Integrating rehabilitation of torture victims into the public health of Iraq*

"Many who live with violence day in and day out assume that it is an intrinsic part of the human condition. But this is not so. Violence can be prevented. Violent cultures can be turned around ...Governments, communities and individuals can make a difference."

Nelson Mandela

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Abstract

For the last three decades torture has been highly prevalent in Iraq. Surveys indicate that close to 50% of households have family members who have been tortured. The traumas of two subsequent wars further add to the traumatisation of the population as does the persistent violence. Re-traumatisation makes healing difficult. As a result trauma-related disorders are likely to be the number one public health problem in Iraq.

In December 2004, the author was tasked with the responsibility of planning and implementing rehabilitation activities for victims of torture in Iraq. Basra, in southern Iraq, was chosen as the place for the first clinical treatment and rehabilitation Centre, the Al-Fuad Centre for Rehabilitation of Torture Victims (FRCT). The Centre was to function as a training institution for the entire country. In an effort to bridge the gap between vast needs and limited resources, the Centre has begun applying a public health perspective, which means to develop its work in relation to the concepts of illness prevention and health promotion. Treatment and rehabilitation, i.e. the secondary and tertiary levels of prevention, can be multiplied through the training of professionals who will be able to establish treatment facilities in new areas of Iraq. By training GPs, psychiatrists and physicians and by expanding FRCT services to victims' families, signs and symptoms of trauma can be addressed at early stages of disorder and long-term illness averted. Human Rights advocacy and legal work at the Centre will address the primary level of prevention through diminishing human rights abuses. Finally, engaging in the reconstruction of the civil society alongside other NGOs and government authorities is to build democracy, which is a cornerstone of health promotion, especially so when the illness panorama is related to violence.

Key words: Torture, rehabilitation, prevention, public health, Iraq

Background

During Saddam Hussein's rule in Iraq torture was used systematically and extensively to prevent and oppress any opposition to the Bathist regime. After the fall of Saddam Hussein's regime in 2003 the use of torture has persisted. Today, the need for rehabilitation of torture victims in Iraq is extensive. However, until recently Iraq had no services

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specifically aimed at rehabilitating torture victims, and the country's health care facilities are in need of assistance and cooperation to meet the special needs of the victims. There is no training of clinical psychologists and the number of psychiatrists is alarmingly low. The Ministry of Health (MoH) and the Ministry of Human Rights (MHR) were both troubled by the plight of those who had suffered punitive ear amputation (due to the decree 115 that was passed by Saddam in 1994 against army defectors) and the gross stigmatization they face in society. The punishment was ostentatiously aiming at instilling fear to prevent others to follow the example of the defectors.

During an assessment mission in Basra, the author was alerted to the situation of these victims both by the MoH and MHR as well as by the non-governmental organization (NGO) that had been formed by the ear amputees themselves.

Regarding torture sequelae, the picture given by NGOs and governmental officials alike was that the proportion of individuals who had been subjected to torture is high and that the torture had often been physically violent resulting in fractures, burns and sometimes life long disability, in addition to the psychological sequelae that were sometimes less obvious to the professionals interviewed. In Basra, like in other parts of Iraq, torture and executions were part of everyday oppression during the regime of Saddam Hussein.

The impressions have been substantiated by a survey by Physicians for Human Rights undertaken in Southern Iraq. During the survey 16,520 household members were interviewed. The results revealed that since 1991 nearly one out of every two families has directly experienced torture or other serious human rights violations.[1]

In addition to the sequelae of torture, during the last three decades the population of Iraq has experienced two wars: The war against Iran and the Invasion of Kuwait. During both of these wars the governorate of Basra was heavily affected due to its geographical position. Both the occupation and the recent sectarian violence have added further to the traumatisation of the population, even if not to the extreme extent in Basra as in many other areas of the country. As the violence continues, it is also the source of persistent re-traumatization of those already afflicted. This adds to the complications of treatment.

In response to the situation the International Rehabilitation Council for Torture Victims (IRCT), commenced implementation of the project "Reaching Torture Victims in Post-War Iraq: Coordinating and Facilitating Interventions to Deliver Rehabilitations Services to Iraqi Torture Victims".

Basra was chosen as the place for establishing the first center that apart from rendering clinical services would also function as a training institution for the entire country. The choice was motivated both from the needs of the population and from the practicality of Basra being relatively secure. Professionals from other provinces of Iraq could come to Basra for training. In case security would become unsatisfactory, training could be held abroad.

