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DEMARCATION OF THE TORTURE CONCEPT

A journal calling itself TORTURE must of course be able to define the meaning of this concept. However, a clear-cut definition is problematic, and, as readers will know, there are several good definitions and explanations, whether they refer for instance to the medical profession or to the world community.

The Declaration of Tokyo, 1975, defines torture as:

"... the deliberate, systematic, or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason."

This can be compared with the UN's Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment of 1984:

1. "For the purpose of this Convention, the term ‘torture’ means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person ..."

The human rights that are violated following ill-treatment and torture are numerous, and they involve both political and non-political detainees and prisoners. Equally it is not unknown for such violations to exist in non-civil rights connections, as within the military.

A country that recognizes and practices human rights is allowed to accuse, examine, and judge acts that are against the country's current and accepted legislation. The methods by which this is carried out must pay due respect to the accused without considering him as guilty before his court case has taken place, based on a decent examination of the accused person's conditions. Torture should be excluded from such a sequence of events. But torture covers a wide field. It is not only a physical act. In marked contrast to brutal handling, torture also includes handling with threats, with consideration, with deceit, putting temptation in the way.

However, when the facts are presented, when research is carried out according to constitutional principles, and when realistic consequences are taken into account with respect to the course of events - all this may imply traumatic experiences, but it is not torture. The distinction is sometimes difficult, and even well-meaning societies that accept and follow current legislation may run into difficulties. Society's will to discuss such violations, to change its concepts and attitudes, is most essential. A positive development has been registered in the world community in this area.

These considerations are in response to the "Letters to the editor" on page 102. The description given is by an author, Major General Makkar (Retired), whose practice differs quite distinctly from that of the large Indian society in which torture is a reality, which is practised in many of the state departments. The author has renounced participation in what was current practice in the Indian military system in two wars, 25 and 31 years ago. The former Major General in the Indian Army presents viewpoints that broaden the torture concept beyond what we want to accept in our non war-torn part of the world. Not least do we want to maintain some psychological aspects in our definition of torture. In mentioning this, however, we do not want to compromise with respect to our concept of torture. On the contrary, the editorial board, with reference to the clause "The views and conclusions expressed by the authors herein do not necessarily represent those of the IRCT", has considered it of value to draw attention to a process of softening and dissociation from direct physical torture which was accepted in a very torture-orientated and humiliating system until 25 years ago. The General's article is an expression of a slow and gradual change of attitude to torture, also manifested in other ways, as for instance in the invitation to Indian doctors to attend a course about the treatment, identification, and notification of torture. Such teaching activities are very important as a follow-up to the huge amount of information material about torture, published in the Indian Medical Journal. Equally important are the efforts in the same direction by the Indian Medical Association - with the assistance of General Makkar.

H.M.
Why some torturers are punished

The trial against Archana Guha’s torturers

Finn Rasmussen, MA*

In 1988 Peter Vesti, medical doctor at the Rehabilitation and Research Centre for Torture Victims in Copenhagen, published an article in the Danish Medical Bulletin: Why are torturers never punished? The article focused on the case of the Indian Ms. Archana Guha who was severely tortured by the Calcutta police in 1974. She was released after three years in prison, and shortly after filed a petition against her torturers. In 1988, 11 years later, the trial was not finished and there were no signs that the torturers would be punished. At the end of his article Peter Vesti wrote: “Cases of torturers being convicted and punished are virtually non-existent as are cases of compensation paid out to the victims.” He advocated the punishment of torturers, finishing his article with: “The time has come to recognize torturers as the criminals they are.”

Maybe the time has finally come. In June 1996, 19 years after Archana Guha filed the case, the trial came to an end. For the torture victim a happy end. The torturers, one of them a retired high-ranking police officer, were sentenced to one year’s simple imprisonment and fined Rs 2,000. (The case was filed against five policemen. Meanwhile two of them are dead and another has disappeared.) Even though an appeal has been lodged against the sentences, this was an important victory for Archana Guha, and a victory that can feed the hope of other torture victims who are fighting for justice. The case of Archana Guha was a case against all odds. Nevertheless, it ended with the judgement in favour of the torture victim. This article aims to elaborate on some of the key reasons for this outcome.

Background

Archana Guha, her sister-in-law Ms. Latika Guha, and a friend were arrested in the middle of the night on 17 July 1974. No formal charges were brought against them. During the next 28 days they were severely tortured at the Calcutta Police Headquarters, Lal Bazaar. Archana was beaten particularly on the hips and under the feet (falanga). She was threatened with rape, burned with cigarettes on her toe nails, and made to understand that if she did not cooperate her family would be tortured as well.

The purpose of the torture was to obtain information about Archana’s brother, Mr. Saumen Guha, who was active in the left-wing naxalit-movement. During the 28 days of torture Archana had no contact with him. The 28 days of torture stopped only when her brother was captured. For Archana the torture was followed by three years of imprisonment. Paralysed and with multiple symptoms of the torture, she was released in 1977. Attention was called to the case by the work of Amnesty International and other human rights organizations, and in 1980 Archana was offered intensive treatment in Copenhagen by the group of doctors and other health professionals under the recently established rehabilitation programme that was later to be known as the Rehabilitation and Research Centre for Torture Victims (RCT). Due to the treatment programme Archana Guha recovered significantly from the torture sequelae. During her treatment she married a Danish citizen and has lived in Denmark since, though with frequent travels to India to follow the case.

