CHAPTER 20

Violence, masculinity and well-being in Africa

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The United Nations Development Programme (UNDP 2007) has indicated that when compared to countries in Western Europe and North America, nearly all countries in Africa have lower levels of life expectancy at birth, some by as much as 30 years. The African Union Commission (AUC 2006) reported that 9 of the 10 countries with the lowest life expectancy at birth in the world are in sub-Saharan Africa. In a number of African countries, life expectancy has been on the decline and premature mortality is relatively high. Since life expectancy at birth and premature mortality are significant indicators of the quality of life in a society, and access to quality medical, social and psychological services remains poor in many African countries, the health and overall well-being of Africans are issues of grave concern.

Some of the major factors that contribute to the high burden of morbidity and mortality in Africa are HIV/AIDS, lower-respiratory infections, diarrhoeal disease and malaria (WHO 2008). Although it is important to remain attentive to the prevalence and dynamics of these leading causes of death in Africa, we argue that violence in its different forms should receive increased attention from national health authorities and public health experts in Africa.

Interpersonal violence and inter- and intra-state conflicts have affected Africa more than any other continent. According to the African Development Bank, violent conflict has

> … exacted a heavy toll in terms of human suffering and lost development opportunities in Africa. Between 1990 and 2005, Africa accounted for about half of the world's battle deaths – the number of people killed in battle. Yet, in situations of conflict, far more people die from disease, starvation, malnutrition, and breakdown of health services than from battle. Thus, war-deaths – which capture these indirect causes of death and also include battle-deaths – tend to be much higher. Conflict also leads to income loss, destruction of infrastructure, and human and financial capital flight. Neighboring countries also bear substantial costs through conflict spillovers, pre-emptive defense expenditures, and catering for refugees. (ADB 2008: xi)

As far as interpersonal violence is concerned, only the low- and middle-income countries of the Americas have higher rates of homicides than Africa. However, more African children under the age of five die from homicide than children on any other continent. Clearly, violence and war have consequences far beyond the body count and physical injuries of their direct victims. The loss for parents, communities and nations of their children, young men and women; the suffering caused

by conflicts; the destruction of roads, homes, transport systems and other infrastructure; and the reversion of development gains is virtually incalculable.

This chapter examines the extent of violence, and consider its possible impact on the well-being of Africans. The link between violence and well-being is usually implied rather than explicit in public health research, national health policies as well as in theoretical development work on public health in Africa. We have attempted to make the link explicit. It is noteworthy that in contra-distinction to other forms of violence, specifically male-on-male violence, the impact of violence against women and on their well-being has received relatively higher attention from researchers and public health authorities. Research on violence against women, in particular violence against intimate partners, has for example indicated its association with the increased likelihood of various medical, psychological and social problems, and therefore reduced well-being (Abrahams et al. 2004; Campbell 2002; Jewkes et al. 2001; Koenig et al. 2003; Maman et al. 2002; Swart et al. 2002). Studies have also pointed out that the consequences of violence against women persist long after the violence has stopped. Campbell, for instance, has observed that the effects of violence against women 'can manifest as poor health status, poor quality of life, and high use of health services' (2002: 1331). Thus, whereas the effects of being struck by a fist or with an object can be observed on a woman's face or body, the less obvious and knock-on effects, such as long-term effects associated with reduced physical, mental and social well-being, are also important and need to be paid attention to.

The relationship between violence and well-being is considered from the perspective of masculinity. Masculinity is seen as a key factor in understanding men's violence towards women and other men, yet it is usually neglected in public health approaches (Anderson & Umberson 2001; Barker & Ricardo 2005; Mullaney 2007; Stevens 2008; Whitehead 2005). As Barker and Ricardo said: 'In Africa, the association of masculinity with violence and risky behaviour has important implications for the efforts of development agencies and governments to reduce violence, vulnerability to civil conflict and the spread of the HIV/AIDS pandemic' (2005: iii). Violence is taken as a crucial element in the construction of ruling African masculinity. Therefore, in societies where avenues for individual and social human development are limited, violence and abuse become even more central in men's strivings to be regarded as successful.

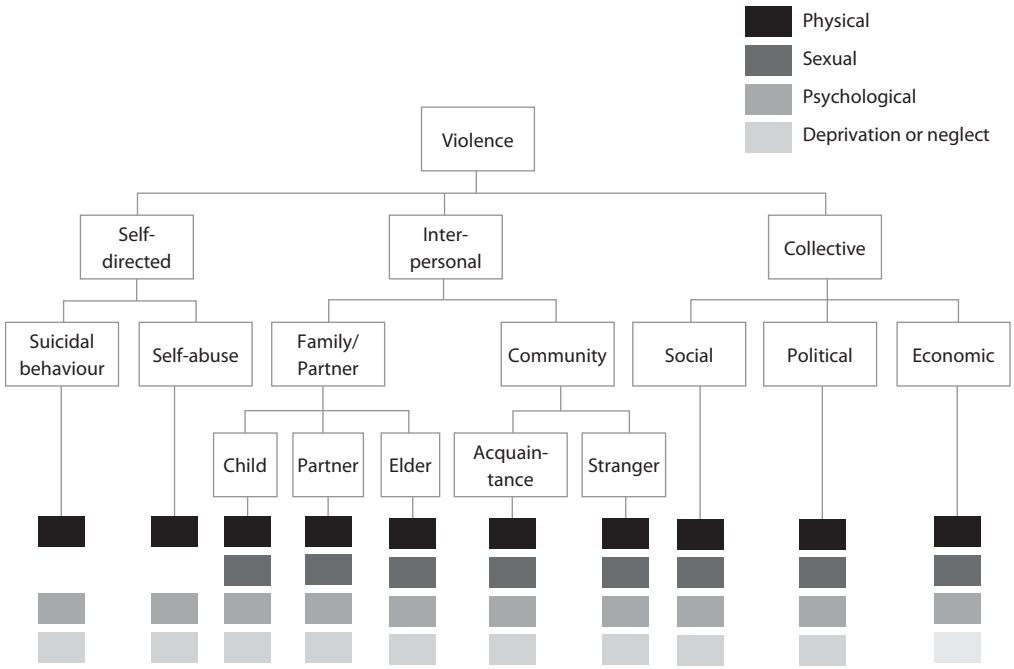
The main contribution this discourse seeks to make is to bring together a number of proxy measures to illuminate the possible presence of well-being or factors that challenge its burgeoning. Even though in any one country there will be specific factors that challenge the promotion of well-being among the population and for different persons, we are concerned with violence and conflict. The main concepts we draw from to assess the presence or absence of well-being in Africa are human development as captured by the United Nations Development Programme (UNDP), and the concept of peace or safety as captured in the Global Peace Index (GPI). However, whilst the two measures can enable the assessment of well-being in and across various countries, as well as make possible links between violence and well-being, there are undeniable gaps that will need new and focused empirical research and the development of new measures. Given the health focus of the discourse, we separated rates of life expectancy (at birth) from the overall Human Development Index (HDI). In view of the focus on violence, rates of intentional injury that indicate the lack of a crucial aspect of well-being – that is, lack of peacefulness or safety – are also tabulated and put alongside the GPI to give a fuller picture of peacefulness and safety. The chapter concludes with a call for increased public recognition of the urgency needed to tackle violence and its impact on the well-being of women and men, and to view them as critical health issues.

