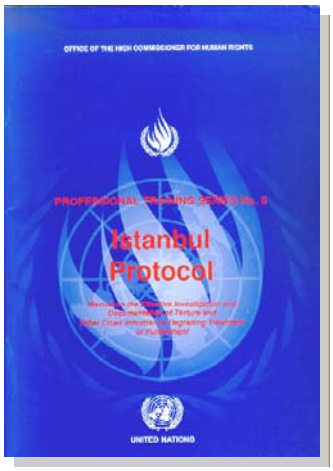
Reference Materials

The Istanbul Protocol: International Guidelines for the Investigation and Documentation of Torture

MEDICAL ASPECTS OF TORTURE AS SEEN IN UGANDA

2004



This guide has been written as part of the Istanbul Protocol Implementation Project, an initiative of Physicians for Human Rights USA (PHR USA), the Human Rights Foundation of Turkey (HRFT), the World Medical Association (WMA), and the International Rehabilitation Council for Torture Victims (IRCT)

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The Istanbul Protocol: International Guidelines for the Investigation and Documentation of Torture

MEDICAL ASPECTS OF TORTURE AS SEEN IN UGANDA

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REFERENCE MATERIALS REGARDING THE USE OF THE ISTANBUL PROTOCOL: INTERNATIONAL GUIDELINES FOR THE INVESTIGATION AND DOCUMENTATION OF TORTURE

The Istanbul Protocol is the first set of international guidelines for the investigation and documentation of torture. The Protocol provides comprehensive, practical guidelines for the assessment of persons who allege torture and ill-treatment, for investigating cases of alleged torture, and for reporting the findings to the relevant authorities. Initiated and co-ordinated by Physicians for Human Rights USA (PHR USA) and Action for Torture Survivors and the Human Rights Foundation of Turkey (HRFT), the Protocol was developed over three years with the involvement of more than 40 organisations, including the International Rehabilitation Council for Torture Victims (IRCT) and the World Medical Association (WMA).

With the generous support of the EU, the 'Istanbul Protocol Implementation Project' was carried out between March 2003 and March 2005 to increase awareness, national endorsement and tangible implementation of the Protocol in five target countries: Georgia, Mexico, Morocco, Sri Lanka and Uganda.

The resource materials presented here were developed as a source of practical reference for health and legal professionals during the trainings conducted as part of the project. The materials were widely disseminated to the 250 individual health professionals and 125 lawyers who participated in the trainings and were also distributed to relevant national institutions and government agencies in the five countries. It is hoped that these materials offer insights and create synergy between the two professions in a joint effort to combat torture.

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INTRODUCTION

In the Ugandan context it is important to consider both the objectives of documentation of torture allegations and the treatment of health complications arising as a result of torture, as many torture survivors in the country have never been able to access any kind of treatment (Kinyanda & Musisi 2000; Kinyanda et al 2003).

For purpose of this chapter, torture is defined according to the United Nations Convention against Torture, 1984, as:

''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 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 for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions.''

The chapter will also deal with issues that go beyond torture – such as cocial cultural maltreatment (domestic violence, female genital mutilation and corporal punishment in schools).

PRESENTATION OF TORTURE

Torture in Uganda – as in many sub-Saharan African countries – takes three main forms, War torture, Custodial torture and Socio-cultural torture. Each of these forms of torture is described below.

