



## **Dealing with the “Complex Emergency” in Zimbabwe: Thoughts on Psycho-social support to the community.**

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### **1. Background**

Whilst there is continual reference to the suffering of those affected by the Zimbabwe crisis, particularly in reference to *Operation Murambatsvina* and the burgeoning food crisis, insufficient attention has been given to the mental health consequences, both psychological and social, of the massive social upheaval and organized violence and torture that has accompanied the crisis.

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 in the absence of the obvious features of war<sup>i</sup>. The types of trauma reported, especially in the past 5 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. It is worth noting again that international commentators are now arguing that there is need to plan for the kinds of assistance for Zimbabwe that would ordinarily be reserved for post-conflict situations<sup>ii</sup>.

A complex emergency requires a strong and sustained humanitarian response, and even the invocation of the “Responsibility to Protect”. Whether this will occur or not, the mental health needs of those affected in the current crisis should to be addressed, and any programme should adopt as a framework the following principles<sup>iii</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;*
- *Utilising of the de-facto mental health system;*
- *Emphasis on training and education;*
- *Implementing, managing, and monitoring 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 are commonly recognised by various expert groups as the basic framework for providing effective mental health care in complex emergencies, and should be applied in Zimbabwe in the development of a national programme for addressing the mental health needs of the Zimbabwe population affected by both the current crisis as well as the earlier periods of trauma.

There are now a number of excellent reports on the crisis facing the displaced in Zimbabwe, so it is of great concern that none have concerned themselves with the mental health dimension of the crisis. Whilst it must be acknowledged that food, shelter, and medical care are always priorities in emergencies, it is also the case that the mental health needs in emergencies are often overlooked. It is for this reason exactly that the UN and other expert groups have made a decided effort to keep the

mental health agenda firmly in the strategies developed for internally and externally displaced populations. This be no less the case for Zimbabwe in its complex emergency.

### **1.1 Trauma and complex emergencies**

The term “complex emergency” is increasingly being used to describe situations of disaster, frequently political in origin and process, which result in the massive destabilization of a state’s capacity to care for its citizens<sup>iv</sup>. As Richard Mollica and his associates have put this, “*A complex emergency is a social catastrophe marked by the destruction of the affected population’s political, economic, socio-cultural, and health care infrastructures*”<sup>v</sup>: no better description could characterize Zimbabwe today.

Now complex emergencies can quite clearly occur as a consequence of natural events, as in the recent Asian tsunami or the effects of Hurricane Katrina on New Orleans, but they can also occur as a consequence of human intervention, as in periods of civil war or low intensity conflict, what may be termed “organized violence and torture”. In this latter case, there may well be destruction of political and economic structures, but here are also frequently the effects of the direct actions of humans on other humans, and no countries in Africa make this more evident than the Democratic Republic of the Congo or Rwanda. A distinction should therefore be made between accidental harm causing trauma, as in natural disasters, and deliberate infliction of harm as is seen in wars, civil wars, low intensity conflict, genocide, and widespread political repression.

This report is not concerned with describing the many ways in which trauma may be inflicted during complex emergencies, but rather to very briefly describe their effects. The most obvious 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>vi</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.

The comment should also be made that it is well-established that psychological disorder due to violence can be caused by physical injury or torture, but equally that mere psychological exposure, as in witnessing violence, or even living in situations of very common physical violence, such as a war can also cause psychological disorder.

## **2. Organised violence and torture in Zimbabwe: an overview**

Organised violence and torture has been documented in all the last three decades of Zimbabwe’s history, as was indicated earlier.<sup>vii</sup> One study showed that 1 adult in 10 over the age of 30 years reported torture and was suffering from a clinically significant psychological disorder as a consequence,<sup>viii</sup> and high rates of torture and consequent psychological disorder were found in a study of former guerrilla soldiers from the Liberation War of the 1970s.<sup>ix</sup>

Even higher rates of torture and its sequelae were found in studies of the Gukurahundi period of the 1980s in Matabeleland.<sup>x</sup> Here it was found that more than 80% of the sample reported torture, and the prevalence rate for consequent psychological disorder was 50% of all adults over 18 years.

