# An In-Depth Study on the Impact of Operation Murambatsvina/Restore Order in Zimbabwe




**ActionAid International**
**in collaboration**
**with the Counselling Services Unit (CSU),**
**Combined Harare Residents' Association (CHRA)**
**and the Zimbabwe Peace Project (ZPP)**



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## PREFACE

The right to govern is premised upon the duty to protect the governed: governments are elected to provide for the security of their citizens, that is, to promote and protect the physical and livelihood security of their citizens. In return for such security the citizens agree to surrender the powers to govern themselves by electing representatives to govern them. This is the moral contract between those who govern and those who are governed. For any government to knowingly and deliberately undermine the security of its citizens is a breach of this contract and the principle of democracy. Indeed, it removes the very foundation upon which the legitimacy of government is based. Just as there is an injunction upon health workers not to harm their patients - *'primum non nocere",* "first do no harm" - so there must be an injunction upon governments that they ensure that any action that they take or policy that they implement will not be harmful. This is the very reason why there was formed in 2001 the International Commission on Intervention and State Sovereignty of the United Nations promulgating the "Responsibility to Protect": States have an obligation to protect their citizens, and the international community has an obligation to intervene when it is evident that a state cannot or will not protect its people. This issue has been brought into sharp relief by *Operation Murambatsvina*, a widespread and systematic campaign launched by the Government of Zimbabwe in May, 2005.

ActionAid International and its partners have issued two reports on *Operation Murambatsvina* to date. The first, carried out in Harare, indicated a wide range of adverse consequences for the residents of Harare as a result of the operation[i]. This was consolidated in the second report, which reported on a nationwide survey[ii]. These two reports confirmed and extended the report of the UN Special Envoy on the forced displacements[iii]. These reports and the many other reports all adopt the same positions in general[iv]:

- That the actions of the Zimbabwe Government were precipitate, excessive and unnecessarily harsh;
- That very large numbers of people have been adversely affected;
- That very large numbers of people have been put at significantly greater risk in a variety of ways;
- That there is an urgent need for humanitarian assistance for those people affected by the operation.

Overall, the various reports indicate that one of the consequences of *Operation Murambatsvina* has been to create a 'complex emergency', placing Zimbabwe in the situation of countries undergoing civil war or low intensity conflicts. In situations of mass violence in particular, there are a wide range of interacting factors that must be addressed with urgency, and these especially implicate economic development, social capital, and human rights[v]. Much of this was raised in the report of the UN Special Envoy'.

The report of the UN Special Envoy was criticized by the Zimbabwe Government on a number of specious grounds, but, as pointed out above, the report has been corroborated in virtually every respect by local Zimbabwean research. Whilst the Government's position on further displacements, evictions, and harassment of informal traders remains unclear, there

are reports that indicate that such actions have continued after the announcement by the Vice-President of the suspension of *Operation Murambatsvina.*

Significantly, the report of the UN Special Envoy holds the Zimbabwe Government responsible for the humanitarian disaster that has followed *Operation Murambatsvina*, but was unable to apportion any specific responsibility. Whilst it is evident that the victims have generally had little opportunity to seek legal redress, and that the Zimbabwe courts have generally been unhelpful, recent judgments in the Zimbabwe courts have indicated that the Zimbabwe Republic Police [ZRP] have been acting unlawfully in the destruction of property and the confiscation of goods.

The Zimbabwe Government continues to deny all accusations and allegations, and shows little concern for the humanitarian consequences of this "disastrous venture", as it was termed by the UN Special Envoy. Whenever it is the subject of adverse reports, the Zimbabwe Government has shown a tendency to vilify and denigrate the authors of such reports, and then resorts to various delaying tactics in order to prevent discussion of such reports[vi]. For example, the Zimbabwe Government refused to give diplomatic accreditation to a high-level official of the African Union, who had come to Harare to understand the situation and report back to the AU in its meeting in Tripoli last month.

However, it is the case that many Zimbabweans are still suffering, with evictions continuing, and this present report demonstrates the consequences for the affected in a number of key thematic areas. These thematic areas where chosen in order to highlight the plight of the victims of *Operation Murambatsvina.*

A brief report on the preliminary findings from this most recent study was recently issued[vii], and the present report provides the detailed findings. A further series of reports may follow in future.

## ACKNOWLEDGMENTS

This report by ActionAid has been made possible through the commitment and conscientious contributions made by a number of AAI partners. The preparation of the Report would not have been possible without the support and valuable contributions of a large number of individuals and organisations. ActionAid warmly acknowledges this invaluable support and the welcoming response from all households and communities contacted during this survey. The Counselling Services Unit (CSU) provided invaluable material support and staff. The ActionAid team was also greatly assisted by the Combined Harare's Residents Association (CHRA) and the Zimbabwe Peace Project (ZPP), who recruited enumerators at short notice to make the whole data collection process possible. The Zimbabwe Association of Doctors for Human Rights (ZADHR), and Zimbabwe Lawyers for Human Rights (ZLHR) provided valuable counsel and advice. Finally, we must also acknowledge all the households and individuals in Harare, Bulawayo, and Mutare that agreed to be interviewed, and those who provided the additional information without which this report is not possible.

## EXECUTIVE SUMMARY

This present study is an extension and elaboration of previous work on *Operation Murambatsvina*. It arose out of the need to have more in-depth information about a number of key areas in their lives and experiences of those affected by *Operation Murambatsvina;* namely, trauma, HIV/AIDS, legal issues, and losses.

A structured questionnaire was used in the collection of data from 1,195 respondents distributed in 58 affected high density wards in 3 urban centres of Zimbabwe. The questionnaire was designed to elicit detailed information on 4 thematic areas: trauma, HIV/AIDS, legal issues, and losses in the affected communities.

Data collected was entered stored and exported into Statistical Package for Social Science (SPSS) Version 13. Subsequently, analysis was done to generate frequencies, descriptive and derived variables.

### Trauma

The effects of trauma were assessed by means of a psychiatric screening instrument (SRQ-8), and a trauma questionnaire.

The results of the SRQ - 8 indicate an exceptionally high prevalence of psychological disorder. A total of 824 persons gave responses in the clinically significant range, 4 or more, which gave a prevalence rate of 69%. As regards an estimate of how many people will need assistance, it can be conservatively estimated that about 820,000 individuals are in need of psychological assistance, but the actual figure is likely to be higher.

Statistical analysis indicated a number of significant relationships between psychological disorder, as measured by the SRQ-8, and trauma. Our data indicated the following:

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

There are also interesting relations between psychological disorder and the contribution of trauma reported by time period. The strongest relationship is with trauma reported in 2005, but the trend is towards increasing levels since the 1990s.

As regards the types of trauma reported, there is the general trend towards Harare reporting more frequent trauma than Mutare and Bulawayo respectively. A general trend was observed, of trauma due to *Operation Muramabatsvina*, which remained the same across the three sites: *lack of food or water* was the most frequent trauma reported across all three sites.

We also examined the relationship between the frequency of trauma types over time, since it is important to understand the cumulative burden of trauma. As can be seen from the table below, there was variation between the three sites over the past few decades, and the pattern overall reflects the known history of each of these periods.

| | Harare | **Bulawayo** | **Mutare** |
|---|---|---|---|
| <1980 | 27.4% | 45.1% | 46.4% |
| 1980-1987 | 30% | 58.3% | 47.3% |
| 1990-1997 | 57.4% | 62.4% | 70.3% |
| 1998-2000 | 80.5% | 65.3% | 89.5% |
| 2001-2004 | 88.9% | 81.6% | 97.9% |
| 2005 | 97.4% | 93.3% | 100% |

Both the frequencies and the mean trauma scores have increased over the years, with a large increase in both from 1998 onwards, which corresponds more or less exactly to the development of the current Zimbabwe crisis. It is noteworthy that the highest frequencies and mean trauma scores are recorded this year, strongly suggesting that *Operation Murambatsvina* has had serious consequences for the mental health of those people affected.

**Trauma over the years: Frequency of trauma items reported**

| | **<1980** | **1980-1987** | **1990-1997** | **1998-2000** | **2001-2004** | **2005** |
|---|---|---|---|---|---|---|
| **Mean Total Trauma scores:** | 1.1 [3.1] | 1.3 [1.6] | 1.3 [1.6] | 3.1 [3.1] | 4.4 [3.4] | 6.2 [3.5] |

**HIV/AIDS**

In the present study, we asked specifically about HIV/AIDS, and the data indicated that 23% of the sample was hosting at least one individual with HIV/AIDS. This was considerably higher than in the previous study – 23% as opposed to 13%. This represents a conservative number of households of about 5,407: this is an absolute minimum of 5,000 individuals whose lives are at risk. Of course, households may have more than one individual suffering from HIV/AIDS, and thus the actual number affected is much higher than this.

The effects on those with HIV/AIDS have been extremely severe. In almost every area, this sample has experienced a loss of care and treatment. The group has even lost access to nutritional support.

Our data also showed that, in every area of care and treatment, the HIV/AIDS households have seen significant and negative changes [see table over]. There is little change in access to clinics, but it must be remembered that most clinics can offer little in the way of medical treatment, except for opportunistic infections. However, very large percentages have lost access to care and treatment, with significantly high numbers receiving no care or treatment.

**Care and Treatment of members with HIV/AIDS**

| | **Before OM** | **After OM** |
|---|---|---|
| **Who was providing care?** | | |
| Family members | 74% | 68% |

| | | |
|---|---|---|
| Trained home-based care providers | 63% | 24% |
| Clinic | 35% | 33% |
| No-one | 5% | 21% |
| **What treatment were/are you on?** | | |
| Nevirapine | 20% | 7% |
| ART | 61% | 33% |
| Opportunistic treatment [eg. TB] | 19% | 11% |
| No treatment | 19% | 46% |
| Other treatments | 39% | 40% |

Or data also showed that, in every area of care and treatment, the HIV/AIDS households have seen significant and negative changes. There is little change in access to clinics, but it must be remembered that most clinics can offer little in the way of medical treatment, except for opportunistic infections. However, very large percentages have lost access to care and treatment, with significantly high numbers receiving no care or treatment.

Our data on the consequences for the sufferers of HIV/AIDS are a cause for the deepest concern. The picture is wholly negative, and ranges from loss of care, even from families, and loss of nutritional support, through to the loss of vital medication, and finally to higher rates of psychological disorder. These are not unexpected results, and could have easily been anticipated in the planning of Operation Murambatsvina; certainly these consequences could have, and should have been pointed out by the Ministry of Health if it had been consulted.

**Legal issues**

As regards housing, it is common for people in situations of scarce urban housing to find more informal modes of accommodation. This may lead to the development of shanty-towns, but, in Zimbabwe's case, and based on the Zimbabwe Government's own data, this was not a serious problem in Zimbabwe. As UNHABITAT has estimated, in 2003, Zimbabwe had a slum population of about 157,000 [3.4% of the total population], a position that was very different to the general African picture.

| | | **Proportion [%]** |
|---|---|---|
| Had building destroyed | | 58% |
| Paying rates | | 76% |
| **Authorized by:** | Not authorized | 36% |
| | Council | 39% |
| | Government | 8% |
| | Politician | 10% |
| | Housing co-operative | 7% |
| Households that had lease agreements | | 34% |
| Leases in their own name | | 31% |
| **Leases in another name:** | Relative | 22% |
| | Friend | 5% |
| | Landlord | 56% |
| | Co-operative | 17% |
| Property registered with a council | | 43% |

Our data strongly endorses the views of UNHABITAT: it does not suggest a large population of slum-dwellers, but rather a population of substantial citizens. A majority was paying rates, and a majority of these had some form of authorization for their occupancy.

**Effects on property**

The effects on people's livelihoods were equally dramatic. The greater majority reported that the Operation had affected their livelihoods, with significant percentages reporting being registered and paying rates. As can also be seen, a large number reported being assaulted whilst in police custody, and the exceeding of the statutory maximum for detention seemed common also.

