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Healing new wounds

VIOLENCE and HEALTH

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PO Box 16250
Doornfontein
2028
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Tel: (011) 484 3078
Fax: (011) 484 3557

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Violence and Health

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Editorial

Almost daily, the headlines in the media relate to violence in this country. Violent political conflict, as well as other forms of violence such as crime, rape and child abuse, has been on the increase since de Klerk announced major political changes in 1990. This has a severe impact on all South Africans. Entire communities are affected and millions of South Africans are potentially susceptible to the psychological effects of trauma. There is a growing need for proactive responses within communities to prevent further violence. The health and welfare sector also has a crucial role to play in assisting the victims of violence.

The first section looks at violence in a social context. The introductory article briefly sketches the increasing incidence of violence in South Africa today. The next two articles are book reviews about violence and black youth. They both emphasise the relationship between violence and the inability of the economy to meet social demands, especially the need for employment. The first review highlights the marginalisation of black youth caused by unemployment and the decline of traditional and family influence over youth. The role of politics in marginalising youth is debated. It is suggested that youth involvement in politics gave them a positive purpose and identity.

According to the second review, youth in the 1980s were faced with the difficult task of participating in civilian life and simultaneously fighting a civil war. Conflict still persists today and this contributes to continued psychological distress, substance abuse and anti-social behaviour, but it is argued that we do not yet have a lost generation. However, in order to reintegrate alienated youth, it is important to provide them with the rights and priviliges of 'normal' society.

Political violence has often manifested itself in the disruption of health services. A study of Cape Town's health services in the violence of 1986 showed that people's usual access to services was affected. The violence also stopped health workers from fulfilling services such as home visits.

Violence has also affected the work of health workers in the form of paralysis (helplessness). Chris Szabo argues that paralysis is not given the recognition it deserves as a serious psychological problem. This is partly because medical personnel have taboos about being defined as psychologically ill and therefore not coping in their work.

The article which follows points out that the amnesty law, recently passed by the ruling National Party to absolve perpetrators of apartheid violence, can have serious psychological effects on victims of this violence. Simpson says that total healing for victims involves a recognition and public acknowledgement of the

wrong done to them, which in turn entails bringing the perpetrators to trial, including appropriate sentencing or clemency.

The second section deals with the psychological effects of violence on its victims. In two interviews, one with a political activist and the other with an ex-Koevoet soldier, we explore how people are psychologically damaged by violence and how people learn to cope. The activist recognised the need to learn to deal with the threat of being involved in a liberatory struggle. The ex-Koevoet soldier eventually recovered from Post-traumatic Stress Disorder (PTSD) by recognising that his involvement in apartheid's war was morally unjustifiable.

These personal accounts are followed by two articles on PTSD. The first discusses the importance of recognising the extent to which it occurs and its potentially damaging consequences on individuals and communities. It argues that progressive health and welfare workers need to put more effort into providing adequate help for victims.

The next article considers the Wits Trauma Clinic's efforts to treat PTSD. The clinic offers a combination of one to one and group therapy. The article stresses the importance of early therapeutic intervention as a means of preventing a victim of violence developing other psychological disorders such as depression.

The third section addresses some of the attempts made by organised health and welfare workers and communities to deal with different forms of violence. The first article deals with the need for emergency service groups (ESGs) to respond speedily in situations of violence and where the movement of health workers in and out of an area is made difficult. Health workers in the progressive sector did establish an emergency service programme in the 1980s, but this is no longer functioning. Sahsso may have a role to play in setting up ESGs again and this needs to be assessed in the light of the institutional resources and training which are available. For this reason, *Critical Health* also publishes a brief report on the emergency service work done by the Red Cross.

Women are particularly vulnerable to a number of forms of violence, including violence within their own homes. Teresa Angless addresses the issue sensitively and suggests ways for health and welfare workers to help these women eventually leave situations of domestic violence. There is a need for appropriate referral mechanisms, more shelters for battered women and mechanisms for assisting battered women to lay charges against their perpetrators.

At Imbali, in Natal, a rehabilitation programme has been established. It provides counselling for victims of trauma and people who have, as a result of that trauma, resorted to violence themselves. The project is community based, involving the training of voluntary counsellors from the community. The effectiveness of

the project is hampered by ongoing violence. In adding to the points raised in the article, Jeanette Schmidt of NICRO comments that work needs to be done in getting communities or leading members of communities to be aware of the possible effects of potential violence in their area. People need to discuss their fears and how they could cope before violent events occur.

Various projects are starting to look at ways of preventing violence. The Centre for Peace Action (CPA) in Eldorado Park is based on the premise that a programme needs to have a long term plan if it is to succeed in lessening violence. It is currently focussing on achieving a presence in the community and sees this as a platform for community development, a change in attitude and a reduction of violence.

The centre runs a women's project which emphasises the need for prevention in helping women affected by domestic violence. This project does not only involve counselling or providing a shelter for battered women, but also education, through workshops at schools and other community centres, alerting people to the social nature of domestic violence.

Critical Health includes a resource list of some of the organisations involved in counselling victims or providing dispute resolution services.

The general section includes an update of the ongoing community development programme in Wattville. The article focuses on the community's assessment of its health service needs and appropriate structures through which its demands can be raised, both now and under a future political dispensation.

This is followed by a brief outline of the NPPHCN's booklet, *Fighting AIDS*.

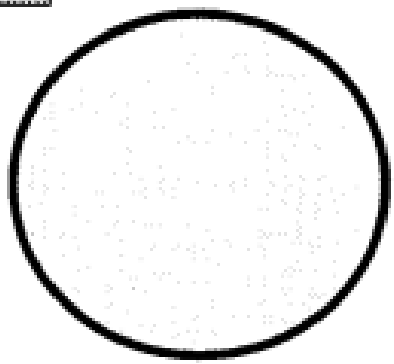
SAHSSO and NPPHCN held a joint conference in December 1992. A number of papers on health policy related issues were delivered by overseas and Southern African speakers. There was a situational analysis of health in South Africa today. The conference then focussed on developing appropriate health policy proposals. The next edition of Critical Health will cover each of these aspects of the conference.

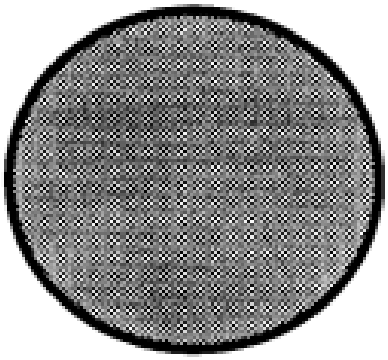
SECTION

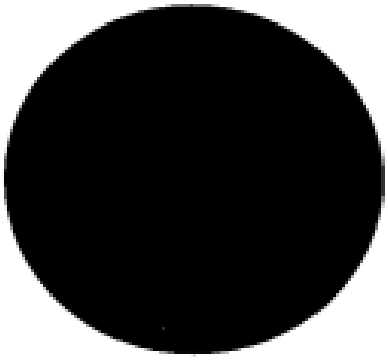
A

Violence and its Social Effects

Violence in SA is widespread and affects every sector of our society. How it impacts on youth and their functioning in society and why youths participate in violence are questions addressed in two book reviews. This section also deals with how violence affects people's access to health services and the helplessness experienced by health workers as a result of overload of trauma cases at hospitals. An additional piece on the government's law on amnesty addresses the potentially harmful affects this could have on the victims of apartheid violence.







Violence in South Africa:
on the increase in the 1990s

Gillian Eagle

South Africa is a violent country. The state has a long history of brutally suppressing opposition to apartheid. Particular periods stand out in this history, including the deaths of numerous township youth during the uprising of 1976, repression in the Vaal in 1984/85 and the introduction of a "State of Emergency" in 1985.

An Increase in Political Violence

The unbanning of the ANC, PAC and SACP in February 1990, the release of Nelson Mandela and other political leaders and F W de Klerk's stated commitment to political change introduced a wave of euphoria and optimism across the country. There was an expectation of a marked decrease in violence, both on the part of the state and its opponents. However, this dream of peace has been transformed into a nightmare as South Africa has moved into a period of unprecedented violence. A comment by the ANC secretary general, Cyril Ramaphosa, following the Boipatong massacre, highlights the gravity of the situation: "more have died since De Klerk become president, less than three years ago, than in forty years of Nationalist Party rule".

The figures for deaths due to political violence from 1985 to 1992 read as follows:

1985	879	
1986	1 198	
1987	661	
1988	1 149	
1989	1 403	
1990	3 699	
1991	2 240	
1992	1 181	(first six months)

This violence can be linked to the apartheid system, but there are also a number of specific factors responsible for the current upward spiral. Various parties and organisations are attempting to increase their political influence. This is a feature of the much publicised ANC-Inkatha conflict. There have been allegations of a third force, linked to the SAP, SADF and the government, which is acting to swell

conflict and discredit the ANC. The white right wing is attempting to hold back political change and re-establish white domination. Violence also stems from the frustration of the dispossessed, particularly the black youth, over the lack of anticipated gains in education, housing and material wealth.

More Assaults, Rapes and Murders

In addition to the escalation in political violence, there is a large increase in a range of other forms of violence, including criminal, domestic and sexual attacks.

Researchers from the Project for the Study of Violence, based at the University of the Witwatersrand, cite a figure of approximately 15 000 murders annually, or 42 per day. They compare this figure to that of the United States, generally accepted as the most violent country in the western world: "In terms of murder per 100 000 people, the figure in South Africa is 49, which is six times that of the United States, which is between 8 and 9 per 100 000."

Furthermore, during 1991, there were 22 765 reported rapes in South Africa, 129 626 reports of assault and 1 556 reports of ill-treatment of children (excluding sexual offences). The number of rapes increased by 12% from 1990 to 1991.

All South Africans at risk

The elderly, women and children are vulnerable and disempowered and are thus easy targets, but violence is not restricted to these groups. Criminal violence directed at the white middle-class is increasing. Police personnel, seen as agents of state repression, are also targets. It seems that very few people are safe from the threat of violence of some kind, although black, working class, township residents appear to have born the burnt of mass attacks, both within their communities and on public transport, in train massacres and taxi wars.

Gillian Eagle is a psychologist lecturing at Wits University

A lost generation:
Review of *Black Youth in Crisis, Facing the Future*

by Mamphele Ramphele (ed.)

Isaac Mogotsi & Reuben Mogomo

The essence of the crisis facing black youth in South Africa is well captured in this readable book. Prominent commentators of the South African social scene have collaborated to produce this timely piece of work.

Chapter One: Social Disintegration in the Black Community

The first contribution by Dr Mamphele Ramphele, deputy vice-chancellor of the University of Cape Town, analyses the crisis and alienation afflicting black youth. She lucidly exposes the factors which account for the disintegration of the black community in South Africa.

These factors include demographic, economic and human development influences. Ramphele also catalogues indicators of social disintegration of the black community, such as the high levels of alcohol and drug abuse, under-performance in all spheres of life, the high crime rate, despair and the flight of skills and positive role models from these depressed communities.

Ramphele also analyses developments that have impacted on black communities such as the rise of the black consciousness movement, the involvement of youth in politics, the 1980s uprising and heightened political competition amongst black groupings. All these influences undermined and weakened the coherence of black communities.

Faced with social disintegration and the violence stemming from it, black people have adopted various survivalist strategies. This included resort to tradition and customs to maintain a semblance of self respect, resort to crime and the dizzying vacillation between resistance and acquiescence. The author acknowledges the short-term potential of some of these strategies for the purpose of survival. She highlights, however, the destructiveness of these strategies on their users in the long run.

Ramphele argues that "the opening up of the political space is a key factor in

the social disintegration of the black community". This is allegedly because of the mismatch between political liberalisation and the non-fulfilment of rising expectations as well as constraints in socio-economic development.

Ramphele concludes that an important starting place en route to a new South Africa is "to recognise the residual capacity within the black community to respond to positive intervention. This capacity resides in individuals, support groups and organised pressure groups".

Chapter Two: Living on the Wrong Side of the Law

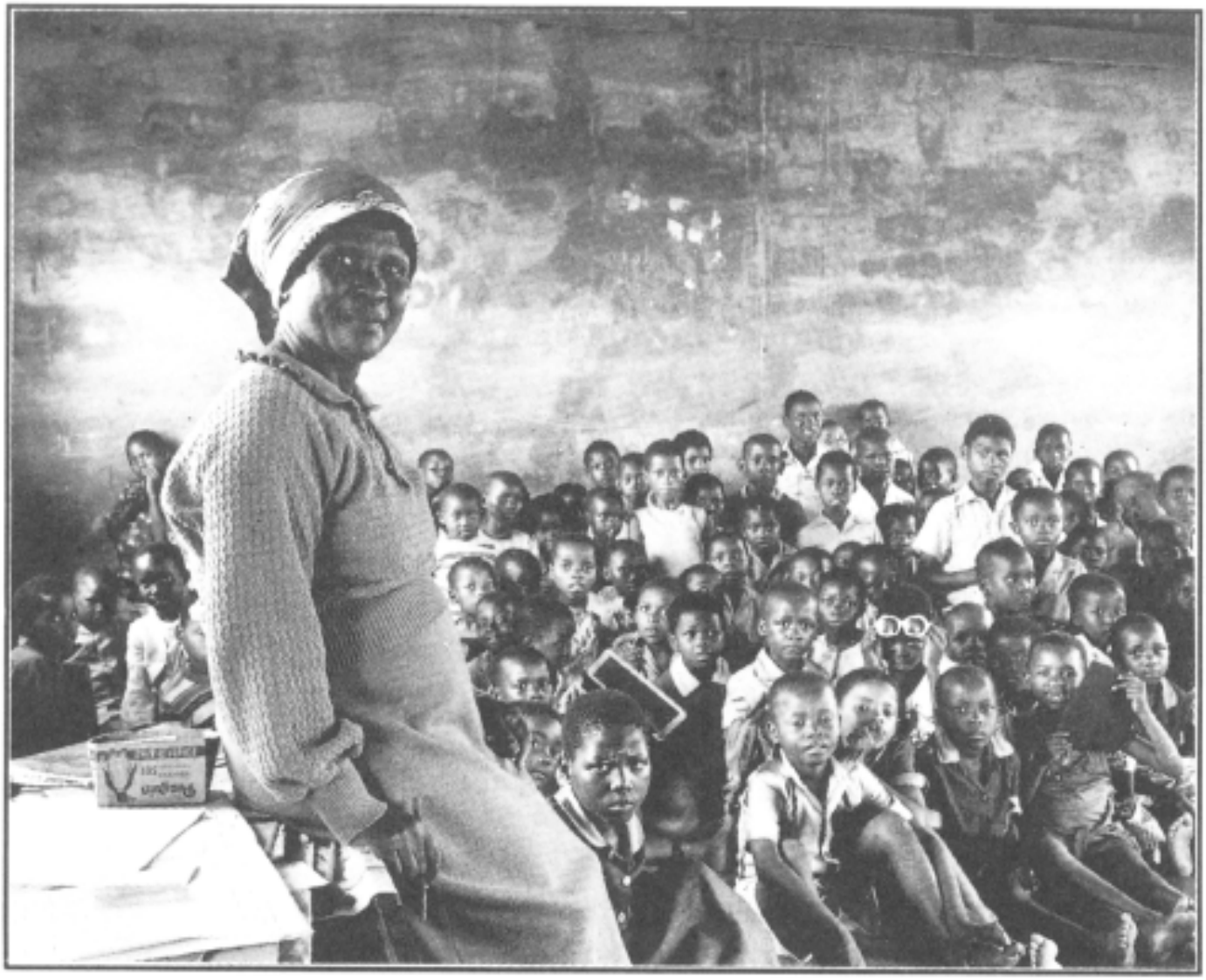
The author, Steve Mokwena, opens with chilling statistics about the extent of youth participation in violence, as well as the extent of their marginalisation. These figures bring home forcefully the seriousness of the issue.

Apartheid, both at the level of legislative acts and through informal repression, is seen as primarily responsible for black youth marginalisation and violence. The author highlights the societal threat posed by youth marginalisation through figures indicating the appalling black matric performance, the level of unemployment amongst black youth and the proportion of black youth in the overall black population.

The marginalisation of black youth is seen in the context of the politicisation of issues affecting the black community. Youth and student involvement in politics became a powerful factor in the struggle of the oppressed against racist rule. The youth, according to the author, "not only directed, but also shaped the political mood of the township".

This had a profound impact. Traditional and customary instruments of control declined in importance. The township family, church, street and school became arenas of struggle. The author shows how this process led youth to challenge all forms of authority. The strategies of 'ungovernability' and 'people's war' further politicised the youth. In turn these strategies exposed the youth to the repressive measures of the apartheid regime. This crisis was also manifested in youth gang activities and street violence.

Unlike the author, we would argue that the involvement of the youth in the political struggles of the 1980s cannot be viewed uncritically as causing the marginalisation of black youth. By offering youth an avenue for self expression and making them feel useful, placing youth at the centre of things as it were, this involvement in the struggle for political change, in fact, 'de-marginalised' the youth. The article should have concentrated more on marginalisation as the "comprehensive disempowerment of black communities, in particular, the youth". How did such disempowerment come about and how is it entrenched? Not only the symptoms, but also the causes of marginalisation should be analysed in some detail.



What is of most value to the development of the country is the provision of basic primary education. *Photo: Market Theatre Photo Workshop*

Chapter Three: Education and Employment

Ken Hartshorne's introduction gives a fresh perspective to the debate on 'school systems' and their relation to work. He argues that the "debate on education and work cannot be contained within a simplistic discussion of 'academic' versus 'technical', vocational or career education". For him, "a relevant, effective academic 'education' provides the background of language, mathematics and science that many modern work situations demand. What matters is how they are learned and taught, and whether they are capable of being used outside the school. What is perhaps of most value to any country and to the economy is the sound provision of basic primary education (literacy, numeracy and basic life skills) which provides a platform on which further education and training can take place; yet this is often defined as academic".

The author, however, over-emphasises languages, maths and sciences. This can be interpreted as a very narrow view of the requirements of the 'world of work'.

