Questions and responses, Dr. Meddings, Ms. Burrows, Dr. Hargarten:

Walter Odhiambo, Kenya, My question is for Dr. Hargarten. In your presentation you raised a very critical issue on how we can actually increase accountability by those who are manufacturing and trafficking the firearms. The proposal of the use of FIN, I’m just wondering whether you think this can also apply to the ammunitions, particularly bullets. How practical is it to monitor the movement of bullets, or to regulate bullets totally? Because in countries like Somalia, it has been found that the prices of firearms decrease tremendously if the bullets are not in the market. And they become very expensive if the bullets are readily available in the market. And how practical is it for the manufacturers of guns to pay reparations for people who have been injured by their guns? This I see is already happening in the United States with regard to tobacco, where people are making very hefty claims from the tobacco manufacturers. Thank you.

Dr. Hargarten: I’ll take the second one first because I think it is the most difficult one to answer and I have little to really offer. There have been attempts to try to assign damages to the manufacturers. That has been meeting a mixed response in the court systems of the United States. And I don’t want to sound too trite but I think the jury is still out on that. I don’t think it’s been determined. I think there have been attempts, there have been critical decisions made in some of the courts on this, and I think the full effect has not been realized. The amount of profits and dollars associated with the gun industry are significantly smaller than the ones related to tobacco. But I think that the political significance of it, the implications for manufacturers are significant, and I think those suits are being felt by the manufacturers in their difficulty in getting buyers for their companies, and so forth. So I think it’s having some effect.

Regarding serial numbers or some identification for bullets. I’m not aware of any efforts to put serial numbers. However, there are states in the United States such as New York which are now with a new gun sale requiring that that firearm have a discharge of the bullet that is then computerized into a system that is later used to help in tracing that bullet with that firearm that is sold. So there are efforts to link the bullet to the firearm by having it test fired into a system that is then put into a computerized system through the Bureau of Alcohol, Tobacco, and Firearms, which helps in linking future events that may be criminally related. So I think that’s a positive step towards increasing the accountability. Right now the serial numbers on the manufacture – on these firearms – have no regulation whatsoever. There’s no standardization. In one state that has looked into this, Massachusetts, there have been some inroads in trying to standardize this. I think we’ve got a lot to do.

Krug: A quick comment, and then a question for Steve. David talked about data collection in disorganized settings, and I want to alert people that next month WHO will release a new document “Guidelines for Injury Surveillance,” which has been developed now during the past three years by a large number of people of which several are in the
room. As well as people who worked on the South African Surveillance System. I hope it will be a very useful tool to all. It will be available on our website.

My question is to Steve. The work that you're doing is definitely groundbreaking in being able to link these different data collection systems together. Could you describe briefly what are the main difficulties you have encountered in doing that, and how you see this being applicable in other countries in the future?

Dr. Hargartan: I think the first level of difficulties has simply been by these agencies suspicious of why we're doing it. I think it goes back to Dr. Meddings’ comment about accuracy, reliability, and accountability for the information. And I think that’s been our first level of challenge, is to be a credible source of information. And not to be an overt advocacy organization. There are many advocacy organizations. We wish to inform those advocacy organizations. We wish to help generate or evaluate policies through better information. So that’s been the first major hurdle is that credibility. Particularly with law enforcement agencies that are skeptical or really compose a vast spectrum of political backgrounds. And so I think it’s very important regardless of which country that that credibility is so important, and that’s the first hurdle. The second hurdle is what I think Stephanie alluded to is resources. We’ve been able to do this with grants from external foundations, and we extract the information. We do not ask those organizations to do anything other than provide us access. And that’s resource intensive, and I think that’s a huge challenge. Because if we expect them to report for us, they are already overburdened, already under-resourced themselves. That’s a huge issue. So the second is resources.

And the third has to go back to the first, which is having a group that’s assembled, that from the time that you start collecting the information you have an advisory board, you have a group of individuals who form a spectrum of backgrounds, organizations, who see that this is credible information. And I think that’s another challenge, another potential obstacle. And I believe may have contributed to some of the things that happened to the CDC back in the mid-1990s where their surveillance project was inappropriately taken away when in fact if they had up front-loaded it with a multi-disciplinary advisory group that may not have occurred.

So I think those are three that I can identify that are major challenges and issues.

Kifлемariam Gebre-Wold, BICC, Germany. I have two questions to Dr. Meddings. One is, you mentioned that quite a number of your data is based on ICRC-run hospitals throughout the world. Could you give us an indication of roughly how many these are and if you could maybe give us an idea of rough numbers in the Horn of Africa. The other is, when you are talking about data that you collect from patients, one thing we have discovered in our work is quite a number of pastoralists do not go to Red Cross hospitals for various reasons, among others in the Horn of Africa because quite a number
of these Red Cross hospitals and the Red Cross Society is very closely linked to
government and so forth. Any idea of how many persons are not coming to your
hospitals, and what that means for the data and the prevention work? Thank you.

