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VIOLENCE AND GLOBAL PUBLIC HEALTH

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Introduction

Violence is a major global public health problem (WHO, 2002) with some likening it to an epidemic being both contagious, as well as causing morbidity and mortality (Slutkin, 2013). Moreover, a public health approach to violence is highlighted as being important in relation to interventions. This chapter will explore violence and its impact on global public health before continuing to explore how an awareness of critical social theories such as structural and cultural violence contributes to a more in-depth understanding of violence. The impact of structural and cultural violence in relation to male violence towards women and girls, including femicide, will be focused upon, as well as a discussion of youth violence.

Violence and Public Health

The World Health Organization defines violence as 'the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in, or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation' (WHO, 2002: 4). Violence is a leading cause of injury, disability, and death and causes fear within communities and homes. For example, 405,000 people died from homicide in 2017, which is more than double the number of people who died from terrorism, natural disasters, and armed conflicts; and in some countries, homicide is amongst the leading cause of death (Roth et al., 2018). In relation to suicides, there were a reported 793,823 deaths by suicide in 2017 (Roth et al., 2018). This is likely to be an underestimate, given the stigma attached to suicide in some countries. Comparing suicide rates from 1990 to 2017, it is

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evident that many European countries have seen a decline in death by suicide across the period, but for some countries, for example, Zimbabwe and South Korea, there appears to be an increase (Our World in Data, 2021). Violence can also have many negative health impacts on those who experience it or witness it. For example, witnessing or experiencing violence increases the risk of mental health issues as well as increases in substance abuse (WHO, 2002). Violence has also been shown to increase the risk of chronic diseases, such as cardiovascular disease, as well as infectious diseases, for example, HIV, and sexually transmitted diseases (Houry and Mercy, 2016). Intimate partner violence (IPV) has been shown to increase the likelihood of infection with HIV in women and girls and has been associated with lower CD4 counts, higher viral loads, and lower adherence to HIV drugs (Li et al., 2014; Hatcher et al., 2015).

The World Health Organization (2002) identifies three categories of violence. These include self-directed violence such as self-harm or suicide; interpersonal violence including domestic violence or IPV, violence towards elders and child abuse, plus rape, gang violence, bullying, and institutional violence, for example, in care homes or prisons. Lastly, it identifies collective violence which is further subdivided into three types: social, political, and economic violence. This would include violence which has a social focus, including mob violence, and acts of terrorism; a political focus, including war and armed conflict, and an economic focus, including acts which disrupt economies. The World Health Organization (2002) also defines violence further according to the type of violence, which is used, into physical, sexual, psychological, and deprivation/neglect.

A public health approach to violence, as espoused by the World Health Organization (2017), is highlighted as being an appropriate approach in which to tackle violence. This approach focuses on violence being preventable and highlights the importance of the collection of data around violence, a focus on understanding the causes of violent acts, an exploration of what works in reducing violence, and, lastly, the implementation of effective violence prevention initiatives or interventions. This public health approach focusing on surveillance, tracking causes and interventions, is used generally in health protection and the tracking of epidemics, enabling a primary prevention response, which focuses on upstream (causal) factors, as well as policy interventions to prevent violence from occurring.

The social determinants of health are important in understanding violence, as they situate the violent acts within a potential causal framework, which can be used to explore upstream factors. The social determinants of health highlight that the conditions in which people live can influence their health outcomes and that to prevent negative outcomes and inequalities, we need to address their fundamental causes (Marmot and Wilkinson, 2006). For example, poverty and inequality as social determinants of health have been shown to be linked to numerous violent acts, including armed conflicts, as well as child maltreatment and street crime, which impact on health outcomes (Brainard and Chollet, 2007). Moreover, the social determinants of health are important in helping us understand how health inequalities per se can be perceived as a violent act.