As mentioned, she filed the case against the involved policemen shortly after her release in 1977. Since then, the accused have used a variety of legal means to prolong the court proceedings. The case took a positive turn for Archana Guha at the beginning of 1994. This happened when the Indian Supreme Court urged the Calcutta City Court to end the trial; the verdict was finally given on 5 June 1996.
An urge for justice
Torture normally aims to break down the personality and resistance of the victim. This itself can be a major hindrance for torture victims to put their torturers on trial. But in the case of Archana it did not work this way. This raises the question of how she found the strength to file the case and pursue justice in a 19 year long legal fight? One answer is of course Archana herself. Obviously it is a strong person who has the courage and strength to keep on insisting on such a case. In an interview a few months after the verdict she stressed the urge to see "real justice" as the reason for going on and keeping up hope under the trial. Justice for her was to see the torturers punished through the legal system. The importance she attaches to justice can also be seen in the fact that she does not give major importance to financial compensation for the torture and years in prison: "Even if I could get a lot of money I would never feel like I feel now. I was never thinking of money, I just wanted to see their punishment. Money never makes me happy. Now I am happy."

Behind her urge for justice lies the need for moral redress and the regaining of respect. The defence consistently tried to create doubt about the grounds of the case, saying that she was lying. The conviction quashed that. "By the judgement it was proved that those policemen tortured us and that we were held illegally in prison and that they violated our modesty," says Archana.

Family support
A crucial element in the success of the case was the support she had from her family, both from her family in India and from her Danish husband. Discussing the trial with Archana for only a few minutes made it clear that it was not only her case – it was a family case. Her brother Saumen and sister-in-law Latika were also tortured, but neither filed a case, concentrating instead on Archana's case. Her brother supported the case in all possible ways, even obtaining special permission in the final stages to function as the legal accuser, while her sister-in-law testified as an eyewitness to the torture that Archana suffered. Without the support of her Indian relatives there would have been no case. Archana also points out the support from her husband as of great importance for making possible her continued participation in the trial.

Archana comments that the case also had huge costs for her family life. The relationship with her Indian relatives suffered under the many years of trial. So did the relationship with her husband. Living in Denmark meant that she had to travel to India for the court sessions. She made the journey Copenhagen-Calcutta about 15 times, each time staying several months in India. This entailed high costs, both financially and personally. The price was "Life, relations and money," Archana puts it.

Support from the Indian society, RCT/IRCT and Amnesty International
In India Archana's fight for justice became a symbolic case of the torture and maltreatment of an innocent citizen by brutal police forces. It received huge attention from the mass media and public support from ordinary citizens. Archana relates how in 1988 the torturers' defence succeeded in convincing the court to dismiss the case because of a statute of limitations. A public protest followed. Indian human rights organizations focused on the case, a signature campaign was supported by thousands of citizens, and the mass media and several well-known authors wrote about the unjust court decision and called for a reopening of the case. Archana's appeal against the decision to dismiss the case was accepted.

Talking about how she survived the many years, Archana repeatedly mentions the support from the Rehabilitation and Research Centre for Torture Victims (RCT), International Rehabilitation Council for Torture Victims (IRCT) and Amnesty International. RCT/IRCT gave the case special attention. First of all Archana received rehabilitation services, but in addition she was given personal, moral, and financial support from the very beginning until today. Amnesty International also made it a high profile case, giving financial support and running it as an action case, informing and pressuring the Indian authorities.

Pressure
Even though the case was reopened in 1988 the manoeuvres of withdrawal continued as the key strategy of the defence. Each major decision in the case was appealed to a higher court as a means of prolonging the trial. This strategy worked with great success until 1994. Then there was a significant turn. The Indian Supreme Court took a firm standpoint in the case and urged the Calcutta City Court to finish it without further delay. From then things started to move smoothly, with the happy result of June 1996.

Why this sudden turn in the case? At least two factors can explain it. At this time there were changes in the judicial system in India and a newly established Supreme Court decided to take a more active stand on human rights issues. One of the very first cases the Supreme Court considered was Archana versus her torturers. In the verdict, the Supreme Court said: "How easy it has become today to delay trials of criminal cases! An accused can stall the proceedings for decades together, if he has the means to do so. We are falling prey to their stratagem."

Another factor is pressure. As mentioned, there was strong public support in India for Archana. Human rights groups, mass media, ordinary citizens, and others pressured the responsible authorities. At an international level, pressure was also put on the Indian authorities. Amnesty International focused on Archana's case on several occasions. At the 30th anniversary of Amnesty International in 1991, Archana's was one of 30 cases that were used for concrete actions. In 1992 Amnesty International ran a major campaign on human rights in India. Archana was mentioned as a victim of human rights violations in the campaign material. RCT/IRCT has also put pressure on the Indian authorities, among other things by lobbying at a political level in the interests of the case. The Danish government also supported the case, e.g. by having an observer present at the trial on the day the conviction was announced. The mass media called attention to the case. And so on. Over a period of several years continuous pressure, from both inside and outside India, was put on the authorities responsible. Without this pressure it is possible that the case would never have ended.

Will more torturers be punished?
The verdict in the case is extraordinary. Still, Peter Vesti's conclusion that conviction and punishment of torturers are virtually non-existent tells a sad truth. Nevertheless, Archana's case shows that conviction and punishment are possible, and it focuses on the importance of persistence, support and pressure. It is a symbolic victory that can be used as moral support by other torture victims and as a success story to inspire the work of human rights organizations.

TORTURE Volume 6, Number 4 1996
The Problem
During the 1980s, and until now, the prevention of torture has been the specific concern of an important sector of the social sciences, namely the judiciary, the sociological and political science, and also in ethics. Only in the 1990s have we come to see it as a question of understanding the significance of torture as a public health problem and as a field of action for prevention strategies in the area of public health.

If we recognize the legitimacy of including the public health sector in the prevention of torture, we are faced with the challenge of defining the specific reach of prevention policies the health sciences can apply when developing strategies to prevent a disorder that is essentially political, i.e., torture, rather than diseases such as tuberculosis or typhoid fever.

