The psychosocial effects of organized violence and torture: a pilot study comparing survivors and their neighbours in Zimbabwe

A. P. REELER AND J. MHETURA

ABSTRACT

Studies of survivors of organized violence and torture are uncommon in the African setting. Studies of the psychosocial effects of organized violence and torture are even less common. A Zimbabwean study comparing survivors of organized violence and torture with their neighbours was carried out in one previously war-affected area of Zimbabwe. The findings indicated that survivors were more economically and socially deprived than their neighbours in many key areas, especially the areas of employment, income, food security and housing. In addition, survivors showed indications of lower self-esteem and belief that they could change their situation.

Seen in the context of the increasing real poverty in Zimbabwe, the findings suggest that survivors of organized violence and torture represent a disabled group that may require targeted assistance by the State in order to overcome the social adversity they experience. The findings also indicate the need to assess more carefully the psychosocial as well as the medical consequences of organized violence and torture, especially in a region where epidemic levels of violence have been experienced in recent decades.

Background

MOST WORK ON survivors of violence and torture has been done either on Western populations, especially on war veterans (Helzer *et al.* 1987, Kulka *et al.* 1988), or on survivors who are either

refugees or forced immigrants in host countries (Kinzie *et al.* 1984, Allodi 1980). In Africa and other Third World settings, clinical or epidemiological studies of the health consequences of organized violence are rare, although there is a large literature making comment upon such effects, especially the effects upon children (Dawes 1994). There are some clinical studies which generally support the conclusions of the Western work (Straker 1993) but few epidemiological studies.

Previous work in Zimbabwe indicated that disorders due to organized violence were prevalent (Reeler 1996, Reeler and Mupinda 1996), but this data was derived from clinic referrals rather than from an epidemiological study. Epidemiological studies of Mozambican refugees resident in Zimbabwe have also indicated that disorders due to organized violence are common (Reeler 1995, Reeler and Immerman 1994). These studies did not, however, specifically examine for torture. The most recent Zimbabwean study indicated that disorders due to organized violence and torture were very prevalent (Reeler *et al.* 1999), constituting about 10% of all morbidity presenting to the primary care setting. However, some caution should be expressed since the sample in this last study was mostly composed of chronic survivors from the war that ended in 1980.

Although there are increasing numbers of studies on the effects of torture most are concerned with the medical and psychological effects and there are no detailed studies on the social and economic consequences of torture. This is perhaps surprising when so much of the published work has been conducted in refugee populations, a prima facie disadvantaged group and when the medical and psychological studies themselves indicate persistent disability and dysfunction in torture survivors. Furthermore, in situations where there has been epidemic violence such as Cambodia or Mozambique, the socio-economic consequences of organized violence and torture (OVT) must take on an even more important meaning in the process of reconstruction and rehabilitation. So questions about the long-term impact of torture cannot focus on the individual and the medico-psychological consequences alone, but must also focus upon familial

and social effects. This point has been made most forcefully by various workers (Kordon *et al.* 1998, Lagos 1996, Reeler 1994).

In Africa and Zimbabwe the palpable poverty in which torture survivors live is a factor that has led many trauma workers to speculate about the efficacy of service delivery when set against this feature in people's lives. The AMANI Trust, a Zimbabwean non-governmental organization working with survivors of organized violence and torture (OVT) has had consistent reservations about how good the prognosis for clients could be when their material situation was generally poor and when they are continually subjected to persistent stresses arising out of this material deprivation.This concern was strengthened by the publication of two well-controlled studies on psychological disorders by the researchers from the Department of Psychiatry at the University of Zimbabwe (Patel *et al.* 1998, Patel *et al.* 1997). The first study clearly demonstrates the relationship between poverty and psychological disorder, especially for women, and indicates that financial stress is one of the strongest predictors of the presence of psychological disorder. This replicates a long-standing observation in Zimbabwe about the prognostic effects of social adversity (Reeler 1986; Reeler and Todd 1994). The 1997 study indicates that a series of factors are strongly associated with poor mental health:

- female gender
- older age
- chronic illness
- number of presenting complaints
- economic impoverishment
- infertility
- recent unemployment
- disability

The second study, which examined the outcome of Common Mental Disorders (CMD), indicates that there is a poor prognosis generally for these disorders with 41% of the sample remaining with clinically significant disorder at 12 months (Patel *et al.* 1998). Two factors were most strongly associated with poor prognosis: disability and economic deprivation.

In AMANI's own work with the survivors of torture poverty is the single most important presenting complaint and forms the bulk of discussions in all counselling sessions. This is reflected, too, in many aspects of the data that has been collected on clients of AMANI. An examination of the case files of clients indicated that social adversity (family, marital, financial and personal problems) was common, as well as high unemployment, low levels of educational attainment and observable poverty. Since these are factors that are frequently seen in the rural populations of Zimbabwe anyhow, it was decided to examine whether survivors of OVT were relatively more disadvantaged.

Method

THE MAJOR aim was to determine the social and economic effects of organized violence and torture (OVT) on survivors living in communities that had previously experienced epidemic levels of violence during the 1970 war of liberation. Since the survivor group has high levels of psychological and physical disability it was necessary to determine whether these factors resulted in higher levels of social adversity than non-disabled persons living in the same communities.

In order to determine the psychosocial effects on survivors of OVT a comprehensive questionnaire was constructed, based on information from the 1993 census (CSO 1993), the Catholic Commission for Justice and Peace poverty datum study (Mundy 1995), the government's own poverty assessment survey (Ministry of Public Service, Labour and Social Welfare 1997), consultations with members of the Department of Rural and Urban Planning at the University of Zimbabwe and the writers' own personal experience of the context.

The assessment focused upon a series of key areas, namely:

- health
- children's health status
- activities and employment
- household income activities
- housing amenities

- agricultural activities
- cropping
- gardening
- use of natural resources
- communication and transport
- household consumption
- perceptions of poverty

The questionnaire was given as a structured interview to all subjects.

Subjects

THE SUBJECTS were chosen from amongst the clients of the AMANI Trust, selected so as to give as broad a representation of all clients and the various areas in which they live as possible. An attempt was made to get at least two persons from each area in Mount Darwin. There were two sets of respondents: clients who were registered with the AMANI Trust and controls, who were not.