For example, in relation to maternal mortality, the rate in Sierra Leone is 1,120 maternal deaths per 100,000 live births, compared to two maternal deaths per 100,000 live births in Norway (World Health Organization, 2021a). This inequality in global maternal mortality rates, which are both preventable and reflect social inequalities, is in themselves violent, as they cause both harm and death. In relation to policy, the Sustainable Development Goals (SDGs) highlight several targets that explicitly aim to reduce violence (United Nations, 2015). These are:

- SDG Target 5.2 Eliminate all forms of violence against women and girls;
- SDG Target 5.3 Eliminate all harmful practices, such as child, early and forced marriage, and female genital mutilation;
- SDG Target 16.1 Significantly reduce all forms of violence and related death rates everywhere;
- SDG Target 16.2 End abuse, exploitation, trafficking, and all forms of violence against children.

Moreover, other SDG goals also focus on reducing structural factors that relate to the social determinants of health, which are in turn implicated in direct acts of violence: this includes ending poverty in all its forms; zero hunger, improving health and wellbeing, reducing gender inequality, and inequalities in education.

Structural and Cultural Violence

Galtung's (1990) critical theory of violence identifies three categories of violence: direct or personal violence, structural violence, and cultural violence. Direct violence corresponds to the types of violence identified by the World Health Organization (2002) above in its definition. Structural violence, on the other hand, can be perceived as a form of oppression that prevents people from fulfilling their potential and negatively impacts their life-chances. In some ways this is like the social determinants of health; in that it highlights how structural factors such as poverty, for example, can result in higher deaths rates amongst poorer people because of a lack of access to health care, a lack of power, or other forms of neglect. However, the concept of structural violence goes further and highlights how those who are less powerful, or more vulnerable, can be reduced to the position of 'non-persons' (Scheper-Hughes, 2004) by social and government policies which become 'normalised' as part of the everyday taken for granted 'status quo'. Poverty, for example, can be perceived as just 'the way the world is', and this injustice results in the general acceptance, rather than outrage, of high death rates amongst women or children in many low-income countries because they are poor or from a particular ethnicity, social class, or religion. Structural violence, therefore, is structural because it is embedded in the political, legal, religious, cultural, and economic organisation of the social world; it is violent because it can cause injury, death, and a lack of opportunity for people. This inequality is then naturalised or justified, or unacknowledged or blamed on individuals,

for their lifestyle choices without recognising how structural factors limit the options available to groups and constrain personal agency. It, thus, becomes an accepted part of 'normal ordinary life'.

Gilligan (1996) has highlighted how structural violence leads to high rates of disability and death amongst those in lower social classes, with the structural violence rendered invisible, and often attributed to other medical causes of death or disability. Others have highlighted how structural violence is the most 'lethal' form of violence (Butchart and Engström, 2002) and can lead to people dying from famines in a world of plenty (Sen, 1982); with Gandhi calling poverty 'the worst form of violence' (cited in Alger and Stohl, 1988). However, it is important to understand that both direct and structural violence are connected, and structural violence can impact directly on the likelihood of direct violence; and direct violence can, in turn, reinforce both structural and cultural violence (Gilligan, 1996).

Cultural violence, on the other hand, legitimatises and normalises both structural and direct violence through ideologies and discourses. Utilising a feminist critical theory lens, an example of this would be the mass media and film industry, which often depicts women as sexualised, emotive, 'other', vulnerable, invisible, and secondary. This type of cultural representation reinforces sexism and misogyny and forms the basis for the ideology of Patriarchy, to infiltrate social institutions and legitimise the domination of women by men. Cultural violence, therefore, refers to representations, thoughts, practices, and discourses and reinforces the structural position of women vis-à-vis men in society (structural violence) as well as direct violence against women (IPV, rape, and femicide). Because cultural violence normalises misogynistic discourses, it can be likened to Marx's idea of 'false consciousness' in that 'the most intolerable conditions of existence can so often be perceived as acceptable and even natural' (Bourdieu, 2001:1).