Subsequently, there was a long period – from 1987 to 1998 – where there were little or no gross human rights violations reported. However, organized violence, torture, and intimidation were seen during the periods leading up to important political events such as elections. There is a strong

correlation between reports on the patterns of violence in Zimbabwe and the lead up to elections. In June 2000, parliamentary elections were held and the period leading to the elections was marred by physical violence, political intimidation by the government sponsored war veterans against anyone who was perceived to be the opposition; despite these drawbacks the MDC won nearly half the seats in parliament.<sup>xi</sup> Since the 2002 Presidential election, there has been no appreciable improvement in the human rights climate. During the period from July 2001 to April 2008, the Human Rights Forum reported 4,662 allegations of torture. The Human Rights Forum, during this period, recorded 35,574 violations. There has been a steady increase in violations during 2006 and 2007, with it being apparent that 2008 may well be the worst year for human rights violations, and possibly torture too, since 2000 [see Table 1 below].

**Table 1**

**Consolidated statistics [numbers of violations reported] per year: July 2001 to April 2008**

[Source: Human Rights Forum]

	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>Totals</b>
Abductions	116	223	52	62	18	11	19	48	<b>549</b>
Arrest & detention	670	274	627	389	1286	2611	2766	286	<b>8909</b>
Assault	0	86	388	401	530	486	865	922	<b>3678</b>
Attempted murder	0	2	10	10	1	3	0	4	<b>30</b>
Death threats	0	12	80	35	9	7	7	23	<b>173</b>
Disappearance	0	28	4	0	0	0	0	0	<b>32</b>
Displacement	0	11	208	189	609	55	0	412	<b>1484</b>
Freedoms	12	39	809	760	1036	1866	3500	1324	<b>9346</b>
Murder	34	61	10	3	4	2	3	10	<b>127</b>
Political discrimination	194	388	450	514	476	288	980	1547	<b>4837</b>
Property violation	356	807	153	132	61	55	16	89	<b>1669</b>
Rape	0	7	6	3	4	1	0	0	<b>21</b>
School closure	0	45	1	0	0	0	0	11	<b>57</b>
Torture	903	1172	497	389	136	366	603	596	<b>4662</b>
<b>Total</b>	<b>2285</b>	<b>3155</b>	<b>3295</b>	<b>2887</b>	<b>4170</b>	<b>5751</b>	<b>8759</b>	<b>5272</b>	<b>35574</b>
<b>Monthly average:</b>	<b>380.8</b>	<b>262.9</b>	<b>274.6</b>	<b>240.6</b>	<b>347.5</b>	<b>479.3</b>	<b>729.9</b>	<b>1757.3</b>	

These figures are an under-estimate by an unknown order of magnitude, and an accurate assessment of the likely need can only come from a community-based study, but, as can be seen in the following section, some inferences can be drawn, and what seems evident is that there are likely to be very large numbers of survivors requiring medical and psychological assistance, and particularly psychological assistance.

### **3. Trauma in Zimbabwe**

Whilst there are very few good epidemiological studies of the incidence or prevalence of disorders due to trauma in Zimbabwe, there are a number of studies that are helpful in understanding the likely picture. These studies suggest that there are a number of periods in which trauma has occurred as a result of mass violence. This has occurred against the background of already existing mental health problems, most usually termed "common mental disorders" [CMD].

The general mental health picture that obtains in Zimbabwe indicates that CMD have been increasing in Zimbabwe over the past three decades. These are summarised in the table overleaf.