The aim of the Centre is to develop holistic rehabilitation methods that are culturally relevant in order to support the large numbers of torture victims. Treatment and training at the Centre would not suffice to meet the needs of the Iraqi population, no matter how well it would function. The frequency of torture and the fact that the trauma does not only affect the individual but also the family and the community at large, indicates that consequences of trauma ought to be part of the public health pro-

gramme, thus reaching larger segments of the population.

With this background, a process was initiated, beginning with the establishment of the Al-Fuad Centre for Rehabilitation of Torture Victims (FRCT). The Centre has been operating since November 2005 but was officially opened at a ceremony on the 13th of March, 2006. The opening was delayed due to security reasons. The ceremony was attended by the deputy Governor of Basra, the Head of the police, medical personnel, academics from Basra University and a large number of human rights activists for a total of 120 people.

Theoretical background of a public health perspective

Means and methods by which a governmental administration tries to improve the health status of the population in a country carry the label of public health. When financial resources are meagre and the health status poor, the public health perspective favours that prevention is given priority over treatment as it can be more cost effective, i.e. rendering more health for money. At the same time, this kind of rationality may be difficult to uphold in the face of suffering individuals, whose treatment is ignored. The right to the best attainable health for the individual has been acknowledged as a Human Right by the UN. Treatment normally has a greater acceptance in the population than prevention, the outcome of which is less visible. It thus seems likely that public health can only work well if treatment is also cared for at a reasonable level. Whereas a public health approach does not exclude treatment, outcome is measured in the entire population rather than in individuals. This is why public health will often rely on epidemiology.

Traditionally, areas of concern for public health have been nutrition and communicable diseases, occupational health and environmental health. Lately there has been a shift of focus to lifestyle related disorders, mental health and violence. In 1995, mental disorders and behaviour-related diseases were described as causing close to 50% of the loss of Disability Adjusted Life Years in a global perspective by a group of researchers from Harvard Medical School.[2] An increased awareness during the last decade of how mental disorders affect mortality[3] would probably place this group of disorders as the number one cause of loss of Disability Adjusted Life Years. Violence is one of the prominent factors that contribute to the increase of mental disorders.[4]

In Iraq there has been a growing concern of Mental Health, and the MoH has created a National Mental Health Council. Both at the national level and at the local level of the Public Health Office in Basra, there is a slowly increasing awareness of the role the widespread traumatisation of Iraq's population plays for mental health. It seems obvious that trauma and its consequences ought to be addressed in the public health planning and hopefully it will be given increasingly more attention.

From a public health perspective, the means by which the health status may be improved are prevention and health promotion. Prevention addresses the effects of identified agents of disease, trying to eradicate them or counteract their consequences, whereas health promotion is less concerned with the specific causes, but tries to enhance salutogenic factors and resilience through healthy lifestyles and good living conditions. For operational reasons prevention is often divided into primary, secondary and tertiary prevention.

The aim of primary prevention is to prevent exposure to harmful agents. It often focuses on the entire population or indi-

viduals at risk in its approach, e.g. through vaccinations against communicable diseases. Secondary prevention focuses on those who have been exposed to a harmful agent, those who are especially vulnerable among exposed individuals or those who are in early stages of developing a disease. Tertiary prevention is equal to treatment, and rehabilitation of individuals with an identified disease back into society.

The main mandate of FRCT is treatment and rehabilitation. Still, the role of FRCT ought to be seen in a public health perspective as its treatment and rehabilitative capacity obviously would not suffice in relation to the numbers of tortured and traumatized people in Iraq. Increasingly, such a perspective has been tried during the development of the project, in order to bridge the gap between the immense needs and the limited resources.

Method of developing the centre

While we were starting the project in Basra several of the international NGOs were about to leave the country. In order to get sufficient knowledge and to involve local stakeholders such as professionals and NGOs in the planning, a series of meetings were held in Basra. It was important to reach broad segments of the society to build acceptance, future support and security. At these meetings we became increasingly aware that any treatment developed would have to be adapted to local circumstances and be culture sensitive in order to gain acceptance. After initial consultations the decision was taken to have a first seminar abroad for professionals in different disciplines, especially from the medical and legal fields. The seminar included presentations covering the UN convention against torture, traumatisation and sequelae of torture, and community effects and responses to torture. The methodology of identification and documentation of sequelae of torture was described with a gender perspective. With this common basis, participants spent the following days discussing perceived needs, structure of a centre-to-be and how to build collaboration between different disciplines and institutions.

