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EDITORIAL

REFLECTIONS AT THE TURN OF THE MILLENNIUM

At the turn of the millennium, many people take the occasion to reflect on the past and to turn over their visions for the future.

For a 25-year-old organization (1) that has engaged itself in a problem that has existed in both past millennia, the task for the future remains overwhelming. Considering the terrible events during the past century, with all its torture, genocide, and crimes against humanity, those of the past year alone suffice for a comprehensive review and summing up.

One matter, however, pushes itself forward, as it was presented in contributions and plenary sessions at the VIII International Symposium on Torture in New Delhi, September 1999. The symposium report that was presented by Shri Virendra Dayal from the National Human Rights Commission of India is published on pp. 22-24 of this issue.

The symposium clearly showed that work against torture has spread to new areas during the past years. The work has also come a step further, and perhaps even its general pattern has changed during these few years, compared with the situation during most of the last 25 years. These 25 years of medical and psychological work with torture have shown that we now have sufficient knowledge about torture, we know how it affects the individual, we know about its methods and after-effects, and we know how to diagnose it.

We have enough experience to be able to speak about torture and its effects in a more substantial and assured way. The basic knowledge, on this medical and psychological basis, allows us to make strong statements to politicians and decision-makers against the practice of torture.

This knowledge and the organization and network are founded on a professional basis: doctors, psychologists, nurses, physical therapists, social workers, etc., with a specific knowledge about torture.

Research has shown that torturers who work for governments aim to break down their victims, and we know that they are always capable of doing so.

When we started talking about torture some 25 years ago, there was silence on what really happened under torture. The torture victims could not break this silence because of the torture-induced shame, guilt, personality changes, low self-esteem, anxiety, and depression.

Inge Genefke, in her opening address at the New Delhi symposium, said: “But who will listen? How can the public be reached? How can the most important decision-makers be reached?” And more questions can be asked. Has the work helped? Are there remedies to break the silence on torture on international, social, or individual levels? Or, what about the torturers, will they go free, as they always used to?

There are many good, positive, and encouraging answers to these questions. Answers showing that time has not stood still, that progress has continued, in fits and starts, during the past years, and that the organizations, declarations of intent, and information initiatives concerning human rights have obtained a considerable and lasting foothold. With respect to the IRCT, a keyword covering the many new initiatives is advocacy – a wide concept that includes opening up to the outside world, press work, exhibitions, hearings, urgent actions, lobbying at national and international levels. The list continues with fund raising, publications, documentation, and special initiatives to highlight 26 June as remembrance day for torture victims. It also includes support for the advocacy function, which contributes to a still growing consolidated network, and finally, availability to take operative action in emergency situations, e.g. in the recent creation of the Pristina Centre in war-torn Kosovo (the inauguration of this centre will be presented in TORTURE 2/2000), and the very latest treatment initiatives in East Timor.

A sign of new ideas in the organization of the international work against torture was seen at the Symposium in New Delhi, where the target group comprised, for the first time in seven years, not only health professionals. This time, the judiciary and the legal profession, the national Indian human rights institutions, and law enforcement agents created a team with health professionals as the two crucial professions, health and law, in the struggle with respect to torture and human rights. It has previously been voiced, also at this first joint venture, whether it might be considered bad in general to link up with representatives from a judiciary system that might be involved in violations of human rights. Would such an alliance not be exploitable and lead to recognition rather than condemnation? This argument must naturally be taken seriously, especially in the countries where the judiciary systems are the exclusive administrators for a government that openly violates human rights. However, where it is possible to find different points of view and to have a dialogue about improvements in the judiciary system, and where there is the will and desire to further human rights with the help of the legal profession, such a joint effort against human rights violations can only be welcomed as one of the victories that was expressed at the VIII International Symposium on Torture.

H.M.

Note
(1) The IRCT was created on the basis of documentation and epidemiological research by the first medical group in Amnesty International, a group that was established in 1974. An article that focuses on this historical background, “From AI’s medical groups towards cross-sectional collaboration against torture”, will be presented in TORTURE 2/2000.
Visits to detained torture victims by the ICRC (I)

Management, documentation, and follow-up(a)

Marina Staiff, MD*

What good and what harm can visits to detained torture victims do? This question is deliberately provocative, for it may seem somewhat unreasonable to wonder how visits to prisoners (1) who have been seriously ill-treated and even tortured could themselves do harm if those visits are carried out by an independent organization staffed by well-intentioned individuals following recognized procedures. The purpose of this outline was to show that, for a number of reasons, it is not entirely unjustified to ask this question. Visiting places of detention can be of use in the struggle to eradicate torture. But in some cases it can be at best useless, and even counter-productive, as will be discussed. The procedures used by the International Committee of the Red Cross (ICRC) when visiting prisoners have been discussed in a series of previous papers,1,2,3 and therefore they will be mentioned only briefly. Instead we will deal more specifically with those aspects of visits that directly concern the type of relationship that is established between the visiting organization and each individual prisoner who has undergone torture.

The aim was to highlight the importance of following up the case of each individual, of respecting the informed choices made by each prisoner regarding what he (2) is willing to allow the visiting organization to do about his case, and the personal aspect of the relationship between the prisoner and that organization's representative.

The ICRC’s mandate to visit prisoners
The ICRC was set up in 1863 as a result of war and a growing awareness of its effects on the individual. The ICRC traditionally acts to protect and assist victims of armed conflict, international or otherwise, by virtue of the mandate conferred upon it by the community of States. At present, the ICRC is active in more than 50 countries. It is independent of all governments, and its actions and decisions are guided exclusively by humanitarian considerations.

The role of the ICRC is twofold. As guardian and promoter of international humanitarian law, it approaches governments or armed opposition groups in order to bring about full compliance with that law. As a humanitarian organization, it strives to protect and assist people affected by armed conflict or internal strife, such as individuals imprisoned in connection with those events, displaced persons, civilians who have been the victims of violations of the law, the wounded, and people separated from their loved ones by fighting.

Work on behalf of prisoners is one of the ICRC’s most specific tasks. In accordance with its mandate, the organization concerns itself with the welfare of any person arrested in connection with an armed conflict, internal strife, or other disturbances requiring action by a specifically neutral and independent organization.

The main purpose of the ICRC’s work in this domain is to safeguard the prisoners’ physical and mental integrity, to prevent or put an end to any ill-treatment, and to ensure acceptable material conditions of detention (3). The ICRC assesses the situation and asks the authorities to take any steps needed to improve the detainees’ treatment and material conditions. In urgent cases, the ICRC itself supplies material relief.

In order to bring about improvements, the ICRC must be in a position to approach not only the political authorities but also the entire chain of command of the security/defence forces. This is necessary if the organization’s conclusions are to be based on reliable information and on as objective an analysis as possible of the problems.

The ICRC reports its findings to the detaining authorities and not to the judiciary or any other investigative body. It does not publish those findings (or, rather, it publishes them only in very exceptional circumstances). Bound by its principle of confidentiality, the ICRC engages in dialogue with the detaining authorities. It thus plays a role complementary to that of other organizations whose essential tool is public advocacy. By virtue of the fact that they accept both the ICRC’s presence in places of detention and the organization’s working methods, the detaining authorities consent to the discussion of sensitive subjects such as torture, and agree to deal with them. In the ensuing dialogue, the ICRC becomes the voice of prisoners who are the victims of ill-treatment. Should the authorities fail to abide by the agreed working procedures once the visits have started, the ICRC will consider suspending its activities until an acceptable arrangement has been worked out. Finally, if all other courses of action have been exhausted, the ICRC may in the end decide to inform the international community of its decision to suspend the visits and the reasons why it has been forced to do so.

Procedures for visits to prisoners
Visits to prisoners by independent entities (whether national or international) represent an important means of detecting and limiting torture – and play a major role in the struggle to eradicate the practice – provided that those visits are carried out in accordance with certain procedures and join together with other mechanisms aimed at preventing torture. The latter range from legal and administrative safeguards to the training of health-care professionals. It goes without saying...
that visits in themselves could never be enough to counter torture effectively.

It is certainly most encouraging that independent monitoring mechanisms are being set up in an increasing number of countries, with the result that periodical visits are made to places of detention in order to ascertain the conditions and treatment of the prisoners held there and to make recommendations, when needed, for their improvement.

Nevertheless, taking the risk of stating the obvious, I would like to stress that visiting is not an end in itself but a means to an end, a tool. And to be effective, that tool must be adapted to the context and the specific work it is intended to perform.

For instance, the impact of independent visits to police stations in different countries has been the object of a recent study, which shows that the manner in which the visiting schemes are developed and their ultimate effect are closely linked to the political, legal, and historical context in which they arise.

The prisoner's needs are determined by the specific reality in a given country's places of detention — with all the factors influencing it. Those needs must determine the objectives of a visiting scheme and the action it will take and methods it will adopt to meet those objectives. The visiting procedures negotiated with the authorities must allow the pursuit of objectives dictated by the situation. If this is not the case, the visits achieve nothing — they are at best useless and perhaps even harmful.

For instance, after considering the problems observed, their causes and degree of seriousness, the ICRC may feel that it is sufficient to visit a place of detention once a year. By contrast, it may decide that it is necessary to visit another place every second day of the week — week after week and month after month — in order to maintain the necessary dialogue with the authorities in charge and to bring about an improvement.

It can be difficult to carry out visits to prisoners in a professional, objective manner, especially where torture is routinely practised. Inexperienced visitors — no matter how well-intentioned — may get a false picture of reality and may inadvertently put prisoners in danger. To reduce the risk, a number of procedural safeguards must be established before every visit.

When the main problem is torture, or the risk of torture, the ICRC considers that it is essential to do the following:

• gain access to the prisoners concerned;
• ensure that ICRC representatives are able to talk with the prisoner freely, in private and in a place chosen by the ICRC delegate;
• record the identity of the prisoners concerned;
• ensure that the ICRC can repeat the visit whenever it deems necessary.

Exceptions may be made to these procedures only under extraordinary circumstances, and only if they serve the interests of the prisoners, and the prisoners alone.

The above-mentioned procedures are intended to achieve two things: first, to give each prisoner a chance to speak freely and in confidence, and, second, to ensure that each case is followed up individually.

This last point is a particularly important requirement when there is the fear that reprisals may be taken against detainees who give private interviews to the ICRC delegates. Prisoners may have been coached by the detaining authorities before the visit and threatened with punishment if anyone complains to the ICRC. If prisoners fear reprisals if they make themselves conspicuous by requesting to see an ICRC representative in private, whether or not this fear is justified, the ICRC proceeds very cautiously. In some cases it may decide to suspend the visit. In others it may decide to interview privately each and every prisoner in the place as a means of preventing the detaining authorities from singling out any particular person.

In any case, systematic follow-up is imperative to ensure the prisoners' safety after the visit.

Individual follow-up of prisoners

The ICRC makes it a working rule that the identity must be recorded in detail of prisoners who represent problem cases (real or potential) needing to be followed with particular care (victims of torture, other ill-treatment, or discrimination; those presenting medical problems; and, naturally, those for whom there is the perceived risk of reprisals, disappearance, or extrajudicial execution). In some cases, the ICRC also registers missing persons and persons presumed imprisoned. Such information is centralized to allow optimal follow-up.

For the ICRC the registration of prisoners is a working tool that enables it to follow individual cases as closely as necessary. The fact that a prisoner is registered by the ICRC does not confer on him any special privilege, and has no legal value per se.

When visiting a given place of detention, it is not always necessary to record the prisoners' identities. However, when torture is not an isolated occurrence but a routine practice, registration and individual follow-up of prisoners is indispensable. Naturally, the more violent the situation in a country, the higher the risk of ill-treatment, and the greater the need for close individual follow-up. As pointed out above, in such situations it can be dangerous to visit without adequate follow-up to ensure that nothing serious happens to prisoners once the visit is completed. An ongoing presence in the field (and the appropriate facilities to this end) thus appears necessary in such sensitive situations.