This new subject of research in public health is one of the violations of human rights used as an instrument of domination and social control, par excellence in recent years. As such, the “pathos” of torture has had multiple effects on human society. This has led to studies in a number of social disciplines. For these sciences, torture prevention is a battle in the political, judicial, and ethical arena to eliminate the fact of torture as a historical occurrence. The concept of preventing torture, in their case, has an unmistakable and very well-defined goal: to create effective social instruments to impede the practice of torture.

This concept of prevention in the social sciences has an equivalent in public health, the concept of primary prevention. This refers to the creation of instruments that hinder the occurrence of a given disease. For the public health sector to confront the problem of torture prevention, it must first answer the question of what is exactly the specific object of prevention. Should it be involved in the prevention of a disorder like torture that is not medical? Should the public health system try to prevent an instrument of domination practised by the state? If it does not, how can it respond to the devastating medical, psychological, and social consequences of torture?

The challenge for those of us who are health workers in the area of human rights is to identify the specific task of public health in the prevention of torture. It also implies an understanding of the components that make up the phenomenon of torture, one being the impact it has on the health/illness process of the population where it occurs.

It is precisely its essentially historical character that compels research on the subject from the public health perspective to include analysis techniques from both health and social sciences. To omit this methodological premise would result in a very limited view of the problem, whether it focuses on a strictly biological bias that excludes social and political factors or whether it is an excessively ideological approach that undervalues the medical and psychological aspects involved.

Torture as a public health problem
Torture is the most common and frequent violation of human rights in Latin America. In Chile alone, an estimated 100,000 people suffered some kind of torture during the dictatorship of Pinochet. In Brazil and Uruguay it reached high levels of technical sophistication in their effort to optimize cruelty.

It has been demonstrated that torture occurs most frequently in the stage of investigation, i.e., before a suspect is condemned. At that time, it is a method to force declarations and establish guilt. This is due to the fact that the penal systems operate with the archaic concept that “confession is the queen of all proof”. Torture has been transformed into a factory of guilty suspects.

The practice has multiplied in prison systems all over the continent, where it is used on political as well as common prisoners. Life in the prisons is noted for its poor material conditions and for the inhuman treatment given by the prison functionaries. The prisons have exaggerated their repressive role, generating a structural violence that has brought about a militarization of the penitentiaries’ system, undoubtedly a last step on their road to failure as an institution of rehabilitation and social reinsertion of the inmates.

Torture as a personal human experience is highly traumatic and involves serious and complex consequences that inevitably damage the bio-, psycho-, and social unity of the individual. At the same time, being the experience of large groups of people, torture is the source of serious psycho-social problems that affect the behaviour of the whole of society.

Given the serious extent of its impact on the health of the individual and society at large, it would seem impossible for public health sectors to avoid addressing the question of torture with preventive goals in mind. Apart from the theoretical and methodological obstacles, there is no doubt that public health must work to prevent human conditions that are the source - as in torture- of illness and psycho-social damage and introduce changes in the patterns of sickness in the human population. A specific contribution can and must be made by epidemiology, mental health workers, psychiatry, and social psychology in this effort.

Triumphs and pitfalls of social and judicial strategies in the prevention of torture
Undoubtedly, there has been an overwhelming effort - within the framework of international law, and due to the prestige won by international agencies working towards improving the human condition - to conceptualize torture and give society the ethical, doctrinaire, and juridical instruments to fight and eradicate it.
In the 1970s and part of the 1980s, Latin America was the setting of various military dictatorships. Some, like those of the southern cone of South America, were particularly blood thirsty. Once the so-called transitions to democratic governments were established in the mid-1980s, obstacles to the fight against torture often remained intact. The constitutional governments were not interested in respecting the international treaties or agreements signed by their countries. In Chile, Pinochet himself signed the Convention Against Torture and later wrote it into the country’s legislation without introducing any change in the practice of torture. On the other hand, the fledgling democracies have inherited a civilian/military duality in state institutions that blocks the introduction of democratic changes. This has allowed the survival of a repressive culture in key areas, e.g. the armed forces, the police force, and the judicial branch.

The real political will of the state to eradicate torture is expressed not only in its legislation, but primarily in the measures it takes to safeguard the enforcement of the law, to see that the law is respected, as well as applying punitive measures. Subscribing to international treaties demands not only the subordination of national laws to meet the conditions of the treaties, but also response by subscribing nations to the community of countries about their enforcement. Jurists agree that today the problem is not the lack of legislation, but rather the reluctance of governments or judicial bodies to enforce legislation.

Social prevention runs up against a brick wall that returns the problem of the practice of torture to the arena from which it came: the political. This implicit conflict between the legal body that protects against torture and an executive body of the law that offers impunity, and, as a result, protects the practice of torture, is only a reflection of the underlying contradiction: the survival of non-democratic bodies within the state. In Chile, the alarming impunity enjoyed by the immense majority of the criminals of the dictatorship is principally explained by the government’s and the parliament’s lack of political will to demand the investigation of the crimes and punishment of the executioners, and also by the corruption of the courts and a large number of their judges. The failure to prevent torture obeys precise political causes. It is only possible to make headway once the permanent institutions of the state are truly democratic and able to change the formal State of Law, i.e. to create a social state in which the law is fully guaranteed.

When considering a possible primary prevention from the public health sector, we must not ignore the limitations of other social sciences, because they have an inevitable influence on the success or failure of strategies the public health sectors choose to follow.

