norman et al., 2007).

Methods

To explore community members' perceptions of risk factors for interpersonal violence, focus group sessions were conducted in five Cape Town neighbourhoods with high rates of violent crime. Focus group sessions are an effective medium for gathering 'a multiplicity of views' on 'shared understandings of everyday life' (Gibbs, 1997), and allow for an exploration into the level of consensus amongst participants (Morgan & Krueger, 1993). We anticipated that the interaction between participants would help reveal community-level beliefs and values about the nature of interpersonal violence in their respective townships.

Ten candidate neighbourhoods were identified from a previous injury surveillance study (Schuurman et al., 2010). We approached the local police, community policing forums (CPF), which included community volunteers working in partnership with the local police, and community development forums that are responsible for community social development to generate a list of potential participants living in these communities. Employing a snowball sampling approach (Biernacki & Waldorf, 1981) to make use of the initial contacts' social networks, early contacts were asked to assist with further recruitment of suitable people within their communities. These criteria ensured that participants knew their communities well enough to engage in meaningful dialogue about local risk factors for violence. Five townships (Figure 2) were eventually selected from the 10, based on availability of participants during the timeframe of the study. According to the 2011 census (City of Cape Town, 2013) Khayelitsha, Gugulethu, Philippi and Samora Machel townships, all have close to 50% informal settlements (unplanned, unauthorised and/or illegal human settlements and areas where housing is not in compliance with current planning and building regulations of each of the Townships (WHO, 2015)), and almost 100% black residents. These are also low-income neighbourhoods

Figure 2. Focus group communities in Cape Town, South Africa.

with close to 75% of all inhabitants in these communities earning less than R3200 (approximately US$320) per month. Mitchell's Plain has close to 5% informal settlements and almost 100% of residents are of mixed race. 38% of income earners earned less that R3200 per month. The five townships account for approximately 990,000 (26%) of Cape Town residents.

A total of 36 community members participated across the five townships, with group sizes ranging from 6 to 11 participants. All participants had either Afrikaans or Xhosa as their first language, and English as a second. All participants were fully informed of the nature of the discussions beforehand and all consented to participate by signing an informed consent form. Ethics approval for this study was acquired from the Office of Research Ethics at Simon Fraser University. The composition of participants varied somewhat, but members of the CPF were present in each group. Other participants included local politicians, a school caretaker, operators of taverns, and a priest.

Focus group discussions (FGDs) were held at local community centres and lasted an hour to an hour and a half. They were moderated by PTM, and were audio recorded. A note taker was also present. Recordings were transcribed verbatim. The discussions were guided by an FGD guide that included questions on perceptions of community safety, risk factors for violence and solutions to reduce rates of interpersonal violence. In order to explore participants' views on risk factors for violence, we undertook a thematic analysis – allowing the data to drive the identification of key themes (Boyatzis, 1998). The initial set of themes were generated deductively from the transcripts by PTM as this author had a better understanding of the context of the FGDs. Data were imported into QSR's NVivo 10 and nodes were developed defining emergent themes. All authors reviewed the themes and the linkages between them. The themes were then summarised according to the ecological framework for interpersonal violence risk factors (Butchart et al., 2004). This framework categorises violence-related risk factors into four interacting levels: individual (personal history), personal relationships, community, and societal (structural influences, cultural norms).

Findings and discussion

The results are summarised in Figure 3 according to how each of the identified factors contributes to the likelihood of perpetration or being a victim of interpersonal violence. The different forms of violence that are linked to the risk factors are also shown in the illustration.

Risk factors associated with perpetration of interpersonal violence

Alcohol and drug use emerged as important determinants for interpersonal violence. Alcohol abuse was frequently reported as a catalyst for fights among acquaintances, and implicated in IPV and violence against children: '… people who are using alcohol, like spouses, they don't rest at home, and they create trouble. They beat children out of nothing' (G1). (G1 refers to Participant 1 in Gugulethu. The same convention is used to refer to all participants: P1, MP1, S1, K1 refer to the first participant in Philippi, Mitchel's Plain, Samora Machel and Khayelitsha, respectively). Participants described binge drinking as an acceptable, or at least expected, habit in some communities – a practice

