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Forensic Examination Missions by Medical Teams Investigating and Documenting Alleged Cases of Torture

OPERATIONAL MANUAL



International Rehabilitation Council for Torture Victims

Forensic Examination Missions by Medical Teams Investigating and Documenting Alleged Cases of Torture: Operational Manual

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Borgergade 13
P.O. Box 9049
1022 Copenhagen K
Denmark
Tel: +45 33 76 06 00
Fax: +45 33 76 05 00
Email: irct@irct.org
Website: www.irct.org

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Forensic Examination Missions by Medical Teams Investigating and Documenting Alleged Cases of Torture

Operational Manual



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Authors

In alphabetical order

Djordje Alempijevic
MD, PhD, Associate Professor, Institute of Forensic Medicine, University of Belgrade, Serbia

Rusudan Beriashvili
Associate Professor of Forensic Medicine, Tblisi State Medical University, Georgia

Jonathan Beynon
MD, independent expert on visits to places of detention and the documentation of torture, formerly co-ordinator for Health in Detention, International Committee of the Red Cross, Switzerland.

Margriet Blaauw
MD, lead author and consultant to the IRCT, Denmark

Ana Deutsch
Clinical Director, Program for Torture Victims, Los Angeles, USA

Pierre Duterte
Medical doctor & psychotherapist, private practice therapist/family counselor, founder of Parcours d'Exil, France

Adriaan van Es
MD, Coordinator, International Federation of Health and Human Rights Organisations, the Netherlands

Ravindra Fernando
Senior Professor of Forensic Medicine and Toxicology, University of Colombo, Sri Lanka

Sebnem Korur Fincanci
Professor of Forensic Medicine, Istanbul University, Turkey, Member of IRCT Council, President of Human Rights Foundation of Turkey

Steen Holger Hansen
Deputy Chief Pathologist, Denmark

Lilla Hardi
Psychiatrist, Head of Section of Psychological Consequences of Torture and Persecution at WPA, Director of Cordelia Foundation, Hungary

Hans Petter Hougen
MD, PhD, DMSc, MPA, Professor, Chief Forensic Pathologist, University of Copenhagen, Denmark

Vincent Iacopino
Senior Medical Advisor, Physicians for Human Rights, Adjunct Professor of Medicine, University of Minnesota Medical School, USA

Gordon Thomas Jehu
MD, University of Copenhagen, Faculty of Health Sciences, Department of Forensic Medicine, Section of Forensic Pathology, Denmark

Peter Mygind Leth
Deputy Chief Forensic Pathologist, Institute of Forensic Medicine, Denmark

Said Louahlia
Pathologist, Quebec, Canada
Former Professor, Head of Department of forensic Pathology, Morocco. Founding member and past President of MAFS

Maria Dolores Morcillo Mendez
Medical Doctor specialist in Forensic Medicine; Clinical and Pathology, Bogota, Colombia

Maria Cristina de Mendonça
Consultant Forensic Pathologist, Portuguese National Institute of Forensic Medicine. Professor of Forensic Medicine, University of Coimbra, Portugal

Jens Modvig
MD, PhD, Health Programme Manager, Rehabilitation and Research Centre for Torture Victims, former Secretary-General of the IRCT, Denmark

Ulla Noring
Psychiatrist, Ministry of Justice, Denmark

Jason Payne-James
Consultant Forensic Physician, Director Forensic Healthcare Services Ltd, Honorary Senior Lecturer, Cameron Forensic Medical Sciences, Barts & the London School of Medicine & Dentistry, London, President of WPMO, UK

Michael Peel
GP - Clinical Lead for Central London Community Healthcare, former Senior Medical Examiner at the Medical Foundation, UK

Máximo Alberto Duque Piedrahíta
Forensic Pathologist, former Head of National Forensic Services, Colombia

Derrick Pounder
Forensic Pathology professor, University of Dundee, UK

Christian Pross
Center Survive, Center for the Treatment of Torture Victims, Professor of Psycho-traumatology at Charité University Medical Center, Berlin, Germany

José Quiroga
Medical Director of the Program for Torture Survivors, Los Angeles, former Assistant Professor in the UCLA School of Public Health, USA

Ole Vedel Rasmussen
MD, DMSc, former member of CAT and CPT, Denmark

Hernan Reyes
ICRC doctor working on detention issues since 1982, Chile/Switzerland. Currently based in Beijing.

Bente Rich
Child-and adolescent psychiatrist, former chief psychiatrist at the Rehabilitation and Research Centre for Torture Victims, Denmark

Sidsel Rogde
Professor Forensic Pathology, Norway

Antti Sajantila
Professor, Specialist in forensic medicine Head of the Department of Forensic Medicine, Hjelt Institute, University of Helsinki, Finland

Daya Somasundaram
MD, FRCPsych, FRANZCP Clinical Associate Professor, Discipline of Psychiatry, University of Adelaide, Australia

Marina Staiff
FMH Specialist in psychiatry and psychotherapy, Switzerland

Jørgen Lange Thomsen
Professor, Head of Institute, DMSc, DMJ (Path), London, UK; FRCPath, Institute of Forensic Medicine, Denmark

Morris Tidball-Binz
MD, Forensic Coordinator Assistance Division, International Committee of the Red Cross, Switzerland

Felicitas Treue
Psychologist, Psychotherapist, Germany; Co-founder of the Colectivo Contra la Tortura y la Impunidad in Mexico

Peter Vanezis
Forensic pathologist, Professor, UK

Duarte Nuno Vieira
President of IALM, IAFS, ECLM and WPMO, Professor of Forensic Medicine and Forensic Sciences, University of Coimbra, Director of the National Institute of Forensic Medicine of Portugal

From the IRCT

Sundra Essien
Attorney, Legal and Advocacy Team

Susanne Kjær
MSc Political Science, Project Manager

Önder Özkalipci
MD, Senior Forensic Advisor, Forensic Physician

Miriam Reventlow
Lawyer, LLM, Head of Legal and Advocacy Team

Acronyms

CPT	European Committee for the Prevention of Torture and Inhuman or Degrading Treatment and Punishment
CT-Scan	Computerised Tomography
DNA	Deoxyribonucleic Acid
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
EC	European Commission
ICC	International Criminal Court
ICN	International Council of Nurses
ICRC	International Committee of the Red Cross
ICTY	International Criminal Tribunal for the Former Yugoslavia
IFRC	International Federation of Red Cross and Red Crescent Societies
IRCT	International Rehabilitation Council for Torture Victims
MRI	Magnetic Resonance Imaging
NGO	Non Governmental Organisation
OHCHR	Office of the United Nations High Commissioner for Human Rights
OPCAT	Optional Protocol to the Convention against Torture
SPT	Subcommittee on Prevention of Torture
STI	Sexually Transmitted Infections
UCN	Unique Case Number
UN	United Nations
UNCAT	United Nations Convention against Torture
UPR	Universal Periodic Review
WHO	World Health Organization
WMA	World Medical Association
WPA	World Psychiatric Association



