

“Action for a Sober South Africa”

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Crime in South Africa

Of the approximately 2.1 million cases of crime reported in South Africa between April 2007 and March 2008, “contact” crimes (murder, attempted murder, rape, assault with intent to inflict grievous bodily harm, common assault, indecent assault, aggravated robbery, and other robbery) accounted for 33% of all crimes. While the incidence of all contact crimes showed a decrease between 2007/8 as compared to 2006/7, the incidence of violent crime remains unacceptably high. For example, the annual murder rate per 100 000 for South Africa is 39 per 100 000, ranking 7th highest out of 117 countries for which data are currently available (Wikipedia, 2008).

Alcohol and the associated burden in South Africa

It has been estimated that the annual per capita consumption of alcohol in South Africa is between 10.3 and 12.4 litres, with the higher level reflecting the amount including homebrewed alcohol (Rehm et al., 2004). According to the World Health Organization (2002), 45% of men and 70% of women in Afro Region E (which includes countries like Ethiopia and South Africa) abstain from drinking alcohol. Therefore, while consumption per adult is only 7.1 litres of pure alcohol per year in this region, consumption per drinker is 16.7 litres per year (Rehm et al., 2003). It has been estimated that per capita consumption amongst drinkers in South Africa is likely to be even higher than the regional average (Parry, 2005). This gives South Africa one of the highest levels of alcohol consumption per drinker anywhere in the world (Rehm et al., 2004).

According to the World Health Organization (2002), in 2000 the global burden of alcohol in terms of death and disability was between 1.6% (for high-mortality developing countries) and 9.2% (for developed regions) of total disability adjusted life years lost (DALYs), accounting for 4.5 billion years lost. While South Africa is a high mortality, developing country, it has recently been calculated that alcohol-related harm accounted for 7.1% of all deaths and 7.0% of DALYs in this country in 2000, resulting in 1.1 million life years lost in that year (Schneider, Norman, Parry, et al., 2007). Alcohol was the third largest contributor to death and disability after unsafe sex/sexually transmitted infections and interpersonal violence. The three largest contributors to the burden specifically related to alcohol included homicide and violence (40% of alcohol’s burden), alcohol use disorders (15%) and road traffic injuries (15%).

Alcohol's role in violence and crime: International perspective

Various categories of criminal behaviour have been identified as having alcohol links such as drinking and driving, homicide, domestic violence, other assaults, sexual violence, and child abuse. A strong link between alcohol use, crime and violence has been established by meta-analysis, with between a quarter and half of homicides or purposeful injuries having been shown to be attributable directly to alcohol use (English et al., 1995; Schultz & Rice, 1991; Single et al., 1998). McClelland & Teplin (2001) directly observed 2365 police-citizen encounters in the USA. Overall, 34% of these encounters were judged to be alcohol-involved, with the following percentages of alcohol involvement reported: violent crime and sexual assault (43%), spousal assault (43%), robbery (39%), public order/vandalism (46%), and other non-violent encounters (23%).

Alcohol is viewed as playing a role in violence and crime in a number of ways, and Graham et al. (1998) have specifically put forward various mechanisms for how this might occur: (i) societal and cultural attitudes, explanations and norms which influence how drinking, drunkenness and the effect of alcohol on behaviour are framed within different societies, (ii) “person factors”, for example, personalities predisposed to aggression may also be those who are inclined to drink heavily, (iii) the pharmacological effects of alcohol itself may include the suppression of various neurotransmitters that would normally inhibit aggression by causing anxiety or fear, (iv) specific drinking contexts which might inhibit or encourage the occurrence of a criminal act or injury, and (v) the interaction of these factors.