WAR TORTURE

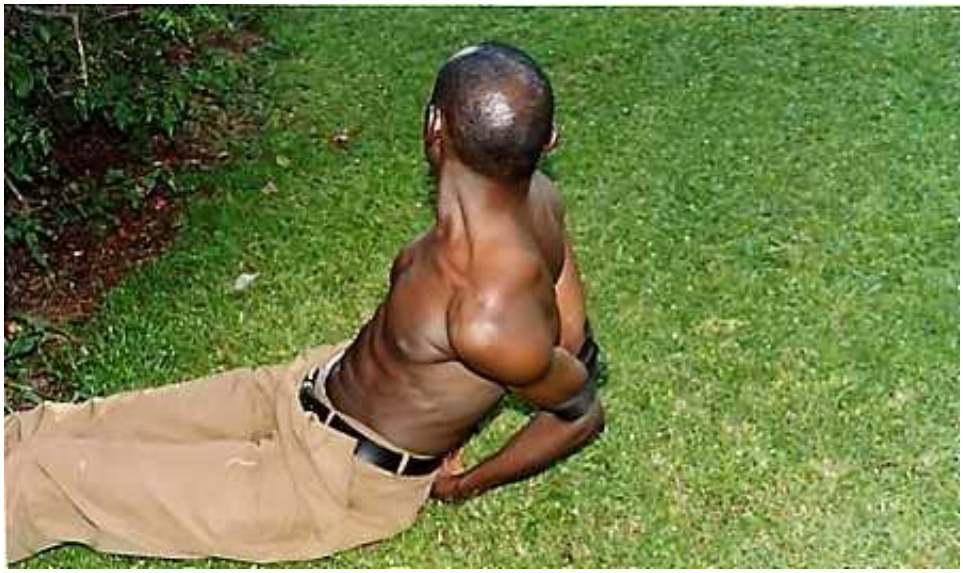
In much of the post-independence history of Uganda, the country has experienced significant social strife due to mass violence resulting from warfare, armed insurgencies, political instability, population displacements and family disruptions. This has resulted in war torture of large sections of the population. Today's estimate is that, out of a total country population of 24 million people, two million people, mostly in north-eastern Uganda, are currently affected by war. These people are either displaced in internally displaced persons' camps (IDPs) or have left their home district and sought shelter in other districts of the country (Parliament of Uganda, 2004). In war torture, the civilian population is usually caught up between the two belligerent sides: the rebel insurgents on one side and the government soldiers on the other. The torture methods applied can be broadly divided into two categories: the physical torture methods and the psychological torture methods. It is important to remember that all physical methods of torture have psychological implications for the victims (Musisi, Kinyanda, Senvewo 1999).

PHYSICAL TORTURE METHODS

The physical methods of torture commonly reported in Uganda include: rape, bayonet/machete/knife injuries, gunshot injuries, landmine blast injuries, *Kandoya* (severe form of tying up), beating and kicking, burning with fire, being forced to carry heavy loads over long distances and being forced to sleep in the bush or swamp for extended periods of time (Musisi et al 1999; Kinyanda and Musisi 2001; Kinyanda and Musisi 2002; Human Rights Watch 2004).

Kandoya

This is a severe form of torture, where the upper limbs are tied behind the back. It results in severe stretching of the anterior thoracic muscles, and is also called the “three piece suit”. It damages the neuromuscular function of the upper limbs (Musisi et al 1999; Human Rights Watch 2004).



Survivors of this form of torture report severe weakness in the arms and inability to carry out manual work, e.g. to work in the garden or to lift heavy objects. One can only imagine the consequences of such impairment to a peasant farmer, whose livelihood depends on his/her ability to use the upper limbs to do manual work.

Kandoya was introduced in Uganda in the early 1980s by the present government, which at that time was a rebel group (the National Resistance Army) which operated in central and southern Uganda. It has since then spread all over the country, particularly in the areas affected by war conflict. The method was exported to Rwanda where it is referred to as *ingoma* by soldiers formerly with the Ugandan army. Later on, the method has also been used in parts of eastern Congo (Musisi et al 1999; Kinyanda 2000).

CUSTODIAL TORTURE

This form of torture may be carried out in places gazetted to detain civilians, such as prison cells, or in non-gazetted places such as the notorious “*safe houses*” or army installations. The abuse of prisoners is no longer routinely carried in Ugandan prisons, but there are instances where some prison officers abuse the rights of people in their care. A prominent example, in which the rights of prisoners were abused and led to both local and international outcry, was in March 2001 when 56 prisoners in a jail in Kanungu in south-western Uganda were forced to excavate the mass graves of victims of the Kanungu cult-instigated mass deaths. This they did with their bare hands and without any protective clothing to the detriment of their psychological and physical health (Kinyanda et al 2000).

Another recent manifestation of this form of torture has been the detaining of civilians in either military installations or in the *safe houses*. These so called *safe houses a*re properties run by the security agencies in Uganda where civilians are sometimes held and subjected to various forms of torture on suspicion of political and criminal offences (Amnesty International 2004, Human Rights Watch 2004, ACTV 2004). The methods of torture that have been documented to be used in the *safe house*s include:

- tearing off nails
- insertion of needles into the nail bed
- suspension of weights onto the scrotum
- having the victim bitten by red ants
- burning with molten plastic
- repeatedly beating the soles of the feet
- threats of putting victims in cages full of reptiles
- stabbing and even killing the victims.