Some careers like journalism or child minding do not require extensive knowledge of maths and science.

The article does caution, nevertheless, that too much is expected of schooling, especially in third world environments with high levels of underdevelopment and unemployment. This is important, as conventional wisdom wants us to believe that massive literacy campaigns can single-handedly 'kickstart' the economy. Such totally unrealistic perceptions are likely to heighten expectations which are never going to be met.

Chapter 4: Marginalised Youth and Unemployment

Riordan Rory's account of a multi-faceted problem - unemployment - reminds us of the endemic crisis in our society which threatens to further marginalise a large section of our population.

Rory suggests that economic policy should be informed by the close monitoring of the success of present policies in job creation, the explicit quantitative targeting of job creation policies, a comprehensive public education programme aimed at redirecting public energy and resources to feasible and/or effective job creation policies and a restructuring of particular policies and employment processes at the level of macro-economic data analysis and government budgets.

The authors of this article both work for the Project for the Study of Violence at Wits University

Black Youth in Crisis, Facing the Future *is published by Ravan Press, Johannesburg, 1992.*

A lost generation:
Review of *Faces in the Revolution*

by Gill Straker

Anne McKay

Media images of the 1980's often show black youth leading marches, stoning police Casspirs, making barricades, at funerals, toyi-toying, at disciplinary committees, 'necklacings' or running meetings. Black youth are characterised as 'a lost generation', 'brutalised', 'barbaric, or as 'freedom fighters' and 'heroes' depending on the media's politics.

Straker looks at these stereotypes. Through interviews with youth involved in the events of 1984 - 1986, she attempts to uncover the effect of political violence on youth bearing the brunt of state and vigilante violence over the last decade or having participated in violent acts themselves. The author concludes that we do not yet have a 'lost generation', though it depends on what happens next.

Case Studies

The book studies 60 youths who fled Leandra township on the Reef in 1986 from vigilante and police attacks. They took refuge at the South African Council of Churches (SACC) Wilgespruit Conference Centre. The conference centre was raided by the police and the youth fled (or were briefly arrested) and regrouped a few days later. Conflict developed between the youth and the staff, and there were conflicts in the group itself. The SACC called in mental health workers to counsel the youth. The book's clinical material comes from the interviews conducted then, the clinical impressions of the counsellors and follow up interviews conducted in 1989.

The case studies are of 'leaders', 'followers, 'psychological casualties' (including substance-abusers) and 'anti-socials' (tsotsis or com-tsotsis). For security reasons these personality profiles are not of individual youth, but composite pictures to illustrate the situation of several youth who fitted into that category. This method gives a sense of the factors that contribute to making a person a leader or anti-social without focussing too much on the details of individuals' lives.

Perspectives

The book focuses on the effects of violent surroundings, youth witnessing violence and participating in acts of violence against those defined as 'enemy'. Implicit in this study is an evaluation of youth according to characteristics valued by a Western psychoanalytic perspective - in particular, a capacity to integrate painful events, an ability to connect with others. The capacity for empathy and guilt are taken as signs of health and resilience.

This understanding of psychological health perceives that violence is an inevitable part of human life, although it is potentially more damaging than constructive. Witnessing, participating in and being a victim of violence is viewed as a trauma with a potential to damage a person's ability to function effectively in the world. The level of damage can be measured according to the individual's ability to respond empathically, to connect and so on.

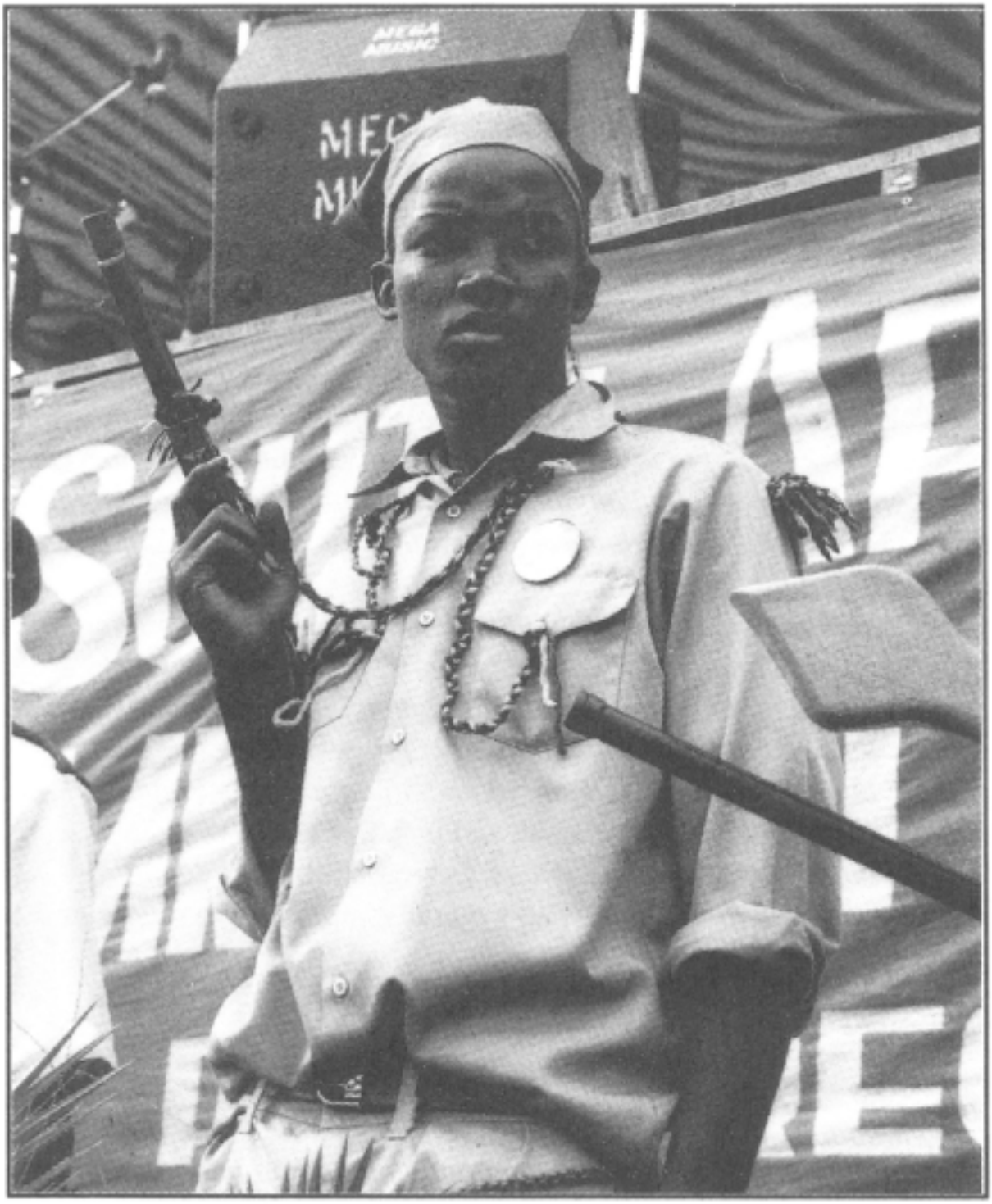
Other theorists argue that violence against an oppressor can endow individuals with the identity of being part of an oppressed mass craving liberation. Although the author acknowledges the value that action against oppression and the solidarity of group identity have for South African youth, the book is concerned with violence as trauma. Even the central question "does violence beget violence" assumes violence as a psychologically damaging and negative series of events.

The research concludes that 50% of the youth interviewed showed signs of psychological distress or damage. The generally repressive political and social situation is acknowledged as a major contributing factor, where township youth have been exposed to "horrifying" levels of violence on an almost daily basis.

Approach

Straker has defined as 'casualties' those youth who could no longer function in everyday life at the time of the second interview in 1989. This includes those who anaesthetise themselves from the pain of their lives by substance abuse to the extent that they are regularly unable to function because of it, those who act out (in criminal and other anti-social acts) and those who are unable to block out the pain and show symptoms of anxiety and depression. Straker comments that this last group who can allow themselves to feel their depression are youth who could live with the complexity of their position without finding an external enemy to project it onto.

Of more concern to the community are the com-tsotsis whose involvement in the struggle seemed to open them up both to a need for belonging to a group and to the potential for violence to meet their needs. Where there was potential for aggressive behaviour in personal anger against emotionally and physically de-



Cadre or casualty? *Photo: Market Theatre Photo Workshop*

prived backgrounds, it was the social sanction of violent acts against a community-defined 'enemy' which made acting out this anger acceptable. However, when the struggle subsided they seemed unable to find other ways of dealing with their anger and continued to act out aggressively for personal gain. However, the author points out, the fact that they feel the need to sustain the slogans and images of the struggle despite community disapproval of their actions, is a sign of hope. It indicates a need for connectedness which can potentially be used to pull them into community activities.

The author notes that much of the literature on war covers situations where the individual becomes a part of an army which combats another from elsewhere. In wartime people are expected and allowed to behave differently, especially combatants. The ability of people to construct a 'wartime self' has been well-documented. This wartime self allows for participating in violence which is not socially accepted in civilian life. And violence is sanctioned against those defined as 'enemy'.

For township youth in the 1980's, the situation was far more complex. They were expected to go to school and participate in civilian activities in the middle of a civil war. They had to keep both their 'peacetime selves' and their 'wartime selves' together in one overarching identity - which Straker describes as an ''enormous psychic task''. With a return to relative normalcy in their township, most of the youth in the sample returned to a civilian, peacetime morality, in which they felt discomfort with arbitrary violence and were clear about the need for discipline and strategy. Only 10% became hardcore tsotsis whose capacity for empathy is damaged and who do not restrain their aggression. Thus there seems to be little evidence of a brutalised generation.

The author argues that psychological distress in war can be short-lived. Key factors in this are adult and community support during and after the traumatic period. If adults in a situation show competence this helps children cope with the experience. The leaders in the Leandra group had supportive families, often with adult members who belonged to unions or civic structures providing role models. Without this support, the youth were vulnerable, more likely to drop out or become criminalised.

Research in other parts of the world indicates the importance of a benign post-trauma environment. This is not the case in South Africa where the conflict has persisted for over a decade, mass unemployment raises the stress levels on youth and the removal of apartheid legislation has hardly affected the poverty and violent social conditions in the townships. Therefore it is not surprising, argues the author, that 50% of the original Leandra group were suffering from some psychological distress three years after their return to the township.

Uses and Shortcomings

The case study format makes for interesting and easy reading. It is brief and accessibly written. Psychological theory is presented in a readable fashion and would be accessible to many with a rudimentary understanding of psychology. Theory is applied to the practical situation of the Leandra group in a way that many non-professionals will recognise and understand the issues from their own experi

ence. Nevertheless it presents a complex argument and requires careful attention.

Community workers will find the categories useful in understanding the dynamics of groups they are working with. Many readers will have been through the experience of the war themselves and may recognise their own complex reactions to the violence in the text. Most valuable is an understanding of the concept of a peacetime and a wartime morality in explaining apparent inconsistencies in how people behave in different situations. Also useful is the understanding of the resources that assist people to cope with trauma, especially community and adult support. The need for belonging and interpersonal connectedness which is expressed in the adoption of a group identity, even by com-tsotsis, gives communities a way to understand and reintegrate alienated youth. There is a useful section on group dynamics in conditions of stress, and an outline of the psychological needs of youth which should be integrated into decisions about priorities for social restructuring in the new South Africa. In parts, however, the argument across chapters is confusing and links are unclear.

The future?

This section is too brief and sketchy, with little by way of making the ideas concrete for readers who need to use the insights to influence their work with youth.

The author describes measures used in other societies dealing with the reintegration of soldiers into peacetime. She proposes some ritual or community ceremony in which combatants are acknowledged and 'debriefed' before being taken back as civilians. This would serve the function of disabling the 'wartime ego' and allowing the taking on of civilian values and norms.

However, an important means of reintegrating youth who have been part of the war is the creation of conditions for a normal civilian life. The rights and privileges of civilian society, such as security, housing, employment and education are critical to creating the conditions for youth to drop their warrior role. Without the rewards of a 'normal' society, there is little incentive for alienated youth to make the transition. Until they feel their needs are met, violence will always be an option for achieving the fulfilment of their needs.

Anne McKay is a clinical psychologist

Faces in the Revolution *is published by David Phillip Cape Town, 1992*

The Impact of Political Violence on Health and Health Services in Cape Town, 1986

Derek Yach

A study of the political violence which occurred in Cape Town townships from the latter half of 1985 was done by the Medical Research Council. The study included communities or sizable segments of communities affected. This article, based on that study, focuses on the period from May to June 1986.

The outbreak which occurred during this period, mainly affected African townships. It was characterised by the mass dislocation of about 6 000 people, and resulted in severe strains being placed on formal, informal and voluntary health services.

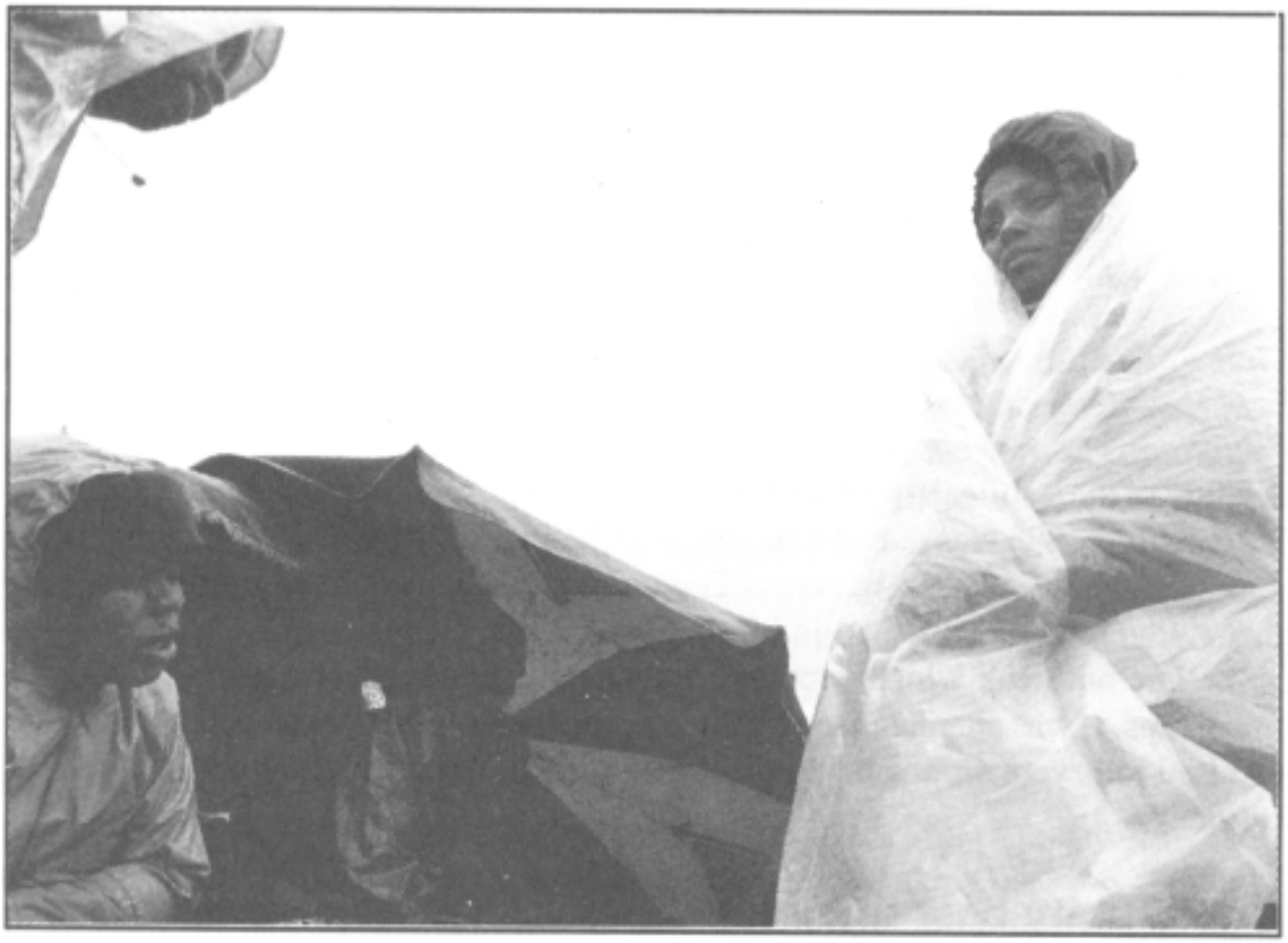
Community based Survey

Investigations into political violence often poses a threat to the safety and security of field workers. Twenty five male and female health workers from the townships were employed as interviewers. They had also participated in developing questionnaires.

Cluster sampling was used because there were no readily available lists of houses or recent maps. It was calculated that a sample of approximately 1 700 households, selected proportionately to township size would be required to yield estimates with suitable precision. A total of 1 545 households were visited.

As a result of the political polarisation that occurred in these communities, several of the interviewers, who had been forced to abandon their homes during the political violence of May to July 1986, were not able to interview safely in Old Crossroads township. Similarly, several current residents in an area severely affected by the violence were reluctant to interview in certain other areas.

Data was collected by a questionnaire covering access to work, school attendance of nurses' children, presence/absence of violence or intimidation, continuity/curtailment of services and nurses assessment of the standard of care during the unrest.



KTC, Cape Town. *Photo: unknown*

Survey Results

Overall, 82,8% of households in the township had access to regular transport, 87% had clean and sufficient water available, 83,2% of households appeared to have regular removal of bucket toilets and 67% reported adequate street lighting.

Problems with these services in the high impact area emerged in the peak months of the violence, between May and July. Over 80% of the disruptions reported in these areas occurred during the peak month. The proportion of households, whose access to family planning or day hospital services was disrupted, was much greater in high impact areas than in low impact areas.

Survey of Nurses

There was a 75,7% response from nurses to the questionnaires. This low response from nurses is probably related to a feeling that participating in the survey might be viewed as 'informing' against the community and so, in a real sense, some nurses might have felt vulnerable. The current analysis is based on a total of 162

respondents.

