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Psycho-Social assistance to Survivors of the Liberation War. A Report on Mashonaland Central Province, Zimbabwe.

A report prepared by the AMANI Trust.

May 2006.

1. Background:

A previous monograph has described the nature of the consequences to survivors of their experience of organised violence and torture [OVT] [1]. There the long-term sequelae of OVT were clearly described, and it could be seen that these were multiple: physical disability, psychological disorder, and social pathology. Here it should be remembered that this was an examination of a population of survivors more than a decade and half after the traumatic events, which indicates that no-one should be sanguine that survivors of OVT heal themselves: war veterans, activists and the politically uncommitted were all affected by the Liberation War. It seems evident that Zimbabweans, in common with all other people, do not cope well with the effects of OVT.

One of the more startling findings from the work of the Amani Trust in Mashonaland Central Province was that the prevalence of OVT had been very high, and the morbidity due to the OVT was similarly high: one adult in 10 was suffering from a significant psychological disorder more than a decade later, and these survivors were suffering from serious psychological disorders as well as physical disability. Extrapolated across the country, as there is no reason to believe that Mashonaland Central Province was unique during the Liberation War, this translates into tens of thousands of victims. This is a population that lives in poverty, and certainly since 1998, lives in extreme poverty, and mostly in rural areas.

In order to provide appropriate assistance to such an impoverished population, the Amani Trust developed a "holistic" strategy organised around a community-based approach. This was in accordance both with best mental health care practice, and also with the views of a number of expert symposia on the effects of organised violence and torture[2].

The approach that was developed by the Amani Trust involved working within a District through 3 phases, as described below. The approach was negotiated with the Provincial and District Health teams, and was intended to move throughout the Province, district by district. The programme began in Mount Darwin District in 1996, after a pilot phase in 1995. The programme moved to Muzarabani District in 1997, and into Centenary District in 1998.

Phase 1:	*basic training of health workers.*
	identification, assessment & counselling of survivors.
	home visiting, family therapy & networking.
Phase 2:	*advanced training in counselling skills.*
	district team building.
	Networking and community work.
Phase 3:	*consolidation of district team.*
	community work.

Inevitably, there were revisions to the programme as experience showed that there were areas that needed more attention, or new problems emerged as a consequence of experience. For example, the Advocacy Programme grew out of the family visiting, which showed significant problems in survivor families, and the community survey in 1998 also indicated that a community development component was necessary in order to both deal with the poverty and the sense of disempowerment felt by survivor

[1] See *Amani (2005), The Medical and Psychological Consequences of the Liberation War. A report on survivors from Mashonaland Central Province, Zimbabwe. July 2005. HARARE: AMANI TRUST.*

[2] Here see *PSYCHIATRIC ASSOCIATION OF ZIMBABWE (1991), Regional Workshop Report on the Consequences of Organised Violence in Southern Africa, HARARE: PAZ; PSYCHIATRIC ASSOCIATION OF ZIMBABWE (1990), Report on an International Conference on "The Consequences of Organised Violence in Southern Africa, HARARE: PAZ Reeler, A.P (1991), The extent and nature of psychological disorder in Zimbabwe, NATIONAL SYMPOSIUM ON MENTAL HEALTH: ZIMNAMH, 30 OCT - 1 NOVEMBER 1991; Reeler, A.P. (1995), Trauma in Mozambican refugees: Findings from a training programme for refugee workers, TORTURE, 5, 18-21.*

families. Thus, a two-pronged approach was developed: one strand aimed at assisting survivors and their families to become better advocates in their own cause, whilst the other strand aimed at protecting families through income-generation. Here, it was felt that the family visiting component was less useful than an approach that brought all geographically-contiguous survivor families together.

Similarly, it was decided in 1997, in consultation with the Provincial Medical Directorate of Mashonaland Central Province, that the district-by-district roll out plan was possibly too laborious, and that it would be more desirable to train a cadre of nurses in the Province in trauma counselling skills. This decision was confirmed by a survey carried out in 1997 [see below]. Accordingly, the Amani Trust began a new programme to train trauma counsellors from each District. This programme was subsequently run in the urban setting, in Chitungwiza, following the Food Riots in 1998, where it was noted that there was a potentially large number of survivors now living in the urban setting.

It was also the case that changes in the programme led to new directions being taken. One consequence of the move to train trauma counsellors was the understanding of the need for forensic capacity in many districts. This led the Amani Trust to run, in conjunction with the Zimbabwe Nurses Association [ZNA], a course in Forensic Nursing. This was one of the first such courses in Africa. This resulted in the training of 22 nurses from virtually every Province in the country. This exciting start has not, however, been followed up by the Ministry of Health and Child Welfare, or the Zimbabwe Nurses Association.

However, the programme that was developed in Mashonaland Central Province overall provides a useful model to examine for the treatment and management of survivors of OVT, and this paper details briefly many of the aspects of the programme, as well as offering a critique of its strengths and weaknesses.

2. Psychological assistance:

Since the most persistent consequence of OVT is psychological disorder[3], considerable attention was given to offering this form of assistance to the identified survivors. It was evident from the outset that, in common with the other Zimbabwean work on community mental health care, that it was not possible to assume that standard Western approaches to counselling and psychotherapy would be appropriate in the rural Zimbabwean setting. Thus, the Amani Trust devoted a significant part of its efforts to investigating appropriate management, and this ranged from studies of innovative psychotherapies through to attempts to develop more rational health delivery. All of this work was conducted mindful of the broader mental health picture and the need to integrate assistance to the survivors of OVT into the existing health care system as opposed to developing stand-alone services. What follows below is a summary of this work.

2.1 Brief Therapeutic Interview

Following on work done by Gillian Straker[4], the Amani Trust investigated the utility of a brief intervention, which was termed the Brief Therapeutic Interview[5]. This approach was developed following the observation that many survivors showed marked symptomatic improvement merely as a consequence of detection, an observation noted earlier in other Zimbabwean work in the primary care setting[6].

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[3] As to what "psychological disorder" means with torture survivors, there is considerable dispute. Here see *Reeler, A.P.(1994), Is torture a post-traumatic stress disorder? TORTURE, 4, 59-65.*

[4] See *Straker, G. (1987), The continuous traumatic stress syndrome - the single therapeutic interview, J.SOC.DEV. IN AFRICA, 8, 48-78.*

[5] It was originally termed the Single Therapeutic Interview [STI], but this was changed to the Brief Therapeutic Interview as the term, STI, was easily confused with a similar acronym referring to "sexually transmitted infections".

[6] See *Reeler, A.P., Williams,H., & Todd,C.H.(1990), Controlled trial of nurse treatment of psychological disorders: A rural primary care study, RESEARCH DAY, SCHOOL OF MEDICINE, UNIVERSITY OF ZIMBABWE, 15 SEPTEMBER 1990.* This study showed

Accordingly, a small clinical study of the effectiveness of a single counselling session on patients with psychological disorders due to torture was undertaken[7]. The therapy approach developed is described briefly below:

1. **Introductory phase**
   Explanation of the "Talking method " as a means of treatment;
   Explain to the client the importance of recording some of the important aspects of the interview and get his or her permission.
2. **Explanatory phase**
   Recap on past assessments;
   Exploring reactions to trauma;
   Exploring current problems;
   Consequences of current problems.
3. **Working phase**
   Working on the priority problems;
   Working on other problems.
4. **End phase**
   Summarising the session;
   Reviewing the session.

The aim of the first 2 phases is to acquaint the client with the findings from the assessments done previously, to link current symptoms to the past experience of violence, and to further link the symptoms to current difficulties. This is largely a process of what might be termed "psycho-education".

During the third phase, the counsellor continues to link the patient's symptoms with torture methods and their after-effects. The major aim is to identify the current problems being faced by the client, to work out with the client the priority problems, and to select one problem for solution. The solution of the problem is worked out with the client, using the client's solution wherever possible, but it was found that frequently the counsellor had to take a very active role in helping to generate solutions. Here, it is important to stress that, for many survivors, their problem-solving ability is so poor or blunted, that they are unable to find solutions to their problem, and, in fact, it is the impaired problem-solving that often forms the basis for seeking assistance.

The end phase involves a summary of the whole session, thus ensuring that the client clearly understood all the assessment issues; that the problem chosen for action was the one that the client actually wished to work on; and that the solution is clearly understood by the client. This session was then followed by further sessions at 3months, 6months, and 1year. At follow up, the same format was used, and a brief assessment of the patient was made.

The sample that was chosen was older than most of Amani's clients, and reported more experience of torture: this was expected since the study was selecting for a group with severe disorders and impact torture. Thus, the study was selecting a clinically significant group. Earlier Zimbabwean work[8] had suggested a general tendency for Common mental Disorders [CMD] to improve over time, with the additional observation that there was slight tendency for severe cases - those with SRQ-20 scores of 10 or more - not to so improve. Thus, the selection of a group with severe disorders meant that it was

significant improvement in patients with psychological disorder merely as a consequence of detection and very brief intervention.