Meddings: Thanks very much, I’ll take the questions in order. You asked how many
hospitals does ICRC have in the world and more particularly how many in the Horn of
Africa. There has been quite a major change in ICRC policy for how we provide surgical
assistance to hospitals. We’ve drifted away from what we call an “independent ICRC
hospital” which is a neutral hospital that has the ICRC emblem. I would say this was the
standard way that we dealt with war surgery up until about 1993. And that carried with
it a lot of logistical connotations and it’s a very special place, an ICRC hospital. It’s a
place where no weapons are permitted within the facility, etcetera, etcetera. They are
very resource intensive, and in between 1990 and 1993 we began successively phasing
those out in favor of supporting local hospitals instead – Not calling them ICRC
hospitals, not putting in as much resources, etcetera, etcetera. We currently have two
ICRC hospitals remaining with us, and I believe on the order of about 130 hospitals that
we are supporting in other countries. Of those, I think - I’m speaking a bit off the top of
my head now – but I think not many, perhaps 5 would be located in the Horn of Africa.
Your comment, in the second question, about pastoralists not actually coming. It’s
interesting to me that you bring up pastoralists because I wanted to make a comment
about this in my presentation. First of all, you need to be aware that the mandate of the
ICRC is completely intertwined with the presence of a conflict in the region, so our
surgical facilities are actually there for the benefit of people who have been injured in the
course of conflict. And one of the things that I’ve been arguing for within the ICRC is we
have historically always called these individuals “war-wounded” because we see this as
our mandate. And I’ve been working on people to think of these individuals as
“weapon-injured” individuals instead because in fact, as I’ve been able to show, many of
these individuals – often on the order of a third – that we are treating for weapon injuries
in our facilities have sustained injuries for reasons that have nothing to do with combat
between military factions at all. And I think that’s important because it highlights a
parallel social process that occurs in militarized settings but doesn’t actually have any
relation to the prosecution of a conflict proper between factions. SO, pastoralists injured
in for example instances of cattle raiding might not come to an ICRC hospital because
they might quite correctly have the perception that ICRC is not actually there for them.
It is there for victims of a conflict. Having said that, I think what’s interesting about your
comment about pastoralists, is this is a wonderful example of how the advent of
widespread availability of military specification weaponry has made enormous changes in
cultural norms. You may know very well that cattle raiding between pastoralist tribes has
been a centuries-old tradition that actually has a lot of positive aspects about it. It’s a
form of redistributive wealth, it’s an activity that actually redistributes cattle wealth
across this part of the world in a very harsh environment. Well, one of the things that has
happened in cattle raiding over the last 20 to 30 years, particularly in the Horn of Africa,
and if anybody’s interested Dylan Hendrickson has written on this extensively, has been
a shift in the nature of cattle raiding away from being a redistributive practice towards a form of social predation, where armed groups of external actors, external to the pastoralist tribes themselves, come in and raid cattle over a large area. And what that has done is it’s actually disrupted the traditional cultural coping mechanisms, what’s been called the “moral economy” that would exist between reciprocal exchanges between cattle herders, and actually been able to overwhelm their traditional ability to manage raids as they have in the past. So I think the pastoralist example – I just wanted to get that in there – it’s a good example of how the technology of modern weaponry has actually induced some major cultural shifts.

*Dr. Jack Piachaud, UK.* I just wanted to ask Dr. Hargarten about continuing in public health and the idea of the vector. The vector is a human being. Is part of the data set looking at the mental state of the person who actually does the shooting? Would this be possible, would it be valuable to collect?

*Dr. Hargarten* – Not to be too discrete about it, but the vector, just like in malaria, the vector is the mosquito, carrying the agent of disease. In this case the gun carries the kinetic energy. The victims involved and the perpetrators associated with in the case of homicides, we collect information on both. So we’re getting detailed information on the victims and the perpetrators, and I think we’re just now beginning to be able to show some of the criminal background efforts and information on those individuals to start to more, I guess in a sense, debunk myths about who these perpetrators are, and who the victims are for the suicides. So it’s very important information to get and we feel that it’s very helpful to start addressing very focused prevention strategies. A 20 year old suicide attemptor is a very different than an 85 year old person. And I think those two require different strategies that I think need to be focused and generated from data. And I think the slide earlier today where the high risk of early on, right after the purchase of the gun, that’s a very critical piece to add to that. So, I agree, your comment is that we need to have that information and we do collect it.