Participants pointed out that the centre would need to be independent from government in order to maintain its neutrality. At the same time it should establish close collaboration with government. The recommendation was to create the Centre as an international NGO in the first phase, in order to obtain sufficient support. Subsequently, when feasible and sustainable, it would turn into a local NGO with full autonomy.

An advisory group was proposed to support the centre. The advisory board appointed had representation both from government bodies and NGOs (Figure 1). From its ranks were supplied the official board of the centre. According to several members, meeting each other in the advisory board has proved fruitful also for building confident relationships between the NGOs and government representatives. Previously there had been no tradition for consultations between government and NGOs.

One difficulty that had to be addressed was the lack of staff with sufficient training. There was a complete lack of clinical psychologists and physiotherapists and a shortage of psychiatrists. Among medical employees, there was no previous experience of multidisciplinary teamwork and cooperation normally followed a hierarchical structure. Administration likewise had a reminiscent hierarchy and administrators also had limited training with modern equipment. Traditionally, treatment of torture victims had been ignored or performed secretly.

In planning the centre's activities the am-

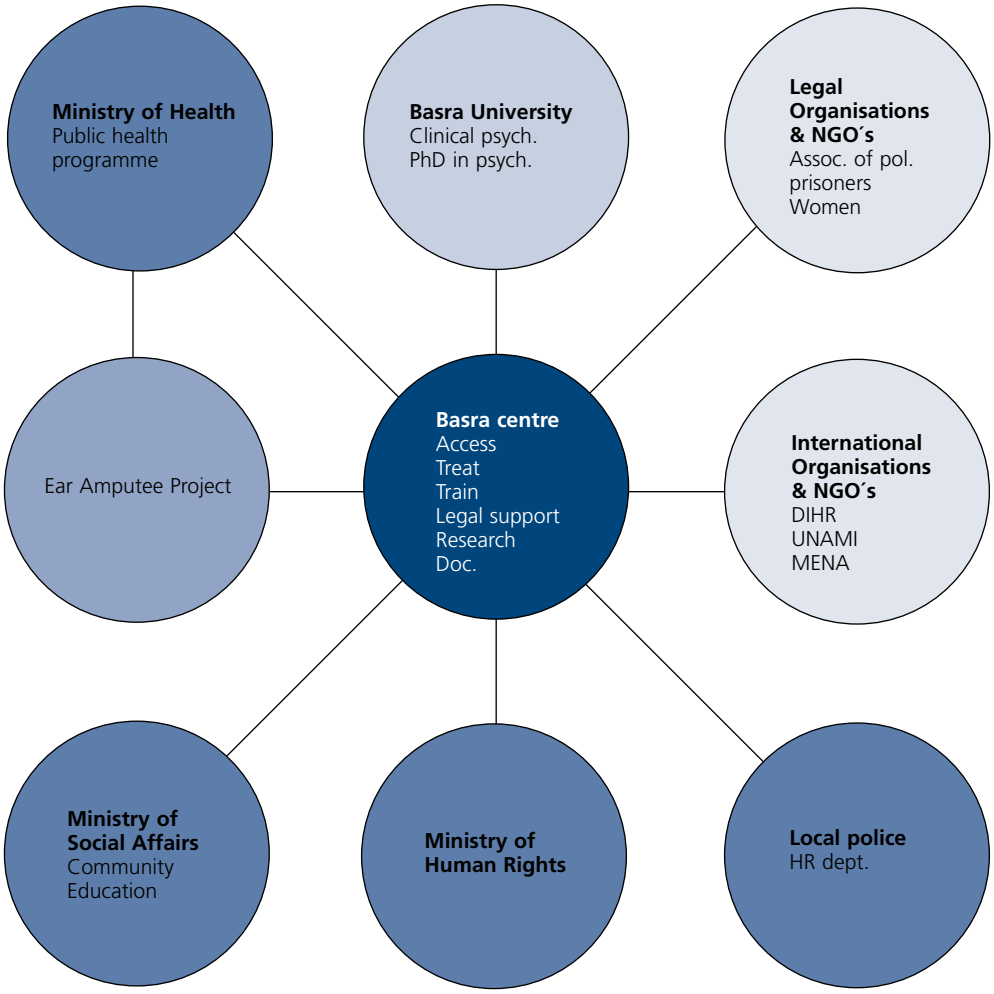

Figure 1. *The original advisory board of FRCT.*

bition was to let the perceived needs of the patients guide the development. A multidisciplinary treatment team was created to cater to the multitude of needs of the victims. Apart from medical and psychological treatment, legal advice would also be provided.