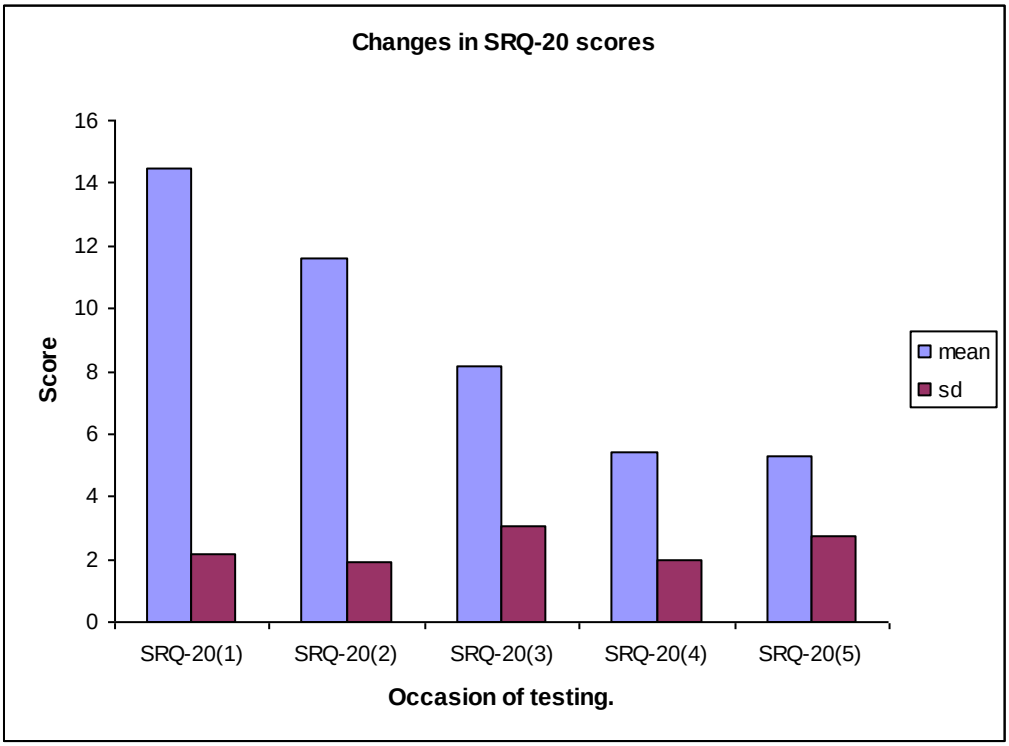
[7] Here see *Reeler, A.P., & Mbape,P. (1998), A pilot study of a brief form of psychotherapy for survivors of torture: The Single Therapeutic Interview, TORTURE, 8, 120-126,*

[8] See *Patel, V., Todd, C., Winston, M., Gwanzura, F., Simunyu, E., Acuda, W., & Mann, A. (1998), Outcome of common mental disorders in Harare, Zimbabwe, BRIT.J.PSYCHIAT., 172, 53-57.*

probable that any improvement seen as a consequence of the therapy was likely to be due to the therapy, and not to normal life changes.

The findings supported the conclusions that the intervention was successful in treating survivors. These were all patients suffering from chronic disorders, with the onset of the disorders more than 2 decades ago in some cases, but all had been suffering for longer than a decade. These results showed all cases improving on all measures, and, importantly in the light of the results of the previously reported Zimbabwean study[9], there was a significant effect of all cases dropping below both 10 and 7 on the SRQ-20.

Figure 1.



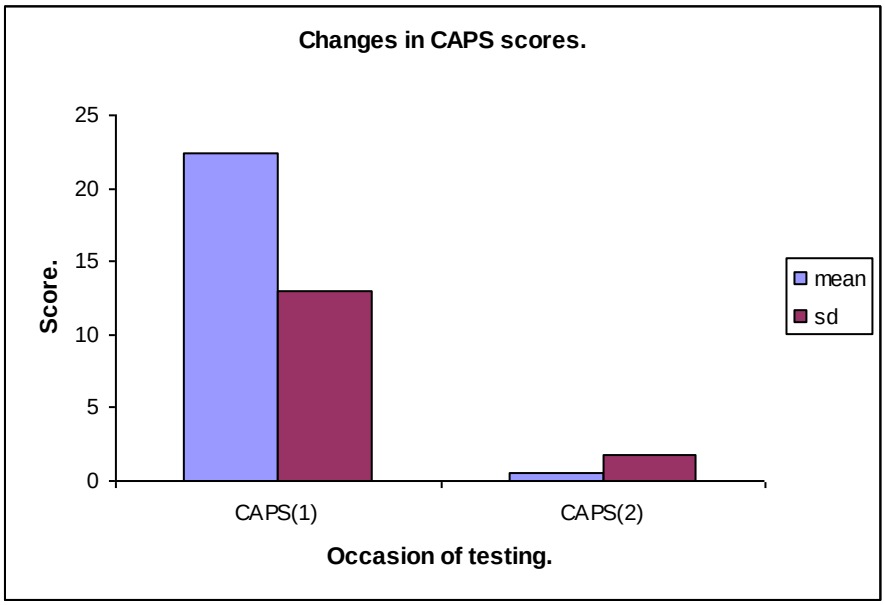
As can be seen from Figure 1 above, there was a small drop in the SRQ-20 scores after the initial assessment [SRQ-20(1)], but no case dropped below the clinical threshold, and the most marked drops in scores occurred after the therapeutic intervention. This is strongly suggestive of a real therapeutic effect for the treatment approach. There was a small therapeutic effect seen as a result of assessment, however this did not result in scores dropping below the threshold for disorder, and the marked changes occurred after the intervention [SRQ-20(2)]. It is also worth commenting that the most marked changes occurred after six, as opposed to three months, which may also suggest a

[9] See again *Reeler, A.P., Williams,H., & Todd,C.H.(1990), Controlled trial of nurse treatment of psychological disorders: A rural primary care study, RESEARCH DAY, SCHOOL OF MEDICINE, UNIVERSITY OF ZIMBABWE, 15 SEPTEMBER 1990.*

natural as opposed to a therapeutically-induced change, but this could be conclusively tested in the absence of an untreated control group.

It was also evident that there were some small changes in the SRQ-20 scores after assessment [SRQ-20(1)], as well as in the clients' behaviour: most smartened themselves up for the second and third interview, and several reported feeling better. The therapeutic effects of assessment are often under-rated, and this data clearly shows that assessment must be seen as part of therapy and drawing upon many of the factors that make therapy effective.

Figure 2.



As can be seen from Figure 2, all the scores on the Clinician-Administered PTSD Scale [CAPS] declined to almost zero, but this was most marked for the group who had clinically significant scores on initial assessment: scores greater than 19 on either the Frequency or the Intensity subscales of the CAPS. A substantial number of the group did not report any PTSD, which was not surprising and in line with previous work[10]. Thus, we did not get any changes in the non-PTSD sub-sample, but very pronounced change in the sub-sample that did report PTSD. These data additionally support the finding that there was clinically significant improvement as a result of the treatment.

As regards the self-ratings [see Figure 3 over], the clients initially showed little change in their symptoms, as measured by the differences observed between the therapeutic interview and the first follow-up at three months. There was then sustained improvement at six months and one year, with the group showing small positive change overall. This small effect could be improved upon by the use of more comprehensive self-report measures, but this also has to be traded against the ability of a largely non-literate client group to complete such measures.

The therapy approach itself seemed to be acceptable to the clients, and was not difficult to implement. It followed logically on the detailed assessment procedure, and the combination of feedback, psycho-education and problem solving is a useful approach to the management of trauma. Obviously, these

[10] Here see *Amani Trust (2005), The Medical and Psychological Consequences of the Liberation War. A report on survivors from Mashonaland Central Province, Zimbabwe, HARARE: AMANI TRUST.*

results must be treated with caution in the absence of a control group, but the survivors treated with this approach nonetheless show sustained improvement on 12 month follow up.

Figure 3.

This was clearly a chronic group of survivors, with clinically significant disorders, and the results showed clear improvement for the whole sample. This suggests that the approach deserves further investigation, especially since the therapy approach is relatively simple in application and could be easily learned by a wide variety of different types of health workers. We are not aware that any attempt to replicate or extend this work has taken place, but the Brief Therapeutic Interview has been used subsequently by the Amani Trust in its work with other survivor groups.

2.4 Problem-solving Therapy

In line with its commitment to improving the management and treatment of clients with mental disorders, the Amani Trust also investigated approaches for the treatment of forms of mental disorder other than those due to trauma or OVT. This work was informed by the continuou**s** observation that nurses seemed to prefer a more directive approach in working with clients with psychological disorders, and hence a study was carried out to investigate an approach based in problem-solving[11]. Furthermore, as noted above, many clients seemed to demonstrate impaired problem-solving, and this was an additional interest in this study.

The approach was very similar to the Nursing Process, an approach with which nurses are very familiar, and which has been used internationally. The process has five stages, and the nurse guides the patients through each of these stages as is described below.

Stage 1 - Problem Identification
Stage 2 - Problem Exploration

[11] See *Amani Trust (2002),A Pilot Study on the Effectiveness of Problem Solving Therapy on Primary Care Patients with Psychological Problems, HARARE: AMANI TRUST.*

Stage 3- Action Plan
Stage 4 - Implementation
Stage 5 - Follow-up

The first stage involved meeting the patient, and explaining that the therapy method would require working on the problems chosen by the patient. The information to be shared with the patient was derived from the initial assessment, and included details from the SRQ-20, the Structured Assessment Form, the Genogram, and the referral source. However, the main point behind Problem Identification was to encourage patients to tell their personal stories, and the assumption was that the telling of the personal story would reveal the current problem or problems[12].