**Strategies for the prevention of torture as part of public health policies**

*About the concept of damages*

The first problem is to conceptualize the effects of torture on the health of the individual, specifically on the human psyche. The medical model gives us certain disciplines, e.g. nosology and nosography, to classify psychiatric diseases whose positivist criteria are too narrow to include the complex conjunction of symptoms that result when human beings are damaged by torture. Starting with these limitations, positions range from a total refusal of all known taxonomy to the adaptation of the trauma to make it fit within certain criteria of standardized diagnosis. Neither the WHO’s ICD-10 classification nor the American Psychiatric Association’s DSM-IV can resolve the problem to full satisfaction. The APA has evolved the concept of Post Traumatic Stress Disorder in successive editions to allow for cases of extreme trauma derived from political violence. However, the staff who attend torture victims insist in their perception that this concept does not address some of the key aspects of the psychological damage, including those related to the political events that give rise to damage and affect later development, the impact on the family, the repercussion on the victim’s historical/life projection, and the socially conditioned deterioration of the subject’s self-esteem.

The nosological challenge is open; to identify a common language not only facilitates the exchange of experiences, but also helps epidemiology and research in the area.

*The importance of epidemiology*

Primary prevention in health starts by planning its strategies with a firm diagnosis of the quality and magnitude of the subject under study. The epidemiological diagnosis of the community furnishes information on the incidence and prevalence of the diseased processes, their distribution among different population groups, their evolution over time, etc. This basic information expresses the impact that a programme of primary prevention has on the disorder.

When trying to measure the trauma of torture from the epidemiological perspective, we run into several technical difficulties that are as yet insufficiently studied (which we already mentioned when speaking of the nosological problems). Among these are the definitions of the universe to be studied, of samples, and of quantitative determinations. Next we come to the data of incidence and prevalence and the approximations of the risk of contagion. The problem arises when we observe that political repression and torture are selective, directed against specific social groups. This makes it impossible to come to global epidemiological indicators.

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that cover the whole population. On the other hand, the previous identification of the population at risk - referring to those who risk illness as a result of torture - is practically impossible. This group must correspond strictly (in the case of the Latin American dictatorships) to those whom the repressive apparatus see, at a given historical moment, as "enemies of the state", according to the doctrine of national security.

Finally, the diversity of the effects torture produces and its global impact on the bio-, psycho-, and social integrity of its victim, forces the epidemiological study to address these effects in an overall manner. Therefore, it should design adequate instruments to register the presence of at least the most important symptoms of these three dimensions.

**Primary prevention**
The extensive dimensions of the damage demand that preventive strategies are planned in a way that is both interdisciplinary and interdependent. Not only should they involve coordination among professionals of different disciplines, but they should also allow for participation of all sectors of society.

To conduct an interdisciplinary campaign that invites participation from all sectors of society implies a horizontal rather than vertical organization, where actions are coordinated. Using participatory techniques appropriate to each social situation, the different actors can construct their proposal for preventive intervention.

Regarding the levels of action, the global character of the trauma produced by torture demands an integrated intervention that involves the three levels of health prevention and promotion. That is, it requires social policies of the state, national health plans and programmes that include state-run and private services, non-governmental organizations, and the community. This network will prove inadequate if it does not consider - with criteria that integrate all sectors of society - other bodies of the state and civilian society (economy, justice, education, parliament, political and social organizations, etc.) to support it with financial, technical, human, and organizational resources for a satisfactory intervention at all levels.

An integrated model of prevention must be rigorously grounded on scientific methodology, built upon solid support from the medical and social sciences. It also requires important interdisciplinary cooperation and endorsement, and adequate organizational, human, and financial support. This is a matter for social policies of the state, a state that has evolved from a perpetrator of the social trauma of torture to one that wishes to repair this damage and promote health and human rights. This is a strategic challenge.

The following section elaborates some of the initiatives of the primary prevention of torture. We see these initiatives as a possible starting point for the development of strategies with the international network that exists today.

**Non-specific prevention**
We understand non-specific prevention as that which promotes and develops health services, emphasizing initiatives and more general procedures that enhance the quality of life. In relation to the prevention of torture, we can identify some of these initiatives:

- Promotion of the doctrine of human rights and forging a national and international culture that sustains the fundamental postulates of the rights of individuals and the defense of human life.
- Promotion and education concerning international law in the field of human rights.
- Development of an international consciousness concerning the obligatory nature of enforcing the mandates of treaties signed by nations and their full and undistorted incorporation in each nation's legislation.
- Promotion and development of ethical and moral principles that strengthen and encourage human relations based on solidarity, personal freedom, and the right to material and spiritual conditions necessary for human dignity.
- The development of initiatives in education, training courses, and diffusion about the above subjects, in different levels of society, principally the armed forces, the judicial branch, in schools and universities, in unions, and in neighbourhoods.
- Support and stimulation of the role of non-governmental organizations in the tasks of investigating and denouncing violations of human rights. Also, to recognize their valuable role as an alternative source of information for international organizations.

Public health, social psychiatry and psychology are all in a perfect condition to schedule specific actions around each of these initiatives. There is an extraordinary health network that would help to make any programme of this nature operative and efficient. The vast extension of the proposed subjects obviously goes beyond the limits of the health sector. The health sector has so far chosen to distance itself when confronted by these challenges, and to delegate responsibilities to other sectors that it mistakenly believes are closer to the subject. We propose making a permanent effort of interdisciplinary cooperation and community participation in elaborating this kind of initiative.