Documentation and data collection were seen as prerequisites for guarding the legal rights of the victims but also to supply a basis for evaluation and quality assurance. Until then data regarding torture and rehabilitation of torture victims had not been collected systematically in Iraq and it was therefore seen as essential for the country to develop methods to assist in creating a medico-legal data base regarding victims. As insight grew that treatment and rehabilitation resources will always be insufficient compared to the vast needs, it became increasingly essential to view the centre's activities in relation to a public health perspec-

tive. How could the Centre contribute to the health in Iraq? It was therefore planned that knowledge gathered through the data base would be utilized for future collaboration with the public health sector, and specifically the mental health programme (Figure 2).

Integrated in the original plan was the assumption that the assistance from IRCT would gradually phase out. Simultaneously FRCT would turn into an independent national NGO. Since January 2007 it has been registered as such. Provided that further funding will be obtained it thus seems likely that the goal of sustainability will be reached. FRCT is now a focal point of a variety of activities, aimed at assisting victims of torture.

Clinical activities

As of February 2007, 242 clients have been registered at FRCT. The largest age group is between 26 and 35 years of age and the

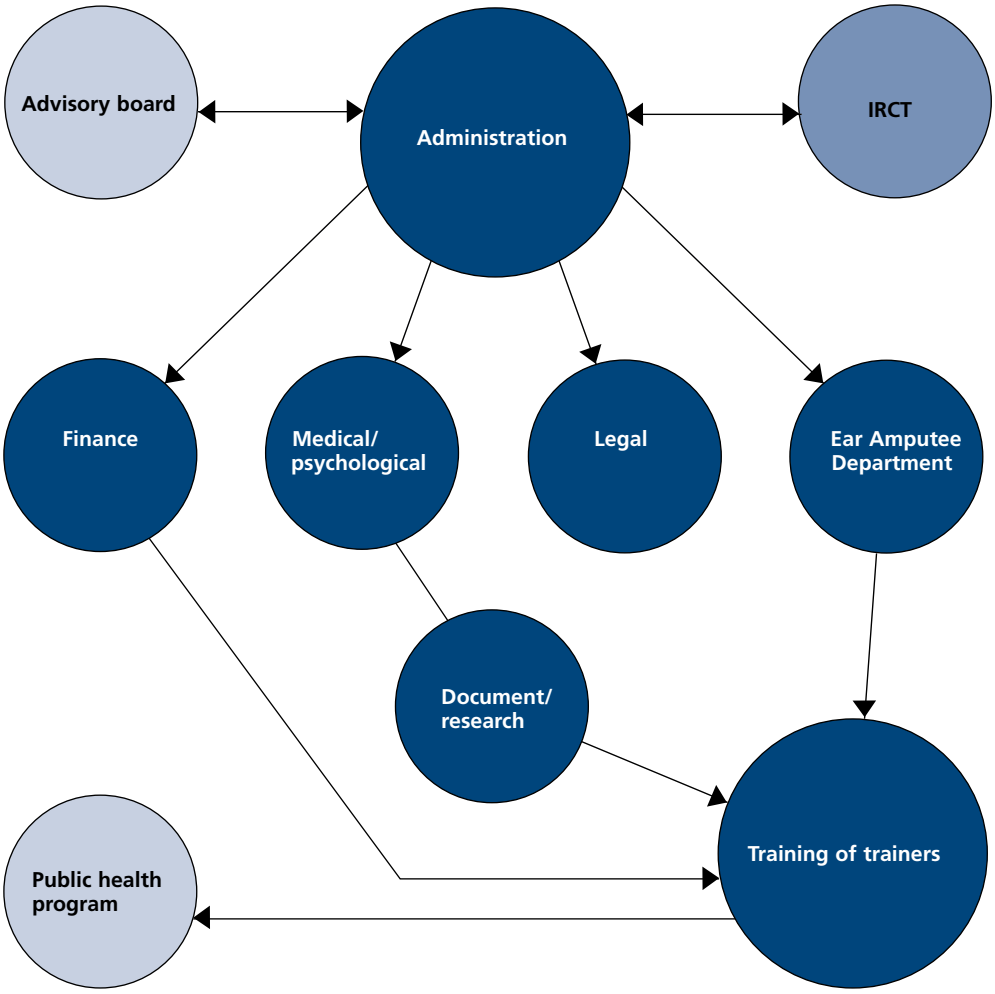

Figure 2. *Organizational structure of the FRCTT (before turning into national NGO).*

mean age of 37.5 years. Educational levels vary from illiterate (10%) to college (9%). About half (51%) of the clients have primary education or lower as highest attained education level, whereas the other half have intermediate, secondary, institution or college education.