Clients were compared with a neighbour (from among the controls) with the intention of comparing torture survivors with people who had not been tortured. In practice this was difficult as many neighbours had also experienced organized violence, although they had not approached AMANI or been referred to AMANI. The clients were recruited from the files by systematic random sampling by taking every tenth person on the register. The criterion for admission amongst the clients was that they must have a severe psychological disorder (a score of more than 10 on the SRQ–20) and a positive history of impact torture. This resulted in 28 clients being selected and they were finally compared with 27 controls. Several of the controls, however, had histories of OVT but had not sought assistance from or been referred to AMANI: only about 50% had no experience of organized violence. In the end we can thus claim only that we have compared those who have sought assistance from AMANI with those who have not.

The purpose of the study was explained to all subjects at the outset and consent to participate was inferred from their willingness to continue with the interview. No subject declined to be interviewed. The instrument was written in English but administered in Shona. It

was piloted on several subjects – not included in the final study – and the appropriateness of the questions was evaluated. The interviewers were two experienced social workers who had extensive experience in working in the rural setting as well as of having participated in similar types of study.

All interviews took place at the homes of the subjects. The interviews lasted between 45 minutes to an hour on average, but could often take considerably longer since the subjects were interested in talking in great detail on many of the topics covered by the interview.

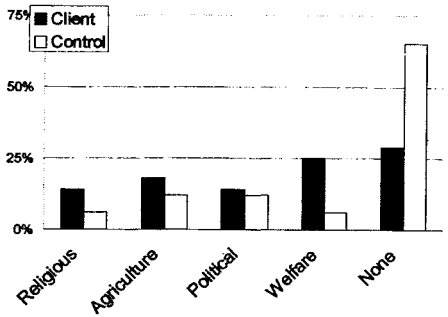
Results

THERE WERE demographic differences in the two samples, with controls having a higher percentage of males (76%) than the clients (54%). The sample age ranged from 25 years to above 60 years with no differences between the two groups. There were no differences in the marital status of the two groups, with the exception that divorce was more common in the control group. Controls tended to have smaller families than clients (42% versus 25%), which would be expected from an older group in which more children had left home.

If understanding written Shona or English can be regarded as evidence of literacy then there are some clear differences between the two groups. The data suggests that only 57% of the clients are literate as compared to 82% among the control group.Since one of the long-term consequences of epidemic violence is argued to be reduced integration into the community (Reeler 1998), we decided to provide some indication of community affiliation. As can be seen from Figure1 below there were marked differences between the two groups in their community affiliation in respect of the formal and informal groups to which the sample belonged.

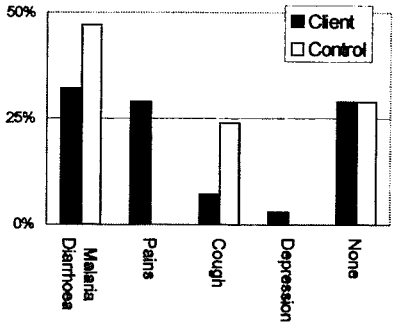
Health is an area that is extremely sensitive to socio-economic factors and, according to the illnesses reported by the respondents in the previous month, more controls than clients reported suffering from malaria and diarrhoea (see Figure 2). Clients reported suffering more from pains, aches and depression than controls. Pains and aches accounts for 28.6% among the client group as compared to 0% among

FIGURE1: TYPES OF COMMUNITY AFFILIATION



the control group and this should have been expected, given the history of impact torture in the client group.

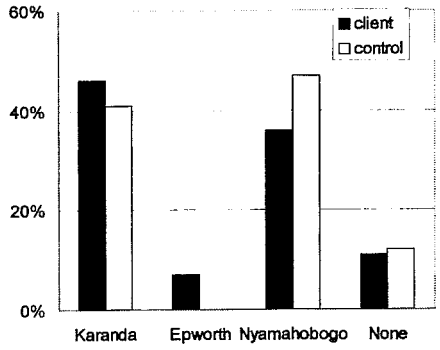
FIGURE 2: ILLNESS IN PAST MONTH



Time lost at work due to illness is another measure. More clients reported having lost a week than the controls (39% versus 24%), but more controls reported longer periods of work lost than the clients (29% versus 18%). This ties in with the types of illnesses reported above, where controls reported serious physical illnesses more frequently than the clients.

Access to health facilities can also determine health status. Here it can be seen from Figure 3 that there were no differences in the two

FIGURE 3: HEALTH CENTRE VISITED



groups in the use of the available health facilities. This was expected since both groups came from the same geographical area.

Since most rural people are regarded as poor, many receive free treatment under government's goal of providing health services to all, but the policy of cost recovery has increasingly lead to this group incurring charges for health care. Most report receiving free treatment (82% in both groups), but there is slightly higher percentage of clients who report paying for health services (4% versus 0%) and this probably reflects the chronic disorders and injuries seen in this group. It also reflects a greater economic burden on clients as compared with their neighbours in the control group.

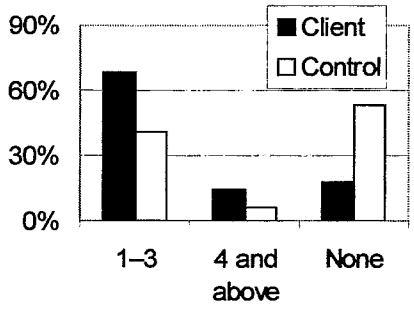
Children

THE STUDY also attempted to examine the health status of the children in the respective groups, since poverty and children's health are very directly related. For those who had young children at home, we examined whether clients and controls were aware of health issues. There were small differences in the views of the two groups towards vaccinations: clients were less likely to have had their children vaccinated than the controls (64% versus 71%). There are several plausible explanations here. Firstly, this difference reflects a general apathy amongst the clients and, secondly, it may equally reflect a refusal to vaccinate, given that the Apostolic Churches have a strong following in the district. Since we did not directly examine the actual

religious persuasion of the sample, we cannot answer the question, but clients were more likely to belong to a religious group.