CD-ROM

- UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
- The Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment Protocol (Istanbul Protocol)
- UN Basic Principles of Human Rights Monitoring, Adapted from the UNHCHR Training Manual on Human Rights Basic Principles of Human Rights Monitoring
- World Medical Association Resolution on the Responsibility of Physicians in the Documentation and Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment
- Photographic Documentation, a Practical Guide for Non Professional Forensic Photography, Article by Dr. Önder Özcalipci, Dr. Muriel Volpellier
- The right to be examined by a doctor of own choice (WMA Lisbon Declaration, UN Body of Principles for the Protection of All Persons Under any Form of Detention or Imprisonment, CPT standards)
- The Torture Reporting Handbook, Camille Giffard, Human Right Centre, University of Essex
- Medical Investigation and Documentation of Torture, A handbook for Health Professionals, Michael Peel and Noam Lubell with Jonathan Beynon
- Anatomical drawings for documentation of torture and ill-treatment (Annex III in the Istanbul Protocol)
- Consent Form templates (see Annex 5)
- Medical Physical Examination of Torture Victims – A practical guide to the Istanbul Protocol for medical doctors (in English, French and Spanish)
- Psychological Evaluation of Torture Allegations – A practical guide to the Istanbul Protocol for psychologists (in English, French and Spanish)
- Action against Torture – A practical guide to the Istanbul Protocol for lawyers (in English, French and Spanish)

The Istanbul Protocol

The Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment and Punishment, commonly known as the Istanbul Protocol, contains the first international standards and procedures on how to recognize and document physical and psychological evidence of torture in court cases. Initiated and coordinated by the Human Rights Foundation of Turkey and Physicians for Human Rights USA, the Istanbul Protocol was developed by more than 75 experts from more than 40 organisations, including the IRCT. It was submitted to the UN High Commissioner for Human Rights on 9 August 1999 and has subsequently been annexed to various UN resolutions and been published by the Office of the High Commissioner for Human Rights (OHCHR) as part of its Professional Training Series.

The Istanbul Protocol is available in Arabic, Chinese, English, French, Russian and Spanish on the OHCHR's website: http://www.ohchr.org/EN/PublicationsResources/Pages/TrainingEducation.aspx. The IRCT has collected translations of the Istanbul Protocol in a number of additional languages. These translations are available at: http://www.irct.org/Read-theProtocol-2701.aspx.

1 Introduction

Torture has been consistently prohibited in international human rights and humanitarian law for more than half a century and has been condemned in a number of international conventions.* The prohibition is absolute and no exceptions, including situations of public emergency and war, may be evoked to legitimise the use of torture. Despite this, occurrences of torture and other forms of ill treatment are still widespread and continue to be practiced in over 100 countries.

International law obliges states to investigate allegations of torture and to punish those responsible. It also requires that victims of acts of torture are able to obtain reparation and have an enforceable remedy to fair and adequate compensation, restitution of their rights and as full a rehabilitation as possible. Nevertheless, torturers are seldom brought to court and torture survivors rarely receive any kind of redress as compensation for their suffering. One of the major challenges in fighting impunity is to obtain sufficient evidence in cases against alleged perpetrators.

Medical[1] examination of alleged victims and documentation of torture can play a crucial role in bringing evidence of torture and ill treatment to light.

In order to support investigations into torture allegations, forensic examination teams often have to travel abroad and may have to work in sometimes politically sensitive climates, or in conflict or post-conflict situations. The missions may contribute to legal investigations into allegations of torture, investigations of human rights violations, the work of international commissions and 'truth commissions', and assessments of needs for treatment.

During the missions teams may face challenges related to local rules and regulations, the availability of diagnostic equipment and facilities, safety and security, language, and confidentiality issues. The teams should consist of resourceful people used to finding solutions; however, finding solutions on the spot is time-consuming and may compromise the quality of the investigation and the time spent with the alleged torture victim.

The Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment – known as the Istanbul Protocol[2] – provides internationally recognised standards on how to identify,

*Throughout the Manual the term 'torture' is used for brevity. It does, however, also include other forms of cruel, inhuman and degrading treatment as defined in Article 3 in the UN Convention against Torture.

document and report symptoms of physical and psychological torture. The 'Model Curriculum on the Effective Medical Documentation of Torture and Ill Treatment' is a comprehensive Istanbul Protocol training resource that was developed to enable health professionals to effectively investigate and document torture and ill-treatment (see http://istanbulprotocolmodelcurriculum.org).

The present manual is designed to provide practical information for agencies and individuals involved in planning and carrying out medical examination missions. It is based on lessons learned from past medical examination missions and on the challenges met during those missions. The manual is meant as a tool to be used in conjunction with the Istanbul Protocol. It does not replace the Istanbul Protocol, nor does it seek to replace the many other existing manuals and guidelines available on the medical examination and documentation of torture[3], on the reporting on torture[4], on human rights monitoring and on visiting places of detention[5]. It does not provide detailed information on how to carry out an examination or how to prepare a report.

It is an operational tool to facilitate the preparation and operational aspects of a mission for the examination and documentation of alleged torture, particularly relating to the survivors of torture. It includes suggestions on the team composition and obligations of team members and the contracting organization, ethical codes, practical information related to the preparation for the mission, security and safety measures, and some basic recommendations for the medical examination. Some sections may also be useful for examinations into extra-legal, arbitrary and summary executions. However, the perspective and purpose of an examination in these instances is different and require that primarily the Minnesota Protocol[6] is taken into consideration.

a. Terminology

In recent years the term 'torture victim' is increasingly being replaced by the term 'torture survivor'. The word 'survivor', is especially important when the focus is on resilience and psychosocial well-being. However, as one of the purposes of this manual is to facilitate the investigation and documentation of alleged cases of torture for legal purposes, the word 'victim' will be used, as this is the standard legal term. It will be used interchangeably with the term 'examinee' when referring to the actual examination. The word 'patient' is used when related to medical matters such as informed consent.

b. Purpose of the manual

The purpose of this manual is to provide easily accessible and practical guidance for performing a medical examination mission to any country.

c. Who is this manual for

This manual is intended mainly for the health professionals participating in a medical examination mission. However,

people from different backgrounds may be involved in the preparation, implementation and follow-up of the mission, including those working on managerial, financial, and logistical issues. A good collaboration and mutual understanding between all persons involved is essential. This manual is for

- The team carrying out the mission
- The project managers and management of the organisation or institution responsible for the mission
- The managers, health and legal professionals of partner organisations in the country where the investigation will take place
- The team in charge of the logistics of the mission, such as the preparation and/or coordination of field activities.

d. How to use the manual

The guidelines and lists in this manual are issues to consider; they are not all-inclusive or prescriptive. Medical examinations and the circumstances in which they are carried out differ from case to case.

The text is made as short and practical as possible. Longer checklists and international guidelines are annexed in the document and/or in the CD-ROM.