**Effects on livelihoods**

| | **Proportion [%]** |
|---|---|
| Operation interfered with livelihood | 70% |
| Registered traders | 36% |
| Traders paying rates to council | 47% |
| Traders not given notice | 84% |
| Mean days given as notice to stop trading | 5 - 11 days |
| Traders arrested | 40% |
| Period in police custody | 2.8 - 15 days |
| Assaulted in police custody | 27% |
| Deaths/injuries as a result of demolitions | 43% |
| Deaths/injuries as a result of police actions | 43% |

**Losses**

It is no small matter to estimate the losses of those affected by *Operation Murambatsvina*, and, as we noted earlier, there are very discrepant estimates to date.

**Actual reported losses of earnings & property**

| | **Loss of earnings** | **Loss of property** |
|---|---|---|
| | ***N=823[69%]*** | ***n=761[63%]*** |
| Total reported | Z$5,482,817,867.00 | Z$23,463,846,404.00 |
| Average reported | Z$6,661,990.12 | Z$30,832,912.49 |

The table adjacent reports the actual figures obtained from the present survey. Extrapolating these figures to the larger survey conducted by ActionAid, 69% represents 16,223 households with lost earnings, whilst 63% represents 14,812 households with losses of property. Now as can be seen from the table below, these figures are very similar to those previously reported by ActionAid.

If, however, the estimate is based on the population, and assuming that at least 2 persons were economically active in each household, then the estimated losses are much higher. Of course, it is not assumed that the property losses alter, only the earnings. Then the estimate for loss of earnings is around Z$3,975,109,573,476, with a total of Z$4,431,806,673,260 [US$2,685,943,438].

**Estimated losses [whole sample by household]**

| | Loss of earnings | Loss of property |
|---|---|---|
| total reported | Z$5,482,817,867.00 | Z$23,463,846,404.00 |
| average reported | Z$6,661,990.12 | Z$30,832,912.49 |
| total sample loss | Z$108,077,465,682.07 | Z$456,697,099,784.56 |
| loss over six months | Z$648,464,794,092.40 | |
| All losses [total] | **Z$1,105,161,893,876.96** | |
| | **US$66,979,508.72** | |

Now which figure is correct in reality – the higher or the lower – is academic in most respects, for the losses are enormous whichever figure is used, and in a population that has been struggling to survive in a highly adverse climate: the world's fastest declining economy. On the most basic figures that we have obtained, each household affected by *Operation Murambatsvina may* have lost something in the order of Z$38 million.

When the losses are seen in the context of the legal issues, then it seems clear that a very significant majority of those affected by *Operation Murambatsvina* have prima facie rights to redress and compensation, as was stated by the UN Special Envoy.

## CONCLUSIONS

### *Trauma*

Firstly, it is clear that our findings both extend and amplify the previous findings. On these findings, there can be little doubt that *Operation Murambatsvina* has had devastating effects on the mental health of those affected. It is clear that this is not due to the Operation alone, but that the organized violence and torture of the past 5 years or so has had the cumulative effect seen in the consequences of *Operation Murambatsvina.* The overall morbidity is enormous – conservatively about 800,000 persons – and reflective of the situation seen in a "complex emergency". It is noteworthy that the UN Special Envoy alludes to such a situation in her report, and the response of the United Nations subsequently reinforces that Zimbabwe has become a "complex emergency". Certainly our findings suggest a picture commensurate with a war rather than a time of peace.

It is important here to point out that we are talking about "clinically significant disorders"; that is, psychological disorders that ordinarily would require the attention of mental health professionals and that are unlikely to heal without such attention. Combined with the effects of the destruction of their homes and their livelihoods, it is even more improbable that these people will heal unaided, and there is a pressing need to develop effective psychological assistance for this population.

Our data do not allow us to specify the types of psychological disorder suffered by the population, and hence there is a pressing need for good clinical follow-up. This is imperative, since some conditions, such as depressive disorders, have higher risk than others, and the risk of suicide and para-suicide must be quickly countered, especially in the situation of high adversity that most sufferers find themselves.

***HIV/AIDS***

Again our findings extend and amplify previous findings. As our findings show, those suffering from HIV/AIDS have lost access to quality care, medical treatment, medications, nutritional support, and many have no support at all. The HIV/AIDS group was also much more likely to be suffering from a clinically significant psychological disorder. All of this was avoidable with proper planning by the Government of Zimbabwe, but no provision has been made at all, and, worse than this, there are many reports indicating that the authorities are even obstructive to attempts to assist. This is wholly unacceptable.

We wish here to make two points. Firstly, that people's lives are at risk is not acceptable, and it is clear that those suffering from HIV/AIDS have been placed now in a situation of multiple risks. This requires an emergency response from local and international groups, irrespective of whether the Zimbabwe Government accepts this or not.

Secondly, there must be serious concern for the effects in the long-term on morbidity due to HIV/AIDS. The risk of treatment-resistant HIV must now be seen as highly probable, and transmission a reality given the hazardous behaviours now reported in this group. The irresponsibility of a government taking such risks with public health in a situation of a massive epidemic beggars belief.

***Legal issues***

Our data do not support in any way the claims of the Zimbabwe Government that they were dealing with criminals or illegal dwellers. Rather our data suggest that these were substantial people, living with the acknowledgement and acceptance of the authorities, and conducting their livelihoods within the highly adverse economic climate of current Zimbabwe. These were not shanty-town dwellers, but people whose rights have been trampled upon. The prima facie evidence suggests that their rights, both personal and material, have been trampled upon, and who deserve redress and compensation.

***Losses***

The losses experienced by those affected under *Operation Murambatsvina* are clearly not trivial, but it is also very difficult to be clear about the overall extent of the losses. On our data, there have been substantial losses incurred, and these will clearly affect peoples' ability to take care of themselves and their families, with the most severe consequences being for those groups seen as particularly vulnerable. Furthermore, those who have experienced losses may well lose the right to claims for damages.

Overall, this survey has extended our previous understanding about the effects of *Operation Murambatsvina*, and can only increase concerns for the welfare of those affected. Our findings indicate the multiple ways in which people have been adversely affected, and, if Zimbabwe was not a complex emergency prior to 18 May 2005, the Zimbabwe Government's callous implementation of *Operation Murambatsvina* has now made a complex emergency a categorical fact. Our findings indicate that ordinary people are now suffering serious psychological disorder as a consequence of their treatment, and that this will seriously impede their ability to cope with the adversity that now they must face.

The duty of care owed by a government to its citizens has been wholly violated, and it is evident that the Zimbabwe Government has failed in its Responsibility to Protect. This must require the international community to take strong and positive steps to ensure both that no further harm will come to the ordinary people of Zimbabwe, and also to provide the immediate support and assistance that these people now need desperately.

## RECOMMENDATIONS

At the outset, we should state that all our previous recommendations still stand. We would wish to add a number of additional recommendations in the light of our findings:

### Medical care

The immediate setting up of a medical task force to provide medical care and treatment to those in need of care, with priority being given to those suffering from HIV/AIDS, women-headed households, and child-headed households;

### Mental health care

The immediate setting up of a mental health task force to provide treatment to those in need of care, as well as the setting up of a training and supervision system for counsellors in the affected communities. Here it must be recognized that the scale of the morbidity will a long-term commitment to care, training and supervision.

### Legal assistance

The immediate setting up of a legal task force to explore the dual issues of the rights infringed and the losses consequently incurred. Since there is a very high probability that the losses experienced by the victims and the rights infringed will be excluded from legal remedy due to prescription, there is extreme urgency for this action.

## TABLE OF CONTENTS

PREFACE ..... i
ACKNOWLEDGMENTS ..... iii
Tony to work on (please acknowledge these) ..... **Error! Bookmark not defined.**
EXECUTIVE SUMMARY ..... iv
RECOMMENDATIONS ..... xi
TABLE OF CONTENTS ..... xii
LIST OF TABLES ..... xiii
ACRONYMS AND ABBREVIATIONS ..... xiv
1. INTRODUCTION ..... 1
2. BACKGROUND TO THE STUDY ..... 5
2.1 Trauma ..... 5
2.1.1 Trauma and complex emergencies ..... 5
2.1.2 Trauma in Zimbabwe ..... 6
2.2 Health and HIV/AIDS ..... 8
3. METHODS ..... 12
3.1 Sampling ..... 12
3.2 Sample size ..... 12
3.3 Areas surveyed ..... 12
3.3.1 Harare ..... 12
3.3.2 Bulawayo ..... 13
3.3.3 Mutare ..... 13
3.4 Instruments ..... 13
3.4.1 Self-Reporting Questionnaire [SRQ-8] ..... 13
3.4.2 Trauma Questionnaire ..... 13
3.4.3 HIV and AIDS ..... 14
3.4.4 Legal issues ..... 14
3.4.5 Losses ..... 14
3.5 Analysis ..... 14
4. RESULTS ..... 15
4.1 Trauma and Operation Murambatsvina ..... 15
4.1.1 Prevalence of psychological disorders ..... 15
4.1.2 Types of trauma ..... 15
4.1.3 Variation in types of trauma ..... 17
4.1.4 Trauma types over the years: ..... 18
4.2 HIV/AIDS ..... 20
4.3: Legal Issues ..... 23
5. CONCLUSIONS ..... 26
5.1 Trauma ..... 26
5.2 HIV/AIDS ..... 26
5.3 Legal issues ..... 27
5.4 Losses ..... 27
6. RECOMMENDATIONS ..... 28

## LIST OF TABLES

Table 1: Sampled areas and proportions sampled....12
Table 2: Prevalence of psychological disorders: Comparison of sample sites. ....15
Table 3: Comparison of scores over sample sites ....16
Table 4: Correlations between SRQ-8 and Total Trauma score per year....16
Table 5: Frequency of responses on Trauma Questionnaire:....17
Table 6: Frequency of responses on Trauma Questionnaire [Percentages and ranks] ....18
Table 7: Trauma over the years: Percentage of persons reporting trauma experience....19
Table 8: Trauma over the years: Frequency of trauma items reported....19
Table 9: Effects of OM on health of households reporting member with HIV/AIDS ....21
Table 10: Frequency of psychological disorder: ....21
Table 11: Care and Treatment of members with HIV/AIDS....22
Table 12: Changes in behaviour following OM....22
Table 13: Effects on property ....23
Table 14 Effects on livelihoods ....24
Table 15: Losses of earnings & property....24
Table 16: Estimated losses [whole sample by household] ....25

## ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| AIDS | Acquired Immuno Deficiency Syndrome |
| ARVs | Anti Retro Viral drugs |
| HIV | Human Immuno Deficiency Virus |
| MDC | Movement for Democratic Change |
| NGO | Non-Governmental Organization |
| OM | Operation Murambatsvina |
| OVT | Organized violence and torture |
| PTSD | Post-Traumatic Stress Disorder |
| PLWHA | People Living With HIV and AIDS |
| SAPP | Southern Africa Partnership Programme |
| SPSS | Statistical Package for Social Sciences |
| SRQ-8 | Self-Reporting Questionnaire |

## 1. INTRODUCTION

> ***"Depression, social withdrawal, physical disability, and loss of skilled labor all serve to degrade available human capacity, as do less tangible impacts such as a reduced sense of control over events and circumstances. Events and conditions also frequently lead to wide disruption of the social ecology of a community, involving social relations within families, peer groups, religious and cultural institutions, links with civic and political authorities etc. Targeted disruption of such structures and networks is often the central focus of contemporary political and military conflict."***[viii]

ActionAid International and its partners have issued two reports on *Operation Murambatsvina* to date. The first, carried out in Harare, indicated a wide range of adverse consequences for the residents of Harare as a result of the operation[ix]. This was consolidated in the second report, which reported on a nationwide survey[x]. These two reports confirmed and extended the report of the UN Special Envoy on the forced displacements[xi]. These reports and the many other reports all adopt the same positions in general[xii]:

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The report of the UN Special Envoy was criticized by the Zimbabwe Government on a number of specious grounds, but the report has been corroborated in virtually every respect by local Zimbabwean research. Whilst the Government's position on further displacements, evictions, and harassment of informal traders remains unclear, there are reports that indicate that such actions have continued after the announcement by the Vice-President of the suspension of *Operation Murambatsvina.* Buildings have been demolished, and arrests of vendors continue unabated.