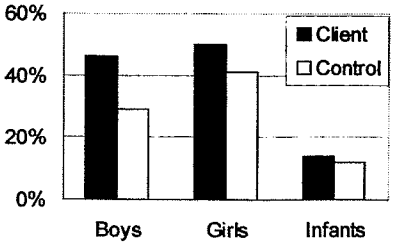
Schooling is another area in which the effects of poverty can be seen. As can be seen from Figure 4 clients are more likely to have young families and this ties in with the reported ages of the respondents, where the controls were a slightly older group than the clients. As they were therefore more likely to have school-age children they faced the consequent economic burden of school fees.

FIGURE 4: NUMBER OF SCHOOL-GOING CHILDREN PER HOUSEHOLD



As regards providing for children in school, clear differences were found, as can be seen in Figure 5. School-going children must posses a minimum of basic clothing such as one pair of shoes, three pairs of

FIGURE 5: MINIMUM AND ABOVE ABILITY TO PROVIDE SCHOOL UNFORMS FOR CHILDREN: CLIENTS AND CONTROLS



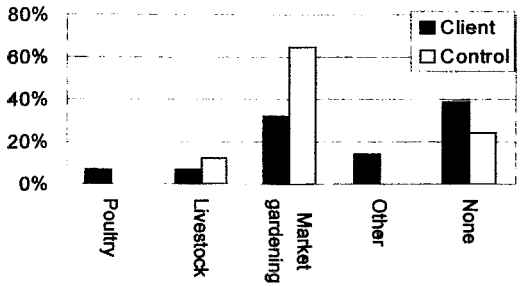
socks, two shirts and two pairs of shorts. Controls reported being less able to provide for their male school-going children.

Although there is generally a similarity between the two groups, the controls report being less able to provide for their boy's needs. This may reflect a variety of different reasons; for example, the clients may be more motivated to send their boys to school than the controls and, as it has been recently observed, there has been an increasing trend for families to discriminate in favour of boys attending school against girls.

Activities and employment

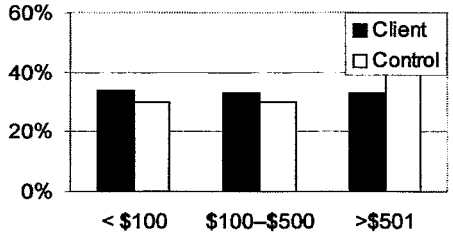
THE STUDY ALSO made an attempt to examine the economic activities of the sample in order to determine whether the disability of torture survivors affects their livelihood. Most of the respondents were small-scale farmers. No differences were observed between the two groups in the types of activities reported. It was also of interest to see whether the sample had had previous employment in the formal sector, since this could determine the capital base of the families assessed. Only 14% of the client group had worked after independence, whereas 41% of the control had taken up some form of employment. This suggests that there was greater unemployment in the client group and hence less access to capital.

FIGURE 6: INCOME RANGES FROM PAST WEEK ACTIVITY



As can be seen from Figure 7 there was also a trend for clients to report more frequently no household income earning activities.

FIGURE 7: HOUSEHOLD INCOME EARNING ACTIVITIES



The general trend is clearly towards controls earning more income than clients. As regards the average income earned from non-agricultural sources, there was a trend for controls to earn more on average (Z$534 as opposed to Z$168) and the controls also earn in a greater range than the clients (Z$1114 as opposed to Z$522).

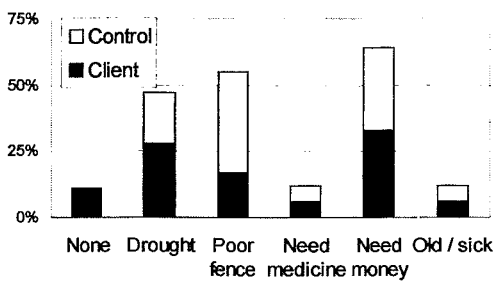
More clients than controls obtained some form of credit for their income earning activities (47% versus 23%). These credits received were mainly for agricultural purpose and varied from seed to fertiliser and pesticides. Loans can be a mixed blessing and it was unclear whether this difference represented the ability of the controls to self-finance their activities or merely their inability or reluctance to use credit facilities.

The sources of income of those who did not take up employment after 1980 were examined. There were marked differences between the two groups in terms of the generation of income, with controls more frequently reporting than clients earning some kind of income (65% versus 25%). However, the ranges of income earned by the two groups was largely similar where they reported earning income, as can be seen from Figure 6.

Household income activities

THE MAIN HOUSEHOLD activity was market gardening, with clients reporting market gardening activities about half as frequently The additional question was whether the sample reported any constraints on their agricultural activities. Clients reported drought and lack of money as the major constraints. The latter factor was also identified by the controls as well as lack of fencing.

FIGURE 8: CONSTRAINTS ON ECONOMIC ACTIVITIES



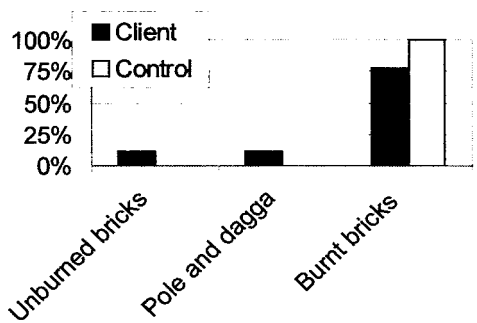
Housing

THE TYPES OF dwelling were broken into three observable types; traditional, modern and mixed. Some marked differences were observed. Among the clients most people (54%) live in traditional homes, while most of the controls (77%) live in mixed homes comprising both brick and traditional structures. This probably can be taken together with the greater likelihood of the controls having had jobs in the formal sector and thus with the capital to build some brick structures.

The type of roof is another factor that determines the durability of the dwelling. Most clients (64%) have thatched roofs as compared to only 53% of the controls. However, the differences observed between the two groups in the types of roofing was not great. The floor types were divided into two: those made of mud and those made of concrete. Little difference was seen between the two groups. The quality of the walls was divided into three categories: unburned bricks,

pole and *dagga* and burned bricks. This is again another factor that determines the durability of the structures. Generally more people in both groups have homes made of burnt bricks and it can be concluded that the controls generally have better homesteads than the clients.