Eighteen nurses needed to make alternative transport arrangements between May and July to get to work. All of these nurses were from either the midwife obstetric units or the day hospital serving the high impact area.

Twenty two nurses were discouraged from going to work during 1986. Seventeen of these stated that this occurred during June. Twenty eight nurses reported some aspect of their nursing services having been stopped during 1986, with home visiting being the most affected service.

Nurses from the high impact areas reported that preventive clinics, postnatal services in maternity antenatal services, and sexually transmitted diseases clinic services had been curtailed during the height of the violence.

With curtailment of certain essential services, difficulties relating to their home situations, personal danger en route to and while at work, and an unexpectedly increased workload, it was important to determine whether the nurses were able to maintain their usual standard of care. Of the 162 respondents, 115 said that they were able to do so. Of the 47 respondents who felt unable to maintain their usual standard of care, 25 were from the midwife obstetric units. This was probably due to the fact that these nurses, in particular, were unable to maintain home visits to mothers and their newborns. These duties are perceived by midwives to be a vital service.

Conclusion

Despite the problems researchers had to confront in doing research in a polarised community, refusals to answer questionnaires occurred in less than 5% of households approached. Moreover, the consistency of results across the areas of the survey, suggest that there was a considerable and widespread impact of political violence on the health of the community and the delivery of health services especially in the 'high impact' (severely affected) communities.

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The article is an abridged version of the original appearing in the ***American Journal of Public Health*** *Vol 78, No 7, July 1988*

Derek Yach is a senior researcher at the Medical Research Centre in Cape Town

Violence and Paralysis in Medical Personnel

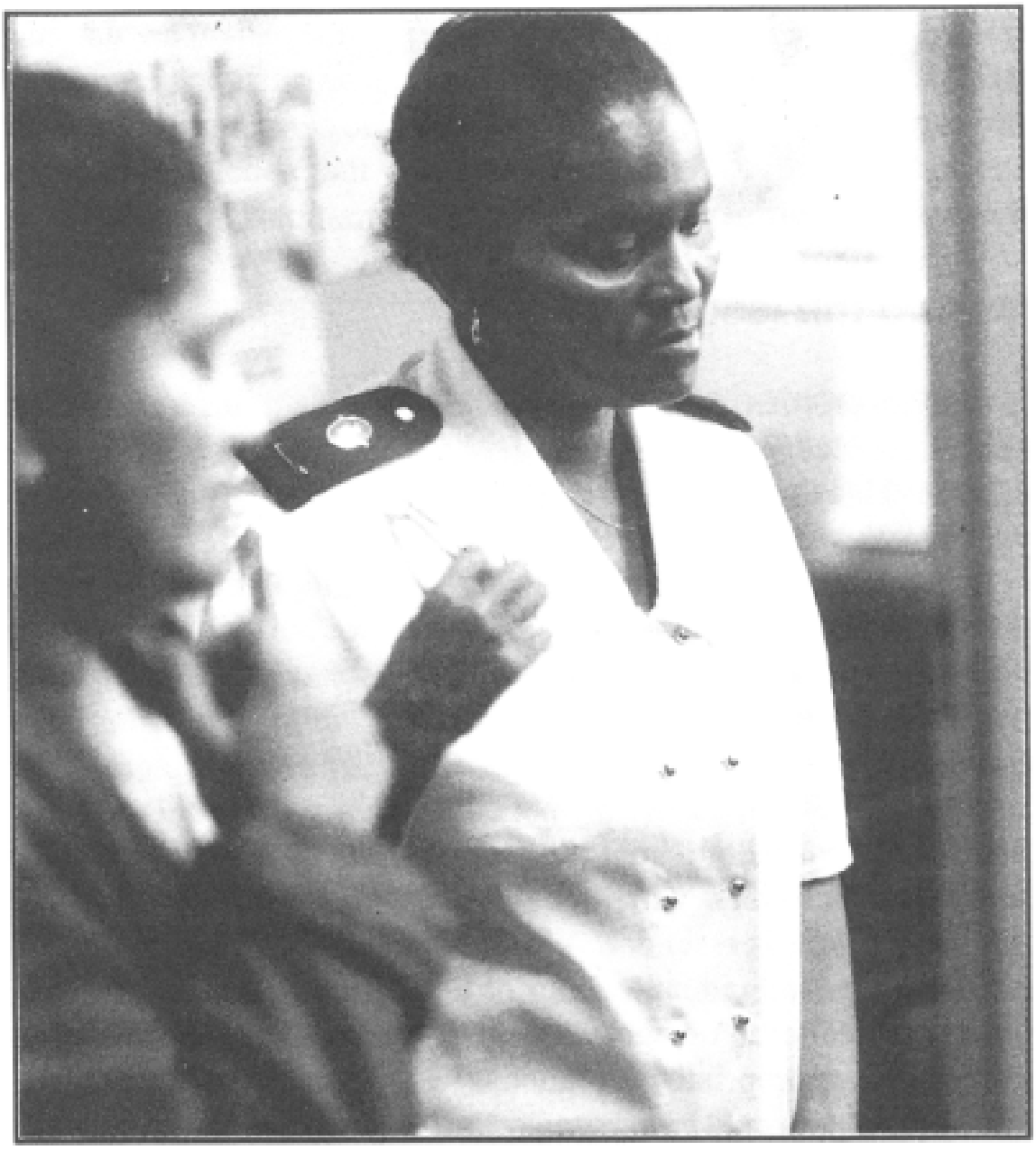
Christopher Szabo & Critical Health

Recent press reports have drawn attention to the overwork and consequent fatigue that medical staff (especially interns) face in hospitals such as Baragwanath and J G Strijdom. This situation appears to be caused by financial cutbacks in health services, one of the results being increasing staff shortages. The work load of all staff, especially interns, is thereby substantially increased.

The situation is further compounded by high levels of political and social violence in the black community. This places enormous pressures on casualty departments and surgical units at hospitals serving these communities. Interns at J G Strijdom Hospital report working 30 hour shifts on a regular basis. The situation at Baragwanath is much the same, especially on weekends when the occurrence of violence is highest. Recent articles in *The Star* newspaper have drawn much needed attention to the impending crisis at J G Strijdom Hospital. Interns have described how the never ending patient load coupled with understaffing often brings them to the point of collapse. Encountering constantly increasing numbers of trauma victims aggravates stress tremendously. It is not uncommon for interns to report dreams or nightmares involving trauma victims. Feelings of exhaustion and depression are common and not easily or readily acknowledged.

Expectations of Medical Personnel

These factors are but some of the many which contribute to feelings of paralysis or helplessness in the care giver. Within the South African context this is an area yet to be comprehensively studied. Medical workers are always expected to cope and be available to serve patients, and are given little opportunity to think of the effects of overwork on themselves. Their helplessness has numerous causes, with loss of staff morale playing an important role. This is influenced not only by having to deal with victims of violence, but by the seemingly unceasing flow of victims. The practice of holistic medicine becomes impossible. In communities like Soweto, socio-economic deprivation, collapse of the family structure and unemployment are widespread. In the case of victims of violence doctors find themselves almost powerless as they are only able to treat the symptoms of a wider social problem.



Facing unceasing flows of victims of violence; how do medical workers cope? *Photo: Ismail Vawda*

A Psychiatric Problem

The situation is aggravated by insufficient funding for health services. Increasing numbers of staff leave the public sector, and their posts are usually frozen, increasing the work burden of remaining staff. To fully understand care giver helplessness, one needs to be aware of the psychological impact of treating victims of violence on an ongoing basis. This represents a chronic form of stress which may result in psychological sequelae in the care giver. A potential response to this stress may be substance abuse in the care giver, amongst a wide spectrum of stress related psychiatric disorders. Ultimately, care giver functioning is impaired and the end result is inability to help patients. However, this helplessness may also be a function of the patient. Non compliance with prescribed treatment, persistent substance

abuse or even aggression towards the care giver by the patient are not uncommon problems. Over identification with the victim or desensitisation to victims (due to prolonged exposure to victims of violence) may also compromise the ability of the care giver to be effective. It is hardly surprising that patients encounter staff in hospital casualty departments who appear to be emotionally 'dead'.

Addressing the Issue

Dealing with the problem of care giver helplessness requires a multidimensional approach. Acknowledgement of the existence of the problem is lacking in terms of objective data. This then should be the first step. Improved funding and provision of relevant services to communities in need is essential and is part of the broader solution to the problem. Recognition of the psychological aspects of care giver helplessness is crucial in terms of appropriate help for the affected personnel being sought. Existing prejudices amongst medical personnel towards psychiatric and psychological services represent a major impediment in addressing the problem. Undergraduate training of medical students, through providing increased exposure to this area of medicine, will in time hopefully rectify the problem.

Once the impairment leading to helplessness is acknowledged, hopefully affected medical personnel will seek help. The availability of psychiatric and psychological services is essential. A team approach in the work situation may to some extent prevent individual feelings of helplessness. Equally important is the ability of a team leader to recognise this problem in team individuals, and make timely referrals to appropriate personnel.

Confidentiality would be of paramount importance, with no stigmatisation of staff members concerned.

Prevention

Ironically, in looking at the solutions to the 'problem' the focus is on symptomatic treatment. Prevention is the obvious answer. In attempting to achieve that, the answer lies in increasing services within the community itself; the services which would address violence as an issue, what causes it and how the community should be preventing it. This in itself does not negate the need for help among care givers, but ultimately community based input might diminish violence and reduce violence related case loads to manageable levels for care givers, thereby reducing their stress and its consequences.

Dr. Christopher Szabo is a psychiatrist at Baragwanath Hospital in Soweto.

Amnesty Means Never Having To Say You're Sorry

Michael Simpson

In South Africa, we have created a society in which good deeds are very often punished and bad ones are generally rewarded. We have become a morally bizarre society, in which to call murder murder, and to call torture torture, is seen to be bad manners. This situation will be enshrined when the government introduces its amnesty law - a Bill of Wrongs is preceding the proposed Bill of Rights.

Those who committed crimes against humanity in the name of apartheid are forgiving themselves, so that they can not be held accountable for the actions of which they were once so proud. Under the amnesty law, the vast numbers of survivors of apartheid repression will be required to remain forever deprived of any justice, redress, or clear public acknowledgement of what happened to them. Those who damaged their victims deliberately will avoid even slight inconvenience, let alone any form of punishment or reparation. Moreover, torturers will retire on fat pensions, to be paid, in perpetuity, by their victims.

Hasty Amnesty Intensifies Suffering

The excuse of "national reconciliation" has frequently been used to justify amnesty, but the granting of hasty amnesty in other countries has never promoted true reconciliation. Rather, it is recognised that this intensifies the suffering of the victims and their families and that it significantly increases the likelihood of continuing strife and violence.

Helplessness and powerlessness are the essential insults of trauma and amnesty imposes perpetual helplessness and powerlessness on the victims. There is a temptation to respond to atrocities by banishing them from awareness, to demand that the unspeakable remains unspoken. But there is a conflict between denial and testimony and this is central to psychological and social trauma. The folklore of all peoples insists that ghosts will not rest in premature graves until the story has been told. Healing of individual and social trauma requires remembrance, truth and revelation. There is a need to reconstruct the story and recognise exactly what happened, after which appropriate mourning can take place.

When a regime imposes amnesty on the country and prevents healing from taking place, individuals and their societies are seriously damaged. We have

The well known f*** you all approach of the government. *Weekly Mail*

learned that this is so from long-term follow-up of the survivors of the Holocaus and related repression during the Second World War and, more recently, from th experiences of our colleagues in South American countries emerging from period of state repression. In these countries, the damage resulting from the immunitie imposed by departing dictatorships now has to be undone.

The Need for Public Acknowledgement

In South America, many victims have been left with no source of police assistanc other than the officers who tortured them, and no source of medical help other tha the doctors who assisted in torture. This is especially true in rural areas. Survivor in our country tell us of torturers who taunted them with this very fact: "I can d what I wish to you, and nothing will ever happen to me. If you ever get out of her no-one will ever believe what you say; you'll never be able to prove that anythin happened to you, and it'll be dismissed as mere political propaganda. By the tim you get out of prison, if ever, you'll be a nobody and I'll be a brigadier".

Survivors of political violence clearly need to be able to know that the fac of their suffering have been officially recognised and acknowledged, before the can complete their healing. Families whose members have disappeared, or a

dead, may never be able to complete the labour of their grief, unless they can discover exactly what happened.

Recent literature on trauma, including feminist literature, also makes it clear that forcing the victim to comply with an unattainable demand that she forgive and forget constitutes further abusive damage. This pseudo-reconciliation, for the sake of the comfort of the victimiser, is clearly unacceptable.

There is another dimension which must not be forgotten: the expectation that amnesty and impunity will be provided encourages further abuses of human rights and further acts of political violence; it is almost a pre-requisite for the widespread use of deliberate trauma as a political method. Far from being a means of promoting reconciliation, establishing amnesty for crimes against humanity is one of the surest methods available of increasing the likelihood that these offences will recur in the future.

Clemency as the Democratic Alternative

No democratic South African government should feel bound to continuing an amnesty imposed on the majority by the perpetrators. The current law should be repealed and everyone who applied for amnesty under it should be investigated and, if appropriate, prosecuted.

A democratic government might provide clemency. Clemency is a very different and more wholesome proposal. It does not reward wrong-doing. It requires full investigation and exposure of what happened, and the full due process of law. This process should encourage serious consideration of mitigating factors, if any, and decide on sentences with due regard to punishment or clemency. However, only a fully democratic government which adequately represents victims of apartheid violence should have the authority to grant clemency.

The Role of Health Workers

Health workers and their representative organisations should strongly oppose the amnesty legislation and press all democratic political bodies in this country to work for annulment and reversal of this law. We must push for the adoption of means of preventing future occurrences of torture, human rights abuses and political violence. We should also strive to assist the survivors of previous trauma. No responsible health worker should be associated with proposals which amount to pseudo-reconciliation for the benefit of the torturers.

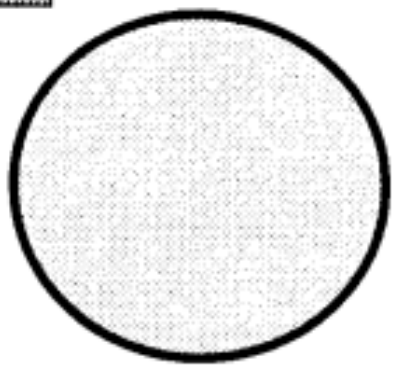
Michael Simpson is a psychiatrist who has been involved in a number of cases involving the torture of detainees.

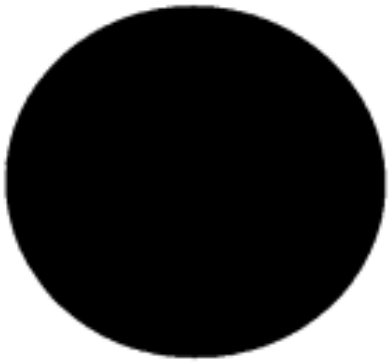
SECTION

B

The Psychological Impact of Violence on its Victims

This section includes interviews with two people who have had difficult experiences of violence, as a perpetrator of apartheid violence and the other as an activist struggling against apartheid. How have they being affected by violence and what mechanisms have they developed to cope with their experiences? A common psychological effect of violence is post traumatic stress disorder (PTSD), a psychological phenomenon which is yet to be given adequate attention by South African health and welfare workers.





Violence:
Introduction to Personal Accounts of a Victim and a Perpetrator

Jackie Loffel

The deep scars which political violence has left on the lives of all South Africans reveal both common and contrasting patterns. The differences depend on where, by choice or circumstance, people are located within the political and broader social order. It also depends on the nature of their roles in the events concerned.

The symptomatology of post-traumatic stress disorder is encountered across the board. The meaning which people give to their experiences of violence, and the ways in which they strive towards integration and healing, naturally differ from context to context.

In the two articles which follow, an ANC activist and an ex-SADF soldier tell their stories. Among the many points of contrast between the two accounts is the sense of underlying strength and purpose on which the activist engaged in a struggle for justice seems to have been able draw, as opposed to the growing sense of personal disintegration of the person perpetrating and exposed to the extreme effects of violence. A violence, which he abhorred from the start, and which he eventually comes to understand as emanating from an unjust system. Important roles for therapy and community support emerge from both accounts.

Jackie Loffel works for
the Johannesburg Child Welfare Society

An Anti-Apartheid Activist Speaks on Violence

Violence affects the lives and close relations of activists in the national liberation movement daily. *Critical Health* spoke to an ANC activist in Alexandra township about her and her family's experience. What follows is a story of survival.

The severest experience of violence I had was in detention. I was detained for two and a half years - the first eight months was solitary confinement at Jeppe and thereafter, Johannesburg Prison. At Johannesburg Prison, I spent the first two months in a communal cell. I was then removed to a single cell, spending the rest of my time there in solitary. I was given absolutely nothing to read and I had nobody to speak to.