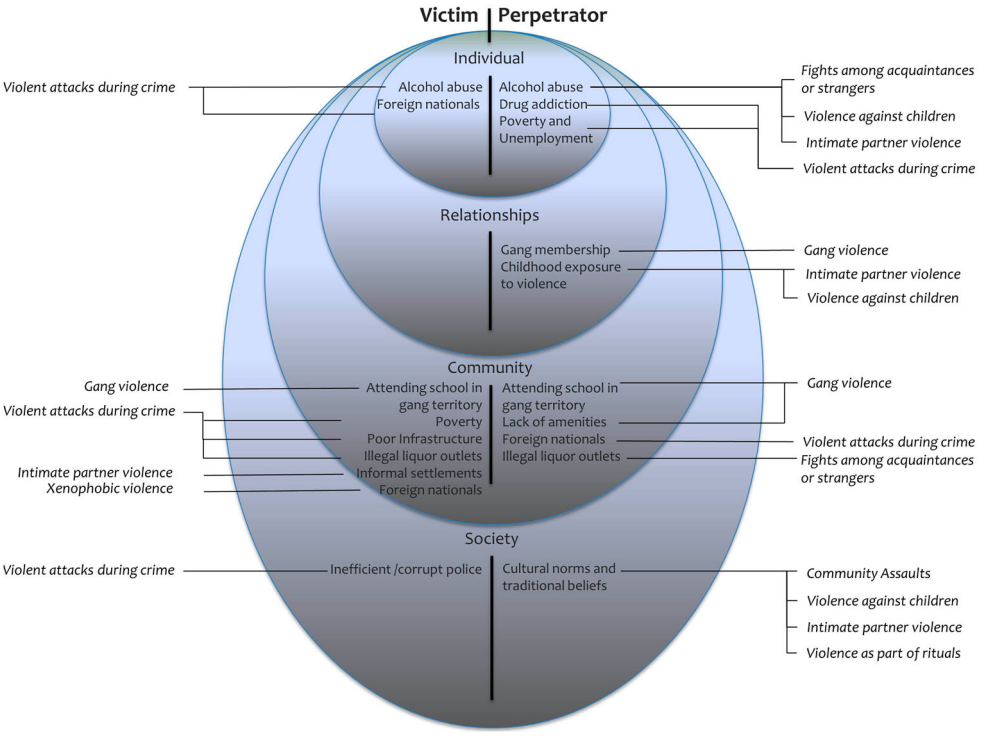

Figure 3. Summary of perceived risk factors for interpersonal violence.

passed on to youths under the age of 18. For example, 16th birthday parties were described as dominated by binge drinking, and subsequently being the sites of violent behaviour: '… most youngsters when they are drunk, they are still young, when they take about twenty beers in those small brains, they will fight' (K1).

Drug addicts were seen as likely perpetrators of violence, especially during commission of robberies to sustain their habits: '… our children when they have taken drugs, sometimes tik (crystal methamphetamine), or dagga (cannabis), because dagga is cheaper, they break into houses, and they stab one another' (K2). Individual poverty and unemployment were also identified as contributing factors, with lack of money often cited as a reason for resorting to alcohol and drugs (as a means of escape), and crime (as a means of earning money).

Personal relationships were described as microcosms in which violence was perpetrated, often condoned, and sometimes learned. Family violence (including IPV and violence against children) figured prominently in participants' accounts, as did descriptions of its general acceptance in the community: '… there is family violence, domestic violence and it's a family matter so no one can get involved, no police no nothing' (S1). Catalysts for this violence varied, but were often financial: '… she wants money and the husband doesn't give money because he was drunk then there was a quarrel' (MP2). Stressors included child support issues, jealousy, and overuse of alcohol. Family relationships were described as a means of learning violent behaviour: 'People who are using alcohol, they abuse children. And you know the children who stay here, begin to act the other way round' (G3).

Lack of amenities such as recreational facilities was seen as a catalyst for gangsterism and its associated violence: ' … first of all the cause of this, for instance gangsterism, it's a lack of activities, there is no infrastructure so they don't have something to do because of lack of infrastructure' (S2). Poor infrastructure was also perceived as facilitating violent crime, with lack of street lighting creating spaces for offenders to go unnoticed. Participants described the lack of a proper addressing system in informal settlements, as well as some formal areas, having the effect of slowing down police response and thereby promoting criminal behaviour.

Foreign nationals were considered an indirect cause of violence. Some foreign-owned informal businesses were said to have thrived on selling stolen goods, thereby encouraging locals to rob people in a quest to sell the stolen goods to these businesses: ' … one guy who is a foreign national, is buying these taps and giving R50 to these young boys and these young boys are running around our area and stealing these taps' (K4). This would sometime result in xenophobic violence against foreign nationals. In Khayelitsha violence by foreign nationals against other foreign nationals was also seen as a direct result of conflict around control of the informal economy. These key differences in how similar risks were prioritised and experienced highlights the value of developing community-level risk profiles, so that community leaders and policymakers can develop and prioritise interventions that resonate with how community members experience interpersonal violence.

