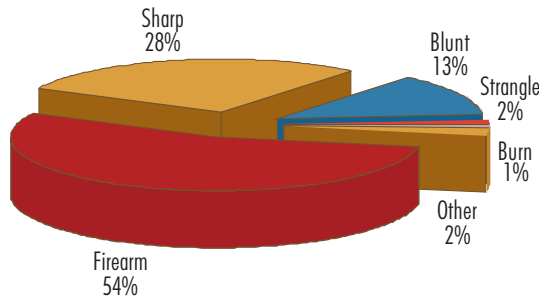


CHAPTER 5. HOMICIDE

Compiled by Christine Harris and Ashley van Niekerk

Among homicides, roughly half the victims died from firearms, one-third from sharp instruments and a further one-tenth from blunt objects (Figure 10).

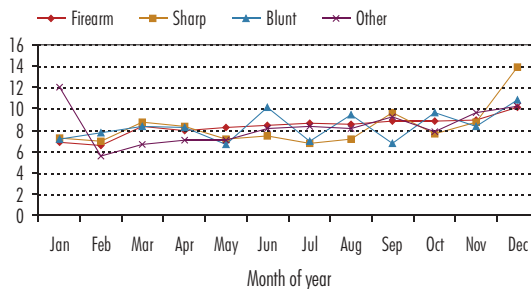
Figure 10. Homicide: external causes, 2001 (N = 11 254).



5.1 HOMICIDE: SEASONAL TRENDS

In 2001 firearm homicides were highest in December (10.1%) and lowest in January (6.9%) and February (6.6%), whereas the rest of the year was consistent at about 8.0%. Sharp object homicides peaked in September (9.6%) and December (13.9%), while blunt object homicides peaked in June (10.1%) and December (10.8%). The December holiday period saw a rise in the three main external causes of homicidal death.

Figure 11. Homicide: leading external causes by month of death, 2001 (N = 11 195).



5.2 HOMICIDE: EXTERNAL CAUSES BY SEX

Firearm homicides followed by sharp object homicides predominated for both males and females. However, the percentages as well as the numbers were much higher in males than in females. Table V shows that overall, there were about 7 male homi-

cide victims for every female victim, and males accounted for 87.0% of all homicides. Higher percentages of blunt object homicide, strangulation and burns were found among females. This combined 'female vulnerable' group had a statistically higher percentage of cases than males ($\chi^2=147.85$ and $P<0.001$).

Table V. Homicide: external causes by sex, 2001 (N = 11 163).

	Male	Female	M:F ratio
Firearm	5477 (56.5)	627 (42.9)	8.7 : 1
Sharp	2818 (29.1)	350 (23.9)	8.0 : 1
Blunt	1138 (11.7)	276 (18.9)	4.1 : 1
Strangle	74 (0.8)	110 (7.5)	0.7 : 1
Burn	34 (0.4)	21 (1.4)	1.6 : 1
Other	159 (1.6)	79 (5.4)	2.0 : 1
TOTAL	9700	1463	6.6 : 1

5.3 HOMICIDE: EXTERNAL CAUSES BY POPULATION GROUP

Although the highest percentage of sharp object homicides was found among Coloureds (see section 1.6 - Terminology) for the first time since 1999, firearms were the leading external cause of homicide. Table VI shows that firearms followed by sharp objects were the major causes of homicidal death among Asians, Africans and Coloureds. Asians followed by Whites recorded the highest percentages of homicide due to firearm, with approximately two-thirds of all homicides due to these weapons. The percentage of blunt object homicides was highest among Whites, and second most common cause of homicidal death among this group. Relatively high percentages of strangulation were found among both Asians and Whites, and since most of these victims were females this may suggest Asian and White female vulnerability to this form of abuse.

Table VI. Homicide: external causes by population group, 2001 (N = 11 169).

	Asian	African	Coloured	White
Firearm	130 (67.0)	5034 (56.5)	639 (41.2)	310 (60.3)
Sharp	34 (17.5)	2431 (27.3)	632 (40.7)	76 (14.8)
Blunt	16 (8.2)	1092 (12.3)	224 (14.4)	82 (16.1)
Strangle	8 (4.1)	113 (1.3)	28 (1.8)	32 (6.2)
Burn	2 (1.0)	48 (0.5)	4 (0.3)	2 (0.4)
Other	4 (2.1)	192 (2.1)	24 (1.5)	11 (2.1)
TOTAL	194	8910	1551	514

5.4 HOMICIDE:

EXTERNAL CAUSES BY AGE

Most firearm homicides (58.7%) fell into the combined age group of 20-34 years. Firearms were the major cause of death among children aged 10-14 years (see Table IV) and accounted for 48.3% of all homicides in this age group. Sharp object homicides accounted for 36.6% of homicides in the 15-19-year age group - a higher percentage than for any other age group. Blunt object homicides and strangulations were most common in the older age groups. The largest single cause of homicide in the 60-64-year age group was blunt objects (29.4%). Although in total there were few strangulations, large percentages were recorded in the vulnerable groups of 1-4 and 65+ years. Figures 12a to 12f show the age distribution for the main external causes of homicide.