But registering a tortured prisoner can also be seen as something more than a working tool and a safeguard for his security, since one purpose of torture is always to destroy the victim's sense of being a member of a family or a group, or simply of society in his or her capacity as a human being. And this purpose is often achieved: victims frequently report a sense of having been dehumanized and thus cut off from human society. It should be added that when the individual is one of a group of other prisoners, his sense of belonging seems to be better preserved than, for example, that of someone living in exile. But that sense of belonging most assuredly fades when individuals are kept isolated from one another for long periods. Registering prisoners on the first visit is a way of saying to them: "As of now, you are one of the people on our list. We will keep track of you as long as you are in prison." This is important not only as a means of reassuring the prisoner, who may fear that his fate will be to "disappear", but also as a means of giving him a sense of belonging (to the group of persons being kept track of by the ICRC), which can function as a temporary reference when his usual web of relationships has weakened.

In some situations, being registered by the ICRC, and for the first time seeing one's representative go in for a private interview, is experienced by the prisoner as a sort of rite: symbolic recognition that he is in a special situation.
The interview with the prisoner
Private interviews with the prisoners by ICRC delegates and doctors are the essential part of a visit, and take up the greatest part of it. The interview makes it possible to document cases of torture, and to hear the prisoner's point of view on any other specific problem. But useful and reliable information can be collected only when a relationship of trust has been built up. This is especially true when a person has been subjected to violence, arrest, interrogation, isolation, renewed interrogation, and the many other phases of imprisonment. Such a relationship can be difficult to achieve. It may require time and patience; it may require several different meetings. In the ICRC's experience, it is easier to cement this relationship when the prisoners know and understand precisely the organization's mandate, its working procedures, and the limits to what it can do.

Not only must these things be crystal clear in the prisoner's mind as regards the ICRC as an organization; there must also be absolute transparency in the personal relationship between the prisoner and the ICRC delegate. That is, the delegate must take care to ensure that what he says is perfectly intelligible, honest, unambiguous, and unequivocal. Apart from anything else, this is a fundamental means of setting the delegate apart from the torturer, who always makes lavish use of language designed to create confusion in the victim's mind.

In some situations it is possible that, far from mistrust, the prisoner may place exaggerated hope in a representative of a national or international body that may be viewed as possessing powers that in reality it does not have; the prisoner may feel that the organization will now protect him in all circumstances. If this happens, the prisoner may then take ill-considered risks by, for example, speaking freely not only within the framework of the private interview but also outside that framework. For this reason it is essential to ensure that the prisoners understand the limits of the protection that can be provided, and to take all possible precautions against the prisoners unnecessarily exposing themselves to danger.

The prisoners' confidence also depends on the absolute certainty that no information – no allegation, no complaint – provided by them in the course of an interview will be reported to the authorities without their express permission.

In short, collecting reliable information, ensuring that the interviewer's approach is clear and unequivocal, and working to secure a humane, empathic relationship are three closely interlinked objectives. Neglecting one can only jeopardize the others, and can have serious consequences. This may sound self-evident, but the reality is that representatives of humanitarian or human rights organizations who visit prisons are all too often so concerned with the actual collection of information and evidence that they neglect this crucial aspect of the process.

Documenting torture
The ICRC's philosophy and practice regarding the documenting of torture have been described elsewhere and have been largely incorporated in the United Nations Manual, currently being published, on the effective documentation of torture and cruel, inhuman and degrading treatment (also known as the “Protocol of Istanbul”).

The prisoner's account is indispensable to the documentation of torture. Torture survivors may have difficulty in recounting the specific details of their ordeal for several reasons, which range from cultural taboos through shame, through various psychological defence mechanisms, through impaired memory, and on to fear and distrust. Such difficulties may in themselves be a sign of the severity of what the person has endured.

The significance of torture for each individual (in cultural, social, and political terms) influences his ability to speak about it, just as it helps to determine the impact torture will have psychologically and socially.

Because of these possible differences in significance, and because of the severity of torture and its consequences, one should therefore, when collecting information, adopt an attitude of informed but receptive inquiry (or even learning), rather than be in a great hurry to diagnose, classify, and quantify. No preconceived standards can ever anticipate the entire range of possible forms of ill-treatment and their global effect.

To yield to the temptation of thinking of torture in a pre-conceived manner, and thus to confine it to pre-established categories, would be counter-productive, both in terms of collecting information and in making representations to the responsible authorities. Experience shows that when you reduce the victims' experience of torture to a catalogue of methods used, it tends in turn to reduce the dialogue to a discussion of this method as opposed to that method, rather than addressing the problem of torture as such.

Phenomenological or descriptive methods are thus probably the most appropriate approaches to torture. Among other things, these approaches guard against statements being made without a firm basis in the form of numerous and consistent accounts, i.e. the conviction that the statement reflects reality as faithfully as possible.

In the ICRC's experience, only by carefully listening to all the views expressed, taking into account their subjectivity, and then weighing them in the light of the overall cultural and social context can the interviewer obtain some idea of the nature and gravity of the ill-treatment to which prisoners have been subjected.

By a process of analysing and cross-checking hundreds of torture allegations in a given situation, the ICRC obtains a picture of that situation that is as detailed and close to reality as possible, and thereby manages to identify the factors according to which the system functions (or rather malfunctions), and on which the practice of torture is based. This process also makes clear the levels at which representations should most urgently be made.

Obviously, the medical and psychological consequences of torture need to be assessed by trained doctors, psychiatrists, and psychologists, because the assessment must be authoritative in the eyes of those to whom it is addressed. In addition, while documenting medical evidence of torture, ICRC doctors are in a position to provide independent medical advice to prisoners. If necessary, medical consultation, treatment, or referral will then be requested for a prisoner by the ICRC.

It is essential that those who interview the detainees – whether or not they are health-care professionals – familiarize themselves as far as possible not only with the cultural, social, and political milieu, but also with the objectives pursued by the torturers, the methods they use, their consequences, and the coping mechanisms most frequently used by those on whom the practice is inflicted. This is necessary not only to understanding what the detainee tells you but also to showing him that you understand.
Conclusions

Visiting detainees who have been subjected to torture is a means of documenting the torture, in order then to make representations to the responsible authorities (with evidence that makes clear what was done, but without indicating to which individual it was done, or with evidence citing individual accounts) in order to make it stop.

ICRC experience also shows that regular and thorough visits to a place of detention can have a direct impact on the treatment of those held there, provided that open dialogue can be maintained with the authorities in charge.

Finally, I would like to ask the following question. When a national or international agency carries out visits to prisoners in situations in which torture is systematically used, how can one be sure that those visits will not prove counterproductive, nor actually expose the prisoners to greater risks?

Though it is very difficult ever to be absolutely certain that the risk is nil, there are a number of measures that can — and must — be taken in connection with such visits. I would summarize those measures as follows:

• substantial knowledge of the manner in which the institutions being dealt with function, as well as of the cultural, social, historical, and political reality;
• a number of working procedures to which the responsible authorities must give clear consent, and which should make it possible to pursue the objectives dictated by the situation (one such procedure being to keep track of each individual prisoner);
• when conducting a private interview with a prisoner, one should remember that collecting reliable information, ensuring that the interviewer's approach is clear and unequivocal, and working to secure a humane, empathic relationship are three closely interlinked objectives. For such an interview to have a beneficial effect for the prisoner, it is essential to be familiar with torture's objectives, methods, and consequences, as well as with the coping mechanisms most frequently used by the victims;
• as an ethical principle, the needs of the prisoners and respect for the informed choices they make must take precedence over all other considerations.

References

7. UN Manual on the effective documentation of torture and cruel, inhuman and degrading treatment, 1999.

Notes

(1) The term prisoner here is to be taken as anyone held in the custody of an official, or even unofficial, authority, and includes detainees, those under arrest, remand prisoners, etc.
(2) The masculine gender will be used exclusively to lighten the text.
(3) It should be emphasized that it is the responsibility of the detaining authorities to ensure the well-being of those whom they take into custody, and that the authorities can be held accountable should they fail to do so.
(4) It should be remembered that the most basic means of protecting persons deprived of their freedom is — and will remain — their immediate and official registration by those who arrest them.
(5) Many torture survivors have pointed out that describing torture that you have suffered at the hands of other human beings is a virtually impossible task. Victims find it so difficult to convey their experiences for the simple reason that there are no words to describe the indescribable.
(6) Especially as it is practised in the most varied cultural settings.

Note

a) The above text is a slightly revised version of a paper originally presented at the VIII International Symposium on Torture, New Delhi. The second part of this presentation will be published in TORTURE 2/2000 with the title "Visits to detained torture victims by the ICRC (II): the psychological impact of visits and interviews with detained torture victims".
Empowerment of traumatized refugees: a developmental approach to prevention and treatment

Guus van der Veer, Psychologist, Transcultural Psychotherapist*

Abstract
On the basis of practical experience (1), concepts provided by developmental psychology and research on the mental health of Holocaust survivors, therapy, help, and care for refugees with mental health problems are described as a form of empowerment in which non-professionals could play an important role. Using the concept of empowerment, possibilities for prevention of enduring mental health problems in refugees are discussed.

The case of a traumatized refugee
Moses was born in 1979 in a large town in an African country. He was the oldest of three children. In 1991 there was some political unrest in his country. His father, who had been working for the government, disappeared. Moses does not know whether his father was killed or whether he went into hiding. Anyway, the police came to his house on many occasions, looking for his father and threatening the family. The authorities made it impossible for Moses to continue his studies.

One day, when Moses was 17, one of his father's friends came and took Moses to the Netherlands as a refugee. Moses was totally unprepared, and did not even have the chance to say goodbye to his mother and siblings. Since then he has had no contact with his family: they do not live at their former address, and Moses is afraid that they have been killed.

After Moses' arrival in the Netherlands, his father's friend disappeared. Moses was taken to a refugee centre. When his request for political asylum was initially rejected, something went very wrong. Moses started hearing voices and eating leaves, and was diagnosed as psychotic. A psychiatrist prescribed anti-psychotic medication for him. After this, Moses developed a torticollis: as a side-effect of the medication his neck muscles started to function abnormally. Actually, he seemed to freeze. His reaction reminded her of schizophrenia, and made it difficult for him to sleep. He then made a serious attempt to kill himself.

Three years later he was referred by his general practitioner to a second psychiatrist. At the time, Moses was waiting for an answer to his request for political asylum. He was very anxious about it, and the doctor was afraid that Moses might become psychotic again or kill himself.

A developmental view
For psychological development to take a healthy course, certain conditions have to be present. Broadly speaking, a child or adolescent needs three things: a sense of security, a supportive social network, and opportunities. Security means continuity and stability in daily life. It includes protection against violence and abuse. And there is only a sense of security when there is not too much reason to worry about the future.

Social network
An adequate social network includes at least one adult who shows that he or she cares and offers support and understanding. An adequate network includes both adults and peers who can serve as role models. A social network is more adequate if it includes at least some people from the same familial cultural background.

In the case of Moses we can ask to which extent these conditions for healthy psychological development were fulfilled. First, were they present before Moses left his country? His father disappeared when he was twelve. After this, the police often harassed him and his family. All this may very well have shattered Moses' sense of security. As far as we know, in those days not too much went wrong with his social network. However, we know that Moses lost some opportunities, especially the opportunity to study.

After his flight to the Netherlands, Moses was placed in a refugee centre that was not specifically equipped to deal with unaccompanied minors; instead he went to one of the big reception centres. The staff members in these centres have the task of preserving order. They are not supposed to protect and personally care for uprooted adolescents.

Moses had to share a room with two adult men. We do not know much more about the adventures of Moses in this centre. The psychiatrist who is presently seeing Moses asked him about his life there, but Moses did not answer her question. Actually, he seemed to freeze. His reaction reminded her of another young refugee, who had been sexually abused. It is not certain whether something like that happened to Moses: until now the psychiatrist thought it wise not to press the matter. But it seems likely that Moses felt quite unsafe in this refugee centre. Moreover, we can conclude that he felt insecure about the future: his request for asylum was rejected because the authorities decided that his story could not be believed.