**Specific prevention**
At this level we propose developing initiatives directed specifically at torture. The objective centres around work programmes that intercede directly to stop the practice of torture:

- Vigilant denouncement of torture, whatever the social or political system is within the country. The denouncement must be explicit and public. It should also identify the state institution responsible for the act and individualize the torturers. Finally, it should insist on legal sanctions for the guilty.
- Denounce the impunity of perpetrators of human rights violations and, particularly, of torturers. Impunity in Latin America's aftermath of dictatorships is the most serious psycho-social hangover and a focus of new traumatic events in our societies. The fight against impunity is central in the prevention of torture. We must remember that one of the socio-political objectives of torture is social intimidation and punishment for those who disagree. That is to say that the intent of torture is to exercise social control and manipulate power. For this reason, impunity for the practice of torture goes against the construction of a social order based on respect for human rights.
- Education among groups about the risk of torture: its origins, its diverse forms of expression, its insertion on the general map of political violence, categorizing as a form of
human rights violations, its medical, psychological and psycho-social consequences, international treaties and internal legislation of countries that proscribe and penalize, etc. Emphasis on military, police and prison institutions.

- Systematic professional training in the health sector about the medical and psychological management of people suffering damage from the experience of torture.
- Promotion of an ethic that rejects torture in professional associations of health workers, to impede their participation in the practice of torture and stimulate its active denouncement.
- Encourage the circulation of findings from the medical-psychological and psycho-social research on torture: clinical symptoms and acute complications, the long-term effects, strategies of therapeutic intervention, psycho-social consequences and methods for intervention in human groups, etc.
- Support the role of non-governmental organizations that work in the area; development of strategies to help bodies of state-run health care. In Chile, CINTRAS has had lengthy experience of working with health teams from the state hospital system with excellent results in personnel training.

- In relation to the jails, support for the Facilitative Protocol of the UN added to the Convention Against Torture that establishes a preventive system with regular visits to detention camps and promotes forms of non-penal seclusion.

We are convinced that primary prevention of torture is possible. Health teams that work in the area of human rights have a leading role in this challenge. This prevention must review the characteristics of interdisciplinary cooperation and social participation. The theoretical and methodological problems that remain will be resolved only as long as an illuminating social practice advances, in which the health teams, as confused as the other actors in the fight against torture, dare to be active subjects in the process.

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Torture in Brazil

Cecilia M.B. Coimbra, Psychologist*

The history of Brazil is the history of torture; torture has been with us throughout our 500 years.

Since colonial times, our history has been stamped by torture. First, the gradual extermination of the native population. Later, the importation of African slaves to the Latin-American continent, where they were not regarded as human beings. Torture was a daily practice, and the punishment, inflicted in public, was witnessed by the entire population. Torture was public and considered natural. Many slaves were murdered in the most horrible ways.

In the following centuries, torture continued to be inflicted on the impoverished layers of the population and on those who, throughout history, confronted the established order.

Why then talk of torture in Brazil in the 1970s, if such practice has been a constant presence in our history? Because it was after 1968, with the Institutional Act 5, that torture became, for the first time in our history, a systematic tool of the Brazilian State. Even duringGetúlio Vargas' dictatorship, known as the Estado Novo (New State - 1937-1945), torture, although used against political opponents, was not institutionalized by the Brazilian State.

The military dictatorship

Torture was institutionalized only after the military coup in 1964, with the National Security Doctrine governing over all other Brazilian laws. In 1968, with the victory of the military far right, called “linha dura” (tough line), the Brazilian state clearly adopted torture as a systematic practice. From that time, in the name of the "national security", thousands of Brazilian citizens were persecuted, exiled, murdered, and many others disappeared.

At that time, very few political prisoners talked publicly about the torture they had suffered. According to a survey of the Projeto Brasil Nunca Mais, coordinated by Don Paulo Evaristo Arns, archbishop of São Paolo, that number was 1843 — a small number when compared with the thousands of people who were actually arrested and tortured.

The official list made by some of the human rights organizations of the killed and missing people in Brazil is far from reflecting what really took place in our country. Only 240 people were reported dead and 144 missing. From fear, many families failed to report their beloved as dead or missing. Also, many political groups do not know the real names of some of their militants who were killed or had disappeared. This is a task that the Grupo Tortura Nunca Mais (GTNM) and other human rights organizations in Brazil are still carrying out.

In addition to persecution and violence, the 1960s and 1970s in Brazil were defined by the massive developments in ways of thinking, feeling, and acting in the world. Those were the years in our country when turning to one's inner self, called "inner-ism", was strengthened and fomented in the urban middle classes, resulting in the de-qualification of the public, of the political. The concern with oneself and one's

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family and with self-knowledge took on ultimate relevance. The result was the boom of “psy” practices in the 1970s. The entire political, social, and historical actuality was then “psycholog-ised”. Events were explained and interpreted according simply to psychological reactions.

It was not by chance that in 1970 a survey, supported by psychologists, was carried out among political prisoners in the Army headquarters in Rio de Janeiro to determine the Psychological Profile of the Brazilian Terrorist. The conclusions reinforced that which was being massively propagandized in our country: those engaged in fighting the dictatorship were unbalanced people, from unbalanced families.

At the time, two categories had been disseminated in the country, both youth-related: the subversive and the drug addict. Both categories were seen as dangerous since they dared to oppose the establishment.

**Human rights violations today**

If previously, in the 1960s and 1970s, it was the political opponents who were killed and persecuted, in the 1980s and 1990s the victims are those who, with their humiliating misery, denounce the perverse economic model presently in effect in Brazil.

Applauding extermination and lynching, taking justice into one’s own hands, this is what is being massively produced and encouraged in Brazil. Therefore judges and culprits are being produced to consummate the so-called “necessary social clearance”. Individualism, competition, lack of solidarity, and emptying of the public spaces are being fomented, together with the production of anti-ethical behaviour; violation of human rights is flagrant and commonplace.

