

Taming the Tools of Violence

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ABSTRACT

This article summarizes why firearms are the most lethal tools of violence, and some pertinent issues public health professionals face when working to ameliorate the effects of gun violence. It surveys large gaps in data and understanding regarding the African context – most research has hitherto been conducted in developed countries. And it reviews international agreements that could be used to mobilize support for public health approaches. Although none focus explicitly on public health, some agreements offer commitments that can be used by people working to improve public health.

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INTRODUCTION

This article is based upon the author's experience as a Peace Researcher working on control of small arms in contexts ranging from participation in intergovernmental meetings to cooperation with Norwegian Church Aid, a development organization. I aim to summarize information and pointers to existing research and initiatives. Best practices (some of which are presented in this article) concerning reducing violence exist, and international mechanisms can be used to access assistance. For Africa, however, large gaps in our knowledge remain, and it is very important that we conduct more research on the problems caused by gun violence on the continent.

THE ROLE OF FIREARMS IN VIOLENCE – INCREASED LETHALITY

Discussions on controlling firearms are often polemical and unfruitful and, in my view, focus on the wrong issues. In frequently polarized “gun control” debates, people who want an outright ban on the personal possession of firearms oppose those who assert their

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right to own a gun for protection or lawful recreation. And governments frequently take retroactive, not preventive actions – using law enforcement, for example, to catch and prosecute perpetrators of armed crimes. While this may lock up the perpetrators, there is scant evidence that it helps reduce overall levels of armed violence. Instead, as Hemenway has argued from the United States experience in *Private Guns, Public Health*, a public health approach to guns is not necessarily about banning them outright or obtaining justice for the victims (1). He describes an alternative comprised of policies and interventions aimed at injury prevention. I describe below similar policies recommended by the World Health Organization (WHO). To develop preventive strategies one must first consider the complex relationship between these weapons violence. Certainly, they are intimately linked, but firearms do not cause violence *per se*. Instead, firearms dramatically increase the lethality of violent acts. Jackson *et al.* (2) describe firearms as “violence multipliers” rather than being a direct causal factor. Appreciating this role of firearms is important for designing preventive measures.

An attack committed with bare hands or a blunt instrument requires sustained effort against a victim who is actively trying to fight back or flee. These attacks often result in hospitalization followed by recovery. Using a knife decreases the victim’s chances of survival, but still he/she may be able to fight or flee. A gun, however, allows the assailant to kill or wound in an instant, and to attack from a distance. Gunshot wounds are much more likely to be lethal – the reason that armies are equipped with firearms (For an overview of the lethality of firearms see Cukier and Sidel (3)). Several studies have highlighted this lethality (4,5). A comparison of hospital admissions of wound victims in South Africa found that 6% of knife wounds were fatal, while 28% of those with firearm wounds died. In Zambia, patients with firearm wounds required longer stays in hospital, and were admitted more frequently into intensive care units (ICU), and required more X-rays than contusions (6). When firearms have replaced traditional weapons in societies with pre-existing patterns of violence, observers found a marked increase in the lethality and destructiveness of conflict. de Koning notes about pastoralists in Uganda:

Although the use of armed violence still mainly derives from values attached to a traditional livestock economy, the

significance and intensity of violence, particularly during cattle raids, has changed dramatically... As a consequence of the use of modern weapons more victims suffered from raids than ever before and many families were left completely deprived of their cattle wealth (7).

Crucially, firearms also increase lethality of “situational” violence, including fights fuelled by alcohol or other intoxicants; and gang violence. This killing may not be premeditated (and murderers may be very remorseful later). Use of firearms can turn a violent incident into one in which people are killed or suffer lasting disability.