Data on the alcohol-crime/injury nexus in South Africa

Over the past 10 to 12 years there has been a wealth of research coming out of South Africa indicating a very strong association between alcohol, crime, violence, and injury:

- The link between alcohol and shebeens and violence (especially murder) was identified in a study undertaken by the South African Police Service in the Western Cape in 1996. Among other things, it was reported that in 64% of cases in which the motive was known, and in 24% of cases in which the circumstances surrounding the murder were known, the crime had been committed after an argument and/or during a fight at or near a shebeen in which alcohol was involved (South African Police Service, 1997).
- In 1997 the Institute for Security Studies reported on the results of research into alcohol and violence conducted in the Northern Cape showing that alcohol was linked with violence, particularly child abuse and rape, and the role of shebeens in the commission of violence was outlined in some detail (Shaw & Louw, 1997).
- A study on the relationship between alcohol use and specific crimes was carried out by the Medical Research Council and the Institute for Security Studies in Cape Town, Durban and Johannesburg in three phases between 1999 and 2000 (Parry et al., 2004). The main focus of this research was the link between drug use and crime, but arrestees in the three cities were also asked whether they were under the influence of alcohol at the time that the alleged crime took place. Overall, for 15% of the alleged crimes, arrestees indicated that they had been under the influence of alcohol. Regarding violent offences, arrestees indicated that they were under the influence of alcohol for 25% of weapons-related offences, 22% of rapes, 17% of murders, 14% of assault cases and 10% of robberies. Levels of alcohol-related crime were particularly high for family violence offences at 49%. Arrestees also indicated that they were often under the influence of alcohol in cases involving property offences, for example, 22%

of cases involving housebreaking and 12% of cases involving the theft of a motor vehicle. When asked why they consumed alcohol or other drugs in relation to crimes, many arrestees indicated they consumed these substances in order to give them courage to commit the crimes (Parry et al., 2004).

- In a docket analysis finalized by the South African Police Service in 2001, it was noted that 9.1% (37/408) of child sexual offence cases in the Western Cape Province involved an offender under the influence of alcohol. This compared to 3.8% nationally (127/3326) (Crime Information Analysis Centre, personal communication).
- In 2001 39% of trauma patients in Cape Town, Durban and Port Elizabeth had breath alcohol concentrations (BrACs) greater than or equal to 0.05g/100 ml (Plüddemann et al., 2004). Levels of alcohol positivity were particularly high for persons injured as a result of violence (73% for Port Elizabeth, 61% for Cape Town and 43% for Durban).
- Research has also been conducted by the Department of Transport into the issue of drinking and driving, and the national daily average of persons driving under the influence of alcohol was found to have increased from 1.8% in 2002 to 2.1% in 2003 (Arrive Alive, 2005). Drinking and driving is an alcohol-defined offence and alcohol therefore has a direct role in the commission of this particular crime.
- In 2003 the Institute for Security Studies also undertook a national survey of persons who were victims of serious assault and reported high levels of alcohol intoxication. In 40% of cases victims believed that the assailant was under the influence of alcohol or other drugs at the time of the assault, and a third of victims conceded to having been under the influence themselves at the time of the assault (Omar, 2004).
- Data from the Non-Natural Mortality Surveillance System (NNMSS) in 2004 indicated that 50% of non-natural deaths in South Africa involved persons with positive blood alcohol concentrations (BACs) and the mean BAC overall was 0.17g/100ml (Matzopoulos, 2005). Levels of BAC positivity were high for both victims of homicides (54% positive, with a mean BAC of 0.17g/100ml) and suicides (37% positive, with a mean BAC of 0.15g/100ml). Over half of transport fatalities had positive BACs and the mean BAC for transport fatalities was 0.19 (almost four times the legal limit for driving in South Africa).
- Research conducted to assess factors related to intimate partner violence found that men who reported problem alcohol use were twice as likely to have committed violent acts against their partners in the past 10 years (Abrahams et al., 2006). Research has also shown that women who drink are also more likely to be victims of violent acts. For example, Kalichman & Simbayi (2004) in a community study in a township outside Cape Town reported that women who had been sexually assaulted were twice as likely to have consumed alcohol. Alcohol therefore is linked directly to crime via perpetrators of crime who have drunk alcohol before the commission of the crime and less directly through victims who put themselves at risk of being a victim of crime through consuming alcohol.
- Among adolescents, alcohol consumption has also been found to be associated with both the perpetration of violent acts and being victimized. For example, Morojele and Brook (2006) found among adolescents in Cape Town and Durban that the more frequently they consumed alcohol, the more violent acts they reported having experienced.