Membership in gangs was seen as a key risk factor for the perpetration of violence. The effect of the closely intertwined drug and gang cultures permeated the schools, even at the primary level: 'There are gangsters at schools from the primary schools up to the high schools' (K3). Participants described children taking drugs as early as age eight years in Mitchell's Plain, and this combination of drug use and gang culture amongst school-age children was seen as the catalyst for outbreaks of fights between pupils belonging to different gangs. Gang members often sought mastery through use of threat and violence:

> The gang rises because 'I want to be masterman or lady because in my house my father is, so I come to school and I put my anger up. Then I got those under me that are very scared of me and I tell them what to do'. (MP1)

Illegal liquor outlets were described as hotspots for violence. Fighting was perceived as a major cause of violent injuries in illegal liquor outlets, and the inherent lack of security associated with these establishments did little to deter:

> … when people are consuming liquor, you find that they are fighting in shebeens (illegal liquor outlets), because their safety is not priority number 1. Nobody is sitting there at the gate and making sure that you are not bringing a knife or gun inside. (K5)

While some illegal liquor outlet owners that participated in the FGDs were keen to participate in ending violence, they were reluctant to embrace interventions aimed at reducing access to liquor, as this would have a negative impact on their livelihoods. 'Blame the drinker not the seller' was a sentiment repeatedly echoed in the FGDs. While there is evidence from international studies that reducing access to liquor reduces alcohol-related violence (Anderson, Chisholm, & Fuhr, 2009; Livingston et al., 2007), if a community does not accept an intervention, it becomes more difficult to implement (Latta & Goodman, 2005).

Violence was also somewhat socially acceptable. In Gugulethu, for example, community assaults were seen by some as an acceptable way of dealing with community offenders. Men's domination in society is accepted as a cultural norm, which is being threatened by modernisation and urbanisation. Participants indicated that the traditional role of the woman is in the home, but due to economic pressures women are now also working outside the home:

> You know we have been brought up in a situation whereby we know the man is the head of the family, and now nowadays, vice versa, where women are the most powerful ones now, getting the more powerful jobs than their male counterparts, and that also can create unnecessary problems. (K6)

The imbalances resulting from women having less time to fulfil their domestic obligations were perceived by men in the Khayelitsha group as cause for IPV. Cultural perceptions of masculinity that promote male dominance and social norms that condone violence by men against women (Jewkes et al., 2002) could thus be drivers for IPV. On the contrary, there is evidence from Bangladesh to suggest that communities with women who are increasingly realising their rights and have active roles outside the home working in formal jobs tend to experience declining rates of IPV (Schuler, Lenzi, Nazneen, & Bates, 2013). Therefore there is need for further exploration of this tension between the dominance of men in society, the rights and freedoms of women, and the implication of both on IPV in the South African context.

Inefficient and corrupt police was described as a contributing factor to violent crime. Participants cited delays in responding, 'You will call the police, they take about two to three hours to come whereas people are crying at home' (G6), and apathy: ' … sometimes they [police] don't care, sometimes they undermine the area' (G7). Further, in some focus groups, participants claimed that members of the police force secretly ran illegal liquor outlets. This suggested that efforts to reduce the negative effect of illegal liquor outlets were hampered by the police themselves. There were mixed views on the contribution that police made to patrol the streets: some claimed they felt unsafe because the police are largely absent from the streets, while some felt unsafe whenever the police were present because of police brutality.

Risk factors associated with being a victim of interpersonal violence

While foreign nationals were viewed as likely perpetrators of violence, being a foreign national was also described as a risk factor for being a victim of interpersonal violence. Many foreign nationals lived in the townships because 'it is more affordable for those who don't have much to live by' (P1). In Philippi, however, these individuals were seen as vulnerable to violence 'because of attitudes amongst us as community members' (P2) and because they 'can easily be identified' (P3).

Poverty at the community level was viewed as an overarching spatial risk factor for interpersonal violence. Participants felt that risk for violence was higher in sections of the communities that were deemed the poorest – those associated with lower incomes and poorer infrastructure. Fighting was reported as being prevalent within the vicinity of illegal liquor outlets. People who had purchased alcohol were described as being at risk of violent assaults from thieves as they made their way home.