Interpersonal, self-inflicted and collective violence in Africa

Following the declaration by the World Health Assembly that violence is a leading public health problem, the World Health Organization (WHO) developed a typology of violence that characterises the different types of violence. The typology classifies violence into three broad categories: i) self-directed or -inflicted violence, ii) interpersonal violence – inflicted by another party or parties; and iii) collective violence – inflicted by larger groups such as states, organised political groupings and militia groups (Krug et al. 2002). These categories are further organised into more specific types of violence, as indicated in Figure 20.1, which also indicates the nature of violent acts as they occur across various categories and subcategories.

According to the WHO, interpersonal violence and self-inflicted injuries are the sixth and eighth leading causes of burden of disease for people aged 15–44 years globally (WHO 2008). At the same time, collective violence, interpersonal violence and self-inflicted injuries and suicide account for an increasing share of the burden of disease, especially among economically productive young adults in developing countries. Bowman et al. (2008) report that the brunt of violence is felt most in low- and middle-income countries and that all but two countries in Africa fall within this category. Since over 90 per cent of violence-related deaths occur in low- and middle-income countries, and the rate of violence-related mortality is nearly two and half times greater than that in high-income countries, Africa bears a disproportionate amount of the impact of violence. With approximately 167 000 deaths from war-related injuries in 2000 (32.0/100 000), the continent contributed the highest number of deaths from wars. This assessment is in relation to all regions of the world (Krug et al. 2002). Africa's rate of mortality from war-related injuries is in sharp contrast to that of high-income countries (0.0/100 000) (Krug et al. 2002).

FIGURE 20.1 *WHO typology of violence*



Source: Krug et al. (2002)

Africa has the second highest rate of homicide (22.2/100 000) among the WHO regions, although behind the low- and middle-income countries of the Americas (27.5/100 000) (Krug et al. 2002). However, the homicide rates for children under five years of age are highest in Africa. The rate of homicide for boys in Africa is 17.9/100 000 and for girls 12.7/100 000 (Krug et al. 2002).

In contrast to other regions of the world, Africa has a lower rate of suicide. In 2000, the suicide rate was 6.7/100 000. This is about two times lower than the global rate of 14.5/100 000. The Western Pacific region and the European region have rates (20.8/100 000 and 19.1/100 000 respectively) that are three times higher than the rate for Africa (Krug et al. 2002).

The African Development Bank has observed that

> … several African countries are currently experiencing violent conflict(s), many more face the threat of violent conflict, while others are just emerging from it. The conflict in the Democratic Republic of Congo has claimed more than five million lives to date. In Kenya, in early 2008, disputed presidential elections triggered inter-communal conflicts, killing hundreds of people and displacing many more. In Chad, intense fighting between rebels and government forces in and around the capital, N'Djamena, claimed several hundred lives in April 2008. In Sudan, the conflict in Darfur has already claimed some 200,000 lives. Between 1997 and 2002, about half of the world's violent conflicts took place in Africa. Civil conflict has been the most common type of conflict in Africa in recent years. There have also been conflicts between nonstate actors, such as in the Niger Delta in Nigeria. Fortunately, wars between sovereign states have ceased. However, tension remains high between some neighboring countries. (ADB 2008: xi)

Africa faces massive developmental challenges, and overcoming contemporary violent conflicts and tensions between neighbours and within countries is a crucial area that national authorities on the continent might wish to pay attention to.

Although relatively little is known about the mental health burden of violence in Africa, available research indicates that interpersonal trauma, such as sexual assault and child abuse, crime-related events, and exposure to community violence, conflict and war are linked to negative psychological outcomes, including cognitive, behavioural and emotio nal symptoms, and psychiatric disorders such as post-traumatic stress disorder (PTSD) (Brown et al. 2009; Ellsberg et al. 2008; Murthy & Lakshminarayana 2006; Musisi 2004; Shields et al. 2008; Suliman et al. 2009; Williams et al. 2007). A psychiatric epidemiological study undertaken in South Africa provides, among other things, national prevalence data on trauma exposure and PTSD (Williams et al. 2004), and socio-demographic predictors of the risk for different types of trauma exposure and levels of distress (Williams et al. 2007). The study suggests that the majority of South Africans have experienced multiple violence-related traumas, with men more likely to experience multiple traumas following their increased exposure to violence (Williams et al. 2007). Kaminer and her colleagues have further established that over a third of the population in South Africa, which is not at war either internally or externally, is exposed to some form of violence during their lifetime, with criminal assault and childhood abuse associated with the greatest number of PTSD cases among men, and intimate partner violence associated with the greatest number of cases among women (Kaminer et al. 2009).

Similarly, recent evidence highlights the deleterious effects of conflict and war on the mental health of the general population, refugees, soldiers and specific vulnerable groups, such as women, children and the elderly. The extent and patterns of psychological and psychiatric morbidity, in particular PTSD/culture-specific PTSD syndromes, depression and anxiety, have been investigated in such

countries as Rwanda, Somalia, Uganda and Sierra Leone. Findings point to a distinct increase in the incidence and prevalence of mental disorders, with prevalence rates in these contexts being associated with the degree of trauma and availability of physical and emotional support (Hess 2008; Murthy & Lakshminarayana 2006; Musisi 2004; Njenga et al. 2006; Onyut et al. 2009).

Males, masculinity, health, violence and war

Research and theory support the contention that one of the main drivers of violent masculinities is the reproduction of sex- and gender-based hierarchies (Carrigan et al. 1985; Ratele 2008). Violence or the threat of violence is a central practice used to produce and perpetuate the unequal relations between females and males as groups, as well as within male groups. Simultaneously, violence becomes constitutive of a certain ideologically dominant form of masculinity in many parts of Africa and the rest of the world. Consequently, constructions of particular forms of masculinity normalise controlling, coercive and aggressive behaviours of men towards women and other men (Redpath et al. 2008). Male violence against women tends to become culturally and socially normative in conditions where men who were previously supported by their society in perceiving women as subordinate find that they can no longer control women or support them economically (Jewkes 2002).

Boonzaier and De la Rey underscore that assertion when they argue that: 'Male violence against women could be described as being enacted in response to a perceived loss of, or an attack on, masculine identity' (2003: 1020). In this context, men's violent practices against women are used to sustain their dominance over women as well as to express their vulnerability where that power is challenged.

