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Epidemic violence and the community: A Zimbabwean case study.

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Background

This paper deals with the problem of epidemic violence and its consequences, most notably with the problem of torture, which is a common consequence of epidemic violence. It is located in that most violent of continents, Africa, and in Zimbabwe in particular. Its relevance, in the context of the new South Africa, is to highlight the virtues of Truth and Reconciliation in contrast with the sins of Reconciliation without Truth, which is the Zimbabwean experience. The reference to the medical model and epidemics is to stress the value of a model of disease in considering extreme violence. This is not a new concept (Zwi & Ugalde.1989), but one worth repeating for its descriptive value.

From the perspective of the communities who are the recipients of all this ill-health, it often appears as if there is a deliberate attempt to destroy them. After all, modern, low-intensity conflicts have women and children as the most common targets of violence, experiencing injuries and deaths from war and abuse, becoming refugees, and generally witnessing the destruction of their traditional ways of life. Top-down, war is glorious, but bottom-up it is sheer hell. And there is no better place to witness this hell than in the field of working with torture survivors, for it is torture than allows us to see the real purpose behind military spending: the use of naked power to maintain position, the impunity to oppress all opponents, the creation of sustained fear to maintain compliance, and the perpetuation of endemic poverty. This is not merely an African story, but can be seen all over the world, in the endless low-intensity conflicts.

This is the story of one the more horrible of all the side-effects of this militarism: torture. The deliberate infliction of harm, and use of abuse to maintain political position and power. It is the story of one District in Zimbabwe, but it is a universal story, currently played out in more than 80 countries of the world according to Amnesty International and the International Rehabilitation Council for Torture Victims. It is the story of one attempt to rehabilitate the survivors, and shows so clearly how easy it is to break or destroy, but how difficult it is to repair and restore.

Mount Darwin District

Mount Darwin is an administrative district in Mashonaland Central Province of Zimbabwe. Situated in the north-east of the country, this district was very early involved in the Liberation War of the 1970's, with the first attack of the ZANLA forces coming in December 1972 at Althena Farm in Centenary, an adjacent district. After the Althena Farm attack, the security forces instituted severe reprisals against the population that was felt to be supporting the ZANLA forces. Schools, clinics, mills, shops, and beerhalls were closed; property was confiscated and destroyed; collective fines were imposed for failures to report the guerrillas; and mass arrests were made, with detentions and interrogations, involving torture, following.

Some crude statistics will illustrate the level of violence. Of 224 persons seen by the AMANI Trust in 1995-1996, 98% report some form of torture. As can be seen from Table 1 below, most had been detained, and a very high percentage reported a family witness to their torture.

Table 1.

History of detention and witnesses to own torture.	
DETAINED:	
Yes	**77%**
No	**21%**
WITNESSES:	
Adult	**39%**
Children	**38%**

The kinds of torture inflicted were severe, and the average number of different forms of physical torture experienced was high: on average about 5 different forms were reported (see Table 2 over). These bald statistics can only give flavour of the violence, and do not do justice to the impact upon the community.

Table 2.

Impact torture reported by survivors.

Beating	**76%**
Severe beating	**81%**
Exposure	**20%**
Suspension, hanging	**36%**
Sustained posture	**15%**
Submarino(wet & dry)	**20%**
Burnings	**10%**
Electrical shock	**24%**
Rape	**7%**
Other	**10%**

However, physical torture was not the only form of torture experienced, as Table 3 below indicates, and psychological torture too was common. It is unwise to underestimate the consequences of psychological torture, for there is considerable clinical and experimental data to demonstrate its adverse effects. Furthermore, Table 1 above indicates the scale of the witnessing of violence, and supports the notion that the community was a target.

Table 3.

Psychological torture reported by survivors.