84% of the victims have experienced their torture in prison or in connection to being arrested and detained. Regarding the forms of torture that victims have experienced statistics are yet to be prepared, but the Centre has revealed in its daily work with victims the following as common patterns of torture: The victims have been arrested, threatened, blindfolded, stripped of their clothes and suspended from their wrists for long hours either to a rotating fan in the ceiling or from a horizontal pole. Electric shocks have been used on various parts of their bodies, including the genitals, ears, the tongue and fingers. They have been beaten with canes, whips, hosepipes or metal rods. Some victims have been forced to watch others, including their own relatives, or family members, being tortured in front of them. Other forms of physical torture described by survivors include falanga, extinguishing of cigarettes on various parts of the body, extraction of finger nails and toe nails and piercing of the hands with an electric drill. Some have been sexually abused and others have had objects, including broken bottles, forced into their anus. Threats have often been extended to include family members.

In addition to physical torture, detainees have been threatened with rape and subjected to mock executions, placed in cells where they can hear the screams of others being tortured, been deprived of sleep, been denied food and water and subjected to solitary confinement in long periods. Often they have not been allowed to visit the toilet without permission.

The torture techniques also include burning with hot irons and blowtorches, dripping of acid on the skin, and breaking of limbs. Ear amputation was the punishment of army defectors according to decree 115, and thus not formally torture (as it was included in the penalty code). The victims of ear amputation have, however, been treated at the Centre. Often an "X" was branded in the forehead of the defecting soldier in order to assure that citizens would not think that he was a wounded veteran.

A case-finding survey conducted by FRCT in collaboration with victims' organizations revealed that about 400 individuals had suffered from punitive ear amputation in the area of Basra.

Physical sequelae are common among FRCT clients, indicating the brutality of the torture, and include fractures (wrongly healed), joint problems especially from shoulders, scars and unhealed skin lesions and pain from different parts of the body. A slight majority of victims present with physical symptoms as their chief complaint (56.5%). Among those who present with psychological complaints, depressed mood is the most frequent (56.4%). Anxiety and personality changes with both extreme withdrawal and difficulties in handling aggressiveness are other common complaints.

The most prominent diagnosis is posttraumatic stress disorder (PTSD) of varying severity. Psychological and psychiatric assessment reveal that more than 60% of victims fulfill criteria for posttraumatic stress disorder (PTSD) both according to a self-rating questionnaire (61.8%) and according to clinical diagnosis (62.8%). Intrusion symptoms (in the form of nightmares, flashbacks etc.), avoidance and hyper-reactivity symptoms are all present. Patients display a high number of avoidance symptoms, which

when present will often lead to a very circumscribed psychosocial life and inability to keep a job. Mental symptoms are also common among close relatives of victims, often fulfilling criteria of a complete PTSD diagnosis.

Most of the victims have impaired working capacity and have often lost their jobs. Many of them are unable to support themselves and their families economically.

The majority of patients have been men (87%), women being more reluctant to come forward due to societal constraints. However, a newly developed, more community directed programme, is aimed to attract women who need rehabilitation. This kind of programme provides the opportunity to reach the whole family including the children. The employment of a female gynecologist with an interest in psychotherapy has started to pay off in a higher proportion of female attendants. She has also attended training in narrative as well as in cognitive psychotherapy.

The Centre has been urged to address the plight of the victims of punitive ear amputation. In an effort to respond to these needs – although not covered for in the original budget – the Centre has, in collaboration with London Clinic (UK) and Mount Vernon Hospital, initiated a programme whereby a couple of patients were operated on in London by highly skilled plastic surgeons specialized in ear reconstruction. In the first phase of the project three surgeons and one surgical nurse from Iraq were trained in London simultaneously. Training was given free of charge, courtesy of the collaborating partners. The successfully completed first phase of this activity received a great deal of press coverage including a documentary by BBC which was extremely well received. As a result of the initial first phase training, three simple cases of ear amputations were successfully operated on in Basra.

In a second phase, an additional two surgeons were sent for training to perform the required surgical procedure. Upon returning to Iraq they have already started operating.