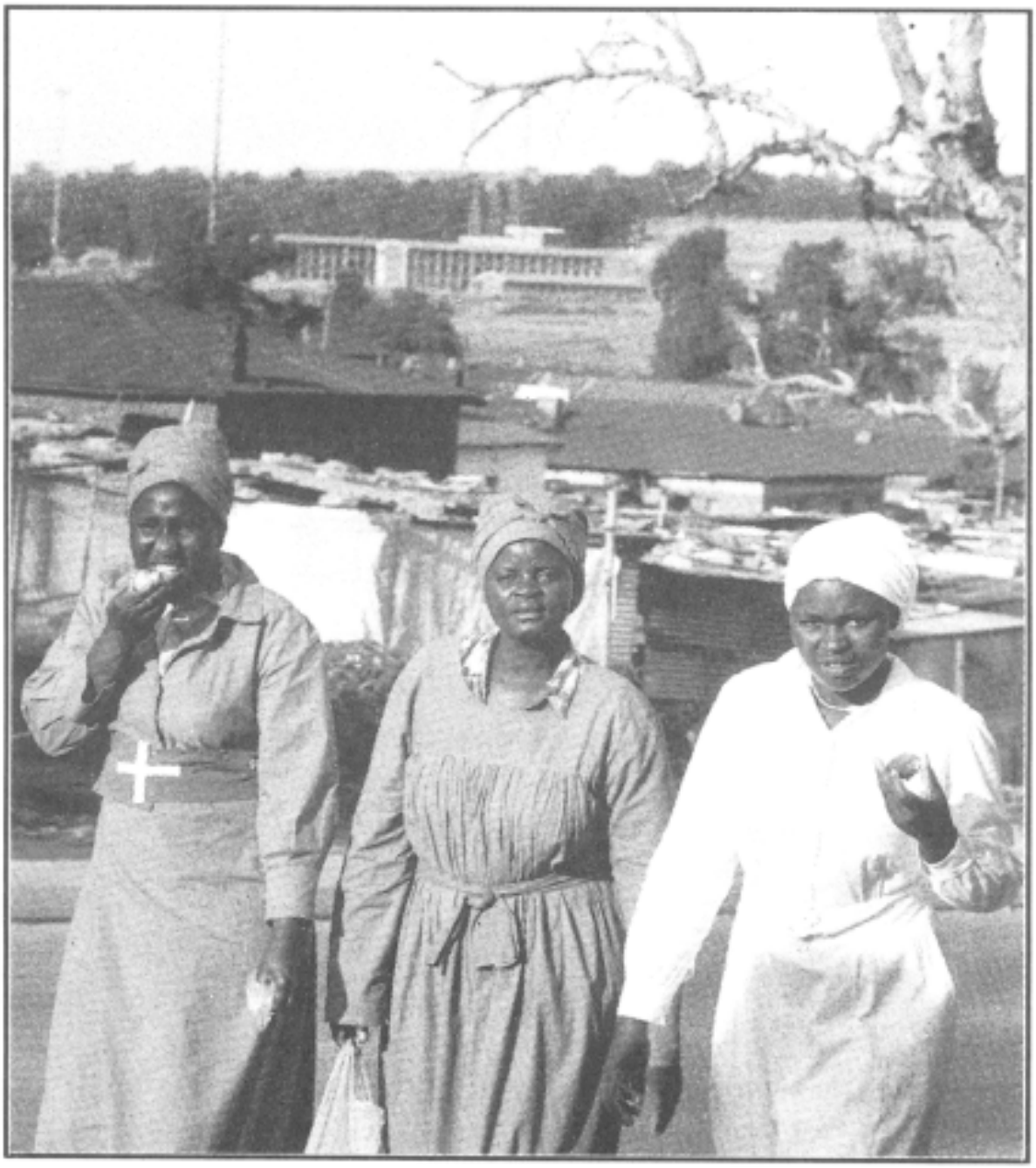
In the first days at Johannesburg Prison, their efforts at interrogating me were backed by threats and abuse. However, I matched their aggression with aggression, and sometimes wardens or police officers would leave my cell with minor injuries. By this means I was able to gain more respect from them, and they never succeeded in weakening my spirit.

Fears of the Child

At the time of my detention I had a five year old son who stayed with my mother in Meadowlands. When I was released from detention he remained in her care. As the violence escalated in the Transvaal and attacks on ANC activists increased he started having nightmares. He would wake up screaming every night. When he was asked to talk about his dreams he would remain silent. Eventually, through the help of some progressive medical people, we secured some therapy sessions at Hillbrow Children's Hospital for him. It took them a month to engage him in speaking openly about his fears. He said that he had dreamed that Inkatha people were attacking his mother and that he was worried they might kill her. The therapists suggested that he stay with me. To some extent this has helped. He seems more secure, because he sees me more often than he did before.

And the Violence Continues ...

The violence continues, however, and the root of my child's fears have not been addressed. Between November 1991 and September this year, about five people on



Although violence is endemic, people have to live their lives the best way they can. *Photo: Market Theatre Photo Workshop*

our branch executive have been killed. We buried one of them recently. He was killed on his way home from an annual general meeting of our organisation. I have had death threats and have been notified by some of my comrades that I was on an Inkatha hit list.

My child still shows signs of extreme fear. He wants to be with me wherever I go, and he always phones me at work to check if I am in. If I'm not in at the office he gets very worried and upset. At one point, he would leave school early and come to my workplace. His school work has been affected, although there has been a marked improvement since therapy. Now the problem really is his relation to his peers. His teachers tell me that he is often excessively impatient with the children he plays with and tends to be aggressive.

The Family: Confronting the Fear

The violence has affected other members of my family in different ways. I should tell you about my younger sisters who lived with my mother in Meadowlands at the time the trouble started. This area was invaded by Inkatha a year ago and has become their political stronghold. Other people in the area, ordinary citizens without active political involvement began to shun my family. They stopped their kids from playing with my sisters because they saw my family to have direct association with the ANC.

For the sake of their safety, my family have moved to Diepkloof, but these girls, once jovial and friendly in their childhood, have become reserved teenagers lacking trust and confidence to make new friends. They are used to staying indoors with my mother. My mother, once a quiet and charming women, has also been changed by the violence. She speaks loudly and is a very forthright person nowadays. Perhaps that is her strength.

The house she stayed at in Meadowlands was a converted hostel near a veld, which she visited whenever a corpse was reported there. She would want to see these corpses to assure herself that it wasn't mine or my brother's. Apart from these corpses she also witnessed horrific scenes of people burnt alive in their homes and of people evicted from their homes by the invaders.

On one occasion, I went to visit her at Meadowlands. I was followed by a group of men whom my mother recognised as people from the hostel. They were very aggressive. They said they knew that I was an ANC person and charged that I had no right to be in the area. My mother showed no fear of them. She confronted them boldly in a war of words, despite my efforts to neutralise the situation. I didn't stay for very long for fear that they might attack us later. They never returned to intimidate her since then.

Despite the threat of death against me, I do not fear for my own safety. I worry, in the event that I were killed, about my child's future - about who would take care of him. I am also the sole breadwinner in my family. I fear that they would not forgive me if I were killed for my political activity. I would want them to appreciate that if I were killed that it was for a good cause.

Critical Health

Healing the Wounds of War:
An Ex-Koevoet Medic Speaks Out

Sean Callaghan with Critical Health

I grew up in the eastern Cape. My perception of the world were strongly influenced by a Christian ethic. In terms of these beliefs, I abhorred violence and war. I did not want to go to the army, but I thought it right to do so. Nobody among my peers or within my family questioned the legitimacy of the call-up.

In registering for the army, one could make a choice about the particular posting one assumed in the army. I dealt with the tension between values of Christian non-violence and the idea of the call-up as an acceptable norm, by choosing to be involved in healing the wounds of war. I applied to become a medical orderly.

Initiation

As soon as we reached our first camp, we had to go through the shock of war ritual, including the signature of a secrecy document and a will sent to our parents. At seventeen, it was a rude shock to have to sign a will and consciously face the close possibility of death. The secrecy declaration also had a damaging effect. With the images of horror one saw at the hospital, you found that you needed to speak to someone close about it, but you were bound from doing so by the secrecy document. The way I found to get around this, was to telephone my mother from a civilian call box on my time off from camp. I also sent letters to her from a civilian post office.

People who came into the army as medical professionals were given a brief orientation course and then became officers. The rest of us did three months of basic military and medical training.

After further training we had a basic knowledge of pharmacology, nursing techniques and first-aid. We also learnt about weaponry and warfare. Our medical training was not very useful for the practice of patient care, and we often had to treat people who were seriously injured.

Medics

A group of us were sent to a hospital, Oshakati Casualty Evacuation Hospital 25km south of the Angola border. This hospital had 40 beds, two general wards and two

Dead SWAPO geurilla carried onto Koevoet Casspir. *Photo: Sean Callaghan*

private wards, reserved for women and for enemy casualties. The staff of the hospital were six general practitioners, ten medics, three nursing sisters, a surgeon and an anaesthetist.

It was very stressful, at the start, finding yourself suddenly playing the role of doctor with the little training you had. For example, if ten cases came in, the doctors would assess the three worst among them and the rest we had to deal with. The doctors were helpful, advising on various practical ways of handling patients and in identifying patients who should go to theatre. With the doctors, we would go into the theatre to do as much as we could, removing shrapnel, doing amputations and so on.

I was introduced to death in a terrifying and gruesome form. After our first night at the hospital we attended a music concert from which we were summoned. We were called back to the hospital to take care of casualties who had just arrived. I have a vivid memory of a case from a mortar attack, with severed arms and legs and wrapped in bloody bandages. This was petrifying, and you wondered if you would be the next to suffer in that way.

A disturbing early experience for me was having to nurse a patient, dying from burns in a land mine explosion. I knew that he would not be alive in the next few

minutes, although he spoke of going home and seeing his girlfriend. I conversed with him until he died, but I always feel that my training had not equipped me for handling a situation like that. I often feel that I should have let him know the truth of his dying state.

But this was not to be the worst of my early experiences at the hospital. Ten of our soldiers, all married and with children, had burnt to death in a military vehicle which had hit a land mine. We spent time in the mortuary trying to identify body parts and cutting contorted limbs so the bodies could fit into coffins. In the process the smell of burnt flesh got into my clothes. When I went back to my room I put on a new set of clothes and left my dirty clothes there. I woke screaming from a nightmare, with the stench lingering in my room. Despite much scrubbing and cleaning, the smell seemed to hold for days and whenever I entered the room I sprayed deodorant which had little effect in alleviating the smell. I could not sleep for almost a week.

Desensitisation

Increasingly, however, I seemed to develop a wall on feelings of sympathy and remorse towards death. There were people dying every day in the hospital. Every month, 150 to 200 casualties were flown in. Of these, 30 to 40 died monthly. Most of them were black members of 32 Battalion fighting deep within Angola. We worked hard to save lives, but the extent of our dehumanisation shows in our attitude to a patient who died at 5am on a News Years Day, hours after hard effort to save his life. We felt no remorse but fury at the patient for having 'dared' to die on us.

This process of dehumanisation or what seemed a blanket insensitivity towards fellow human beings was intensified in the time I left the hospital and joined Koevoet patrols as a medic. We would go, fifty in a team of five casspirs, on the trail of SWAPO guerrillas. We were paid R1 000 if we brought back a body dead or alive, and between R500 and R750 for captured AK-47s. Large weapons like rockets or mortar tubes were worth more than the bodies we brought in. Every time we returned from the kill we would strap bodies to the mudguard or on the side of casspirs. It was an appalling sight after driving through the dense Namibian bush, the bodies were so ravaged in the process that there was hardly any skin left on them. We tried to have these bodies identified once we were back at base.

A scoreboard was kept at base to mark the killing record of each group. When we were off camp we would check score to see how we were doing against our competitors. One thing I often did was to speak to my mother for an hour every week, telling her about things that happened. I also told her about our scores, and it seems, she became increasingly worried about the changes I was going through.

Sean tending a wounded geurilla. *Photo: Koevoet*

I received a devastating emotional shock when she came to meet me at the airport and withdraw from me when she saw how dirty and unshaven I was.

Stress

Some of the few white casualties we had, died accidentally or by suicide. There was almost total lack of emotional support and counselling for us. In the area of my Koevoet camp, over the time of Christmas and New Year of the first year that I was there, ten guys shot themselves with R-4 rifles.

I suppose what these signs of emotional trauma among soldiers shows is that the dehumanising process is never absolute. I remember my first contact with a SWAPO person, a captured unit commander whom they chained to his bed. In conversation, he demonstrated a strong command of various languages, and he enjoyed reading *Huisgenoot*. He could also name a few eastern Cape towns that I had grown up in. I realised from this encounter that the enemy were also human and not the stupid, unreasonable fiends we were taught to believe they were.

Later, after my first round of military service, I suffered nightmares. One source of my nightmares was the merciless killing of one of my patients, a captured guerrilla, by my unit commander.

It was on one of these expeditions of trailing after SWAPO guerrillas that the first signs of what a psychologist later diagnosed in me as post traumatic stress showed.

When our casspir detected the footprints of a guerrilla, we would follow that for days. The whole process is so tense, you are never sure of what's ahead and you're always worried that he might have a rocket launcher or is leading you into an ambush. When the person was cornered it was such a relief to kill him.

On one occasion a SWAPO rocket went through our engine stopping us dead in our tracks. It was about twilight, and all we could hear were shots and there were light flashes all over. It was so frightening. When it was over there was a corpse of a guerrilla before us. I felt so relieved to be alive, yet I was so angry that the corpse before us had tried to kill me, I just kept firing at it. I soon felt so sick I just puked and puked. It was a feeling of nausea which had little to do with the gory state of the corpse. I could not understand why it was happening. There was just a feeling of almost total emotional numbness, too much seemed to be going on, it was too much to cope with, everything just seemed to close down on me.

When I returned home I spoke openly about my adventures in the army and showed friends some pictures of corpses. However, openly relating to others my experiences in the army was not sufficient to keep the nightmares at bay. The latter were always triggered by the images of war that I saw in films. These brought back in vivid detail the experience that I had during national service. I would hear sounds and see images that were not there and behaved with ultra-vigilance in re-enacted scenarios of war. I found difficulty distinguishing between reality and the film imagery of war. It would often take me a week before I could function normally.

These, however, passed. But in 1991, the nightmares returned. This time they were triggered by another call-up. Nobody suggested therapy to me, but I approached a psychiatrist who diagnosed me to have post traumatic stress disorder (PTSD). I was sent to a psychiatric ward, and was told I could stay for as long as it took to recover. A doctor there, who saw me for about three hours, decided that I did not have PTSD which he said I had healed myself through speaking about my war experience to friends. He suggested that it was okay for me to do a camp. I am thankful that was the last camp I had to do.

At present I do reconciliation work, and I cannot imagine going to the army ever again. I bemoan the lack of support that soldiers receive in the army, and I would like to set up a support group to assist ex-soldiers find their bearings in an environment outside of the military.

Sean Callaghan now works for the Initiative for Reconciliation

Post-traumatic Stress Disorder:
a Response to Abnormal Circumstances

Michael Simpson

It has long been recognised that psychological and social trauma can cause psychological symptoms which persist long after the traumatic event. Victims of the 1666 Great Fire in London, the American Civil War, the Russo-Japanese War and the First and Second World Wars experienced very similar reactions. The 'victims' symptoms were variously called 'nostalgia', 'combat fatigue' and 'shell-shock' (the latter term was used because, for a time, it was mistakenly believed that damage was caused by some form of concussion from continuous artillery bombardment).

The recurrent tragedy is that many basic lessons about recognising these problems and aiding the victims have been forgotten or ignored. These have had to be learned again during each conflict, at great cost in human damage and suffering. There has been a tendency to ignore or deny the extent of such damage and to ignore the victims, because this seems to be the more comfortable response. This has compounded the misery of victims, who are often blamed for cowardice, weakness or lack of commitment to the struggle or nation, when they are merely normal individuals responding to highly abnormal circumstances.

The Abuse of Psychology

In most forms of conflict, war and political violence, the extent and duration of the psychological damage caused to combatants and civilians has been far greater than the more obvious physical damage. Moreover, it has become increasingly common to intentionally inflict psychological trauma on the opposition. Over thirty years ago, William Sargant wrote that the politico-ideological "struggle for the mind of man may well be won by whoever becomes most conversant with the normal and abnormal functions of the brain, and is readiest to make use of the knowledge gained".

In this country and many others, we have seen the planned use of the structured stresses of captivity, coercive interrogation and torture, deliberately designed to induce traumatic stress disorders in captives, in order to force them to reveal information, to change political polarity and to betray their former comrades, or to produce lasting psychological impairment. We have also witnessed the deliberate fostering of violence within communities, including those in Crossroads and Natal, and across South Africa's borders, for example, Mozambique.

Diagnosing PTSD

The American Psychiatric Association's Diagnostic and Statistical Manual (DSM-3) introduced a diagnostic term for the psychological damage following a traumatic event, namely Post-traumatic Stress Disorder (PTSD). The table below shows the criteria by which this diagnosis is made.

Diagnostic Criteria for Post-traumatic Stress Disorder (DSM-3R, 1987)

A. *The person has experienced an event outside the range of usual human experience that would be markedly distressing to almost anyone, for example: a* serious threat to one's life or physical integrity; a serious threat or harm to one's close relatives or friends; sudden destruction of one's home or community; the sight of another person who was recently, or was in the process of being, seriously injured or killed in an accident or by physical violence.

B. *The person persistently re-experiences the traumatic event in at least one of the following ways:*
1. Recurrent or intrusive distressing recollections of the event (in young children, repetitive play in which themes of the trauma are expressed);
2. Recurrent distressing dreams of the event;
3. Sudden acting or feeling as if the traumatic event were recurring, including a sense of reliving the experience, illusions, hallucinations and dissociative (flash-back) episodes, even those that occur upon awakening or when intoxicated;
4. Intense psychological distress at exposure to events that symbolise or resemble an aspect of the traumatic event, including anniversaries of the trauma.

C. *The person persistently avoids stimuli associated with the trauma or has a numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:*
1. Efforts to avoid thoughts or feelings associated with the trauma;
2. Efforts to avoid activities or situations that arouse recollections of the trauma;
3. Inability to recall an important aspect of the trauma (psychological amnesia);
4. Markedly diminished interest in significant activities (in young children, loss of recently acquired developmental skills such as toilet training or language skills);
5. Feeling of detachment or estrangement from others;
6. Restricted range of affect, for example,inability to have loving feelings;
7. Sense of a foreshortened future, for example, no expectation of a career, marriage, children or a long life.

D. *The person has persistent symptoms of increased arousal (not present before the trauma) as indicated by at least two of the following:*

1. Difficulty falling or staying asleep;
2. Irritability or outbursts of anger;
3. Difficulty concentrating;
4. Hyper-vigilance;
5. Exaggerated startle response;
6. Physiological reactivity on exposure to events that symbolise or resemble an aspect of the traumatic event, for example, a woman who was raped in an elevator breaks out in a sweat when entering any elevator.

