



## Thoughts on national healing

### *Research and Advocacy Unit[RAU]*

#### **Background**

Civil society has long anticipated the current dynamics and questions facing those concerned with transitional justice in Zimbabwe. In 2003, against the background of inter-party talks about possible transition, a Symposium was held in Johannesburg, which made comprehensive recommendations on the ways to manage the consequences of organized violence and torture, including ways in which truth, accountability and healing should take place. Here see Appendix 1 on *Mechanisms for Addressing the Needs of Victims*.<sup>i</sup>

However, it is apparent that the national situation has changed (and deteriorated) considerably since 2003. A strong argument can be made that Zimbabwe now conforms to the kind of situation currently termed a "**complex emergency**". In the context of economic collapse, the collapse of all supportive services [health and social welfare], severe food shortages, and mass violence, Zimbabwe resembles a country at war, but without the obvious features of war. The types of trauma reported, especially in the past five years, conform in most respects to those seen in obvious times of war - the profiles for the pre-Independence period and Matabeleland in the period 1980 to 1987 are markedly similar to that seen nationally since 2000. Certainly, the mental health consequences seem wholly similar to what would be seen in other complex emergencies where there has been obvious war.

The most manifest effects are physical, seen in illnesses and injuries, which may be short-lived, but also may lead to long-term disability. However, the most persistent consequences will be psychological, and especially if the trauma was deliberately inflicted<sup>ii</sup>. Here four points should be emphasized:

- Firstly, the most probable long-term consequence of experiencing organized violence and torture is the development of a psychological disorder.
- Secondly, the probability of psychological disorder following organized violence and torture increases with the frequency of experiencing physical harm, such as torture.
- Thirdly, the probability of psychological disorder increases with the number of exposures to trauma such as organized violence and torture.
- Fourthly, whilst men are probably the most common primary victims of OVT, women and children are disproportionately the most common secondary victims, and certainly secondary victims are much more common than primary victims.

An additional concern in the aftermath of mass violence is the possibility of continued violence and serious retributive violence in which the previous victims begin to take revenge for their abuses. Whilst no intervention can claim that this can be wholly avoided, active intervention may well mitigate the scale, especially if the mental health interventions are allied to peace building, and blanket amnesty is not applied. The current trends towards retribution will not be curtailed by impunity or amnesty, rather these juridical actions are likely to inflame the situation. As was pointed out in the 2003 recommendations, there is need for comprehensive consultation with the victims and the communities – which should be allied to healing and

peace-building – prior to any decision being made about the nature of any accountability process. As was stated in the Recommendations:

*Prior to the establishment of these mechanisms there must be an extensive process of consultation with the victims and the broader community about the mechanisms and the sort of persons who should be made responsible for operating them. Civic organizations and the churches should assist in this process.*

Such a comprehensive consultation process will clearly take time, probably no less than 18 months (and ideally open-ended), and the involvement of the communities in determining the future response to the past **may** have a salutary effect on minimising retributive violence.

### **Dealing with complex emergencies<sup>iii</sup>**

A complex emergency requires a strong and sustained humanitarian response, and any programme should adopt as a framework the following principles<sup>iv</sup>:

- *The co-ordination of mental health care;*
- *Good basic assessment of the problems and the establishment of a monitoring process;*
- *Implementation of an early intervention phase;*
- *Utilisation of the de-facto mental health system;*
- *Emphasis on training and education;*
- *Implementation, management and monitoring of a culturally competent system of care;*
- *Stress on ethics and community participation;*
- *Care to prevent negative mental health consequences in mental health providers;*
- *Commitment to outcome assessment and research.*

These principles can be applied within a variety of different approaches, but whichever approaches are used they should be guided by these principles. Zimbabwe is fortunate in that approaches to dealing with the aftermath of complex emergencies have been developed locally over the years, and these can be used again in dealing with the current situation<sup>v</sup>.

### **Developing a community response to trauma**

Although it will be imperative for the capacity of the state health services to be improved, this will obviously be a long-term process, and there is need for an immediate response. This can only be effected by using the existing resources within the communities such as they may be. As pointed out by Mollica et al<sup>vi</sup>, this needs to follow what is termed the “psychosocial” approach:

*The psychosocial approach suggests that although people are affected in many ways, three areas in particular are affected: human capacity (ie, skills, knowledge, and capabilities), social ecology (social connectedness and networks), and culture and values. People need support to enhance both their own and the community's psychosocial well-being by strengthening each of these areas.*

There are a number of approaches that can be utilised here that have already shown some efficacy with older populations of survivors<sup>vii</sup>. One more recent approach that shows considerable promise, and has a fair track record is termed the “Tree of Life”. The Tree of Life is a healing and empowerment workshop that combines the concepts of story telling, healing of the spirit, reconnecting with the body and re-establishing a sense of self-esteem and community<sup>viii</sup>. This process was developed from traditional ways of dealing with difficult issues in communities amongst the Native Americans, and shares common features with many similar circle processes<sup>ix</sup>. It is carried out over a period of two to three days with a group living and sharing meals together. During the course of the workshops, it was discovered that the victims are more at ease when they are all from the same community rather than a group of strangers, this allows them to gain the trust and respect sooner rather than later.