Gaps in the Data from Developing Countries

Many studies present links between the prevalence of firearms and rates of mortality or morbidity. Cukier and Sidel, in particular, provide a recent primer (3, 8–10). Unfortunately, cross-national correlations have usually focused on developed countries because disaggregated mortality statistics are lacking in many developing ones. In WHO’s mortality database for the Africa region (called “AFRO” and covering most of sub-Saharan Africa), there are data on only seven countries, and even for these, the available data are estimated to cover < 50% of the overall picture. (A WHO online table listed only six African countries – Zimbabwe, South Africa, Seychelles, Sao Tome and Principe, Mauritius, and Egypt – as countries for which any data are available. Egypt is not included in the WHO’s AFRO region.) (11)

Other sources, such as crime data, supplement health information, but in Africa these are also very patchy. Research organizations such as the Canadian Small Arms/Firearms Education and Research Network (SAFER-Net), the Swiss-based Small Arms Survey, and the Norwegian Initiative on Small Arms Transfers (NISAT) (12) have together collected data on firearm mortality from various sources. When in 2005, my co-authors and I developed a world map of gun violence, based upon comparing national levels of firearm mortality, we used data from public health sources, crime statistics, and even battle death estimates (2). Even so, much of Sub-Saharan Africa remained quite literally a grey area.

Data on possession of small arms in Africa are even more difficult to obtain. Anthropological fieldwork or reports by non-governmental organizations (NGOs) or journalists reveal widespread weapons ownership in some areas. Often insufficient police infrastructure exists to enforce licensing regulations. Even where weapons are licensed, national level data are hard to obtain, although surely this problem is not restricted to Africa, as in the United States, there are no accurate national statistics on the numbers of firearms in civilian possession. Researchers rely upon estimates and proxies.

Africa has suffered more than its fair share of wars. In such circumstances, obtaining local information and collating it into national statistics can be unachievable. Armed conflict, moreover, engenders an environment in which controlling the possession of weapons is often impossible. Weapons used by government or opposition forces may leak into civilian markets. In many cases this is a deliberate policy, as civilians are often drafted into armed militias. Civilians also obtain weapons via corrupt sales by combatants, trafficking networks stimulated by the fighting, or by looting weapons from battlefields. Many researchers blame leakage of weapons into civilian hands during armed conflict as a cause of high levels of violence often experienced after a peace agreements (see, e.g., publications by Marsh (13) or Moser and Winton. (14)). Unfortunately, countries that have the most profound needs to control weapon ownership and to learn from accurate information on public health effects of guns, remain those where even the latter is most difficult to obtain. To help build a cadre of professionals who can help ameliorate this problem, countries must foster and support researchers who live in a region and work in local hospitals and public health. As Chair of an European Union funded research network, I have been active in developing links between researchers based in Europe and those based in Africa. COST Action A25, as it is called, has organized scholarly meetings and conferences to which people based in Africa (and other parts of the developing world) have been invited to share their experiences with researchers from Europe. We recently organized such a meeting in conjunction with the IPPNW biannual World Congress to share information and discuss how to develop better data sources and methods for measuring morbidity due to gun violence.

PUBLIC HEALTH STRATEGIES TO CONTROL THE TOOLS OF
VIOLENCE

Controlling tools of violence can limit the damage. Gun control may not decrease the number of violent acts, but it helps to reduce their lethality. To this end, WHO's 2002 *Preventing Violence: A Guide to Implementing the Recommendations of the World Report on Violence and Health* includes several recommendations concerning firearms. About Cali, Colombia, it reports "the high proportion of homicides committed with guns prompted prohibitions on the carrying of guns in public during high-risk weekends, holidays, and election days." And, "Findings revealed that homicide rates fell 14% when the ban on carrying guns in public was strictly enforced" (15). The WHO report notes that certain firearms policies had "shown promise in reducing violence or risk factors for violence" (15):

- forbid firearm sales to high-risk purchasers;
- mandatory sentences for gun use in crimes;
- promotion of safe storage of firearms and other lethal weapons;
- waiting periods for firearm purchases;
- owner liability for damage by guns;
- disrupt illegal gun markets; and
- enforce laws prohibiting illegal transfers of guns to youth.

The report noted that the following initiatives had been found *not* to work:

- laws permitting gun carrying in public;
- gun-safety training; and
- gun buy-backs.