E. *The duration of the disturbance (symptoms in B, C and D) is at least one month.*

PTSD was previously thought to be fairly uncommon, but more recent studies have shown that there may be a high occurrence of PTSD, even in comparatively peaceful communities. We have seen that PTSD occurs as a result of war, torture and political violence within communities, but it is also caused by a wide range of other stresses, including rape, incest, child or woman abuse, crime and natural and other disasters. In South Africa, the social decay resulting from long standing repression and political violence has increased the incidence of many of these forms of social and familial trauma and thereby enhanced people's susceptibility to being damaged by them.

Many surveys have confirmed that 60 to 80 per cent (or more) of those exposed to severe traumas are likely to develop PTSD. Some follow-up studies of disasters found 80 per cent of young children had symptoms of PTSD one to two years later, compared with 30 per cent of adults, strongly suggesting that children are more vulnerable.

It has been recognised in cases of disaster, severe political violence and similar events that it is not only the direct victims who develop significant symptoms and problems. The structure and function of entire communities can be severely affected. There are also indirect victims among the helpers, including ambulance staff, doctors and nurses and body handlers.

Drugs and Psychotherapy

Early treatment, within the context of a supportive community, can provide effective and lasting relief. There is clear evidence that, although the trauma may be psychological in origin, the effects include definite chemical changes in brain function. Careful use of appropriate psychotropic drugs can be invaluable in

Funeral of massacre victims. The extent and duration of the psychological damage caused has been far greater than the more obvious physical damage.
Photo: Julian Cobbing

providing effective therapy. Such pharmacological treatment may enable the survivor's brain chemistry to return to their normal state, and thus enable them to fully participate in, and benefit from, psychotherapy, which can be ineffective if used on its own.

Individual psychotherapy can be most valuable. This should be provided by skilled and properly trained therapists, except in the simplest of cases. When therapy is simple, almost anyone can do it. But when there are setbacks, complications, and crises, the naive and self-accredited counsellor can be seriously out of his or her depth, and the consequences can be serious. Group therapy has also proved valuable. Expert consensus, however, is that for reliable benefits, such groups should be run by people trained in group therapy and with real experience in the trauma field.

Without treatment, PTSD may last for decades. Furthermore, severe trauma can lead to clearly noticeable effects in survivors, their children and perhaps even their grandchildren. It is also important to recognise that PTSD can begin long after the traumatic stressor. Survivors can become disabled after everyone has stopped paying attention to their situation.

Overcoming PTSD in South Africa

In South Africa, the combination of political, social and familial trauma has affected millions of individuals and, in many instances, entire communities. Some attempts have been made to assist the victims of trauma, but they have fallen well short of what is required.

During the 1980s, individuals and groups from the major democratic health organisations worked under repressive conditions to assist victims clinically and medico-legally. There was considerable risk to both the counsellors and the counselled. It was also very difficult to conduct evaluations of the effectiveness of our work and to develop new methods of helping victims. It is hoped that, once these conditions of repression have been fully overcome, better quality research, programme evaluation and care systems will be developed.

It is also clear that we can gain from effective collaboration and liaison with our many international colleagues. Experiences in other countries can be highly relevant to our own local needs. At a meeting on the issue in Amsterdam, it was obvious that far too little disciplined and expert work has been done in South Africa so far. The true individual and social healing this country needs will only be possible when respectful and effective attention is paid to the consequences of trauma, thereby helping the survivors of apartheid to be freed from its grip.

Michael Simpson is a psychiatrist and is an expert on PTSD.

Violence and Mental Health:
Post-Traumatic Stress and Depression

Gillian Eagle

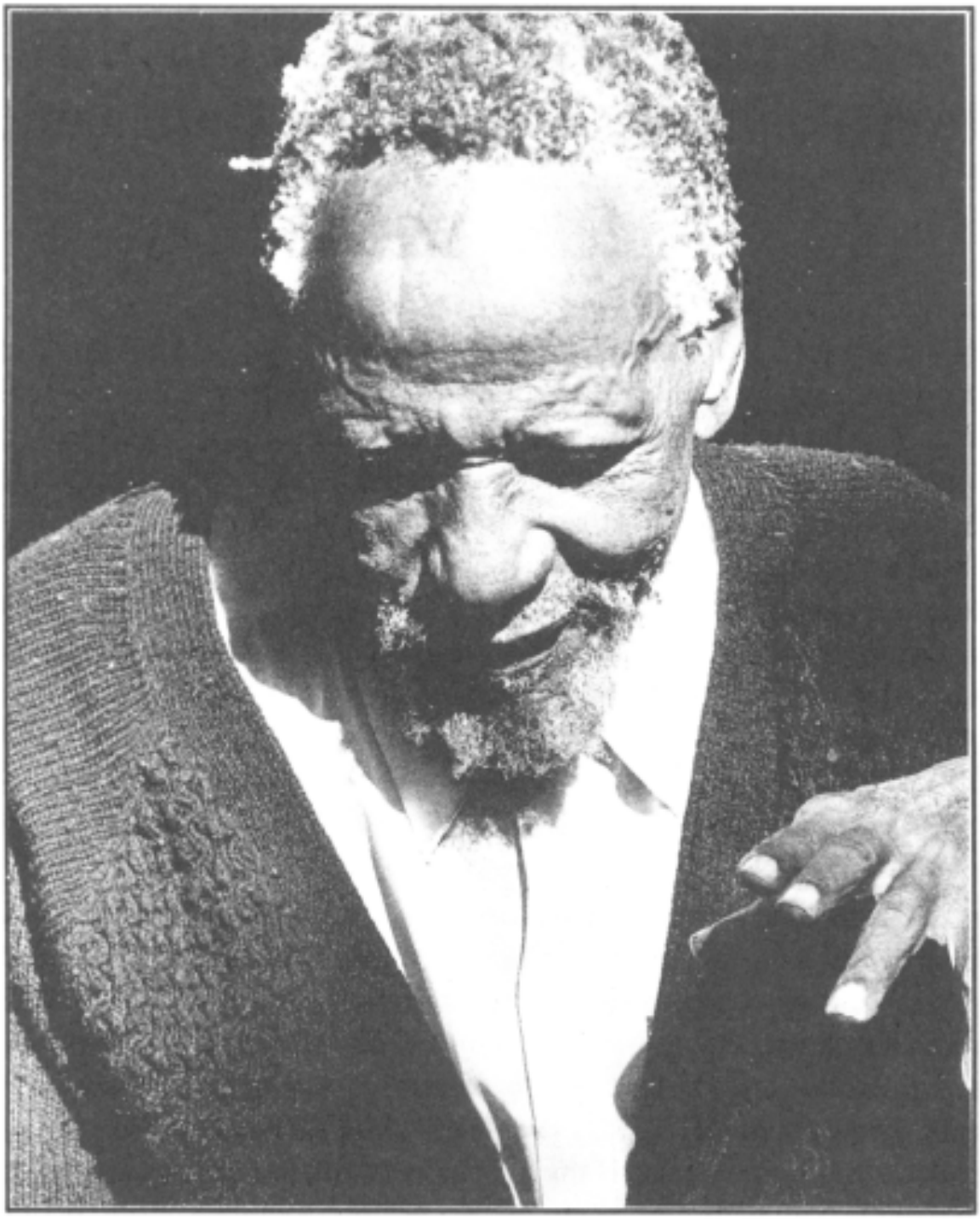
Violence can result in direct physical injury to victims and often has a severe psychological impact as well. The holistic treatment of victims involves an understanding of trauma and psychology. The close inter-relationship between body and mind also suggests that patients may recover better from physical injuries if their psychological trauma is dealt with at the same time.

Many victims of violence may not have physical injuries but will have suffered damage to their mental health. Thus mental health intervention is of central importance. Given the scale of violence in South Africa at present, it is crucial that we continue to develop our understanding of the effects of violence and constantly improve our treatment methods and services.

The Psychological Consequences of Violence

Victims, witnesses and, occasionally, perpetrators of violence can suffer from post-traumatic stress as a result of exposure to a traumatic incident or precipitating event. Survivors of violence can present with intrusive recollection of the event, emotional numbing or withdrawal and hyper-arousal. In some cases, personal or situational factors may intensify the effects of the trauma, resulting in Post-traumatic Stress Disorder (PTSD). (See the DSM 3-R Diagnostic Criteria for PTSD in the article before this one). If the psychological effects of trauma go untreated, more complicated disorders may develop. This includes clinical depression, psychosomatic symptoms, phobias, chronic anxiety and 'acting-out behaviours', for example, alcohol abuse and wife battery.

Post-traumatic stress is associated with powerlessness, an acute disruption of one's existence and extreme discomfort. Thus, victims usually present with acute features of anxiety and regression. They can lose their trust in their own ability to cope as well as their faith in humankind. Many survivors of violence become frightened of the symptoms they experience and, failing to recognise them as "normal", fear that they may be going mad. It is important for both mental health personnel and their clients to remain aware that post-traumatic stress is the natural response of a 'normal' person to an 'abnormal' situation, rather than the result of some intrinsic pathological process.



PTSD is a 'normal' response to an 'abnormal' situation. *Photo: Tessa Colvin*

In working with trauma survivors, several local mental health personnel became aware of the limitation of the DSM 3-R categorisation of PTSD. In terms of DSM 3-R, symptoms were expected to gradually diminish once life returned to normal, usually within a six month period. It became apparent to South African personnel that many victims were returning to situations in which danger persisted and multiple traumas could be commonplace. Gill Straker, a clinical psychologist, conceived of the category, Continuous PTSD. Clients suffering from this condition had symptoms similar to PTSD, but their symptoms were prolonged and, rather than diminishing, they intensified over time.

Short-term Psychotherapy

In keeping with DSM 3-R, the preferred treatment for most victims of violence is short-term psychotherapy. It is felt that medication represses, rather than alleviates, symptoms. This often creates a further dependence and lack of sense of control on the part of the client, who is already experiencing decompensation. However, psychotropic medication can be useful to ensure that clients have adequate rest in the form of unbroken sleep.

At the Wits Trauma Clinic, victims of violence are initially offered four treatment sessions and the therapy is usually short-term, averaging 2 to 3 meetings. In each session an attempt is made to incorporate the following components: assisting the client to re-experience feelings and thoughts by means of a detailed recounting of the event; 'normalising' the client's symptoms by focussing on expected responses to trauma and the 'adaptive' function of these responses; and helping the client to recognise and to establish coping mechanisms to deal with the violence and its aftermath. This may include establishing support networks and referral to appropriate sources. A common phenomenon is 'survivor guilt' and a fourth aspect of treatment is the restructuring of maladaptive thinking in this regard.

The therapist's role is to solicit information, offer support and affirmation and serve an educative function. Due to the tendency for people to regress after situations of extreme and unanticipated stress, clients are often vulnerable and the therapist needs to pace the intervention to match the client's resources. However, counsellors need to be careful not to set up dependence in the relationship. The goal is to assist the client to regain a sense of self-sufficiency as soon as possible. In some cases, it is possible to reframe the client's sense of the experience to a point where he/she recognises some mastery and may even experience a sense of increased commitment to living, having survived the trauma.

Continuous Stress and Previous Trauma

In cases of continuous traumatic stress, psychotherapy has to be modified to allow the person to maintain optimal defences. The therapeutic approach would be more cognitive in emphasis, avoiding deep emotional catharsis and focusing strongly on the development of coping and survival mechanisms. In these cases, longer term supportive therapy may be necessary.

Other conditions may also necessitate long-term intervention. These include the exposure of pre-existing trauma, for example, sexual abuse; a lengthy period of silence around an event, such as a rape that happened years previously; or pre-

existing psychiatric or personality problems. At the Wits Trauma Clinic, therapists are generally advised to keep their intervention somewhat narrowly focussed on the traumatic experience which brought the client for treatment, rather than follow up on other problems, unless these appear to be integrally related to the trauma. Where such complicated presentations arise, clients are usually given the option of referral to other agencies or therapists for longer term counselling, following the trauma work.

Group Therapy

One to one counselling is the first treatment of choice as victims tend to experience events very personally and often wish to protect close friends and relatives from the worst of their experience. However, there are occasions when group counselling can be very effective, particularly as an adjunct to individual counselling. Group therapy can be very powerful in 'normalising' symptoms, as participants recognise common features in others. It can also provide a support system which allows for the sharing and reinforcement of coping skills. At the Trauma Clinic, we have engaged in some very effective couple counselling.

We have run debriefing groups with personnel who have been involved in offering treatment in situations of violence. There may also be a need for debriefing groups for members of violence monitoring teams, media workers, politicians and others who are constantly witnessing violence. Other forms of intervention include the sharing of information through the medium of pamphlets, newspapers, radio and television and educative programmes in schools and other settings. For example, the Project for the Study of Violence has initiated a school programme on mediation and negotiation skills as alternatives to resorting to violence in dealing with conflict situations.

Trauma counselling can be viewed as both curative and preventative. If victims receive good therapeutic intervention as soon as possible, this can prevent the development of other serious disorders. With early intervention, clients often acquire knowledge which they can use to assist others in their community.

Counsellors almost inevitably experience an increased sensitivity to their own vulnerability as a consequence of providing trauma counselling. Counsellors need to have access to peer support so as to have the opportunity to talk through the feelings which this type of work evokes.

Violence and Depression

The DSM 3-R criteria for PTSD include a number of symptoms which are related to anxiety and depression. Emotional numbing, loss of interest in outside activities

and withdrawal from social contact are all features of depression. Concentration difficulties and sleep disturbance can occur in post-traumatic stress and clinical depression. Thus, there are common as well as different features in the two categories of disorder.

In our experience at the clinic, depression usually only tends to arise following complications in the experience and treatment of PTSD. In one rape case, a black woman experienced secondary victimisation by her community and the police and this led to depressive features. These features came to a head when her rapists were acquitted in court, at which point she developed suicidal impulses. In situations where mastery of the situation seems impossible for personal or structural reasons, for example, through loss of employment following traumatic injury, a sense of helplessness and hopelessness is perpetuated and depression is a logical consequence of these feelings.

Anger Against the Self

Depression resulting from loss often represents the turning of anger inward against the self rather than against the cause of the loss, for fear of possible retribution. The aggressor may dehumanise or objectify the victim who, in turn, can experience this dehumanisation as a temporary loss of 'identity' or a loss of a sense of personal power in one's ability to appeal to the perpetrator. Victims often describe the shock and disbelief they felt when they were targeted by apparently arbitrary or feelingless violence. The victim fears reprisal and this tends to invoke powerful feelings of impotence and regressive behaviour such as pleading or even loss of control over body functions.

If survivors do not have an opportunity to recognise these responses as 'normal' and adaptive, they may be unable to transcend this sense of powerlessness. If such feelings endure and become dominant in the person's functioning, depression may ensue. For this reason, an important feature of psychotherapy is the facilitation of anger in a contained setting, where the client has the opportunity to express feelings of rage and fantasies of revenge. This can be viewed as part of 'normalising' the symptoms, allowing the person to channel their aggressive energy in a socially acceptable manner, for example, in taking the perpetrator to court, giving evidence to a commission of enquiry or training in self defence. In cases where victims have been exposed to previous trauma or abuse, there is a tendency to 'learned helplessness' in which they internalise a 'victim identity'. Longer term therapy is usually required.

Loss of Hope

However, for many communities in South Africa, 'learned helplessness' may well be a social, rather than a personal, phenomenon. Many people in oppressed communities appear to have lost hope. During the apartheid years, black township residents could clearly identify the enemy, in the form of the security forces, which threatened their community from outside. However, the present violence is often internal to communities, unpredictable, highly visible in its impact and the perpetrators are not easily identifiable. The continued exposure to violence, together with an inability to clearly perceive its origins and motivations, leaves community members drained and often resigned to their situation. Gibson, Mogale and Friedlander (1991) cite evidence of this despair in the drawings of children from Alexandra Township. The drawings reflect a preoccupation with death and injury and a pervasive feeling of 'deadness'. The mothers of these children also suffer from depressive symptoms.

Evidence of widespread clinical and sub-clinical depression in community groupings was also noted in a study of internal refugees around Pietermaritzburg. Michelson assessed a large group of people displaced by violence. In many cases, these survivors of violence were dealing with multiple losses, including loss of loved ones, loss of home and possessions, loss of livelihood and loss of their community. She found significant levels of both PTSD and depression in her subjects.

Informal clinical observations have suggested a general increase in depression in the South African population as the economic recession makes itself felt, violence increases and political developments progress slowly and unevenly. The country seems to be exhausted by decades of unrest and struggling to maintain hope.

However, we cannot afford to ignore the political gains that have been made and the resilience of both communities and individuals in facing and dealing with the threats they have been exposed to. We need to make effective gains for peace before even this resilience is lost.

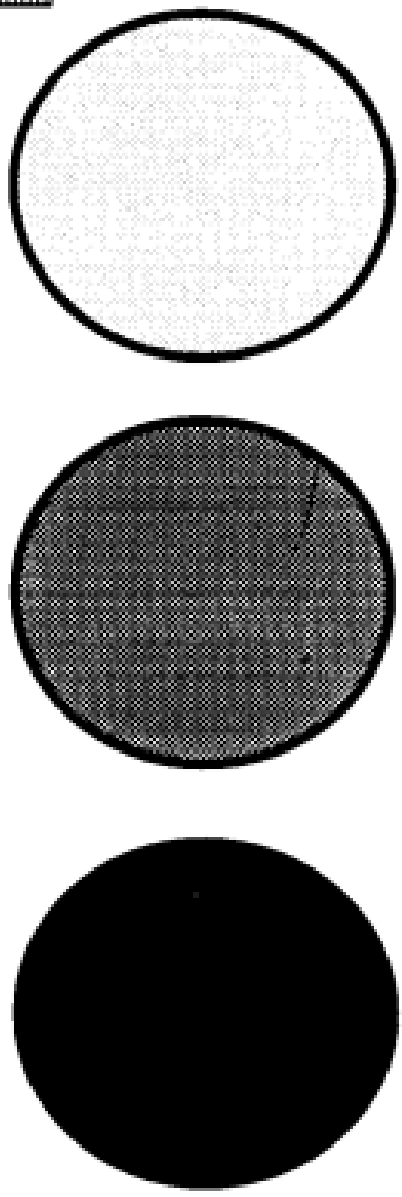
Gillian Eagle is a psychology lecturer at Wits University

SECTION

C

Health and Welfare Responses to Violence

Violent situations often require emergency responses. What is being done to ensure that resources and sufficient emergency service workers are available? Health and welfare workers are establishing projects in communities to address the various effects of violence. As immediate responses to the situation, these projects often involve purely curative work, although emphasis is increasingly being placed on preventative measures to help people cope with trauma or curb violence, both in communities and within the household.