Chapter notes

1. For the purpose of this manual, the term medical includes other health professional areas (e.g. psychological). Reference is made to the Istanbul Protocol: "The documentation of torture is generally a multi-disciplinary task in which doctors and other health professionals (for example nurses and psychologists) have important roles." http://www2.ohchr.org/english/about/publications/docs/8rev1.pdf, page vii

2. http://www2.ohchr.org/english/about/publications/docs/8rev1.pdf

3. E.g. M. Peel, N. Lubell and J. Beynon; Medical Investigation and Documentation of Torture: A Handbook for Health Professionals; Human Rights Centre, University of Essex, U.K. 2005 , http://www.fco.gov.uk/Files/KFile/MidtHb.pdf

4. E.g. Camille Giffard, The Torture Reporting Handbook: How to document and respond to allegations of torture within the international system for the protection of human rights, http://www.essex.ac.uk/Torturehandbook/handbook(english).pdf

5. E.g. APT, Monitoring Places of Detention: A Practical Guide, http://www.apt.ch/index.php?option=com_docman&task=cat_view&gid=58&Itemid=259&lang=en

6. Manual on the Effective Prevention and Investigation of Extra-Legal, Arbitrary and Summary Executions, http://www.mnadvocates.org/4jun20046.html

2

The Forensic Examination Team

The team should consist of independent professionals with recognised competence in the investigation and documentation of torture. They should be experienced and trained in dealing with people who are seriously affected by traumatic events. Empathy is a paramount condition for anyone working with victims of torture[7]. When selecting the team members, the focus should placed first on the needs and well-being of the alleged torture victim and his/her family.

The team should match as well as possible with the expertise required in the case, and normally would consist of a psychologist/psychiatrist and a medical doctor/forensic expert. Despite the fact that some experienced forensic experts have developed the competence to carry out both physical and psychological evaluations, having a separate and experienced psychologist or psychiatrist on forensic documentation of torture in the team should be a priority for the team composition. Other required specialists may be added (e.g. nutritionist, gynaecologist, lawyer, etc.). Furthermore, consideration should be given to the general profile of the team members to make sure that this is appropriate for the particular case (e.g. nationality, cultural background, religion, language skills).

The gender of the team members should also be taken into account, especially in the case of claims of sexual abuse. Females alleging torture should, if at all possible, be seen by female examiners and interpreters, at least in the first instance. In many cultures, women are unwilling to disclose details of ill-treatment in front of a man, so the account will be incomplete[8]. If this is not possible, a third person of the same sex as the alleged victim should be present during the examination.

Team members may come from different countries, work in different forensic settings, have different experiences, and have different mother tongues. It is important that they equally understand the purpose of the mission and have a shared understanding that they can communicate in one language. One member of the team should be appointed as the team leader and should be the focal point for communication

Depending on circumstances the team may be complemented with local staff, including health professionals, who may hold crucial knowledge in relation to methods of torture, local norms, etc. However, care should be taken that the inclusion of local professionals in the team does not compromise their security (see 5e). In addition, the team may consider seeking consultations with local experts (see Chapter 6).

Potential conflicts of interest should be avoided in the selection of team members. A conflict of interest is understood to exist when professional judgement concerning the examination might be unduly influenced by a secondary interest. Examples of conflict of interest are

- Relatives or friends of the alleged victim
- Previous public declarations of personal opinions related to the case or the alleged victim
- Previous formal hierarchical relationship with the alleged victim.

Chapter notes

7. Reyes, Hernan, MD, DMSc, Doctors in prison: documenting torture in detention, Torture Volume 18, 3 Nov. 2008, http://www.irct.org/Admin/Public/DWSDownload.aspx?File=%2FFiles%2FFiler%2FTortureJournal%2F18_03_2008%2F176-182_Doctors_in_prison.pdf

8. Michael Peel, Noam Lubell, Beynon, Medical Investigation and Documentation of Torture, page 59, http://www.fco.gov.uk/Files/KFile/MidtHb.pdf

3

Ethical Codes, Cultural Relativism and Confidentiality

a. Ethical codes

According to the Istanbul Protocol, 'All professions work within ethical codes, which provide a statement of the shared values and acknowledged duties and set moral standards with which they are expected to comply'[9]. Members of the team should adhere to the relevant ethical codes as described in the Istanbul Protocol paragraphs 47 -72. The codes should be specified in the contractual agreement for the mission delegates (Annex 3). Codes include

- United Nations statements relevant for health professionals
- Statements from international professional bodies, such as the World Medical Association (WMA), the World Psychiatric Association (WPA) and the International Council of Nurses (ICN)
- National codes of medical ethics.

Furthermore, team members should be aware of and respect the basic principles of monitoring as described in the United Nations (UN) Training Manual on Human Rights Monitoring[10] (see CD-ROM).

b. Do no harm

The physical and psychological examination of a person who has suffered severe traumatic experiences must be handled with great sensitivity. In practical terms this means that the best interest of the examinee must be considered at all stages, even if this will be at the cost of the examination and documentation process. It must also be clearly communicated to the examinee that there is no guarantee that the medico-legal documentation will be beneficial to reaching a successful result in court nor to achieving reparations. The alleged victim should also be informed of potential negative consequences of an examination, such as risks to their own or their family's security.

c. Informed consent

Before an examination or treatment, patients should be informed of the facts relevant to the examination or treatment and a valid written consent from the patient should be obtained. This principle reflects the right of the patients to determine what happens to their own bodies[11]. The WMA's Declaration of Lisbon[12] specifies the duty for doctors to obtain voluntary and informed consent from mentally competent patients to any examination or procedure. Although specific ethical and legal standards governing valid informed consent vary greatly among jurisdictions, informed consent is generally understood

as a combination of four key elements: information, competency, voluntariness and consent.

According to the Istanbul Protocol, 'physical examination for evidence purposes in an inquiry requires consent in the sense that the patient understands factors such as how the health data gained from the examination will be used, how it will be stored and who will have access to it' [13].

The patient should understand the objectives of the examination, the process, the use of evidence, the roles of each of the team members (including the interpreter), the possibilities and the limitations of the mission, and the possible outcomes and consequences.

Valid informed consent should also be obtained for photographic documentation of injuries, samples collection and audio recordings of interviews. The consent should be reflected in a form signed by the patient and the examiners. See Annex 5 for further information and templates of two different consent forms. Where relevant, the form(s) should be translated into the local language prior to the examination.

Where possible, it is advisable to consult a legal practitioner in the relevant jurisdiction to ensure valid consent for use in future legal proceedings.

d. Confidentiality

All those involved in the mission, including non-medical staff involved in the facilitation of practicalities of the mission, should be conscious of the sensitivity of the mission. Their obligations related to confidentiality should be specified in the contract (Annex 3). There should be a careful assessment of what information can and what cannot be shared with people outside the team. A well-meant advocacy or awareness raising initiative, or a simple slip of the tongue can be detrimental to the mission, the success of the case, and sometimes the safety of persons involved.

Additionally, the fundamental ethical principle of doctor-patient confidentiality implies that, as a general rule, the examination should be conducted in private with the sole presence of the medical team and, where relevant, the interpreter. The alleged victim may specifically request the presence of a particular third person but even in this case it is advisable for the team to spend a few minutes alone with the examinee and, if necessary, an independent interpreter. For further information on the modalities of the examination, see Chapter 6.

e. Impartiality

The medical team carrying out a forensic examination is bound by principles of impartiality and independence. In practical terms this means that they should refrain from public comment on the case while it is ongoing, and only have professional interaction with the alleged victims and others involved in the case. Thus, for example, the team should not

socialise with the examinee or his or her associates, nor shall they accept gifts as this may raise doubts about the credibility of the experts and of the medical opinion provided. Any contact with the legal representatives of the examinee and other stakeholders should be assessed on a case by case basis.

f. Cultural relativism and respect

Beliefs that seem self-evident and 'natural' in one culture may be regarded as strange in another.[14] Cultural differences between the team members and the alleged torture victim may cause communication problems and lead to misunderstandings. It is important not to fall into the trap of ethnocentrism, 'viewing other peoples and ways of life in terms of one's own cultural assumptions, customs and values', although human rights standards such as the prohibition of torture are universal. The local partners should be asked for guidance on 'do's' and 'don'ts' prior to the examination. Each member of the team must receive a proper briefing on the cultural context, and on the behaviours expected of the team members during the mission (see also 4a). Sometimes, particularly when the examinee belongs to a specific ethnic group, it may be helpful to consult an anthropologist or expert in that particular culture to advise on cultural behaviour, typical maladies, beliefs, and ways to express feelings and emotions.