FIGURE 9: TYPE OF WALLS



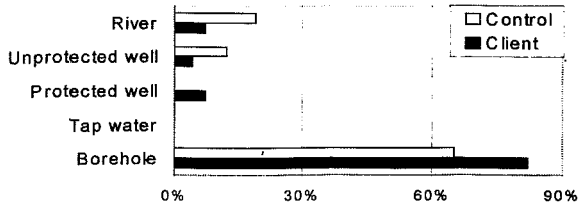
An attempt was made to estimate the condition of the houses. Here some differences were observed. There was a trend for clients to have more "worn out" or "used and rundown" housing than the controls (42% versus 24%) but there were no differences in the number of "new and well-kept" houses. In general there was a consistent trend for clients to live in poorer housing than their neighbours in the control group.

Amenities

THE QUALITY of drinking water is a significant factor in good health and the 1992 census indicated that few people in Mount Darwin District had access to protected water. As can be seen from Figure 10 below there is a trend for clients to have better access to protected water than the controls. This ties in with the reports by the controls of more diarrhoeal disease than the clients.

Boreholes were not very far away from people's homes, so that 86% of the clients and 65% of the controls have boreholes within a

FIGURE 10: SOURCES OF DRINKING WATER

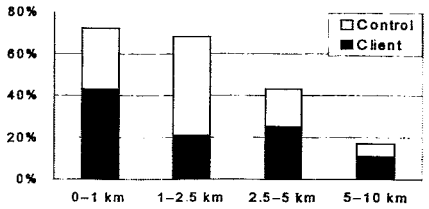


distance of 0 to 1 km. from their home. However, controls generally reported having greater distances to walk for water.

Toilet facilities are yet another indicator of poverty and access to protected toilet facilities has well-known health consequences. Few in either group have access to Blair toilets[1] but a greater number of clients have this form of toilet (29% versus 18%).

Firewood, used for cooking rather than lighting, is one of the most important resources needed by rural people and the district shows obvious signs of severe deforestation. As can be seen from Figure 11, there were some differences found between the two groups, with slightly more clients reporting that they had to travel distance greater

FIGURE 11: DISTANCE TO FIREWOOD COLLECTION POINT



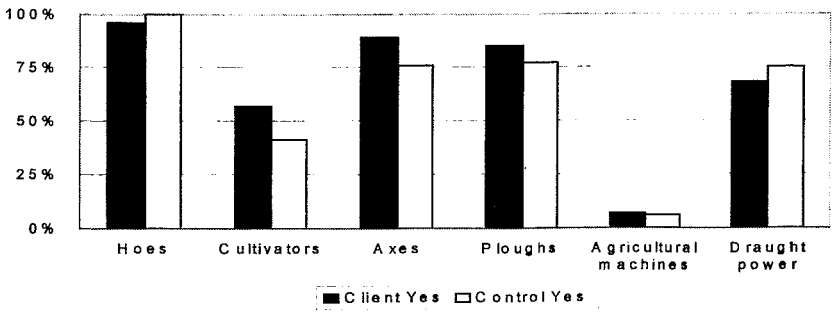
than 2.5 kilometres to collect firewood, but the controls as a whole generally reported having to travel greater distances than the clients.

[1] Fly-protected pit latrines with soakaways

Cropping

AGRICULTURAL ACTIVITIES are distinguished from household income activities in that the former deals mostly with the earning of income from the production of cash crops and livestock. The availability of adequate land, both in size and quality is therefore significant and here we note that Mount Darwin lies in an area with poor soils and low rainfall. Of the clients, 61% as opposed to 35% of the controls, report having adequate land. More people (65%) in the control group felt that the land was not adequate to the needs of their families. Rural agriculture requires such basic equipment such as hoes, axes, draught power and ploughs, in addition to adequate land. As can be seen from Figure 12, differences were reported by the two groups in the availability of various farming implements. Neither group reported much access to machines such as shellers and there were no great differences in the availability of hoes, axes and cultivators. Clients reported less availability of draught power for ploughing and owning fewer cattle, but greater access to ploughs, so this finding is difficult to interpret.

FIGURE 12: AGRICULTURAL MACHINERY AND IMPLEMENTS AVAILABLE

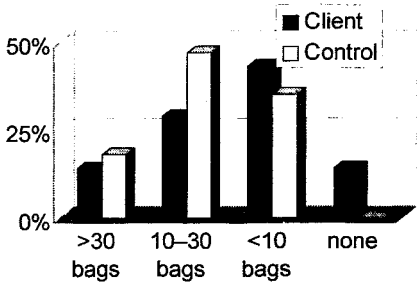


The ownership of cattle and the confiscations and losses incurred during the liberation war are a frequent topic of conversation amongst AMANI's clients. Ownership of cattle ensures the availability of animal draught power, a vital component of rural agriculture. Clients

reported owning fewer cattle than the controls: about 39% of the clients own less than 5 cattle as compared to 17% of the controls, but 59% of the controls reported owning more than 5 head of cattle as opposed to only 39% of the clients. A significant proportion of both groups report owning no cattle.

Adequacy of pasture is measured by its sufficiency to the whole community. Pastures are communal. 56.5% of clients reported having sufficient pastures but some clients felt this was inadequate. Since maize is the major staple food it was expected that all respondents grew it but only 86% of the clients grew maize as compared to 100% of the controls. This will have obvious implications for food security. This finding is given added depth by the results of the yields from maize growth. As can be seen from Figure 13, there was little difference between the two groups in the numbers who harvested more than 30 bags of maize, but in general controls harvested more than clients and a significant number of clients reported harvesting nothing.

FIGURE 13: MAIZE HARVESTED



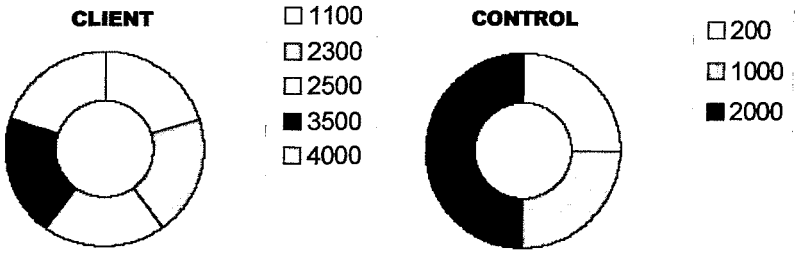
This is further to be added to the results comparing the use of the maize harvested. Most clients (95%) use their maize for consumption as compared to only 75% of the controls. Controls thus grow more and receive greater income than the clients.