Patients referred to the centre for reconstructive ear surgery go through a medical checkup as well as psychological supportive therapy prior to their surgery. The majority of the ear amputee victims are smokers. Due to the very thin and sensitive blood supply around the ear area, smoking risks failure of the procedure. Smokers therefore attend group supportive therapy to quit smoking prior to operation. As an outcome of the ear reconstructive surgery project, Iraqi surgeons are now able to perform the operations at some hospitals in Iraq. An especially equipped operation theatre has been allocated to FRCT for one week each month in collaboration with the MoH. Psychosocial needs of the ear amputees are cared for at the FRCT like for all other patients.

The basis of the clinical work is teamwork with a wide variety of professional staff involved to address the sometimes complicated medical and psychological sequelae of torture; nurses, physiotherapists, social workers and physicians like general practitioners (GPs), orthopedic surgeons, gynecologists, and plastic surgeons. Psychiatric and psychological treatment as well as social support is regularly integrated into all treatment plans. Due to lack of clinical psychologists and psychotherapists in Iraq, we have developed methods that build on the patients' narratives in combination with pedagogical interventions. Another method that is based on the victims' beliefs is now being developed. The method relates psychological interventions to the content of religious texts.

Family therapy is increasingly practiced at the Centre. The high level of teamwork is a novelty to Iraqi medical tradition and has thus called for planning and supervision. It has been well received.

Each victim referred to the Centre is interviewed and introduced into the working mode and facilities of the centre as part of an initial pedagogical programme. The victim is then assessed with standardized psychometric self-rating instruments in addition to the clinical evaluation. All victims are then seen by a GP and a psychiatrist. When called for, other specialists will get involved and see the patient at the Centre. A social worker will map the social situation of the patient and, when needed, perform home visits to talk to family members. A treatment conference will propose a treatment plan and a contact person will be selected for the patient. This person will discuss the

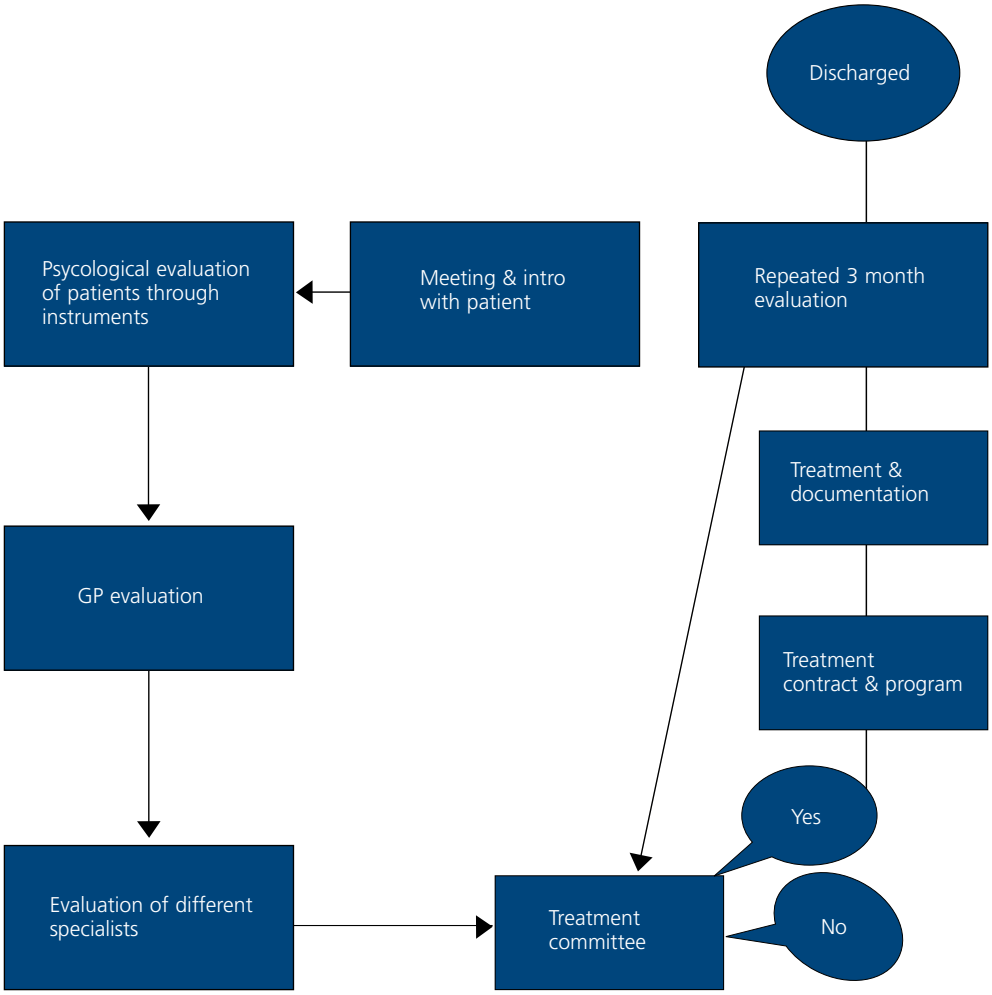

Figure 3. *Mode of reception, treatment and evaluation of treatment at the FRCT.*