Chapter notes

9. http://www2.ohchr.org/english/about/publications/docs/8rev1.pdf, page 11

10. http://www.ohchr.org/Documents/Publications/training7part59en.pdf

11. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_103643 Reference guide to consent for examination or treatment, second edition 2009

12. http://www.wma.net/en/30publications/10policies/l4/index.html

13. http://www2.ohchr.org/english/about/publications/docs/8rev1.pdf

14. Hardon et al. Applied Health Research: Anthropology of Health and Healthcare, Het Spinhuis, revised edition, 1 March, 2005.

4

Preparations for the Mission

The preparation of the mission is very important and may determine its success. A long-planned mission where arrangements are made far in advance would be optimal, but is often not the reality. The following deals with general preparations related to the mission. For more information on issues related to safety and security, see Chapter 5.

The objectives of the examination should be clear to all involved. The obligations and responsibilities of the mission team, the contracting organisation and the local partners, as well as the time-frame, should be stated in the contract and the terms of reference (Annex 3).

Annex I of the Istanbul Protocol describes the Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment the responsibility of States to investigate allegations of torture within its jurisdiction.[15] Team members should know who has invited them, on whose authority and in what capacity they will be working. Transparency is recommended, but in some cases this would not be an option, and teams will have to work with great discretion.

Preparations are needed to understand the local context, to gain background information about the case, the available infrastructure, including the possibility of additional diagnostic tests. Ideally, time should be available for team members to communicate before the mission, especially if they are coming from different professional backgrounds and different parts of the world.

a. Local context and country information

Team members should orient themselves with general background information on the country, information on the human rights situation, relevant legal issues, the political, social and health situation in the country, and practical tips, prior to the mission.

General background information

- Brief history of the country
- Geography
- Language(s)
- Brief political background
- Security situation (see Chapter 5)
- General information on the population, distribution, ethnic groups
- Local culture, customs, norms and values, including gender issues

- Religion(s)
- Who does what in the country? Information on relevant work of UN agencies, non governmental organisations (NGOs), professional organisations such as national medical associations, bar associations, etc.
- Diplomatic missions of team members home countries, and European Commission (EC) delegations
- Infrastructure

The human rights situation

- Relevant reports from local and international human rights organisations
- Available reports from the UN Special Rapporteur on Torture, the United Nations treaty bodies (e.g. the Committee against Torture, the Subcommittee on Preventing Torture (SPT), the Human Rights Committee), the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment and Punishment (CPT), or the Universal Periodic Review (UPR)
- Status of international conventions, such as the ratification of the UNCAT and Optional Protocol to the Convention against Torture (OPCAT)
- Previous, on-going or planned investigations and the contact persons for these
- Possible role/impact/outcome of the mission in the local context

Relevant legal issues

- The legal and institutional frameworks that apply in the country and region visited; these will frame the conditions of access to examinees (e.g. authorization, informed consent), confidentiality, subpoenas, witness obligations, etc.
- The legal procedures and possible obstacles to justice for victims of human rights violations; this information may assist the team to better appreciate how the legal process can affect the well-being and psychological condition of the victim in addition to the torture
- Requirements for the local juridical process, such as standard procedures, chain of custody, standards of proof for medical evidence, etc.
- Availability of competent local legal assistance in case of misunderstandings or conflicts with the local authorities

Health situation in the country

- Information on communicable diseases (see also 5d)
- Availability of medical specialists such as orthopaedics, psychiatrists, gynaecologists
- Availability of and access to medical diagnostic tests

Practical issues

- Communications (telephone, internet, satellite, etc.)
- Acceptance of foreigners by local population
- Recommended clothing
- Local currency, use of credit cards
- Weather conditions
- Local time, holidays
- Local travel facilities
- Food

For further country information, see Annex 6.

b. Information relevant to the case of alleged torture/ill-treatment

The purpose of the investigation needs to be clear. Is it to bring alleged perpetrators to court, to support an asylum case, to claim reparation? Is it part of a broader investigation into human rights violations in the country? Who has invited the team, on whose authority and in what capacity will the team members be working? The team should be provided with all relevant information regarding the case, including medical records, official documents such as court documents related to any alleged arrest or detention, photographs taken during or shortly after the period of alleged ill-treatment, etc (see also 4g). All possible measures should be taken to secure the confidentiality of these data (see also 5b).

c. Support for the alleged torture victim and his/her family

Possibilities to support the alleged victim(s) should be considered prior to the final decision on the involvement of the expert team. A plan should be made together with the local partners, such as rehabilitation centres for victims of torture.

Ideally, there should be psychosocial, medical, legal, and humanitarian support available before, during and after the mission. In many cases victims live under poor conditions, isolated, and sometimes with little or no support system. Unfortunately, support may be difficult (or impossible) to provide, for example, for people in places of detention. Documenting torture should never be an absolute objective in itself.[16] The well-being and safety of the alleged torture victims should at all times be prioritized.

The local team should prepare the examinee as much as possible for the process of the examination, explaining the procedures of the investigation, the possible short and long-term implications and consequences of the evaluation for him or herself and his or her relatives. Both examiner and examinee should realise that the interview and examination can be very stressful. There is always a risk of re-traumatisation. The objectives of the examination should be clear. It is important for the team to learn about the expectations of the examinee, which may be too high. The team should be clear about its limitations.

d. Interpreters

Translation is a very sensitive issue. It would of course be preferable if the team members and the examinee spoke the same language, but working with an interpreter is often inevitable.

Careful recruitment of an interpreter is needed. The interpreters must be vetted to make sure that they possess the right professional qualifications and are independent and not intimidating to the examinee, so that an enabling environment is created in which the alleged victim feels secure to open up. Considerations should include professionalism, independence, gender (see Chapter 2), political affiliation, cultural and social background, etc. Whether to recruit an interpreter locally or bring an interpreter from abroad needs to be evaluated carefully, and depends on the specific context of the mission and the situation in the host country. Considerations should include command of the same local dialect as the examinee, risks for and pressure on the interpreter, influence exerted by local authorities or third parties, interpreter's own exposure to alleged atrocities, etc. An external interpreter may be neutral and better trusted by the alleged victim than a local interpreter. This is particularly true when the alleged victim may be interviewed while still in detention.

Possibilities of making use of interpreters working for rehabilitation centres or international organisations and NGOs in the host country should be explored. Local offices of the UN, EC delegations or embassies as well as the secretariats of international monitoring bodies such as the CPT, UNCAT or SPT might be helpful in providing references to reliable interpreters.