It is apparent that the Zimbabwe Government still continues to deny all accusations and allegations, and shows little concern for the humanitarian consequences of this "disastrous venture". However, it is the case that many Zimbabweans are still suffering, and this present report demonstrates the consequences for the affected in a number of key thematic areas. These thematic areas where chosen in order to highlight the plight of the victims of *Operation Murambatsvina.*

ActionAid International, and its partners, carried out a nation-wide survey in an attempt to understand more fully the effects of *Operation Murambatsvina*, and the findings of this survey convey a very sad and sombre picture indeed.

A total of 1,193,370 individuals were affected by Operation Murambatsvina in the six sampled urban areas. Harare was the hardest hit area accounting for 71% of individuals affected by the Operation. Bulawayo was the second worst affected nationally. However, the proportion of individuals in Bulawayo affected were less than 30% and this figure is the lowest at city or town level.

The overall population sampled was 127,587 with an average household size of 5.5. Approximately 12% of homesteads visited were headed by elders (aged over 60 years) and only 1% (142) were headed by minors (commonly referred to as child headed, below 18 years). Furthermore, children aged between 0 -17 years made up 71,691 members (or 56%) of the total population sampled. The proportion of male and female children was roughly equal (51% vs. 49%). Thirty one percent (31%) of interviewed households were hosting orphans, whilst a further 13% were hosting at least a chronically ill individual. A minority of 6% were hosting at least a mentally/physically challenged person.

The survey also inquired about the primary source of income affected by the *Operation* in terms of the sample:

- A majority (70%) of urban dwellers were engaged in informal trading[xiv] prior to "*Operation Murambatsvina*;
- The primary sources of income that were cited to have been disrupted (70%) as a result of the *Operation* include: tuck shop ownership (9%), flea market (12%), fruit and vegetable vending (17%), offering accommodation (15%), cross border trader (7%), skilled trade/artisan (13%) and petty trade (6%) such as sale of firewood;
- Formal employment was only cited by 16% of the respondents as a primary source of income, whilst a further 4% claimed not to have any source of income or livelihood activity before the Operation.

The survey also examined a wide range of factors in peoples' lives that may have been affected by *Operation Murambatsvina*, and the findings give cause for considerable concern:

**Shelter**

A majority (70%) of respondents reported that they had lost shelter. Loss of shelter was two fold: tenants being evicted as a result of demolitions, and landlords' losing sections of their homes as a result of the demolitions.

**Source of income**

76% of interviewed households reported that they had lost their sources of income. This figure was similar to the 73% that had lost primary sources of income (livelihoods) as a direct result of the *Operation*.

**Education for children**

School drop out was reported to be 22%. However, a further 44% of households interviewed reported that they were in a precarious position in funding and accessing schools for their children, currently and in future.

**Property**

Forty eight percent (48%) of households visited reported that they had incurred losses of property.

**Health**

Slightly over 25% of people interviewed attributed the deterioration of health of their loved ones as a direct result of the operation.

**Food security**

Approximately, 54% of households sampled claimed that they had become food insecure as a consequence of the *Operation*.

**Household safety and security**

Almost half (44%) of the homesteads reported that household safety and security had been compromised as a result of the operation.

**Disruption of family unit**

More than three quarters of the respondents reported losing shelter. Almost 40% of homesteads visited reported that family units had been disrupted as a result of the operation. Mostly children and spouses had been relocated to the rural homesteads or other suburbs, if this was possible.

**Increased vulnerability for women, children and orphans (OVCs)**

35% of the interviewed homesteads acknowledged that women and children had become more vulnerable to abuse as a consequence of the Operation. Furthermore, a high proportion of these were from female-headed households.

These findings, as well as the many other findings not summarized here, clearly demonstrated the multiple and severe adverse effect of *Operation Murambatsvina* on residents of the six areas surveyed, mainly in the high density suburbs.

Accordingly, ActionAid International, and its partners, made a number of recommendations for the support and assistance of those affected:

**Immediate Humanitarian Support**

1. Immediate support to restore school attendance to at least 24,332 children recorded in the survey who are not attending school as a direct result of the operation.
2. Medium term measure support to ensure a further 26,244 children do not drop out of school.
3. Direct livelihood restoration support to at least 164,602 households of small traders who lost their livelihoods as a result of the operation.
4. Immediate assessment of people rendered homeless by the operation, where they are, and immediate provision of emergency shelter for this caseload.
5. Immediate targeted food aid to at least 811,899 individuals (139,982 households) affected not in holding camps and churches.
6. Immediate access to ART and quality care for people living with HIV and AIDS and are currently displaced.
7. Targeted support for displaced women headed households to reduce the multiple vulnerabilities that they face.
8. Humanitarian agencies should increase their coverage and scale up their responses to ensure greater and holistic support to the affected households.

**Medium term policy support**

1. Legislation review to support informal sector activities and restore income security for affected families that constituted 73% of the respondents in this study.
2. Inclusive planning and recovery process to ensure appropriate, pro-poor and people-centred recovery and rehabilitation process.
3. The Government of Zimbabwe should be accountable for the upholding of civil and human rights for all affected households.
4. Greater donor response to the humanitarian imperative, and support to civil society response programmes for more effective coverage.
5. Deliberate scaling up of access to information and awareness to ensure that affected households are informed of their entitlements and where to secure them.

Regrettably, these recommendations have been almost wholly ignored by the Zimbabwe Government, as have been the recommendations of the UN Special Envoy. The Zimbabwe Government persists in claiming the necessity for the Operation, denies the adverse consequences of the Operation, and continues with forced displacements, despite stating that the Operation was complete.

## 2. BACKGROUND TO THE STUDY

As indicated above, there were a number of areas in the first two studies that seemed to deserve further attention, either because the data gathered was insufficient for a good understanding of the issue, or because the issue itself was of particular significance, or because greater understanding could be crucial to identifying the kinds of assistance that should be given to the victims of *Operation Murambatsvina*. We highlighted a number of issues in relation to trauma in the overview report, but here we deal in greater detail with this issue.

### 2.1 Trauma

Whilst there has been continual reference to the suffering of those affected by *Operation Murambatsvina*, little attention has been given to the mental health consequences of this social upheaval. Displacement always has mental health consequences, whether this is due to natural disaster or manmade events, and, in respect of the latter, this applies to whether the displacement is internal or external. For example, the prevalence of Post-Traumatic Stress Disorder [PTSD][xv] and Depression is often 2 to 3 times higher in refugee populations than in a normal population[xvi].

As was noted in the previous ActionAid International reports, significant numbers of those interviewed reported suffering trauma as a consequence of *Operation Murambatsvina*. In the first study, on Harare, almost 40% of respondents interviewed claimed that they had been traumatized by the operation, and also, despite the low proportion of child headed households, this seemed to be reported in 82% of child headed households. In the second study, very similar rates of trauma were reported, with 35% of the sample alleging that they were suffering trauma. These reports can too easily be discounted as unsubstantiated complaints in the absence of any corroborating evidence of trauma, and hence we were determined to assess the veracity of these claims, as well as to determine the need for psycho-social assistance for the victims.

#### 2.1.1 Trauma and complex emergencies

The term "complex emergency" is increasingly being used to describe situations of political conflict, in the main, that result in the massive destabilization of a state's capacity to care for its citizens[xvii]. As Mollica and his associates have put this: "A complex emergency is a social catastrophe marked by the destruction of the affected population's political, economic, socio-cultural, and health care infrastructures"[xviii]. In our view, no better description could characterize Zimbabwe today, whether or not the causes are examined.

Now complex emergencies can quite clearly occur as a consequence of natural events, as in the recent Asian tsunami or the effects of Hurricane Katrina on New Orleans, but they can also occur as a consequence of human intervention as in periods of civil war or low intensity conflict characterized by organized violence and torture. We should here therefore make a distinction between, on the one hand, accidental harm causing trauma and, on the other hand, deliberate infliction of harm as is seen in wars, civil wars, low intensity conflict, genocide, and widespread political repression.

Now we are not concerned here to describe the many ways in which trauma may be inflicted during complex emergencies, but rather wish to very briefly describe their effects[xix]. The

most obvious effects are physical, seen in illnesses and injuries, which may be short-lived, but also may lead to long-term disability. However, the most persistent consequences will be psychological, and especially if the trauma was deliberately inflicted[xx]. Here we wish to merely emphasize three points.

Firstly, the most probable long-term consequence of experiencing organized violence and torture is the development of a psychological disorder. Secondly, the probability of psychological disorder following organized violence and torture increases with the frequency of experiencing physical harm, such as torture. Thirdly, the probability of psychological disorder increases with the number of exposures to trauma such as organized violence and torture.

Given this understanding, we thus were interested to understand more clearly the statements of the victims of *Operation Murambatsvina* alleging that they were suffering from trauma. We also examined very briefly the literature relating to organized violence and torture in Zimbabwe.

### 2.1.2 Trauma in Zimbabwe

*Operation Murambatsvina* is not the first complex emergency to be seen in Zimbabwe, and, over the past three decades, Zimbabwe has suffered from national disasters, such as drought or floods, as well as a number of very serious episodes of organized violence and torture. The relevance of referring to the past disasters and conflicts is that each of these episodes has generated a number of victims of trauma, some of whom will have suffered brief reactions to the trauma, whilst others, in the absence of specialized assistance, may have gone on to develop persistent trauma disorders. For example, it has been shown that there are still many victims of the Liberation War who continue to suffer from psychological and physical disability many decades after the original trauma[xxi].

Whilst there are very few good epidemiological studies of the incidence or prevalence of disorders due to trauma in Zimbabwe, there are a number of studies that are helpful in understanding the likely picture. These studies suggest that there are a number of periods in which mass trauma has occurred:

- *The Liberation War of the 1970s;*
- *The so-called "Gukurahundi" period of the 1980s;*
- *The "Food Riots" of 1998;*
- *The violence since 2000, mainly associated, but not exclusively, with elections in 2000, 2002, and 2005;*
- *Operation Murambatsvina.*

The morbidity due to the Liberation War has been the best documented to date, and the most reliable study indicated a likely prevalence of trauma sufferers of approximately 1 adult in 10 over the age of 30 years in 1997[xxii]. There has been no specialized medical or psychological assistance for these victims, although war veterans have been beneficiaries of a number of occasions of compensation.

Morbidity due to the Gukurahundi has also received some attention. One small study in Gwanda District indicated that 5 adults in 10, over the age of 18 years, were suffering from significant psychological disorders, with over 90% of the sample reporting an experience with organized violence and torture[xxiii]. The majority of these experiences dated from the 1980s rather than the Liberation War.

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

Finally, there has been an epidemic of organized violence and torture since February 2000, and this is attested to by a vast outpouring of reports since that time. Very few studies have been done on the victims, and certainly no proper epidemiological studies. There are two indicative studies, however. The first, examining internally-displaced commercial farm workers, demonstrated that 85% of the sample were suffering clinically significant psychological disorders[xxv], whilst the second, a "snap survey" of Zimbabwean refugees in Johannesburg, Gauteng, indicated a point prevalence rate of 14% in the sample[xxvi].

These latter two studies are important for the purposes of understanding the effects of O*peration Murambatsvina* since they examine populations of displaced persons. Estimates of psychological disorders due to trauma are understandably much higher amongst refugees or internally displaced persons than they are in the general population, as they are in specific populations such as those living in complex emergencies such as civil wars, or low intensity conflicts. Estimates for the rates of psychological disorder are available for all such groups in Zimbabwe, as well as for the rates of psychological disorder in the general population.

As the studies demonstrate, the prevalence rates vary widely according to the population sampled. In studies of persons attending primary care facilities, estimates of morbidity are generally in the range of 20-30% of the total clinic population[xxvii]. These were figures taken during the late 1980s and the 1990s, and provide a base rate for the prevalence of psychological disorder in times of "peace" and relative economic stability. Studies of the victims of organized violence and torture also vary, as we have described above, depending on the scale of the violence. Clearly, studies of populations of victims – war veterans, Mozambican refugees, or displaced commercial farm workers – show much higher rates.

So which profile will fit the victims of *Operation Murambatsvina*? And here we must remember our earlier comments in respect of trauma generally: that the probability of displaying a significant psychological disorder will vary according to the type of trauma and the number of exposures to trauma.