The first epidemiological studies indicated a picture that largely similar to that obtaining in western countries as well as in African countries, with prevalence rates of roughly between 20 to 30%. Some rates were higher, but generally the pattern was similar to that seen in most of Africa.<sup>xii</sup> However, it

appears that the rates have shifted upwards in a dramatic fashion in recent years, as seen in a recent unpublished community survey in Harare, which showed a prevalence rate of nearly 40%. There was also a marked shift in the risk factors associated with CMD, with experience of violence increasing risk significantly, and most startling the association with having goods confiscated, which increased the risk by 14 times. Thus, it would appear that not only has the deteriorating socio-economic environment had a deleterious effect on the mental health of Zimbabweans, but also that the increased levels of violence have been having an effect.

There is good understanding of the health consequences of organized violence in Zimbabwe. The morbidity due to the Liberation War has been best documented to date, and the most reliable study indicated a likely prevalence of trauma sufferers of approximately 1 adult in 10 over the age of 30 years in 1997. The Government has not provided any national programme of specialized medical or psychological assistance for these victims, although war veterans have been beneficiaries of a number of occasions of compensation. Morbidity due to the Gukurahundi has also received some attention. One small study, in Gwanda district, indicated that 5 adults in 10 over the age of 18 years were suffering from significant psychological disorders, with over 90% of the sample reporting an experience with organized violence and torture<sup>xiii</sup>. The majority of these experiences dated from the 1980s rather than the Liberation War.

There is no good estimate of the morbidity due to the violence occasioned by the Food Riots in 1998. At the time the Zimbabwe Republic Police estimated that over 3,000 persons had been arrested, and the Human Rights Forum was able to obtain data on 1,431 cases of persons that had been arrested. Only 44 persons eventually elected to report to the Human Rights Forum, but 36% were diagnosed as having clinically significant psychological disorders. It is clearly inappropriate to extrapolate from such a small sample, but it is probable that the numbers affected were significant<sup>xiv</sup>.

Finally, there has been a virtual epidemic of organized violence and torture since February 2000, as seen in Table 1 above, and this is attested to by the vast outpouring of reports since that time. Very few studies have been done on the effects on victims, and certainly no decent epidemiological studies. There are two indicative studies, however. The first, examining internally-displaced workers from the commercial farms demonstrated that 85% of the sample was suffering clinically significant psychological disorders<sup>xv</sup>, whilst the second, a "snap survey" of Zimbabwean refugees in Johannesburg, Gauteng, indicated a point prevalence rate of 14% in the sample<sup>xvi</sup>.

These latter two studies are important for the purposes of understanding the effects of *Operation Murambatsvina* since they examine populations of displaced persons. Estimates of psychological disorders due to trauma are much higher amongst refugees or internally displaced persons than they are in the general population, as they are in specific populations such as those living in complex emergencies such as civil wars, or low intensity conflicts. In 2005, in the aftermath of Operation Murambatsvina, ActionAid International conducted a community survey,<sup>xvii</sup> and this indicated the following:

*The major finding was an extremely high rate of clinically significant psychological disorder in the sample. 69% of the sample had scores in the clinically significant range, which indicates a probable population needing psychological assistance of about 820,000 persons. The prevalence was higher in the HIV/AIDS group [75%]. Secondly, a number of significant relationships were found between psychological disorder and the reported "Experience" of trauma:*

- *A significant relationship between current psychological disorder and the number of trauma events reported;*
- *A significant relationship between current psychological disorder and trauma due to OVT [organized violence and torture];*
- *A significant relationship between current psychological disorder and trauma due to displacement events;*
- *A significant relationship between current psychological disorder and repeated exposure to trauma.*

*Thus, it can be concluded that the very high prevalence rate of psychological disorder is significantly related to the trauma experienced, with the strongest effect seen in relation to displacements such as Operation Murambatsvina. Thirdly, significant correlations were found between clinically significant psychological disorder and increasing rates of reported trauma over the decades. The strongest associations were with recent trauma, and especially the trauma reported in 2005.*

It was also evident in the ActionAid study that women were considerably more vulnerable than men, with older women-headed households and single women-headed households the most vulnerable. Clearly, unaccompanied children and child-headed households are likely to be the most vulnerable. Additionally, there is considerable evidence that children have very common witnesses to the OVT that has taken place since 2000, and the many reports of violence within rural communities indicate this.