Focus of the “Sober South Africa” workshop

The focus of the two-day “Sober South Africa” workshop was on alcohol rather than on all substances. It is clear that other drugs are also related to crime in South Africa (Parry et al., 2004), but it was decided to focus on alcohol due to the ubiquity of alcohol-related crime and because it is generally recognized that more evidence-based strategies exist to address alcohol (and alcohol-related crime) than strategies directed to addressing drug abuse (and drug-related crime). Inevitably some of the strategies outlined below will also impact on drug-related crime and future efforts to increase attention on reducing drug-related crime will benefit from successes around reducing alcohol abuse.

The overall aim of the “Sober South Africa” working group was to strategise on how to create an alcohol safe South Africa. Specific objectives included:

- highlighting and reviewing the problem of alcohol-related crime,
- imagining what the problem would look like if it was fixed,
- reviewing and brainstorming policy solutions,
- prioritizing these solutions based on evidence,
- strategizing the way forward (identifying who owns the solution, defining actions to be taken and identifying key players, noting who is missing, and identifying next steps),
- identifying how will we know if it is fixed (indicators of progress and how they will be measured), and
- identifying ideas for sustainability.

Interventions were considered in five broad areas for which there is good evidence for their effectiveness based on international experience and which are likely to have a good chance of having a positive impact on crime in South Africa (Mosher & Jernigan, 2001; Parry & Dewing, 2006). These included:

- drinking and driving countermeasures,
- brief treatment for problem drinkers (especially those convicted of drink driving offences or being trauma unit patients having breath alcohol concentrations greater than or equal to 0.05g /100ml),
- addressing the retail sale of alcohol from shebeens and taverns,
- reducing the density of liquor outlets in South Africa, and
- reducing the impact of alcohol industry marketing.

In addition, strategies that would increase political will by the government to address alcohol misuse were also considered. While it was recognized that there are other areas for which there is evidence of effectiveness, such as raising alcohol excise taxes to increase the price of alcohol and brief interventions through the primary health care system (Babor et al., 2003), for various reasons they were not specifically addressed during the workshop.

Structure of the workshop

The workshop was managed by a trained facilitator. Resource persons included Professor Charles Parry (Director of the Medical Research Council’s Alcohol & Drug Abuse Research Unit (ADARU)), Dr Neo Morojele (Deputy Director of ADARU), Mr Richard Matzopoulos (MRC Crime, Violence & Injury Lead Programme), and Dr David Jernigan (Johns Hopkins University, USA). Over the two days more than 30 participants from various sectors came together to strategise on how to create an alcohol safe South Africa. Participants included academics, public

and private health and social service providers, representatives of liquor traders associations, persons working for NGOs (such as the Automobile Association, Road Safety Foundation, South Africans Against Drug Driving, and Substance Misuse Use Advocacy Research & Training), advocacy and intervention groups (e.g. Soul City), police, staff from the South African Revenue Service, experts on advertising and the built environment, etc.

Strategies to create an alcohol safe South Africa: Outcomes from the working group discussions

While individual behaviour was recognized as being important, the working group prioritized systemic level interventions. Two big ideas were put forward as likely to have a big impact on reducing alcohol-related crime in South Africa.

First, it was stressed that we need to facilitate greater community ownership of the alcohol environment in our communities. Among other things community members need to become much more involved in making decisions around the licensing of liquor outlets in their communities. Specifically this relates to issues like selling hours and even days of sale. It was, for example, proposed that communities should have a say in whether they want alcohol sold on social grant payout days. They could also pressure outlets directly or the regulating authority in areas where alcohol-related crime and injuries are high to reduce hours of alcohol sales. This has been shown to reduce alcohol-related assaults and murders in at least two areas in South Africa (Parry & Dewing, 2006).