## 2.2 Health and HIV/AIDS

With any massive displacement, and especially in the context of a complex emergency, health issues are a major concern. In the second survey, a number of issues related to health were canvassed, and these gave considerable cause for concern, as summarized below:

- **Health**: Slightly over 25% of people interviewed attributed the deterioration of health of their loved ones as a direct result of the Operation.
- **Food security**: Approximately, 54% of households sampled claimed that they had become food insecure as a consequence of the Operation. Being urban areas, most of the food supply to the family is sourced from the market.
- **Disruption of family unit**: More than 75% of the respondents reported losing shelter, and another 40% of homesteads visited reported that family units had been disrupted as a result of the Operation. Mostly children and spouses had been relocated to the rural homesteads or other suburbs if this was possible.
- **Increased vulnerability for women, children and orphans**: 35% of the interviewed homesteads acknowledged that women and children had become more vulnerable to abuse as a consequence of the Operation. Furthermore, a high proportion of these were from female-headed households.
- **Loss of quality care (Home Based Care):** The national average from the households sampled was 14% of the respondents claiming that they had lost HBC. When this data was further disaggregated to capture households hosting the chronically ill (?), it resulted in a subsequent increase to 40%. This could a result from HBC providers and recipients being dislocated by the Operation.
- **Loss of Comprehensive treatment (ARVs):** Approximately 15% of surveyed households reportedly had lost ARV treatment as a result of the Operation. Of these, 35% were households that had mentioned hosting chronically ill individuals.

Clearly, the public health consequences of displacing enormous numbers of people can be extremely serious: apart from the more obvious effects around disease, in a country like Zimbabwe with a very high number of persons suffering from HIV/AIDS, an additional number of concerns that must be addressed.

Surprisingly, the health consequences of *Operation Murambatsvina* have drawn little adverse comment from local professional bodies, apart from the Zimbabwe Association of Doctors for Human Rights [ZADHR] which has issued several public statements. In the first, ZADHR made a strong appeal to the Ministry of Health to take the necessary steps consonant with its mandate to look after citizens' health:

> *ZADHR urges the ministry of Health and Child Welfare to exert whatever influence it has on its partners at the most senior levels of government to halt these abuses and immediately institute an effective program of restitution which, at the minimum ensures that those affected be properly re-housed and nourished.*

When there was no apparent response from the Government, ZADHR issued a second statement making plain their concerns about the health issues:

> *ZADHR's particular concern for health leads us to emphasise the manifest and predictable effects of Murambatsvina in terms of*
> *(1) the likelihood of further deaths due to arbitrary physical trauma, as incurred this week in Porta Farm, as a result of the thoughtless violence of the demolition methods,*
> *(2) deaths due to exposure and hypothermia among already vulnerable children, chronically ill adults and the elderly, forced to live through nights in the open at the coldest time of the year,*
> *(3) The spread of infectious disease due to the lack of proper sanitation or water supply for hundreds of thousands of people,*
> *(4) The generation of ideal conditions for the spread of epidemic disease (eg cholera and typhoid) from those directly affected into the general population,*
> *(5) the increase in incidence of malnutrition due to the breakdown of food supplies as family income generation methods are destroyed, in a context in which basic foodstuffs are already at a premium,*
> *(6) The exacerbation of the HIV epidemic as community structures are fractured and dispersed and the vulnerability of women, adolescents and children to sexual exploitation is magnified,*
> *(7) The inevitable emergence of widespread drug-resistant HIV as treatment programmes are disrupted.*

Noting the government's claims that *Operation Murambatsvina* was part of a long-planned strategy, ZADHR further commented:

> *The speciousness of the government claim is further evidenced by the total lack of preparedness of the key Ministries of Health, Social Welfare and Education to respond to the ensuing humanitarian and health crisis. It is clear that these ministries were not even consulted let alone involved in any planning process.*

Of particular concern are the effects on persons with HIV or AIDS, as indicated in the ZADHR statement, both in terms of the possible spread of the disease and the consequences to those people with the disease. Here there two issues. The first is to do with the compromising of patients' health care through the disruption of their drug treatment, whilst the second is to do with the emergence of drug-resistant forms of the disease. These were not issues covered in any depth in the two previous surveys, and clearly it is of major concern to the public interest that the effects here of *Operation Murambatsvina* are well-understood.

### 2.3 Legal issues

There has been considerable acrimony over issues of legality; both the issues related to whether the Government was operating within the law during the operation, and also the issues related to the rights of persons whose goods were confiscated, or property destroyed. Many of these matters have been covered in other reports, and we will not deal with these except in passing reference[xxviii].

One area remains poorly understood however, and this is any information about the numbers of people who had valid permits for trading, or valid rights to the property that they owned. Here a number of court actions have been mounted, and, to date, most seem to have failed. However, two decisions are important, as they suggest that citizens' rights have been disregarded.

In the first case, Justice Cheda of the Bulawayo High Court ruled that the conduct of the ZRP in destroying shacks and buildings, and in confiscating goods from vendors, was unlawful. As he commented[xxix]:

> *"This conduct on the part of the police was unlawful. Police are empowered to enforce the law but can only do so within the confines of the law and not outside it. The indiscriminate and wanton destruction as described by applicant and not denied by first and second respondents cannot be allowed."*

An even more recent case, dealing with continued evictions, resulted in Zimbabwe Lawyers for Human Rights obtaining an uncontested injunction preventing 400 families from being evicted from the high-density suburb of Mbare[xxx]. This case raises again the question of the precipitate nature of *Operation Murambatsvina*, and the issue of whether most people may have been able to obtain legal relief from eviction or destruction of their properties[xxxi].

Useful as the small number of court actions are in understanding the limits of legality for both Government and citizens, they cannot give any impression of scale. As was noted in the second ActionAid International report, very high numbers reported losses:

- **Property**: Forty eight percent (48%) of households visited reported that they had incurred losses of property.
- **Source of income**: Overall, 76% of interviewed households reported that they had lost their sources of income. This figure is similar to the 73% that had lost primary sources of income (livelihoods) as a direct result of the Operation. The increase may be attributable to multiple sources of income that households are engaged in to ameliorate vulnerability. Strikingly, this generally affected all households in the same proportion.

The pressing issue, and one related to some of the conclusions in the report of the UN Special Envoy, is the number within this overall total that had valid rights to practice their business or occupy the property that they lived or worked in. This clearly deserved further investigation.

### 2.4 Losses

Linked to the issue of legal rights is the issue of losses incurred by those affected by the Operation. In the two previous reports by ActionAid International, attempts were made to estimate the losses incurred by the victims of *Operation Murambatsvina*. The second report estimated that Z$488,534,000.00 [US$29.5 million] were lost as a direct result of the Operation, but this did not include any data from Harare, which had been surveyed first and where no data relating to economic losses was collected. The interviewees indicated that they had sustained appreciable losses in the following areas:

- Shelter
- Sources of income
- Property

Assuming on the basis of the ActionAid data, that Harare was 60% of the national loss, then this figure would look more like Z$1,221,335,000.00 [US$73,574,397.00]. Of course, this only deals with direct losses, and does not include the potential losses of earnings from rents, selling, small scale manufacturing, services, etc.

Additionally, we should recall the comments of the recent Article IV consultation by the International Monetary Fund. Noting the massive decline in the Zimbabwe economy, the IMF commented:

> *Zimbabwe's human development indicators—once among the best in sub-Saharan Africa—have deteriorated sharply to a rank of 147th out of 177 countries in the world. More than two out of three Zimbabweans are unemployed while poverty and emigration have risen sharply. The HIV/AIDS pandemic has been left largely unchecked, with the infection rate estimated at about 25 percent of the adult population. Life expectancy has declined to below 40 years from around 60 years fifteen years ago, while child mortality has risen sharply to 126 (per 1,000 live births) from 90 in 1995, partly reflecting declining immunizations and the AIDS pandemic.*[xxxii]

Clearly the IMF has expressed considerable concern over the plight of ordinary Zimbabweans, and, in the assessment of the Executive Board of the IMF, they commented further:

> *Executive Directors expressed deep concern over the continued sharp economic and social decline in Zimbabwe, with prospects of continued triple-digit inflation, further output declines, and increased poverty. Food security is an urgent issue, given the sharp fall in agricultural production. Directors noted that stagnant export earnings and the necessary rise in food imports will squeeze non-food imports, increasing Zimbabwe's vulnerability to external shocks. In addition, the substantial humanitarian and economic consequences of "Operation Restore Order" pose further downside risks to the outlook. Directors observed that without a bold change in policy direction, the economic outlook will remain bleak, with particularly detrimental effects on the poorest segments of the population.*

Overall, the IMF report indicates the need for wide-reaching reform to be undertaken by the Zimbabwe Government in order to stop the economic decline, and ameliorate the consequences for the very poor.

Given the dearth in all these estimates, and the pessimistic views over the likely performance of the Zimbabwe economy, it is clearly important for ActionAid International to understand how Operation Murambatsvina has impeded the ability of ordinary Zimbabweans to cushion them against this exceedingly harsh economic climate.

## 3. METHODS

A structured questionnaire was used in the collection of data from 1195 respondents in 3 urban centres of Zimbabwe, namely Harare, Bulawayo, and Mutare.

**Training of enumerators:** Enumerators who had previously participated in the Operation Murambatsvina studies were engaged for this study. Training of enumerators took place at a central location, where 30, 20 and 10 enumerators from Harare, Bulawayo and Mutare, respectively, were trained on the administration of the instrument. Pre-testing and subsequent modification of the instrument took place during the training day.

### 3.1 Sampling

Administrative boundaries were used since these would help in the identification and prioritization of wards and assess the impact of the Operation and direct influence on defining livelihood characteristics of households. Furthermore, this ensured that overlapping of areas covered was avoided. Three urban areas were selected based on the previous survey, which suggested these were the worst affected areas. An enumerator was responsible for data collection in each ward over a 3 day period. A total of 58 wards were surveyed, as follows:

### 3.2 Sample size

**Table 1: Sampled areas and proportions sampled**

| Area | Number of wards | Sample size | Proportion of sample (%) |
|---|---|---|---|
| Harare | 28 | 570 | 48% |
| Bulawayo | 21 | 386 | 32% |
| Mutare | 9 | 239 | 20% |
| **Total** | **58** | **1195** | **100%** |

### 3.3 Areas surveyed

#### 3.3.1 Harare

Harare is the capital city of Zimbabwe with an estimated population at 1,444,534 based on the most recent census (excluding Chitungwiza which is home to 321,782 and Epworth, 113,884). Most industrial and commercial companies are located in Harare. Harare has 45 administrative wards and of these 30 are high density suburbs. Offices of government are located in Harare. Currently city council affairs of the city are being run by a government appointed commission after the line minister responsible for local government fired the elected opposition MDC mayor and the 45 ward councillors.

### 3.3.2 Bulawayo

Bulawayo is the second largest city in located in the south western part of Zimbabwe. Bulawayo has an estimated population of 676,787 people. Until recently Bulawayo had a thriving industrial sector however, due to perennial water shortages and the general decline in the economy, Bulawayo's industrial base has been severely compromised. Bulawayo has 29 administrative wards and of these 19 are high density suburbs. The incumbent mayor for Bulawayo is from MDC.

### 3.3.3 Mutare

Mutare is located in the Eastern highlands of Zimbabwe, a scenic tourism area, and shares the border with Mozambique. It is the third largest city in Zimbabwe, after Harare and Bulawayo, with a population of 170,106 in its 18 wards, of which 12 wards are high density suburbs. Currently, the city council is headed a government appointed commission. The elected MDC mayor was relieved of his job after accusations of mismanagement by the line ministry. However, speculation is rife that this is in retaliation after the mayor facilitated the UN Special Envoy's visit around Mutare after the commencement of her fact finding mission.