During the second stage, the therapist attempted to understand the story and change unfamiliar or vague concepts into more specific concrete terms so that the problem could be more accurately defined. The aim was to avoid dealing with biased or distorted perceptions of the problem. There was use of open, closed and leading questions such as:

Why the situation is seen as a problem?
Who else is affected by the problem and how?
What has been done about the problem or what could have been done?

The aim of the third stage was to derive concrete problems amenable to concrete solutions, and to help the patient decide upon the priority problem. The action plan involved the identification of solutions to the problem and assisting the patient to prioritise them. Sometimes, there was the need to look at what new skills would be required by the patient to achieve the required goal. The therapist assisted the patient to look at the following:

What does the patient want to do?
How is it going to be done?
Who is going to be involved?
What agencies can provide help or useful information?

Some patients may have needed help to bring the plan into action, while others may have decided to implement the plan without assistance. Any of the following could have been necessary during the fourth, or the implementation stage:

Information giving;
Referral to appropriate agencies and sources;
Changing the patient`s view;
Motivation;
Homework;
Support.

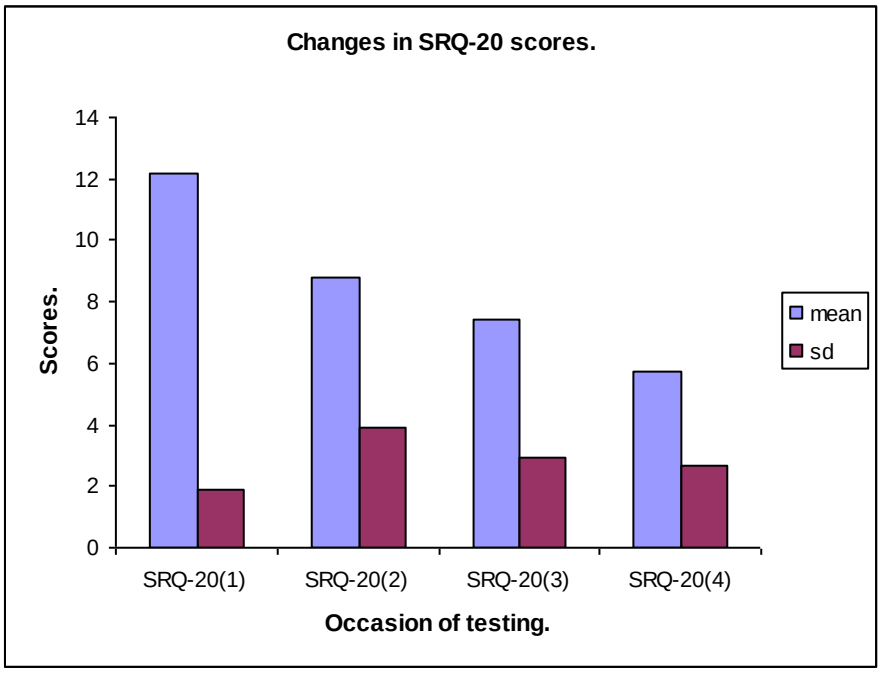
It was obviously difficult to be prescriptive about implementation, since the problems could vary so widely: problem-solving is very different to many other therapy approaches where a diagnosis, say of depression, is followed by a prescribed treatment, say cognitive behaviour therapy.

The final stage involved reviewing the patient`s progress on achievement of goals. New problems were noted and new solutions were also generated. If more than one problem had been identified the patient was assisted to move on to the next problem and new solutions for the problem were devised. The follow up interviews were done at 1, 3, and 6 month intervals.

[12] Here see *Reeler AP (1993), Psychotherapy as story telling: A Popperian conjecture, CHANGES, 11, 205 215.*

These results showed all cases improving on all measures, and, similar to the study reported above, there was a significant effect of most cases dropping below both 10 and 7 on the SRQ-20. We can have confidence, however, that the group was a clinically significant group since only patients with SRQ-20 scores in excess of 10/20 were selected. There was a marked drop in the SRQ-20 scores after the initial session, with 3 cases dropping below the clinical threshold. The most marked changes in scores occurred after the three month period.

Figure 4.
Changes in Self-Reporting Questionnaire(SRQ 20): six month follow-up.



As regards the self-ratings, the clients initially showed changes in their problem, as measured by the differences observed between the therapeutic interview and the first follow-up at three months. There was then sustained improvement at six months, with the group showing small positive change overall. This small effect could be improved upon by the use of more comprehensive self-report measures, but this also has to be traded off against the ability of a largely non-literate client group to complete such measures.

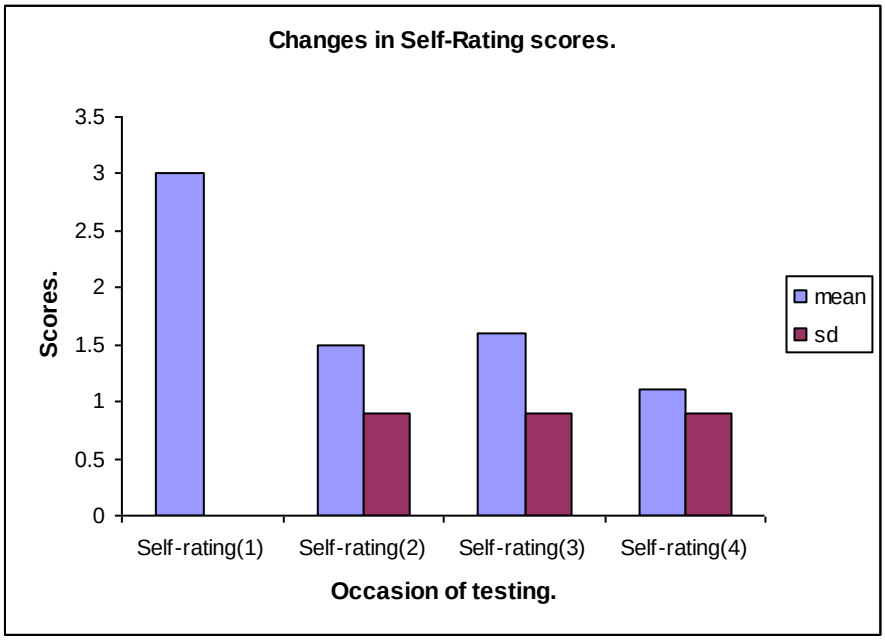
The therapy approach itself seemed to be acceptable to the clients, and was not difficult to implement. The clients seemed to appreciate the focus upon their expressed problems rather than the purely symptomatic approach that is the most common experience in the primary care or outpatient setting. The problem solving approach also differs from other forms of counselling or psychotherapy in that it uses the same method for all problems, although the solutions clearly differ from client to client.

These were encouraging results. 70% of the group showed clear improvement on the SRQ-20 by the end of the six month study period, with 90% showing improvement on the self-ratings. This pilot indicates that it would be interesting to now test the approach more rigorously, either by comparison with other therapy approaches or by using a matched sample with a treatment and no treatment comparison.

Thus, the overall aim, that of finding a treatment method for the primary care setting, seemed satisfied. The approach is simple to implement, makes sense to the client, and, most important of all,

uses skills with which most nurses are already familiar. This is important when it is considered that most psychological disorders will only ever attend at the primary care or outpatient level, and where virtually all these clients will not receive specialist mental health care. Thus, an approach that requires a minimum of skill re-training has decided advantages for the primary care setting, and follows the general approach already tried in the Zimbabwean setting.

Figure 5.
Changes in Self-ratings: six months follow-up.



2.5 Outcome of treatment

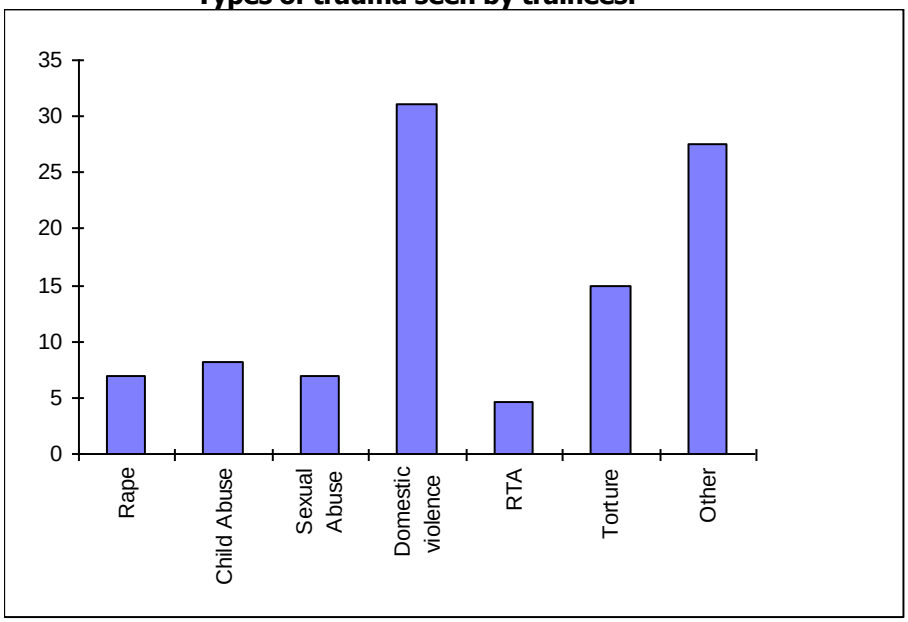
Although Amani staff themselves offered counselling to the survivors that they assessed, the primary interest in Amani's work was in ensuring that the nurses and other health workers that they trained would be able to do this too. To this end a extensive training programme was mounted [see below], and, accordingly, a follow-up of the cases treated by the nurses and social workers trained was undertaken in 1999. AMANI staff examined the case files of all the patients seen by the Trauma Counsellor trainees and the findings are reported below.