Women's vulnerability to men's sexual and gender-based violence during and following armed conflict, as well as their engagement in peace-building processes and the resolution and prevention of conflict, are recognised by various international institutions and frameworks as important issues to address. The United Nations Security Council Resolution on Women, Peace and Security, for example, is specifically directed at the impact of war on women as well as women's contributions to conflict resolution and sustainable peace.[1] Among other things, the Resolution calls for an increase in the participation of women at decision-making levels in conflict resolution and peace processes; encourages the mainstreaming of a gender perspective into peacekeeping operations and all other aspects relating to women and girls; identifies the need to ensure the protection of and respect for human rights of women and girls; highlights the special needs of women and girls during repatriation and resettlement and for rehabilitation, reintegration and post-conflict reconstruction; and emphasises the responsibility of all states to put an end to impunity and to prosecute those responsible for sexual and other violence against women and girls. Likewise, the Security Council has called for an immediate and complete cessation of acts of sexual violence against civilians in conflict zones, unanimously adopting Resolution 1820 on 19 June 2008.[2] The Resolution notes that 'rape and other forms of sexual violence can constitute a war crime, a crime against humanity, or a constitutive act with respect to genocide' (p. 3). It recognises that civilians represent the vast majority of victims of armed conflict, and that women and girls are particularly at risk of sexual violence, including in some cases as a tactic of war to shame, dominate, terrorise and disperse and/or forcibly relocate civilians. The Resolution stresses that such violence could significantly intensify armed conflicts and impede peace processes, and affirms the Council's commitment to adopting steps to address sexual violence targeted at civilians. Recognising that violence against women constrains their participation in public life and therefore in development,

1 United Nations, 2000, S/RES/1325, available at http://www.un.org/events/res_1325e.pdf. Accessed on 18 December 2009
2 United Nations, 2008, S/RES/1820, available at http://www.ifuw.org/advocacy/docs/UN_SC_Resolution1820.pdf. Accessed on 18 December 2009

and in concert with the resolutions noted above, the United Nations Secretary General launched the UNiTE to End Violence Against Women campaign early in 2008. The campaign spans the period 2008–15 and aims to raise public awareness and increase the political will and resources for preventing and addressing the global pandemic of violence against women and girls (United Nations 2009).

These resolutions and statements by the United Nations doubtless serve an important function in calling attention to the global problem of violence against women and girls. However, it is crucial to note that they do not explicitly refer to the fact that it is males who are almost always the perpetrators of violence against women, rape and other forms of sexual violence. This is a serious omission that needs rectification. Related to that, and thus also needing attention, is the role of aggressive forms of masculinity in violence against women and girls. Without scrupulous investigations into violent masculinities, issues of development and well-being of both females and males in troubled societies of Africa may not be adequately addressed (Barker & Ricardo 2005).

Generally, then, actual and threatened violence have been shown to be formative elements in the domination by men as a group over women, by some men over other men as a group, as well as in how manhoods are made (Ratele 2008). Physical dominance, aggressive dispositions and violence are used by men as 'resources for structuring, negotiating and sustaining masculinities, particularly among men who because of their social positioning lack less dangerous means' (Courtenay 2000: 1391). Besides their uses by men to bring about hierarchy between each other, intimidation and coercive measures are employed to put women in their place (Seedat et al. 2009).

Violence and war are but two of the many problems brought about by the excesses and harmful ideologies of ruling African masculinities (Adomako Ampofo & Boateng 2007). Harmful ideas of masculinity are a factor in men's health-related behaviours too. Men may commit suicide because they are unwilling to express that they are in pain and need help from others. Studies have in fact found that regardless of age, race, ethnicity and socio-economic background, men are on the average less likely than women to seek professional help for mental health problems (Addis & Mahalik 2003). A need to demonstrate emotional control, the denial of vulnerability, the pressure to appear strong, the dismissal of any need for help are some of the behaviours and attitudes that may be counterproductive to men's well-being. In their desire to appear powerful, men can often be led to harm themselves, not just others (Courtenay 2000).

Men also engage far less than women in health-promoting behaviours and healthy lifestyle patterns. Studies indicate that the prevalence of risk behaviours among adults is more common among men than women for behaviours such as smoking, drinking and driving, using safety belts, getting health screenings and awareness of medical conditions (Addis & Mahalik 2003; Courtenay 2000). Compared to women, men are more likely to engage in behaviours that increase the risk of disease, injury and death (Courtenay 2000).

Most studies on the association between violence and masculinities in Africa fail to look closely into how men's violent reactions against women and other men might be the result of an interaction between prevailing ideologies of warlike masculinities and elements of compromised societal and psychological well-being (Ratele 2008). In view of the fact that violence and conflict are observable more in African countries, or neighbourhoods within African countries, where development is comparatively low, there is a sound rationale to examine whether and how the well-being of a population might lead to a reduction in the levels of violence within a society.

Well-being

Even though it is widely used, the concept of well-being is complex with no agreed upon definition (Berenger & Verdier-Chouchane 2007; Diener 1994; Gandhi Kingdom & Knight 2004; Moller 2004). On the one hand, health, wealth, employment, education and national development are seen as being among the important criteria in defining well-being. These criteria describe what may be referred to as the economic criteria of well-being. On the other hand, researchers who prefer to concentrate on psychological well-being often interchange mental health with subjective well-being. They consider the important factors for well-being to be life satisfaction, behavioural and emotional adjustment, interpersonal relationships, happiness, self-regard and the lack of unpleasant affect. We do not dwell on the extensive debates that have occurred in well-being studies. Instead, due to a number of considerations, we take a pragmatic approach to well-being. A major consideration in using some elements of economically based conceptions of well-being and some of psychologically based understandings of well-being has to do with the lack of quality data that are comparable across countries. Ready data that can be used to measure and compare the well-being of populations within and across different countries are always scant and fragmentary, but the data situation is worse for Africa. The best that can be done in the current situation is to use available information that can illuminate as far as possible the approximate levels of well-being across countries.

An equally important consideration is the wish to examine well-being in relation to violence. The links between violence and well-being tend to remain unexamined in research on both well-being and violence. Nonetheless, even though there have not been sustained continent-wide efforts to stop wars and bring down the levels of violence, both violence and wars have long been seen as significant issues with effects on good governance, economic development, social welfare provision and health systems in many African countries. The apparent inevitability of conflict and violence in several African countries may be the reason that Africa, as compared to other continents, indicates a quality of life that has worsened rather than improved in the last few decades (AUC 2006). Violence and war do not only result in human fatalities; they also erode cultural and social capital, undermine prospects for just socio-economic growth, harm the environment and deplete the capacity of the state to govern. Violence cannot be regarded only as an issue that relates to systems of policing, criminal justice, military, security and defence, and as an issue that brings challenges to development and growth (Bowman et al. 2008). It has to be recognised as a problem that impacts negatively on the life choices, life satisfaction and happiness of individuals who are the direct victims of violence and war, as well as on the well-being of nations and continents.

The *World Report on Violence and Health* observed that

> … the human cost (of violence) in grief and pain…cannot be calculated. In fact, much of it is almost invisible. While satellite technology has made certain types of violence – terrorism, wars, riots and civil unrest – visible to television audiences on a daily basis, much more violence occurs out of sight in homes, workplaces and even in the medical and social institutions set up to care for people. Many of the victims are too young, weak or ill to protect themselves. Others are forced by social conventions or pressures to keep silent about their experiences. (Krug et al. 2002: 3)

The obverse of this situation has received no attention at all. The social, psychological and economic consequences of lasting peace and safety in society on the mental health of individuals, on their trust of others as a key element of community and societal networks, on material and intangible heritage, on the environment and, of course, on wealth and general societal development may be very hard to calculate, but that is not an adequate reason to underestimate them.