Verbal abuse	**74%**
Threats against person	**62%**
False accusations	**63%**
Sexual abuse	**12%**
Threats against family	**33%**
Simulated execution	**29%**
Abuse with excrement	**7%**
Other	**4%**

These data have dealt with the individual or conventional forms of torture, those aimed at individuals, usually political activists, but they do not accurately describe the more social purpose of torture, that of destroying communal action and political will. In Zimbabwe, this purpose can be described clearly, particularly in respect of the post-Independence violence. During the 1970's, a policy of forced villagisation was instituted: termed "keeps" or "protected villages", the population was forced to reside in these villages by night with a strict dawn-to-dusk curfew imposed. Between 1973 and 1978 almost 750 000 rural people were forced into keeps throughout Zimbabwe. The life within these villages was extremely hard, and malnutrition, starvation, overcrowding, and inadequate sanitation were commonplace, as the investigations of the Catholic Commission for Justice and Peace (CCJP) demonstrated (CCJP.1976; CCJP.1975). The aim of this policy was to destroy the possibility of support for the guerrillas, but popular support for a just cause could not be suppressed, and Table 4 (over) illustrates, just how they saw themselves as active in the process of liberation.

Table 4.

Political affiliations of survivors.	
Leadership	**0.5%**
Active member	**36%**
Member	**6%**
Supporter	**45%**
No affiliation	**10%**

As can be seen, the survivors report having very definite relationships to the political struggle of the 1970's. The people were subjected to enormous stress as their loyalty became a key issue, as the Rhodesian security forces tried in every way to neutralise the support for the guerrillas, and used every means at their disposal to do this. This is not unusual, but the inevitable consequence of modern guerrilla warfare. Even medical doctors were used, and at least one documented example had doctors and research scientists assisting the Selous Scouts in providing poisoned clothing to the guerrillas. The climate of fear and suspicion created by these undercover operations fractured community trust, and pitted neighbour against neighbour, and even family member against family member. This view is bolstered by the reports from survivors of the direct effects upon their own families, a view supported further by the reports of war veterans (Reeler & Mupinda.1996).

Table 5.

Effects on other members of survivors' families.	
Detention	**23%**
Imprisonment	**8%**
Torture	**62%**
Disappearance	**20%**
Deaths	**23%**

In all, a picture of epidemic violence, with few escaping some experience, and a very high number reporting the torture of a relative. However, as even such eminent commentators on the Zimbabwe war as Terence Ranger have pointed out, this has lead to relatively few investigations of the common experience. Indeed, it might be said, in defence of my earlier thesis, that common experience has been ignored, even suppressed. However, whether by default or design, this has resulted in the silencing of suffering.

The silencing of suffering

In Zimbabwe, there is a long and bitter history of not telling the truth, all enforced by impunity, the most final form of silencing. It is a frequent occurrence that governments when confronted by the uncomfortable consequences of their actions, pass laws to excuse these actions. This is not just by the use of draconian and sweeping laws like the Emergency Powers, Law and Order (Maintenance) or Presidential Powers Acts, but by the passing of specific statues of impunity like the infamous Indemnity and Compensation Act of 1975 or by amnesties: these apply to both Rhodesia and Zimbabwe. However, the real effects of impunity are scarcely seen by many people, and certainly in Zimbabwe there are very few advocates for a Truth Commission and a firm adherence to the Constitution. This is scarcely surprising when no government in the past three decades has avoided the use of draconian legislation, all have used statutes of impunity, and none have respected the Constitution enough to uphold it in all respects. The illegal regime of Ian Smith merely tore up the constitution, whilst the post-Independent government of ZANU-PF use Presidential Powers and legislative

amendments to avoid any conflict between the Constitution and the legal implications of its actions. A quick history of the past three decades bears out this argument.