Restrictions in daily life
With regard to his social network, we know that as an adolescent Moses was suddenly cut off from the rest of his family. Within the space of a few hours he lost his entire supportive social network. The staff of the refugee centre did not really have much to offer him to compensate for this loss.

Today, four years after his arrival in the Netherlands, Moses still does not have a permanent residence permit. In the newspapers he occasionally reads about compatriots being expelled from the Netherlands. In this respect, also, he...
is unable to experience much security. In the meantime, Moses managed to build up a small social network: he has some friends. He still does not have many opportunities for further development. Government regulations and procedures certainly do not work in his favour at the moment. The temporary residence permit he received has expired. The immigration authorities have as yet no reason to deny him an extension of his stay, but the department of immigration is more than eight months behind in issuing documents. It makes Moses a bit nervous that his papers are not in order. What is worse, his outdated papers are not accepted by many Dutch institutions. This means that Moses does not have the necessary papers to allow him to go to school, to learn a trade, and to improve his knowledge of the Dutch language. Renewing his bankcard, or getting a telephone connection also present problems. He is also not allowed to work.

Prevention of mental health problems
If the conditions for healthy development are lacking, the most obvious preventive approach is to try to provide these conditions. Suppose Moses was your son or your younger brother. What kind of reception would you want him to receive after his arrival as a refugee in a foreign country? First, you would hope that some decent, genuinely interested adults would meet him. Adults who would protect him, guide him, and try to keep him on the straight and narrow path. You would hope that he would meet some peers with a similar background, peers who could understand how he felt, and also teach him from their own experiences: for adolescents it is sometimes easier to learn from peers than from adults. You would like him to have the opportunity to do something useful with his days, such as studying or working. And to have some fun as well.

Crisis situation
One does not have to be a genius to think about a few simple measures that might have prevented Moses from getting into a crisis situation. If he had only received a little more attention from a few good people in the centre when he arrived; a bit more care and protection and coaching. For example: if Moses had been met by a few volunteers, either Dutch people or refugees from his own country, or both, he might not have started chewing leaves. These groups of volunteers could have served as a protective factor. Their support could have compensated for all the stress Moses had to deal with. If this had been so, he might have been able to cope with his difficulties without getting into a crisis situation.

This is of course all speculation, based on common sense reasoning. But in the light of empirical evidence, it seems plausible.

Group consciousness
Helmreich² studied the fate of former Jewish concentration camp prisoners after their arrival as refugees in the United States. It appears that many of these people do not suffer from different, or more, mental health problems than the average American. Only a minority had sought professional help. For the majority, the mutual support provided within Jewish social networks was sufficient. Sadly, from our experience with refugees in Western Europe today, we can say that it is possible that these former concentration camp prisoners had more reason to feel safe and secure in their new place of residence than the refugees of today. Some of them had a rough time waiting in camps before they were admitted to the United States. But after arriving there, their right to remain in the United States was not under discussion. There was no messing about over the rejection of asylum requests and the long procedures involved in this.

The Holocaust survivors who came to the United States did not arrive under ideal conditions. They did not always receive a warm welcome. But there were several Jewish organizations that worked on behalf of them. Helmreich also mentions the important role played by friends, relatives, people they met in the community after their arrival, the Jewish press, and so on. But maybe their own efforts were just as important. These survivors developed their own networks, networks that produced or sponsored plays, lectures, newspapers, and radio programmes. Also, they participated in activities that exposed them and accustomed them to American life and culture.

According to Helmreich, a trait he calls group consciousness was very helpful for many of these survivors. Those who had the feeling that they belonged to a group experienced a common bond of suffering that gave them strength as they faced new hardships and challenges. We are talking here about a group of very traumatized people. They certainly did not easily forget their traumatic experiences. But, against all odds, they were able to develop as mentally healthy individuals, people who on the whole did not have more, or more serious, mental health problems than the average American citizen.

A change in paradigm
One may wonder why the research done by Helmreich has not become something of a bible for psychiatrists and psychotherapists. The study was based on 170 in-depth interviews made a few years ago, as well as a study of archives containing 60,000 interviews conducted by social workers with refugees when they first came to the United States during the 1940s.

There are signs that may indicate a change in paradigm, at least in countries outside Western Europe and North America. In Third World countries that suffer the aftereffects of armed conflict, a new generation of mental health workers has become active, and they do not seem too impressed by Western views on trauma counselling. These people say that rebuilding their shattered communities and mobilizing its resources are much more important and much more effective than individual treatment, although individual treatment may be useful in some cases. What does their experience mean for the therapy, help, and care of refugees in Europe? In order to stimulate spontaneous processes of recovery, and to prevent psychiatric disorders, Western therapists and care-providers could encourage refugees to organize themselves to help each other, instead of making them believe that they should either cope as individuals or use professional help.

The case of Moses – continued
As was mentioned before, during the crisis situation Moses was briefly hospitalized. After this he was transferred to a refugee centre where he received a bit more of the kind of care a boy of seventeen needs for a healthy psychological development. As a result of the painful experience of the torticollis, his self-confidence had suffered a severe blow and he needed some extra support. At present he is living in a regular apartment in a Dutch city.

Treatment or empowerment?
Recently Moses was again referred to a mental health facility because his family doctor was afraid that he might become
focused on putting Moses at ease. In this way she managed to inspire enough trust in Moses for him to come back for a second meeting. During this meeting, she suggested that they work on getting control over his symptoms. In the face of his sleeping problems and feelings of tension, Moses felt powerless. The therapist tried to change this by doing relaxation exercises with him which made him feel less tense and which he could also do on his own. She also said that she thought that Moses might not feel much like talking about the past, and that he was probably more interested in making realistic plans for the future. When Moses agreed, she suggested that, in order to work with him on his future, it might at some time be useful to look back for a while at the past. Then she returned to Moses' present complaints. She offered Moses an explanation of how his symptoms had arisen, and gave him the opportunity to ask questions. It became clear that Moses had been afraid of going crazy for a long time; the psychiatrist's explanation of his symptoms had a very reassuring effect. In addition, the psychiatrist offered to support Moses in his contact with his lawyer about his asylum case.

The planning phase
Moses became a regular visitor. It had been agreed that the meetings with the therapist would last 30 minutes. But he had a lot to talk about and always wanted to stay a bit longer. Moses seemed to get very attached to the therapist. The conversation was mostly about present day problems. For example: because he did not have a residence permit, he was not allowed to go to school to do an advanced Dutch language course and some vocational training. The psychiatrist made a plan with him about how he could improve his Dutch without going to school: by learning one interesting word every day. Moses made it two words a day, which he discussed with his psychiatrist during their meetings. She encouraged him to go to the library to read simple books.

The regeneration phase
Other topics of discussion were conflicts with his roommates, volunteer work he could do in order to practise his Dutch and learn more about the Dutch way of life, and how he could enjoy the summer by taking part in activities that did not cost too much. The last discussion resulted in his going on a bicycle trip through the Netherlands with a group of friends.

Moses only occasionally talked about the past. Once, the psychiatrist asked him about his first weeks in the refugee centre. Moses became very tense, and his only answer was, "My future has been destroyed". The therapist reacted by doing a relaxation exercise with him, which was also an exercise that gave him the opportunity to express his anger. On another occasion, Moses described his life at home with his mother and siblings, how pleasant and easy it used to be.

Could non-professionals provide this type of care?
In the therapy with Moses, the psychiatrist did not do anything requiring a lot of specialist skills or knowledge. In fact, she said that the interviews with Moses went well because she managed to put aside all her thoughts about therapeutic techniques except relaxation exercises. She concentrated on making contact with Moses, listening to him, and giving him control over what was discussed during the meetings. She said:

"I had to unlearn asking too many questions that were interesting for my diagnosis, but unrelated to what was on his mind. I know that some of my colleagues would find it unsuitable for me as a therapist to help Moses in his contact with his lawyer.

Moses has to deal with problems that are as yet beyond his and my capabilities. We discuss these problems. I don't pretend that I have a solution for them. I make him feel that I understand that he is suffering a lot, and that the burden he carries is a heavy one. I think that this recognition means a lot to him; and because I give this recognition he is now more able to look at the brighter things in life.

I do things that in normal circumstances a father or mother would do. But then without all the dependency: he does not expect me to invite him home at Christmas."

A trained non-professional could have done the same things as the psychiatrist. That is not surprising, because there is ample empirical evidence to suggest that there are more similarities than differences between the kind of help provided by professionals and the kind of help offered through informal social support. 3 In both forms of help the same sorts of processes play a part, e.g. supporting the person in maintaining some self-esteem, providing support by giving information on the nature of a problem or possible courses of action, encouragement, reinforcement of positive expectations, reassurance that things are bound to improve, and sometimes concrete practical help or instrumental support. In both forms of help a confiding interpersonal relationship with a liked and respected person appears to have a major impact. (2) Moreover, there is a body of evidence suggesting that for people with emotional problems, help by non-professionals is not less effective than help provided by educated professional helpers. 3

Of course, both types of help have strong and weak points. Professional helpers are strong in keeping professional distance, and are therefore strong in being objective and non-judgmental. But they may be weak in understanding the daily life of clients from underprivileged groups, such as refugees. When non-professional refugees help refugees who have just arrived in Western Europe, the opposite is the case. These helpers are very familiar with the daily problems encountered in a foreign country, they know how it feels when a request for political asylum is rejected, and how it is to be cut off from family and friends. But they may at times be judgemental, when a refugee has a completely different style from theirs of coping with his problems.

Training non-professionals to become helpers
What attitudes, concepts, and skills should be included in training programmes for non-professionals who want to help people with mental health problems? As far as attitudes are concerned, non-professionals may have to learn that many people have problems that are beyond the capabilities of both client and helper. When this is so, listening and sharing the feeling of powerlessness can still be a very effective form of help. The problems will not disappear, but the client will feel
accepted, recognized, understood, less lonely, and emotionally supported. And this will result in his feeling better and more energetic.

Moreover, non-professionals may have to become more aware of when they are being judgemental. Then they can also develop the habit of considering whether they are really able to help a person whose behaviour does not conform to their own ideas about what is wise or morally correct.

Understanding the phenomena that are usually summed up with the concept of counter-transference may be very valuable for non-professional helpers. These phenomena can be discussed without using the professional term, based on a description such as: “feelings you can have about a person you want to help.”

With regard to skills that are useful for non-professional helpers, the ability to give psycho-education seems most important. Psycho-education here refers to explaining how the complaints, frequently mentioned by the people they want to help, come into existence. So refugees who want to help other refugees, but who do not have a professional education in the mental health field, could benefit from teaching on the nature of nightmares, panic attacks, sleeping problems, outbursts of aggression, sexual problems, and somatic complaints for which the doctor can find no physical cause. These refugees could also be informed about the different ways of coping with these symptoms. One could discuss with them what can happen to a family after one of the members has been severely traumatized. They could be made familiar with the consequences of sexual violence. And finally, they could be trained to convey this knowledge in simple terms, to both individuals and groups.

This sort of training should not be a one-off event. It should be a process lasting at least two years, during which training alternates with periods of practical experience and organized opportunities for reflection on this practical experience. One could add here that presenting a training course for non-professionals who have grown up in a different culture is not a matter of routine. It requires openness to different opinions about mental health and to traditional approaches to healing that exist in the participants’ cultures. Moreover, the participants themselves have often suffered very traumatic experiences, and therefore the training should include plenty of opportunities for them to reflect on their own personal experiences.

Empowerment of refugees in Western countries
Refugees, even when they have been severely traumatized themselves, could become very effective helpers. Training refugees who have no professional education in the mental health domain to become helpers for companions in emo-

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Notes
(1) The author has worked as trainer for counsellors in Central America, the former Yugoslavia, and Central and South-east Asia.
(2) However, people with problems that are more severe or of longer duration are more likely to be taken to professional helpers.
(3) There may be different reasons for this. Some professionals seem to avoid emotional contact with people whose experiences may shake their world views. Others may want to avoid the confrontation with feelings of powerlessness. Still others seem to be wavering on the brink; avoiding situations they fear might turn out to be ‘strange and unfamiliar’. For example, some professional helpers, without even trying to work with people from a different cultural background, argue that they first need extensive training from an anthropologist.