The highest percentage of homicidal burn victims was in the age group 20-24, this group accounting for over one-quarter (26.1%) of all homicidal burns.

Figure 12a. Firearm homicide by age, 2001

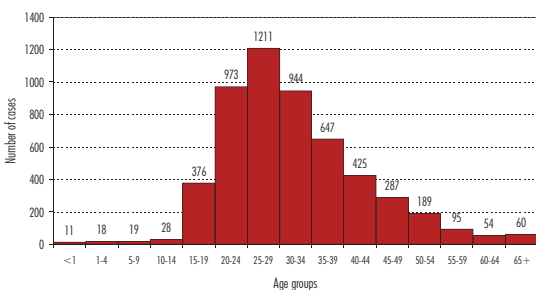


Figure 12b. Sharp homicide by age, 2001

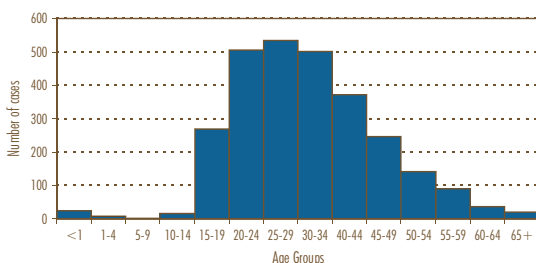


Figure 12c. Blunt homicide by age, 2001

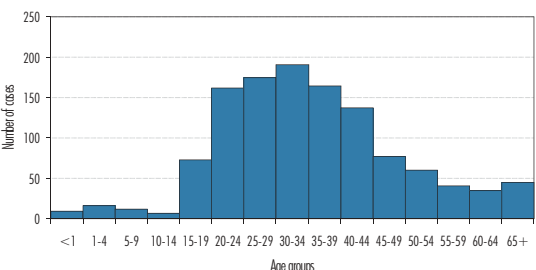


Figure 12d. Strangulation by age, 2001

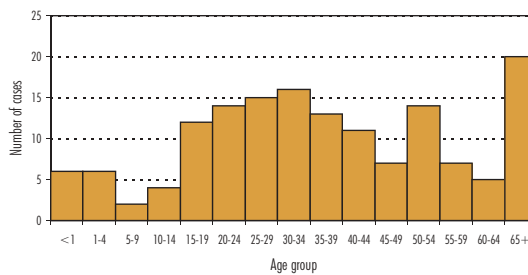


Figure 12e. Homicidal burns by age, 2001

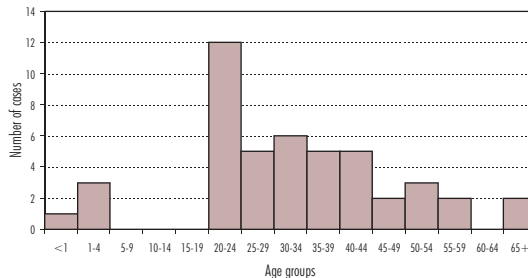
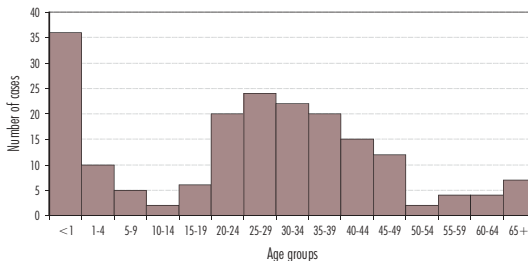