The Role of Emergency Services Groups

SAHSSO

At the launch of the South African Health and Social Services Organization (SAHSSO) in July 1992, guest speakers from the civic and liberation movements appealed to SAHSSO to respond to the emergency needs of our people in the current wave of political violence.

Emergency response work has been a major component of the work done by the progressive health movement during the repression of the 1980s and 1990s. This work was set up during the first state of emergency in the mid 1980s. This was a necessary response to state repression and violence and the very real threat people faced when seeking medical attention for wounds sustained in the violence. Against all standards of humanitarian behaviour, wounded activists were arrested and harassed at doctors' surgeries and in hospitals.

The response to this by the progressive health and legal sector was to run weekend workshops to train people in basic first aid, counselling skills and legal rights.

The first aid training taught people to recognize the severity of injuries in order to assess the risk from injury against that of victimization in a situation where a person's condition was serious. Trained people were equipped with first aid kits to treat a number of conditions such as bleeding, shock, tear gas toxicity and broken bones. Emphasis was placed on the most common and likely injuries such as gun shot wounds from live ammunition and birdshot, blunt and sharp instruments, for example, batons and pangas.

The programme was coordinated nationally and operated in many regions, for example, PWV, western and eastern Cape, Border, Natal, OFS, Transkei and northern Transvaal. Set up by NAMDA, the project was run as a combined project with OASSSA, Detainee Support Committee and HWA/SAHWCO and regional structures where they existed.

The programme was managed by a small staff complement and volunteers from each organization.

What did ESGs achieve?

Large numbers of activists were trained in counselling skills and first aid. The programme also concerned itself with the plight of hunger strikers, the medico-

legal assessment of political prisoners and trade unionists injured by police. Considerable numbers of ex-detainees and political prisoners were helped by this programme.

One of the weaknesses of the project was that the counselling services were largely once off visits with referrals and not an established service with full time staff to treat PTSD and other effects of detention. The clients were seen by committed doctors and therapists in their voluntary capacity who worked on a roster basis. This service was only available for limited number of hours a day. This often meant a waiting list of clients waiting around for health workers who might have emergencies in their full-time jobs.

Problems with the first aid training were largely related to decisions about who should be trained. Trainees were selected from communities by community structures. Committed participants often had high political profiles. The police in fact often arrested the full ESG team during times of political activity. They would be released after a few days, effectively immobilizing them as first aiders when they were needed most. This was not incidental, they were arrested and questioned precisely around this activity. The programme often faced the dilemma of who to train and who would be most reliable and available. The training was very expensive with trainees being provided with fully equipped first aid kits which were often lost or confiscated. Clearly these factors mitigated against the pro-

At play in the midst of a storm? *Photo: unknown*

gramme meeting its objectives.

The National ESG programme was formally dissolved in December 1991. A major factor in this was the lack of donor funding to sustain the programme. Also, most detainees had been released and there were fewer political prisoners. Communities were no longer requesting training for first aid, caught up in the euphoria and hope following the unbanning of the liberation movements.

The only remaining area of activity was the provision of emergency medical teams at rallies, marches and other forms of protest.

What role for this kind of work in the future?

The problem of safe access for injured persons out of unrest areas and the safe conduct of health teams into these areas is of particular concern. Provision for this is an obvious and serious omission of the National Peace Accord Document and procedure. SAHSSO should pressurize the progressive movement and the state to institute this kind of practice.

At present SAHSSO has emergency health teams which form a sub-group of SAHSSO at a regional level. In the southern Transvaal the training of health workers in the provision of first aid and emergency medicine has commenced.

The role of SAHSSO in the provision of emergency services in the present political violence remains undefined. At the launch of our region a request was made by the Soweto Civic Association (SCA) to train members of the self-defence units (SDU) basic first aid. The SCA voiced an urgent need by the civic movement for training and SAHSSO must assess whether it can undertake a programme of this nature. While SAHSSO draws its members from the health and social services sector, these activists are already employed on a full time basis and their involvement in our organization is on a voluntary basis after hours.

In order to run an effective and cohesive service for the community, community members need to be trained and equipped to deal with medical emergencies and this training has to be sustained. Clearly, SAHSSO will need full time employees to run a programme of this nature and given its present financial constraints an ESG programme at this stage seems unlikely. SAHSSO may be able to undertake the task of running weekend workshops in the various regions for the civics in order to impart basic skills around the management of injured people.

This debate needs to be urgently addressed not only by SAHSSO but also by the progressive movement and attention must be given to the provision of safe medical care to the community.

SAHSSO

The Red Cross and Emergency Services Work

International Committee of the Red Cross

Given the suggestion in the previous article of constraints experienced by progressive workers in sustaining an ESG programme, Critical Health publishes extracts from an International Committee of the Red Cross (ICRC) report on its violence related emergency services to highlight the resources available for this work. SAHSSO was approached to comment on their work in the light of the Red Cross report, and have responded that two of their members were undergoing emergency service training by the Red Cross. The issue, however, does deserve further consideration by the progressive sector.

The ICRC has been active in South Africa for almost 30 years. In the mid-1980s, in co-operation with the South African Red Cross Society (SARCS), the ICRC began community programmes in townships on the Reef. In 1988 a joint relief operation for victims of violence was started in Natal, which was extended to the Reef in 1990.

The ICRC provides support for the SARCS first-aid training programme in troubled areas. Courses aim to impart the knowledge and skills people need to help the injured in disaster situations and to encourage the creation, training and active intervention of SARCS first-aid teams in the event of unrest. Thanks to this training and preparedness, Red Cross teams cared for more than 100 of the injured at the recent shootings in Bisho, and evacuated more than 40 to hospital.

The Red Cross is involved in establishing small first-aid groups in the townships and hostels who can be speedily mobilized whenever an attack occurs. The role of the Red Cross is to function as an impartial agency which is available to assisting people injured on all sides.

The Natal side of the Red Cross programme began in mid-1988. So far, more than 80 000 people have been assisted. On the Reef, the programme began in August 1990 and has helped more than 35 000 people. Assistance to victims of violence and their families included burial vouchers, worth up to R600, provided to families to offset the cost of burying relatives who were recently killed in the violence, as well as, blankets, food, cooking pots, kitchen utensils, jerry cans and shelter to families whose dwelling and property were destroyed in the violence.

International Committee of the Red Cross

Violence in the Family:
Issues in the Counselling of Battered Women

Teresa Angless

The continuing violence in South Africa leaves no-one unaffected. Women are additionally vulnerable to violence in the form of sexual harassment, rape and battering. Many women are more likely to be injured or hurt inside the family than outside. Battering occurs in up to 50% of American and British marriages, whereas in South Africa at least one in four women are regularly beaten up by their male partners.

With this high rate of occurrence, all health workers are likely to deal with women who are battered. Professionals often add to the problems of battered women through a lack of specific training and an absence of a comprehensive policy to address battering. Health workers often adhere to damaging myths which hold women responsible for the battering and blame them for their own abuse. Some of these myths include the notion that women enjoy it, that they provoke it and that only sick men batter etc. Many battered women are repeatedly not believed. They are blamed and thereby left feeling guilty and helpless.

Analysis of Battering

Health workers need to understand battering as a social problem. They need to take into account an analysis of power relations in the broader society and how these impact on gender relations. Battering is an extreme form of the accepted dominant-submissive roles that men and women, respectively, are socialised to play. Battering is a frequently condoned way for men to re-establish control and maintain dominance. An analysis of battering which takes cognizance of these power relations should inform counselling relationships in which the main aim is the empowerment of battered women, helping them to regain access to their own strengths and skills.

Uncovering Battering in the Health Setting

Because of societal attitudes which blame women, much shame surrounds the issue of battering. Women in modern culture are largely held responsible for the success

of their relationships and so may feel bound to cover up the presence of battering.

The increasingly privatized nature of the family serves to keep much battering hidden. All too often health workers collude in this silence. The tremendous pressure of time, feelings of discomfort and helplessness as well as health workers' own prejudices can lead them to avoiding the issue, thereby sending women back to life threatening situations unaided. Women are all to readily prescribed anti-depressants and tranquillisers to 'help them cope'. These often tend to dull women's capacity to make choices and institute changes. Many battered women have gone for years without receiving help. Eventually they believe that help is not available. Health workers need to make space for battering to be disclosed and openly discussed in an accepting and non-judgemental climate. The battered women's experience needs to be validated and the complexity of the situation acknowledged. Realising someone else accepts the situation as real helps women feel less crazy and may encourage them to take steps in changing the situation.

Moving at the right pace

Working from within a medical model may create a tendency to expect instant cures. Dealing with battering requires much patience and time. The action to be taken may seem obvious to an outsider who then gives advice or dictates what should be done. Leaving a life-partner is no easy task. A woman may feel duty bound to remain with an abusive partner, especially where children are involved. Messages from family and society may reinforce this with the result that some women feel too guilty to even contemplate leaving. Women are socialised into believing that they need a man and must be dependent on him. Economic dependence and the lack of resources for single women, such as employment opportunities and child care facilities, are a real constraint. The diabolical housing shortage makes finding alternative accommodation often impossible.

Hearing about the abuse may be difficult for health workers who need to deal with their own feelings about violence, the woman and her batterer. It is important not to allow our feelings and judgements to cloud the counselling relationship. Witnessing the effects of the abuse on women may make it difficult for health workers to appreciate the tremendous ambivalence experienced by the battered woman. It is important to realise that many women may still love their partner, especially where the violence is intermittent and interspersed with good times. For all battered women there is always the hope that things will improve - letting go of this hope is perhaps one of the biggest losses battered women must face.

As with all social problems a danger of generalising is present. It is necessary to recognise the unique meaning of the relationship for each particular woman and

Health workers need to take their cue from the woman, because she is the best expert of her own situation. *Photo: Ismail Vawda*

to explore this with her. This would allow health workers to better appreciate the mixed feelings and huge loss implicit in leaving the relationship, albeit violent. Space must be provided for battered women to explore the full range of their feelings and to accept that they need to return to the relationship several times before arriving at a final decision to leave. Health workers need to take their cue from the woman, because she is the best expert on her own situation.

One effect of exposure to violence, especially verbal and emotional abuse, is a lack of trust in oneself and one's ability to make decisions. An essential component of the empowerment process is to demonstrate confidence in the woman and her ability to make the best decisions for herself.

Presenting Options - Making Choices

Health workers need to be knowledgeable on the options available to battered women and to present them in a clear and unbiased way.

Previous options made and avenues of help sought can be explored to see what has worked in the past. Options may range from staying in the home, divorce or moving suburbs and cities. Conjoint (couple) counselling should only ever be considered on the women's own request and recommendation.

Given the present socio-economic conditions and tremendous lack of resources for women, leaving a relationship permanently may not be an easy option. Avenues of protection for the woman then need to be explored. Health workers should be insisting on adequate police protection for battered women and access to interdicts should be facilitated. Community resources need to be mobilised to provide protection and emergency shelter for women and their children.

Health workers need to network with other services available to battered women and to become familiar with appropriate referral sources. Local women's organisations could be used as support networks but additional and improved state provided services need to be lobbied and fought for constantly. A policy of referral to social workers should be adopted wherever possible, and liaison with social workers should be encouraged. Battered women need advocates for legal aid and police protection. The availability of housing for single women, in general, also needs to be improved.

Perhaps the most immediate and severe service shortage is the lack of safe shelter for battered women. Presently there are only two shelters for battered women in South Africa, yet these are needed in every city and town. Other possibilities such as safe-houses or the utilisation of clinic or day hospital facilities as emergency shelter need to be explored.

Keeping accurate medical records which may expedite criminal charges is a further way in which health workers can assist. The health setting itself needs to become a place that takes battering seriously, raising awareness of the issues through in-service training, displays, posters and campaigns. Battering is a life-threatening situation which health workers cannot afford to send women back into unassisted.

Teresa Angless works for the School of Social Work at the University of Cape Town.

The Imbali Rehabilitation Programme

Bathabile Dlamini

The social damage caused by the violence cannot be statistically estimated. When you stay in the townships or any other place affected by violence, you can see that the victims are not estimated accurately because those doing the counting do so for the sake of statistics rather than for the sake of helping clients.

Clients of the Imbali Rehabilitation Programme suffer trauma, resulting from the loss of family members, loved ones and friends. When the violence was at its height, many were left with severe emotional scars. All they thought of was revenge. In our experience at Imbali, this seems to aggravate trauma because retaliation does not bring back a lost person.

Among those who have lost their closest friends or relatives are people who do not have shelter or any means of living. In order to create a means of living, these homeless people often indulge in crime. Definitely, if a person becomes involved in crime he ends up brutalizing his own people. This in itself contributes to that person's isolation from his relatives and community.

As a result of trauma many have left school and end up without a job or any means of living. When teenagers are neither in school nor at work they expend their creative minds on other, often destructive, activities.

The Project

The Imbali Rehabilitation Programme is run by a management committee of eight, and has three additional people running sub-committees in counselling, education and dispute resolution. They do so on a voluntary basis.

The programme's counselling sub-committee helps those who have been psychologically and emotionally affected by the violence. It is known that people who have traumatic experiences need help. This help must come from people they know very well, people who can keep their concerns confidential. This helps them ventilate their feelings freely knowing very well that they have confidence in the person who is treating them.

Treatment

The counselling subcommittee of the programme has already started targeting people from the community who have counseling skills and those that can be trained in counselling. Treatment has already started among clients who need assistance desperately, that is, those who have been so adversely affected by the violence that they have reached a point in which they did not care on whom they exercise their revenge. For these people, their victims could be any member of society or people they have been working with before.

There are different ways of treating traumatized people. This can be done through the one to one method of discussion with the traumatized person. You allow the person to ventilate all that is assumed to contribute to his or her situation and try to find out the circumstances that might have led to that.

We also have group work sessions where we have discussions about things that take place generally, things that can be discussed in a group situation. This is where clients find out that they are not the only ones who have a problem of trauma and they also find out that there is room for change. It also helps them to see the need for reintegrating into the family and the society. It helps them to see that their families and society need them desperately because of the roles they have played previously.

The other method of treating traumatized people is popular theatre where the traumatized act out their own experiences. This too, helps them to ventilate.

The other important aspect is community work. This is done because community members isolate people who are abusive towards them. In order to help the community accept those clients who want to return to a normal life, it is very important to explain the causes of crime, unemployment and other abnormal factors in society and the effects of these.

Difficulties

I think it will be unfair not to mention that there are those who are very difficult to treat because of lost hope, despair and loss of trust. If they see that you keep on following them up, they even harass you with the aim of keeping you away from them. The problem is that some of the traumatized people do not see that one has to keep on approaching them until they see the need for counselling. All in all, they need the help.

One should also say that it is mostly the youth that have been affected by the violence. In most cases it is young males. It is very difficult to treat a male because of their belief that women cannot keep things confidential and because of the social subordination of women.

Ultimately, permanent results can only emerge if there is no more violence and democracy can take root. *Photo: Market Theatre Photo Workshop*

Counselling can be done effectively if the violence abates. Yet the question remains: What will happen if violence erupts again? The programme functions best in consultation with the community. Such consultations, on matters concerning the community, has attracted up to 2 000 people on a regular basis. The best time to hold such meetings is at night. However, whenever there is a major upsurge in violence in the area people are daunted from attending meetings. This, in addition to our lack full time staff, affects our work severely.

This leads me to suggest that at present we are doing temporary counselling. People are still going to engage the enemy regime in order to achieve liberation. Counselling with permanent results will only begin when the black people of South Africa are liberated.

Bathabile Dlamini works at the Imbali Rehabilitation Programme in Natal

Violence Prevention through Community Development:
The Centre for Peace Action Model

Mohammed Seedat, Martin Terre Blanche, Alex Butchart and Victor Nell

Overt political violence in this country gets extensive coverage in local and international media and obscures the interpersonal violence which pervades our society. According to police statistics, there were many more cases of rape, assault, homicide and child abuse than cases of public violence in 1991. While police may have motivations for underplaying political violence, it remains true that the high profile of political violence occurs against the backdrop of largely invisible, yet endemic, interpersonal violence.

Furthermore, the origins of political violence are often understood to lie in political and socio-economic inequities, whereas interpersonal violence is explained in psychological or narrow legalistic terms, such as "criminality". This conceals the important point that, ultimately, each "type" of violence shades into and feeds upon the other - violence is always violent.

Prevention

A curative approach to the effects of interpersonal violence can strengthen the resilience of those who must return to the homes and communities in which the violence took place. But it could also entrench the myth that interpersonal violence is an individual phenomenon. It is, in fact, a social issue that should concern state and public bodies. The only good cure is cure offered in a social context in which prevention is emphasised.

For this reason, the Health Psychology Unit (UNISA) established the Eldorado Park Violence Prevention Programme in 1990. Eldorado Park is about 20km south west of Johannesburg, with an estimated population of 200 000, many of whom are unemployed or factory workers. The area is a product of apartheid, having been created 27 years ago, when so-called "coloured" people were removed from various areas around Johannesburg such as Sophiatown and Vrededorp. The programme is now called the Centre for Peace Action (CPA).

It was founded on the premise that it was necessary to introduce a combination of actions that flow from the top down and from the bottom up. Top down inter

ventions must address structural issues such as provision and monitoring of community friendly, accountable policing, improvement of living conditions and better access to good education.