INTERNATIONAL INITIATIVES

Domestic research highlights the public health consequences of small arms and light weapons, or "SALW" (as illustrated in the other papers in this Special Section). Many parties have also used international initiatives to mobilize assistance. African countries are covered by regional agreements and international initiatives focused on inhibiting international transfers of weapons (and particularly black market trafficking) rather than assisting public health professionals. Nevertheless, some elements of these international commitments offer important leverage points.

The 2001 *UN Programme of Action (PoA)*, is the most important agreement. It offers several opportunities to people working on public health. (See Valenti *et al.*, *Armed Violence: A Health Problem, a Public Health Approach* in this Special Section.) Importantly, it mandated the creation of national SALW coordination agencies (PoA II.4) in all United Nations member countries. In many countries, these agencies have taken on a wide role and include members of civil society including the medical community. Other elements of the Programme of Action also explicitly recommend engagement with civil society. The UN Programme of Action has permitted public health professionals in Africa to argue for government action and support from international donors. A 2005 decision by the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee's (DAC) that "security system reform" and "enhancing civil society's role in the security system" should be accounted as Official Development Assistance may give groups in Africa more direct access to donor support. (The OECD dates back to 1948 and its 30 members comprise the world's most economically developed liberal democracies). The DAC's Network on Conflict, Peace, and Development Co-operation is, as of February 2007, developing guidelines to implement its decision concerning small arms control, so its full impact is still unclear. It does, however, seem to offer the potential to increase funding for SALW-related projects as donors integrate these activities into their general aid budgets rather than use specific budget lines for small arms. A pro-posed Arms Trade Treaty (ATT) – a legally binding convention that would bring the arms trade under international law – has, today, the highest visibility. The International Action Network on Small Arms (IANSA) is one of the three organizations leading the ATT campaign for a legally binding convention governing the arms trade. IANSA's public health network is coordinated by IPPNW and through IPPNW's involvement, many doctors and public health professionals globally have become actively involved in the campaign.

Many African regional agreements concern SALW, three in particular:

- 2004 Nairobi Protocol for the Prevention, Control and Reduction of Small Arms and Light Weapons in the Great Lakes Region and

the Horn of Africa was signed by Burundi, Democratic Republic of Congo, Djibouti, Ethiopia, Eritrea, Kenya, Rwanda, Seychelles, Sudan, Tanzania, and Uganda and contains 25 articles. Article 14 concerns “Public/Community Education and Awareness Programmes” and encourages government cooperation with civil society.

- 2006 Economic Community of West African States (ECOWAS) Convention on Small Arms and Light Weapons, their Ammunition and Other Related Materials covers Benin, Burkina Faso, Cape Verde, Côte d’Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, and Togo. Its preamble recognizes the “important contribution of civil society organizations in the fight against the proliferation of small arms and light weapons,” which is reiterated in several articles, specifically when discussing development of national action plans to implement of the Convention. Article 23 importantly calls upon member states to work closely with civil society organizations in raising awareness of the small arms problem.
- 2001 Protocol on the Control of Firearms, Ammunition and Other Related Materials in the Southern African Development Community (SADC) Region covers Angola, Botswana, Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe. It focuses mainly upon legal issues, such as civilian possession of weapons, and control of the arms trade. Article 13, however, calls for public education programmes, that might offer an opportunity for engagement by people involved with public health.

Like the Programme of Action, these regional agreements focus on controlling the legal and illegal trade in SALW. As they are legally binding agreements, they carry far greater weight than the hortatory UN Programme of Action. They offer an opportunity for public health professionals to demand to be part of the governmental process. Indeed, at the regional level, dynamism on the small arms issue has been most evident. Unfortunately, no similar agreements cover North Africa. As the agreements are relatively new, they continue to offer new opportunities for engagement between civil society and governments.

CONCLUSION

There is much work to be done in Africa. Use of firearms dramatically increases the lethality of violence. Armed conflicts and criminal violence make Africa a region gravely affected by gun violence. Yet compared to other parts of the world, we still know very little about the dynamics of armed violence in Africa. Tried and tested ways to reduce gun violence exist, and international mechanisms can provide assistance. These opportunities need to be realized.

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