## 3.4 Instruments

### 3.4.1 Self-Reporting Questionnaire [SRQ-8]

The Self-Reporting Questionnaire [SRQ-8] is a widely-used psychiatric screening instrument, developed in Zimbabwe. It was derived from the Self-Reporting Questionnaire [SRQ-20], developed by the World Health Organization in 1980, and the SRQ-20 has been widely used in Africa as well as in other developing countries[xxxiii]. The SRQ-20 was developed in order to provide an instrument for reliably detecting non-psychotic mental disorder, and has been shown to be both valid and reliable in a large number of different African settings, including Zimbabwe[xxxiv]. The SRQ-20 has additionally been used in Zimbabwe in a number of studies of the effects of organized violence and torture[xxxv].

The SRQ-8 was derived from the SRQ-20, and shown in a Zimbabwean study to be both reliable and valid[xxxvi]. It is a simple 8 item questionnaire, investigating 8 common symptoms in the past week. All scores in excess of 4 can be taken as indicating significant psychological disorder.

### 3.4.2 Trauma Questionnaire

The Trauma Questionnaire was based on the Harvard Trauma Questionnaire [Vietnamese Version] that had been modified for use in previous Zimbabwean studies[xxxvii]. The Harvard Trauma Questionnaire has been widely used in a variety of different settings, and a number of versions have been developed for specific settings[xxxviii].

The Zimbabwean questionnaire was modified by the addition of several items that were designed to capture some aspects of *Operation Murambatsvina* that were not in the original Zimbabwean version. These items related to confiscation or destruction of property, sexual abuse other than rape, and feelings of dependency on others. This gave a 23 item questionnaire.

The Harvard Trauma Questionnaire is usually given as a screening instrument for the detection of disorders due to trauma, but in the present study this was done by means of the SRQ-8, with the Trauma Questionnaire being used purely as a method of reporting upon the kinds of trauma experienced and witnessed by the interviewees.

In respect of each item, the interviewees were asked whether they had "experienced" or "witnessed" the particular event, and were also asked in which time period they had experienced or witnessed this event. This was done in order to understand the cumulative effects of trauma on the persons being displaced or affected by *Operation Murambatsvina.*

### 3.4.3 HIV and AIDS

Previous work conducted which included collection of qualitative data in previous studies and emerging issues guided the structuring of the instrument. Further, issues raised in the Special Envoys Report also helped in the formulation of questions pertaining to HIV and AIDS. Of special interest was quality care (Home Based Care) and comprehensive care (ART and treatment to opportunistic infections). As already highlighted people living with HIV and AIDS are a special interest group since their needs are critical and due to the high HIV and AIDS prevalence rates in Zimbabwe.

### 3.4.4 Legal issues

Questions surrounding the legality of Operation Murambatsvina have been a point of contention, with the GoZ claiming that it was acting within the laws of the land. However, civic society strongly disagrees. A lot has been said on who had and had no approval on trading and construction of homes. Therefore as a follow up to this, questions were designed to capture these aspects.

### 3.4.5 Losses

The impact of Operation Murambatsvina has been debated both by civic society, actor alike and GoZ, with the later claiming minimal losses. In the national study conducted by ActionAid losses recorded were substantial. However, this was not disaggregated data. Losses were recorded as losses. In this study, an attempt is made to differentiate income and property lost as a result of the Operation.

## 3.5 Analysis

Initially, after data collection, questionnaires were screened and post-coding done. Thereafter, information collected was entered into a central data base. Subsequently, data was cleaned, processed and analyzed in using both Statistical Package for Social Sciences (SPSS) Version 13 and Microsoft Excel. In addition, a discussion was held with enumerators to gain additional insight and emerging issues that was not captured on the questionnaire.

# 4. RESULTS

## 4.1 Trauma and Operation Murambatsvina

In the following sections, we present the findings related to trauma prior independence to date.

### 4.1.1 Prevalence of psychological disorders

The results of the SRQ-8 indicate an exceptionally high prevalence of psychological disorder. A total of 824 persons gave responses in the clinically significant range, 4 or more, which gave a prevalence rate of 69%. The mean score for the whole sample [n=1195] was 4.8[sd.2.5]. This is nearly 3 times higher than previous rates obtained from a general setting in Zimbabwe, and is much more in keeping with the rates obtained from populations with obvious trauma, such as refugees or victims of war.

**Table 2: Prevalence of psychological disorders: Comparison of sample sites.**

| | **Number & Percentage** |
|---|---|
| **Harare** *[n=570]* | 458[80.4%] |
| **Bulawayo** *[n=386]* | 196[50.8%] |
| **Mutare** *[n=239]* | 170[71.1%] |

As can be seen from Table 2 above, the prevalence rates were variable of the three sites, with the highest prevalence being found in Harare. Additionally, the mean scores were highest in Harare, and, together, these two indices show greater severity for this site. This supports the earlier finding by ActionAid that Harare was more severely affected by *Operation Murambatsvina* than other areas in Zimbabwe.

As regards an estimate of how many people will need assistance, it can be conservatively estimated that about 820,000 individuals are in need of psychological assistance, but the actual figure is likely to be higher, as we only interviewed one person per household, and whole households are likely to have been as affected as the persons interviewed.

### 4.1.2 Types of trauma

Statistical analysis indicated a number of significant relationships between psychological disorder, as measured by the SRQ-8, and trauma. Here we derived a number of different scores: a Total Trauma Score [the total number of different trauma events experienced, irrespective of time], a score for items reflective of organized violence and torture [OVT items], a score for items reflective of *Operation Murambatsvina*- type events [OM items], and a score for the number of different time periods in which trauma was experienced [Different years affected].

**Table 3: Comparison of scores over sample sites**

| | SRQ-8 | Total Trauma Score | Score on OVT items | Score on OM items | No. of different years affected |
|---|---|---|---|---|---|
| **Harare** *[n=570]* | 5.4[2.3] | 6.9[4.5] | 1.5[1.7] | 3.4[2.2] | 3.8[1.4] |
| **Bulawayo** *[n=386]* | 3.7[2.5] | 5.2[3.7] | 1.2[1.5] | 2.6[1.7] | 4.1[1.4] |
| **Mutare** *[n=239]* | 4.9[2.5] | 6.7[3.6] | 1.5[1.5] | 3.1[2.03] | 4.5[1.3] |
| **Total:** | **4.8[2.5]** | **6.3[4.2]*** | **1.4[1.6]*** | **3.1[2.03]*** | **4.03[1.4]*** |

*[xxxix]

As can be seen in Table 3 above, there are regional variations in the scores derived from the questionnaires, but, overall, there are significant relationships between the probability of psychological disorder and the total number of trauma events reported [Total Trauma Score], the number of trauma events indicative of violence [OVT items], the number of trauma events indicative of displacement [OM items], and the number of different time periods in which trauma was experienced. As can be seen [footnote 24 below] the strongest relationship was with OM items on the Trauma Questionnaire.

Therefore, our data show the following:

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

Thus, our data indicate that the severity of trauma, the effects of OVT and displacements [OM items], and the number of times trauma is experienced are all significantly related to psychological disorder. There is, thus, a "dose-response" effect found, and *Operation Murambatsvina* has contributed significantly to this effect.

**Table 4: Correlations between SRQ-8 and Total Trauma score per year**

| <1980 | 1980-1987 | 1990-1997 | 1998-2000 | 2001-2004 | 2005 |
|---|---|---|---|---|---|
| 0.034 | 0.022 | 0.064* | 0.098** | 0.11** | 0.113** |

***p=0.01; **p=0.05**

Finally, as can be seen from Table 4 above, there are interesting relations between psychological disorder and the contribution of trauma reported by time period. The strongest relationship is with trauma reported in 2005, but the trend is towards increasing levels since the 1990s.

### 4.1.3 Variation in types of trauma

As can be seen from Table 5 below, there is wide variation in the types of traumatic events reported by the sample as a whole. *Lack of food or water, ill-health without access to medical care, lack of shelter, any other situation that was very frightening or feeling that life was in danger*, and *confiscation or destruction of property* were significantly more frequent than any other types of trauma reported. Additionally, *feeling dependent on others* was also markedly more frequent, and all of these together indicate the traumatic consequences of *Operation Murambatsvina*. As pointed out earlier, most of these items were included because of their hypothesized salience to *Operation Murambatsvina*, and this effect was found in fact. As can also be seen from Table 5, items related to organized violence and torture were also reported with a relatively high frequency. *Torture, imprisonment*, and *severe beatings* were reported with much the same frequency as in the reports of human rights organizations, but the traumas of ordinary life - motor traffic accidents, industrial accident, rape and sexual abuse other than rape – are less commonly reported. Although there is variation across the three sites, the rankings for thee frequencies of the various items were remarkably consistent and statistically significant [see Table 5 below].

**Table 5: Frequency of responses on Trauma Questionnaire: Experiences only [Percentages & Ranks] *[n=1195]***

| | Number | Percentage & Ranks |
|---|---|---|
| Lack of food or water | 915 | 76.6% ***[1]*** |
| Ill health without access to medical care | 580 | 48.9% ***[3]*** |
| Lack of shelter | 536 | 44.9% ***[5]*** |
| Imprisonment | 236 | 19.8% ***[16]*** |
| Serious injury | 247 | 20.7% ***[15]*** |
| Caught up in combat | 325 | 27.2% ***[10]*** |
| Rape | 79 | 6,.6% ***[22]*** |
| Forced isolation from others | 273 | 22.9% ***[14]*** |
| Being close to death | 320 | 26.8% ***[11]*** |
| Forced separation from family members | 350 | 29.3% ***[9]*** |
| Murder of family or friends | 97 | 8.1% ***[21]*** |
| Unnatural death of family or friends | 195 | 16.3% ***[17]*** |
| Murder of stranger or strangers | 48 | 4.02% ***[23]*** |
| Lost or kidnapped | 110 | 9.2%***[20]*** |
| Severe beatings | 392 | 32.8% ***[8]*** |
| Torture | 293 | 24.5% ***[12]*** |
| Motor traffic accident | 206 | 24.5% ***[12]*** |
| Industrial accident | 152 | 12.7% ***[19]*** |
| Natural disaster(flood, fire, etc) | 438 | 36.7% ***[6]*** |
| Any other situation that was very frightening or you felt that your life was in danger | 586 | 49.1% ***[2]*** |
| Confiscation or destruction of property | 582 | 48.7% ***[4]*** |
| Sexual abuse other than rape | 172 | 14.4% ***[18]*** |
| Feeling dependent on others | 436 | 36.5% ***[7]*** |

Table 6 below shows the comparative frequency of responses for the 3 sites sampled. As can be seen, there is the general trend towards Harare reporting more frequent trauma than

Mutare and Bulawayo respectively. The general trend observed above, of trauma due to *Operation Murambatsvina*, remains the same across the three sites: *lack of food or water* being the most frequent across all three sites.