Cotton is a crop that is increasingly grown as an income earner and there is little difference between clients and controls when it comes to growing cotton but there is a difference in the amount of

cotton harvested. Fewer clients reported large yields (9% versus 25%), but more clients had average yields than the controls (54% versus 25%). Since on average controls grow more cotton this group would be expected to make more money than the clients. Significantly more controls that clients (67% versus 44%) earned in excess of Z$2000.00 from the sale of cotton. Groundnuts can be both a cash and consumption crops and both groups reported growing these crops with similar frequency. Tobacco is the highest income-earning crop grown in Zimbabwe. Both groups reported growing tobacco but it was grown rather more frequently by the members of the control group (100% versus 83%).

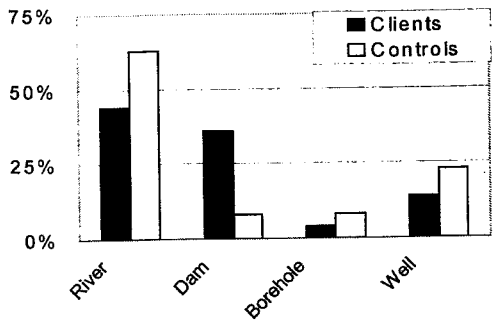
The clients reported making more money from tobacco than the controls, especially those with higher levels of income. This suggests that clients have moved away from maize into tobacco production, which may improve their income but does not strengthen food security. Additionally, tobacco is a more capital-intensive crop, for which credit was probably required and also more vulnerable to drought and pests than either maize or cotton.

FIGURE 14: INCOME FROM TOBACCO IN Z$



Most of the money earned from crops grown is controlled by the husband (67%) within the client group as compared to only 46% in the controls. This often has implications for family welfare since money controlled by women is directly available for the family, whilst money controlled by men may not be: this can mean families going hungry even when there is an income.

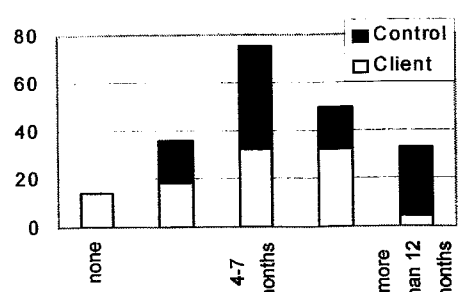
FIGURE 15: WATER SOURCE.



Gardens

VEGETABLE GARDENS in the rural areas play a pivotal role in the provision of vegetables for both consumption and sale. Clients are slightly more likely to have a vegetable garden than the controls: 86% of clients as compared to 77% of the controls have a member of the family with a garden. Successful vegetable gardening is dependent on water availability and this was generally similar in both groups. However, the nature of the water source must be considered: here we see that both groups have access to both rivers and other sources, with the clients reporting greater access to sources other than rivers.

FIGURE 16: PERIOD FOOD STOCKS WILL LAST



Another constraint on successful vegetable production is protection from grazing by animals, particularly cows and goats. Controls stated they had greater access to permanent forms of protection than clients (32% versus 8%) but also we should note that they had also reported lack of access to fencing as a significant constraint on their activities so this requires further explanation. The reasons for not having a garden in the two groups are not widely different. The main reasons are disability, no land and no water.

All these activities impact on food security. Food security can be obtained in two ways. Firstly, by specifically growing food crops for storage and later consumption and supplementing this with vegetables and protein from livestock. Secondly, cash crops can be grown for income and the income used to purchase food later. A mixed strategy may also be adopted where food crops are grown and supplemented with food purchased with income earned from the production and sale of cash crops. Figure 16 reports the estimates by the sample on the food stocks available to them during the year.As can be seen there is a trend for controls to report more stocks than clients. No controls report the absence of food stocks and more than 25% report stocks that will last well into the following year. This suggests that both groups may experience food shortage and require supplementary feeding. However, more clients than controls report having received drought relief more than once (8% versus 0%), but also more clients have never received any form of drought relief (7% versus 0%).

Use of natural resources

APART FROM agricultural activities, rural people may become involved in horticulture or use local indigenous resources from forests and most people have grown fruit trees or use local indigenous trees. However, deforestation is a significant problem in Mount Darwin District. This is due in part to population growth, but also due to the massive tree cutting that took place during the liberation war. Very few clients (29%) have woodlots compared with the controls (59%), despite the fact that many more clients than controls cite distance as a problem for collecting fuel.

People also use other natural resources from the local environment such as grasses for various use, plants for medicine, etc. The utilization of natural resources is very high in both groups. Some of these items are used for income generation but with very small profits: for example, thatching grass is sold and poles for construction are cut from indigenous trees.

Communication and transport

THE MOST COMMON medium for receiving information for both groups is the radio although the client group is less likely to have access to other forms of information and even less access than the control group to the radio. The major mode of transporting field produce is animal-drawn (89% and 82% in each group) The general use of other modes of transport such as bicycles is minimal.

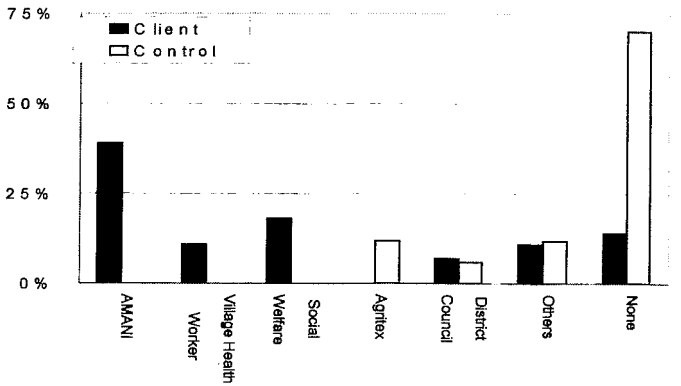
Very few members of either group own animals for transport and both groups rely on borrowing animals to move produce. For personal travel the bus is the most common form of transport.