(Amnesty International 2004, Human Rights Watch 2004, ACTV, 2004).

The torture methods used in these places are similar to those reported in the international literature, as the perpetrators are state agents who have been trained in torture methods outside the country. There has been a lot of public outcry about these places.

SOCIO-CULTURAL MALTREATMENT

This form of torture is rooted in the socio-cultural beliefs of the different tribes and institutions of Uganda. The tribal-related forms of torture include:

- domestic violence
- female genital mutilation (FGM) which is still practiced by some communities in north-eastern Uganda
- the centuries old cattle-rustling and raiding in north-eastern Uganda. Cattle rustling by Karamojong raiders has had particularly devastating consequences for the more than two million inhabitants of the Teso region. This population has suffered the death of loved ones, physical and psychological torture, and the destruction of the entire region's herd of cattle and the consequent destruction of their age-old socio-economic way of life.

On the institutional level, there is the widespread corporal punishment in schools, that has sometimes led to permanent maiming of children, in some cases even to death. Torture sanctioned by arguments based on religion has been documented in Uganda, particularly in those religious groups that are on the fringes of the religious movement. The worst case of such religiously inspired torture was in March 2001, when more than 1000 cult members were killed in a cult-instigated mass murder and suicide at Kanungu in south-western Uganda (Kinyanda and Musisi 2002).

SEXUAL VIOLENCE

Sexual violence takes many forms including:

- single episodes of rape
- gang rape
- sexual comforting
- forced incest
- sex in exchange for gifts or security
- being forced into marriage
- abduction with rape
- attempted rape and being forced to witness violent sexual acts

(Musisi et al 1999; Kinyanda and Musisi 2002).

Case vignette

A 20 year-old girl was admitted to a hospital in central Uganda with conversion symptoms (hysterical symptoms). She was unable to walk or talk and often had periods of hyperventilation and pseudo-seizures. These symptoms started when she reported for the first time at her new school in north-eastern Uganda (over 200 kilometres away from the hospital where she was being examined). It was discovered that soldiers had raped her in the past, and that she was worried that she may go through a similar experience now that the war had broken out again in the district of her new school.

The attending physician in the capital city of Kampala far removed from the war-afflicted north-eastern Uganda could easily have missed the underlying reasons for this patient's problems if he had not taken a good social history that also inquired about exposure to war torture. This story illustrates the importance of taking a good social history in a country like Uganda, where prevalence of war exposure is around 10% (IDEAS/ Ministry of Health of Uganda/ SHSSP/ADB 2004/).

ASPECTS OF PHYSICAL TORTURE

- Deep tissue bruises acquired as a consequence of blunt trauma might not be seen on the surface, particularly in the dark-pigmented skins of Africans. However, in the lighter skin complexions the lesions may be visible.
- African skin may develop hypertrophic scars and keloids in response to injury.
- Sharp trauma may be caused by the use of knives, bayonets, machetes or panga.
- Thermal injuries may be induced by burning with molten, dripping plastic. When burning with molten plastic, a water jerrican is usually put over the body of a restrained individual. This results in characteristic linear lesions (*necklace pattern*) usually in two or three rows running down the back of the individual.

- Electrical injuries may be observed in victims of torture by state agents, but has not been reported among victims of war trauma.

- The commonly reported skin complaints include generalised pruritus and reports of painful scars. The painful scars will usually have been sustained many years previously and are often the focus of torture-related psychological complaints. These scars have often healed, and the reported pain is often disproportionate to the physical presentation (Musisi, Kinyanda and Senvewo 1999).

- Survivors of torture that occurred many years back have been observed to have gastrointestinal complaints such as loose stools, chronic vague stomach aches and dyspepsia and intolerance of certain foods (Musisi, Kinyanda, Senvewo 1999). Their symptoms appeared to result from chronic stress, that has led to hyper arousal of the autonomic system. These symptoms are usually accompanied with other symptoms relating to increased autonomic function such as excessive sweating, recurrent “fever” and reports of palpitations (Musisi, Kinyanda, Senvewo 1999).