**Table 2**  
**Zimbabwean studies of the prevalence of CMD and Trauma**

Study	Sample	Instrument	% prevalence
<b>Community mental health:</b>			
Williams & Hall [1987] <sup>xxviii</sup>	District Hospitals	SRQ-20	11%-37%
Reeler, Williams & Todd [1991] <sup>xxix</sup>	Primary care clinics	SRQ-20	24%-28%
Community survey [2006. unpublished] <sup>xx</sup>	Primary care clinics	Shona Symptom Questionnaire	39%
<b>Trauma samples:</b>			
Amani Trust [1996] <sup>xxxi</sup>	War veterans	SRQ-20	73%
Amani Trust [1997] <sup>xxxii</sup>	Community survivors	SRQ-20	13%
Reeler et al [1998] <sup>xxxiii</sup>	Primary care clinics	SRQ-20	51%
Human Rights Forum [1998] <sup>xxxiv</sup>	Food riots victims	SRQ-8	36%
Amani Trust [2002] <sup>xxxv</sup>	Commercial farm workers	SRQ-8	81%
Action Aid International [2005] <sup>xxxvi</sup>	Victims of Operation Murambatsvina	SRQ-8	69%
Idasa [2006] <sup>xxxvii</sup>	Zimbabwe refugees in South Africa [street survey]	SRQ-8	47%
ZTVP [2007] <sup>xxxviii</sup>	Women refugees in South Africa [clinic attendees]	SRQ-8	71%
SACST [2008] <sup>xxxix</sup>	Zimbabwe refugees in South Africa [multiple sites]	SRQ-8	49.5%
WOZA women [2007] <sup>xxx</sup>	WOZA members	HTQ	53%

### **3.1 Community consequences of organized violence and torture**

Gross human rights violations, especially when they are part of a discriminatory political system such as apartheid, have profound and widespread effects beyond the narrow effects of torture. This was clearly part of the aim of the Truth and Reconciliation Commission: to describe the broad effects of apartheid. In studies in Zimbabwe, work with survivors of gross human rights violations such as torture clearly indicated that the survivors were suffering from a wider range of handicaps than

merely the medical or psychological, and a number of studies were carried out to examine these additional areas of deficit. The findings from the most reliable of these studies are briefly reported below<sup>xxxi</sup>. Survivors and their families were compared with their nearest neighbours in a detailed interview study.

Firstly, there were a number of differences in social and economic factors between the survivors and their neighbours:

- greater illiteracy;
- higher unemployment;
- spend more money on health care;
- less income in the past week;
- less earnings in the past year;
- lower household expenditure;
- more dependency upon credit [greater potential indebtedness];
- poorer housing[both structurally and state of repair];
- tendency to travel further for fuel wood;
- grow less maize, cotton and tobacco;
- less food security [months of food available];
- more frequent recourse to drought relief;
- less likely to have fruit trees or wood lots;
- less use of natural resources;
- less access to information;
- more likely to use charity or social welfare.

Secondly, the survivors showed many signs of having less self-esteem and greater apathy than their neighbours:

- more likely to see war as a reason for poverty;
- less optimistic that the situation can be changed;
- more dependent on outside help [believe they need money help as opposed to empowerment help].

The first group of differences represents real and substantial differences in the social and economic well-being of the two groups. The survivors were markedly less well-off than their neighbours in many areas, and it seems fair to conclude that survivors had greater social adversity than other groups in the same community. This is probably not surprising, and would be found for other disabled populations. However, it does mean that survivors are more vulnerable to ongoing stresses, which will in turn exacerbate their medical and psychological problems. It is noteworthy that this is exactly the interpretation that was given by the survivors themselves, and it was indeed their preoccupation with the practical problems of their lives that originally alerted workers to the significance of social adversity. This is likely to have even greater effects for the current population of survivors.