**Table 6: Frequency of responses on Trauma Questionnaire [Percentages and ranks]**

| | **Harare** *[n=570]* | **Bulawayo** *[n=386]* | **Mutare** *[n=239]* |
|---|---|---|---|
| Lack of food or water | 73.3% ***[1]*** | 79.5% ***[1]*** | 79.5% ***[1]*** |
| Ill health without access to medical care | 51.2% ***[5]*** | 47.4% ***[2]*** | 43.9% ***[6]*** |
| Lack of shelter | 51.9% ***[4]*** | 32.2% ***[6]*** | 48.5% ***[5]*** |
| Imprisonment | 23.7% ***[14]*** | 15.8% ***[14]*** | 16.7% ***[16]*** |
| Serious injury | 25.1% ***[13]*** | 18.7% ***[10]*** | 13.4% ***[17]*** |
| Caught up in combat | 30.4% ***[11]*** | 16.6% ***[13]*** | 36.8% ***[7]*** |
| Rape | 8.4% ***[22]*** | 4.9% ***[22]*** | 5.2% ***[23]*** |
| Forced isolation from others | 30.5% ***[10]*** | 13.9% ***[15]*** | 18.8% ***[13]*** |
| Being close to death | 27.2% ***[12]*** | 31.9% ***[7]*** | 17.9% ***[14]*** |
| Forced separation from family members | 33.5% ***[8]*** | 18.7% ***[10]*** | 36.4% ***[8]*** |
| Murder of family or friends | 8.8% ***[21]*** | 6.7% ***[20]*** | 8.8% ***[21]*** |
| Unnatural death of family or friends | 22.9% ***[15]*** | 8.3% ***[18]*** | 13.4% ***[17]*** |
| Murder of stranger or strangers | 3.7% ***[23]*** | 1.04% ***[23]*** | 9.6% ***[20]*** |
| Lost or kidnapped | 11.2% ***[20]*** | 6.7% ***[20]*** | 8.4% ***[22]*** |
| Severe beatings | 32.1% ***[9]*** | 32.9% ***[5]*** | 34.3% ***[9]*** |
| Torture | 22.5% ***[16]*** | 30.3% ***[8]*** | 20.1% ***[12]*** |
| Motor traffic accident | 17.2% ***[17]*** | 13.9% ***[15]*** | 22.6% ***[11]*** |
| Industrial accident | 16.5% ***[18]*** | 7.5% ***[19]*** | 12.1% ***[19]*** |
| Natural disaster(flood, fire, etc) | 39.7% ***[7]*** | 17.9% ***[12]*** | 59.8% ***[2]*** |
| Any other situation that was very frightening or you felt that your life was in danger | 55.4% ***[2]*** | 33.4% ***[4]*** | 59% ***[3]*** |
| Confiscation or destruction of property | 53.9% ***[3]*** | 40.9% ***[3]*** | 48.9% ***[4]*** |
| Sexual abuse other than rape | 15.9% ***[19]*** | 9.9% ***[17]*** | 17.9% ***[14]*** |
| Feeling dependent on others | 43.2% ***[6]*** | 28.8% ***[9]*** | 33.1% ***[10]*** |

*[xl]

### 4.1.4 Trauma types over the years:

As was seen above, when we classified items on the trauma scale into hypothetical classes - *Operation Murambatsvina* [OM] and Organized Violence and Torture [OVT] - we found strong correlations between these classes and psychological disorder, as measured by the SRQ-8. We also found strong agreement between the sites over the relative frequencies of the individual trauma items. We then next examined the relationship between the frequency of trauma types over time, since it is important to understand the cumulative burden of trauma. As can be seen from Table 7 below, there was variation between the three sites over the past few decades, and this variation corresponds to the known facts about events during these times. For example, people living in Matabeleland were much more likely to suffer trauma in the period 1980-1987 than people living in other Provinces, with the combination of the mass violence accompanying Gukurahundi as well a number of very severe droughts during the 1980s. Over the years Mutare shows greater frequencies of reported trauma than the

other 2 sites, but, as was also seen earlier, Harare had greater frequencies of people with higher trauma scores (greater number of different trauma types experienced). The pattern overall reflects the known history of each of these periods.

**Table 7: Trauma over the years: Percentage of persons reporting trauma experience**

| Year range | Harare | Bulawayo | Mutare |
|---|---|---|---|
| **<1980** | 27.4%* | 45.1% | 46.4% |
| **1980 - 1987** | 30% | 58.3%* | 47.3% |
| **1990 - 1997** | 57.4% | 62.4% | 70.3%* |
| **1998 - 2000** | 80.5% | 65.3%* | 89.5% |
| **2001 - 2004** | 88.9% | 81.6% | 97.9%* |
| **2005** | 97.4% | 93.3%* | 100% |

*[xli]

As can be seen from Table 8 below, both the frequencies and the mean trauma scores have increased over the years, with a large increase in both from 1998 onwards, which corresponds more or less exactly to the development of the current Zimbabwe crisis. It is noteworthy that the highest frequencies and mean trauma scores are recorded this year, strongly suggesting that *Operation Murambatsvina* has had serious consequences for the mental health of those people affected.

**Table 8: Trauma over the years: Frequency of trauma items reported**

| | <1980 | 1980-1987 | 1990-1997 | 1998-2000 | 2001-2004 | 2005 |
|---|---|---|---|---|---|---|
| **Food** | 3.3% | 13.7% | 25.9% | 21.7% | 45.4% | 76% |
| **Medical** | 1.3% | 5% | 6.2% | 17.5% | 35% | 56.9% |
| **Shelter** | 2.6% | 5.1% | 5% | 8.9% | 15.4% | 66.4% |
| **Imprisonment** | 5.2% | 4.8% | 4.3% | 16.4% | 20.6% | 23.4% |
| **Injury** | 3.6% | 4.8% | 5.9% | 15.7% | 23.3% | 16.4% |
| **Combat** | 2.1% | 2.7% | 8% | 22.6% | 25.2% | 15.9% |
| **Rape** | 2% | 3.3% | 1.7% | 8.4% | 10.7% | 8.2% |
| **Isolation** | 3.1% | 4.4% | 2.3% | 9.1% | 12.2% | 26.8% |
| **Close to death** | 2.9% | 5.9% | 3.2% | 12.4% | 16.1% | 17.5% |
| **Separation** | 2.8% | 5.5% | 2.5% | 9.3% | 10.1% | 33.6% |
| **Murder of family** | 4.9% | 6.8% | 2.6% | 9.8% | 11.5% | 6.2% |
| **Unnatural death** | 3.4% | 6.2% | 6.1% | 12.9% | 17.9% | 14.4% |
| **Murder of stranger** | 2.8% | 4.3% | 2.1% | 8.8% | 10.5% | 5.8% |
| **Kidnapped** | 2.8% | 3.9% | 2.8% | 10.7% | 11.3% | 8.7% |
| **Severe beatings** | 6.1% | 6.9% | 5.3% | 24% | 31% | 19.9% |
| **Torture** | 5.3% | 8.1% | 2.8% | 16% | 21.7% | 13.9% |
| **Frightening time** | 2.1% | 6.2% | 4.7% | 15.9% | 19.4% | 18.8% |
| **Confiscation** | 2.3% | 3.4% | 1.3% | 6% | 14% | 56.2% |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Sexual abuse** | 2.3% | 3.8% | 2.9% | 11.5% | 17.8% | 30.3% |
| **Feeling dependent** | 1.5% | 1.8% | 3.7% | 6.4% | 14.3% | 46.4% |
| **Mean Total Trauma scores:** | **1.1[3.1]** | **1.3[1.6]** | **1.3[1.6]** | **3.1[3.1]** | **4.4[3.4]** | **6.2[3.5]** |

## 4.2 HIV/AIDS

In the previous national survey, a total of 23,511 households were surveyed, with a total population of 127,587, and an average household size of 5.5. The national survey attempted an estimation of the vulnerable groups within this overall population. These groups include; households hosting orphans, households with chronically ill members, female-headed households, elderly-headed households with no productive-age (18 to 60 years) members, and households headed by minors (less than 18 years) commonly referred to as child headed households.

As a measure of vulnerability, the analysis classified all households into the above five categories. Most households interviewed demonstrated situations exhibiting vulnerabilities in several categories (39%). The breakdown showed the following: 1 category only: 12%; 2 categories: 36%; 3 categories: 39%; 4 categories: 8% and only 4% in the 5 categories. Chronically ill individuals were found to be present in 13.4% of households surveyed. Further analysis revealed that, in these 13.4% households, a total of 23,344 individuals were chronically ill. However, we felt that both these statistics may have been an underestimation due to the stigma still attached to HIV/AIDS.

It has been estimated that the prevalence rate in Zimbabwe is approximately 25%. In the previous national survey we requested information on chronically ill individuals, those who have been ill for 3 months or longer prior to the study, and are suffering from a recurring illness, which results in loss of productive labour. This would include individuals with HIV/AIDS, TB and other long-term illnesses. Therefore, chronic illness is used as a proxy for HIV/AIDS since establishment of HIV/AIDS status would be both difficult and controversial.

In the present study, we asked specifically about HIV/AIDS, and the data indicated that 23% of the sample was hosting at least one individual with HIV/AIDS. This was considerably higher than in the previous study – 23% as opposed to 13%. This represents a conservative number of households of about 5,407: this is an absolute minimum of 5,000 individuals whose lives are at risk. Of course, households may have more than one individual suffering from HIV/AIDS, and thus the actual number affected is much higher than this.

**Table 9: Effects of OM on health of households reporting member with HIV/AIDS**

| | Proportion [previous] |
|---|---|
| Households hosting HIV/AIDS person | 23% [13%] |
| Affected by Operation Murambatsvina | 79% |
| Lost quality care [home-based care] | 61%[40%] |
| Lost comprehensive care [ARTs] | 46%[35%] |
| Lost monitoring for viral load count [CD4 cell count] | 35% |
| Deterioration in health | 65% |
| Lost treatment for opportunistic infections | 45% |
| Relocated to area where treatment and support is limited | 48% |
| Lost nutritional support | 55% |
| Lost HIV/AIDS information | 33% |
| Lost access to reproductive health support [condoms] | 22% |

As can be seen from Table 9, the effects on those with HIV/AIDS have been extremely severe. In almost every area, this sample has experienced a loss of care and treatment. The group has even lost access to nutritional support.

**Table 10: Frequency of psychological disorder:**
**Comparison of HIV/AIDS group with whole sample**

| | Households with HIV/AIDS person | Whole sample |
|---|---|---|
| Do you sleep badly | 67% | 60% |
| Do you cry more than usual | 50% | 41% |
| Do you find it difficult to enjoy your daily activities | 81% | 77% |
| Do you find it difficult to make decisions | 77% | 71% |
| Is your work suffering? | 79% | 75% |
| Are you able to play a useful part in life? | 70% | 62% |
| Has the thought of ending your life been in your mind? | 41% | 36% |
| Do you feel tired all the time? | 62% | 55% |
| Score citing at least 4 of these indicators of trauma | 75% | 69% |

As can be seen from Table 10, the consequences of trauma have been more severe on the households with HIV/AIDS sufferers, and the frequency of clinically-significant psychological is significantly higher in this group.

**Table 11: Care and Treatment of members with HIV/AIDS**

| | Before OM | After OM |
|---|---|---|
| **Who is/was providing care?** | | |
| Family members | 74% | 68% |
| Trained home-based care providers | 63% | 24% |
| Clinic | 35% | 33% |
| No-one | 5% | 21% |
| **What treatment were/are you on?** | | |
| Nevirapine | 20% | 7% |
| ART | 61% | 33% |
| Opportunistic treatment [e.g. TB] | 19% | 11% |
| No treatment | 19% | 46% |
| Other treatments | 39% | 40% |

On more detailed interviewing of the consequences, it can be seen, in Table 11 above, that, in every area of care and treatment, the HIV/AIDS households have seen significant and negative changes. There is little change in access to clinics, but it must be remembered that most clinics can offer little in the way of medical treatment, except for opportunistic infections. However, very large percentages have lost access to care and treatment, with significantly high numbers receiving no care or treatment. Here we should bear in mind the comments from ZADHR, that interruptions to HIV/AIDS treatment can have a variety of consequences, both for the individual patient and the population as a whole.

Table 12 [below] indicates the numbers now indulging in "risky" behaviour, and, as can be seen, the frequencies are not trivial. The responses are entirely what might be expected by desperate people, and a response to being placed in a situation of extreme adversity as that occasioned by Operation Murambatsvina.

**Table 12: Changes in behaviour following OM**

| Respondents that have engaged in or witnessed risky behaviour as a result of OM: | **Proportion [%]** |
|---|---|
| Casual relationship (sex) | 45% |
| Commercial sex | 50% |
| Stealing | 69% |
| Increased vulnerability and abuse of children | 44% |

In conclusion, our data on the consequences of *Operation Murambatsvina* for the sufferers of HIV/AIDS are a cause for the deepest concern. The picture is wholly negative, and ranges from loss of care, even from families, and loss of nutritional support, through to the loss of vital medication, and finally, to higher rates of psychological disorder. These are not unexpected results, and could have easily been anticipated in the planning of Operation Murambatsvina; certainly these consequences could have been predicted by the Ministry of Health if it had been consulted prior to the launching of the Operation, and should now be acknowledged by the Ministry as an expected consequence of such an Operation.

### 4.3: Legal Issues

As noted earlier, the issue of the infringements of people's legal rights has provoked considerable discussion. The Zimbabwe Government has continuously argued that *Operation Murambatsvina* was an action to contain illegal dwellings and illegal trading in order to contain crimes and criminal activities. This was doubted by the UN Special Envoy, and other authorities, who have all pointed out that the resort to the informal sector as a means of livelihood is common throughout Africa and much of the under-developed world: where the formal economy is unable to provide jobs and livelihoods, then it is logical and generally encouraged that citizens find other ways of providing for themselves and their families.