Working From Below

However, because violence has become so common, many South Africans have coped with it by desensitising themselves to its occurrence and psychologically insulating themselves from its bloody horrors and its pervasive influence upon self-esteem, family life and social expectations. These effects can only be addressed by working from below and creating opportunities for ordinary people of all ages to explore and transform those facets of their own lives and environments that may have been distorted by the experience of apartheid and violence. Given the scope of the problem being addressed, an intervention such as the CPA can only be expected to have a measurable impact on violence levels in the medium to long term. This paper outlines our attempts to create a model which describes the CPA as it develops. The model is structured as a five-tier pyramid (see the table). In levels I and II (Achieving a Presence and Community Involvement), the CPA establishes itself in the community and initiates a process which results in Community Development (level III), which is a prerequisite for Attitude Change (IV) and ultimately a reduction in violence levels (V).

A Detailed View of the Centre for Peace Action Development Model:

V. Violence Reduction

- Reported violence should increase, then peak and decline.
- Actual incidents of violence should become fewer relative to baseline measures and statistics from surrounding areas.
- There should be an increased perception of personal safety.
- Individuals should indulge in risky behaviour less often.
- Particular kinds of violence (for example, women abuse, corporal punishment, gang violence) should each decrease.

IV. Attitude Change

- Feelings of hopelessness and disempowerment which may exist should subside; people should have stronger feelings of self-esteem and dignity.
- There should be greater awareness of and willingness to discuss women abuse; the stigma attached to rape and battery should disappear;
- women should be able to define the kind of oppression to which they are subjected.

· Gang violence should lose its glamour; violence should no longer be "cool".

III Community Development

· There should be a growing sense of community pride and power.
· The community should develop shared objectives, with tolerance for diversity.
· There should be numerous civic structures and groups (for example, support groups, income groups, child care groups, youth groups and small businesses) functioning autonomously from the programme.
· Existing structures should function more effectively, or (in the case of gangs) become involved in more beneficial activities.
· The programme should develop a separate identity from UNISA, becoming fully community controlled, and possibly state-funded.
· The programme should play a leading role with other community structures in developing a comprehensive health, social welfare and public safety policy for Eldorado Park; it should lobby the state for facilities.

II. Community Involvement

· The programme should offer numerous seminars, workshops, etc, geared towards community involvement.
· There should be numerous volunteer committees or groups, meeting regularly, receiving training and showing enthusiasm for their work.
· Individual counselling should become less important and group work more important.
· There should be a high through-flow of people from the community at the programme offices; people should feel comfortable about coming to the programme.
· Staff should spend much of their time outside the office.
· The programme should be seen to be offering facilities, particularly recreational facilities for youth.

I. Achieving a presence

· The programme should achieve a higher profile in the community.
· The Eldorado Park public should understand the types of services offered.
· More clients should report for counselling and other services and should express satisfaction with the service.

The CPA is currently operating mainly at levels I and II. Particular emphasis is being placed on the Centre's visibility and the degree and quality of community involvement in its activities. A movement into the arena of community development will now be under way. Activities targeted at the bottom three levels should also be expected to start having carry-over effects into levels IV and V. In other words, the pyramid should change shape over time. Some years from now, it should be roughly diamond-shaped, with the middle levels receiving most attention. Finally, it should assume an inverted pyramid shape (see the figure overleaf).

The CPA currently consists of eight core projects, namely women's services, violence intervention based at schools, family services, youth services, volunteer counselling training, small business development services, a history project and an outreach campaign. Three of these projects are briefly described below to illustrate the first three levels of the model and highlight the extent to which the CPA has succeeded in moving beyond cure and towards prevention.

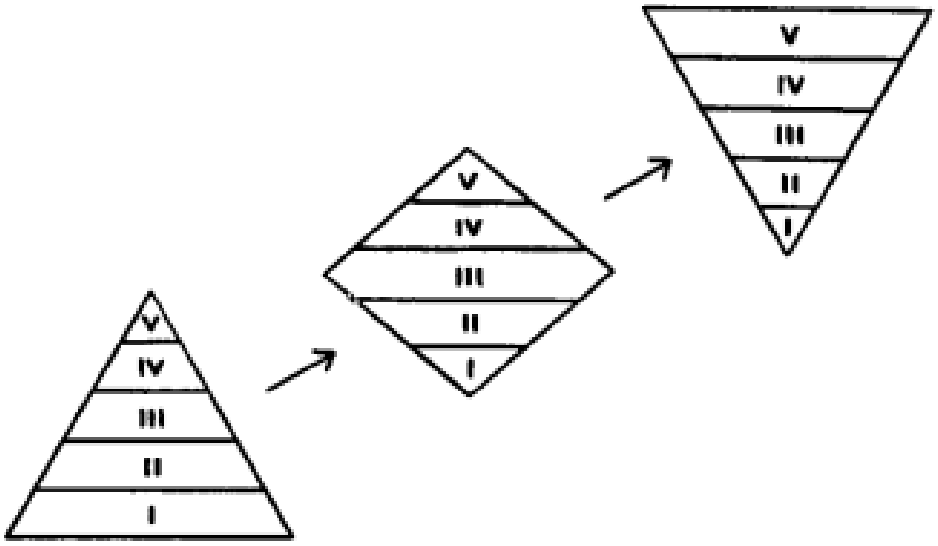
Achieving a presence: The Peace Action Campaign

A survey showed that only 10% of a sample of 100 Eldorado Park residents knew of the CPA's existence at the end of the first year of operation. A Peace Action Campaign was launched to increase the Centre's visibility and promote a culture of peace in the community. Presentations on topics relating to violence prevention were made at all 24 schools in Eldorado Park and Klipspruit West, some churches and nearby factories. Posters, banners and handbills were produced and distributed by schoolchildren. There were press releases to local and national media, radio talk shows and television appearances.

The campaign culminated in a Peace Action Week in October 1992. Individuals trained by the CPA, including volunteer counsellors and parent effectiveness trainees, graduated at an Honours Evening. Local artists, photographers and craftspeople displayed their work and dancers and rap artists performed. There was a Fun Day which included flea market stalls and various youth and family orientated activities. We have not evaluated the Campaign's impact by means of a survey, but there have been increased referrals and requests for workshops and presentations and it is clear that the Centre is considerably better known in the community.

Community Involvement: The History Project

The Eldorado Park History Project was set up so that residents can reclaim their history and culture and forge a constructive identity. The project is guided by a core



Changing Emphasis over Time. *Graphic: George Dor*

group from the community who meet weekly at the Centre to collate and edit information which has been gathered. Most information is collected through interviews with residents. The project is starting to feed information back to the community in the form of newsletters and exhibitions. It is setting in motion a process whereby knowledge is developed in and by the community, so as to reflect not only the "average" citizen's experience, but also that of individuals who are all too often side-lined in such initiatives, such as small-time gangsters, school drop-outs and shanty dwellers.

Community Development: The Small Business Project

The incidence of interpersonal violence is closely related to the availability of employment and the level of income. Therefore, the creation of income generating activities is central to a violence prevention programme. The CPA established a small business project for unemployed people. There is an intensive four week course in basic business skills and the Centre assists in raising capital to start up small businesses. It provides a consultancy and mentorship service to pre-empt crises in the new enterprises.

We have outlined a model to guide the continuing development and growth of the CPA, referring to three core projects in order to illustrate the first three developmental levels of the model - achieving a presence, engaging the community in the Centre's activities and working towards community development. It should not, however, be thought that the projects described fit neatly into different development levels, since each also has an impact at other levels. Thus the Peace Action Campaign, which was primarily intended to address level I, also resulted in a significantly increased degree of community participation (level II) and most probably had some impact at higher levels. However, the model helped to highlight

People need to reclaim their history and culture and forge a constructive identity. *Photo: Ismail Vawda*

the importance of attaining increased visibility first if the other aims of the CPA, including violence reduction, are to be met.

Broad-based and long-term interventions such as the CPA can easily lose focus, and both salaried and volunteer staff may find it difficult to relate current activities to the eventual goals of intervention. A developmental model such as that described here, provided it remains open to change and is not used prescriptively, can serve an invaluable function in orienting and structuring activities in terms of ultimate goals.

Mohammed Seedat, Martin Terre Blanche, Alex Butchart and Victor Nell work for the Health Psychology Unit at UNISA .

Casting off the Cloak of Oppression:
Countering Violence Against Women

Zubeda Dangor & Mohammed Seedat

The Eldorado Park Centre for Peace Action has a programme on the prevention of violence against women. The programme conducted a needs assessment survey prior to embarking on service provision or intervention. A hundred women were interviewed about their perceptions of violence, the most pressing problems in their area, the counselling services they knew of and the resources they would like to see established.

Survey

The results of the survey indicated that unemployment, gang violence, substance abuse and spouse abuse were major problems. The respondents also highlighted the lack of services for abused women and children. They expressed a need for a wide range of resources, including shelter, police assistance and medical attention. However, there was a powerful emphasis on curative, as opposed to preventive, resources.

Respondents raised a number of reasons why abused women do not seek help. These include fear of further abuse by their partners; the feeling that these are private matters; and shame, humiliation or ostracism in trying to seek help. They suggested that men assault their partners because of insecurity and poor self image, which combine to produce an excessive need to dominate and subordinate women. Other important factors include being under the influence of alcohol and drugs, lack of housing, financial problems and unemployment.

There are a number of possible reasons why the women interviewed requested curative, rather than preventive services. These include a limited awareness on issues of women's subordination and a helplessness and involvement with the violence in their own lives. Existing mental health services are based on individual curative treatment and there is a lack of awareness of the nature of pro-active and preventive services that could be established.

Curative services are clearly necessary for women whose lives are consumed by interpersonal violence, but pro-active, preventive services are also urgently re-

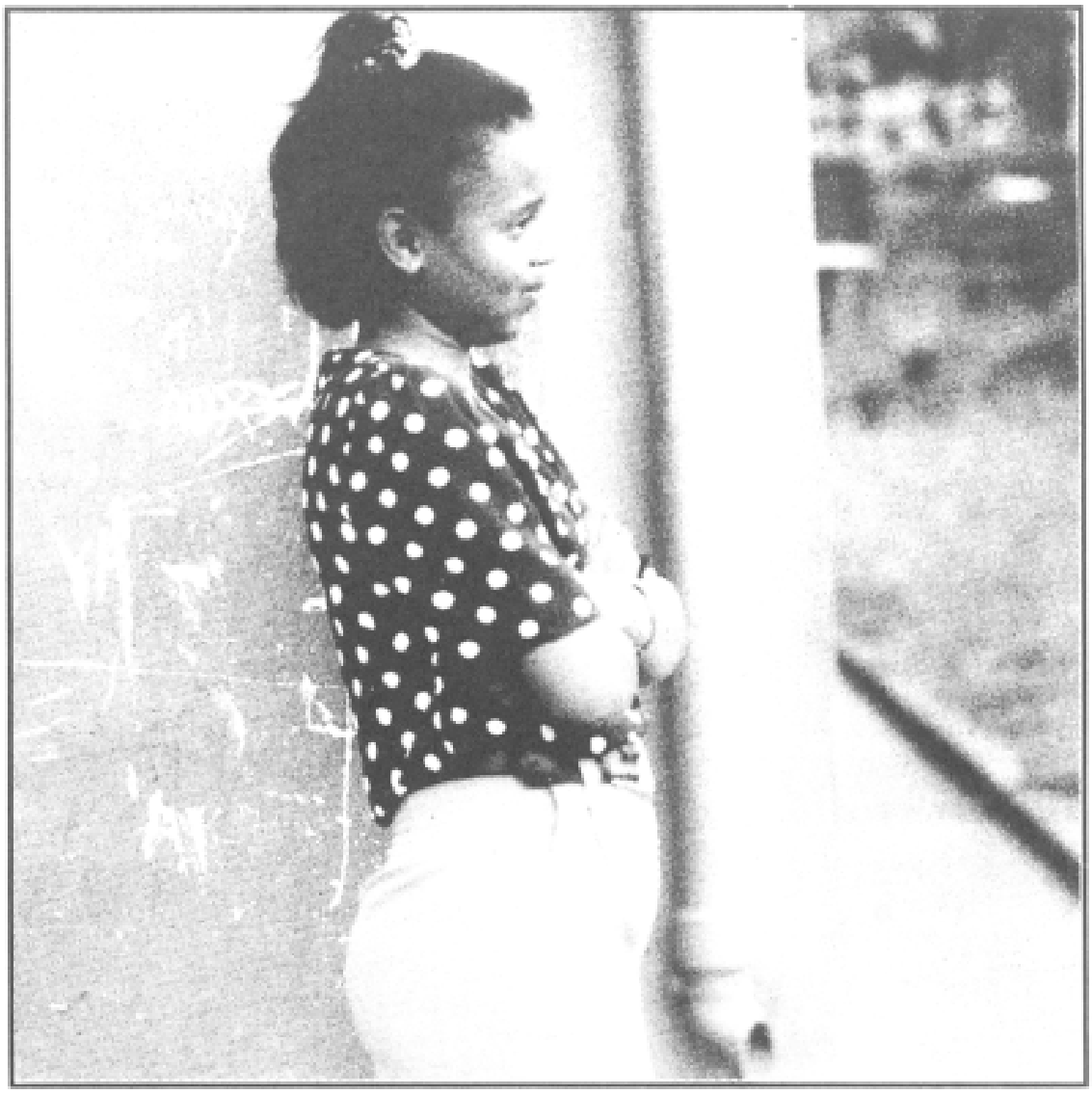
Women need to be alerted about the problems relating to violent relationships. *Photo: Naseema Saloojee*

quired. There is a need to raise awareness and educate both youth and old people that violence can not be condoned, as well as to inform women about their legal rights and to enable them to understand that violence is a social epidemic. Work also needs to begin at pre-school and primary school levels to alert children about the problems relating to violent relationships.

Curative and Preventive Services

The women's section of the Eldorado programme counsels survivors of violence, conducts community workshops and presents talks at clinics, factories and churches. It is also in the process of establishing a shelter for women who have been abused by their partners; creating, facilitating and sustaining drop-in activity groups that address the psychological needs of women; training and sensitising current social service providers who work with survivors of violence; and consolidating the existing network of safe-houses serving women survivors. Over the course of the next year, we will consider training with the South African Police with a view to preventing the re-victimisation of survivors of violence.

The services offered are based on the experiences of oppressed women. By providing these services, it is anticipated that women will first be able to break the silence regarding the abuse in their lives. Secondly, once they are able to share their problems with other women, the isolation cycle is broken and women begin to



The programme addresses the psychological needs of women. *Photo: Ismail Vawda*

appreciate the social nature of the problems of violence against women. When women as a group get together to collectively resolve an issue such as battering, the problem is initially addressed at the level of practical gender interest. It is a response to immediate perceived needs that arise from the concrete conditions of women's positioning by virtue of their gender. However, at a certain point, strategic gender interests are tackled and women decide to challenge patriarchy and male domination directly by adopting adequate measures against male violence and control.

It should be noted that the emancipation of women is a laborious and slow process. The purpose of this programme is to enable and strengthen women sufficiently so that they are able to deal with their personal lives and, having gained some strength, are able to work with other women on political issues surrounding women's lives.

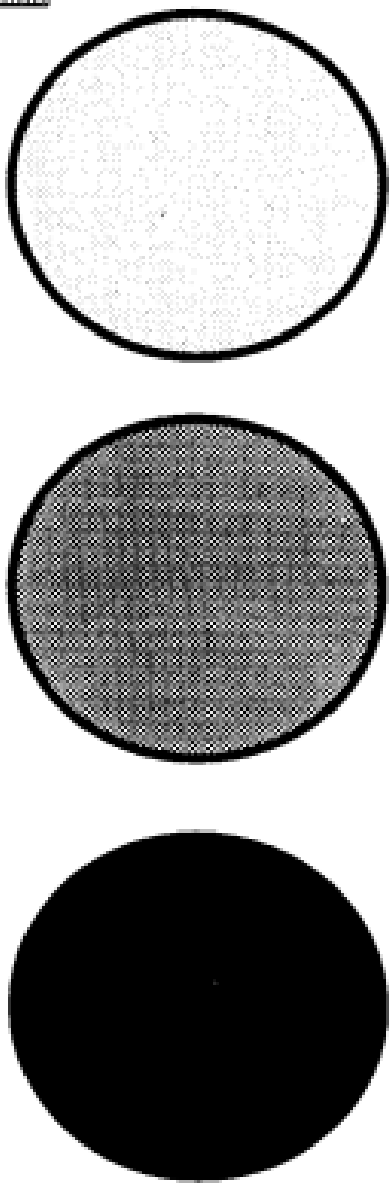
Zubeeda Dangor and Mohammed Seedat work for the Health Psychology Unit at UNISA.

SECTION

D

General Section

In 1990 Wattville residents struggled successfully for a clinic in Tamboville, but it still does not provide an adequate service. The community, together with various organisations, is now re-assessing its needs and debating the roles and responsibilities of the state, local government and community. The NNPHCN has recently released a handbook on AIDS which aims to educate people about the HIV virus and the importance of safe sex.



Health and Development
in Tamboville, East Rand

Planact

In 1990, the community of Wattville organized by their civic, the Wattville Concerned Residents Committee (WCRC), occupied land owned by the Benoni Town Council and named it Tamboville. After subsequent negotiations, the town council committed R2m for the development of serviced sites. This was a gain for the community in their struggle for land, housing and community controlled development.

One of the demands of the community was for a clinic. The existing clinic combining limited services provided by the Benoni Town Council and the Transvaal Provincial Administration (TPA) in two separate parts of a building is situated in Actonville adjacent to Wattville. The services include basic preventative health care (immunization, family planning, ante natal care, TB and few pap smears) and even some basic curative health care (first aid and services for minor ailments). The closest provincial hospital providing a wider range of services is located in Boksburg, about 15 kilometres from Wattville, and is not readily accessible in terms of cost and location.

Wider Consultation

Through negotiations in the Joint Technical Committee, representing the WCRC, and the Benoni Town Council, the local authority undertook to provide basic services from a rudimentary clinic provided by the Rotary club in Tamboville. This service now provides minimal services to Wattville residents on one day a week. However, compared with the health service needs identified by the community at a workshop in 1990, the services provided by these facilities are unsatisfactory or inaccessible.