Preferably, the interpreter should be identified well in advance of the mission to allow for joint preparations together with the team. In any case, the interpreter should be thoroughly briefed prior to and debriefed after the engagement, and ethical standards should be included in the employment contract. This is particularly important in cases where the interpreter is not a trained professional (see Annex 4). Further guidance can also be found in the 'Use of interpreters' paragraph 150-154 of the Istanbul Protocol[17] and in the OHCHR Training Manual on Human Rights Monitoring[18].

e. Preparation for psychological evaluation[19]

There should be agreement among team members on the choice of tools to be used for the psychological evaluation. If the team decides to use questionnaires, they should be validated for the purpose and the context, and preferably be available in the local language. Some questionnaires may be very useful, while others may be culturally inadequate. In several countries studies have been conducted on the sensitivity and validity of specific questionnaires. This information should be collected through national and international professional bodies.

f. Preparation for physical examination

Local resources may be limited in some countries. Although many health professionals may prefer to work with their own basic equipment, standard kits (see Annex 2) should be available for the missions, such as

- A documentation kit
- A basic medical examination kit
- A personal kit
- A first aid kit

Depending on the mission and the local facilities, it may be useful to bring a sexual assault kit. Collaboration with local partners is essential (see Chapter 6).

g. Existing medical and non-medical information, including photographs

If existing medical information is available, this should be sent to the team as soon as possible prior to the mission, and translated beforehand if needed. The information can consist of: data on medical history prior to torture, medical records on entry or exit from detention or from transfer between detention facilities, medical records following the alleged torture, including the results of any medical diagnostic tests, etc. Photographs that may help to illustrate specific injuries following the alleged torture are particularly useful. Preferably, these should clearly identify the examinee and the anatomical location of the photograph, as well as the date when the photographs were taken.

Non-medical information may also be useful for the examination and overall assessment of the allegations of torture. This information can consist of: legal affidavits, witness statements, similar/related stories of torture, information of common torture methods in the country/region, etc. If such information is available, it should also be sent to the team as soon as possible prior to the mission, and translated beforehand if needed. In case of confidentiality and security concerns, the information should be made accessible to the team at the point of arrival, and time should be allocated for assessment of the information prior to the interviews with the alleged victims.

h. Diagnostic facilities in the country

Clinical skills are the most important diagnostic tool for a medical examination. Diagnostics tests may however provide relevant additional information. Existing medical data, along with information on the alleged torture methods applied, may indicate the need for further medical tests or scans to be ordered. Prior to the mission the team should assess which diagnostic tests it may need and the possibilities for these tests to be carried out. The examiners may prefer to request relevant tests be performed prior to the mission, so that the results may be taken into consideration at the point of the

examination. The quality, independence and reliability of the diagnostic facilities should be assessed. Diagnostic tests are described in Annex II of the Istanbul Protocol. Tests may include

- X-rays
- Scintigraphy
- CT Scans
- MRI
- Ultrasound
- Biopsies[20]
- Laboratory for basic blood tests
- Urine and toxicological tests
- Collection of DNA samples
- Basic ophthalmologic examination
- Basic examination of hearing capacities
- Tests for STIs and HIV/AIDS[21]

Language and the provision of background information should be carefully managed in the request to a diagnostic facility. The word 'torture' should be avoided and instead a phrase such as 'history of multiple trauma' should be used. In some cases, registration data may be sent to authorities, and torture victims could be intimidated afterwards. The patient's consent should at all times be respected.

Chapter notes

15. Annex 1, Principles on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, http://www2.ohchr.org/english/about/publications/docs/8rev1.pdf

16. Reyes, Hernan, MD, DMSc, Doctors in prison: documenting torture in detention, Torture Volume 18, 3 Nov. 2008

17. http://www2.ohchr.org/english/about/publications/docs/8rev1.pdf, page 29

18. OHCHR Training Manual on Human Rights Monitoring, Professional Training Series 7, http://www.ohchr.org/Documents/Publications/training7part59en.pdf, page 113

19. http://www2.ohchr.org/english/about/publications/docs/8rev1.pdf, General considerations for interviews, Chapter IV, paragraph 119-159

20. There are different opinions about the use of punch biopsies. While kits are available and easy to carry along, there is the danger of infection and bleeding, which may cause problems with local authorities. Punch biopsies should be performed in local clinics in clinical settings by experienced local health professionals. Punch biopsy by a team member should be the last choice and should be carried out only if a local partner is available to follow up on the tests.

21. It needs to be assessed whether treatment of STIs and HIV/AIDS is available, for example, through partner organisations. If the investigation involves recent survivors of rape there is a need to work with an experienced forensic specialist and specific protocols should be followed (see Annex 5).

5

Safety and Security Measures

The primary security concern should be for the alleged torture victims, their relatives and communities. The contracting organisation has the ultimate responsibility for security, health and safety matters. Security risks can be reduced by using common sense and taking precautions. The guidelines below are not all-inclusive and should be adapted to the local situation.

a. Security assessment

The safety and security situation depends very much on the country to be visited, and whether the alleged act(s) of torture have taken place in the country itself or in a third country.

Possible measures to avoid or minimize risks for all involved should be carefully considered. A careful risk assessment needs to be carried out prior to the mission in close collaboration with the local partner. The risk assessment could be based on information provided by the local partners, the updated assessments of foreign ministries, and other relevant websites (see Annex 6).

b. Security of data

All possible measures to secure data should be taken. The alleged victim should be given a Unique Case Number (UCN) prior to the mission. All documents and information, including photographs, videos, audio recordings, should be labelled with this UCN only. Personal information on the alleged torture victims should be kept separate and secure, and only be accessible to the team leader. The only exception would be related to additional diagnostic tests/images carried out in local facilities. A secure place in the vehicle to store essential documents (e.g. passports) may be needed in case of an emergency evacuation.

Care should be taken with the information shared through e-mail correspondence or stored on lap-tops brought on the mission.

c. Safety and security measures for the alleged torture victim and his/her family

Following the doctrine of ‘do no harm’, the mission team, the local team and the alleged torture victim him/herself should be aware that the participation in a forensic examination for the investigation and documentation of an alleged case of torture holds a potential security risk, especially if the examination takes place in the country where the alleged act(s) of torture have taken place. Also special care should be taken if the alleged victim has been evacuated for examinations in

another country as he/she may also gain unwanted visibility. The risk of reprisal against the alleged victim should be carefully considered and, under some circumstances, may preclude a medical evaluation.

Local organisations are often well equipped to judge the situation on the ground and may have support networks that could be drawn upon, but local and international NGOs may not always have the means to ensure the safety of alleged victims and witnesses, especially if the person is held in a place of detention.

Regular follow-up visits carried out by the local partner to check on the well-being and security of the alleged victim could be a possible safeguard. These follow-up visits should start shortly after the mission. If there is a fear of reprisals, the national and international community and public information could be alerted.

d. Safety and security measures for the mission team

Before the assignment, team members should receive a briefing on all known risks relevant to the mission, and possible measures to avoid/minimize these risks. Obligations and responsibilities of the contracting organisation and responsibilities of the individual team members are to be clearly communicated before the mission and specified in the contract.

If the mission is to a country with a relatively high security risk, such as conflict areas or countries where there are widespread and systematic human rights abuses, informing relevant embassies and/or the EC delegations about the mission and the team, without disclosing any sensitive or confidential information regarding the case should be considered. In some countries, and depending on the mission, it may be possible to participate in a security briefing or training by the UN or the International Committee of the Red Cross (ICRC).