Note
a) This paper was presented at the European conference “Empowerment of traumatized refugee families” Jn Copenhagen 21-23 October 1999. Please also refer to page 20 in this issue of TORTURE.
The physical and psychological findings following the late examination of victims of torture

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Introduction
The Medical Foundation for the Care of Victims of Torture was set up in 1986 by a group of clinicians and others working with victims of torture in the UK Medical Group of Amnesty International. Although the Medical Foundation is principally a human rights and therapeutic organization, there has been an increasing number of requests for doctors and other clinicians to produce medico-legal reports on asylum-seekers as part of their claims for refugee status. The Asylum Team at the Medical Foundation reviews all these requests from legal representatives, and about half of those referred are given appointments to see examining doctors. In some cases reports are not written, either because the doctor is not confident of the veracity of the story that he or she is asked to document, or because there is nothing on which to write an expert report. Some inconsistencies in the history are normal, particularly when the different stories are given to people with different professional backgrounds, such as doctors, lawyers, and immigration officials, over a long period of time. It should always be stressed that the absence of physical and psychological signs must never be used as evidence that torture has not occurred.

Of the 2,873 new patients accepted by the Medical Foundation in 1998, reports were written in 924 cases by 32 doctors at the Medical Foundation. This is an increase of 48% from 624 reports written in 1997. By the time an asylum-seeker sees a doctor at the Medical Foundation, he or she will have been released or will have escaped from detention in another country, travelled to the UK, obtained legal advice, and been referred. Patients will therefore have been tortured quite some time in the past. The median delay is about two years, although it is not uncommon to be asked to see individuals some six or eight years after they have been tortured. Many will have been detained and tortured on several occasions, and so may have several generations of scars. It is extremely rare to see someone less than six months after he or she was tortured, and this is what is meant by the "late examination".

The Medical Foundation is based in a relatively small building that is intended to be as reassuring as possible for victims of torture. The waiting room is on the ground floor, and most of the consulting rooms are on the first and second floors. The majority of patients are seen here, although a few are examined in UK Immigration Detention Centres, and occasionally in prisons. The majority of patients are seen with the help of one of the Medical Foundation team of interpreters. Most doctors introduce themselves and the interpreter in the waiting room, and show the patient to the consulting room. This gives the doctor a chance to observe unobtrusively how the patient rises from the chair and climbs the stairs. The consulting rooms have a desk against the wall so that the centre of the room is clear for the doctor and the patient; and, when used, the interpreter can form a triangle. Occasionally a doctor who is new to the Medical Foundation will observe the consultation, but normally no other person is present at the consultation.

Unless there is a good reason to the contrary, female patients are seen by female doctors and with female interpreters. This is because there is frequently a history of rape that the victim may be unwilling to discuss in front of males, and this history is not always known at the start of the interview. It is also necessary for the patient to expose all her body in stages to the doctor, and most female asylum-seekers are uncomfortable to do this in front of a male doctor. For men, particularly those who have been sexually assaulted in detention, the situation can be much more complex. In general they should be seen by a male doctor, although occasionally men prefer to talk about sexual abuse in front of a female interpreter, because describing it in front of a male of their own cultural background is too difficult.

The consultation starts with the doctor introducing him or herself and explaining the purposes of the interview. The interpreter, if present, will introduce him or herself as well, and say a few words about his or her independence and confidentiality. Doctors at the Medical Foundation come from a wide variety of medical backgrounds, and the exact form of the consultation will depend very much on his or her previous experience. Some start by discussing the past and social history of the patient, to put the experiences of detention and torture in context. Others open by asking questions about the current physical and psychological state. The third option is to start by asking directly, "When was the first time that you had problems with the authorities in (your country)?" This then structures the consultation in the same form as the final report. All three sets of information need to be sought, and generally it does not matter in which order. However, sensitivity to the reactions of the patient means that any line of questioning can be deferred until he or she is ready to talk about it. Questions of detail about the circumstances of detention help to gain confidence in the authenticity of the history. These would include such questions as "How big was the cell?", "Was there any lighting?", and "How could you go to the toilet?" In obtaining information about methods of torture used, it is important to avoid leading questions, although it is often necessary to ask follow-up questions to elicit details that the client may consider either too embar-

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The commonest finding following the late examination of graphs in an expert report, it is essential to be certain of the lesions, and it can be very helpful in giving an opinion on the when the patient supplies a plausible attribution.3 Very Most scars are non-specific, but some individual scars can be may ignore small scars that he or she considers unimportant, and hygiene usually makes this sign unhelpful. Cigarette burns can be quite distinctive. Typical scars are 5-10 mm in diameter, with a depigmented centre and a hyperpigmented periphery.5 Some are larger and irregular in shape from the cigarette being rubbed in. Where the cigarette was not pressed in so firmly, it can leave a small non-specific area of hyperpigmentation. Burning with a hot metal rod or similar device commonly leaves sharply demarcated atrophic scars. Scars from hot water or, less commonly, caustic substances, leave a pattern of scarring and hyperpigmentation from which the flow of liquid is often quite clear. A single episode of scalding could of course be from a domestic accident, but when there is evidence of several episodes, it is much clearer that this is the result of torture. Incisions may be caused by bayonets, often separated from the rifle, or by knives or broken bottles. Sometimes the scars remain narrow and clearly defined, but often it is difficult to distinguish them from scars caused by laceration, particularly if the victim did not receive medical attention after the injury. Regular patterns of small incisional scars in Africans are more likely to be tribal markings or caused by traditional healers, but sometimes such scars have been caused by torture.6 Whipping can sometimes leave lines of hyperpigmentation, especially in darker skin. In those with Middle Eastern skin types, hyperpigmentation is commonly seen up to five years after the incident, but has usually faded within ten years. Classic tramline scarring is much rarer. Sometimes sharp objects such as pieces of razor blade are embedded in the whip, and they leave more identifiable patterns. Military belts with heavy buckles, such as the Zairian cordelette, may also leave regular scars. These lesions are rarely confused with striae. Striae are caused by sudden gain or loss of weight, so they are also seen in some former detainees. They tend to be irregular rather than linear, and have a well-recognized distribution.5 They are commoner in dark-skinned individuals. Less regular patterns of hyperpigmentation are seen following abrasions, again particularly in darker skins. Tight ropes or handcuffs may leave marks around the wrists, and marks following rope burns can be seen elsewhere on the body where the individual has been tied up or suspended. These are rarely pathognomonic individually, but the locations and distribution of the marks can support the history of torture. Fingernails and toenails can be extracted or crushed during torture, but the late appearance is usually indistinguishable from innocent trauma or infection. Self-inflicted scars are seen from time to time, although the pattern and location usually allows them to be distinguished from scars of torture.7 Some asylum-seekers attribute lesions to their torture that are clearly from another source. Sometimes this is the result of misunderstanding, in that the individual believes that he or she did not have any scars before the torture, and therefore all the marks on his or her body must be from the torture. In other cases it is probably a deliberate exaggeration. This is difficult for the doctor to manage. However, the lesion must be documented together with the patient’s attribution and the doctor’s opinion, even if this might undermine the overall credibility of the patient. If the doctor believes from other lesions that the patient has been tortured, this should be stressed. More commonly, patients are very willing to point out scars that are not related to torture, and this can sometimes add to their credibility.6 Falanga (beating on the soles of the feet) is a common method of torture, particularly around the Mediterranean and in the Middle East. Patients will usually describe painful, swollen feet for days or weeks after the torture. Some describe pain on walking several years later, often up the front of the lower leg, others may suffer from pain in the foot in bed at night. There may be some tenderness of the sole of the foot on palpation.3 However, the recognized syndromes of permanent damage to the foot probably occur only in those whose feet were beaten most severely.6 Slaps to the ear can sometimes damage the eardrum. However, the finding of tympanic scarring does not exclude childhood infections. Palestinian hanging (suspension by the arms tied behind the back) can lead to neuropathy of the brachial plexus, especially if it has been prolonged. Sometimes there are residual signs of this, and if they are still present after two years, they will probably be permanent. Patients sometimes give a clear
history of weakness and loss of specific movements after suspension, which then recovered over the subsequent weeks. Such a history in someone who has no understanding of the clinical processes involved can be very supportive of a history of torture. Usually there is a long-standing complaint of pain and tenderness in the muscles of the shoulder girdle, and limitation by pain of movements, especially rotation. Some of this may be psychosomatic, though there is usually a real organic element.8

Almost all forms of torture include an element of sexual humiliation, but it is difficult to estimate the incidence of sexual assault as part of torture because it is under-reported.9 Although far fewer women than men are detained, those women who have been tortured in detention are extremely likely to have been raped or otherwise sexually abused. Vaginal rape and objects pushed into the vagina can cause immediate damage, but this heals in time, although HIV and other sexually transmitted diseases may persist, as might the fear of having contracted them.10 In women who have delivered babies, especially subsequent to the rape, there will be no discernible physical findings.11 If there has been no other torture, this can be very difficult to document, because the doctor's opinion will have to be based on the demeanour of the woman and her description of her psychological symptoms. Sexual abuse of males is probably much less common, but there are currently no data on this. When there are conclusive physical signs from other forms of torture, a man may not disclose sexual abuse, so it is necessary to be particularly sensitive to this possibility during this part of the history taking. Torturers often tell men when assaulting their genitalia that they will become impotent, which may become a self-fulfilling prophecy. Most men are less distressed once they have talked about their sexual abuse, and have been reassured about the physical sequelae.12

Urethral strictures and thickening of the distal urethra are sometimes found in men who have had objects inserted into the penis, and there are few other causes of this. Scrotal and penile wounds usually heal without a scar, so when scarring is found, it indicates severe injury, such as may be caused by electric shocks delivered through crocodile clips. Anal rape or objects pushed through the anus in either sex can sometimes lead to scarring. Scarring from anal fissures is seen in a proportion of the general population, but sometimes a doctor will see scarring in an unusual part of the anus, or scarring that is larger than commonly seen following anal fissures.13

Psychological assessment

Most asylum-seekers describe a range of psychological symptoms, although not always from asking open questions. For example, they may not perceive their disrupted sleep pattern as a medical problem. Psychosomatic symptoms are particularly common, but most asylum-seekers believe them to be physical, and this must be documented. The symptoms include sleep disturbances, particularly lying awake worrying, then waking with nightmares when they do get to sleep.3 Sometimes it is difficult for them to differentiate between a nightmare and an intrusive memory. Depression and anxiety are common, and there may be a behaviour pattern to avoid stimuli that remind them of the trauma. These are the symptoms of Post Traumatic Stress Disorder (PTSD),14 but they are described by others as the universal symptoms of loss and suffering.15 It is rarely possible to establish the original stressor from the symptoms described by the patient. The experience of seeking asylum is stressful even for those who have not been tortured, and the thought of being returned to the country of origin makes the symptoms worse.16 The patient's description of psychological symptoms should be listed, together with a description of the individual's demeanour and, if they are available, independent descriptions of behaviour. It cannot be said that they prove a story of torture, but they can be supportive of it. Ultimately they are further pieces in the jigsaw picture of an individual's history of abuse. This leads to the expert opinion on whether the symptoms and signs are likely to have been caused in the way the patient describes.

Writing the report

The history should be written in as great detail as seems relevant, particularly focusing on episodes of ill-treatment. It should be made clear that this is what the patient said, while not implying that it must necessarily be true. When there are discrepancies with other previous written statements, these should be resolved if possible by discussion. The physical findings should be listed in a logical order and each given an attribution by the patient. The examiner's opinion as to whether it is consistent, whether it agrees with the patient's account, should also be added.

Since it is seldom possible to state categorically that lesions must have been caused by torture in the manner described, the examiner should make an assessment of likelihood. Terms such as "compatible with" or "consistent with" can be used, meaning that the lesions could have been caused in the manner described by the patient, but that there are many other possible causes. The term "fully consistent with" is best used to mean lesions that are likely to have been caused in the manner described by the patient, and that there are few other possible causes. Very occasionally it is possible to say that the injuries could not have been caused by accident or disease.