A total of 79 case files were examined. The majority of the cases were female (54) and the mean age of the cases was 31 years (sd.12.6). As can be seen from Figure 6 [see over], there were a variety of types of trauma seen by the trainees, with domestic violence and torture being the most frequent. The torture cases were all chronic cases from the Liberation War.

The health workers had received training in both the assessment and treatment of survivors, and the training in treatment had revolved a number of different approaches: problem-solving, family therapy, the brief therapeutic interview, and de-briefing. The training was bolstered by the provision of a number of manuals, developed especially for this programme[13].

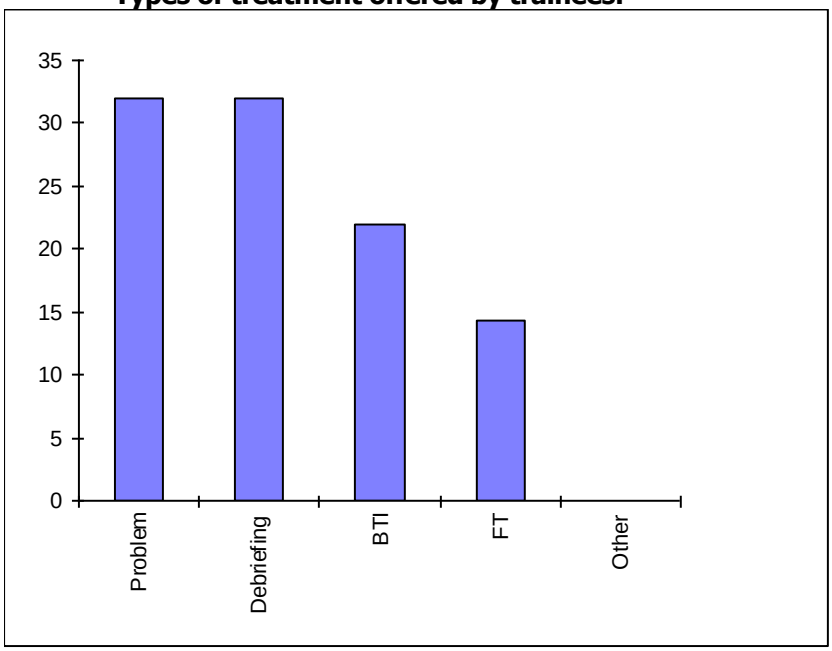
[13] See Appendix 1 for details of the manuals, copies of which may be obtained from the Amani Trust.

Figure 6.
Types of trauma seen by trainees.



Of the types of therapy offered, problem solving and de-briefing were the most common. However the trainees did use all types that had been taught [see Figure 7 below]. It was interesting to see the preference for problem solving and de-briefing and discussion with the trainees indicates that they were using these for different types of cases. Problem solving was used in cases where the presenting problem was usually social or had an economic focus in the problem, such as lack of school fees. De-briefing was reserved for the more acute cases and used as an immediate method for dealing with the trauma. For example de-briefing was used in cases of rape or sexual abuse.

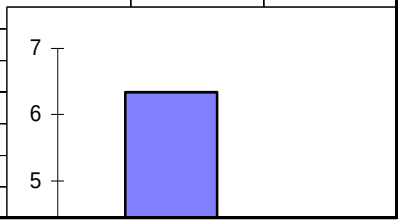
Figure 7.
Types of treatment offered by trainees.



It was interesting to see the outcome of the clients treated by the trainees. It was hoped that the trainees would routinely use the SRQ-8 or the SRQ-20 on a regular basis to assess outcome on follow-up, but for a variety of reasons this was not done. There were considerable differences between the trainees in the frequency with which they used objective measures to assess outcome, with at least two trainees doing this on a routine basis. Most relied on self-report to assess outcome.

Figure 8.
Outcome of trainees' treatments: Pre and post scores on SRQ-20.

6.315789474	3.578947368	10			
1.335524515	1.426565007				
				SRQ1	SRQ2
			mean	6.32	3.58
			s.dev	1.34	1.43



As can be seen from Figure 8, there was a general trend towards improvement as measured by the SRQ-20, although the cases seen do not appear to have been very severe, as evidenced by the low mean SRQ-20 score taken before therapy began [SRQ-20(1)].

The results of those cases for whom self-report scores were kept show a strong effect for improvement: 85% (33 cases) were rated as improved as opposed to 15% (6 cases) that remained the same or got worse.

In addition to managing cases, the trainees also made referrals when they felt the need. The major point of referral was to doctors, which is unsurprising, but it was also gratifying to see that the trainees made use of most local resources, and did not show dependency upon AMANI as the major source of support. This can be interpreted as weak evidence for local sustainability.

This brief review indicates that nurses and other health workers can be trained in methods of psychological management, and, furthermore, that simple, cost-effective methods of psychological treatment can be successfully applied in the community setting. We will comment later upon the relative strengths and weaknesses of the approaches developed by the Amani Trust, but next we move to a brief review of the training programme developed.

3. Training Health workers:

As indicated earlier, the Amani approach to assisting survivors was built around a holistic strategy that saw a community mental health focus as central. In this focus, the devolving of skills to the District level and the primary health centre was fundamental. Thus, the training of health workers in the skills necessary for the management of psychological disorders, and disorders due to trauma, became a major activity. Between 1995 and 2000, the Amani Trust invested great energy and resources in the training of health workers, and here the focus was primarily upon nurses who were, and still are the core of the district health service. What follows below is a summary of this work.

3.1 Primary care nurses

Since 1995, the AMANI Trust had been in a collaborative relationship with the District Health Team of Mount Darwin District. Although the primary focus was on developing assistance to survivors of torture and organised violence, the aim was also to strengthen the District's psychiatric service. To this end, a series of small studies were conducted, and, although these were mainly concerned with examining the effects of the violence in the 1970's on the survivors, these reports were relevant to the development of a District Psychiatric service. Following on an initial pilot study in 1995, AMANI introduced a community-based programme in Mount Darwin District to address these problems; both the ordinary psychological disorders, but also the disorders due to torture and organised violence. This programme ran from March 1995 to September 2000, when it had to be curtailed.

As a part of this community-based programme, the AMANI Trust ran training courses in primary mental health care for nurses, as well as other health workers. The basic training focused on the basic knowledge and skills for detecting, assessing, and managing psychological disorders presenting to primary care and hospital outpatient departments. The course also contained an input on the assessment and management of survivors of organised violence and torture. Manuals were developed to support this basic course[14]. About 150 nurses and health workers went through this course in three Districts – Mount Darwin, Muzarabani, and Centenary.

3.1.1 The Basic Skills Programme 1995 – 1998

The major objective of the Basic Skills Programme was to create awareness in the health team of the prevalence of CMD, and to provide basic skills in the detection assessment and management of these disorders. There was also input on disorders due to organised violence and torture since these had been shown by epidemiological studies to be a very common sub-set within CMD.

The programme revolved around the following areas and was supported by a manual[15]:

- *Definition of the common psychological disorders;*
- *Classification of psychological disorders;*
- *Identification of the incidences of hidden psychiatric morbidity;*
- *Detection of psychological disorders including the use of SRQ- 8;*
- *Completion of the psycho-social histories of patients;*
- *Selection and referral of clients appropriately;*
- *Application of basic counselling skills and simple intervention methods.*

These were very successful courses, and strongly endorsed by both the trainees and the management. The training led to a much greater awareness about both CMD and OVT and to the formation of District Mental Health teams.

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[14] See *AMANI. [1997](A), Survivors of Torture in Mount Darwin District, Mashonaland Central Province: Overview of Report and Recommendations, LEGAL FORUM, 9, 49-60. see also AMANI.[1997](b)], Report on Psychological Disorders in Clinics and Hospitals in Mount Darwin District, Mashonaland Central Province, HARARE: AMANI.*

[15] See *Reeler,A.P. [1995], The Chiweshe Nurse-Counsellor Programme: Resource Manual (revised), HARARE:AMANI; Reeler,A.P. (1995), Assessment of the Consequences of Torture and Organised Violence: A manual for field workers, HARARE:AMANI*.

3.1.2 The Core Counsellors Programme 1997 – 1999

The next level of course was offered to a smaller group, chosen from those who attended the basic training. This was a 12-month course, with monthly teaching sessions and ongoing supervision of cases. About 18 nurses went through this course in two Districts – Mount Darwin and Muzarabani.

This programme was designed to increase the capacity of the District service and create a group of more experienced and better-trained counsellors who could back up those nurses who had been through the Basic Skills Programme. The course covered the following:

- *Screening and make detailed assessments of patients with psychological disorders;*
- *Applying the counselling tools/skills to a variety of situation that they come across;*
- *Conducting individual counselling using the problems solving and single therapeutic interview techniques;*
- *Applying the family therapy algorithm in the counselling of families;*
- *Participating in peer counselling within working areas;*
- *Supervising and assist colleagues on all aspects of counselling.*

3.2 The Trauma Counselling Programme 1999 – 2000

The last aspect of Amani's training represented a shift in AMANI's training philosophy. Following extensive discussions and a needs assessment, it was decided in 1998 to offer training on a Provincial basis, revolving around a training-of-trainers approach. A needs assessment indicated that disorders due to trauma were a very common problem seen by Provincial health workers, and that there was a need for generic trauma counselling training. It was not possible to mount this programme in 1998, and the Trauma Counselling programme was finally launched in March 1999.