Figure 12f. Other homicide by age, 2001

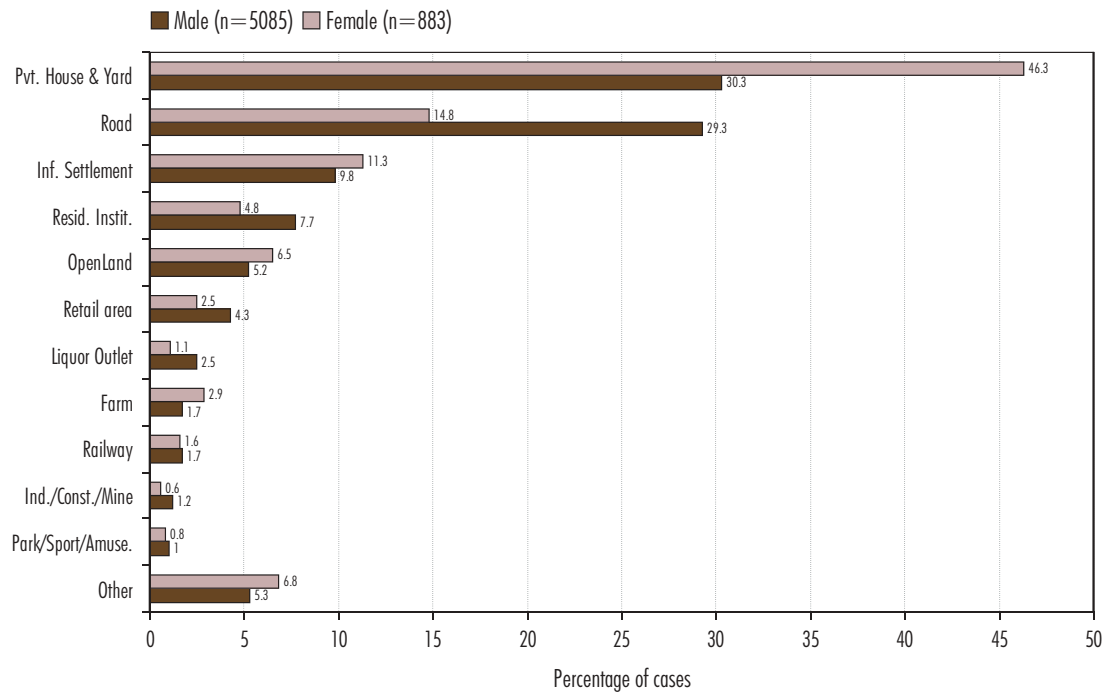


5.5 HOMICIDE:

SCENE OF INJURY BY SEX

For both females and males, most injuries occurred within the confines of a home followed by injuries on the road (Figure 13). Females, had a higher percentage of injuries in and around the home compared to males, while the opposite was true for injuries that occurred on the road or pavement. With the next four big categories, more females were injured in informal settlements and on open land, whereas more males were injured in residential institutions and retail areas.

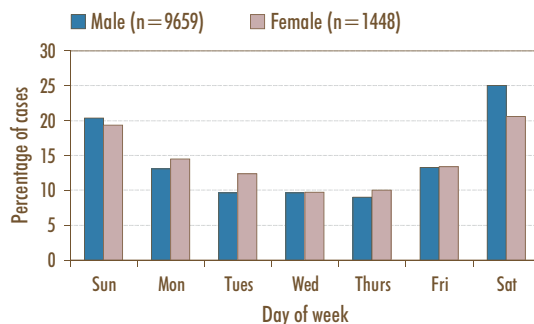
Figure 13. Homicide: scene of injury by sex, 2001 (N = 5968).



5.6 HOMICIDE: DAY AND TIME OF DEATH DAY

For males and females the highest percentage of homicides occurred on a Saturday followed by a Sunday (Figure 14). The percentages for these days were, however, higher among males - 45.4% of male cases occurred over the weekend (Saturday and Sunday), while 40.0% of female cases did. Females had a higher percentage of homicides on all days except during the weekends. The largest variation in the percentage of homicides for the two sexes was on a Saturday (males had 5.4% more cases) and on a Tuesday (females had 2.8% more cases).

Figure 14. Homicide: day of death by sex, 2001 (N = 11 107).



TIME

Female homicides rose sharply from 19h00, peaked at 20h00 and had elevated levels until 23h00. This four-hour period accounted for 23.0% of female

homicides. Male homicides peaked at 21h00 (7.0% of all male homicides), and the 3-hour period from 20h00 to 23h00 accounted for 26.7% of male homicides. During mid-morning female homicides peaked again at 09h00.

5.7 HOMICIDE AND BLOOD ALCOHOL CONCENTRATION

Blood alcohol concentrations (BAC) were available for 4706 (41.8%) of the homicide victims. Figure 16 shows that 52.9% of homicide cases were alcohol-related, with 89.1% of alcohol-positive cases at or above 0.05g/ 100 ml (the legal limit for driving and hence a proxy measure for impaired judgement)

Figure 15. Homicide: time of death by sex, 2001 (N = 9400).