Another way in which information may be disseminated in rural communities is through organizations working in the communities. Figure 17 shows the frequency with which the sample had been visited in the past three months by the most common community-based agencies in the district. As can be seen, clients were much more likely to have received some form of visit than the controls. It is noteworthy, however, that the controls were much more likely to have received a visit form Agritex, which may be a factor in fostering better agricultural production.

Household consumption

HOUSEHOLD CONSUMPTION is clearly related to income for the purchase of items. The major consumable items used in the past month were soap, maize-meal, salt, sugar, paraffin and vegetables. We attempted to estimate the use of these. There were few differences in the use of soap during the past month in the two groups. Maize is the basic food consumed by most Zimbabwean families and there were small differences in the two groups, with clients reporting higher consumption of maize than controls (79% versus 65% consumed more than 5 buckets per month). This may be related to

FIGURE 17: FREQUENCY OF VISITS BY ORGANIZATIONS

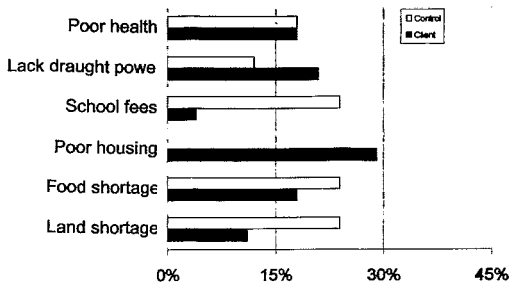


family size, since the clients had slightly larger families than the controls. Similarly, there were small differences in the use of salt with the controls reporting using more salt than the clients. This may reflect the greater spending power of the control group

Perceptions of poverty

ALTHOUGH IT IS possible to determine levels of poverty objectively, it also necessary to assess whether these objective measures are perceived in the same manner by the population under study, Accordingly we included some questions designed to assess whether the sample perceived themselves as poor, as well as their perceptions of their neighbours' poverty. As can be seen from Figure 18 below, there were differences between the two groups in what they saw as constituting poverty. The controls identified lack of land, food shortage and the inability to pay school fees as the dominant characteristics of poverty whilst the clients saw poor accommodation and the lack of draught power as the most salient features. Clients also identified a wider range of factors as being indicative of poverty. The sample was also asked what they thought were the main causes of poverty among victims of torture and organized violence. As can be seen from Figure 19 there were differences between the two

FIGURE 18: CHARACTERISTICS OF A POOR HOUSEHOLD



groups. Clients saw war destruction as a more frequent cause than the controls, whilst the controls saw disability and lack of draught power as more significant than the clients.

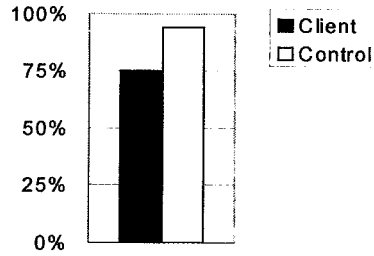
FIGURE 19: OPINION ON MAIN CAUSES OF POVERTY

Inner circle = Clients

Outer circle = Controls

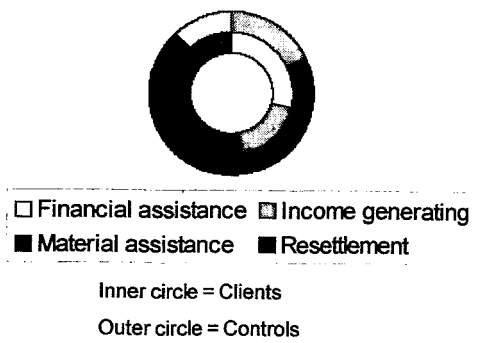
There were few differences between the two groups in what they saw as the best solutions for rehabilitating the victims of torture and organized violence. Similarly, there were few differences between the two groups in their views about whether their neighbour has opportunities to escape from poverty. The clients were more

FIGURE 20: ABILITY OF NEIGHBOUR TO IMPROVE



pessimistic than the controls about the prospects of escaping from poverty, as can be seen from Figure 20. This suggests that the relatively successful experience of the controls made them have more self-reliant than the clients. The finding that the greater the experience of success, the greater the belief in subsequent success, has had empirical validation in recent years (Bandura.1989).

FIGURE 21: POVERTY ALLEVIATION STRATEGIES



This view is supplemented by the findings on the strategies that the two groups see as relevant to escaping poverty. As can be seen from Figure 21, clients are more dependent in requiring money to escape poverty, whilst the controls, with a greater belief in their own abilities and resources, make use of material inputs to create their own opportunities.

Clients reported more aches, pains and depression than the controls. This suggests 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. In addition these are symptoms that would be expected from the selection criteria: severe psychological disorder and impact torture.

There were no differences reported between the two groups in use of or access to the various health facilities, nor were there differences in the amount of time lost due to illness. There was slight trend for clients to spend more money on health care, but this was small. The controls appeared to have a greater frequency of observable disability than the clients but they complained significantly less about such disability than the clients. The additional presence of psychological disorder in the clients may here be significant, but this can only be a tentative conclusion in the absence of screening for psychological disorder in the controls.

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, we did not sample the frequency of consultation, which would have been a useful indicator and has implications for the economic costs suffered due to illness. We have one small indication in the amount expended on health care indicated by a related Zimbabwean study (Patel *et al.* 1997). 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.

In general both groups report high levels of poverty and inability to provide adequately for their children, irrespective of whether the child is of school-going age or not. Neither group appears to reach the minimal standard of provision for school-going children. Against these indices of poverty it is thus encouraging to see the high levels of vaccination reported in the children.

Most of the subjects are subsistence farmers and derive their income mainly from agricultural activities, especially form the selling

of crops and animals. This is unsurprising. However, the controls were more likely to undertake some form of employment and more likely to have earnings coming from sources other than agricultural activities. The controls reported more frequently that they had recently received income and were slightly more likely to have earnings in the higher ranges than the clients. These findings suggest greater economic security for the controls.

Although the activities described are regarded as income generating, very few in either group derive much income from these activities. The main activity described for both groups was market gardening, but this activity does not generally yield much income for either group. However controls generally earn more than twice as much as clients.

Market gardening is an activity that requires natural resources such as land and water as well as a certain degree of both capital and labour investment if it is to be successful. The clients received more credit than controls. This can be a problem if it increases indebtedness and it is worth noting here that clients reported drought as a constraint more frequently than controls.