Second, action at various levels needs to be supported by a strong national commitment in the form of a single body, possibly an Alcohol Health Promotion Foundation. There was substantial support for having such a body funded by a 1% levy on turnover from the major manufacturers of alcohol, “1% for health”. The newly enacted National Liquor Act (Government of South Africa, 2004) requires alcohol manufacturers in their license application to state how they intend to contribute to combating alcohol abuse. This is commendable, but the policy intention (of balancing the competing interests of stimulating economic development with minimizing the social costs to society) needs to be strengthened by adding a levy to facilitate new initiatives to reduce alcohol related crime more directly by persons and organizations without a competing interest in alcohol sales. The idea of “the polluter pays” was raised back in 1997 in the original policy document on which this legislation was based (Department of Trade & Industry, 1997).

In the past the National Treasury has been against earmarked taxes (Parry, Myers & Theide, 2003), but such taxes already exist in the form of the Road Accident Fund which is funded by a levy on petrol sales. Taxes on carbon emissions are also under consideration in South Africa. One advantage of such a levy is that it would be directly related to the amount of alcohol produced, with more alcohol produced resulting in more funding being available to address the social costs of alcohol. The Western Cape is already considering requiring a proportion of the license renewal fee from liquor retailers be used for “combating the negative social consequences of the abuse of liquor; educating persons engaged in the sale and supply of liquor; and educating the general public in the responsible sale, supply and consumption of liquor” (Province of Western Cape, 2008, p. 16). While this is a move in the right direction, it is not likely to be sufficient to have a meaningful impact on its own. Furthermore, such measures have not been considered by other provinces.

This national organization would not replicate existing programmes (e.g. the South African National Council on Alcoholism & Drug Dependence), but would instead be used to kickstart, support and maintain the proposed community mobilization efforts (Big Idea 1) and various new

initiatives, like stimulating alternative economic activities for persons who are involved in survivalist selling of alcohol, supporting counter-advertisements, providing funding for policy-oriented research, establishing new networks for persons and agencies broadly involved in addressing alcohol abuse, and promoting alcohol policy information exchange. Public accountability is important and this organisation should report annually on progress made. It should also facilitate a partnership between civil society and the government in moving the agenda forward in reducing the burden of alcohol in society.

Key areas for intervention and priority strategies within each area as agreed by the working group members are set out in Table 1 below. For each of the areas in Table 1, further details regarding the problem, how it might look like when “fixed”, specific action steps, indicators of progress, and ideas for sustainability have been noted, but are not reported in this document.

Table 1. Listing of key areas for intervention and priority strategies within each area

Area	Strategies
Drinking and Driving	Place stronger limits on novice drivers, e.g. 0.00g/100ml for first three years after obtaining a drivers license
	Increase (a) random breath testing, (b) compulsory testing at all crash scenes and other serious moving traffic offenses
	Marketing, education and communication: (a) develop a culture of social host responsibility, (b) institute a social marketing campaign to change behaviour around drinking and driving, (c) institute evidenced-based driver education in schools
Treatment for persons convicted of DUI	Redevelop and standardize alcohol/drug safety intervention programmes for persons convicted of driving under the influence (DUI)
	Establish a toll free number for where people can get help
Treatment for persons arriving intoxicated at trauma units	Provide training to health care workers (in public and private settings e.g. trauma units) in proper screening, brief intervention and referrals, increase capacity of treatment centres to address alcohol problems, increase access to detoxification and long term treatment
	Establish a toll free number for where people can get help
More responsible retail sector	Strengthen community participation in licensing (e.g. decrease hours in problem areas, bans on selected days e.g. election days, grant payout days).
	Bring unlicensed outlets into regulated market
	Enforce existing laws about responsible liquor sales and be proactive around training, defusing violence before it happens
	Outreach and training to servers and sellers
Reduce physical availability of alcohol	Stimulate alternative small business activities in other sectors
	Mandate alcohol free school zones (no sales or use by anyone, youth or adult) and ban alcohol use on public transport
Alcohol marketing counter-measures	Ban (a) alcohol sponsorship of sporting events entirely or at least where more than 15% of the viewing audience are under age; (b) dangerous products, e.g. alcopops, sachets; (c) alcohol industry sponsorship of events appealing to children or families or involving motor sports; (d) alcohol industry funding of government functions
	Require <i>external</i> regulation of alcohol advertisements (pre-approval)
	Impose physical placement restrictions on alcohol marketing, i.e. outdoor advertising near schools, libraries, playgrounds
	Require “equal time” for public health counter-advertising, paid for by earmarked tax
Increasing political will to address alcohol problems	Establish an alcohol Health Promotion Foundation
	Increase media advocacy around alcohol issues and generally raise public awareness around the problems associated with alcohol abuse and the need for more responsible behaviour
	Promote recognition of alcohol as a drug through use of language of “alcohol and other drugs” rather than “substance abuse,” or “alcohol and drugs”