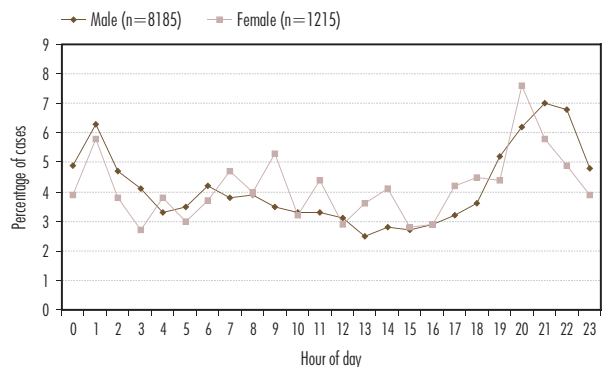
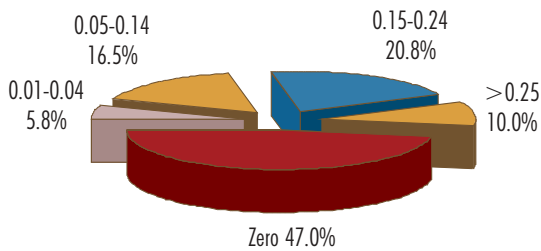


Figure 16. Homicide: percentage of deaths by blood alcohol concentration, 2001 (N = 4706)

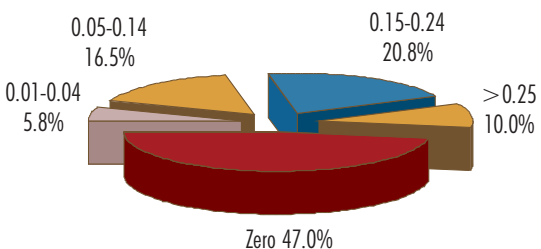


The highest alcohol-relatedness (76.7%) was found among sharp object homicides (Table VII). Most of these cases had elevated levels - 93.2% of the positive cases had levels greater than or equal to 0.05 g/100 ml. Over half the blunt object homicides and nearly 40% of burn and firearm homicide cases were alcohol-related. About one-third of strangulation cases were alcohol-positive, which was also the lowest percentage of alcohol-positivity among all categories of homicide.

Table VII. Homicide: blood alcohol concentration by external cause of death, 2001 (N = 4706).

	Zero	0.01-0.04	0.05-0.14	0.15-0.24	>0.25	Total	Mean positive BAC (+ - Std dev.)
Firearm	1559 (60.4)	151 (5.9)	400 (15.5)	360 (13.9)	111 (4.3)	2581	0.14 (0.08)
Sharp	364 (23.3)	81 (5.2)	290 (18.6)	527 (33.7)	301 (19.3)	1563	0.19 (0.09)
Blunt	207 (48.6)	31 (7.3)	73 (17.1)	71 (16.7)	44 (10.3)	426	0.16 (0.1)
Strangle	42 (64.6)	2 (3.1)	4 (6.2)	10 (15.4)	7 (10.8)	65	0.19 (0.09)
Burn	8 (61.5)	1 (7.7)	1 (7.7)	2 (15.4)	1 (7.7)	13	0.16 (0.1)
Other	34 (58.6)	5 (8.6)	7 (12.1)	7 (12.1)	5 (8.6)	58	0.16 (0.12)
All homicide	2214 (47.0)	271 (5.8)	775 (16.5)	977 (20.8)	469 (10.0)	4706	0.17 (0.09)

Figure 16. Homicide: percentage of deaths by blood alcohol concentration, 2001(n=4706)



5.8 HOMICIDE: IMPLICATIONS FOR PREVENTION

This report indicates that homicide remains the most significant contributor to non-natural mortality in South Africa. In the following section we examine some of the implications for the formulation of injury prevention policies and strategies. While focused areas of intervention are required to address the results presented, this report, consistent with international norms proposed for example by the WHO, asserts that a multi-faceted and holistic approach is needed to address the massive public health threats posed by interpersonal violence.

FIREARMS AND SHARP OBJECTS

More than half (54.7%) the homicides were perpetrated with a firearm, while 28.3% were caused by sharp objects. While there is an array of strategies for preventing interpersonal violence, very few of these have been rigorously evaluated. A number of intervention types have been proposed with some support over the years. It has been asserted that the most effective homicide reduction strategies include co-ordinated combinations of legislative, environmental, engineering, educational and social responses.