According to Americas Watch, the assassination of children and adolescents in Brazil has increased astonishingly. In a document dated February 1994 they denounced the fact that, between 1988 and 1991, 5644 children and youths, aged between 5 and 17 years, were killed violently.

In the countryside, leaders of landless workers are tortured and murdered daily. From 1964 to 1993, 1781 people were killed. These figures were collected by the Comissão Pastoral da Terra (Committee of the Land Pastoral) and the Movimento dos Trabalhadores Sem Terra (Movement of the Landless Workers).

The number of workers enslaved, submitted to constant torture, in several private properties reached 40,694 from 1988 to 1993.

According to a survey made by the Conselho Indigenista Missionário (Missionary Indigenous Council), only 42 Indians were killed in 1993. From 1990 to 1993, there was the massacre of 105 landless Indians, especially because of land disputes.

Extermination and genocide walk hand in hand with impunity. No one has ever been punished. Just as the torturers who killed and hid bodies in the 1960s and 1970s were never punished, today’s murderers also go unpunished.

The GTNM’s regular denunciations of human rights violations have been essential for the creation of a social attitude that can condemn those practices and abolish torture definitively in our country and in the world.

However, Brazilian authorities have shown little receptivity to national and international claims.

The socio-economic situation that Brazil is facing aggravates the scenario of human rights violation. Unemployment reaches more and more segments of society, and the homeless population increases daily. According to a recent survey, over 60 million Brazilians are below the misery line.

**The Grupo Tortura Nunca Mais/RJ and some of its activities**

The GTNM/RJ in its work tries to demonstrate that the 1960s and 1970s belong not only to the past. What is happening today in our daily life is forgotten, when torture is commonplace and even natural, when entire populations are tortured and exterminated.

Even the training of the Armed Forces in Brazil is marked by torture; young men learn to torture in training exercises in which torture is inflicted on them by the instructors. Human Rights organizations have been informed of many cold-blooded murders committed in the military schools.

The GTNM/RJ has been alert to all these issues, has publicized them, and has tried to produce something new about them. An example is the Projeto de Apoio Médico-Psicológico e de Reabilitação Social (Project of Medical and Psychological Support, and Social Rehabilitation for Victims of Torture), the first and only one of its kind in the country. The demand for the Project today is great, considering Brazil’s current historical, economic, and social situation.

The only financing we have for this project is provided by the UN. This is not enough to meet the project’s demands and those of other projects that are also essential for GTNM’s operation. The rest of the work is all done by volunteers, since there is no other funding.

This is the great challenge GTNM/RJ has had to face in our country, where no government support is available for working for Human Rights. On the contrary, we are faced with severe hindrances from the public organizations.

Public Health services in Brazil are very poor, and special attention to victims of institutionalized torture and violence is not provided. There are few psychology professionals with this kind of expertise, because Brazilian universities do not include the theme in their curricula.

This picture gives a notion of how hard it has been and how much effort the Grupo Tortura Nunca Mais/RJ has had to make to support its work during these 10 years. International solidarity has been paramount for us.
Medical fact-finding mission to Israel

Investigating the attitudes concerning "moderate physical pressure" on the part of the Israeli authorities, August 1995

Karin Helweg-Larsen, MD* & Gorm Wagner, MD, PhD*

The Danish Medical Group of Amnesty International, represented by Gorm Wagner, MD, PhD, Associate Professor of the University of Copenhagen, and Karin Helweg-Larsen, MD, Senior Researcher, Danish National Board of Health, participated in a medical fact-finding mission in Israel, headed by Doctor Elizabeth Hodgkin, International Secretary, Amnesty International, London, 10-17 August 1995.

The purposes of this mission were:
- To investigate the methods of physical and psychological pressure commonly used by the Israeli Security Services, and to evaluate whether these methods violate human rights and the UN Torture Convention, which was ratified by Israel in 1991.
- To examine the involvement of the medical profession in the use of physical and psychological pressure in the interrogation of detainees, and its relation to the Tokyo Declaration.

The medical fact-finding mission thus had two components.

First, by interviews with Israeli and Palestinian NGOs, to obtain knowledge about the use of physical and psychological violence in the interrogation centres, and to examine some of the reports by former detainees of the pressure (torture) used during their detention.

Second, by meetings and discussions with the Israeli Medical Association and the Medical Service of the prisons, to obtain knowledge about the medical service in prisons, and if possible the medical service in the interrogation centres, and to discuss the awareness of the ethical obligations of the Medical Association and the medical profession in general when examining and treating any person deprived of his/her liberty.

Background

Amnesty International and other NGOs, as well as the International Committee of the Red Cross (ICRC) and the UN Committee Against Torture (CAT), have during recent years repeatedly published their concerns about the unacceptable treatment of detainees by the Israeli authorities, notably the General Security Services (GSS), which is a secret organization under the jurisdiction of the Israeli Prime Minister and without parliamentary control.

Following information about confessions given by Palestinian detainees due to torture in the GSS centres, a commission was set up in 1987 to investigate the use of physical and psychological pressure in the interrogation centres. The commission was headed by Judge Landau of the Supreme Court.

The Landau report by the Israeli State on the interrogation methods on the GSS was published in October 1987. It clearly demonstrated that confessions had been extracted by torture. The report, disregarding this information, recommended that the GSS agents who had systematically lied to the court should not be prosecuted. The Commission further condemned what was called "moderate physical pressure" in future interrogations of Palestinian political detainees in the GSS centres.

The Landau report contains a second part that is secret, but is believed to describe methods which are to be used as "moderate physical pressure". It has not been possible to obtain concrete information about inclusion of any medical advice in the guidelines.