proposed plan with the patient, who may accept it, reject it or suggest alterations. After treatment is commenced, progress will be measured by regular reassessments through applying the same instruments that were used at intake.

The condition of each patient will be re-evaluated every three months; continuation or discontinuation of treatment is decided based on these evaluations. For a schematic view of the treatment mode see Figure 3. The social worker mentioned above is also responsible for a micro grant programme that has so far only been tried on a dozen of occasions when victims have been unable to economically support themselves and their families. If they have presented an economically sound idea of an income generating activity they have been given support of a few hundred USD, e.g. to buy an oven in order to start a bakery. The majority of these projects have been successful. One has lead to a business that has expanded and employed others, but a couple of the projects have failed.

Data collection and quality assurance

At intake, all patients are interviewed by a specially trained educational psychologist, who, in addition to the interview, will use standardized self-rating instruments like the Self-rating Inventory for PTSD (SIP-22),[5] Self-rated Health,[6] Hopkins Symptom Check List, HSCL-25,[7] and Depression Subscale of SCL-90 (13 items).[8] Through an interview with a psychiatrist, a clinical diagnosis is established. The double diagnostic system built into the system allows us to get a better understanding of the patient and at the same time enables us to validate the self-rating instruments. All patients are seen by a GP for a general medical evaluation and documentation of physical sequelae of torture. Doctors at FRCT have been trained in medico-legal documentation of torture in accordance with the Istanbul Protocol.[9]

Specialist evaluations, when called for and the patient's subjective evaluation add to the perspectives. A social worker maps the patient's personal history and social life prior to and after torture.

All data collected – with the exception of data that may be sensitive from a security perspective – are directly fed into an SPSS programme as part of daily routines.

The data collection serves multiple aims. Apart from legal aspects it serves the purpose of quality assurance needed by the Centre. At the same time data collected gives the basis for research purposes, e.g. to measure PTSD prevalence among patients, their needs, co-morbidity etc. But data will also serve to gather knowledge for the mental health programme in order to better address the needs of traumatized people. FRCT has established collaboration with the Public Health Office in Basra with the dual purpose of introducing health office staff to the needs of traumatized people and at the same time learn the strategies of prevention and health promotion on a societal level. As a result, a joint mental health programme is gradually developing. Not only health hazards and symptoms but also salutogenic factors – such as social network – are recorded in the register. The fact that internationally recognized and culturally validated instruments are applied gives the possibility of international comparisons.

Training

Training seminars have been conducted with different professional groups, including police officers, teachers, journalists, judges and lawyers. GPs have been a central group receiving training regarding trauma and PTSD. About 700 professionals have so far taken part in these seminars. In ad-

dition, a common training programme with the Public Health Office in Basra has been developed.

Seven seminars arranged outside Iraq have dealt with legal and clinical aspects of torture, including forensic aspects, how to combat torture and how to organize and administer rehabilitation services for torture victims. Although a pronounced aim of the seminars has been to facilitate the organization of the work in Basra, participants have not been limited to FRCT staff but also included professionals from other parts of Iraq. One seminar, however, was exclusively for FRCT staff. Subjects covered have included computer skills, office administration, the SPSS statistical package, teamwork etc. Lately, much time has been devoted to developing psychotherapeutic skills, both in narrative therapy and cognitive therapy. The latest seminar selected participants who will in future function as trainers for their peers. One seminar, arranged in collaboration with The Olof Palme International Centre addressed conflict management. In collaboration with the Danish Institute of Human Rights, a seminar focusing on combating torture and policing based on human rights values has been provided to high ranked police officers and lawyers.

Thirty-nine seminars covering similar subjects have been organized inside Iraq by FRCT, although human rights and legal aspects have had a slightly more prominent position. They have also included training in data collection and documentation.