With the sweeping policy and legislative reforms of the 1990s, there has been a considerable recent focus on the development and implementation of appropriate legislation to control access to and use of firearms, and the prioritisation of enforcement measures to ensure compliance. Legislation regarding the carrying of sharp objects should also be enforced more rigorously. In addition, public and educational campaigns are asserted by a range of sectors and agencies as integral components to long-term violence prevention initiatives. Community development, social support, home visitation, parenting, safe schools, and mentoring programmes are all potential good practice interventions for inclusion in national, provincial, city, or neighbourhood violence prevention interventions.⁵

DAY, TIME, SEASONAL TRENDS AND ALCOHOL

As expected, the NIMSS has identified clear cyclical trends to the occurrence of homicides. These are most prevalent over the Easter, July and Christmas holiday periods, and occur primarily after working hours and over weekends. Alcohol consumption is much higher during these periods and has been implicated as a key contributor to the homicide rate. Considering this relationship, the Lead Programme, along with other agencies, has proposed that combinations of legislative control, social development programmes and education be promoted to manage the contribution of alcohol consumption to interpersonal violence, especially over high-risk periods.

SEX

The NIMSS findings indicate female vulnerability to strangulation, blunt object and burn homicides. Although victim-perpetrator information is not currently available (available approximately 2 years after the fatal incident), previous studies have shown that perpetrators are usually male. The above is consistent with national concerns about women abuse and domestic violence. For every female murdered with a firearm, it is estimated that there are thousands who are constantly threatened and live in fear and terror. In this context, the support and expansion of women's groups are emphasised.

⁵ Borrmann E, van Eeden R, Wentzel M. 1998. Violence in South Africa: a variety of perspectives. Pretoria: Human Sciences Research Council.

It is proposed that the infrastructure of medico-legal services including the associated criminal justice agencies for victims of abuse and rape be strengthened to prevent repetitive incidents of crime.

POPULATION GROUP

The identification of injury profiles according to racial group may facilitate the identification of appropriate interventions for different settings and communities. Firearms followed by sharp objects were the major causes of homicidal death among all Asians, Africans and Coloureds, while firearms and blunt objects were the major causes of death for the White victims. As indicated earlier, a comprehensive approach to homicide prevention has received wide support and ideally should include broader socio-economic and structural interventions to those that are more community and neighbourhood specific, including social support, home visitation, parenting programmes and so on.

AGE

The NIMSS data have also identified a relatively high percentage of child homicide victims (10.1%) under the age of 20. The literature indicates that child victimisation results from the complex combination of the perpetrator's biological, psychological, educational and social attributes. South African research into the identification of these determinants is a priority. In addition to the society- and community-wide approaches, a number of interventions prioritising the protection of children include social support for families in distress, home visitation interventions, parenting programmes, peer-support, and mentorship initiatives.

SCENE

Much of South Africa continues to be marked by inadequate basic infrastructure, e.g. housing, street lighting, electricity and demarcated leisure areas, the absence of which is asserted to increase the individual's risk of victimisation, especially among vulnerable groups. Adequate crime prevention

through environmental design (CPTED) measures are also suggested to reduce the opportunity and motive for crime, at the same time protecting and reducing the vulnerability of potential victims. Concurrently, the social environment in high-risk areas needs to be modified to encourage societal harmony through active youth and other recreational programmes. Law enforcement should also take cognisance of the different types of crime in different suburbs - the wealthy are more often the victims of property crime, while violent crime dominates among the poor.⁶

SCENE BY SEX

The finding that females are more likely to be assaulted in the home may be indicative of the contribution of domestic conflict and stress. Potential public health interventions range from legislation to criminalise intimate partner abuse to educational programmes on gender and power relations in schools.

CONCLUSION

While the above concentrates on focused areas of intervention, one must appreciate that a multi-faceted and holistic approach is needed to address the foundational issues of crime and violence. The first step using the public health model would be to define the nature, extent and profile of the problem, and therefore on-going surveillance studies in conjunction with victimisation studies are crucial. Appropriate interventions should be pilot-tested and evaluated on an on-going basis. Priority should be given to addressing the macro-level contributors to homicide rates, such as housing, water, electricity, employment, land, and health care. Education to prevent and control homicide should be directed as widely as possible, e.g. to classrooms, work-sites, recreational areas, youth programmes, medical treatment areas and the media. To obtain a concerted effort, active co-operation is needed from individual, private and public sectors of the community.

⁶ Suffla S, Seedat M & Nascimento A. 2002. A qualitative evaluation of medico-legal services in Gauteng, South Africa: Service accessibility and quality of care. *African Safety Promotion: A Journal of Injury and Violence Prevention* 1(1): 24-36.