Assessing well-being in relation to violence

The visible and invisible costs of violence on well-being are bound to be difficult to calculate, and no measures are available to capture the costs of violence on the health, social, developmental and psychological well-being of people. We have elected to bring together a number of proxy measures to both illuminate well-being and indicate possible linkages between violence and well-being.

Human Development Index

The first approximate concept underlying our assessment of well-being is human development as defined by the UNDP and concretised in the HDI. The UNDP defined human development as

> … a process of enlarging people's choices. In principle, these choice[s] can be infinite and change over time. But at all levels of development, the three essential ones are for people to lead a long and healthy life, to acquire knowledge and to have access to resources needed for a decent standard of living. If these essential choices are not available, many other opportunities remain inaccessible. But human development does not end there. Additional choices, highly valued by many people, range from political, economic and social freedom to opportunities for being creative and productive, and enjoying personal self-respect and guaranteed human rights. (1990: 10)

The UNDP developed the HDI to measure and compare the level of development in different countries. The HDI combines normalised measures of life expectancy, literacy, educational attainment and standard of living measured as GDP per capita for countries worldwide.

The HDI extends beyond GDP to a broader definition of development. The latter is based on the work of Amartya Sen and others who provided the conceptual foundation for a human development approach that is inclusive of enlarging people's choices and enhancing human capabilities and freedoms, enabling them to live a long and healthy life, have access to knowledge and a decent standard of living, and participate in the life of their community and decisions that affect their lives (UNDP 2009). Accordingly, the HDI measures development by combining indicators of life expectancy, educational attainment and income into a composite development index. The index is not a comprehensive measure of human development as it excludes important indicators such as gender or income inequality, as well as the more difficult to measure indicators such as respect for human rights, political freedoms, happiness and cultural capital. However, it does provide a broader lens for observing human progress and the complex relationship between income and well-being (UNDP 2009).

While the HDI incorporates a measure of life expectancy, given the focus on health-related well-being, it was important to separate out and specify life expectancy (at birth) and adult mortality rates in order to highlight the pertinent aspects of well-being. The figures for life expectancy (at birth) are from the WHO (WHO 2009a), and the rates of adult mortality are from the WHO statistical information system (WHOSIS 2006).

Life expectancy at birth, which refers to the average number of years that a newborn within a given population is expected to live if current mortality rates hold (Adetunji & Bos 2006; WHO 2009b), is seen as the single most important indicator of socio-economic development (AUC 2006). Studies indicate that life expectancy hinges on, among other things, national income and sex or gender (Baingana & Bos 2006; Bradshaw & Timaeus 2006; Heron et al. 2008). Individuals in high-income countries on average live longer than individuals in middle- and low-income countries, while globally females usually have a higher life expectancy at birth than males. To illustrate, the WHO (2008) reports that life expectancy at birth in 2006 in the United States, a high-income country, was

estimated at 80 years for females and 75 years for males, while life expectancy at birth in Zambia, a low-income country, was estimated at 43 years for females and 42 for males. Life expectancy for males and females in 2006 in Africa was estimated at 50 years and 52 years respectively, compared to life expectancy for males and females in the European region at 70 years and 78 years (WHO 2008). According to the AUC (2006), life expectancy at birth in Botswana, Lesotho, Swaziland and Zimbabwe declined as a result of the spread of the HIV/AIDS, and this has to be taken into account in reading the tables on both life expectancy and adult mortality. In these four African countries, life expectancy at birth in 2007 was estimated by the WHO (2009a) to be 56, 45, 48 and 45 years respectively, which is in marked contrast to life expectancy at birth in countries such as Belgium (80 years), Luxembourg (80 years) and Switzerland (82 years) (WHO 2009a).

Global Peace Index

The second evaluative tool we used to approximate well-being is the GPI, which ranks countries by their level of peacefulness (Vision of Humanity 2009). Among the dimensions of the GPI are those that are seen as indicating that peace or safety may be threatened by perceptions of criminality in society, political instability and number of persons in a country's jails. Like the HDI, one of the main advantages of the GPI is that it allows us to rank African countries by their peacefulness, which is considered an important aspect of well-being.

The GPI is the first index to rank countries of the world by their peacefulness. The first GPI was launched in 2007, and subsequently revised in 2008 and then 2009. In 2007, the GPI ranked 121 countries according to their relative states of peace. This number expanded to 140 and 144 countries in 2008 and 2009 respectively (Vision of Humanity 2007, 2008, 2009).

The index is constructed of 23 qualitative and quantitative indicators that include internal and external factors ranging from a country's level of military expenditure to its relations with neighbouring countries and the level of respect for human rights. The indicators are scaled from 1 to 5 and assembled around three key measures, namely: i) measures of ongoing domestic and international conflict; ii) measures of societal safety and security; and iii) measures of militarisation. The first set of measures signifies that peace may be jeopardised by the increasing frequency of external and internal conflicts; deaths arising from externally and internally organised conflicts; the level of internally organised conflict; and conflictual relations with neighbouring countries. The second group of measures indicates that peace may be threatened by increasing perceptions of criminality in society; high numbers of displaced people as a percentage of the population; political instability; a high level of disrespect for human rights; the potential for terrorist acts; a high number of homicides per 100 000 people; a high level of violent crime; the likelihood of violent demonstrations; a disproportionate number of jailed persons per 100 000 population; and a disproportionate number of internal security officers and police per 100 000 people. The third category suggests that the level of militarisation is directly linked to a country's level of peacefulness. Militarisation is signalled by military expenditure as a percentage of GDP; number of armed services personnel per 100 000 people; volume of transfers (imports) of major conventional weapons per 100 000 people; volume of transfers (imports and exports) of major conventional weapons per 100 000 people; funding for United Nations peacekeeping missions; aggregate number of heavy weapons per 100 000 people; ease of access to small arms and light weapons; and military capability and sophistication. Importantly, the GPI has been tested against a number of potential determinants of peace, including levels of democracy and transparency, education and material well-being. Perceptions of corruption, gender inequality, willingness to fight, life expectancy, unemployment, hostility to foreigners and infant mortality are some of the items used to concretise the information on drivers of peace (Vision of Humanity 2007, 2008, 2009).