Conclusions

Even many years after a person has been tortured, it can still be possible for a doctor to provide an expert opinion to support the history. Under the 1951 Refugee Convention, an asylum-seeker must demonstrate a reasonable fear of persecution to avoid being returned. In the UK, it is necessary to demonstrate only that there is "a reasonable degree of likelihood" that he or she has been tortured. This is quite possible when physical signs are present, if an assessment is made in the doctor's mind as to other possible causes of the lesions individually and collectively. Such documentation should also be valuable in supporting an allegation of torture when a higher standard of proof is required, such as in a criminal prosecution. It must always be stressed that the absence of conclusive physical signs, or of any physical and psychological signs and symptoms at all, does not disprove an allegation of torture.

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Resignation of Professor Bent Sørensen from CAT

According to the minutes of the 407th meeting of the Committee Against Torture (CAT), held at the Palais des Nations, Geneva, on 18 November 1999, “the Chairman [Mr Burns] said that Mr Sørensen, who had been on the Committee since its inception 12 years previously, would probably not be returning in the future, and he therefore wanted to express the Committee’s appreciation to him for the many years of devoted work. A distinguished surgeon with an international reputation in torture rehabilitation, Mr Sørensen had also been a driving force behind the International Rehabilitation Council for Torture Victims; he had been instrumental in introducing the procedures adopted by the Committee in its early years, and his presence on the Committee was certainly one of the reasons why it had been so effective. He had succeeded in making a body that was composed largely of lawyers aware of the medical aspects of the problem of torture; that was a considerable achievement. On behalf of the Committee, he expressed gratitude to Mr Sørensen for his many years of service.”


CAT elections

The following four current members of the Committee Against Torture (CAT), who have served on CAT to everyone’s satisfaction, have been re-elected as members of the Committee:

- Mr Peter Thomas Burns, Canada
- Mr Guilbril Camara, Senegal
- Mr Alejandro González Poblete, Chile
- Mr Andreas Mavrommatis, Cyprus

The remaining vacancy was filled by a woman with an outstanding curriculum vitae:

- Ms Felice Gaer, United States of America.

ANNOUNCEMENTS

Professor Bent Sørensen’s Travel Grants

Professor Bent Sørensen’s* Travel Grants in Support of Medical Doctors’ and other Health Professionals’ Participation in International Activities to Combat Torture and its Consequences were established under the RCT on the occasion of former president of RCT (1984-90) Bent Sørensen’s 70th birthday, March 8, 1994.

A number of travel grants will be available this year to enable medical doctors and other health professionals from all parts of the world to participate in international activities aiming at combating the practice of torture and providing appropriate care and assistance to victims of torture.

These travel grants will be awarded to cover the cost of participation in scientific or professional meetings as well as in fact finding missions and study trips relating to torture and its consequences. Travel grants may also be awarded to allow participation in relevant education and training activities either as faculty or student.

The grants will be awarded by a review committee appointed by the board of the RCT and will be based on written applications received before May 1, 2000. The applications should contain:

1. Purpose
2. Budget
3. C.V.

and should be sent to:

Professor Bent Sørensen’s Travel Grants
Rehabilitation and Research Centre for Torture Victims
Borgergade 13
DK-1300 Copenhagen K
Denmark

* Bent Sørensen, Professor, MD, DMSc, former President of RCT; former Rapporteur to the UN Committee Against Torture (CAT) and former First Vice-President of the Council of Europe’s Committee for the Prevention of Torture (CPT).
Cases of organized violence and torture in Zimbabwe in 1999

Anthony P. Reeler, Clinical Psychologist, LLB, BA, MSc*

Background
The Zimbabwe Human Rights NGO Forum, the “Human Rights Forum”, was formed by nine organizations to address the problems of the Food Riots in 1998. Apart from legal assistance to many persons arrested and imprisoned on remand, the Human Rights Forum provided assistance to 42 persons who approached the Forum for assistance following injuries due to shootings or torture. The Forum issued appeals to the Government for an independent inquiry and compiled a brief report in support of this appeal and the allegations. The appeals and the report were ignored by the Government.

Allegations and harassment
There have been credible allegations of torture in the case of three Americans arrested for the illegal possession and transportation of weapons. The allegations were again supported by medical evidence, and this testimony was accepted by the trial judge, Mr Justice Adam, in mitigation of sentence. Here the Attorney-General, instead of commencing proceedings against the torturers, launched an intemperate attack on the judge, which is currently the cause of an action for contempt against him.

At least two persons have had to be assisted in obtaining asylum because of well-founded fears for their safety. One case involves a person associated with the labour movement. Having survived a murderous attack in 1998, he was subjected to continuous harassment by State agents, causing extreme fear and distress to his family. The harassment continued subsequent to his fleeing the country, with the last episode occurring on the eve of the launch of the Movement for Democratic Change. The other case involved a young man who may have been a witness to the torture of the three Americans. After a lengthy period of harassment, he too fled the country, and, here too, harassment of his family by State agents has continued.

Violations, killings, and torture
The Human Rights Forum has received an increasing number of requests for assistance in cases of gross human rights violations. There has been a case of an extra-judicial killing, when a suspected criminal was beaten to death by members of the ZRP in Mhondoro. The cause of death was established at a second autopsy after protest by a local member of parliament, and the officers concerned have been charged with murder.

Torture would appear to be on the increase, not merely in political cases, and there have been a series of reports of torture in the media.

There have also been allegations of the torture of students from the Harare Polytechnic who were arrested following disturbances in October, and also allegations that three University of Zimbabwe students were tortured by security guards of the University. What is noteworthy in the reports are the allegations of the use of "falanga", or beating on the soles of the feet, by both the police and the security guards. Falanga has not previously been reported widely in Zimbabwe, but has been growing in frequency through the 1980s and 1990s. It has been observed elsewhere that falanga tends to increase as the more obvious methods of torture become detected, or as public pressure against the use of torture grows.

Governmental attitude
Firstly, it is evident that there is very little attempt by the government to take allegations of gross human rights violations seriously. This was the case in respect of the serious allegations made about the behaviour of the Zimbabwe Republic Police and the Zimbabwe National Army during the Food Riots, and continues to be the case today.

Secondly, there is the clear position of the Government that certain cases of political torture are justified. It is the case that the President, senior Ministers, and even the Attorney-General are on record as condoning the torture and ill-treatment of the Standard journalists. Although these statements have been repudiated publicly, their effect is continually minimized by additional statements.

Thirdly, it is seems evident that members of the ZRP practise torture in routine fashion, while the uniformed branch are frequently guilty of assault. That assault is routine can be gathered from the involvement of private security guards in assaults, obviously under the impression that assault is a routine part of police work.
Inter-American Court on Human Rights condemns the State of Guatemala for the brutal murder and torture of five street youths

In its first ever case involving children, the Inter-American Court on Human Rights (the Court), based in San José, Costa Rica, has condemned the State of Guatemala for violating the American Convention on Human Rights when uniformed agents of the State of Guatemala brutally murdered five street children and youths in June 1990. Four of the youngsters had been brutally tortured.

The five youths, aged between 15 and 20 years old, were murdered in 1990 by two National Police officers. The tortured and mutilated bodies of Henry Giovani Contreas, Federico Clemente Figueroa Tunchez, Julio Roberto Caal Sandoval, and Jóvito Josue Juárez Cifuentes were found dumped in the Bosques de San Nicolas, an isolated area of Guatemala City, the capital of Guatemala. Some of the youths had had their eyes burned out and their tongues severed; all had been shot through the head. A fifth youth, Anstraun Villagráñ, was fatally shot in the back by the two same police officers some time after the original killings. Villagráñ was a friend of the other four youths.

After a protracted legal battle in Guatemala, which lasted four years, and after death threats and the murder of two key witnesses by others, seven judges from various countries in the Americas heard the testimonies of a number of witnesses for Casa Alianza, including two mothers of the victims, and four police officers, who were witnesses for the State of Guatemala. The sentence comes during the Court's XLVI period of session.

Significantly, the State of Guatemala was also condemned for violating Articles 1, 6, and 8 of the Inter-American Convention for the Prevention and Punishment of Torture. The Court's decision was made public on 2 December 1999.

"This is the first ever case in the 30-year history of the Inter-American Court where there is a ruling on children as victims of human rights abuses. All too often we forget about the children who are victims of wars and violence created by adults," commented Bruce Harris, the English Regional Director of Casa Alianza.

Having now condemned the State of Guatemala, in its next sessions, expected to be held in February, the Court will discuss the settlement and the amount of damages to be awarded to the families of the victims.

Selected list of publications

received in the IRCT International Documentation Centre


Caring for victims of torture and organized violence

26 November 1999, Ramallah, West Bank

Dr Mahmud Sehwail*

This international conference was organized by the Palestinian NGO, the “Treatment and Rehabilitation Center for Victims of Torture” (TRC), which is located in the Palestinian city of Ramallah and was founded by a group of medical professionals in 1997.

To be especially noted were the papers read on behalf of the Gaza Community Mental Health Programme, written by Dr A. Tawahina, entitled “The psychological effects of torture: an empirical study of tortured and non-tortured Palestinian prisoners in Israeli prisons”. It reported a well-designed and executed research project conceived locally, with a local Gazan subject population. Other papers included: “Narrative therapy with trauma victims” by Dr Sameh Hassan of the Near East Cultural and Educational Foundation of Canada (NECEF). A report on the newest technologically advanced investigations with scintigraphy imaging to detect hard and soft tissue sequelae of physical torture of Turkish prisoners was presented by Dr Veli Lök of the Human Rights Foundation of Turkey in Izmir. On more philosophical lines were presentations by Dr Helen Bamber, Medical Foundation for the Care of Victims of Torture, London, and by Dr Dan Filk, Physicians for Human Rights (PHR), Israel.

The rest of the nine formal presentations dealt with the issue of health as a human right and with prohibition against the involvement of doctors in the practice of torture, such as “Health as a human right, programmatic applications” by Dr F. Allodi and Dr J. Graff of NECEF, Canada, who outlined the legal instruments, mostly emanating from the United Nations since 1948, with specific guidelines for the protection of health in general and in concrete populations. Drs Elisabeth Gordon and Duncan Forrest, Medical Foundation, presented “The torturer as a perverse physician”, and Dr Avi Raps of PHR, Israel, presented “Medical professionals participating in torture”, which dealt with the extremely serious and sensitive issue of medical personnel taking part, directly or indirectly, in the torture process. These were balanced by the more positive and equally necessary angle of the “Role of physicians in promoting health and preventing human rights abuses”, presented by Dr Mahmud Sehwail, Director of TRC in Ramallah.

The forum voted unanimously to write and send a communal letter, in this case to the President of the Israeli Medical Association, that urged the President to state clearly and unambiguously the position of the Association towards the involvement of Israeli physicians in the violation of the rights of Palestinian and other prisoners in Israeli prisons, and to make it known to all members of the Association, the Government, and the Israeli society.

The infrastructure and organizational details, so important and often so difficult in this region, were of the highest order, smooth and flawless. The contents and process of the scheduled presentations by internationally known experts were of singular quality.

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European conference: Empowerment of traumatized refugee families

21-23 October 1999, Copenhagen, Denmark

Edith Montgomery, PhD*

The aim of this conference was to bring together European experts and decision-makers in order to discuss lessons learnt from community work with traumatized refugee families. The point of reference was psycho-social courses for traumatized refugee families (PCTF) a method developed and implemented by the Danish Red Cross in cooperation with Save the Children, the Danish Refugee Council, and the Association of Danish Educational Psychologists. These courses, which are described in a booklet published in Danish, English, French, and German, (1) have three objectives: strengthening the prospects of resuming a normal life for refugees, strengthening families’ efforts to re-establish the family roles and unity within the family, and strengthening the ability of children and adults to rediscover and develop their own resources. The content of the courses has been adjusted according to lessons learnt during the process, and stakeholders (families and municipal social workers) have expressed high satisfaction. A thorough evaluation may explain the relations between the theoretical background and the experience-oriented knowledge obtained during the course.