The aims of the programme were several-fold and covered a variety of different forms of trauma. The course was mounted in conjunction with the Family Support Trust and the Musasa Project. The former was an NGO dealing with child abuse whilst the Musasa Project dealt with domestic violence. Both these forms of trauma were indicated as common in the needs assessment.

The basic aims were as follows:

- *To identify 5 different types of trauma and their effects on individuals, families and communities;*
- *To Assess trauma using at least 4 of the various instruments;*
- *To Apply at least 3 intervention techniques to different types of trauma;*
- *To Identify caring procedures for carers.*

The course covered a wide area within trauma as follows:

- *Detection of psychological disorders;*
- *Assessments;*
- *Depression/Anxiety;*
- *Trauma and violence;*
- *Counselling and Communication;*
- *Debriefing;*
- *Family Therapy;*
- *Problem solving therapy;*
- *Brief Therapeutic Interview;*
- *Care for caregivers.*

This course was supported by several manuals[16], and the follow up consisted of monthly supervision visits for six months, and a one-day Refresher course after the first three months post training. At the end of the six months, trainees were taken for a five-day Trainers' course. A total of 15 Health workers, including Social Workers, were trained as Trainers, who were expected to train others in Year 2000.

As is seen in Section 3.3 below, the training programme was successful, both in terms of the transfer of skills and in the outcome of the treatments offered.

3.3 Nurse Survey [1999]

This was an attempt to evaluate the effects of the Basic Skills and the Core Counsellor programmes, and to identify the need for more specialised training in trauma counselling. A questionnaire survey was complemented by a more formal evaluation by an independent consultant, who interviewed a cross-section of the trainees and administrators in Mount Darwin District.

Table 1.
Demography of the sample.

Age[mean; s.dev]:	30.9[4.7]
Gender:	
Male	6
Female	22
Qualification:	
SRN	21
SCN	9
Specialism	4
Additional training	16

Of the respondents, about half had not received any training by AMANI. Of those reporting training, all had received the Basic Skills programme and three-quarters had attended the Core Counselling programme. These were acceptable numbers for evaluation purposes since the sample was 44% of the Core Counselling programme.

The trainees all indicated that the Basic Skills training was useful to their everyday work, whilst most (85%) indicated that the Core Counselling programme had been useful. In answer to how often the trainees had used their skills in managing psychological disorders, most indicated using the skills on a near daily basis as can be seen from Table 2 [see over].

Table 2.
How often acquired skills used

Never	1
Once a month	0
Once a fortnight	1
Once a week	1
Every day	9

The average number of clients seen was about 18 per nurse, with a total of 210 patients over six months. Three participants indicated that they had seen many patients, but gave no numbers. Despite these relatively low numbers, it should be borne in mind that these nurses saw the patients in addition to their other duties – they were not specialist counsellors or psychiatric nurses- and the effect of this work was to provide additional capacity to the health service.

Torture and trauma were examined separately. The trainees were asked whether they had seen torture or trauma cases, and 11 of the 12 indicated that they had. The trainees had not seen as much

[16] See *Reeler,A.P. [199]), The Chiweshe Nurse-Counsellor Programme: Resource Manual (revised), HARARE:AMANI; Reeler,A.P., MBAPE, P., HLATYWAYO, E., MATSHONA-DUBE, J., & MHETURA, J. [1999], A Trauma Counselling Handbook, HARARE: AMANI.*

torture or trauma cases as ordinary cases of psychological disorder, but they had nonetheless seen a large [86 cases] number between them.

One participant indicated that he had seen many patients and had no figures. Of the kinds of treatment offered by the counsellors, counselling was the most frequent. The majority [10] recommended this training to be part of all nurse training, whilst a small number thought the contrary [2]. A variety of reasons were offered for the recommendation, and a selection of their responses is shown below.

> *"It equips one with the necessary skills in dealing with torture victims."*
> *"Helps in use of resources i.e., we won't prescribe unnecessary drugs in cases where counselling only can be effective."*
> *"Every nurse meets a patient who needs counselling so it is easier when one has the skills instead of referring to nurses who did a counselling course who may be off duty."*
> *"These skills should be incorporated into their training as nurses come across torture, rape and psychiatric patients."*
> *"It enhances proper management of a patient using a holistic approach."*
> *"It is useful in detection of anxiety and depression."*
> *"Psychological problems can then be identified within the Community."*
> *"A good guidance to correct diagnosis preventing patients from shopping around seeking treatment."*
> *"A lot of patients seen present with psychological problems but nurses do not know how to manage them accurately."*
> *"Counselling training gives the nurse an understanding of human behaviour and opens up channels of assisting clients with satisfaction and confidence."*

3.4 Rehabilitation technicians

In Zimbabwe, as in other developing countries, access to an experienced physiotherapist is rarely possible for many patients in the community. To obviate this problem, Zimbabwe developed a cadre of health worker, the Rehabilitation Technician (RT), to assist the physiotherapist and occupational therapist. These workers are based at district hospitals, and provide the first line of care for patients with physical disabilities, providing basic assessment and rehabilitation. The RTs are supervised and supported by physiotherapists based at the Provincial Hospital, and these two cadres of health worker thus provide a rehabilitation service from the community through to tertiary care.

The aim of this programme was to provide a training programme for Rehabilitation Technicians in the assessment and management of trauma victims, including torture and organised violence. All the RTs in Mashonaland West Province were trained in 1996/97. The project was developed together with the Provincial Rehabilitation Department of Mashonaland West Province.

The project, which was based at Bindura Hospital, was in two phases, and lasted approximately 18 months. During Phase I, a manual, suitable for use by the rehabilitation technicians, was developed. This was based upon the manual developed by the Rehabilitation and Research Centre for the Victims of Torture [RCT] in Denmark, and adapted for local conditions and para-professional workers. This manual was adapted by local physiotherapists, and the assessment and management protocol developed by the physiotherapists tested in a pilot study. This involved assessments of a group of torture survivors by two independent physiotherapists. Patients were seen individually by a physiotherapist, an occupational therapist, and a doctor[17].

[17] For details of the assessment, see *Amani (2005), The Medical and Psychological Consequences of the Liberation War. A report on survivors from Mashonaland Central Province, Zimbabwe. July 2005. HARARE: AMANI TRUST.*

The final instrument and the manual were taught to 10 rehabilitation technicians in the course of a 5-day workshop. The trainees then returned to their stations and implemented their training. Each trainee received visits from the supervising physiotherapists over the following two months, with independent assessments of their work and supervision of ongoing cases being provided by the Provincial Department of Physiotherapy.

The trainees returned for a 2 day supervision workshop after three months. This provided an opportunity to evaluate the training, correct any problems, and obtain feedback from the trainees about any difficulties or omissions in the training or the procedures. An interim evaluation will then be carried out by the project team from AMANI and the Provincial Physiotherapy Department, and any corrections needed to the manual, the protocol, or the training, were made.

It was hoped that this project would result in the production of a manual and protocol suitable for Rehabilitation Technicians, which it did. Furthermore, the programme was extended to Matabelaland in 1999 with the launch of the Matabeleland Programme of the Amani Trust. Attempts were made to formalise the programme in the Ministry of Health, but this did not materialise. However, this little initiative was a promising start to extending physical care of survivors, and demonstrated that rehabilitation technicians could be useful cadre to involve in the community care of survivors of torture.

3.5 Forensic Nurses

The interest in forensic nursing grew both out of the understanding of the need for such a cadre of professionals, and the exposure to such a programme at an Amnesty International conference in South Africa. The Amani Trust sent a member of staff to participate in a forensic nurse training course in the Northern Cape in 2000, and, on the basis of this experience, negotiated with the Zimbabwe Nursing Association to hold a similar course in Zimbabwe. This programme was held in June 2001, following a series of meeting with Provincial Nursing Officers and the Zimbabwe Nurses Association (ZINA).

In order to understand more clearly the need for forensic nurses, a survey was carried out to assess the knowledge and attitude of Human rights violations and medical ethics among nurses. The results were used to assist in the designing of the training programme in Clinical Forensic nursing. About 800 questionnaires were distributed to Nurses in the Harare City Clinics, Central Hospitals including Chitungwiza, Independent and Occupational Health clinics. Secondly, several meetings were held with Stakeholders to discuss the training objectives.

The survey provided interesting results, but generally vindicated both the need for forensic nurse training and more teaching in the field of medical ethics[18].

The course was conducted in accordance with the requirement of the International Association for Forensic Nurses from 18th June – 13th July 2001, at the Medical School. The course had 4 expert facilitators from the United States, as well as several local ones each with a specialty. 22 participants from all Provinces, including 3 clinical Officers from Amani Trust, attended.

Supervision by Ms Hlatywayo, the Amani coordinator, started in September and continued to February 2002. She did monthly follow-ups to every participant at his/her station.

A refresher course was held in December 2001 for the participants. 19 of the 22 participants attended to review progress, share experiences and recommend a way forward for the future development of Forensic Nursing in Zimbabwe. Most of the participants said that they benefited from the course and are using the skills gained.