There are basically three types of housing: traditional, modern and mixed. In general traditional houses are synonymous with poverty whilst modern houses are more indicative of a degree of economic well-being: this is not an immutable law, but the generalization holds to a large degree. As was seen above there was a tendency for clients to live in poorer quality housing and also for these houses to be in a poorer condition than those of the controls.

As regards the amenities – clean water, toilets and fuel – there were some interesting differences between the two groups. Clients had more access to clean water which was also generally closer to their homes. This ties in with the reports by controls of more frequent waterborne illnesses. This also accords with differences between the two groups in the type of toilet facilities available, with clients more likely to have a Blair toilet than controls. Clients reported having to travel greater distances on the whole to fuel wood sources than controls and they use fuel wood more frequently than cow dung. A range of crops is grown – maize, tobacco, cotton and

nuts – and some of these (maize and nuts) are grown for both sale and consumption, whilst the others (tobacco and cotton) are wholly grown for sale. The clients generally have made sturdy attempts to generate income but these seem to be at the expense of food security. Tobacco apart, clients seem less successful at income generation than the controls. Taken together with the earlier finding that clients were less likely to be involved – and less successfully involved too – in market gardening, this suggests a group that is vulnerable to food deficiencies, especially in the years of drought which are not uncommon in the region. Certainly the clients report having to make application for drought relief more frequently than the controls.

As regards gardening, there can be very little success without access to permanent water such as boreholes. Most rivers, dams and wells are seasonal, which makes them unreliable for market gardening all year round. The problem of lack of water is compounded by the damage done by grazing animals during the dry season and here the cost of fencing is significant. Most fencing of gardens is done by tree or bush branches cut from local trees, usually acacias. This exacerbates deforestation.

The communal mode of transport is based on two systems: animal-drawn and buses. Animal transport is critical for most domestic tasks, while the bus is crucial for all travel over 5 to 10 kilometres. Both groups are dependent on borrowing animal-drawn transport and very few own their own.

Both groups rely upon the radio for information and very few have any access to newspapers or the television. Clients have less access to the radio, which is consonant with their greater poverty. An additional source of information is through community groups such as agencies: clients have much greater access to such groups. However the majority of these contacts are with agencies dealing with disabled and disadvantaged persons. The controls have much greater frequency of contact with Agritex, which may be a factor in this group's relatively better agricultural performance.

There were differences in the spending power between the two groups, with the controls reporting greater spending power than clients. This is consonant with the earlier findings of greater income

earning by the controls. The groups were different in their views on the causes of poverty. The clients' reasons were closely related to OVT – war destruction, confiscation of cattle (lack of draught power) and poor accommodation – while the controls put forward more traditional reasons such as land shortage, food shortage and the inability to pay school fees. There were also marked differences in their attributions of the ways out of poverty. The controls gave reasons that were much more consistent with greater self-reliance than the clients. This may be an important difference, leading to a poorer performance in life, which is one of Bandura's most central findings (Bandura 1989), as well as reflecting one of the more common effects of OVT, that is, a diminished belief in one's one's own ability to change things (Basoglu *et al.* 1996)

Conclusions

APART FROM studies on refugee populations, information about the psychosocial consequences of OVT in Africa is scanty. This is a new field and still bedevilled by the hostility and suspicion of many governments towards examining the consequences of gross human rights violations. Increasing numbers of studies have examined the medical and psychological consequences of OVT, but it is necessary to understand the psychosocial consequences, especially in settings where the violence has been of epidemic proportions. There remains a pressing need to understand the broader consequences of OVT and, as many authorities stress, the medium and long-term consequences may be as devastating of the short-term medical and psychological consequences (Danieli 1998, Kordon *et al.* 1998, Lagos 1996). The present investigation, despite its limitations, provides the beginning of an empirical understanding of these issues.

Limitations of the study

BEFORE DISCUSSING the findings we should make brief comment upon the limitations and the strengths of the study. Firstly, this was very small sample drawn from a single district, so it can be argued that it is hard to make generalizations based on these findings. However, the sample interviewed here corresponds to the major sample of clients seen previously, was chosen by random sampling

and the criteria used for selecting were valid; so it is also the case that the findings are robust.

Secondly, there was a degree of confounding due to the fact that many of the controls also reported a history of OVT. This is not surprising in view of the scale of the violence in the 1970s. Therefore the comparison is between persons who seek help and those who do not and probably indicates a difference between those who can cope and those who do not. Several of the findings support this view: for example, the controls have fewer health complaints related to pain or depression, spend less money on health care and have greater belief in their own efficacy. Against possible confounding is the clear demonstration that the two groups live in the same environment have access to all the same social and economic facilities and have been subject to all the same stresses since 1980.

Thirdly, the conclusions drawn have been inferential rather than statistical and thus may be unwarranted in certain respects. However, we point out against this that the magnitude of the some of the differences found gives us considerable confidence that the differences observed were real.

Major findings

We can now briefly outline the major findings of the study. As noted above, we have drawn these conclusions under each heading. Firstly, there were a number of differences in social and economic factors between the survivors and their neighbours. Among the survivors was found:

- Lower literacy and higher unemployment levels;
- They had less access to information;
- They spent more money on health care, earned less income in the past week and less earnings in the past year;
- They had a lower household expenditure and were more dependent upon credit (and thus potentially more vulnerable to indebtedness);
- Their housing was poorer (both structurally and as regards its state of repair);
- They tended to travel further for fuel wood, grow less maize, cotton and tobacco, were less likely to have fruit trees or woodlots and

made less use of natural resources: consequently they had less food security (measured by the number of months during which food was available);
- They had more frequent recourse to drought relief and were more likely to use charity or social welfare.

Secondly, the survivors showed many signs of having lower self-esteem and greater apathy than their neighbours. They were:
- more likely to see war as a reason for poverty;
- less optimistic that the situation can be changed and
- more dependent on outside help (believing they need money help as opposed to empowerment help).