Plenary presentations, group work, and discussions

Magne Roundalen, Norway, pointed out how war traumas in children necessitate repeated use of more primitive, emotional brain structures at the expense of the neocortical brain, with its cognitive functions of language and thought. Talking about the experiences is necessary for cognitive processing and release of the overloading of the emotional brain. Nora Sveaass, Norway, emphasized the need to deal with how people make sense of their experiences. The important research question is “what kinds of disasters and traumatic events have what kind of consequences for whom under what environmental conditions”. Instead of a more traditional individualized rehabilitation model, she recommended an integrated holistic assistance that permits case management at the health system level combined with strengthening of the family system, the social support systems, and a priority given to employment and activity. Guus van der Veer, the Netherlands, told about his experiences in training refugees to become helpers. (2) This renders the refugees less dependent on the help system, and at the same time gives new meaning to the helper. Helping others can result in a feeling of competence, and often also invites favourable reactions from the social environment. Peter Elsass, Denmark, raised the question of whether it always is the best thing to remember, or if traumatic memories at times are best forgotten. How memories are dealt with and how they are remembered is interconnected. In a local community in Peru, for instance, the people have a shared memory that is connected to the history of the community, while people in a similar community in Columbia have a very individualistic memory of traumatic events. The Peruvians had dealt considerably better with the effects of their experiences than the Colombians, without the help of professionals and psychotherapy.

Working groups: suggestions and views

Considerable time was used in smaller working groups dealing with various aspects of empowerment and the dilemmas facing professionals working with refugees. From the many topics, some suggestions and views crystallized in the general discussion:

• Empowerment of the refugee implies involving the refugee in our daily work, in order to offer him/her the choice and the opportunity to master and control his/her own life.
• Professionals need to explore how they can function best as advocates for families, and how they can make themselves available in an authentic, genuine way, and at the same time respect the expertise of the clients on their own lives.
• The concept of empowerment is a seductive one. There is a danger that the concept might be deprived of its meaning and become almost a slogan. We need to focus on how we can prevent a patronizing usage of the concept.
• Empowerment also implies that justice is done on a superior level – across national borders. Is it at all possible to talk about “empowerment”, when the refugee is marked by the uncertainty of the future? When he is still waiting for a reply to his asylum application? When he finds himself in the periphery of society, living in a shelter for refugees in complete anonymity?
• All psycho-social endeavours involving refugees are conceived in a specific political and social context, which should not be ignored by the professionals. Practitioners and researchers need to deal with the question of how their knowledge can inform and influence the political level and be of consequence in the political debate.

Evaluative comments by Professor Peter Elsass

Five years ago the topics of such a conference would have been more specifically therapeutic, such as dealing with the
concept of transference and counter-transference. The present conference was characterized by a practical outlook: social intervention was the main topic, while freer discussion and co-operation with paraprofessionals and non-professionals were still possible. The metaphor of empowerment illustrates the shift to a practical outlook; it is a vague concept, but nevertheless useful if it can generate energy and discussion.

Conclusions of the conference

• Empowerment of traumatized families is conditional upon national legislation embracing clearly defined statements of the offers to traumatized refugees. There is no in and around Europe extensive knowledge and experience relating to psycho-social rehabilitation of refugees. It is of decisive importance for both the refugees and the recipient countries that optimum use be made of this knowledge and experience.

• Empowerment of traumatized children can only be achieved to the full extent by implementing the recommendations of the International Children's Convention at all levels. This can be done by ensuring that in schools, kindergartens, and wherever else children are met by professionals, the necessary effort is made to enable refugee children to live a good life. Experiences from, for example, the work of the Danish PCTF-project (Psycho-social Courses for Traumatised Refugee Families) have shown that, through an integrated psycho-social effort, it is possible to assist many children in better control of their own existence.

• Many factors contribute to the integration and rehabilitation of traumatized families. Some of these factors relate to fundamental social issues, such as safe housing conditions, employment, speedy processing of applications, family reunification, etc. For improved and quicker integration and rehabilitation, it is imperative that authorities and organizations in the individual countries actively support these factors. General legislation relating to general conditions for immigrants cannot be regarded as adequate for refugees, who ought to be governed by a code of practice that satisfies a need for mental and social rehabilitation.

• The optimum use of existing professional knowledge in the European countries demands forums for an ongoing dialogue between refugees, professionals, and politicians. The European conference in Copenhagen revealed a need for a European forum to collect and exchange existing knowledge and existing experiences as a basis for both political and professional initiatives. Such a forum would furthermore serve to inspire and influence other relevant forums. It is recommended that such a forum, meeting for example once a year, be established under European Community auspices.

Notes

(1) Psycho-social Courses for Traumatised Refugee Families, 1999. Danish, English, French, or German copies of this booklet can be obtained free of charge from: »Flygtningehøjskolen«, Att: Ms Hanne Kolze, Programme Manager, The Danish Red Cross, P.O. Box 2600, 2100 Copenhagen Ø, Denmark; Telephone: +45 35 25 92 35, Fax: +45 35 25 93 60, E-mail: hanne_kolze@redcross.dk

(2) Please refer to page 8 in this issue of TORTURE.

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The VIII Symposium on Torture was held at the turn of the century and the millennium, and it is a fitting time to take stock of how far we have come, and where we are going. What is the message that we take away from the debates of the last three days, for the 21st Century? I believe that it is a strong message of hope. The 20th Century has been blighted by more crimes of genocide, more torture, and more crimes against humanity than any other period of history. But at the same time we have seen the steady growth of a broad human rights movement, which has grown stronger and more purposeful with each decade. The movement against torture has been one of the central pillars of the human rights movement. This particular grouping has grown from small beginnings to the strength that we see represented here today. At this Symposium on Torture, we have heard 198 papers, organized into 40 sessions, presented to more than 300 delegates from 64 countries.

The 1999 Symposium is particularly important because it involves a dramatic broadening of the scope of the movement. The work against torture spearheaded by RCT and the IRCT began with the health professionals who encountered the physical and psychological effects of torture in the survivors they treated. In this symposium health professionals have joined forces seriously for the first time with other organizations, law enforcement agents, and the media. In the era of mass communication, the active involvement of the media will make the difference between success and failure in winning the hearts and minds of the people in this task. I believe that important groundwork for this cooperation has been laid in this symposium.

**Two categories**

The subject matter of the symposium can be seen as falling into two broad categories. The first deals with torture that is current — where it is happening, what its effects are on survivors, and what treatment strategies help survivors. The second is forward-looking, and is basically about strategies that will lead to prevention, from the level of international law to the levels of in-service training for criminal justice officials, and the sensitizing of the general public about human rights issues. In this review it will not be possible to mention every country or every important contribution, but this should not be taken as lack of regard for the very important work being done in each setting. Time constraints compel us to review broad trends and important developments arising from the work presented at this symposium.
As it was at the beginning of the work against torture, the starting point for action is still "blowing the whistle" on torture. A number of papers at this conference have identified and described human rights abuses in their countries or in refugee populations. These are reports, usually by health professionals, that torture is being systematically perpetrated in a particular country, including descriptions of the methods and practice of torture, and the effects on the survivors. As always, the sheer extent of the evils and abuses that we face is shocking; but the fact that they are being brought into the light, and that dedicated workers are engaged with these problems, is heartening in the struggle that we are waging.

As before, health professionals who have violated their oath by perpetrating or collaborating with torture have been particularly singled out. In the past, abuses — normally by only a small number of corrupt professionals — in various countries have been documented, and at this conference evidence and analysis of unprofessional or abusive conduct by doctors have been presented. The most common picture is of the doctor who “covers up” torture through misleading medical reports; but at this meeting we have also heard of doctors in Africa and elsewhere who have been actively involved in torture and killing.

One of the key concerns of participants was how to ensure protection of medical doctors and other health professionals reporting evidence of torture. Special emphasis was given by delegates to the importance of national medical associations, for instance, in providing support and protection to doctor members who place themselves at risk by refusing to cover up torture.

Children and women
Special topics in this area included sections on torture of children and women.

It was clear from the presented papers that children are severely affected by torture inflicted on themselves or on family members, and that there are frequently severe trans-generational effects on families. It was noted in the discussion that similar phenomena have been reported in Holocaust families, and that these “post-authoritarian regime” problems are increasingly emerging in South American countries some 20 years later.

The torture of women gained particular prominence in this symposium — not least because of the recent incidence of sexual torture of women in the Balkans, and the genocide and abuses in countries such as Rwanda. This has focussed increasing attention on the use of rape as an expression of dominance, and as an explicit form of torture of women. Many women delegates stressed the connection between torture of women and repressive social iniquities that place women under the power of men. These gender iniquities were seen as perpetuating domestic violence as well, and one of the vigorously debated issues in the conference was whether the definition of torture should be extended to include abuses such as domestic violence. Another expressed view was that legislation already covered domestic violence, and that this should rather be strengthened. It is clear that this debate raises a number of very serious issues and that it needs to be fully debated in the future.

The Istanbul Protocol
An important step forward in the fight against torture was taken with the development of the Istanbul Protocol — a tool intended to be universally applicable for legal and medical investigation and documentation of torture, which has drawn on expertise from around the world. The use of the Istanbul Protocol was formally endorsed by the Symposium delegates, and this will contribute towards the widespread implementation of highly professional procedures where torture is alleged.

Treatment and rehabilitation
The treatment and rehabilitation of survivors will be a priority as long as torture persists, and a wide range of papers described treatment strategies that are being used to deal with torture in varying contexts. These included detailed accounts of individual and group therapies, and good reviews of community-based work that utilizes the strengths of the natural healing network that survivors relate to in everyday life. The easy connection that survivors make to such networks, their accessibility, and their shared cultural assumptions with survivors make it sensible for torture services to put time into consultation and training in this area. A number of associated papers also looked at “alternative” therapies — using Eastern healing approaches such as yoga to rehabilitate torture survivors. Delegates were actively interested in exploring new, culturally appropriate healing strategies, rather than clinging too rigidly to Eurocentric therapies that may be less effective in many situations. There was also repeated discussion of the need for more “survivor-centred” therapies, with a more equal relationship between client and therapist, where the experience and active participation of the survivor is given priority.

Prevention
However, the most powerful forward thrust of the conference lay in the field of prevention. Simply put, prevention has two main mechanisms: we need positively to transform attitudes and beliefs about human rights, through informing and educating at every level, and through creating societies that are democratic, just, and equitable; and we need a credible deterrent, by setting up the right legislation and enforcing accountability through national and international courts.

These were reported on and debated at every level:
• at the level of national and international law;
• at the level of political pressure to change laws and to ensure compliance with human rights instruments; a further deterrent politically is the adaptation of the Statute of Rome on the International Criminal Court, the constitution of international Tribunals in the former Yugoslavia and Rwanda, and the increasing capability of treaty bodies and other UN processes.
• through National Human Rights Institutions and NGOs, which for the first time were well-represented at this Symposium and are well-positioned to provide a powerful advocacy force; the possibility of collaborative partnerships between Human Rights institutions and bodies such as the IRCT is likely to accelerate progress in the prevention of torture. This has effectively opened up a new front in collaborative work in this field.
• at the level of professional education, at both the basic training stage and in-service training, inter alia for health professionals, legal professionals, the judiciary, police, and prison services. One of the most constructive areas of endeavour, from a preventive standpoint, has been the increasing emphasis on human rights training of police and security forces in several countries.
• at the crucial area of social awareness of human rights issues in the general public – most importantly through the media, which in an age of communication play a tremendously powerful role in helping to shape public understanding and opinion. The immensely destructive role that the media can play was raised in debate in relation to the use of the radio in fanning genocidal hatred in Rwanda; it was seen as crucial for the media to play an informed and socially responsible role in this area.
• at the deterrent level, it is clear that substantial headway is being made against impunity. A series of Truth and Reconciliation Commissions have begun to force an open disclosure of crimes. National leaders are increasingly being held accountable for human rights violations, and certain of them have been indicted. Most importantly, we have seen the beginnings of prosecutions of torturers. In a plenary session we heard that in three different cases the Yugoslav and Rwanda International Crime Tribunal gave a decision on the crime of torture, and found several accused guilty, including a politician, a military police commander, a camp commander, and camp guards. The importance of this was that torture was found to violate customary international criminal law, and the elements of torture were established, similar to those set out in the Torture Convention. The Trial Chamber found that sexual violence and severe physical or mental harm were acts of torture. This is enormously important and influential jurisprudence in the fight against torture.
• at quite a different level of restitution and deterrence, increasing attention is being given to redress to survivors. No government seems to have put in place a wholly satisfactory solution to this problem, but there have been interesting developments. In India, for example, following decisions of the Superior Courts and the National Human Rights Commission, the State has begun to pay reparation to torture survivors, and on occasion to exact this payment in whole or in part from the perpetrator. This gives new meaning to accountability, and approaches a more equitable restorative justice.