Firstly, in 1975 the Rhodesian government passed the notorious Indemnity and Compensation Act, which pardoned all actions committed in the line of duty to the state, and even had the temerity to make the Act retrospective to 1972, to the start of the war, to excuse the human rights violations of earlier years. This frustrated the possibility of the Justice and Peace Commission suing on behalf of any of the survivors of torture. Secondly, in 1980, by accepting that no charge would be brought against any person on any side who had committed a human rights violation, the warring parties created impunity in their efforts to reach peace, and the current government was, and continues to be, applauded by the world for its reconciliation. Thirdly , ZANU-PF provided impunity by reverting to very similar legislation as the illegal regime of Rhodesia by passing yet another act of impunity - the Emergency Powers(Security Forces Indemnity) Regulations.1982 - during the troubles in Matabeleland, and, finally, in 1987, the ZANU-PF government formally created impunity for the many human rights violations with an amnesty for all parties to the Matabeleland emergency: both the ZPRA guerrillas and all Government forces were excused their actions. The cumulative effect of all of this impunity is to silence all comment of any legal kind, and, ultimately, to silence all comment, even the dialogue of the everyday.

The controlling of silence

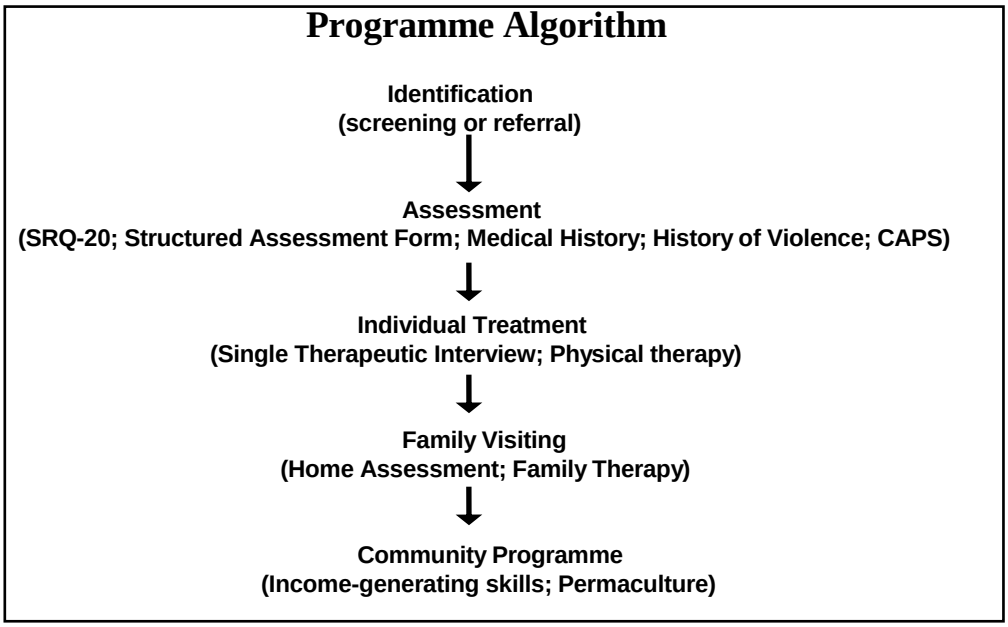
Acts of impunity are not enough, however, to maintain silence. There has to be a vigorous campaign to support impunity, which has been the case since Independence in 1980. The ordinary dialogue is distorted by the Government's control of the media in all its forms, by the interpenetration of all forms of administration by the ZANU-PF party, and by the endless of use of Constitutional amendments and Presidential Powers. The preventing of criticism becomes an additional form of silencing the dialogue of everyday suffering. One effect of this silencing is seen in the apathy shown over the years by voters in general elections: there has been a steady decline in the percentage vote since 1980. In the last election, held in 1995, the ZANU-PF government attained a majority in parliament without a vote being cast, when more than 50% of the seats, most of these rural seats, were returned unopposed. Whether this represents apathy or fear remains a point of issue.

However, the dialogue of the everyday in Mount Darwin has had little space in which to flourish. In the intervening years since Independence, the lot of the people of Mount Darwin has continued to be hard. Impoverished by the war and handicapped by a series of devastating droughts, the district is still afflicted in so many ways, all measurable in health terms. HIV, malnutrition, malaria, tuberculosis, and dysentery are all common, and, as we know, these are all related to poverty. Life has improved little, and hardship and hunger have become these peoples' partners in life. Their current situation can easily be described by reference to the data from both the 1992 Census and the clinical interviews.