The approach can easily be taught to survivors, results in the formation of small group affiliations, and can form the basis of cohesive groups around which other activities can be implemented. With the enormous displacements and political polarisation that have taken place over the past nine years, it cannot be

assumed that communities have maintained the cohesiveness that characterised the rural areas in the past, and hence it may be necessary to assume that a degree of community re-building will need to take place.

There will be need to integrate healing approaches with peace building approaches, and an important first step will be careful mapping of the churches, NGOs and civil society organizations that are doing peace building and healing within the communities. This mapping can then lead to the development of a strategy that accords with the principles outlined earlier.

### **State psycho-social support for victims of organized violence and torture**

Any community approach will need to interface with the formal health system in the end, so that the more serious cases can be referred on to professional help. However, it seems relevant to point out that both approaches can develop in parallel: improving, or even creating the capacity of, the formal health system to manage the needs of survivors, can develop alongside the development of community-based assistance. Experience with Zimbabwean survivors in recent years has shown considerably that they have more resilience than might have been expected from the literature, and hence there is reason to be optimistic that low-cost, para-professional approaches may go a considerable way to meeting the needs of the many thousands of survivors.

However, there will still be need for referral systems for the more damaged individuals, some of which may be provided by churches and NGOs, but there will remain the crucial need for the formal mental health system to provide support. Below are some suggestions for a strategy to develop a responsive mental health system<sup>x</sup>.

#### **Identification of victims**

It is evident that no treatment can be efficacious if the correct diagnosis is not found, and here it is extremely important to note the very low rates of detection by health workers. Detection of psychological disorders is generally very poor, even amongst doctors, and the survivors of torture are no exception to this finding. The remedy for poor detection is training of health workers in detection skills, and training can be easily done, and can have immediate benefits.

*All health staff at the primary care and secondary care levels should be trained in the identification of psychological disorders, including disorders due to torture and organized violence.*

#### **Assessment**

Disorders due to torture and organized violence present special difficulties in assessment for health workers, and will thus require the combined efforts of a team rather than single worker. Here it is important to stress that the fundamental aim of all assessment must be to facilitate treatment or rehabilitation, although assessments may also be used to determine compensation. The current state of the medical services and the enormous morbidity due to violence may preclude the development of a specialist service for this client group, but a minimum service can be developed.

*It is therefore recommended that assessment of torture survivors be carried out at the District level by a team comprising doctor, psychiatric nurse, rehabilitation technician, and social worker. This team should be supported by either referral to centrally-based specialists, or, better, the regular attendance of these specialists at the District level.*

#### **Treatment**

Treatment must operate from the understanding that full cure may be impossible for most survivors of torture and organized violence, and thus rehabilitation may be the only goal. Furthermore, there must be the acceptance that rehabilitation may have to continue for the duration of a survivor's life, and thus must be continuously available. There probably should be compilation of a register of survivors locally in order that the continuous care needed by torture survivors can be continually monitored.

Treatment must be holistic, dealing with the physical, the psychological, and the social. Treatment should stress equally the individual, the family and the community, and thus will require a team approach. Survivors of torture and organized violence must be offered counselling, both individual and family, physical therapy, and community development in order to maximize their fullest possible recovery.

*It is therefore recommended that each District have a core of trained counsellors and rehabilitation technicians, supported locally by a psychiatric nurse and doctor, with support from centrally-based specialists in the various modalities mentioned.*

## **Organization of services**

The principles of primary health care - cure, rehabilitation, prevention and promotion - should always guide the organization of services for survivors of torture and organized violence. This requires the recognition that the point of health care be available close to patients' homes, and that the staff of these health facilities be able to manage the conditions that present to them. A suggested model is as follows:

<b>Primary Health Centre</b>	<i>Identification of disorders. Management of minor disorders. Referral of more complex conditions, including disorders due to torture and organized violence.</i>
<b>District Hospital</b>	<i>Assessment of severe disorders. Individual counselling. Family counselling. Physical therapy. Medical interventions. Co-ordination of community work.</i>
<b>Provincial Hospital</b>	<i>Assessment of complex conditions. Specialist treatment.</i>