Many of the initiatives involve civil society (e.g. around getting communities to be more engaged in proactively addressing alcohol problems in their communities and in developing a culture of social host responsibility when providing alcohol to people in one's home), but government agencies such as Department of Health, Department of Social Development, Department of Trade & Industry (DTI), Department of Education, Provincial Departments of Economic Affairs & Tourism, Provincial Traffic Police, Government Communication & Information System (GCIS), and the South African Police Service (SAPS) will need to step up to the plate in several ways, for example:

- testing for alcohol at all crash scenes,
- passing legislation around 0,00g/100 ml of alcohol to be allowed in novice drivers,
- requiring a levy to be imposed on the turnover of alcohol manufacturers who have licenses with DTI,
- redeveloping and standardising alcohol safety intervention programmes for persons convicted of drink driving,
- providing training to health care workers in trauma units to screen for alcohol problems and provide brief interventions and referrals where necessary,
- imposing greater restrictions on alcohol advertising (beyond the proposed warning labels which are expected to come into being in January 2009),
- imposing earmarked taxes on alcohol advertisements in the media to pay for counter advertisements (e.g. if not “equal time” then a ratio such as one counter advertisement for every five alcohol advertisements)
- making schools alcohol free zones (for everyone),
- requiring external regulation (pre-vetting) of alcohol advertisements, and
- getting police to be more proactive about addressing alcohol problems associated with shebeens, taverns and other drinking outlets (for example by allocating a number of establishments to individual police officers to liaise with).

To move forward in many of these areas will require support from civil society organizations and the general community. Civil society and the community in general will need to become less apathetic about alcohol abuse, alcohol marketing practices and retail practices that affect them. To make the efforts of civil society more meaningful mechanisms are needed that will educate South Africans about the consequences of alcohol use, existing legislation, and how and where they can be more actively involved. Community Policing Forums (CPFs) were recognized as having an important role to play.

Conclusion

The members of the working group agreed that they were not united against alcohol use, but were rather united for community participation (for community members to play a role in how alcohol is sold and used in their communities); for children's rights – the right to live in environments where they are safe and do not have to be exposed to alcohol-related violence or to alcohol-related poverty; for parents not having to lie awake at night wondering if their children will be victims of a drink driving incident or alcohol-related assault; and for creating a society into which future generations would be happy to be born.

The initiative to reduce alcohol-related crime will be sustained by informing and mobilizing communities to play a meaningful role in alcohol issues in their own environments (grassroots action), and by establishing a new national organization dedicated to facilitating, supporting and in some cases even overseeing specific action. The initiative includes calls for specific action to be considered, including alcohol free school zones (not just for learners but also parents and educators), zero alcohol limits permissible for novice drivers, equal time for public health counter-advertisements, and external pre-vetting of all alcohol advertisements for suitability.

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