In 1992, various health authorities including the Benoni Town Council, and non-government organisations and networks associated with the democratic movement were approached to assist the community in their initiatives to have comprehensive, integrated health care provided for Wattville residents. The Aids Centre at the South African Institute for Medical Research (SAIMR) and the National Progressive Primary Health Care Network's (NPPHCN) Aids programme have both expressed keen interest in assisting the launching of the community based Aids programmes as a component of a comprehensive primary health care project.

Through negotiations the Benoni Town Council agreed to provide serviced sites for Tamboville. *Photo: Gizelle Wulfsohn*

A working group involving the civic, the Community Health Committee and the other interested parties have been meeting to plan a coordinated approach to the planning, implementation and operationalisation of the project.

The Benoni Town Council has expressed a willingness to work with the community driven initiative, as they are investigating the integration of curative services into their clinics, a policy the TPA is trying to encourage.

Workshopping Needs

At a workshop held in October 1992, which included inputs by the SAIMR's Aids Centre, Alexandra Clinic Development Office, Planact and various members of the NPPHCN and the WCRC, the health service needs specific to the community were identified.

Various issues were discussed to assist planning for the development of the health care centre. The issues include:

- the integration of presently separated health care services;
- community participation in the planning, implementation and management of health care programmes and centres;

- access to and sustainability of resources required including building finance and running costs;
- community education and skills training;
- suitable structures and mechanisms for community-based health centres;
- the reconstruction of the roles and responsibilities of the state, community organization and other parties.

The objective of the project, it has been agreed, is the development of a comprehensive, integrated primary health care service located in a community health centre. The community health care needs were discussed within the context of present government policy and administrative framework through which such needs are not being met.

The limitations of present government policies were discussed and it become clear that despite stated policy of increased focus on a path towards primary health care, it is not being implemented. There is an absence of actual commitment as only 10% of the total national health budget is spent on these services, and rather, private health services are being hugely subsidized through medical aid contributions by employers being tax-deductible. The present policy to privatise health and other services will limit people's access to affordable services.

The situation is worsened in that health service authorities are still practicing separate development.

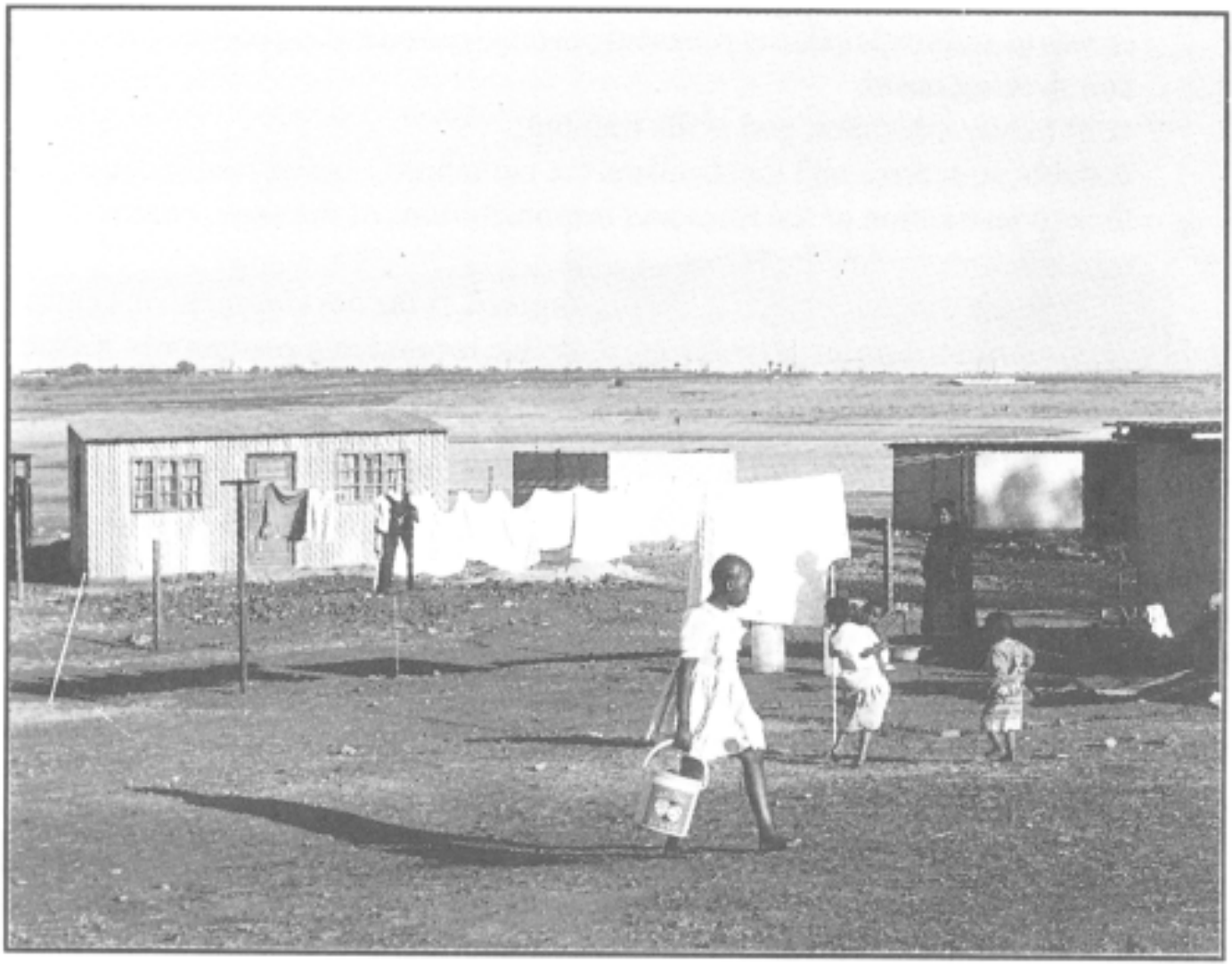
Roles and Responsibilities

Questions regarding the delivery of services and where decision making is, or should be made, were raised: who decides what services are needed; what resources are required; who should provide these; what roles and responsibilities are appropriate for the state, local government and the community.

A presentation on the current policy and the unilateral restructuring initiatives being implemented by the present government assisted discussions about planning toward objectives where health services will be adequately resourced, affordable, accessible and locally controlled.

It became clear that even when communities make demands to have their needs addressed, and even if they are to make collective local choices about how these are to be met, the problem of maintaining and sustaining what they acquire out of their struggle is dependent on the role that each of the players identified above perform. In particular the local authority with its resource base has to be integrated into implementation of plans. This is a form of joint venture between the civic and the local authority whose role and responsibility has to be defined.

In the case of Alexandra, the Clinic has collaborated with the local civic but has received most of its support through donors and Wits University and a much



Tamboville. Civics have to demand that local authorities, with their greater resource and skill base, engage in joint ventures with the civic. *Photo: Gizelle Wulfsohn*

smaller proportion from the national department of health. Alexandra Clinic has been successful in developing with little support from its wealthy neighbouring local authority, Sandton. Wattville, on the other hand, is pursuing sustained comprehensive development - which includes the construction and running of a health facility. Not having access to an institution such as Wits University, the civic has to demand responsibility from the local authority. This includes the Benoni Town Council, and the TPA, both of whom have a range of resources. Ultimately, they have a far greater resource and skill base than the civic. While Alexandra Clinic has for so long not depended on the Sandton municipality for resources, there is a responsibility of such a local authority with a rich resource base to engage in a joint venture. This applies to future negotiations between civics and local authorities in general.

In order to sustain comprehensive development the civic has to engage the local authority, including the TPA and RSC with its greater resource and skill base in

joint ventures (bearing in mind the varying levels of administrative jurisdiction these local authorities have). For example, a community might successfully get the government, local authority or private sector organization to provide the capital costs for the health centre, but may find that the policy framework of these bodies does not allow them to provide any further support to the initiative. The capital costs for a health centre would equal three years of running costs. What this means is that while it may be relatively easy to build a clinic, delivery of actual services is not guaranteed. The Benoni Council might only provide selective PHC services which, for instance, would not include counselling or treatment for people who are HIV positive because it is not within its jurisdiction to treat sick people.

Community initiated projects such as that in Tamboville may have to bear heavier costs than is anticipated when choices regarding clinic facilities are made. One of the conclusions of the workshop was that given the limitations of current state policies, communities and non-government organisations can only fill very small gaps in the health care needs of communities. For example, it has been determined that a clinic that would service Tamboville would require approximately 120 - 150 brands of medicines. It needs to be determined whether the clinic would be able to buy those medicines using the government tender which is 10 - 20% of the cost of buying privately or whether the civic would have to buy such resources at private rates.

Thoughts on the Future

Clearly, the state will have to play a much greater role in financing and maintaining services, and for this to occur efficiently the administrative structure would have to be drastically deracialised and reconstructed. This will not only mean ridding the country of present apartheid bureaucratic structures, but also clearly defining the role of democratic community institutions facilitating community participation and working with accountable management structures.

For the PHC project to be successful, it is clear that it must be based on community needs. To be effective it needs to be linked through democratic community control to reconstructing and institutionalizing relationships with the local authority. The project involves substantial investment in Wattville, and links via community structures to other needs and projects are regarded as essential. The community's strength and the advantages of integrating development planning and programmes should be built on wherever possible. This must include the strengths and skills of the community as a whole as well as integrating those resources and skills of the local authority into programmes. This will enable sectors such as education, environmental hygiene and other social sectors to take advantage of opportunities. Organizational development, management and skills training, and

The strengths and skills of the community must be utilised while avoiding uneven development. *Photo: Gizelle Wulfsohn*

other needed skills of community enterprise and institutions can also be gained.

Civic capacity must also be linked laterally between different development projects. It must be recognised that the "strengths and skills" within the community need to be addressed continuously to avoid uneven development serving some but not other community interest groups.

Projects such as the Tamboville one, have to be sure that under a future dispensation it does not allow community participation to become an excuse for the state to make communities bear the financial responsibility for under-resourced services, which the state should provide. The project must ensure that appropriate structures are set in place to facilitate community participation in management structures and policy decisions. Effective management in the transition process, at both the local and national levels, needs to be pursued.

Planact is an organisation working in the field of housing, local government and urban development.

Educating People about AIDS:
Review of *Fighting AIDS: A Handbook for Community Groups*

by National Progressive Primary Health Care Network

Critical Health

The value of education programmes in combating the spread of human immunodeficinecy virus (HIV) infection is not often appreciated. This is underlined by the initiative homosexual people took, particularly in the United States, to introduce the concept of and programmes around safer sex. The consequence of this has been a decrease in the spread of the virus among homosexuals since the 1980s.

The short-term potential of educating and changing the sexual behaviour of heterosexual people, by contrast, seems limited. Widespread success is constrained by strong religious and societal taboos and myths about sex and disease. In less developed countries it is additionally constrained by poverty and limited facilities for counselling or propagating the use of condoms. In this context, educating people about HIV and the need for safer sex as a preventative measure against the spread of the virus, requires a sensitive approach to overcoming people's myths and prejudices regarding HIV and who can be infected by it. It also requires an understanding of the societal conditions (for example, poverty, limited health services) which contribute to the spreading of the disease.

In an accessible and entertaining way, this is the approach adopted by the National AIDS Programme of the NPPHCN in its publication *Fighting AIDS*. The publication is designed to facilitate group discussion and workshops in communities, although its use of cartoons followed by simple text to elaborate and explain issues raised by the cartoon characters facilitates accessibility to individual readers. In this way *Fighting AIDS* might be a very useful guide to parents and teachers of young children as well.

The publication starts from a fairly thorough analysis of what HIV and subsequently Acquired Immuno Deficiency Syndrome (AIDS) are, the various ways in which they are spread. It also explains the meaning of safe and unsafe sex. This is followed by a discussion on treatment and people coping with the potential of themselves or their loved ones having HIV or AIDS. Suggestions are made as to the support members of the community can give to HIV or AIDS sufferers. Such involvement in supportive work is suggested as a way for people to overcome myths about how the disease is spread. The last section makes valuable suggestions

about how various communities, church and political groups could educate their peers or followers about HIV and how to prevent it. The back page contains a glossary of some of the terms used in the text.

The writers are cautious to defend the reader's right to choose their sexual practices freely and to have sex as much as they want and with as many people as they want. The point is not to extol chastity (though abstinence from sex is seen as a reasonable choice) but to promote safer sex.

Critical Health

Fighting AIDS: A Handbook for Community Groups
is published by the NPPHCN, October 1992

More information about this publication and about HIV and AIDS is obtainable from:

- **PPHCN National Aids programme (011) 337 7126/7**
- **The Community Aids Information Support Centre (Johannesburg City Health) (011) 725 6710**
- **Aids Counselling Line (Lifeline): 0800 - 012322 (toll free)**

Violence Resource List

Critical Health publishes a brief list of some of the organisations involved in trauma counselling and in dispute resolution. It is by no means comprehensive, although it is hoped that the list will be useable to community organisations and individuals affected by political and other forms of violence.

Advice, Counselling and Support

Cape Town:
1. Manenburg People's Centre
P O Box 15, Manenburg 7767
Tel: (021) 696 2200\1
2. National Institute for Crime Prevention and Rehabilitation of Offenders (NICRO)
P O Box 10005 Caledon Square, Cape Town 7905
Tel: (021) 461 7253 Fax: (021) 461 5093
3. Rape Crisis
P O Box 15496, Vlaeberg, 8018
Tel: (021) 47 9762

Durban:
1. Crisis Care
P O Box 56366, Chatsworth, 4030
Tel: (031) 43 1269\77\84 Fax: (031) 43 1239

Johannesburg:
1.Centre for Peace Action Eldorado Park)
P O Box 293, Eldorado Park, 1813
Tel: (011) 342 1140\1\2 (ask for fax line)
2.Crisis Centre Randburg
12 Selkirk Avenue, Blairgoweri
(011) 787 9555
3. Life Line
Box 95135, Grant Park
(011) 728 1347
4. NICRO
4 Floor Charlsten House, Commissioner Street
(P O Box 11410 Johannesburg 2000)
(011) 295 236
5. People Opposing Women Abuse (POWA)
P O Box 93416, Yeoville, Johannesburg 2143
Tel: (011) 642 4345

6. Project for the Study of Violence Trauma Clinic
Department of Psychology, University of the Witwatersrand
P O Box Wits 2050
Tel: (011) 716 3675
7. Radio 702 Crisis Centre
35 Van Der Merwe Street, Hillbrow
Tel: (011) 642 4462
8. S A Red Cross Society
P O Box 8726, Johannesburg
Tel: (011) 29 2449
9. Soweto Help Centre
(011) 473 2505, 474 2074/ 2663

Pietermaritzburg:
1. Imbali Rehabilitation Programme
P O Box 18, Plessislaer, Natal 4500
Contact Bathabele Dlamini
at (0331) 422 768

Pretoria:
1. International Committee of the Red Cross
794 Church Street East, Sunnyside, Pretoria 0132
Tel: (012) 43 7335\6\7\8 Fax: (012) 43 4471
2. Lawyers for Human Rights (LRH)
713 Van Erkom Building, Pretoria Street, Pretoria 0001
Tel: (012) 212 135 Fax: (012) 325 6318

Conflict Resolution

Bloemfontein:
1. Bloemfontein Initiative for Reconciliation and Democracy (BIRD)
P O Box 8101, Bloemfontein 9300
Tel: (051) 48 3256 Fax: (051) 48 1580

Cape Town:
1. Centre for Intergroup Studies (CIS)
37 Grotto Road, Rondebosch, 7700
Tel: (021) 650 2503\4 Fax: (021) 685 2142
2. Quacker Peace Centre
3 Rye Road , Mowbray, Cape Town 7700
Tel: (021) 685 7800 Fax: (021) 686 8167

Durban:
1. Women for Peaceful Change Now (WPCN)
P O Box 18281 Dalbridge 4014
Tel: (031) 305 5164 Fax: (031) 301 6611

Hermanus:
1. Volmoed Trust (Volmoed)
P O Box 130, Hermanus 7200
Tel: (0283) 212-82 Fax: (0283) 23272

Johannesburg:
1. Community Dispute Resolution Trust (CDRT)
Centre for Applied Legal Studies, University of Witwatersrand
Private Bag 3, Wits 2050
Tel: (011) 339 6640\8 Fax: (011) 339 6649
2. Five Freedoms Forum (FFF)
P O Box 260 727, Excom 2023
Tel: (011) 339 2003\9 Fax: (011) 339 2920
3. Independent Mediation Service of South Africa
Auto and General House, 1 Park Road, Richmond
Tel: (011) 482 2390 Fax: (011) 726 2540
4. Women for Peace (WFP)
P O Box 87233, Houghton 2041
Tel: (011) 646 4501 Fax: (011) 646 1209
5. Koinonia Southern Africa (KSA)
P O Box 64364, Marshalltown 2107
Tel: (011) 834 64346 Fax: (011) 834 1334

Port Elizabeth:
1. South African Association for Conflict Intervention (SAACI)
University of Port Elizabeth
P O Box 1600, Port Elizabeth 6000
Tel: (041) 504 2376\2175 Fax: (041) 504 2575

Pretoria:
1. Commission for Justice and Peace - SACBC
P O Box 941, Pretoria 0001
Tel: (012) 323 6458\9 Fax: (012) 3266218

Violence Monitoring Groups

Cape Town:
1. Black Sash
5 Long Street, Mowbray, Cape Town 7700
Tel: (021) 685 3513\3814 Fax: (021) 685 7510

Johannesburg:
1. Human rights Commission (HRC)
P O Box 32723, Braamfontein 2017
Tel: (011) 403 4450
2. Project for the Study of Violence
Psychology Department, University of the Witwatersrand
P O Wits, Johannesburg 2050
(011) 716 3890

Violence, Peace and the Military

Johannesburg:
1. Conscientious Objector Support Group of South Africa (affiliate of ECC)
P O Box 591, Kengray 2100
2. End Conscription Campaign (ECC)
P O Box 537, Kengray, Johannesburg 2100
Tel: (011) 836 8423 Fax: (011) 834 3189
3. Military Research Group
P O Box 503, Lanseria 1748
Tel: (011) 701 3013\ 702 2324 Fax: (011) 702 2334

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