## **Compensation**

Compensation is a likely to be a central feature of the disgruntlement driving retribution, and it will be difficult to ignore this completely. A list of violations for which compensation should be paid for individuals has been provided by the Governing Council of the United Nations Compensation Commission<sup>xi</sup>. This list may be described shortly as follows:

- Category A: A spouse, child or parent of the individual who suffered death;
- Category B: The individual suffered serious personal injury involving dismemberment, permanent or temporary significant disfigurement, or permanent or temporary significant loss of use or limitation of use of a body organ, member, function or system;
- Category C: The individual suffered sexual assault or aggravated assault or torture;
- Category D: The individual witnessed the intentional infliction of events described in Categories A, B or C on his spouse, child or parent;
- Category E: The individual was taken hostage or illegally detained for more than three days, or for a shorter period, in circumstances indicating an imminent threat to his or her life;
- Category F: On account of a manifestly well-founded fear for one's life or of being taken or illegally detained, the individual was forced to hide for more than three days;
- Category G: The individual was deprived of all economic resources, such as to threaten seriously his or her survival and that of his or her spouse, children or parents, in cases where assistance from his or her Government or other sources has not been provided.

Individual compensation will be highly problematic, and, given the extremely high numbers of people affected in the past nine years, let alone those from the 1980s and the 1970s, exceptionally expensive. Hence, it will seem inevitable that recourse will have to be made to forms of community compensation, outside of the more egregious violations for which it will be hard to avoid individual claims. The form of community compensation will obviously need to have strong assent from the communities themselves, and thus it will be important that this is addressed in the consultative process referred to above.

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## **Declaration of Civil Society and Justice in Zimbabwe Symposium**

### **Mechanisms for addressing the needs of victims**

Victims of all past human rights abuses have the right to redress and to be consulted about the nature of the mechanisms that will be established to address their needs.

The mechanisms that are established must be victim-centred and must be capable of addressing the needs of victims in a meaningful way.

Prior to the establishment of these mechanisms there must be an extensive process of consultation with the victims and the broader community about the mechanisms and the sort of persons who should be made responsible for operating them. Civic organizations and the churches should assist in this process.

The main mechanism for dealing with past human rights abuses will be a Truth, Justice and Reconciliation Commission. This Commission will have the following functions:

Regarding the human rights abuses prior to 1960 the Commission's main functions will be:

- *to investigate human rights abuses that occurred prior to 1960 and compile a full and accurate record of these abuses;*
- *to determine the social and economic effects of these abuses;*
- *to establish the extent to which these historical abuses continue presently to negatively impact upon the rights of Zimbabweans;*
- *to make appropriate recommendations about remedial steps to address the needs of victims of these abuses and present injustices emanating from past injustices;*
- *to refer cases involving gross human rights violations to the Attorney-General for possible criminal prosecution.*

Regarding the human rights abuses subsequent to 1960 the main functions of the Commission will be:

- *to take steps to ensure the protection and preservation of evidence of human rights abuses;*
- *to investigate human rights abuses that have occurred between 1960 and the date upon which this Commission commences its operations, including violations during a transitional period and compile a full and accurate record of these abuses using available documentation, victim statements and testimony from perpetrators;*
- *to require persons accused of human rights violations but who deny that they committed such violations to appear before the Commission so that these cases can be fairly investigated and findings can be made;*
- *to require persons who admit to having committed human rights violations over this period to appear before the Commission, make full and accurate admissions about their involvement;*
- *to recommend that those found to have committed gross human rights abuses should be removed from any positions of power and authority that would allow them to commit further human rights abuses in the future;*
- *to recommend appropriate remedial steps to provide reparations to victims, including referral of cases for prosecution, non-repetition of abuse, rehabilitation, provision of monetary compensation to individuals or communities that have been particularly badly*

*affected by grave human rights abuses, ordering perpetrators to pay monetary compensation or make other types of reparation to victims;*

- *to explore the desirability of facilitating genuine community reconciliation;*
- *to facilitate processes of community driven exhumation, reburial and memorialisation.*
- *To be effective this Commission must be independent, credible, efficient, adequately resourced, accessible and victim-friendly.*

Civic organizations should monitor and support the operations of this Commission.

Victims appearing before this Commission must be treated with sensitivity and respect and be given protection against reprisals.

There is need for a proper gender balance on this Commission and particular attention must be paid to the special needs of women and children victims.

The government formed after the transition must commit itself to co-operate with and to support the activities of this Commission and must give an unequivocal undertaking to implement its recommendations wherever possible.

The participants called for the conducting of a comprehensive people driven constitutional reform exercise that will lay emphasis on the protection of all human rights and the establishment of a number of Commissions to protect and promote these human rights.

There should be special Commissions to deal with land, gender issues and economic crimes such as corruption, asset stripping and debts incurred by previous governments in connection with human rights abuses.