Eight symposiums have also been organized, sometimes in collaboration with victim organizations. In addition, seven peer supervision programmes have been implemented.

FRCT collaborates with Basra University in developing curricula for clinical psychologists. Karolinska Institutet in Stockholm has been approached to take an active part in this task and has responded positively. A programme in basic psychotherapy for Iraqi physicians has also been approved by Karolinska Institutet.

Training may multiply the outcome of clinical work. Clinical professionals from different parts of the country have repeatedly attended seminars arranged by the FRCT and thus established links with the Centre.

Several of the FRCT trainings have been more directed to primary prevention as they have targeted human rights and legal issues, thus helping in preventing exposure to human right abuses.

Prevention

From a public health perspective treatment and rehabilitation could be seen mainly as tertiary prevention, which is considered to have a limited impact on public health. But the multiplying effect that lies in training of new health professionals, especially if they acquire enough knowledge to function as trainers themselves, has then not been taken into account. With this perspective, training, and training of trainers (ToT) should be viewed as one of the central commitments of FRCT.

By applying a family perspective in the centre's activities, the FRCT will also work on a level of secondary prevention; i.e. through treating traumatized individuals prior to the development of PTSD or other serious disorders severe sequelae may be averted and chronic stages prevented. Relatives of our patients are often seriously affected, but may not have reached the stages of disorder that are difficult to reverse. In this way, the counseling of couples has frequently contributed to an increased understanding on the part of the spouse, and given means to deal with aggressiveness or avoidant behavior. In many cases divorce has been prevented.

Similarly, through training of professionals, especially GPs, who reach traumatized people in their daily work, early stages of disorder may be detected and addressed. Doctors who, as part of their service, attend to the prisons (both male and female prisons) do notice traumatisation among the inmates and have been able to engage in treatment.

The activities of FRCT have on many occasions been covered by TV and radio and opportunities have then been given to explain in a simple language the psychological consequences of torture. Describing common symptoms in a generalizing way is very reassuring for numerous victims of torture who feel that they are alone in their suffering and sometimes fear that they are becoming mentally ill. Without doubt this is secondary prevention and at the same time a way of raising the knowledge level of the general public and of professionals.

Family work is planned to be further developed and expanded at FRCT, both as a means of reaching more females who are reluctant to come forward for treatment and also for having an opportunity to assess and attend to the situation of children. Such activities should be seen as examples of primary prevention.

The training of judges, police and investigating officers, and prison staff as well as doctors, regarding the United Nations Convention against Torture, the Istanbul Protocol, clinical signs of torture and traumatisation as well as stressing their professional obligations are other examples of primary prevention.

The FRCT training programme, with a focus on trauma and the consequences of trauma on the family and community, has now been included as part of the developing programme on mental health in Basra. FRCT is also engaged in the National Network for Mental Health in collaboration with the National Mental Health Council. The Centre intends to share its gathered experience regarding torture, sequelae of torture, effects on relatives and possible preventive measures. The Mental Health Council is regularly invited to take part in the center's training activities. Another task delegated to the FRCT from the Mental Health Council is to create a national bank of psychometric instruments that are linguistically and culturally validated. This work has not yet been finalized.

Towards health promotion?

To address a health promotion strategy in Iraq in its present situation of continuous violence may be seen as utterly unrealistic. Factors that are detrimental to mental health are abundant and violence seems never ending.

Naturally the main responsibility of health promotion falls outside the boundaries of any health institution, as most decisions affecting health are taken at higher political levels. Still, the civil society may play a role regarding many factors that contribute to health promotion: The dissemination of knowledge and respect for human rights, respect for professional obligations and accountability and the creation of an atmosphere where human rights violations can be openly discussed are such factors. The fact that victims are suddenly seen and their plight addressed may instill hope and contribute to a more humanitarian interpersonal understanding. In this respect there is still a gender difference, male victims being the ones who have come forward first. Female victims still often feel that there is shame attached to their victimization and families have difficulties in handling the situation in more constructive ways than through denial. Here is obviously an area where the pres-

ence of a treatment institution increasingly attending to woman and opening dialogues with NGOs like women associations, victims' organizations, and influential professionals may play a role. Our pronounced aim is to increase the proportion of new female attendances from the present 14% to 30% in one year's time. The large number of seminars that the centre is capable of arranging is a powerful way of discussing and influencing attitudes.

Engaging in the reconstruction of the civil society alongside other NGOs and government authorities is to build democracy, which is a cornerstone of health promotion, especially so when the illness panorama is violence related.

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