One member of the team should be the focal point for security measures (management of log books, communication, collection and distribution of alerts, security updates, etc).

General tips

- Have a supply of cash, both local currency as well as US Dollars on hand
- Do not keep all money in the same place
- Stay alert, watch luggage and keep documents and money safe
- Bring a flash light with extra batteries

Documentation

Documents such as passports, identity cards, driving licences, visas, health certificates and return tickets should be in order. The team members should also carry documentation of their professional licence and specialisation. It is recommended to make two sets of copies

of all important documents. One set could be brought on the mission, the second set left with family or friends.

Contact details and information list

All members of the mission team should provide the contracting organisation with relevant information regarding their health status and contact details in case of emergency (Annex 1).

The members should at all times carry an emergency contact list with telephone numbers such as

- Their embassy
- Their insurance company
- The travel agency
- The organisation responsible for the mission

Normally it would also be useful to carry the contact details of the local partner and other team members. In some situations, however, it may put them at risk.

Insurance

All travelling team members should be covered by travel and health insurance. For travel to conflict areas or areas of high risk, it should be assessed if normal health/travel insurance covers the mission or whether an additional insurance is required. It should be clear in the contract how much liability is with the mission team and how much with the contracting organisation, for example, in case of permanent disability or loss of life.

Hotel

The team should stay, if possible, in a secure hotel in a safe area or in the compound of the partner NGO. The team should familiarize itself with the surroundings of the hotel or compound, and should know which places to stay away from.

In conflict zones or areas with high criminality, rooms on the ground floor or facing an outside corridor should be avoided, to prevent easy access from the outside. At the same time rooms should be low enough in case of fire (preferably not higher then the seventh floor). The nearest fire escape should be checked. It is also important to make sure that the exit is indeed open.

The hotel room should preferably have a safe to store valuables. In many countries the authorities could pressure the hotel management to open the safe or safe boxes in individual bedrooms, so they should not be considered completely secure.

Health issues in connection with travel

Physical and environmental changes and jetlag encountered during international travel may affect the well-being and health of team members. Prior to the mission information is needed on

- Health risks such as communicable diseases
- Vaccinations, required and recommended, such as yellow fever in several countries

- Water and sanitation, and food
- (Medical) evacuations in case of emergencies

Team members are responsible for arranging any necessary vaccinations or medications and to take all recommended preventive medicines in due time. Medical consultation should preferably take place 4–6 weeks before the journey if vaccinations are required.

For general information on obtaining updated country information on communicable diseases and required vaccinations, see Annex 6.

Stress management

A combination of factors such as practicalities before the mission, taking time off from the regular job, travelling, security and safety issues can all add up to accumulated stress. The examination itself may cause vicarious stress.

Team members should know their own abilities and limitations, and be able to recognise common signs of stress in themselves and in others. They should be aware of effective coping mechanisms and stress management techniques, and of the risks of common behaviours that are ineffective in coping with stress such as heavy drinking, smoking and large amounts of caffeine intake. Staff in charge of logistics may also be at risk of accumulative stress, especially if they become very much emotionally involved. There should be mutual support meetings between members during the mission.

Pre- and post mission support should be available if needed.

For further reading and relevant links, please see Annex 6.

Communication

All team members need access to communication during their mission. This should be arranged by the contracting agency. If a satellite phone or walkie-talkies are provided, team members should be clear how to use them beforehand, or receive instruction during the first briefing on arrival in the country.

Mission members should have regular contact with the programme manager of the contracting organisation. In case of travel to an insecure area, contact should be made on at least a daily basis.

After the mission

Team members should have a debriefing or exit interview at the end of the assignment with the programme/project coordinator. Health checks and personal counselling should be available if needed.

e. Safety and security measures for the local partner

The visit of an international team may draw unwanted attention to the work of local partners. There are several examples of local staff members being harassed or even arrested after the visit of an international team. It is important for the international team members to liaise with

the local partner organisation and seek their guidance. Daily collaboration with the local partner is essential.

f. Safety and security measures for the interpreter

Not only has the interpreter the difficult task of accurately translating linguistically challenging information, (s)he is also exposed to the history of the alleged torture victim. The interpreter should be prepared for this. She or he should be offered a debriefing or exit interview with the team members. Interpreters may learn important and sensitive information during the examination. They may be, or may become, pressured into becoming informants. See also 4c and Annex 4.

g. Visibility and security

As a general rule visibility should be avoided and only be admitted in exceptional cases. While visibility can mean security in some cases, it may be very dangerous in others, especially in a country where torture still takes place and in cases where the alleged perpetrators are still active.

An exception regarding visibility may be made when the investigation is related to severe human rights abuses by previous regimes. These investigations should be seen in the 'historical context'. The main purpose of the investigation is to reconstruct acts that occurred in the past, and torture victims may seek publicity. Also in these cases, it should be carefully assessed if visibility is desired.

6

Recommendations for the Medical Examination and Report

Detailed considerations for interviews, medical history, physical examination, psychological/psychiatric evaluation and the medico-legal report fall outside the scope of this manual and are not included in the text. They are described in several works, such as the Istanbul Protocol[22] and the Medical Investigation and Documentation of Torture[23]. In the text below there are some additional comments only.

a. Involvement of local experts

Where possible, it can be beneficial to carry out the examination together with a local team of health professionals, provided that the examinee consents to this and all parties feel comfortable with the arrangement. If local expertise exists, collaboration with an international team can help give weight to the local expertise. If adequate local expertise does not exist, the interaction with international experts can serve as a capacity building exercise, but care is required not to confuse the purpose of the mission with a training exercise. Where relevant, the medico-legal report can be co-signed by the international and local examination team.

In any case, meetings with local forensic doctors or health practitioners from centres or institutions where forensic examinations are usually performed are recommended. These experts can be identified in cooperation with local partners.

b. Time required for the examination

Examiners should always allocate at least twice the time they usually allocate in routine forensic examinations. In addition, more examination time is needed for interpretation. Sometimes extraordinary conditions may prevent a thorough evaluation of physical and psychological injuries. In these circumstances the team must decide whether or not to continue the evaluation, if more proper conditions cannot be negotiated. However, performing an examination under imperfect conditions can be sometimes better than no examination.

c. Photography

Forensic photography is crucial for documentation of physical evidence. It is essential that the photographs are taken and handled correctly. They should be transferred to a USB flash drive as soon as possible after the examination. The expert should prioritise keeping the pictures safe. Informed consent for their use needs to be obtained from the examinee (Annex 5). For detailed guidelines please refer to the article “Photographic documentation,

a practical guide for non professional forensic photography" (on CD-ROM).

d. Audio recording

Recording the interview can be very helpful, but may also present security concerns. Furthermore, there may be the risk of reminding the victim of the interrogations. A recorder may only be used when the objectives of the interview/ examination are clear to, and have the informed consent of, the torture survivor (Annex 5).

e. Recommendations regarding visits to places of detention

The first challenge is to get access to the place of detention. This should in principle be arranged before the team arrives. The detainee should be met in private. In some cases it may be possible to examine the person outside the detention centre. There are several international declarations, standards and principles stating 'the right to be examined by a doctor of own choice' that can be used to obtain access (see CD-ROM), but these arguments may be ignored by the relevant authorities, especially in states that disregard the UNCAT. Sometimes, formal authorization will be required and should be sought prior to the mission.