Bourdieu's theory of symbolic violence is relevant here and demonstrates how the symbolic, for example, knowledge, art, social life, science, religion, and language influence worldviews or societal views and reinforce domination. This domination or injustice is hidden as the 'natural way of things', what Bourdieu (2001) refers to as 'Doxa', and he highlights the importance of questioning the 'taken for grantedness' of the world (Bourdieu, 1977). Bourdieu (1977) states that rather than accepting the social order as the way things are, we need to critically understand that relations within society are the result of history, power, and contextual factors, and not the natural order of things. Critical Race Theory, with its emphasis on race and racial difference as social constructs, as opposed to biology, is also relevant. Race, like gender, can be perceived as a system of oppression, which is socially constructed, and is a product of social contexts, social relations, and social organisation, which privileges 'whiteness' (Delgado and Stefancic, 2001). Within such a system, structural, cultural, and direct violence can be used to maintain a social order of oppression vis-à-vis people of colour; this is evident in events in the USA in relation to endemic police violence against black people (Mesic et al., 2018).

Femicide and Male Violence against Women and Girls

Male violence against women and girls is a significant global issue and implicates both structural and cultural violence. For example, the World Health Organization (2021b) estimates that around 736 million women, or one in three, have been exposed to IPV or sexual violence from a non-partner. Another issue is femicide or feminicides, the misogynous killing of women and girls by men, which is often legitimised by patriarchal social, and cultural institutions. This can include both intimate-related and non-intimate-related murder: honour and dowry-related killings, homophobic, and transphobic murders; and gender-based pre-natal abortions, as well as infanticide of girls (Radford and Russell, 1992). Across the globe, femicide is increasing at the same time as the general murder rate is decreasing (United Nations, 2019) and in 2017, 87,000 women were murdered, with 58% killed by family members (24%) or intimate partners (34%) (UNODC, 2019).

Women are, therefore, more likely than men, to be killed by people they know, with much of this violence being perpetrated in the home. Looking at specific countries, we can detect high rates of femicides in Honduras (6.2 femicides per 100,000 women) (Economic Commission for Latin American and the Caribbean, 2021); whilst in the UK, during the period 2009 to 2018, at least 1,425 women were killed by men, meaning that a woman died every three days (Long et al., 2020). In relation to regions of the world and intimate partner femicide, the African region has the highest rate, with 3.1 deaths per 100,000 women (UNODC, 2019), whilst concern has also been raised about the racist femicide of Indigenous women; with Indigenous women in Canada being approximately six times more likely to be murdered than non-Indigenous women (Canadian Femicide Observatory for Justice and Accountability, 2021).

Structural and cultural violence are implicated in male direct violence towards women and girls. Feminist critical theory shows us that patriarchal societies can be perceived to represent women as 'other' to men (De Beauvoir, 1949), and the 'otherness' ascribed to women is often characterised by one of dehumanisation, as well as dominance, with women subordinated to male power, and the structures which support male power. The subordination of women to men constitutes structural violence, creating inequalities, a lack of access to resources, including land and money, gender pay gaps, the devaluing of women's contributions, limits on freedom in public spaces, a lack of representation in politics, as well as criminal justice systems, which are discriminatory. Cultural or symbolic violence is also implicated within representations of violence against women in the media and in film, as well as hegemonic ideological justifications, which devalue women, and support the position which is ascribed to them. Direct violence by men, towards women and girls, therefore, reflects both structural and symbolic/cultural violence and is an exertion of power over the subordinated or devalued (Bourdieu, 2001). It is also important to understand how intersectional identities, such as gender and ethnicity, can make it more likely that women and

girls are subjected to violence by men. Racialised violence by white men towards Indigenous women often has at its core structural inequalities such as the women's poverty, as well as colonial narratives, that represent Indigenous women as 'other', perceiving them as more disposable (Razack, 2016). This dehumanisation, as well as their socio-economic position, i.e., structural, and cultural violence, is likely to explain, in part, the higher rates of direct violent femicide towards this group of women (Razack, 2016; García-Del Moral, 2018).