TABLE 20.1 *HDI rank and value, life expectancy at birth, and rates of adult mortality for African countries*

United Nations Human Development Index value, 2006 (UNDP 2008b)				Life expectancy at birth, 2007 (WHO 2009a)			Adult mortality rate (probability of dying between 15 and 60 years per 100 000 population) both sexes (WHOSIS 2006)		
No.[1]	Global HDI rank	Country	HDI value	No.[2]	Life expectancy at birth (years)	Country	No.[2]	Adult mortality rate/ 100 000	Country
1	52	Libyan Arab Jamahiriya	0.840	1	74	Tunisia	1	751	Zimbabwe
2	54	Seychelles	0.836	2	73	Mauritius	2	722	Lesotho
3	74	Mauritius	0.802	3	72	Libyan Arab Jamahiriya	3	662	Swaziland
4	95	Tunisia	0.762	3	72	Morocco	4	617	Zambia
5	100	Algeria	0.748	5	71	Seychelles	5	564	The Republic of South Africa
6	107	Gabon	0.729	5	71	Algeria	6	533	Malawi
7	115	Equatorial Guinea	0.717	7	70	Cape Verde	7	508	Sierra Leone
8	116	Egypt	0.716	8	68	Egypt	8	504	Tanzania
9	118	Cape Verde	0.705	9	65	Comoros	9	495	Uganda
10	125	The Republic of South Africa	0.670	10	63	Eritrea	10	493	Angola
11	126	Botswana	0.664	11	61	São Tomé and Principe	11	478	Niger
12	127	Morocco	0.646	12	59	Gabon	12	477	Mozambique
13	128	São Tomé and Principe	0.643	12	59	Madagascar	13	468	Botswana
14	129	Namibia	0.634	12	59	Senegal	14	467	Central African Republic
15	130	Congo, Republic	0.619	12	59	Namibia	15	457	Liberia
16	137	Comoros	0.572	12	59	Gambia	16	449	Equatorial Guinea
17	141	Swaziland	0.542	17	58	Togo	17	445	Chad
18	140	Mauritania	0.557	17	58	Sudan	18	436	Cameroon
19	142	Ghana	0.533	17	58	Mauritania	19	434	Burundi
20	143	Madagascar	0.533	20	57	Ghana	20	431	Côte d'Ivoire
21	144	Kenya	0.532	20	57	Benin	21	427	Mali
22	146	Sudan	0.526	20	57	Ethiopia	21	427	Burkina Faso
23	150	Cameroon	0.514	23	56	Liberia	23	326	Ethiopia
24	151	Djibouti	0.513	23	56	Botswana	24	423	Nigeria

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United Nations Human Development Index value, 2006 (UNDP 2008b)				Life expectancy at birth, 2007 (WHO 2009a)			Adult mortality rate (probability of dying between 15 and 60 years per 100 000 population) both sexes (WHOSIS 2006)		
No.[1]	Global HDI rank	Country	HDI value	No.[2]	Life expectancy at birth (years)	Country	No.[2]	Adult mortality rate/ 100 000	Country
25	152	Tanzania	0.503	23	56	Djibouti	25	417	Congo, Dem. Rep. of
26	153	Senegal	0.502	26	55	Congo, Republic	26	416	Kenya
27	154	Nigeria	0.499	27	54	Côte d'Ivoire	27	407	Guinea-Bissau
28	155	Lesotho	0.496	27	54	The Republic of South Africa	28	386	Congo, Republic
29	156	Uganda	0.493	27	54	Kenya	29	385	Rwanda
30	157	Angola	0.484	30	53	Guinea	30	350	Gabon
31	159	Togo	0.479	30	53	Angola	31	343	Djibouti
32	160	Gambia	0.471	30	53	Equatorial Guinea	31	343	Guinea
33	161	Benin	0.459	33	52	Cameroon	33	336	Togo
34	162	Malawi	0.457	33	52	Tanzania	33	336	Namibia
35	163	Zambia	0.453	33	52	Congo, Dem. Rep. of	35	331	Ghana
36	164	Eritrea	0.442	33	52	Somalia	36	327	Benin
37	165	Rwanda	0.435	37	51	Niger	37	323	Somalia
38	166	Côte d'Ivoire	0.431	38	50	Malawi	38	296	Sudan
39	167	Guinea	0.423	38	50	Rwanda	39	288	Mauritania
40	168	Mali	0.391	40	49	Nigeria	40	271	Senegal
41	169	Ethiopia	0.389	40	49	Mali	41	278	Gambia
42	170	Chad	0.389	40	49	Burundi	42	268	Madagascar
43	171	Guinea-Bissau	0.383	40	49	Burkina Faso	43	251	Eritrea
44	172	Burundi	0.382	44	48	Swaziland	44	241	São Tomé and Principe
45	173	Burkina Faso	0.372	44	48	Uganda	45	230	Cape Verde
46	174	Niger	0.370	44	48	Guinea-Bissau	46	214	Comoros
47	175	Mozambique	0.366	44	48	Mozambique	47	186	Egypt
48	176	Liberia	0.364	44	48	Central African Republic	48	174	Seychelles
49	177	Congo, Dem. Rep. of	0.361	49	46	Zambia	49	161	Mauritius

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United Nations Human Development Index value, 2006 (UNDP 2008b)				Life expectancy at birth, 2007 (WHO 2009a)			Adult mortality rate (probability of dying between 15 and 60 years per 100 000 population) both sexes (WHOSIS 2006)		
No.[1]	Global HDI rank	Country	HDI value	No.[2]	Life expectancy at birth (years)	Country	No.[2]	Adult mortality rate/ 100 000	Country
50	178	Central African Republic	0.352	49	46	Chad	50	146	Libyan Arab Jamahiriya
51	179	Sierra Leone	0.329	51	45	Lesotho	51	136	Tunisia
52	*161	Somalia[3]	0.284	51	45	Zimbabwe	52	135	Algeria
53	**151	Zimbabwe[3]	0.513	53	41	Sierra Leone	53	119	Morocco

Notes: [1] Countries ordered in terms of rank (from top to bottom)
[2] Countries ordered in terms of value (from top to bottom)
[3] These UN member countries lacked sufficient cross-national comparable data of good quality. Of the 192 UN member states, only 179 and two additional countries were ranked according to their HDI value.
* Somalia's latest available HDI value and rank comprise 2001 data, obtained from UNDP (2001).
** Zimbabwe's latest available HDI value and rank comprise 2005 data, obtained UNDP (2007).

Even though the GPI incorporates measures of violence and conflict, given the focus of this chapter, we decided to draw other measures into our assessment of the presence or absence of unpleasant conditions (specifically the levels of violence or conflict) or of affect to define well-being. In this case, we used rates of intentional injury as indicative of lack of well-being.

How do different African countries measure up? Assessing well-being in relation to violence

The 2007/08 UNDP Human Development Report, which recorded data from 179 countries, showed that all except one of the countries in the middle- and low-HDI clusters are located in Africa. An HDI value below 0.5 is considered to represent 'low development' and an HDI of 0.8 or more is considered to represent 'high development'. African countries which were found to have a high HDI value are the Libyan Arab Jamahiriya (0.840), Seychelles (0.836) and Mauritius (0.802) (Table 20.1). As expected, countries which had the highest life expectancy and lowest adult mortality rates were generally the same countries that had the highest HDI values, and vice versa. For example, the Libyan Arab Jamahiriya, which had the highest HDI rank in Africa, had the third highest life expectancy at birth rate and the fourth lowest adult mortality rate in Africa. Similarly, Mauritius, which ranked third highest on the Africa HDI rankings, had the second longest life expectancy at birth and the fifth lowest adult mortality rate.