Living in informal settlements was seen as leaving one at higher risk of experiencing violence. People in informal settlements are more likely to live far away from public transport; the longer the distance people had to travel at night, the more likely they were to be victims of violent assaults. As a consequence, some participants desired upgrading and integrating former informal settlement dwellers into formalised settings. However, without an increase in their income it was also perceived that this transition could serve as a catalyst for robberies and burglaries and, as a consequence, the violence that often accompanies theft. Others noted that after upgrading the informal settlement in Freedom Park, there was a rapid increase in IPV even though gang violence reduced significantly. The complex interplay between structural or social determinants, and the day-to-day lives of these participants was thus apparent in this issue of informal settlements. The root cause of informal settlements is multidimensional and lacks a simple linear solution (Abbott, 2002; Pieterse, 2008). However, Bauer (2010) gives examples of initiatives for upgrading informal settlements in Khayelitsha, which resulted in a 30% reduction of violent crime.

The reported lowering of gang violence in Freedom Park is also a testament to the impact of upgrading informal settlements. However, the higher visibility of domestic violence following formalisation of settlements possibly indicates that interpersonal violence may have simply become more apparent, after addressing the spatial risk brought about by informality of settlements. Thus living in an informal settlement is likely not a direct cause of IPV but rather of more pervasive factors including patriarchy as a social norm (Jewkes et al., 2002) and the general cultural acceptance of violence as part of conflict resolution.

Another possible explanation for increase in IPV could be linked to the privatisation of housing space as a result of upgrading informal settlements. Previous research has shown that as violence occurs less in public spaces it will likely become more privatised for the same populations (Cooney, 2003). Privatisation of space has been shown to potentially diminish social cohesion in a manner that leaves communities less able to combat violence through the informal community structures and social networks that existed when the community was still largely informal (Brown-Luthango, 2015; Seekings, Jooste, Muyeba, Coqui, & Russell, 2010). This social cohesion is an important protective factor against the occurrence of IPV (Brown-Luthango, 2015). The implication for urban upgrading programmes is that they would likely need to be complemented by other parallel interventions aimed at strengthening the pre-existing informal social structures that promote social accountability.

In general, while participants tended to concentrate on proximal risks, the set of factors that emerged from these sessions hinted at the intricate web of influences that interact to generate risk. A sense of this interconnectedness was apparent as participants described stressors at the individual level that were a function of broader societal determinants and individual behaviours rooted in social and cultural norms. For example, many of the identified risk factors were predicated on, or related to, systemic poverty. While poverty is a determinant of interpersonal violence (Linos & Kawachi, 2011), the descriptions of poverty within these communities offer a nuanced, contextualised understanding of how poverty influences risk for interpersonal violence at different levels. For example, the data showed that, at individual and relationship levels, poverty as a consequence of unemployment can act as a stressor and trigger for family violence. At the community

level, impoverished neighbourhoods were seen to represent a heightened risk for encountering violence. At a societal level, structural inequalities were described as fostering tension between populations with varying income and means.

This study's process of going to the community to gather data and input on the risks for interpersonal violence revealed how these risk factors are enacted within these townships. The findings revealed that, while there was a strong commonality in identified risks across the five townships, individual communities differently experienced and prioritised some of the risks. Incorporating the community perspective into a community risk profile could prove a considerable asset for public health and community leaders charged with developing preventive interventions to reduce interpersonal violence (Latta & Goodman, 2005). It also encourages community buy-in: being invested in the problem definition and problem resolution can be a powerful facilitator to acceptance of societal change.

The limitations of this study's approach of using FGDs have been documented by (Smithson, 2000) and include a suppression of participants view points by dominant voices in the group, and 'a tendency to move towards normative discourses', which makes it challenging to tease out new knowledge. Specifically, there was a relative lack of attention on the part of the FGD participants to IPV. There are several possible explanations for this including: (1) we did not ask specifically about it; (2) this type of violence is relatively common in the informal settlements and may be subsumed into more general discussions of inter-personal violence; and (3) the mix of genders in the FGDs could have reproduced the patriarchal structures in society thereby suppressing the voices of women on the topic of IPV. Therefore, despite the nuanced understanding of the perceived risk factors, the findings may still not represent a completely unbiased picture of the situation on the ground.

Conclusion

This study used focus groups to elicit community perceptions of risk factors for interpersonal violence in five townships in Cape Town. Participants' responses revealed that, while risk for interpersonal violence can be enacted at multiple levels, their principal concern lay with the immediate factors that affected their daily lives – those that would, in turn, lend themselves to community-level preventive interventions. While more distal societal factors continue to pose long term challenges for policymakers, in the shorter term, the ability to delineate the risk profile for a given township – validated by its community members – will aid community leaders in prioritising community-level interventions that will resonate with their residents, ranging from the introduction of recreational programmes to the zoning of illegal liquor outlets. Incorporating community voices into prevention planning will contribute to the ongoing community-based discourse on action against violence, and enable local-level identification of both general and specific determinants of interpersonal violence.

Note

1. A DALY is a composite burden of disease measure combining YLL and years lives with disability.

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