The second group of findings speaks to the psychological consequences of OVT and the social adversity. Survivors have low self-efficacy, and this is due in part to the original violence and in part to the failure to overcome the social adversity. Rather facetiously it may be commented that nothing breeds success like success, but this is a truism with powerful application here. It is endlessly demonstrated by studies on individuals that OVT creates powerlessness and a lack of self-efficacy, and many commentators point out that this is replicated in the social and political arena<sup>xxxii</sup>. These findings speak to the heart of this problem: survivors are traumatised into feelings and beliefs of powerlessness, perform less well in the many tasks of life, and the failure compounds and reinforces the lack of self-efficacy. It takes little imagination to see how this then translates into community, social and political apathy, and provides severe problems for the development of rural areas. This is a point that has been made again and again by refugee workers and community workers in areas that have experienced epidemic violence.

This must all be viewed within the context in which these survivors were and are living. In real terms, the supporting facilities - health and social welfare - around them have been eroding at an alarming rate. The problems being experienced by the health delivery system were highlighted by the government's own Poverty Assessment Study Survey in 1997, which estimated that more than 45% of Zimbabweans were experiencing regular food shortage - below the food poverty line - and moreover, that only 26% of Zimbabweans were "not poor" in economic terms - 74% were now classified as poor in 1997 as compared to 62% in 1995. It is well to remember that this is also a population at risk for HIV and AIDS like all other population groupings in Zimbabwe, and thus the issues of multiple deprivation and disability are not issues that can be disregarded in the development of a policy on reparations. Clearly, the socio-economic environment has deteriorated considerably since this study was done, and all these rates have shifted downwards and upwards in very dramatic fashion; hence the continual reference to "complex emergency".

#### **4. Psycho-social support for victims of organized violence and torture**

Given the broad sweep of the issues outlined above, it is apparent that a policy for rehabilitation must have a number of different aspects, and should conform to the prescription outlined earlier. Below are outlined, a set of recommendations that will address these, which focus initially on the improving the service delivery capacity of the health services. These conform to recent expert opinion:

*Early mental health interventions should focus on supporting public health activities aimed at reducing mortality and morbidity; offering psychological first aid, identifying and triaging seriously ill patients who need specialised psychiatric care, and mobilizing community-based resiliency and adaptation to the new circumstances affecting people during the emergency.*<sup>xxxiii</sup>

##### **4.1 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, as the work of the AMANI Trust has shown in Zimbabwe, training can be easily done, and can have immediate benefits<sup>xxxiv</sup>.

*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 organised violence.*

##### **4.2 Assessment**

Disorders due to OVT 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 be used to determine compensation. It should be evident from much of the previous discussion that assessment of survivors of OVT will require both physical and psychological assessment, and that comprehensive assessment will require the services of a range of health professionals: doctors, psychologists, physiotherapists, occupational therapists, nurses and social workers. 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. The development of the role of a Forensic Nurse Examiner may be a crucially important method of addressing the problem of assessment, and examples of using this cadre of nurse are available both in Zimbabwe and South Africa.<sup>xxxv</sup>

*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.*

### **4.3 Treatment**

Treatment must operate from the understanding that full cure may be impossible for most survivors of OVT, 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 organised violence must be offered counselling, both individual and family, physical therapy, and community development in order to maximise 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.*

### **4.4 Organisation of services**

The principles of primary health care - cure, rehabilitation, prevention and promotion - should always guide the organisation of services for survivors of OVT. This requires the recognition that the point of health care be close to patients' homes, and that the staff of these health facilities be able to manage the conditions that present to them. AMANI's experience in Zimbabwe suggests that services can be organised to provide effective detection and referral from the periphery, providing there is the appropriate training of staff. A suggested model is as follows:

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

At the District level, this means the creation of a team of counsellors with the expertise to manage severe disorders, including those due to OVT, and this team should include nurses, social workers, and rehabilitation technicians.