[18] See *AMANI (2001), Knowledge, attitudes and experiences of nurses on human rights, their violations and medical ethics in Zimbabwe. May 2001. HARARE: AMANI TRUST.*

Generally, the nurses found their new skills useful, particularly in respect of sexual assault and abuse cases. One forensic nurse was accepted as an expert witness in a child rape case in the Chinoyi Provincial Magistrate's court: presiding magistrate said in this case that he wished there more forensic nurses in order to expedite such cases. At the review, the nurses also pointed out that their documentation of all cases had improved as a result of the training, and their new understanding of the importance of examination and documentation.

3.6 Developing District mental health services

In order to consolidate the training, the Amani Trust also made an attempt to work with the District health team to develop a referral and treatment system. The major aim here was to protect the trained nurses from having to handle cases beyond their expertise, since observation and experience had shown that the most frequent de-motivating factor for nurses applying their skills was having to manage extremely difficult cases. Whilst these were generally cases of major mental disorder, they were not exclusively so, and frequently complex cases involving family disputes were found to be beyond the capacity of nurses in primary care clinics in the community. Here it must be remembered that nurses living intimately within the communities that they serve, and are as much at the mercy of complex community problems as their patients.

In order to ensure that the District retained the capacity to manage psychological disorders and survivors of violence, Amani initiated discussions within the District aimed at formulating a District psychiatric policy. Representatives from Amani, Mount Darwin District Hospital, Karanda Mission Hospital, and the Provincial Medical Directorate met to fulfill these aims. This group produced a management algorithm for the District, which was implemented after a pilot period. Additionally, Amani was requested to assist the District in the preparation of a project proposal for the establishment of a District Psychiatric Unit. Amani assisted by conducting a series of point prevalence studies at the hospitals and several rural health centres, and the compiling of a detailed statistical analysis of the presenting problems.

The findings of this research indicated a clear need for a developed psychiatric service in Mount Darwin District. Following the suggestions of the World Health Organisation and local Zimbabwean workers, some recommendations were made as to how this service might be organised, as well as the likely needs for such a service. These recommendations were accepted in full by the Hospital Management Board and the modalities for implementation worked out. The Amani Trust's work not only lead to a greater awareness of the problems caused by organised violence and torture, but also lead to both a greater awareness of psychological disorders with a commitment to provide an improved service to these patients.

AMANI also supported the Districts directly with clinical supervision visits following the training workshops. These visits were frequently a mixture of training and consultation. On average, every clinic, and the person trained by AMANI, was seen at least once every two months.

4. Community work:

As indicated above, the Amani Trust had, from the outset, a view that a community-based approach was fundamental to the development of an effective programme.

4.1 Family visiting

The first stage of the community programme involved the visiting the homes and families of all identified survivors. This was done so that the functioning of the families could be assessed, as well as determining what levels of support were available for both the survivor within the family, and the family within the community. It became very clear from the outset that the survivor families displayed many features of social and psychological dysfunction. For example, early work showed that the

families that included "disappeared" members were suffering a range of problems as a consequence on the non-burial of their family members[19].

4.2 Assessing the needs of survivors in the community[20]

Since the family visiting programme had strongly indicated severe poverty among the survivors, it seemed important to determine whether this poverty was peculiar to survivors or merely a reflection of the general poverty in the Province. Thus, in order to determine the psychosocial effects on survivors of OVT, a comprehensive questionnaire was constructed, based on information from the 1993 Census, the CCJP poverty datum study, the government's own poverty assessment survey, consultations with members of the Department of Rural and Urban Planning at the University of Zimbabwe, and personal experience of the context.

The assessment focused upon a series of key areas as follows below:

- health;
- children's health status;
- activities and employment;
- household income activities;
- housing amenities;
- agricultural activities:
  - cropping;
  - gardening;
  - use of natural resources;
- communication & transport;
- household consumption;
- perceptions of poverty.

The questionnaire was given as a structured interview to all subjects. The subjects were chosen from amongst the clients of the Amani Trust, and chosen to give as broad a representation of all clients and various areas in which they live. An attempt was made to get at least 2 persons from each area in Mount Darwin. There were two sets of respondents: Clients [survivors], who were registered with the Amani Trust, and Controls, who were not registered with AMANI, and were immediate neighbours of the Clients.

It was apparent that several Controls had histories of OVT, but had not sought assistance from or referral to Amani: about 50% had no experience of organised violence. In the end, the comparison was between those who sought assistance from Amani with those who had not.

Clients reported more aches, pains and depression than the Controls. This suggested that one major difference between the two groups lies in the ability of the Controls to cope with any disability or disorder due to OVT; it may also reflect the fact that Controls did not experience significant OVT. Additionally, these were symptoms that would be expected form the selection criteria: severe psychological disorder and Impact torture.

There were no real differences between the two groups in access to and use of health facilities, but some differences in the kinds of illnesses, and the days lost due to illness. However, the study did not sample the frequency of consultation, which would have been a useful indicator, and had implications for the economic costs suffered due to illness. There was one small indication in the amount expended

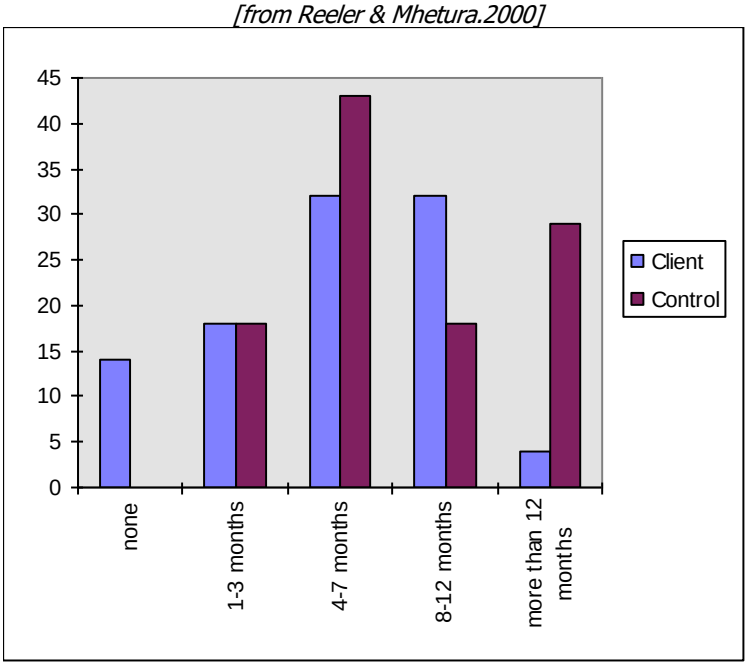
[19] See *Mupinda, M. (1997), Loss and grief among the Shona: the Meaning of Disappearances, LEGAL FORUM, 9, 41-49.*

[20] See *AMANI (1998), The Psycho-Social Needs of Survivors of Organised Violence and Torture in the Community, HARARE: AMANI*; see also *Reeler, A.P., & Mhetura, J. (2000), The psychosocial effects of organised violence and torture: A pilot study comparing survivors and their neighbours in Zimbabwe, JOURNAL OF SOCIAL DEVELOPMENT IN AFRICA, 15, 137-169.*

on health care, which was noted by a related Zimbabwean study[21]. This study indicated that persons suffering from Common Mental Disorders [CMD], who will include a significant number of survivors, spent significantly more on medical treatment than other categories of patients.

One of the most pressing matters for rural families if that of food security, and, as can be seen from Figure 9 below, it was evident that survivors generally had worse food security than their neighbours.

Figure 9.
Period food stocks will last.
[from Reeler & Mhetura.2000]



In general, it was evident that both groups reported high levels of poverty and inability to provide adequately for their children, irrespective of whether the child was of school-going age or not. Most of the subjects were subsistence farmers, and derived their income mainly from agricultural activities, especially from the selling of crops and animals. However, the Controls were more likely to have some form of employment and more likely to have earnings coming from outside agricultural activities. The Controls reported more frequently that they had received recent income, and were slightly more likely to have earnings in the higher ranges than the survivors. These findings suggested greater economic security for the Controls. Although the activities described were regarded as income generating, very few in either group derived much income from these activities. The main activity described for both groups was market gardening, but this activity did not generally yield much income for either group. However, it was noteworthy that Controls generally earned more than twice as much than the survivors.

There were differences between the two groups in their spending power, with the Controls reporting having greater spending power than the survivors. This was consonant with the findings of greater income earning by the Controls.

It is interesting that there were differences between the groups about what were the causes of poverty. The survivors had reasons that were very much related to OVT - war destruction, confiscation of cattle [lack of draught power], and poor accommodation - whereas the Controls saw the more

[21] See *Patel, V., Todd, C., Winston, M., Simunyu, W., Acuda, W., & Mann, A. (1997), Common mental disorders in primary care in Harare, Zimbabwe: associations and risk factors, BRIT.J.PSYCHIAT., 171, 60-64.*

traditional reasons - land shortage, food shortage, inability to pay school fees. There were also marked differences in their attributions of the ways out of poverty, with the Controls giving reasons much more consonant with greater self-efficacy than the Clients. This may be a very important difference, leading both to poorer performance in life, as well as reflecting one of the more common effects of OVT, a diminished belief in one's self-efficacy.

Overall, 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.