The first group of differences represent real and substantial differences in the social and economic well-being of the two groups. The survivors (clients) are markedly less well-off than their neighbours in many areas and it seems fair to conclude that survivors experience greater social adversity than other groups in the same community. This is probably not surprising and would be found to be true of other disabled populations. However, it does mean that survivors are more vulnerable to ongoing stress that will, in turn, exacerbate their medical and psychological problems. It is noteworthy that this is exactly the interpretation that is given by the survivors themselves and it was indeed their preoccupation with the practical problems of their lives that originally alerted us 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 (Straker 1987, Lopez and Marcelino 1995).

The second group of findings speaks to the psychological consequences of OVT and social adversity. Survivors have low self-efficacy and this is due in part to the original violence they experienced and in part to their failure to overcome social adversity. Above we rather commented that nothing breeds success like success, but this is a truism with a powerful application here. It is endlessly demonstrated by studies on individuals that OVT creates a feeling of powerlessness and many commentators point out that this is replicated in the social and political arena (Kordon *et al.* 1998, Lagos 1996). Our findings speak to the heart of this problem: survivors are

traumatized into beliefs of powerlessness; they perform less well in the many tasks of life and their 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 point 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. The problems being experienced by the health delivery system have been highlighted by the government's own Poverty Assessment Study Survey (Ministry of Public Service, Labour and Social Welfare 1997) and this study, which is now completely accepted by many authorities, estimates that more than 45% of Zimbabweans experienced regular food shortage – below the food poverty line – and moreover, that only 26% of Zimbabweans are "not poor" in economic terms – 74% are classified as poor at the time of writing as compared to 62% in 1995. If survivors are below these thresholds, this is indeed alarming and suggests that some pro-active measures will be necessary to alleviate the consequences of disability and poverty in survivors. It is as 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.

REFERENCES

AMANI 1997 (a). *Survivors of Torture in Mount Darwin District, Mashonaland Central Province: Overview of Report and Recommendations.* Legal Forum 9, 49–60

AMANI Trust 1997 (b). *Report on Psychological Disorders in Clinics and Hospitals in Mount Darwin District, Mashonaland Central Province.* Harare

AMANI Trust. 1995. *The Chiweshe Nurse–Counsellor Programme: Resource Manual* revised. Harare

AMANI Trust. 1995. *Assessment of the Consequences of Torture and Organized Violence: A Manual for Field Workers.* Harare

Amnesty International. 1984. *Against Torture*. London, Amnesty International Publications

Arcel, L.T. 1995. *PsychoSocial Help to War Victims: Women Refugees and their Families.* Copenhagen, IRCT

Bandura. A. 1989. Perceived self-efficacy in the exercise of personal agency. *The Psychologist* **2**, 411–425

Basoglu, M. et. al., 1996. Appraisal of self, social environment and state authority as a possible mediator of post-traumatic stress disorder in tortured political activists. *Journal of Abnormal Psychology* **105**, 232–236

Catholic Commission for Justice and Peace 1975. *The Man in the Middle*. Salisbury

Catholic Commission for Justice and Peace 1976. *Civil War in Rhodesia*, Salisbury

Central Statistical Office 1992. Census Report. Harare

Central Statistical Office 1993. Census Report. Harare

Combat Poverty Agency 1989. *Pictures of Poverty, Twelve Accounts of Low Income* Dublin. Angus Press

Danieli, D. 1998. *International Handbook of Multi-generational Legacies of Trauma.* New York, Plenum Press

Kordon, D., L. Edelman, D. Lagos and D. Kersner, 1998. Argentina: Psychosocial and clinical consequences of political repression and impunity. *Torture* **8**, 43–47

Lagos, D. 1996. Argentina: Psychosocial and clinical consequences of political repression and impunity in the medium term. *Torture* **6**, 13–15

Lopez, J. and E. Marcelino, 1995. *Torture Survivors and Caregivers: Proceedings of the International Workshop on Therapy and Research Issues.* Philippines: Center For Integrative and Development Studies

Ministry of Public Service, Labour and Social Welfare 1997. *Poverty Assessment Study Survey: Main Report. Social Dimension Fund SDF.* Harare, Government of Zimbabwe

Mwanza, L.K. 1995. Participation of non-governmental organizations in social development process in Africa: Implications. *Journal of Social Development in Africa* **10**

Mundy, V. 1995. *The Urban Poverty Datum Line in Zimbabwe.* Harare, Catholic Commission for Justice and Peace

Patel, V., C. Todd, M. Winston *et al.*, 1997. Common mental disorders in primary care in Harare, Zimbabwe: Associations and risk factors. *British Journal of Psychiatry* **171**, 60–64
Patel, V., C. Todd, M. Winston *et al.*, 1998. Outcome of common mental disorders in Harare, Zimbabwe. *British Journal of Psychiatry* **172**, 53–57
Reeler, A.P. 1998. Epidemic violence and the community: a Zimbabwean case study. *Community Development Journal* **33**, 128–139
Reeler, A.P. 1998. Compensation for gross human rights violations: Torture and the War Victims Compensation Act. *Legal Forum* **10**, 6–21
Reeler, A.P. 1994. Is torture a post-traumatic stress disorder? *Torture* **4**, 59–65
Reeler, A.P. and R. Immerman, 1994. An initial investigation into psychological disorders in Mozambican refugees: Prevalence and clinical features. *Central African Journal of Medicine* **40**, 309–315
Reeler, A.P. and M. Mupinda, 1996. An Investigation into the sequelae of torture and organized violence in Zimbabwean war veterans. *Legal Forum* **8**, 12–27
Reeler, A.P. and M. Mupinda, 1995. Report of a pilot project to assist survivors of torture and organized violence in Mount Darwin District, Zimbabwe, April–July 1995. Harare, AMANI
Reeler, A.P. and C.H. Todd, 1995. An overview of psychological disorders and psychiatric services in Zimbabwe in Y. Pillay and A. Bhana eds., *Proceedings of a Primary Mental Health Care Workshop*. Durban: University of Durban-Westville
Reeler, A.P., H. Williams and C.H. Todd, 1993. Psychopathology in primary care patients: A four-year study in rural and urban settings. *Central African Journal Of Medicine* **39**, 1–8
Sarantidis, D., et. al., 1996. Long-term effects of torture of victims during the period of dictatorship in Greece. *Torture* **6**, 16–18
Straker, G. 1987. The continuous traumatic stress syndrome – the single therapeutic interview. *Journal of Social Development in Africa* **8**, 48–78