Breaking the silence

One of the central themes that has been woven throughout the presentations and debates of this conference at every level was silence and the breaking of silence.

• We have to break the silence about torture at the international level, through the enforcement of international human rights conventions and protocols, and by giving priority to torture in international criminal tribunals.
• We have to break the silence at the international political level, where, in the past, governments have politely averted their gaze on the grounds of domestic jurisdiction.
• We have to break the silence at the national level, where impunity can be seriously challenged by revising legislation and by the establishment of bodies such as truth commissions, which can force into the open past abuses by state officials.
• We have to break the silence at the level of the neighbourhood and family. The overlooking of abuse of women and children as “domestic matters”, not spoken of, must end, and new laws, where needed, and increasing assertiveness must be given every support.
• Finally, the silence must be broken at the level of the individual psyche. In this symposium, therapist after therapist, from every theoretical perspective, emphasized the importance of bringing repressed or chronically avoided traumatic material into the open, so that the survivor can deal with it constructively and resume a fulfilling life.

In conclusion, this has been a most valuable symposium, in which we have seen participants from widely varied backgrounds co-operating in a most enriching way to deal with a common problem. We are left with the belief and the faith that the prevention of torture is truly a multidisciplinary task, and that in the long run, we shall prevail together.
DE JURE, DECLARATIONS, ETC.

DELHI DECLARATION ON FREEDOM FROM TORTURE

Adopted at the closing plenary session of the symposium on September 25, 1999,
as presented by Justice V.S. Malimath, Chairman and Prof. Erik Holst, Co-Chairman

PREAMBLE

Since the Vienna Declaration and Programme of Action was adopted in June 1993 a number of developments have taken place. These include

1. A steadily increasing number of states have ratified the UN Convention Against Torture. Several more have signed the Convention and initiated the process of ratification. However, the number of states having ratified the Convention Against Torture in full and without reservations is still regrettably small. Therefore in many cases the individual protection foreseen under the Convention is denied.

2. An increasing number of national human rights institutions have been established, many of which have given priority to the problem of torture.

3. Despite continuance of impunity laws in certain countries, the number of alleged perpetrators formally indicted and actually brought to trial is on the increase nationally as well as internationally.

4. The recognition of the need to provide comprehensive reparation to victims of torture is gaining ground nationally, as well as internationally.

5. Access to professional health and legal assistance is available to an increasing number of survivors of torture worldwide.

6. Relevant training and material concerning torture is available to a growing number of health professionals and law enforcement personnel, civil and military. However, few countries — even state parties to the Convention Against Torture — have systematically implemented such training in the curricula of all relevant professions as foreseen in the Convention. Relevant training material has also not been made available in all the languages required at country level.

7. An initiative has been taken by a number of concerned NGOs and health professions to update and expand existing manuals for forensic medical examination of suspected victims of torture. The resulting Istanbul Protocol outlines principles for investigations and diagnostic tests. It also suggests international minimum standards expected to be considered shortly by the UN.

8. Multilateral and bilateral funds for assistance to victims of torture have been on the increase but are still far from sufficient to allow continued operation and the necessary expansion of appropriate services for survivors of torture and their families.

9. An increasing number of states have joined the European Convention for Prevention of Torture accepting unhindered access to any place of detention including psychiatric services under the jurisdiction of a state party. However, the efforts within the UN Commission on Human Rights trying to create a similar system at the global level have still not resulted in consensus.

10. In 1997 the UN General Assembly instituted June 26 as international day in memory of victims of torture. This day is now being observed all over the world.

However the symposium also noted with concern

1. Although torture, as a matter of state policy, has ended in certain countries that have witnessed changes in regime, it continues to be widely prevalent in many countries where it is still either accepted, or at least tolerated, as part of law enforcement interrogation and punishment.

2. War and situations of armed conflict within and between states have, in recent years, given rise to the gravest human rights violations including torture.

3. Health professionals in many countries still find themselves under duress to condone or cover up torture in violation of their codes of ethics and the UN Principles of Medical Ethics.

PROGRAMME OF ACTION

The symposium urges the following action at the national level

1. Sensitization of the political leadership to issues concerning torture.

2. Accession to the UN Convention Against Torture where this has not taken place.

3. Accession to the Statute of Rome on the establishment of the International Criminal Court.

4. Expediting revision of national laws to deal comprehensively with the prosecution of torturers and reparation to victims of torture.

5. Significant increase in the number and size of state contributions to the UNVFVT as well as identification of and systematic canvassing of potential supplementary donors to the UNVFVT.

6. The systematic and effective monitoring by national human rights institutions of instances of torture, particularly of custodial violence.

7. Undertaking of every effort to promote a culture of non-violence and the respect for human rights.

8. Repealing of laws providing impunity to torturers.

9. Special consideration to practical ways of protecting women and children against torture.

10. Greater involvement of all components of civil society, including health, legal, and other professions as well as non-governmental organizations and the media in the fight against torture.

The symposium further urges the following actions to be taken by the UN

11. Expediting consideration of an Optional Protocol to the Convention against Torture allowing international access to all places of detention under the jurisdiction of State Parties to the Protocol.

12. Expediting consideration of the proposed UN Principles for Restitution, Compensation and Rehabilitation of Victims of Grave Human Rights Violations and Fundamental Freedoms.


14. Ensuring diligent prosecution of alleged torturers and effective protection and redress to victims of torture and their families within the framework of the procedures being developed for the International Criminal Court.

15. Providing technical assistance to the production and effective global dissemination of relevant teaching material on torture issues for health, legal, law enforcement, and other concerned personnel.

16. Providing technical assistance for recurrent international and national information campaigns with a view to creating and maintaining public awareness of the continued practice of torture and of the need to provide effective reparation to torture survivors and their families.

17. Strengthening the capacity and resource base of the UN mechanisms supporting the fight against torture.

TORTURE Volume 10, Number 1 2000
Helpful tips for living a new life

The staff of the Association for Services to Torture and Trauma Survivors Inc. (AsEiTS) in Perth, Australia, have produced “self-help” pamphlets for torture and trauma survivors. The idea and creation of these pamphlets are a good example of how contact with torture and trauma survivors can be established by a simple and useful introduction to a difficult subject. We therefore would like to draw attention to this initiative.

The pamphlets entitled “Helpful tips for living a new life” were created in response to the need expressed by members of the Afghan, Burmese, and Kurdish communities in Perth for information on common problems they were facing and simple ways to help deal with those problems. In addition people wanted more information on what defines torture and trauma and how organizations such as AsEiTS can assist people who have experienced torture and trauma. The idea and creative process behind the pamphlets are credited to Schools Development Officer Jan Mantell, Health Promotions Officer Susan Lee, Community Worker Kim Tomlinson, and the illustrator, Ahmad Wali Ali.

The pamphlets were produced in April 1999 by AsEiTS, with the support of members of the Afghan, Burmese, and Kurdish communities in Perth.

An English translation and copies are available from AsEiTS:

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Australia
Telephone: +61 9325 6272
Fax: +61 9221 5092
E-mail: asetts@nettrek.com.au
The Archana Guha case:

Against torture in police custody


Miss Archana Guha, Latika Guha, and other members of the family woke up at about 1.30 a.m. on 18 July 1974, in the middle of the night, when they heard a noise as if the front door was being pushed. When they opened the door, a group of persons entered the house. They said they had come from Lalbazar. They searched the house. No warrants for seizure or arrest were shown, but the family was taken to the police station.

All were tortured on the first day. Their hands and legs were tied together with a rope, and a pole was inserted below the elbows and knees; the ends of the pole were placed on two chairs in a suspended position. They were beaten on the soles of the feet with a lathi (club) as in falanga, called kochua. They were slapped mercilessly on the cheek. Their elbows and soles and the nails of the big toes were burnt with the glowing end of a cigar.

The next evening, Kamal, at the instance of the accused, Runu, pushed Archana by her hair towards a wall, pulling her back by the same means before contact with the wall. This continued for about 15 minutes. On 13 August 1974, Archana had pain in her head throughout the day, and she lost power and energy: the lower part of her body became paralysed.

In the prison she was first examined by two doctors in 1975. On 9 February 1976 she fell unconscious and was sent to the Medical College Hospital, Calcutta. She remained there for 10 months, her condition worsening until it became critical. On 17 November 1976 she was released on parole and taken to her home. She was then completely bedridden, the lower part of her body being paralysed. Saumen Guha was released on 21 June 1977.

The case was filed on 20 August 1977, and Archana came before the Chief Metropolitan Magistrates Court on a stretcher. The doctors provided medical reports, suggesting the traumatic origin of the paralysis.

Not a single organization came forward to stand by the victims in 1977. The so-called APDR (Association for the Protection of Democratic Rights) gave no help in any form or in their battle.

Amnesty International enquired from London every evening about the progress of the case. The Danish Ambassador to India personally discussed with them in Calcutta the strategy of filing a medical certificate from RCT about Archana before the Trial Court.

After release from prison, Saumen Guha was compelled to study law systematically. He was not a lawyer, by training or profession, but he was given permission by the Court to conduct the case. Dr Inge Geneffe encouraged him enormous-ly. The strategy of their battle was very carefully kept confidential.

The Archana Guha case was filed before the Chief Metropolitan Magistrate, Calcutta, on 20 August 1977, and, after almost 19 years' battle, judgement was delivered by the Metropolitan Magistrate, 7th Court Calcutta, on 5 June 1996. The accused policemen were sentenced to simple imprisonment for one year and a fine of 2000 rupees.

Archana recovered later through prolonged treatment, lasting for years, in Denmark under the aegis of the Danish Medical Group of Amnesty International at the University Hospital of Copenhagen. The treatment was followed up by the Rehabilitation Centre for Torture Victims (RCT).

At the end – happiness and victory.

Professor Dr Veli Lük
Human Rights Foundation of Turkey
Menekse 2
Ankara
Turkey

A needful manual – without sentiments


This multidisciplinary book provides a platform for research-minded activists and action-minded researchers who share a humanitarian concern for victims/survivors of antihuman crimes, abuse of power, and, particularly, for victims of government-sanctioned torture.

As a manual and source of information, the book should be recommended for the use of lawyers, politicians, physicians, psychologists, psychiatrists, religious leaders, human rights advocates, and students of medicine, law, and psychology. The physical and/or psychological torture victims themselves, their families, relatives, fellow men, and second or third generation descendants might also find it a valuable resource. The book is focused on the physician's role and can be used as a clinical guide to diagnose and treat the traumatic stress, and the mental and/or physical harm caused by political government-sanctioned or common violence.

But the book is still more a challenge, calling for protest and action against the antihuman crimes. For many years, and still today, physical and mental torture and its vic-
BOOK REVIEWS

tims/survivors have somehow remained hidden by governments. These facts and their after-effects are often ignored, kept silent and suppressed by the law, by scientific and even church communities. As a result of such a diffused ignorant pragmatic state, and of the impunity of the perpetrators, we can nowadays witness signs of widespread psychological pollution as terror after-effects. It seems to be very typical in post-socialist countries.