These survivors have little education, high unemployment, and very few work related skills. They mainly survive on subsistence agriculture, and thus are very susceptible to the vagaries of the weather. Food security and employment are major reported problems and usually the focus of all clinical conversations. This is scarcely surprising. Fewer than 1% have access to piped water. Most (98%) still cook using increasingly scarce firewood, and more than 30% do not have access to a toilet of any kind. Infant mortality is high, and the medical facilities are meagre and increasingly stretched: 2 hospitals and 11 clinics for 200 000 people. These facilities are focused upon curative care mainly, especially with the burden of an HIV epidemic. However, more than 30% of clinic and outpatient clients are those suffering from psychological disorders. One in ten of the total adult morbidity is a victim of organised violence and torture(AMANI.1997).

The approach to Rehabilitation

Our approach has been to develop a holistic model for rehabilitation, one in which the needs of the entire community are taken into account, and one in which conventional rehabilitation will stand in partnership with community development. There are thus three mains strands to our approach, which can be summarised in the form of an algorithmic process. The steps are not necessarily followed in every case. For example, family therapy would not be offered to a family that did not require it, and nor would families be expected to participate in community programmes if they felt self-sufficient. The description of the model may feel very mechanical or medical to many, but we try to make our own actions as explicit as possible, both to be transparent to the community and in order to share the model more easily with other professionals. The simplicity also makes our actions more easily accountable.



As can be seen, the movement is from the individual to the community. Whilst it was not entirely clear what would be involved when this project began, it is now apparent that a service to the survivors in a district involves at least 3 clear phases.

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.

These phases are roughly one year in duration, depending on the size of the district and the numbers to be trained. The process requires at least two field workers, one working at the hospital and clinic level, and one working with the community. It also requires one staff member to provide the training and co-ordination for the team. This model is interesting because it uses the kind of personnel that might ordinarily be expected within a district, and thus provides a realistic model for a district. Social Workers and Psychiatric Nurses are already placed within the district service, albeit reporting to different ministries, and the most that any district might expect beyond this is occasional visiting by psychologists or psychiatrists. So in terms of sustainability, AMANI does not introduce to the District anything that could not be found within a district, or provided within a district if the organization of services was different that at the outset.

The plan that has evolved sees a gradual move from one district to another, keeping contact with all previous districts and ensuring that the development does not erode, and, as mentioned above, there are three main strands to this phased approach.

(i)Clinical Programme:
The clinical programme is concerned with the direct care of survivors, which is well-described by the algorithm above. Detailed assessments are carried out on every identified or referred survivor, with the intention that this will guide the management process as well as forming the basis for a claim for compensation. All survivors are offered individual counselling, and they are visited at their homes. The home visit aims to ascertain the family's functioning and their needs, as well as to ensure that the family understands the cause and nature of the client's disorder or disability. If necessary, family therapy sessions are provided.

Several small projects have been initiated in order to determine the efficacy of AMANI's counselling service. We are examining the efficacy of a single therapeutic interview, which may be described as a very simple approach to debriefing. A single therapeutic interview, supplemented by family visiting, seems to be the most useful intervention in the rural setting where patients are unable to return for regular weekly or fortnightly sessions. A selected group of patients needing counselling has formed the cohort, and are being followed up at 3, 6 and 12 month intervals. Additionally, a project to assess the efficacy of family therapy is being developed, and the first few families have been seen.

(ii)Training Progamme:
The training programme aims to create the capacity in the District to manage the problems of the survivors, but it attempts to do this within the context of a primary care psychiatry service. We believe that a programme will survive if it meets the needs of may different groups, but that a programme focused upon one group only will not.