Similarly, as regards housing, it is common for people in situations of scarce urban housing to find more informal modes of accommodation. This may lead to the development of shanty-towns, but, in Zimbabwe's case, and based on the Zimbabwe Government's own data, this was not a serious problem in Zimbabwe. As UNHABITAT has estimated, in 2003 Zimbabwe had a slum population of about 157,000 [3.4% of the total population], which is relatively low in the context of the African continent[xlii].

Thus, it was of interest to examine the extent to which Zimbabwean citizens had some legal right to housing, trade and other legal rights, either formally granted or informally encouraged by the Government. This is especially so in the light of court decisions indicating that the evictions, demolitions, and arrests were outside the powers of the police.

As can be seen from Table 13 below, our data strongly endorses the views of UNHABITAT: it does not suggest a large population of slum-dwellers, but rather a population of substantial citizens. A majority was paying rates, and a majority of these had some form of authorization for their occupancy. It is common cause that the Zimbabwe Government, politicians, and Councils have supported land occupancy, and not only in the rural areas. It has been almost a litany since 2000 that lack of land has been at the base of Zimbabwe's problems.

**Table 13: Effects on property**

| | | **Proportion [%]** |
|---|---|---|
| Had building destroyed | | 58% |
| Paying rates | | 76% |
| **Authorized by:** | Not authorized | 36% |
| | Council | 39% |
| | Government | 8% |
| | Politician | 10% |
| | Housing co-operative | 7% |
| Households that had lease agreements | | 34% |
| Leases in their own name | | 31% |
| **Leases in another name:** | Relative | 22% |
| | Friend | 5% |
| | Landlord | 56% |
| | Co-operative | 17% |
| Property registered with a council | | 43% |

The effects on people's livelihoods were equally dramatic. As can be seen from Table 14 below, a sizeable majority reported that the Operation had affected their livelihoods, with significant percentages reporting being registered and paying rates. As can also be seen, a large number reported being assaulted whilst in police custody, and the degree to which the statutory maximum

period for detention was exceeded is notable. Here it is worth pointing out that this was similarly reported during the Food Riots in 1998[xliii].

**Table 14 Effects on livelihoods**

| | **Proportion [%]** |
|---|---|
| Operation interfered with livelihood | 70% |
| Registered traders | 36% |
| Traders paying rates to council | 47% |
| Traders not given notice | 84% |
| Mean days given as notice to stop trading | 5-11 days |
| Traders arrested | 40% |
| Period in police custody | 2.8 - 15 days |
| Assaulted in police custody | 27% |
| Deaths/injuries as a result of demolitions | 43% |
| Deaths/injuries as a result of police actions | 43% |

Given the recent High Court decision on the legality of police action, and the high number of persons arrested and assaulted, there must be some consideration of redress for the infringements of these citizens' fundamental rights. This should be in addition to redress for the losses incurred. However, here it must be pointed out that there is some urgency, as civil actions in Zimbabwean law are subject to prescription in time, and it is already 6 months since the commencement of the Operation. With less than 2 months remaining for registering civil claims, and as most of those affected are without the means to pursue legal action, it is highly probable that the victims of *Operation Murambatsvina* will lose their right to claim. This will be the grossest of injustices.

### 4.5 Losses

Now much of the difficulty in estimating losses depends upon the unit of analysis: whether the economic unit is the household or the individual. Additionally, estimates can also vary according to the US$ exchange rate used: in the large ActionAid survey the Z$ rate to the US$ was calculated at Z$1650 to US$1.

Working with households gives much lower estimates of losses, as is seen below in Tables 15 and 16.

**Table 15: Losses of earnings & property**

| | **Loss of earnings** | **Loss of property** |
|---|---|---|
| | ***N=823[69%]*** | ***n=761[63%]*** |
| Total reported | Z$5,482,817,867.00 | Z$23,463,846,404.00 |
| Average reported | Z$6,661,990.12 | Z$30,832,912.49 |

Table 15 reports the actual figures obtained from the present survey.

Extrapolating these figures to the larger survey conducted by ActionAid, 69% represents 16,223 households with lost earnings, whilst 63% represents 14,812 households with losses of property. Now as can be seen from Table 16, these figures are very similar to those previously reported by ActionAid.

**Table 16: Estimated losses [whole sample by household]**

| | | |
|---|---|---|
| total reported | Z$5,482,817,867.00 | Z$23,463,846,404.00 |
| average reported | Z$6,661,990.12 | Z$30,832,912.49 |
| total sample loss | Z$108,077,465,682.07 | Z$456,697,099,784.56 |
| loss over six months | Z$648,464,794,092.40 | |
| all losses [total] | Z$1,105,161,893,876.96 | |
| | US$66,979,508.72 | |

If, however, the estimate is based on the population, and assuming that at least 2 persons were economically active in each household, then the estimated losses are much higher. Of course, it is not assumed that the property losses alter, only the earnings. Then the estimate for loss of earnings is around Z$3,975,109,573,476, with a total of Z$4,431,806,673,260 [US$2,685,943,438].

Now which figure is correct in reality – the higher or the lower – is academic in most respects, for the losses are enormous whichever figure is used, and for a population group that was already below the poverty datum line/relatively deprived and struggling to survive in what is the world's fastest declining economy. On the most basic figures that we have obtained, each household affected by *Operation Murambatsvina* may have lost something in the average order of Z$38 million.

When the losses are seen in the context of the legal issues, then it is clear that a very significant majority of those affected by *Operation Murambatsvina* have prima facie rights to redress and compensation, as was stated by the UN Special Envoy. The losses are consequent on illegal actions by the Zimbabwe Government if it can be established that those affected had rights to their property and rights to be carrying out their business. However, as we pointed out above, these rights may be lost through prescription of time, and this would add further injury to an already injurious situation.

# 5. CONCLUSIONS

## 5.1 Trauma

Firstly, it is clear that our findings both extend and amplify the previous findings. On these findings, there can be little doubt that *Operation Murambatsvina* has had devastating effects on the mental health of those affected. It is clear that this is not due to the Operation alone, but that the organized violence and torture of the past 5 years or so has had the cumulative effect seen in the consequences of *Operation Murambatsvina*. The overall morbidity is enormous – conservatively about 800,000 persons – and reflective of the situation seen in a "complex emergency". It is noteworthy that the UN Special Envoy alludes to such a situation in her report, and the response of the United Nations subsequently reinforces that Zimbabwe has become a "complex emergency". **Certainly our findings suggest a picture commensurate with a war rather than a time of peace**.

It is important here to point out that we are talking about "clinically significant disorders"; that is, psychological disorders that ordinarily would require the attention of mental health professionals and that are unlikely to heal without such attention. Combined with the effects of the destruction of their homes and their livelihoods, it is even more improbable that these people will heal unaided, and there is a pressing need to develop effective psychological assistance for this population.

Our data do not allow us to specify the types of psychological disorder suffered by the population, and hence there is a pressing need for good clinical follow-up. This is imperative, since some conditions, such as depressive disorders, have higher risk than others, and the risk of suicide and para-suicide must be quickly countered, especially in the situation of high adversity that most sufferers find themselves.

## 5.2 HIV/AIDS

Again our findings extend and amplify previous findings. As our findings show, those suffering from HIV/AIDS have lost access to quality care, medical treatment, medications, nutritional support, and many have no support at all. The HIV/AIDS group was also much more likely to be suffering from a clinically significant psychological disorder. All of this was avoidable with proper planning by the Government of Zimbabwe, but no provision has been made at all, and, worse than this, there are many reports indicating that the authorities are even obstructive to attempts to assist. This is wholly unacceptable.

We wish here to make two points. Firstly, that people's lives are at risk is not acceptable, and it is clear that those suffering from HIV/AIDS have been placed now in a situation of multiple risks. This requires an emergency response from local and international groups, irrespective of whether the Zimbabwe Government accepts this or not.

Secondly, there must be serious concern for the effects in the long-term on morbidity due to HIV/AIDS. The risk of treatment-resistant HIV must now be seen as highly probable, and transmission a reality given the hazardous behaviours now reported in this group. The

irresponsibility of a government taking such risks with public health in a situation of a massive epidemic beggars belief.

### 5.3 Legal issues

Our data do not support in any way the claims of the Zimbabwe Government that they were dealing with criminals or illegal dwellers. Rather our data suggest that these were substantial people, living with the acknowledgement and acceptance of the authorities, and conducting their livelihoods within the highly adverse economic climate of current Zimbabwe. These were not shanty-town dwellers, but people whose rights have been trampled upon. The prima facie evidence suggests that their rights, both personal and material, have been trampled upon, which therefore calls for redress and compensation.

### 5.4 Losses

The losses experienced by those affected under *Operation Murambatsvina* are clearly not trivial, but it is also very difficult to be clear about the overall extent of the losses. On our data, there have been substantial losses incurred, and these will clearly affect peoples' ability to take care of themselves and their families, with the most severe consequences being for those groups seen as particularly vulnerable. Furthermore, those who have experienced losses may well lose the right to claims for damages.

Overall, this survey has extended our previous understanding about the effects of *Operation Murambatsvina*, and can only increase concerns for the welfare of those affected. Our findings indicate the multiple ways in which people have been adversely affected, and, if there was any doubt about Zimbabwe being a "complex emergency" prior to 18 May 2005, that doubt has been removed by the Zimbabwe Government's callous exercise which it labelled *Operation Murambatsvina*.

In carrying out Operation Murambatsvina the Government of Zimbabwe has not only failed to provide for the physical and livelihood security of its citizens, the essential duty of government, but has knowingly itself undertaken a campaign which has destroyed livelihoods and jeopardized the physical wellbeing of hundreds of thousands of its citizens: the Zimbabwe Government has failed in its 'Responsibility to Protect' and the international community must therefore intervene to prevent further harm to the ordinary people of Zimbabwe and to provide the humanitarian and other assistance that these people desperately need.

## 6. RECOMMENDATIONS

At the outset, we should state that all our previous recommendations still stand. We would wish to add a number of additional recommendations in the light of our findings:

### Medical care

The immediate establishment of a medical task force to provide medical care and treatment to those in need of care, with priority being given to those suffering from HIV/AIDS, women-headed households, and child-headed households;

### Mental health care

The immediate establishment of a mental health task force to provide treatment to those in need of care, as well as the setting up of a training and supervision system for counsellors in the affected communities. Here it must be recognized that the scale of the morbidity will require a long-term commitment to care, training and supervision.

### Legal assistance

The immediate setting up of a legal task force to explore the dual issues of the rights infringed and the losses consequently incurred. Since there is a very high probability that the losses experienced by the victims and the rights infringed will be excluded from legal remedy due to prescription, there is extreme urgency for this action.

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[i] See *A Study on the Impact of "Operation Murambatsvina/Restore Order" in 26 Wards of Harare High Density Housing Areas ActionAid International in Collaboration with Combined Harare Residents Association (CHRA) July 2005.*

[ii] See *A Study on the impact of "OPERATION MURAMBATSVINA/RESTORE ORDER" in Zimbabwe, ActionAid International – Southern Africa Partnership Programme (SAPP-ZIMBABWE) in collaboration with Combined Harare Residents Association (CHRA) and Zimbabwe Peace Project (ZPP), August 2005.*

[iii] See *"Report of the Fact-Finding Mission to Zimbabwe to assess the Scope and Impact of Operation Murambatsvina by the UN Special Envoy on Human Settlements Issues in Zimbabwe".*

[iv] See *Zimbabwe Human Rights NGO Forum (2005), Order out of Chaos, or Chaos out of Order? A Preliminary Report on Operation "Murambatsvina". June 2005.HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum (2005), The Aftermath of a Disastrous Venture. A Follow up report on "Operation Murambatsvina". August 2005.HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Solidarity Peace Trust (2005), Discarding the Filth. Operation Murambatsvina. Interim report on the Zimbabwean government's" urban cleansing" and forced eviction campaign May/June 2005. 27 June 2005. SOUTH AFRICA & ZIMBABWE: SOLIDARITY PEACE TRUST.*

[v] See *Mollica ,R F, Lopes Cardozo, B, Osofsky, H J, Raphael, B, Ager,A, & Salama, P(2004), Mental health in complex emergencies, LANCET, 364: 2058–67.*

[vi] See *Zimbabwe Human Rights NGO Forum (2005), The Aftermath of a Disastrous Venture. A Follow up report on "Operation Murambatsvina". August 2005.HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM.*

[vii] See *ActionAid (2005), An in-depth study on the impact of Operation Murambatsvina/Restore Order in Zimbabwe. Preliminary results. ActionAid International in collaboration with the Counselling Services Unit (CSU), Combined Harare Residents' Association (CHRA) and the Zimbabwe Peace Project (ZPP). November 2005*.