The five highest-scoring sub-Saharan countries are, in descending order, Gabon, Equatorial Guinea, South Africa, Botswana and Namibia. They are respectively ranked 6, 7, 10, 11 and 14 on our Africa HDI and 107, 115, 125, 126 and 129 respectively globally. Their HDI values indicate a medium level of development. Although officially ranked in the group of countries with a medium level of human development (0.670), South Africa, which also happens to have the largest economy in Africa, is an instructive case in that it shows the disconnect between national income and well-being. In terms

of human development, it ranks below countries with much smaller economies, such as Equatorial Guinea and Algeria. In contrast to North Africa, progress in sub-Saharan Africa is reported to have stagnated partly due to economic reversal, but essentially due to the catastrophic effect of HIV/AIDS on life expectancy. Furthermore, in addition to insufficient resources, lack of coordination and weak policies, violent conflict is charged as a factor that continues to slow down development progress on the African continent (UNDP 2009).

However, there were unexpected findings. For example, Gambia, ranked 32 in Africa and 160 globally with an HDI value of 0.471, had a relatively favourable life expectancy of 59 years (as compared, for instance, to Angola, Uganda and Lesotho, which have higher HDI values) and low adult mortality rate of 278 per 100 000 (compared to Namibia and Kenya, which are also ranked higher than Gambia by the UNDP). Similarly, Eritrea, with an HDI value of 0.442 and a rank of 164 in the world and 36 in Africa, had a relatively favourable life expectancy and a low adult morality rate.

Unanticipated findings were also discovered when examining life expectancy at birth in relation to life expectancy between 15 and 60 years respectively (that is, adult mortality rate). It was reasoned that each had to be considered as individually indicative of the health of the population of a country, and thus of the level of development. The expectation was that countries that ranked low on the HDI must logically have low life expectancy at birth as well as elevated rates of adult morality. From the measures used in this study, it is clear that this is not always the case. Countries which were placed low on the latest global and African HDI country rankings, such as Mali (168 and 40 respectively) and Mozambique (175 and 47), have life expectancies at birth of under 50 years, as expected. However, these countries have quite different rates of adult mortality. Mali's life expectancy at birth is 49 years and its adult mortality rate is 427/100 000. In contrast, even though Mozambique's life expectancy at birth is close to Mali's at 48 years, its adult mortality rate is higher (477/100 000).

Such unexpected findings suggest other explanations for the high life expectancy and low adult mortality rates besides national income. These findings would not have been evident had we not considered rates of adult mortality in addition to the HDI in assessing countries.

Three possible alternative explanations can be offered. First, what these findings suggest is that while poorer than countries such as Angola and Kenya (as indicated by the HDI), a country like Gambia may be paying more attention to health-related well-being (as indicated by rates of adult mortality and life expectancy at birth) and does not have as high levels of violence as the other countries.

The second explanation may have to do with the quality of the data from different countries on all or specific variables under examination. It may be that the reliability of the data for the different countries is open to question and should be treated with caution.

Lastly, it is possible that there are shortcomings in relation to the measures themselves. Even though the UNDP (2008a) has claimed that the HDI attempts to look beyond GDP to a broader definition of well-being, and uses a range of indicators, it may still have glaring shortcomings. The question is, does the construct of development as operationalised in the HDI neglect some critical contextual factors, such as the respect for human rights, levels of violence against women and socio-economic inequality within a country? If these three factors are deemed important considerations in assessing well-being, the HDI is not equal to the task of fully assessing levels of well-being among Africans. Although there are other important factors that the HDI overlooks, these contextual factors are likely to have a bearing on HDI rankings and values were they to be factored into the calculations of the HDI. At the moment, the neglect of critical contextual factors leads to unexpected and inconsistent findings on measures of health and quality of life.

TABLE 20.2 *GPI ranking and score, and rates of intentional injury of African countries*

Global Peace Index ranking, 2009 (Vision of Humanity 2008)				Intentional injuries: Age-standardised death rates from self-inflicted injuries, 2002 (WHO 2004)		
No.[1]	Global rank	Country	Score	No.[1]	Per 100 000	Country
1	34	Botswana	1.643	1	15.3	Côte d'Ivoire
2	44	Tunisia	1.698	2	13.6	Sierra Leone
3	46	Libyan Arab Jamahiriya	1.710	3	13.1	Central African Republic
4	47	Malawi	1.711	4	12.6	The Republic of South Africa
5	51	Gabon	1.758	5	11.9	Angola
6	52	Ghana	1.761	6	11.4	Mauritius
7	53	Mozambique	1.765	7	11.0	Malawi
8	54	Egypt	1.773	8	10.8	Rwanda
9	58	Zambia	1.779	8	10.8	Burundi
10	59	Tanzania	1.798	10	10.2	Seychelles
11	61	Equatorial Guinea	1.801	11	10.1	Somalia
12	63	Morocco	1.811	12	10.0	Liberia
13	65	Namibia	1.841	13	9.8	Congo, Republic
14	71	Burkina Faso	1.905	14	9.5	Namibia
15	72	Madagascar	1.912	15	9.2	Eritrea
16	80	Senegal	1.984	15	9.2	Kenya
17	86	Rwanda	2.027	15	9.2	Niger
18	95	Cameroon	2.073	18	9.1	São Tomé and Principe
19	96	Mali	2.086	19	8.9	Lesotho
20	100	Angola	2.105	20	8.7	Sudan
21	103	Uganda	2.140	21	8.3	Mali
22	106	Congo, Republic	2.202	21	8.3	Burkina Faso
23	110	Algeria	2.212	23	7.8	Mauritania
24	113	Kenya	2.266	24	7.6	Guinea
25	123	The Republic of South Africa	2.437	25	7.5	Zimbabwe
26	124	Mauritania	2.478	25	7.5	Botswana
27	117	Côte d'Ivoire	2.342	27	7.3	Equatorial Guinea
28	127	Burundi	2.529	27	7.3	Nigeria
29	128	Ethiopia	2.551	27	7.3	Congo, Dem. Rep. of
30	129	Nigeria	2.602	27	7.3	Chad

Intentional injuries: Age-standardised death rates as a result of war, 2002 (WHO 2004)

No.[1]	Violence	Country	No.[1]	Per 100 000	Country
1	60.7	Sierra Leone	1	193.6	Burundi
2	51.1	Angola	2	130.2	Congo, Dem. Rep. of
3	45.6	The Republic of South Africa	3	112	Somalia
4	41.6	Liberia	4	91.8	Liberia
5	38.6	Somalia	5	57.9	Sudan
6	33.2	Côte d'Ivoire	6	52.6	Congo, Republic
7	33.1	Sudan	7	43.9	Uganda
8	32.6	Namibia	8	33.8	Zimbabwe
9	29.6	Guinea	9	32.3	Côte d'Ivoire
10	28.8	Nigeria	10	19.0	Angola
11	28.6	Central African Republic	11	18.3	Algeria
12	26.5	Ethiopia	12	16.5	Guinea
13	27.9	Uganda	13	16.4	Central African Republic
14	27.3	Congo, Dem. Rep. of	14	10.9	Senegal
15	25.4	Rwanda	15	9.9	Sierra Leone
16	23.4	Burundi	16	9.0	Rwanda
17	20.6	Congo, Republic	17	7.2	Mozambique
18	19.0	Niger	18	5.5	Kenya
19	18.2	Kenya	19	3.7	Nigeria
20	17.1	Burkina Faso	20	2.3	Eritrea
21	16.9	Mali	21	2.1	Namibia
22	15.9	Equatorial Guinea	22	2.0	Chad
23	15.5	Mauritania	23	0.6	Ethiopia
24	15.8	Guinea-Bissau	23	0.6	Guinea-Bissau
25	15.0	Chad	25	0.2	Djibouti
26	13.6	Zimbabwe	26	0.1	Mauritania
27	13.3	Senegal	26	0.1	Niger
28	13.1	Algeria	26	0.1	Malawi
29	13.0	Cameroon	29	0	The Republic of South Africa
30	12.8	Togo	29	0	Zambia