In 1995, staff from the hospitals in the District were trained in a basic psychiatric management approach, supported by a specially prepared manual. The programme was later extended to the staff of the Rural Health Centres. The staff at these centres, 22 in all, participated in a series of 5-day workshops, and were then followed up for supervision purposes by AMANI staff at their work stations. In 1996, 2 groups of staff chosen from amongst the previously trained personnel began an advanced counselling course; one group from each of the 2 participating hospitals. This course aimed at providing each hospital with a core group of trained counsellors, capable of managing individual, group, family and trauma counselling to referred patients from within the hospital and from the rural health centres.

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 has 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. AMANI has begun a project to train these health workers in the assessment and management of trauma victims, including torture and organised violence. This project has been developed together with the Provincial Rehabilitation Department of Mashonaland Central Province. The project is in two phases, and will last approximately 12 months, and it is hoped that the project will result in basic assessments and treatments being available for trauma victims, including torture survivors, at the district hospital level..

(iii)Community Programme:
This is the slowest of the programmes to develop, but has no less importance. The survivors are invited to community meetings to discuss their problems as they seen them, which is the first step in creating a network of families. The home visiting leads to local meetings of groups of families, where they share their experiences and talk about their current problems. The current problems always revolve around poverty and its effects. The AMANI Trust, in responding to these concerns, has begun a programme to address these, which revolves around sustainable agriculture, or “permaculture”, small-scale income generating projects, and we hope in the future to address the problem of deforestation.

The emphasis will be on training again, with the community making the decisions about what projects to embark on and how to organise themselves. Here we hope that the disempowerment of the 1970’s will be practically combated by economic empowerment in the present.

Conclusions:

The aim of our programme is to empower people, not to impose anything upon them, and thus we are patiently waiting to see the community response so we can, in partnership, develop structures and processes. It is axiomatic to us that the process should be empowering, and nothing like the processes that originally harmed the community: the community must have a very strong say in what develops and what is created. The community must itself break the imposed silence of organised violence in order to be free. Thus, breaking the silence is the crucial therapeutic process for us. When people are able to tell their stories fearlessly and with pride, then the process of disempowerment is ended. Human rights begin and end with the right to tell our own stories, free of intimidation and abuse, and, for the survivors in Mount Darwin District, this requires the courage to break the silence. Community development can only begin when the community finds its voice, which requires the breaking of the silence.

We have now learnt several things from our work. Firstly, it is clear that storytelling is power. It has been salutary indeed to see the effects of the stories being witnessed. The value of "story telling" and "witnessing" cannot be emphasised enough in the therapeutic process. As our clients have repopulated their history, so they have become more assertive about their needs and their rights, but story telling also has had important consequences for us as therapists and community activists. Working with survivors has been very challenging to our cherished notions about psychopathology and psychotherapists. We, as therapists, are often guilty of valuing our story, our theory, over that of the client. We have begun realise that therapy is an epistemological encounter: we are engaged in a debate over theories and methods with our clients, and it is not clear whose theory should be valued.

Secondly, we have learned that all action must be holistic. When one takes on a community problem, one takes on the community as a whole: the people, their history, their land and relationship to the land, their modes of production and their organisation, and all the political relations that go with that community. One is forced to develop a policy that stretches from individual counselling to the lobbying of governments. When AMANI considers the effects of violence on Mount Darwin, it must consider the destruction of the environment through to the failure of the government to sign and ratify the UN Convention Against Torture. When we listen to the stories of the survivors, this is what we hear, and this defines our treatment of the consequences of epidemic violence.

Thirdly, we have begun to understand the value of Truth and its relationship to accountability. When impunity becomes a common place method of governments avoiding the consequences of its actions, then community development, like any other area of civic activity, becomes threatened. Communities need government to be accountable for its actions and to them if they are to obtain the support they need for their development. For us in Zimbabwe, the accommodation to poverty of our rural communities requires us to struggle to turn silence into speech, acceptance into criticism, and inertia into action, and this will a long process in the context of several decades of silencing.

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