Additionally, 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 represented real and substantial differences in the social and economic well-being of the two groups. The survivors [Clients] were markedly less well-off than their neighbours in many areas, and it seems fair to conclude that survivors have 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 the Amani Trust to the significance of social adversity. As several commentators have observed, the problem for survivors of OVT is not post-traumatic stress but ongoing stress. [22]

The second group of findings speaks to the psychological consequences of OVT and the social adversity. These survivors had low self-efficacy, and this seems due in part to the original violence and in part to the failure to overcome the social adversity. It may be rather facetiously commented

[22] See *Lopez, J., & Marcelino, E. (1995), Torture Survivors and Caregivers: Proceedings of the International Workshop on Therapy and Research Issues, PHILIPPINES: CENTER FOR INTEGRATIVE & DEVELOPMENT STUDIES; Straker, G. (1987), The continuous traumatic stress syndrome - the single therapeutic interview, J.SOC.DEV. IN AFRICA, 8, 48-78.*

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. 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 this 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 are living. In real terms, the supporting facilities - health and social welfare - around them are eroding at an alarming rate. At the time of this survey, it was estimated by the government's own Poverty Assessment Study Survey, in 1997, 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 this 1997 survey as compared to 62% in 1995.

Clearly the figures will be considerably worse currently in 2005! If survivors are below these thresholds, this is alarming indeed, and suggests that some proactive measures will be necessary to alleviate the consequences of disability and poverty in survivors. 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 that these are families that must develop the parents and workers of the future.

4.3 Advocacy programme

The advocacy programme developed out of the survey mentioned above, as well as the earlier understanding that Amani's clients had been unable to make any progress in advancing a case for their rehabilitation or compensation for over a decade.

A primary goal of the advocacy programme was to give Amani's clients a sense of agency in their lives by participating in a campaign to lobby Parliament to effect changes to the War Victims Compensation Act. Earlier work by the Amani Trust had suggested severe problems with this Act, and a need to amend the Act to take care of problems not envisaged in 1980 at Independence[23]. Although the Amani Trust itself made representations to the Government on this issue, and especially to the Commission to Investigate Abuses of the War Victims Compensation Fund, it was felt that the best advocacy on this issue would come from the survivors and their families themselves. This programme had two related components: the first was the advocacy facilitation programme, whilst the second addressed the issue of poverty, and revolved around training in permaculture and support for agricultural activities. The participants were mostly drawn from those survivors seen during the family visiting programme.

4.3.1 Advocacy groups

In order to develop the lobby and advocacy capacity of the survivors and their families, a programme of bringing representatives of local groups together to discuss the issues around their torture and its consequences. This programme, which was highly participatory, engaged groups of survivors from the Liberation in extended discussions about their trauma, the issues requiring redress, and determining a way to develop a victim-driven advocacy campaign[24].

[23] See *Reeler, A.P (1998), Compensation for Gross Human Rights Violations: Torture and the War Victims Compensation Act, LEGAL FORUM, 10, 6-21.*

[24] See *MHETURA, J (2000), The neglected issues in rehabilitation of old victims or organised violence and torture: Areas of importance with regards to Zimbabwe victims of organised violence from 1972 to 1980. HARARE: AMANI TRUST.*

In all, 260 survivors were consulted during the process, which began with an analysis of the history of the Liberation and its effects on the participants[25]. This followed a several stage process, as follows:

- Historical analysis: identification of key local events, including battles, arrests, torture, and the roles played by the participants:
- Linkages: identification of linkages between key events and subsequent torture;
- Livelihood analysis: identification of modes of coping during this time;
- Institutional analysis: identification of major perpetrators and their bases, camps, etc.

This data was collated and then fed back to the participants, with the major aim of providing a local history of events.

Subsequent workshops then focused on the development of an advocacy campaign, in which the following themes emerged:

- Establishment of a District register of survivors of torture;
- Expansion of the War Victims Compensation Act to cover torture survivors more fully;
- Expansion of outreach programmes of the Ministry of Health and Child Welfare to explicitly target survivors of torture;
- Deliberate inclusion in all economic and social development programmes.

The programme was developing extremely well, and the final stages were beginning to be put in place. These involved the setting up of an organizational structure for the victims, and the start of a campaign to lobby the Zimbabwe Parliament on the needs of survivors. Unfortunately, this programme came under threat during the 2000 Parliamentary election, and was forced to close down in late 2000.

4.3.2 "Sellouts"

An additional concern within the advocacy campaign was that of those survivors living within the community who would have been identified as "sellouts" during the Liberation War. As was noted in the previous monograph, not all survivors were victims of the Rhodesian security forces, and 10% of the cases seen reported being victims of the guerrilla forces. Many of those identified by the community or the guerrillas as "sellouts" were tortured and summarily executed, leaving their families alienated and unsupported in the community. Many of the families moved away from the community to other parts of Zimbabwe in order to avoid the stigmatisation that came with the label, but some returned after a number of years.

The Amani Trust, in both its clinical and community work, came across such persons, and was alarmed to discover that the labels still applied, and that these folk had not been re-integrated into the communities in which they were living. A small research project was established in 1999 within the advocacy programme to identify these families, and to determine their needs and problems. The intention here was to find ways to re-integrate these families fully into their communities, but, unfortunately, the project, despite collecting interesting data, was unable to continue after the elections in 2000.

4.4 Permaculture gardens and income-generation

This aspect of the community programme was predicated, as mentioned above, on the findings about the poverty experienced by the survivors and their families. It began with a programme of training representatives of the survivor groups set up in the principles and practices of permaculture. The aim

[25] See *MHETURA, J (1999), Living with trauma: justice and reparation after the Liberation Struggle in Zimbabwe, HARARE: AMANI TRUST.*

here was to assist the various survivor groups in the setting up and running of collective market gardens.

The Amani Trust provided the training, and then assisted each group in the process of negotiating with local authorities for the allocation of land for the market gardens. The Amani Trust then provided the inputs for the project, and also provided ongoing supervision. This first phase was highly successful, and resulted in the groups not only being able to bolster their own food security, but also to provide vegetables to the surrounding community. This produced small income for all the groups, and enabled them to earn sufficient income to maintain the project in the subsequent year.

However, it was clear that the market garden project, whilst meeting some of the food security needs, required extension if food security was to be guaranteed. The Amani Trust then implemented a second component of the programme, the support for a collective maize growing project. Following the identification of suitable land, and the negotiation for its use from the local authorities, the members of the groups were instructed in the use of a revolutionary approach to the growing of maize and the targeted use of fertilizers. This had been developed by the Department of Agriculture of the University of Zimbabwe.

Once again, this was highly successful, and resulted not only in the families growing sufficient maize for their own use, but also in growing a surplus for sale. Thus, it seemed that the joint problems of food security and income generation were being overcome. However, in order to consolidate the move of these families out of extreme poverty, the Amani Trust decided to extend the possibilities of income generation, and instituted a third component, a cotton growing project, using once again the targeted fertiliser approach mentioned above. This was again very successful, and resulted in substantial income being generated.

In a very short time, these survivor families had moved from being highly dependent on support to being able to fund their own activities, but, more importantly, had become resources within their own communities, deriving considerable self-esteem and influence. One measure of the success of this aspect of the community programme was seen in the number of approaches by non-survivor families for inclusion in the family.

4.4.1 1999-2000 season

The 1999-2000 season was the first year in which the combined market garden and maize growing project was implemented. As can be seen from Table 6 below, this resulted in all groups earning small amounts after their own food security needs had been met. The table shows the gross tonnage grown and the income earned by each group[26].

Table 6.
Maize Harvest [1999- 2000]

Group	Size of harvest	Income
Pachanza	1 tonne	Z$2,000
Nyamutamba	2.3 tonnes	Z$6,602
Nyamashava	1 tonne	Z$5,924 [GMB]
Chomakuyo	2 tonnes	Z$1,044 [GMB]
Kakeza	1.3 tonnes	Z$4,800

The table shows two groups that sold to the Grain Marketing Board; these two groups were in the same area and had better rainfall than other three areas. The reason for the good harvests was the proper application of fertilizer and good crop management, even though rainfall was erratic during the season.

[26] These sums may seem paltry by the standards of 2005, but represented significant income in 1999 and 2000. It is likely that the groups would have earned at least 100 times this amount in 2005, but, more importantly, the groups not only provided for their own food security but also earned income as well.

As can be seen from Table 7 below, which summarises the market garden production for the two seasons – 1999 and 2000 – all groups showed an improvement in the second year. These figures represent income earned only, and do not indicate the volume grown or the volume consumed by the families themselves.

Table 7.
Garden production [1998/1999-1999/2000]

Group	1999	2000	Total
Pachanza	Z$500	Z$2000	Z$2,500
Nyamutamba	Z$1,400	Z$1,352	Z$2,752
Nyamashava	Z$20	Z$2,449	Z$2,469
Chomakuyo	Z$3,300	Z$4,990	Z$8,290
Kakeza	Z$1,200	Z$4,900	Z$6,100

The number of people that benefited from the food security programme were both direct and indirect. In the year 2000, a number of people outside the programme benefited, and given the current economic hardships the figure will continue rising. The Amani Trust estimated that about 6000 families benefited from the maize and garden components in 2000.

4.4.2 2000-2001 season

The 2000-2001 season was the first year in which all three components of the programme were implemented. As can be seen from Table 8 below, there was an appreciable increase in the tonnage of maize produced by the groups involved, with nearly an eighteen-fold increase in the maize produced and 41-fold increase in money earned.