[viii] See *Agger, a., Loughry, M (2004), Science-based mental health services: Psycho-social programs*, in *Mollica, R.F. Guerra, R. Bhasin, R. & Lavelle,J (Eds), BOOK OF BEST PRACTICES. TRAUMA AND THE ROLE OF MENTALHEALTH IN POST-CONFLICT RECOVERY, Project 1 Billion: International Congress of Ministers of Health for Mental Health and Post-Conflict Recovery, 2004*.

[ix] See *A Study on the Impact of "Operation Murambatsvina/Restore Order" in 26 Wards of Harare High Density Housing Areas ActionAid International in Collaboration with Combined Harare Residents Association (CHRA) July 2005*.

[x] See *A Study on the impact of "OPERATION MURAMBATSVINA/RESTORE ORDER" in Zimbabwe, ActionAid International – Southern Africa Partnership Programme (SAPP-ZIMBABWE) in collaboration with Combined Harare Residents Association (CHRA) and Zimbabwe Peace Project (ZPP), August 2005*.

[xi] See *"Report of the Fact-Finding Mission to Zimbabwe to assess the Scope and Impact of Operation Murambatsvina by the UN Special Envoy on Human Settlements Issues in Zimbabwe"*.

[xii] See *Zimbabwe Human Rights NGO Forum (2005), Order out of Chaos, or Chaos out of Order? A Preliminary Report on Operation "Murambatsvina". June 2005.HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum (2005), The Aftermath of a Disastrous Venture. A Follow up report on "Operation Murambatsvina". August 2005.HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Solidarity Peace Trust (2005), Discarding the Filth. Operation Murambatsvina. Interim report on the Zimbabwean government's "urban cleansing" and forced eviction campaign May/June 2005. 27 June 2005. SOUTH AFRICA & ZIMBABWE: SOLIDARITY PEACE TRUST*.

[xiii] See *Mollica ,R F, Lopes Cardozo, B, Osofsky, H J, Raphael, B, Ager,A, & Salama, P(2004), Mental health in complex emergencies, LANCET, 364: 2058–67*.

[xiv] Informal trading includes; flea market, tuck shop, vending, skilled/artisan, offering accommodation, and petty trade.

[xv] Post-Traumatic Stress Disorder [PTSD] is a psychological disorder occurring the aftermath of a catastrophic stressor, such as a hurricane, or torture, and characterized by a complex of symptoms arounf intrusive thoughts, heightened physiological arousal, and other symptoms.

[xvi] See *Mollica ,R F, Lopes Cardozo, B, Osofsky, H J, Raphael, B, Ager,A, & Salama, P(2004), Mental health in complex emergencies, LANCET, 364: 2058–67*.

[xvii] See *WHO (2003), Mental health in emergencies: mental and social aspects of health of populations exposed to extreme stressors. Geneva: Department of Mental Health and Substance Dependence. WHO.*

[xviii] See again Mollica ,R F, Lopes Cardozo, B, Osofsky, H J, Raphael, B, Ager,A, & Salama, P(2004), Mental health in complex emergencies, LANCET, 364: 2058–67.

[xix] A simple description of trauma can be taken from the definition of PTSD: *"The person has experienced an event that is outside the range of usual human experience and that would be markedly distressing to almost everyone"*.

[xx] There is an extravagantly large literature dealing with the effects of organized violence and torture, but the interested reader is referred to the article mentioned above. Here see again *Mollica ,R F, Lopes Cardozo, B, Osofsky, H J, Raphael, B, Ager,A, & Salama, P(2004), Mental health in complex emergencies, LANCET, 364: 2058–67*.

[xxi] See *Reeler, A.P., Mbape,P., Matshona,J., Mhetura,J., & Hlatywayo,E. (2001), The prevalence and nature of disorders due to torture in Mashonaland Central Province, Zimbabwe, TORTURE, 11, 4-9; Reeler, A.P., & Mupinda, M. (1996), An Investigation into the psychological sequelae of Torture and Organised Violence in Zimbabwean war veterans, LEGAL FORUM, 8, 12-27*.

[xxii] See again *Reeler, A.P., Mbape,P., Matshona,J., Mhetura,J., & Hlatywayo,E. (2001), The prevalence and nature of disorders due to torture in Mashonaland Central Province, Zimbabwe, TORTURE, 11, 4-9;* See also *Amani (1998), Survivors of Torture and Organised Violence from the 1970 War of Liberation, HARARE:*

*AMANI; Amani (1998), The Psycho-Social Needs of Survivors of Organised Violence and Torture in the Community, HARARE: AMANI.*

[xxiii] See *Amani (1998), Survivors of Organised Violence in Matabeleland: Facilitating an Agenda for Development, Report of the Workshop, BULAWAYO: AMANI.* See also *CCJP & LRF (1997), Breaking the Silence Building True Peace A Report on the Disturbances in Matabeleland and the Midlands 1980 to 1989. Catholic Commission for Justice and Peace and the Legal Resources Foundation; ZIMABABWE HUMAN RIGHTS ASSOCIATION (1999), Choosing the Path to Peace and Development; Coming to Terms with Human Rights Violations of the 1982-1987 Conflict in Matabeleland and Midlands Provinces, HARARE: ZIMBABWE HUMAN RIGHTS ASSOCIATION.*

[xxiv] See *Zimbabwe Human Rights NGO Forum (1998), Human Rights in Troubled Times: An Initial Report on Human Rights Abuses During and After Food Riots in January 1998. HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum (1999), A Consolidated Report on the Food Riots 19—23 January 1998, HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM.*

[xxv] See *Amani (2002), Preliminary Report of a Survey on Internally Displaced Persons from Commercial Farms in Zimbabwe, HARARE: ZIMBABWE.*

[xxvi] See *ZTVP(2005), Zimbabweans in Gauteng. A survey on refugees and their experiences. PRETORIA: IDASA.*

[xxvii] See *Reeler, A.P.(1991), Psychological disorders in primary care and the development of clinical services: An African perspective, THE PSYCHOLOGIST, 4, 349 353; Reeler, A.P., Williams,H., & Todd,C.,H.,(1993), Psychopathology in Primary Care patients: A four year study in rural and urban settings, CENTRAL AFRICAN JOURNAL OF MEDICINE, 39, 1 8; Patel V et al. 1997. Common mental disorders in primary care in Harare: associations and risk factors. British Journal of Psychiatry 171: 60-64; Patel V et al. 1998. Outcome of common mental disorders in Harare. British Journal of Psychiatry 172: 53-57.*

[xxviii] See *Zimbabwe Human Rights NGO Forum (2005), Order out of Chaos, or Chaos out of Order? A Preliminary Report on Operation "Murambatsvina". June 2005.HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM; Zimbabwe Human Rights NGO Forum (2005), The Aftermath of a Disastrous Venture. A Follow up report on "Operation Murambatsvina". August 2005.HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM.*

[xxix] See Zimbabwe Independent, 'Police blitz unlawful', 13 August 2005.

[xxx] See The Mail & Guardian (SA), "Harare squatters win court reprieve", 10 October 2005.

[xxxi] Here see section on "Failure of the courts to dispense justice", in *Zimbabwe Human Rights NGO Forum (2005), The Aftermath of a Disastrous Venture. A Follow up report on "Operation Murambatsvina". August 2005.HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM.*

[xxxii] See *IMF (2005), Zimbabwe: 2005 Article IV Consultation—Staff Report; Public Information Notice on the Executive Board Discussion; and Statement by the Authorities of Zimbabwe October 2005. IMF Country Report No. 05/360.*

[xxxiii] See *Reeler, A.P.(1991), Psychological disorders in primary care and the development of clinical services: An African perspective, THE PSYCHOLOGIST, 4, 349-353*

[xxxiv] See *Reeler, A.P., Williams,H., & Todd,C.,H.,(1993), Psychopathology in Primary Care patients: A four-year study in rural and urban settings, CENTRAL AFRICAN JOURNAL OF MEDICINE, 39, 1-8.*

[xxxv] See *Reeler, A.P., Mbape,P., Matshona,J., Mhetura,J., & Hlatywayo,E. (2001), The prevalence and nature of disorders due to torture in Mashonaland Central Province, Zimbabwe, TORTURE, 11, 4-9;* See also *Amani (1998), Survivors of Torture and Organised Violence from the 1970 War of Liberation, HARARE: AMANI.*

[xxxvi] See *Patel, V., & Todd, C. (1996), The validity of the Shona version of the Self-Report Questionnaire (SRQ) and the development of the SRQ-8, INT.J.METHODS IN PSYCHIAT.RES., 6, 153-160.*

[xxxvii] See *Amani (1997), Report on Psychological Disorders in Clinics and Hospitals in Mount Darwin District, Mashonaland Central Province, HARARE: AMANI; Amani (1998), Report on Psychological Disorders in Clinics and Hospitals in Muzarabani District, Mashonaland Central Province, HARARE: AMANI..*

[xxxviii] See *Mollica RF, Wyshak G, de Marneffe D, Khuon F, Lavelle J. Indochinese version of the Hopkins Symptom Checklist-25: a screening instrument for the psychiatric care of refugees. Am J Psychiatry 1987; 144: 497–500.Mollica RF, Caspi-Yavin Y, Bollini P, Truong T, Tor S, Lavelle J. The Harvard Trauma*

*Questionnaire: Validating a Cross-Cultural Instrument for Measuring Torture, Trauma and Posttraumatic Stress Disorder in Indochinese Refugees. J Nerv Ment Disease. 1992; 180:111-116; Mollica RF, Caspi-Yavin Y, Lavelle J, Tor S, Yang T, Chan S, Pham T, Ryan A, de Marneffe D. The Harvard Trauma (HTQ) Manual: Cambodian, Laotian, and Vietnamese versions. Torture. 1996; Suppl 1:19-42; Mollica RF, Sarajlic N, Chernoff M, Lavelle J, Vukovic I, Massagli MP. Longitudinal study of psychiatric symptoms, disability, mortality and emigration among Bosnian refugees. JAMA 2001; 286: 546–54.*

[xxxix] Correlations (Pearson, 2-tailed): SRQ-8 and Total Trauma Score [0.42; p=0.01]; SRQ-8 and OVT Score [0.36; p=0.01]; SRQ-8 and Operation Murambatsvina (OM) Score [0.46; p=0.01]; and SRQ-8 and Number of different years affected [0.111; p=0.01].

[xl] The ranks were significantly correlated: Harare/Bulawayo [0.89; p=0.01], Harare/Mutare [0.91; p=0.01], and Bulawayo/Mutare [0.83; p=0.01].

[xli] There were significant differences between the sites for all years [Tabled=7.88; p=0.005]: **<1980** [Chi-square=81.98], **1980-1987** [Chi-square=26.22], **1990-1997** [Chi-square=64.21], **1998-2000** [Chi-square=359.02], **2000-2004** [Chi-square=703.67 ], and **2005** [Chi-square=1036.63].

[xlii] See *"Report of the Fact-Finding Mission to Zimbabwe to assess the Scope and Impact of Operation Murambatsvina by the UN Special Envoy on Human Settlements Issues in Zimbabwe".*

[xliii] See *Zimbabwe Human Rights NGO Forum (1999), A Consolidated Report on the Food Riots 19—23 January 1998, HARARE: ZIMBABWE HUMAN RIGHTS NGO FORUM.*