- The chronic gynaecological sequelae of torture observed in this country include perineal tears, urinary fistula, faecal fistula, chronic sexually transmitted disease including HIV/AIDS, chronic lower abdominal pain, secondary infertility and painful sexual intercourse (Mirembe et al 1999, Mirembe et al 2001, Otim et al 2002).

- The commonly reported chronic surgical complications following torture include recurrent back pains, discharging wounds, leg ulcers, painful swollen joints, fractured limbs, burn contractures, gunshot injuries, and chronic osteomylitis (Beyeza, Naddumba and Buwembo 2001, Kirya, Epodoi and Buwembo 2002).

PSYCHOLOGICAL METHODS OF TORTURE

The psychological methods of torture include:

- verbal threats
- interrogations
- being detained in military installations
- attempted rape
- abductions
- destruction of property and livestock
- being forced to kill, to fight, have incest or provide sexual comforting
- deprivation of food, water and medicine
- being forced into marriage
- being forced to witness torture of others
- staying in an internally displaced persons camp.

(Musisi et al 1999; Kinyanda and Musisi 2001; Kinyanda and Musisi 2002).

The broad aim of such torture is political: to destroy the individual or to break them spiritually and then use the broken person to spread terror throughout the rest of the community (Musisi, Kinyanda and Senvewo 1999).

PSYCHOLOGICAL ASPECTS OF TORTURE

The psychological sequelae of torture that have been documented in Uganda include acute post traumatic stress disorder, chronic post traumatic stress disorder and complex post traumatic stress disorders. These PTSD syndromes are often occurring with co-morbid depression, anxiety disorder, somatisation disorders, atypical psychosis, chronic pain syndromes and chronic fatigue (Musisi S, Kinyanda E, Senvewo 1999, Kinyanda and Musisi 2001, Kinyanda et al 2002). Epilepsy is a common neuropsychological complication of torture, particularly following head injury (Musisi, Kinyanda, Senvewo 1999).

DIAGNOSTIC SERVICES

The physicians in a primary care setting may have to rely on physical examination and documentation, as diagnostic tools such as biopsies may not be readily available or affordable by their clients. Photographs of the lesions to document them may be an option. However, at regional and tertiary level, hospital biopsies of the skin lesions may be possible.

Byanyima and colleagues (2001) undertook a review of the radiological images of 78 patients who had attended the ACTV treatment centre and they observed that most of the patients had had radiological investigations done at least 12 months after they had experienced torture. Most of the X-ray findings (60.3%) were normal, despite physical complaints that necessitated the radiological investigations. This points towards a possible psychological basis for the pains and aches. For those (34.6%) with positive radiological findings these included: chronic osteomyelitis (90%) usually secondary to gunshot injuries, foreign bodies in soft tissues (3.8%), dislocation (2.6%) and mal-union of bones (2.6%). A common incidental finding was broncho-pneumonia (3.8%) (Byanyima, Kiguli and Kawooya, 2001).

Local case story

Mrs A. A. R is a middle-aged widow from northern Uganda (a war-torn part of the country). Fifteen years ago, she moved to the capital city of Kampala to escape the civil war that continues to plague her home district.

Referral: Was seen at a hospital in the capital city.

Source: This patient was referred by a physician to the psychiatric unit of the attending hospital with what was thought to be psychiatric symptomatology. The patient had never sought psychiatric help before.

Chief Complaint: The patient reported a one-month history of fainting attacks which occurred whenever she was in class, (she is a primary school teacher).

Present illness: The patient presented with a one-month history of fainting attacks. These attacks usually occurred when she was in class teaching pupils. Whenever she got these attacks, she had to interrupt her class and go and rest at home. The sequence of events during these fainting attacks was that she would feel the ceiling in class spinning round, then she would support herself on either the blackboard or the table in front of the class. She would then have to abandon teaching, but she never lost consciousness. The attacks appear to have been precipitated by a misunderstanding she had with a fellow teacher. This teacher made derogatory comments about her previous traumatic

experiences. This was at a time when one of the perpetuators of her trauma (late president Idi Amin) was terminally sick and was featuring in the headlines. Her trauma history reveals that she has been tortured during two time periods. The first torture experience occurred between 1973-1975 during the Idi Amin regime. During this time, she suffered sexual harassment and her best friend was abducted and killed.