In January 1994, the UN CAT considered the persistent reports about Israeli violations of the Torture Convention, and recommended that all provisions of the convention against torture should be incorporated into the domestic law of Israel. The Chief State Attorney of Israel, who was interviewed by CAT, maintained the need of GSS to use certain methods of "moderate pressure" against terrorists.

CAT recommended that interrogation procedures should be published in full and seen to be consistent with the standards of the Convention Against Torture and Other Degrading Treatment. CAT further recommended that a programme of education and re-education should be undertaken for the GSS, the Israeli Defence Forces, the police, and the medical prison and police services. An immediate end should be put to the current interrogation practices in Israel.

No legal steps have yet been taken to fulfil these recommendations. There are numerous reports in 1995 from NGOs, former detainees, and some Israeli politicians about ongoing violations of human rights in Israel and the occupied territories.

The medical fact-finding mission

Meetings with NGOs

We initially had meetings with the following NGOs: the Public Committee Against Torture, represented by, among others, Hannah Fridmann and Stanley Cohen; Al-Haq, Law in the Services of Man, represented by Hussein-Daifallah and Kaled Batravi; the Mandela Institute, represented by Ahmad Sayyad and others; B'tselem, represented by, among others, Eltan Feiner; and Hamok Ked, Hot Line Legal Advice, represented by Tamar Pelleg Sryck. We also met representatives from the International Committee of the Red Cross.

METHODS OF "MODERATE PHYSICAL PRESSURE"

In-depth discussions with these organizations and interviews with former detainees made it clear that the following methods of "moderate physical pressure" were still delibe-
rately used in the interrogation centres, including police and prison systems:
- Sleep deprivation for several days.
- Tying up or hand-cuffing in positions giving pain, for example with the hands fixed in a high position and the feet barely touching the ground or fixed on small chairs or in the so-called banana tie.
- Beatings on the face, chest, testicles, stomach, or any part of the body, including the so-called gas pedal method, pressing the interrogator’s foot against the detainee’s testicles.
- Shaking – this procedure will be discussed separately.
- Hooding, used for hours or days during or between interrogations.
- Threats to harm the detainee or his family.
- Food deprivation.
- Being kept in small closets between interrogations and at any time when the detainee is moved from one place to another.
- Being kept incommunicado for several days without access to a lawyer or family.

The International Red Cross is in general not granted access to the prisoners until fourteen days after arrest.

**SPECIAL ISSUE “SHAKING”**

On the last day of the mission the government decided to restrict the use of “shaking” to special cases. The Prime Minister declared officially in August 1995 that about 8,000 people had been “shaken”, and that only one had died.

The shaking method was not known to the Danish Medical Group of Amnesty International before the spring of 1995. It does not seem to appear in the reports of torture in Israel before 1994.

- **Death by shaking**

  In April 1995 a young Palestinian was interrogated by the GSS in Jerusalem. He became unconscious in the interrogation centre and was brought to a hospital, where he died two days later. An autopsy, performed by Professor His, professor of forensic medicine at the Israeli Institute of forensic medicine in Tel Aviv, and assisted by Professor Derick Pounder, forensic pathologist, Dundee University, UK, representing Physicians for Human Rights, showed that the cause of death was subdural haematoma and brain damage consistent with the sequelae of severe shaking.

  By interviewing some former detainees we learned that shaking has been widely used, at least since 1994. The shaking is performed violently and repeatedly for long periods, during which the detainee is kept tied in awkward positions. The detainee is furthermore fatigued by sleep deprivation and has no power to resist the violent shaking of the head and neck. The shaking consequently produces symptoms of motion of the brain, including unconsciousness, severe headache, eye and ear symptoms, and pain in the neck and back, and it may provoke chronic symptoms due to minor or moderate brain damage.

  In order to aid a preliminary evaluation of the possible long-term effects of shaking we made a neurological examination of one detainee.

- **Chronic brain damage? Medical examination of a case of former shaking**

  A male student from Birzeit University, in his twenties, was arrested at the university in mid-August 1994 and kept in the GSS interrogation centre in Ramallah until early October 1994 – 54 days in all. During his detention he underwent long periods of interrogation with deliberate use of shaking, mostly when he was placed on a small chair, hand-cuffed behind his back to the chair, and deprived of sleep for several periods.

  His present complaints included: migraine-like headache concentrated in the left part of the head, attacks of vertigo and periods of more permanent vertigo, eye symptoms (periods of blurred vision), loss of memory and concentration, and tiredness.

  - The medical examination

    **A young man of normal stature and weight, with no obvious mental disorder.**

    - Sensation normal.
    - Standing with eyes open: normal pupils and normal reaction to light, slight rapid nystagmus to both right and left.
    - Finger-to-finger test with eyes open, normal; with eyes closed, 1-2 cm deviation.
    - Finger-to-nose test with eyes open, normal; with eyes closed, some uncertainty.
    - During examination loss of balance and seeking support on the wall to the left.
    - Rapid walking to and fro for 14 feet caused loss of balance at the 5th turn and intense vertigo.
    - Palpation: nothing abnormal on the head, but pain on palpation of the left temporal region. Tenderness over the occiput, with palpable tense and tender attachments of the occipital muscles.
    - Right shoulder: unable to place right hand on top of skull due to pain, lacks 10-15 cms.
    - Unable to place right hand in the middle of his back due to pain, lacks about 15 cms.
    - Palpation: tense and tender muscles along the spine and medial side of the right scapula. Less tender and tense below the left scapula.

  Conclusion:

  - Physical examination compatible with chronic damage of the central nervous system that could well have been caused by the shaking procedures.
  - Unidentified shoulder damage with decrease of movement and palpable secondary muscular tension and tenderness.

  Since the physical examination was carried out without access to precise diagnostic tools, full neurological examination including CT-scanning is called for.