The mandate of the Commission on economic crimes should include:

- *referral of cases to the Attorney-General for possible prosecution;*
- *in conjunction with other appropriate state agencies, taking of vigorous steps to recover misappropriated state assets;*
- *imposition of financial penalties upon those who were financial beneficiaries of human rights abuses.*

*A substantial portion of the assets recovered by this process should be devoted to compensating individuals and communities harmed by past human rights abuses.*

All these Commissions must be given an explicit mandate to recommend measures aimed at redressing socio-economic injustices of the colonial and post-colonial periods.

The new Government must immediately establish a reparations fund to compensate victims of human rights abuses. Concerted efforts must be made to tap all possible sources of local and international finance for this fund, including assets recovered by the Economic Crime Commission. If financially feasible, full compensation should be paid to those who suffered the greatest harm as a result of grave human rights abuses and some more limited compensation should be paid to other victims. The fund should also be used to establish local development projects in areas particularly badly affected by past human rights abuses.

All victims must be provided with free and proper health care and social support to deal with the lifetime disability that can arise from violations of their human rights.

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- i See also Themba Lesizwe (2004), *Civil Society and Justice in Zimbabwe, Proceedings of a symposium held in Johannesburg, 11-13 August 2003*, PRETORIA: THEMBA LESIZWE.
  - ii There is an extravagantly large literature dealing with the effects of organized violence and torture, but the interested reader is referred to the article mentioned above. Here see again Mollica, R F, Lopes Cardozo, B, Osofsky, H J, Raphael, B, Ager, A, & Salama, P(2004), *Mental health in complex emergencies*, LANCET, 364: 2058-67.
  - iii This is based on a previous paper. See Reeler, A P (2008), *Dealing with the "Complex Emergency" in Zimbabwe: Thoughts on Psycho-social support to the community*. HARARE: RESEARCH & Advocacy UNIT [www. Kubatana.net].
  - iv Here see Mollica, R F, Lopes Cardozo, B, Osofsky, H J, Raphael, B, Ager, A, & Salama, P(2004), *Mental health in complex emergencies*, LANCET, 364: 2058-67; see also Mollica, R.F. Guerra, R. Bhasin, R. & Lavelle, J (Eds), *BOOK OF BEST PRACTICES. TRAUMA AND THE ROLE OF MENTAL HEALTH IN POST-CONFLICT RECOVERY*, Project 1 Billion: International Congress of Ministers of

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Health for Mental Health and Post-Conflict Recovery, 2004.

- v See, for example, Amani (1996), *An Investigation into the Sequelae of Torture and Organised Violence in Zimbabwean war veterans*, HARARE: AMANI; Amani Trust (1998), *Survivors of Organised Violence in Matabeleland: Facilitating an Agenda for Development - Report of the Workshop*, BULAWAYO: AMANI TRUST; Amani (1998), *Survivors of Torture and Organised Violence from the 1970 War of Liberation*, HARARE: AMANI.
- vi Here see again Mollica, R F, Lopes Cardozo, B, Osofsky, H J, Raphael, B, Ager, A, & Salama, P (2004), *Mental health in complex emergencies*, LANCET, 364: 2058–67.
- vii See Amani (2000), *Training nurses in the assessment and management of psychological disorders: Report of Amani Trust's programme in Mashonaland Central Province, Zimbabwe*, HARARE: AMANI TRUST; Reeler, A.P., & Mbape, P. (1998), *A pilot study of a brief form of psychotherapy for survivors of torture: The Single Therapeutic Interview*, TORTURE, 8, 120-126.
- viii See Reeler, A., Chitsike, K., Maisva, F., & Reeler, B (2008), *The Tree of Life. Empowering and healing the survivors of torture*. Torture [in press].
- ix See, for example, Yoder, C (2005), *The Little Book of Trauma Healing. When Violence Strikes and Community Security is Threatened*, PENNSYLVANNIA: GOOD BOOKS.
- x These are not novel suggestions, but were provided initially to the Chidyausiku Commission in 1997. See again Amani (1998), *Survivors of Torture and Organised Violence from the 1970 War of Liberation*, HARARE: AMANI. Also Reeler, A. P (2003), *Empowering survivors of torture and organized violence*. Paper produced for the Khulamani Trust.
- xi See United Nations (1994), *Report of the Panel of Experts Appointed to Assist the United Nations Compensation Commission in Matters Concerning Compensation for Mental Pain and Anguish*, Geneva: United Nations; See also United Nations Security Council (1992), *"Determination of Ceilings for Compensation for Mental Pain and Anguish"*, Decision taken by the Governing Council of the United Nations Compensation Commission, Fourth Session, Geneva, 20-24 January 1992.