It is extremely difficult to carry out an examination in a prison setting. Conditions for a state-of-the-art examination may be restricted, while the outcome may still be valuable. Time available in detention settings may be very limited and there may be no access to additional diagnostic tests. Possible restrictions and limitations should be clarified prior to the mission, as well as the influence they may have on the outcome of the examination. Importantly, there is a risk of reprisals for the detained person, and - if no appropriate follow-up measures are guaranteed - it should be carefully considered whether to go ahead with the planned examination.

There are many manuals and guidelines regarding visits to places of detention. The purpose of these manuals is often to facilitate the monitoring of the human rights situation, such as under the OPCAT and visits of the European Committee for the Prevention of Torture (CPT); the monitoring is based on collaboration rather than on confrontation (see Annex 6).

f. Medico-legal report

It is important to clarify any legal requirements relating to the format and submission of the report. There may be a demand that the report carries original signatures of the examiners or that the report must be notarised or certified prior to submission. Sometimes reports by foreign experts are only accepted by the court if the experts have had their medical licence authorised by relevant local medical authorities.

Since team members will often be resident in different countries, it is recommended to agree and arrange for the process of finalisation and submission of the report

during the mission itself. Time should be allowed for possible translation of the report back into the local language.

The original copy of the report should be handed over to the alleged victim or his/her legal representative as appropriate. The contracting organisation should keep a copy of the report.

Chapter notes

22. Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, http://www2.ohchr.org/english/about/publications/docs/8rev1.pdf

23. Michael Peel, Noam Lubell, Beynon, Medical Investigation and Documentation of Torture, http://www.fco.gov.uk/Files/KFile/MidtHb.pdf

Preventing torture through investigation and documentation

The IRCT promotes torture documentation and the Istanbul Protocol through training, advocacy, university collaboration and facilitation of forensic examinations and reports.

Visit www.preventingtorture.org for more information and guidance on the investigation and documentation of torture as a means to combat impunity, ensure reparation for survivors and prevent torture.

Annex 1

Pre-travel Personal Data

The following data should be kept confidential and only be used in case of emergency

Personal Information

Name_____
Date of Birth_____
Address_____
E-mail address_____
Passport Details (Nr., Issue date, Expiry date, Place of issue) _____
_____
Insurance Company and Policy Number_____
Telephone_____Mobile phone number_____
Contact details in case of emergency (Next of kin*)_____

Health Information

Blood group_____
Vaccinations for travel if needed_____
Malaria prevention if needed_____

General Health Status

_____
_____
_____

Any other relevant health information (known allergies/medication etc)

_____
_____
_____

Health / Travel Insurance Details

Company_____
Contact_____
Policy number_____

* Next of kin is a person most closely related to a given person

Annex 2

Checklist Basic Kits

Documentation kit

- Camera with adequate lens; macro objective for detailed pictures. Bring additional batteries and memory card.
- Voice and video recorder
- Body diagrams, additional drawings from the Istanbul Protocol, etc.
- Flash light or other powerful light source

Basic medical examination kit

- Stethoscope
- Sphygmomanometer or other blood pressure meter
- Diagnostic set: Otoscope / ophthalmoscope, working on batteries. Batteries should preferably be stored outside the equipment, especially if the mission takes place to warm and humid countries. Bring additional batteries.
- Penlight, wooden medical (popsicle) stick
- Reflex/percussion hammer, tuning fork, pins, Q-tips or cotton balls
- Measuring tape and magnifying glass
- Photographic rulers with colour scale and space to write the case number, date and place; preferably grey, not white (e.g. IRCT forensic ruler)
- Gloves
- Tweezers
- Sample kits

Sexual assault kit

- Disposable gynaecological tools
- Disposable proctoscopes in cases of suspected male rape (MSM)
- Sample collection materials; sterile swabs
- Emergency contraceptive pills
- Gloves
- Masks

Personal kit

- Soap/ alcohol / Hibiscrub / hand sanitizer

First Aid Kit

Annex 3

Contractual Obligations

Contracts and terms of reference should include:

- Objectives of the mission
- Obligations and responsibilities of the team members and the contracting organisation
- Code of Conduct
- Relevant ethical codes
- A confidentiality clause
- Safety and security responsibilities
- Insurance of the team members (incl. liability in case of an emergency evacuation or disability or loss of life)

Annex 4

Guidelines for the Use of an Interpreter

The following points are recommendations to consider when employing an interpreter for the purpose of conducting interviews and examinations of alleged torture victims.

We recommend referring to the OHCHR Training Manual on Human Rights Monitoring[24] and the 'Use of interpreters' paragraph 150-154 of the Istanbul Protocol[25] for further details and guidance on the selection and instruction of interpreters as well as the conduct of interviews with an interpreter.

Briefing the interpreter

- The interpreter should receive a thorough briefing on the context and the structure of the interview in private, before the interview begins. This is particularly important if the interpreter is not a trained professional.
- The interpreter should be offered the possibility of a debriefing/post examination interview.
- The interpreter should be aware of and bound by strict confidentiality and ethical guidelines in his/her contract (see below).
- The interpreter should be aware of the sensitivity of the information and the potential vulnerability of the examinee, which might influence the conduct of the interview.
- The interpreter should be aware of the particular importance to relay questions exactly, word for word to the extent possible, and slowly, one at a time, so as to make sure that the examinee understands them.
- The interpreter should be aware that the content of the interview may cause him/her distress, particularly with regard to receiving information on possibly violent or very personal details.
- The interpreter should possess the relevant understanding of and sensitivity to the local culture, gender and discrimination issues.

Contractual obligations

Owing to the sensitivity of the information and the potential vulnerability of the examinee, the interpreter should commit to observing basic ethical standards, i.e. confidentiality, accuracy, impartiality and conflict of interest. These should be explicitly included in the contract to be signed by the interpreter and the requesting party and violations should be regarded as serious breach of contract.

- Confidentiality

The interpreter should agree that any information received in relation to the task is to be considered strictly confidential. The contract needs to specify whom information can be discussed with and the interpreter should not disclose, publish or otherwise reveal any of the confidential information received from the requesting party to any other party whatsoever.

- Accuracy

The interpreter should commit to rendering to the best of his/her ability, a complete and accurate translation without adding, altering or omitting anything that is stated.

- Impartiality

The interpreter should commit to being impartial and refraining from any conduct that could seem biased. In particular the interpreter should in particular not allow his/her own personal opinion, political views or religious beliefs to influence the interpretation or attitude.

- Conflict of interest

The interpreter should commit to immediately disclosing any real or perceived conflict of interest, including external pressure and threats to security and safety, that might arise with regard to the parties involved or the matter of interpretation.

Notes:

24. OHCHR Training Manual on Human Rights Monitoring. Professional Training Series 7, http://www.ohchr.org/Documents/Publications/training7part59en.pdf, page 113

25. http://www2.ohchr.org/english/about/publications/docs/8rev1.pdf, page 29

Annex 5

Informed Consent

Capacity/Competency

A patient must be competent to consent to an examination or procedure. Competency refers to a patient's mental ability to understand the nature of information discussed related to the examination and appreciate the consequences of any decision taken.