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Global Peace Index ranking, 2009 (Vision of Humanity 2008)				Intentional injuries: Age-standardised death rates from self-inflicted injuries, 2002 (WHO 2004)		
No.[1]	Global rank	Country	Score	No.[1]	Per 100 000	Country
31	133	Central African Republic	2.733	31	7.2	Guinea-Bissau
32	134	Zimbabwe	2.736	32	6.7	Cameroon
33	138	Chad	2.880	33	6.6	Togo
34	139	Congo, Dem. Rep. of	2.888	33	6.6	Benin
35	140	Sudan	2.922	35	6.4	Madagascar
36	142	Somalia	3.257	35	6.4	Senegal
37	N/A	Seychelles	N/A	35	6.4	Swaziland
38	N/A	Mauritius	N/A	38	6.2	Gambia
39	N/A	Cape Verde	N/A	39	6.1	Gabon
40	N/A	São Tomé and Principe	N/A	39	6.1	Zambia
41	N/A	Comoros	N/A	39	6.1	Mozambique
42	N/A	Swaziland	N/A	42	5.5	Ghana
43	N/A	Djibouti	N/A	42	5.5	Djibouti
44	N/A	Lesotho	N/A	44	5.4	Ethiopia
45	N/A	Togo	N/A	45	4.5	Tunisia
46	N/A	Gambia	N/A	46	4.4	Comoros
47	N/A	Benin	N/A	47	4.1	Libyan Arab Jamahiriya
48	N/A	Eritrea	N/A	48	3.9	Cape Verde
49	N/A	Guinea	N/A	49	3.8	Algeria
50	N/A	Guinea-Bissau	N/A	50	3.4	Uganda
51	N/A	Niger	N/A	51	2.4	Morocco
52	N/A	Liberia	N/A	52	1.7	Egypt
53	N/A	Sierra Leone	N/A	53	N/A	Tanzania

Note: [1] Countries ordered in terms of value (from highest to lowest)

Turning to the GPI, the latest index shows that in Africa the most peaceful country in 2009 was Botswana, ranked at 34 in the world, and the least peaceful were the DRC (ranked at number 139 in the world), Sudan (140) and Somalia (142) (Table 20.2).

Other African countries that feature high in the top 50 of the global GPI are Tunisia (44), Libya (46) and Malawi (47). The positions of Tunisia and Libya on the GPI are consistent with their positions on the HDI, while Botswana and Malawi are less so. Given the relatively high rates of adult mortality and low life expectancy at birth in Botswana and Malawi (compared to Tunisia and Libya), one possible conclusion to make is that peacefulness and safety as conceived by the GPI have no direct bearing on whether or not one lives to a healthy old age. The question is: what good are the peacefulness and safety of a country if many of its citizens will not live long enough to enjoy that security and tranquility?

Intentional injuries: Age-standardised death rates as a result of war, 2002 (WHO 2004)

No.[1]	Violence	Country	No.[1]	Per 100 000	Country
31	12.7	Benin	31	N/A	Libyan Arab Jamahiriya
32	12.3	Madagascar	–	N/A	Seychelles
33	12.0	Mozambique	–	N/A	Mauritius
34	11.8	Gambia	–	N/A	Tunisia
35	11.4	Malawi	–	N/A	Gabon
36	11.2	Gabon	–	N/A	Equatorial Guinea
37	10.7	Ghana	–	N/A	Egypt
38	9.6	Eritrea	–	N/A	Cape Verde
39	9.0	Comoros	–	N/A	Botswana
40	8.6	Lesotho	–	N/A	Morocco
41	7.3	Botswana	–	N/A	São Tomé and Principe
42	6.8	Swaziland	–	N/A	Comoros
43	5.3	São Tomé and Principe	–	N/A	Swaziland
44	5.1	Zambia	–	N/A	Ghana
45	4.1	Djibouti	–	N/A	Madagascar
46	3.5	Seychelles	–	N/A	Cameroon
47	2.8	Libyan Arab Jamahiriya	–	N/A	Tanzania
48	2.6	Mauritius	–	N/A	Lesotho
49	2.3	Tunisia	–	N/A	Togo
50	2.3	Cape Verde	–	N/A	Gambia
51	1.5	Egypt	–	N/A	Benin
52	1.3	Morocco	–	N/A	Mali
53	N/A	Tanzania	–	N/A	Burkina Faso

These contradictions notwithstanding, Botswana's high and improved position is in sharp contrast to that of its neighbouring states, South Africa (123 out of 144 countries of the world) and Zimbabwe (134). These two countries have been singled out in the GPI report as among the world's least peaceful societies. Zimbabwe was one of the worst performers on the following indicators: level of organised internal conflict, respect for human rights, relations with neighbouring countries, perceptions of criminality in society, ease of access to weapons of minor destruction, political instability, level of violent crime and likelihood of violent demonstrations (Vision of Humanity 2009). It received a score of 4 and worse on all of these, where a score of 1 is most peaceful and 5 least peaceful. South Africa performed as unfavourably as Zimbabwe – receiving scores of 4 or worse – on all of the same indicators, except on respect for human rights and relations with neighbouring countries. South Africa also received the worst possible score (5) on number of homicides per 100 000 people and a score of 4 on military

capability/sophistication. Along with Madagascar, South Africa is cited as one of the five countries (the others being Mexico, Latvia and Yemen) that experienced the greatest deterioration in peacefulness (Vision of Humanity 2007, 2008, 2009). South Africa descended in rank from 99 out of 121 countries in 2007, to 116 out of 140 countries in 2008, to its current rank (123 out of 144 countries); Madagascar moved from 41 out of 121 countries in 2007, to 43 out of 140 countries in 2008, to its current rank of 72 out of 144 countries.

In sum, all the countries that had the biggest falls in peacefulness are racked by violent protests, political instability, threats of terrorist attacks, increased levels of criminal violence, currency crises or drug wars (Vision of Humanity 2009).

What the GPI offers when considered in the light of the HDI are those indicators that the latter neglects, even though they apparently have an impact on well-being. In short, to think of development without considering a country's peacefulness and safety is curious. In turn, though, what the HDI offers when examined in relation to the GPI is those measures that the latter glosses over but that surely have a determining impact on the peacefulness of countries and societal safety. In our assessment we conclude that an instrument that aims to assess societal safety and a country's peacefulness, yet overlooks significant indicators of health like premature adult mortality, has a grave shortcoming.