- **Other comments on shaking**

  We interviewed two other former detainees who explained that they had been kept in the GSS interrogation centre for 20 days without sleeping and with repeated daily shaking. The shaking provoked severe pain in the head and neck. The head had been shaken violently from side to side and forwards and backwards, producing dizziness and loss of consciousness.

  The medical fact-finding mission learned that no systematic investigation of the consequences of shaking had yet been undertaken. There had been no serial neurological examinations that included sophisticated tests on former detainees.

  A Palestinian psychiatrist thought that about 40% of all former detainees suffered from post-commotional syndrome, according to his clinical experience.
Follow up

The Danish Medical Group of Amnesty recommends that an evaluation of the consequences of shaking should be initiated as soon as possible. A protocol concerning a case-control study of possible sequelae of shaking will be presented in the hope that the investigation will start during autumn 1995.

Preparation for this project has included discussions with Catherine Grosso, an American sociologist working temporarily at the Human Rights Action Project, Birzeit University, West Bank. We were informed that the university has about 3,000 students, and that an average of 15 students and teachers are arrested every month and submitted to "moderate physical pressure", including shaking. Amnesty would support such an investigation.

Information from the Israeli Forensic Institute

During a meeting with Professor Hiss, head of the Forensic Institute in Tel Aviv, we were told that there had been recent cases of sudden deaths of detainees some days or months after their detention. Since 1992 six Palestinians had died in custody. An autopsy was performed in all cases, but in two or three of them no cause of death was found. Few or none of the cases who died outside custody had been autopsied.

The medical profession and torture

Problems concerning the medical services in the interrogation centres include:
- Medical prison and police services are not independent (impartial) because they are under the Ministry of Police.
- Language: Not all, if any of the doctors and paramedics speak Arabic and understand the detainees.
- Medical staff are not identifiable - no names are given and white uniforms are not always used.
- Doctors are not all members of the medical association and are thus not obliged to conform to medical ethical codes, e.g. the Tokyo Declaration.
- Some doctors do refer to the principles in the Tokyo Declaration: "medical doctors must not participate in any form of torture ...", but by that means they are closing their eyes and ears in order not to participate in or witness any torture, other cruel or degrading treatment in interrogation centres under their medical surveillance.
- Lack of awareness of physical and psychological symptoms following torture ("moderate physical pressure").

THE MEDICAL ASSOCIATION

The Israeli Medical Association, IMA, is a member of the World Medical Association and has endorsed the Tokyo Declaration. We learned from several NGOs that a former approach to the Medical Association about the possible involvement of medical doctors in the interrogation centres had not been successful – there has been no participation of the Medical Association in several symposia over the last few years although the symposia have been dealing with the use of torture in the interrogation centres and the public role of physicians.

Meeting with Dr. Sam Tyano, professor of child psychiatry, head of the Israeli Psychiatric Association, revealed that the association found no problems concerning prisoners or detainees. They maintained that all psychological observations of prisoners and detainees were according to international standards. It was not possible to discuss concrete or principle involvement in depth.

The President of the IMA, Dr. Yoran Bletcher, and the head of its ethical board, Professor Eran Doliv, and its judicial councillor briefed us about the concerns of the IMA. We heard that the ethical board had recently initiated a one-week trainee course specially directed towards medical doctors serving in prisons. The course included clinical forensic examination, medical ethical codes, and discussions of human rights principles. The IMA had sent copies of the Tokyo Declaration to all the members and would in the future highlight the work in the ethical board.

The ethical board expressed interest in concrete documentation of violations of human rights by medical doctors in Israeli interrogation centres and prisons, and was provided during the meeting with a case of an asthmatic Palestinian detainee who was examined medically before interrogation. He had subsequently been hooded and handcuffed in a way that allowed the use of an anti-asthmatic spray during the following use of "moderate pressure" by interrogation. The name of the doctor was given to Dr. Doliv.

The ethical board stressed that they had aimed the trainee course in human rights at all doctors in the prison service, but they informed us that they did not know which doctors served in GSS interrogation centres. They denied that interrogation centres were situated in prisons. They would need to have knowledge about which doctors were serving in the GSS centres before they could initiate any action.

They promised to contact the Ministry of Health to learn whether the Ministry had any information about such doctors, who they claimed were not members of the IMA. They would look for information about the names of medical doctors who had received medical licenses but had not graduated from Israeli medical schools.

INTERVIEW WITH THE MEDICAL PRISON SERVICE SYSTEM

We had a meeting in the prison outside Tel Aviv with Doctor Seligbaum, head of the Israeli Medical Prison Service, and the doctor in charge of the prison hospital, and with the medical administrator of the prison drug prevention programme. During the meeting, which lasted 3½ hours, they told us that the medical standard in prisons was high, that general awareness of professional ethical principles was mandatory, and that post-graduate trainee courses were offered to all members of the medical staff, including paramedics.

Interrogation centres are also placed in prisons, but in separate buildings. They are served by the normal medical prison services. Paramedics have the most contact with detainees, seeing them several times a day in the interrogation centres and before they enter the centres.

The paramedics were said to have several months of compulsory training and are recruited from the army, among other places. They primarily conduct the medical rounds in the interrogation centres. We learned that they visit all detainees in the GSS four times daily and report if they have any complaint, in which case they would call the medical doctor.

They told us that any complaint of violation would be duly examined by the head of the medical prison service. We were told that he might have two cases per year. No regular "fitness attestation" was in use, and they did not recognize an example that supposedly had been used in GSS centres.

Prisoners were examined before their detention in prison or their interrogation in the GSS centre, but it was not possible to learn the purpose of these examinations, nor to learn how often lesions were registered that might be due to prior interrogation in other centres before entering the prison.

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