Table 8.
Maize Harvest [2000-2001]

Group	Size of harvest	Income
Pachanza	21 tonnes	Z$147,000
Nyamutamba	11 tonnes	Z$77,000
Nyamashava	14 tonnes	Z$98,000
Chomakuyo	10 tonnes	Z$70,000
Kakeza	6 tonnes	Z$42,000
Chimumvuri	19 tonnes	Z$133,000
Gumbeze	40 tonnes	Z$280,000
Total:	**121 tonnes**	**Z$847,000**

As can be seen from Table 9, the cotton growing project was similarly successful, producing over 27 bales of cotton and earning Z$228,816.

Table 9.
Communal cotton project: bales harvested [2000-2001]

Group	Bales harvested	Income
Kakeza	2	Z$20,400
Nyamashava	3	Z$16,873
Nyamutamba	2	Z$17,743
Pachanza	3	Z$11,592
Chimumvuri	3	Z$19,500
Gumbeze	3	Z$39,200
Chomakuyo	5	Z$42,408
Chawarura	3	Z$39,200
Kabvuma [1]	2	Z$20,400
Kabvuma [2]	1.3	Z$1,500
Total:	**27.3**	**Z$228,816**

The garden project was estimated, in 2000-2001, to contribute a further Z$49,750, with an average of Z$4,950 per garden being estimated.

Thus the combined income from all groups and all projects can be assumed to be in the order of Z$1,125,566.00 for the season ended 2001. Although this figure may look paltry in the context of the prices and inflation of 2005, this was an enormous sum for this impoverished community. In 2000, it was estimated that the project was benefiting about 6,000 people, directly and indirectly, and, in 2001, this was revised upwards to a figure of some 20,000 people. So the primary groups, who are victims and their families, were having an appreciable effect on the community around them, and this clearly contributes to a sense of empowerment. Here it is relevant to refer back to the findings of the community survey, and especially the findings about the lack of self-esteem and dependency. This programme has undoubtedly offered an important additional component in the rehabilitation of torture survivors.

There were of course problems. Groups experienced theft of vegetables, cotton and maize. Animals destroyed cotton and monkeys ate vegetables and tomatoes in some areas. Some planned activities had to be shelved due to factors beyond the control of the programme. Shortages of fuel affected the ability of Amani staff to reach the community, and the disturbances on adjacent commercial farms from 2000 onwards meant the loss of occasional employment.

In August 2001, Amani had to close down all the operations in Mashonaland Central. The then upcoming Presidential elections meant that the area had become a "no-go" area for organizations whose programmes that were perceived to be at odds with the aims of ZanuPF. However, it is gratifying to learn that several of the groups set up have continued to function since the closing down of the programme, and a follow-up of these groups will take place as soon as the political situation allows this. That the groups have survived on their own is a testament to the strength of the original programme and to the sustainability of the intervention.

5. Conclusions:

This review of the programme mounted by the Amani Trust provides considerable food for thought about the ways in which survivors of torture may be assisted in their recovery. The approach developed was explicitly an attempt to provide a holistic model for care, in which the individual, the family and the community were all included. Furthermore, the approach was conceptualised within a community mental health framework, and considerable attention given to the training of existing health workers and the embedding of the care for torture survivors within the Provincial and District health services.

The results are clearly very encouraging. Novel and appropriate methods for counselling survivors and other categories of sufferers from psychological disorders were developed. It must be admitted that the evidence cannot be claimed to meet the canons of rigorous scientific evaluation, but they nonetheless are strong evidence that the approaches developed work. It is significant that the approaches developed could be used by non-mental health professionals, and clearly more attention should be given to both more detailed evaluation of the therapy approaches developed and their use by para-professionals.

It is evident that considerable resources were devoted to the partnership with the Provincial and District health services, and it is submitted that this is in the very best traditions of the relationships that should pertain between State services and non-governmental organisations. The Amani Trust clearly attempted not to supplant the State health services, but, having identified gaps in those services, attempted both to fill these gaps and to also leave the State service with the capacity to fill the gaps itself.

Similarly, the Amani Trust identified difficulties in the community with the position and status of the survivor families, and attempted to meet these through an elaborate and innovative programme of assistance. All too often there is talk about the empowerment of survivors, but mostly this revolves around issues of contesting impunity and legal rights. The Amani Trust programme in Mashonaland Central Province attempted to achieve empowerment by addressing directly the factors that contributed to the sense of disempowerment experienced by the survivors and their families. The advocacy programme not only focused on making survivors the direct advocates of their own cause, but also ensured that their social and economic position was such that they could sustain this advocacy.

Although the Amani Trust programme in Mashonaland Central Province was conceived as a holistic response within a community mental health framework, it is clear that the programme shares many features with what is commonly termed '"Community-Based Rehabilitation" [CBR]. Community-based Rehabilitation is argued by many to offer the most comprehensive approach to the care of the disabled, and clearly the survivors of organised violence and torture must be regarded as a disabled population. CBR can also be argued to offer the most appropriate model for dealing with the consequences of mass trauma or disaster. As Boyce and others have recently argued:

> *On a practical level, CBR programs aim to rehabilitate and train individuals with disabilities, as well as to find ways to integrate them into their communities. In effective CBR programs, persons with disabilities, their families, the community, and health professionals collaborate to provide non-institutional services in an environment where services for persons with disabilities are seriously limited or totally absent. The essential feature of CBR is its focus on the processes supporting partnership of diverse groups and community participation. CBR programs assist local people to develop sustainable processes and systems that: deliver clinical services in remote areas; train personnel; promote Disabled Peoples' Organizations; plan, manage and coordinate local services; and provide appropriate technology. In areas of armed conflict, CBR programs typically aim to work with other agencies that are active in emergency aid and re-construction, which are often the only functioning organizations in the area.*[27]

According to Boyce et al, the following describes some common ways of adapting the key elements of CBR programs to increase their peace-building impact.

- *Promotion of Positive Community Attitudes and Behaviours towards Disability;*
- *Empowerment of Persons with Disabilities enabling Integration within Society;*
- *Knowledge and Skills Transfer to Promote Self-help Skills;*
- *Development of Rehabilitation Services/Resources Based upon Needs Identified by Persons with Disabilities and their Families;*
- *Community Decision-making, Implementation, and Accountability to the Community;*
- *Partnership and Cooperation among Persons with Disabilities, their Families, the Community, and Rehabilitation Personnel;*
- *Development of Rehabilitation Technology Utilizing Local Skills and Materials;*
- *Co-ordination with, and Referral to, a Network of Specialized Interventions, Including Institutions, to Provide Professional and Technical Support and Training which may be Unavailable within the Community.*

Most, if not all of these elements are found in the Amani Trust programme described above, even though the programme was not originally conceived of as a Community-Based Rehabilitation programme.

[27] See *Boyce, W., Koros, M., & Hodgson, J., Community based rehabilitation: a strategy for peace-building, BMC International Health and Human Rights 2002, 2:6.*

For the future, and addressing the problems that will likely emerge when the present Zimbabwe crisis is resolved, it also possible that CBR, and, in the Zimbabwe context, the approaches developed by the Amani Trust, may contribute strongly to a little appreciated consequence of this rehabilitation work, the contribution to peace building. It is not frequently appreciated that non-governmental organisations can make a significant contribution to the building of peace, and that the so-called "track two diplomacy" adopted by non-governmental organisations and civic bodies may not only assist in the ending of conflict, but also in ensuring that peace is sustained. As one commentator has put it:

> *"Economic and social reconstruction is crucial to the success of the peace process. In addition to advancing human rights, third parties have a crucial role to play in rebuilding and reconstructing civil society for long-term peace and stability. There is a vital link between sturdy civic institutions, including the norms and networks of civic engagement, and the performance of representative government. Not only is civil society important to democracy, but it also has a significant role to play in consolidating the peace process in countries making the transition from war to peace. Because third parties often provide the necessary foundations for democratic institutions, international development agencies and non-governmental organizations have a pivotal contribution to make to the task of post-conflict rebuilding".*[28]

Hopefully, the work of the Amani Trust described above can be seen as just such a contribution to the maintenance of peace after the bitter conflict of the Liberation War, but it may also offer a model for the future and for assisting in the emergence of a new and peaceful Zimbabwe.

Acknowledgements:

None of the work reported here would have been possible support of a number of funding agencies. Here, the Amani Trust would like to acknowledge the Oak Zimbabwe Foundation, DANIDA, the United Nations Voluntary Fund for the Victims of Torture, the IRCT, the RCT, the Swiss Embassy, and USAID.

It is also important to acknowledge the enormous effort made by the staff of the Amani Trust and the Trustees of the Amani Trust. The support of members of the School of Medicine of the University of Zimbabwe is also gratefully acknowledged, as is the support of the Zimbabwe Nurses Association.

The support and involvement of the Provincial Medical Directorate for Mashonaland Central Province, and all the very dedicated health workers in the Province was a very material reason for the success of all of this work. Their names are too numerous to mention, but they will all see themselves in this work.

Finally, the contribution of the survivors and their families cannot go unmentioned. It takes enormous courage to confront the consequences of organised violence and torture, no matter how many years after the event, and their enthusiastic participation has enabled the country to understand the legacy of organised violence and torture. We can only hope that their efforts will not have been in vain, and will contribute in the end to a Zimbabwe free from torture.

[28] See *Ball N, Halev T: Making Peace Work: The Role of the International Development Community. Baltimore, MD, John Hopkins University Press 1996.*

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