For reasons of her safety, her parents had her transferred to a village in northern Uganda where she had to pursue training as a primary school teacher against her will. She again suffered trauma in the period between 1986-1988, when a civil war broke out in northern Uganda. She suffered abduction by rebel soldiers, gang rape, multiple episodes of severe beatings and being left to die. She also had to sexually comfort a rebel commander and she witnessed the killing of people, the destruction and stealing of household property and livestock and was forced to become a spy for the rebels. In 1988 she moved to the capital Kampala to escape this torture.

HTQ Trauma events:

1. Material deprivation	+
2. War like conditions	+
3. Bodily injury	+
4. Forced confinement and coercion	+
5. Forced to harm others	+
6. Disappearance, death or injury of loved ones	+
7. Witnessing violence to others	+
8. Brain injury	+

Past history:

General Health:	-	good
Childhood illness	-	measles, frequent malaria attacks
Adult illness	-	none, no history of psychiatric illness
Injuries	-	suffered head trauma in 1987
Operations	-	none

Current health status:

Medications	-	Antidepressants.
Alcohol	-	Is a social drinker, does not abuse Marijuana
Tobacco	-	no use
Diet	-	takes typical African dishes
HIV	-	not known

Family history:

Father and Mother	-	alive though retired and live in the war-troubled northern Uganda
Brothers/sisters	-	No medical/psychiatric problems
Children	-	Has three children, all attending school

No family history of mental illness

PSYCHOSOCIAL HISTORY

Born and raised in the capital city of Kampala the daughter of a middle class family. She trained as a teacher in northern Uganda although she would have preferred to do motor-vehicle mechanics. Married at 26 to a businessman who died in 1997 as a result of cardiac complication caused by excessive alcohol consumption. She lives hand-to-mouth trying to meet the needs of her three children from the meagre salary she earns as a primary teacher in Kampala.

The teachers at school know about her traumatic past, with most teachers being supportive to her, except one who made derogatory remarks.

REVIEW OF SYSTEMS

- General - has kept her weight
- Skin - has healed scars on her scalp and the back of left arm due to previous torture
- Head - suffered injury in 1987
- Eyes - no abnormalities
- Ears - normal
- Nose/sinus - normal
- Mouth/throat - no abnormalities
- Neck - no abnormalities
- Breasts - no abnormalities; rarely conducts self-breast exam
- Respiratory - normal
- Cardiovascular - no known heart disease
- GL - normal
- Urinary - no abnormalities
- Genital - menarche at age 14 para 3+0, three living children
- Musculoskeletal exam - no abnormalities
- Peripheral vascular - no abnormalities
- Neurologic - no abnormalities
- Hematologic - no abnormalities
- Endocrine - not assessed
- Psychiatric - see present illness and mental status exam.

PHYSICAL EXAMINATION

Mrs A. A. K is of medium height, a slender, middle-aged lady. Throughout the interview she kept closing her eyes and wiping her face as if trying to remove unpleasant memories. She was dressed in clean clothes. She talked about her past torture experiences guardedly.

- Pulse - 64 per minute
- Temp - normal
- BP - 120/60
- Ht - not done
- Weight - not done
- Skin - has healed scars on the left temporal scalp area and at the back of her left arm
- Head - with normal limits (WNL)
- Eyes - WNL
- Ears - WNL

- Mouth - WNL
- Neck - WNL
- Lymph nodes - WNL
- Thorax and lungs - WNL
- Cardiovascular - WNL
- Breasts - no masses or abnormalities
- Abdomen - no organomegaly
- Genitalia - normal, no virginal discharges
- Peripheral vascular - WNL, no obvious abnormality
- Musculoskeletal - WNL
- Neurological - WNL

Laboratory findings

- Haematological indices are normal.

Mental Status Examination

- General Appearance: extremely cautious, neatly dressed and vigilant
- Oriented: fully oriented
- Memory: past and present memory is intact; concentration good
- Affect: depressed
- Mood: sad, distressed about the remarks made by the teacher otherwise resigned about her fate
- Cognitive: No signs of psychosis or hallucinations
- Neurological signs, diarrhoea, appetite is good, no weight gain, enjoys her work.