Regardless of their shortcomings, though, the GPI and the HDI offer us a start in analysing and working towards well-being in Africa. It is important to note that the two indices and the additional measures employed here are proxies of the approximate levels of well-being, and the links between well-being and violence as denoted by what are argued to be revealing indicators of direct and structural violence and their outcomes. These proxies are considered to act as beacons signalling the levels of well-being and the possible intersection between violence or peace and a society's well-being. The utility of these values is that it also allows for a comparison to be made between countries in the region. It is clear that the GPI and the HDI have severe limitations, even if they are the best available approximations. They have to be supplemented by other data, as we have tried to do.

Well-being, masculinity and violence

The measures of human development and peacefulness utilised in the examination of well-being within and across different African countries suggest that interpersonal, collective and self-directed violence may have a direct and indirect impact not only on the lives of those immediately involved but also on the well-being of the population. As expected, countries such as Kenya, Côte d'Ivoire, South Africa, Zimbabwe, Chad and the Sudan, which ranked low on the latest GPI or had descended in their ranking on peacefulness and safety, are the same countries which experienced some form of violence or threat to peacefulness (Vision of Humanity 2009).

How is the violence or threat to peacefulness to be explained? The contention, then, is that certain forms of masculinity pose a serious threat not only to the lives of individual women and men who find themselves the victims of collective and interpersonal violence. Prevalent aggressive masculinities are antithetical to the well-being of countries. Aggressive masculinities are harmful to societies in that the aggression is directed against everyone, females and males. Whereas females tend to be victimised by males' physical and sexual violence, it is males who tend to be disproportionately involved in interpersonal violence and war, as both perpetrators and victims. As the World Report on Violence and Health observed in 2000:

> [M]ales accounted for 77% of all homicides and had rates that were more than three times those of females (13.6 and 4.0, respectively, per 100,000). The highest rates of homicide in the world are found among males aged 15–29 years (19.4 per 100,000), followed closely by males aged 30–44 years (18.7 per 100,000). (Krug et al. 2002: 10)

In Africa, the estimated age-standardised male mortality caused by homicide in 2000 was 33.4 per 100 000 (or 82 000 males), whereas the estimated age-standardised female mortality caused by homicide was 11.8 per 100 000 (or 34 000) (Krug et al. 2002: 10). Compared to zero deaths in the Western Pacific Region, 122 000 males and 45 000 females were estimated to have died from war-related injuries in Africa in 2000. The second highest rates were found in the South-East Asia region, where 63 000 males and females died of war-related injuries.

War, which often includes sexual violence as a weapon, and interpersonal violence, which covers intimate partner and sexual violence against non-intimates, are pivotal practices in perpetuating gender inequality and male–male inequality. Thus, war and violence become critical in the definition of manhood since hostile, controlling and coercive behaviours of men towards women and other men are perceived as acceptable in predominant forms of masculinity (Boonzaier & De la Rey 2003; Redpath et al. 2008; Seedat et al. 2009).

Without losing sight of the positive contributions that men have made to the world and in Africa, 'much of what is bad in the world, from genocide to terrorism, and including interpersonal violence, is essentially the product of men and some of their masculinities' (DeKeseredy & Schwartz 2005: 353). This has to do with, among other things, the fact that traditional notions of masculinities globally and in Africa are closely associated with weaponry (firearms, swords, spears, knives, stones and rocks, for example) and its uses in interpersonal violence, in the same way that masculinity is associated with weaponry (military aircraft, tanks, bombs, poison gas, and so forth) and its uses in international and civil conflicts. Besides the domination of women, sexual prowess, leadership and money, ruling ideas about manhood in Africa and other parts of the world are usually based on a show of muscles and pluck (Luyt 2005), rather than on attentiveness to others, openness to the world and readiness to admit mistakes.

Masculinity as competitiveness, strength and heroism readily translates into privileging of a willingness to go to war and be violent (Seedat et al. 2009). Male violence against females and other males functions not just instrumentally but more often expressively: to assert men's ideas about their own manhood to others and prevail over them (DeKeseredy & Schwartz 2005). Studies have shown that there is a mutual association between militaristic values and traditionally dominant forms of masculinity. The valorisation of militarism is an important part of the ruling ideologies of idealised manhood globally and in Africa, while at the same time militarism feeds into ideologies of masculinity through privileging aggressiveness, cruelty, stoicism and risk taking, and suppressing empathy for other's pain (Cock 1993; Gill 1997; Higate & Hopton 2005; Nagel 1998; Sasson-Levy 2002). Research has indicated that there are obvious and direct connections between violence and conflict and the way that men are formed as men (Barker & Ricardo 2005). In her critique of the authoritarian military regimes of Nigerian rulers Babangida and Abacha, Amina Mama noted that 'in the thinking of ordinary Nigerians, the military man exemplifies the masculine ideal' (1998: 4). In South Africa, the history of white racio-nationalist military and security violence and black nationalist liberation armed struggle has shaped the form of masculinity that came to be dominant in society, one which 'valorize(s) the martial attributes of physical strength, courage, and an acceptance of hierarchical authority' (Coovadia et al. 2009: 13). Du Pisani notes that 'the heroic warrior (with General Christiaan de Wet as the supreme example) was a prominent metaphor of Afrikaner masculinity' (2001: 165). A similar image is apparent among the Zulu, with King Shaka considered by many as the all-time representative of true masculinity. The image

of a Zulu man around the world is an individual 'carrying a rawhide shield, knobkierie and spear', to paraphrase Jacklyn Cock (1993: 53). Whilst these ideas, images, metaphors and valorisations might serve to perpetuate stereotypes about one group or another, some men from the stereotyped groups may in fact not be unhappy about being depicted as militaristic, warlike, authoritarian and heroic. Such self-images of men, when they result in violence and conflict, are possibly associated with reduced levels of well-being.

Conclusion

While the costs of injury to and loss of life of the direct victims of collective and interpersonal violence are obvious, this chapter has shown that violence and conflict associated with prevalent forms of masculinity are an under-appreciated threat to the well-being of countries. The chapter brought together a number of proxies to assess the approximate levels of well-being or factors that challenge its burgeoning. Violence and conflict were singled out as crucial facts that challenge the promotion of well-being in many African countries.

The lack of comparable data on many countries in Africa is a serious drawback for anyone aiming to examine within-country and cross-country comparisons of levels of well-being. The importance of adequate reliable data for any public health policy and development planning cannot be overestimated. The lack of quality data is itself a possible indication of the unmet informational needs of many people in several African countries. Despite this, the chapter used two tools to assess the levels of well-being in Africa: the first based on the concept of human development as captured by the UNDP's HDI, and the second based on the concept of peacefulness or safety as captured by the GPI. Given the focus of the study, we separated out rates of life expectancy (at birth) from the overall HDI, and brought rates of adult mortality within and across different African countries into the assessment of well-being. Furthermore, we included in our assessment of the links between well-being and violence the rates of intentional injury for different countries – these are seen as indicative of a lack of well-being.

The tools used here show that in many African countries, interpersonal, collective and self-directed violence appears to have an impact on well-being. There is therefore a need for increased public recognition of the ill effects of all forms of violence on the well-being of a country, and not only on the direct victims of violence. At the same time, while the two measures and the additional information used here enable us to make a rough approximation of the presence or absence of well-being, and to make some links between violence and well-being, there are clearly crucial gaps that need new empirical research and the development of measures.

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