Youth Violence

Youth violence, defined as physical fighting, to more severe assaults and homicide, is a serious global public health problem (WHO, 2020). Around 200,000 homicides occur each year amongst young people (defined as ages between 10 and 29), which account for 42% of the global homicide rate (WHO, 2020). Almost all the perpetuators of youth violence are male who account for 84% of the victims, with most of these victims being in low- and middle-income countries (WHO, 2015; 2020). Globally, youth violence appears to be decreasing, but this decrease is greater in higher-income countries, as opposed to lower- and middle-income countries (WHO, 2020). Youth violence not only impacts on young people directly in relation to injury and death but also impacts on the health and wellbeing of young people and their communities, which can lead to increased feelings of fear and decreased community cohesion, including depleted levels of social capital (WHO, 2015).

Structural violence is a causal factor in youth violence and all studies highlight structural elements, such as poverty, lack of opportunity, access to resources and power, discrimination, and marginalisation, as key to understanding direct violence, such as youth violence (WHO, 2015; Hyman et al., 2016). The Children's Commissioner for England (2019), for example, reported how structural factors, such as family poverty, living in high crime areas, high unemployment, local illicit drug trades, and economic inequality, were associated with youth violence and gang membership. Furthermore, Nation et al. (2021) demonstrate how, for example, social and housing policies contribute to the marginalisation of people of colour in the USA, which increased rates of community youth violence. Moreover, they highlight how many violence prevention interventions focus on individual factors, rather than social and structural factors, perceiving violence as a personal or interpersonal failing, as opposed to a societal structural issue.

This discourse of individual failure or choice can be perceived as a form of cultural or symbolic violence which supports structural violence (Galteng, 1990; Bourdieu, 2001) by obscuring how structural forces such as poverty impact youth violence. This is apparent in Zoetti's (2020) research in the Brazilian city of Salvador and the north-eastern state of Bahia, which have prominent levels of youth homicide, and violence related to gangs and the drug trade. Violent young people in these areas are represented as 'other', which supports, in turn, the State's extremely violent response to young people, who are categorised in this way.

They 'deserve' the violence which is meted out to them by police because they 'chose' to be 'bandits'. Moreover, the Brazilian government and the criminal system accept 'the violence perpetrated and suffered by marginalised youths as an unalterable social fact, inherent to their, supposedly chosen, condition of sub-citizens' (Zoetti, 2020: 275). This normalisation of individual choice in relation to violence results in the structural social conditions in which young people live, including high crime environments, and elevated levels of marginalisation and poverty, being played down as causal factors in their violent behaviour. Instead, cultural or symbolic violence shifts the responsibility away from societal inequality onto the young people themselves, further marginalising, punishing, and demonising them (Bourdieu, 2001), whilst simultaneously upholding the status quo, and systems of oppression.

Conclusion

This chapter has highlighted how violence is a global public health issue, which has been likened to an epidemic, requiring a public health approach, in its preventions and identification. Critical social theories of structural and cultural violence have been introduced, and we argue that an understanding of these theories is key to understanding direct violence, such as youth violence and male violence towards women and girls. We have also argued that structural violence is a violent act and can impact upon communities and individuals, directly restricting their capabilities and opportunities to live a fulfilled and healthy life. An understanding of structural and cultural violence is key to violence prevention per se and needs to underpin policies and interventions, aimed at reducing violence.

Research Points and Reflective Exercise

With reference to the discussions in this chapter, begin to reflect upon the following:

1 Reflect upon your own country and explore a) how structural and cultural violence impacts the health and wellbeing of individuals and communities and b) what violence prevention policies have been introduced and how far do they engage with the concepts of structural and cultural violence?
2 How far do you think public health approaches can reduce violence?

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