Screening instruments

Hopkins Symptom checklist-25(HSCL-25) Depression symptoms only

Symptoms	(1) Not at all	(2) A Little	(3) Quite a bit	(4) Extremely
Low energy	X			
Self blame	X			
Crying	X			
Lowered libido	X			
Poor appetite	X			
Difficulty sleeping	X			
Sadness			X	
Hopelessness	X			
Loneliness	X			
Suicidal ideation	X			
Feeling trapped	X			
Worrying			X	
No interest	X			
Everything an effort	X			
Worthiness	X			

Harvard Trauma Questionnaire PTSD symptoms only

Symptoms	(1) Not at all	(2) A Little	(3) Quite a bit	(4) Extremely
Recurrent memories		X		
Re-experiencing the event	X			
Nightmares	X			
Detachment	X			
Unemotional	X			
Startled	X			
Poor concentration	X			
Trouble sleeping	X			
Guardedness			X	
Irritability		X		
Avoiding activities reminiscent of trauma	X			
Inability to remember traumas	X			
Less interests in daily activities	X			
Feeling there is no future	X			
Avoiding trauma thoughts	X			
Sudden emotional or physical reaction when reminded of trauma				X

MRS. A. A. K'S PROBLEM LIST AND PLAN

Mrs. A. A. K'S Problem can be summarised as follows:

Trauma History

1. Suffered traumatic events during two time periods: 1973-1975 and 1986-1988. Involved abduction, chronic harassment, exposure to war and sexual abuse.

Assessment: Has suffered a traumatic history for much of her early adulthood. Had a privileged upbringing as a daughter of a middle class family. She has suffered major life events, including chronic harassment from state operatives, abductions, death of a close friend, multiple rapes, sex comforting, forced conscription into rebel ranks. Has poor social support as her husband died in 1997 and the parents are old. Suffers from chronic financial difficulties, as she has to fend for her three children. The other teachers at the school where she works have come out strongly to support her and she is grateful for that.

Plan: Mrs. A. A. K is a highly traumatised woman from the war-torn northern Uganda. She is suffering from pseudo-seizures, as a manifestation of a conversion–dissociative reaction with chronic post traumatic stress disorder.

Medical problems

1. Possible seizure disorder

Assessment: Given her history of multiple head injuries, there was a need to rule out a seizure disorder secondary to brain injury. Electro Encephalography (EEG) and computerised tomography (CT scan) have been requested. These examinations had not been done at the time of the interview (these examinations are paid for by patients, so there is little chance that she will have them done, given her difficult financial circumstances).

2. Major depression

Assessment: Clinical assessed revealed that she had some features of depression. This is supported by the positive items on the HSCL-25 Depression item.

Plan: Was started on antidepressants and counselling was initiated.

3. Post traumatic stress disorder (PTSD)

Assessment: Initial assessment revealed that the patient was experiencing some of the symptomatology of PTSD, i.e. recurrent memories, guarded-ness, irritability, and sudden emotional or physical reaction when reminded of the trauma.

PSYCHOLOGICAL PROBLEMS

1. Resigned about her fate and a deep mistrust of men

"I have been raped more than 100 times, both when I was a child and in adulthood. Raped both in peace times and in war situations. I don't think I am sexy. But when I am left with a man like you and me now, the next thing is that the man wants to rape me. My late husband also first raped and impregnated me, then he married me."

Plan: Mrs. A. A. K needs supportive counselling. But given that the only service available is an over-stretched government counselling service run by a volunteer clinical psychologist, there is little chance that she will get it. Also given the cost implications connected with coming to town to have these sessions, there is little chance that this will ever happen. Despite her extensive trauma history, this was the first time she was accessing psychiatric/psychological assistance.

Stress at place of work: Current episode appears to have been precipitated by derogatory comments made by a fellow work-mate about her previous trauma history.

Plan: Disciplinary action has been taken against this teacher. Fortunately other teachers have come out to support her which she highly appreciates (contributing to the food and drink she was consuming whilst in hospital and taking care of her children in her absence).

To build a social support network for her, based on the supportive work-mates.

- **Spiritual (existential problems)**

She was converted to the "saved" faith – a healing Christian religion, and she feels that the church and its members are a great help to her.

(Case first presented at the first Master Class of the Harvard Trauma Project held in Orveito, Italy, 2003).

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