For example, in post-Soviet Estonia many survivors of the Soviet terror regime exhibit posttraumatic stress disorder, e.g. concentration camp syndrome, introverted orientation, distrust, and deep, often almost incorrigible feelings of injustice and persecution. They are often disturbed by the upset of the economic violence of parvenu.

The problems of caring for victims of war and political violence are now most real in former Yugoslavia and in the Chechnya population, so terribly victimized by Russia.

Metaphorically speaking, we should administer more antipathetic material to the public opinion and conscience against perpetrators who use torture. The IRCT's movement and this book are to be thanked for doing this. Our victimology differs resolutely from the exploitation of the situation of victims by politically motivated "victimagogues".

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A legacy from which to learn


One of the unique aspects of South Africa's Truth and Reconciliation Commission (TRC) was its focus on the role of health professionals in human rights abuses under apartheid, principally through two days of special hearings devoted to the health sector in June 1997. This publication, co-edited by Audrey Chapman of the American Association for the Advancement of Science (AAAS) and Len Rubenstein of Physicians for Human Rights (PHR), represents the results of an investigation conducted at the request of the TRC by a delegation composed of AAAS, PHR, and collaborating bodies in 1997. This investigation sought to assist the TRC in its mandate to determine "as complete a picture as possible of the causes, nature and extent of the gross violations of human rights ... including the antecedents, circumstances ... and contexts of such violations".

The report builds on previous research conducted by AAAS that exposed widespread violations of human rights during apartheid, including the systematic use of torture, and argues that past practices under apartheid both within the health system and more generally in society continue to shape current health professionals' thinking.

Central to accounts of medical complicity in human rights abuses under apartheid were state-appointed doctors known as district surgeons. The book chronicles in some detail the reasons for their failure to adhere to norms that protected the rights of their prisoner-patients. These include their isolation from peers, heavy workloads, lack of adequate ethical and human rights training, ignorance of national and international laws, fear of victimization by the authorities, and the fallacy of neutrality. Most importantly, the absence of peer leadership and personal values led to choices that subjugated the interests of their patients to that of the state when faced with situations of dual loyalties.

The book also identifies the vital role of professional organizations in South Africa that could have made a critical difference had they intervened on behalf of human rights. It reserves particular criticism for the South African Medical and Dental Council for its past record and its banal submission to the TRC hearings. Despite ample evidence for the involvement of medical professionals in torture and other abuses, the Council professed no plans for the reinvestigation of these violations, for the setting of human rights standards for the profession, and no interest in reforming the processes for disciplinary procedures. Given the book's perspective that past perpetrators must be held accountable in order to change apathy towards human rights in the profession, this ongoing neglect by the Council reflected a "willful failure to come to terms with its past [complicity]."

One of the strengths of the book is its detailed analytical framework that links the everyday practice of discriminatory racist health care to the more egregious abuses typified by doctors' collusion in the torture of political detainees under apartheid. Thus the spectrum of abuses by health care professionals detailed includes violations of commission (such as failing to report abuses, filing false medical reports, and supporting policies that enabled detention and torture), violations of omission (failing to respond to apartheid inequalities), violations of the obligation to treat, and violations of discrimination. Common to all these violations was a moral disengagement by health care providers that allowed them to see victims and targets of apartheid as less than human.

The most valuable feature of the book is its detailed and extensive list of recommendations, aimed at providing practical guidance for a society seeking to change and establish a culture of human rights in health. These recommendations touch on a wide range of strategies, ranging from the elimination of racial discrimination in health, to reform in health professional education, professional practice, and professional regulations and the bodies that shape them. Key within these are specific recommendations to establish independent monitoring for human rights violations in the health sector, including the documentation of evidence of torture and ill-treatment.
This publication is a valuable addition to the growing body of literature devoted to exploring the relationship between health and human rights, and should be read by all researchers, bioethicists, practitioners, and policy-makers concerned with the prevention of torture and human rights abuse. By learning from the past, we can understand better how to prevent abuses in the future - that is the positive legacy we can make of apartheid.

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Important second edition


This book was first published in January 1987.

It was then my pleasure to review the book, from which review I quote:

"The book deals with all that must be of interest to people working with human rights.

Rodley writes extensively about international law and the treatment of detainees and prisoners, and we are taken behind the scenes in order to see how the large international organizations, and in particular the UN, are working. The book starts with the horrors of the Second World War, and from there the reader is taken through the international efforts until today. (The book is dedicated to the author's grandparents, who were both killed in a Nazi concentration camp in 1942.)""

At the publication of the book, Nigel Rodley said that he could not imagine how any person could manage to write more than one book during their lifetime. Fortunately, he was proved wrong, since the new publication is a new book with a wealth of important details about what has happened since the last edition.

As one of the most important developments concerning the work against torture since the first edition should be mentioned the creation in 1989 of the Council of Europe's Committee for the Prevention of Torture (CPT). There are now 40 CPT member countries, while 10 years ago there were only 15. The special Rapporteur against torture has become a well-established institution, whose field of work is described. Finally two ad hoc international criminal tribunals have been set up, for the former Yugoslavia and Rwanda, and they have stimulated the establishment of a permanent international criminal court.

The first part of the book is dedicated to the work against torture. Then come the following subjects: extra-legal executions, the death penalty, "disappeared" prisoners, conditions of imprisonment or detention, corporal punishment, arbitrary arrest and detention, and international codes of ethics for professionals.

It is important to emphasize that the word "prisoners" has a broad definition in the book: "any persons who are so positioned as to be unable to remove themselves from the ambit of official action and abuse. The term 'prisoner' is not therefore limited to its most familiar usage, implying a person confined after due legal process to a formal institution of detention as a result of conviction for a criminal offence, or a remand pending trial".

The most important conventions and resolutions concerning various fields are described. The whole process of debate, suggestions for changes, and the final text of the finished declaration are discussed in such a thorough and fascinating way that one obtains a good understanding of the weaknesses and strengths of the various rules and regulations, and at the same time an insight into the dynamics behind the complicated process of reaching a final convention text.

The most important conventions and resolutions are printed at the end of the book. The table of contents is detailed, the subject index excellent, and the references numerous.

It is praiseworthy that the author has found time to update this important book, which is highly recommended for all those who take a serious interest in human rights.

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OBITUARY

Sten W. Jakobsson 1938-1999

A notable figure and pioneer in the work for torture survivors and human rights, Sten W. Jakobsson recently passed away at the age of 60. Sten Jakobsson was lecturer in forensic medicine and showed an early interest in the torture sequelae that he observed as a doctor. This knowledge eventually crystallized into dedicated work to examine the physical consequences of torture. In time this work was manifested in the establishment of Centrum för tortyr- och traumaskadade (CTD) [centre for torture and trauma victims] in Stockholm in 1992. In 1995 Sten Jakobsson took the initiative to establish the cross-disciplinary forum Svensk förening för hälsa och mänskliga rättigheter (HMR) [: Swedish association for health and human rights].

Sten Jakobsson was a giving and stately person, he attracted attention wherever he went, and he inspired and showed great human emotions. His papers and lectures at congresses and meetings were always characterized by commitment to and concern for the fate of the people for whom he worked.

H.M.

FROM THE MEDICAL LITERATURE


The Rehabilitation Center for Torture Victims in Ioannina has published a cumulative report of activities covering the years 1994-1999. The report is an excellent organizational survey that describes an active rehabilitation centre - the second centre to have been established in Greece. In addition to descriptions and statistics regarding the centre's activities, it also contains articles on the consequences of torture for individuals and for society.

The publishers have stated that with the simultaneous publication of the report in Greek and English they wish "to sensitize the citizens to the continuing existence of acts of torture and maltreatment, to update them on the consequences of such horrible acts and to request from the citizens assistance in the fight for the rehabilitation of torture victims, the punishment of those who are guilty and the prevention of such phenomena".

With this publication the publishers have also wished to show that "a small group of people from the Greek province can intervene in the social and political being, and that this intervention will not deflate as time goes by, but it will become stronger and more effective".

Revised reprint of IRCT publication on psycho-social help to refugees


The 1995 publication Psycho-social help to war victims, which documents the BOSWOFAM project on psycho-social support for women and their families in Bosnia-Herzegovina and Croatia in 1993-1995, has recently been republished in a slightly revised edition by the IRCT.

"The first edition was reviewed in Torture 4/95 by psychologist Nora Sveaas, who wrote, "It is a multidisciplinary and multicultural team that developed the BOSWOFAM projects of psycho-social support for women and their families, and it is the many voices in the projects that are heard in the book. [...] The team has given us an important document both on needs and on ways of intervening. Their experiences inspire professionals, and show that it is possible."

The book can be ordered from: IRCT, Publications Division, Borgergade 13, P.O. Box 2107, 1014 Copenhagen K, Denmark, Phone: +45 33 76 06 00, Fax: +45 33 76 05 00, E-mail: publications@irct.org.
Instructions to authors

General remarks
The editorial board of TORTURE is grateful for small news items as well as articles dealing with aspects connected to torture, rehabilitation of torture victims, and the fight against torture.

Summary of requirements
We prefer articles, reviews, and other material to be word processed in a PC DOS/Windows format, for example Word Perfect or Word, and the text should be forwarded on a disc or by e-mail (only file attachments in Mime/Base64 format are acceptable) as well as in a printed copy.

Your manuscript should be prepared in correspondence with the uniform requirements for manuscripts submitted to biochemical journals. These requirements – the Vancouver system – are described in detail in Br Med J 1991; 302:338-41 or N Engl J Med 1991; 334: 424-8.

A good illustration (photo, drawing, or table) is always very welcome.

The manuscript should be accompanied by a covering letter with the name, address, telephone and/or fax number, as well as e-mail if available, of the corresponding author. The letter should give any additional information that may be helpful to the editor.

Details of address of the author/authors, qualifications such as MD or PhD, and full professorship are published as a footnote to papers, and this information should be provided on the title page of the manuscript.

The editorial board assumes that the material submitted for publication in TORTURE has not been presented anywhere else for consideration with a view to publication at the same time as an evaluation is being made by the board of TORTURE.

If the material has been published on a previous occasion, please state where and when.

The editors retain the customary right to style and, if necessary, shorten material accepted for publication.

If you want to make a review of a book dealing with aspects concerning torture, please remember to give details about the publisher, number of pages and the price, preferably in USD. The review should in the shortest possible way give a personal evaluation of the book – a mere description of the contents and some quotations are not sufficient.

The review, which must be max 1/2 a TORTURE page long, equal to approx. 60 lines of 50 taps, should be given an appropriate title.

References
Should be numbered in the order in which they appear in the text.

ARTICLES IN JOURNALS

Standard journal article
(List all authors, but if the number exceeds six, give six followed by et al.).


Organization as author

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BOOKS AND OTHER MONOGRAPHS

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Editor(s), compiler as author

Organization as author and publisher

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OTHER PUBLISHED MATERIAL

Newspaper article

Audiovisual

Legal material

UNPUBLISHED MATERIAL


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FORTHCOMING CONFERENCES AND SEMINARS

Jerusalem, Israel
29 October–3 November 2000

The Promised Childhood, Jerusalem 2000 Congress

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24 June – 2 July 2000

Council of Europe: Pilot master class for experts in police and human rights

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The IRCT is a private non-profit foundation, that was created in 1985 by The Rehabilitation and Research Centre for Torture Victims (RCT), Copenhagen.

The objectives of the foundation is on an international basis to promote the provision of specialized treatment and rehabilitation services for victims of torture and to contribute to the prevention of torture globally.

To further these goals the IRCT seeks on an international basis

• to develop and maintain an advocacy programme that accumulates, processes, and disseminates information about torture as well as the consequences and the rehabilitation of torture

• to operate a documentation centre about torture and related topics

• to establish international funding for rehabilitation services and programmes for the prevention of torture

• to promote education and training of relevant professions in the medical as well as social, legal, and ethical aspects of torture

• to encourage the establishment and maintenance of rehabilitation services

• to establish and expand institutional relations in the international effort to abolish the practice of torture, and

• to support all other activities that may contribute to the prevention of torture.