*It is therefore recommended that attention be given to the creation of a District service team, composed of psychiatric nurse, social worker, and rehabilitation technician, supported by a group of trained counsellors. Furthermore, this team should be responsible for counselling, physical therapy, and community development.*

## **5. 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, 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 wellbeing 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. One approach that shows considerable promise, and has a fair track record is termed the "Tree of Life". The Tree of Life was originally developed as an approach for assisting unemployed youth. It was adapted to the needs of Zimbabwean political violence victims living in exile in South Africa in 2002.<sup>xxxvi</sup> This process was introduced to victims in Zimbabwe in 2004 as an attempt to address the psycho-social difficulties faced by survivors in Zimbabwe, most of whom still lived under threat and were displaced.

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. 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>xxxvii</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.

An evaluation of this approach indicated that 36% showed significant clinical improvement, and the sample as a whole showed significant changes in their psychological state.<sup>xxxviii</sup> More complete information was available for a smaller sample [19], which showed 39% having significant improvement. On follow-up, 44% were still experiencing difficulties, with most [72%] experiencing economic difficulties. On the positive side, 56% reported coping better, only 9% reported health problems, and most were still connected to the group with which they participated in the process. All felt that that the process had helped them, had helped them learn new things, and had changed in the way that they felt about their torture.

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 none 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. The strength of approaches, such as the Tree of Life, is that they rely on people from the community itself, and creates a hub from which many other activities can develop. For example, the Amani Trust, in its programmes in Mashonaland Central in the 1990s, allied group processes to community development, and facilitated the creation of community agricultural projects that were highly successful until they were shut down by the disturbances in 2000.

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 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.

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<sup>i</sup> This position is increasingly being argued by observers of the Zimbabwe crisis. See Moss, T., & Stewart, P. (2005), *The Day After Comrade Bob: Applying Post-Conflict Recovery Lessons to Zimbabwe*. Working Paper Number 72. December 2005,

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- WASHINGTON: CENTRE FOR GLOBAL DEVELOPMENT. See also Moss, T., & Stewart, P. (2005), After Mugabe, Zimbabwe will need post-conflict support, December 2005. CGD Notes, Centre for Global Development.
- <sup>ii</sup> See again Moss, T., & Stewart, P. (2005), *The Day After Comrade Bob: Applying Post-Conflict Recovery Lessons to Zimbabwe*. Working Paper Number 72. December 2005, WASHINGTON: CENTRE FOR GLOBAL DEVELOPMENT.
- <sup>iii</sup> 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 Health for Mental Health and Post-Conflict Recovery, 2004.
- <sup>iv</sup> See WHO (2003), *Mental health in emergencies: mental and social aspects of health of populations exposed to extreme stressors*. Geneva: Department of Mental Health and Substance Dependence. WHO.
- <sup>v</sup> 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.
- <sup>vi</sup> 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.
- <sup>vii</sup> See Amani (1996), *An Investigation into the Sequelae of Torture and Organised Violence in Zimbabwean war veterans*, HARARE: AMANI; Amani (1998), *Survivors of Torture and Organised Violence from the 1970 War of Liberation*, HARARE: AMANI.
- <sup>viii</sup> See Reeler, A.P., Mbape, P., Matshona, J., Mhetura, J., & Hlatywayo, E. (2001), *The prevalence and nature of disorders due to torture in Mashonaland Central Province, Zimbabwe*, TORTURE, 11, 4-9.
- <sup>ix</sup> See Reeler, A.P., & Mupinda, M. (1996), *Investigation into the sequelae of Torture and Organised Violence amongst Zimbabwean War Veterans*, LEGAL FORUM, 8, 12-27.
- <sup>x</sup> See Amani Trust (1998), *Survivors of Organised Violence in Matabeleland: Facilitating an Agenda for Development - Report of the Workshop*, BULAWAYO: AMANI TRUST.
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