In many jurisdictions, minors[26] are presumed to be incompetent to consent and the informed consent of a parent or guardian will be required prior to any procedure or examination. In this regard, also the provisions of the Convention of the Rights of the Child should be respected, in particular Article 3 related to the best interest of the child and Article 12 related to the right to participate in decision-making processes that may be relevant in their lives and to influence decisions taken in their regard.

Information

The duty to provide adequate information to the patient regarding the examination rests with the examiner. The language used should clarify rather than confuse. Avoid using professional jargon. When informed consent is sought from a child the language should be appropriate for the child's age and development.

Information includes:

- The purpose of the examination
- Voluntary participation: a patient must voluntarily agree to participate in an examination or procedure. This requires that the patient be free from undue coercion and that, to the extent feasible, the examination be conducted in a context that allows voluntary choice. Information should clearly indicate that the patient can choose to participate or not
- The type and duration of examination; how it will be carried out
- The process: describe or explain the exact process that will be followed on a step-by-step basis, including approximate duration
- Potential risks: Explain and describe any possible risk, describe possible actions that can be undertaken and limitations in case something goes wrong
- The possibilities and limitations of the mission
- The use of evidence
- Confidentiality procedures: the patient should be informed of confidentiality procedures for sensitive information and which, if any, third parties will have access to records produced during the examination
- Contact persons

Consent

Only if the above issues have been addressed and the patient has fully understood the information can she or he be asked to give consent. Consent should be obtained for the examination or procedure and separately for any

additional elements or procedures not considered routine to general patient examinations. This includes, but may not be limited to, photographic documentation of injuries, samples collection and audio recording of interview. Additional consents may be contained in the same consent form, but should be clearly marked and have individual signature or consent blocks (see Template 1).

Consent to Release to Third Parties (investigatory bodies, law enforcement, commissions, etc.)

The release or disclosure to third parties of any records collected during the examination requires a separate and distinct informed consent (see Template 2). Whether this consent can be collected at the time of the examination depends on fulfillment of the elements of informed consent. For example, if an investigation has not yet commenced and there is insufficient information available at the time of the examination to assess the risks or possibilities of releasing the information, the patient should not be asked to consent to a release at that time. Released information should be accompanied by a statement indicating that the released information contains confidential medical records and may not be disclosed to anyone other than the person(s) listed.

Notes:

26. Persons, generally speaking, under the age of 18, although it may vary by country.

Informed Consent to Medical Examination

Indicate which examination(s) will be performed (If additional explanation is needed, please include below)

Medical ☐ Psychological ☐ Psychiatric ☐ Other (Please Specify) ☐ _____

Prior to an examination, it is necessary that you give your informed consent. By signing this statement, you are confirming that you have been informed of the nature of this examination or evaluation and you freely consent to the examination(s) indicated above. Please review the following points before signing:

The purpose and objectives of this examination have been fully explained to me, and I understand that one of the objectives of this examination is to facilitate the investigation and documentation of alleged cases of torture or other ill-treatment for legal purposes.

The process of the examination has been explained to me in clear terms which I understand.

I understand the benefits and the potential risks or discomforts associated with this examination.

I understand that this examination may include related diagnostic tests, sample collections or interviews. I may decline to participate in any of these related procedures without negative consequences.

I understand that my participation in this examination is completely voluntary. I may withdraw consent or discontinue participation at any point throughout this procedure.

I understand that all information supplied and produced during this examination will form part of my confidential medical record. My confidential data will be stored in a secure location, and I will need to give further consent before any confidential images, recordings, or medical records are shared with third parties for legal proceedings or any other use beyond what is necessary for an effective examination and what is required by law.

I have had the opportunity to ask questions about the examination and any questions that I have asked have been answered to my satisfaction.

I understand that I have the right to review and inspect my medical records at any time prior to or after consent, and I have the right to receive a copy of my medical records upon request.

Forensic Photography:

I consent to have photographs taken of me for examination and evaluation purposes. YES ☐ NO ☐

Audio Recording:

I consent to have audio recordings taken for my examination and evaluation purposes. YES ☐ NO ☐

Name of Patient_____ Signature_____ Date_____

Name of Parent or Guardian (if minor)_____ Signature_____ Date_____

Name of Interpreter_____ Signature_____ Date_____

Name of Examiner_____ Signature_____ Date_____

Informed Consent for Release of Medical Information

Records to be released/Dates: Describe information to be disclosed and dates of service for records released in a manner that specifically identifies the relevant information:

_____
_____

Research/Teaching: I consent to have the medical records listed above made available for teaching and research in the healthcare context. I understand that the image may be seen by members of the public, in addition to scientists and medical practitioners in their professional education. All identifying information will be removed and every attempt will be made to ensure my anonymity. I understand, however, that complete anonymity cannot be guaranteed.

YES ☐ NO ☐

Publication: I consent to have the medical records listed above made available for use in medical and scientific journals, textbooks and publications. The material will be published without any identifying information such as my name and every attempt will be made to ensure my anonymity. I understand, however, that complete anonymity cannot be guaranteed.

YES ☐ NO ☐

Other Releases: I consent to have the medical records listed above made available to the following person(s) or category of persons and for the following purposes (describe who will receive information and purpose for disclosure).

YES ☐ NO ☐ _____

The potential risks and benefits of releasing my medical information to the above third parties have been explained to me in terms I understand.

I understand that my authorization is voluntary. I may refuse to sign this consent without negatively effecting future treatment or relationship with the person(s) or organisation(s) requesting authorization to release my information.

I understand that I may revoke this consent at any time by contacting the person or organisation requesting this authorization.

By signing this form or placing my mark in the signature section, I confirm that I have read this consent form or it has been read or translated to me in language I understand. All of my questions related to this release have been answered to my satisfaction.

Name of Patient_____ Signature_____ Date_____

Name of Parent or Guardian (if minor)_____ Signature_____ Date_____

Name of Interpreter_____ Signature_____ Date_____

Annex 6

Useful Links and Further Reading

IRCT resources

- http://www.irct.org
- For detailed information and guidance on investigation and documentation of torture as a means to combat impunity, ensure reparation for survivors and prevent torture see http://www.preventingtorture.org. This website also contains an electronic library with a range of useful resource materials, including practical guides to the Istanbul Protocol for medical doctors, lawyers and psychologists. All three guides are available in English, French and Spanish and are also accessible on the enclosed CD-ROM
- Iacopino V, Ozkalipici O, Dandu M, Wong G, Moreno A. Model Curriculum on the Effective Medical Documentation of Torture and Ill Treatment. Available at: http://istanbulprotocolmodelcurriculum.org

Country information

- World Health Organization Country Information: http://www.who.int/countries/en/
- World Bank Country Information: http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/0,,pagePK:180619~theSitePK:136917,00.html
- The Office of the United Nations High Commissioner for Refugees: http://www.unhcr.org/cgi-bin/texis/vtx/home

Health related country information

- For general information and updated country information on communicable diseases and required vaccinations, see the International Travel and Health Website of the WHO: http://www.who.int/ith/

Human Rights Information

- Amnesty International: http://www.amnesty.org/
- Human Rights Watch: http://www.hrw.org/
- The Office of the United Nations High Commissioner for Human Rights (OHCHR): http://www.ohchr.org/EN/Pages/WelcomePage.aspx
- Universal Periodic Review: http://www.ohchr.org/EN/HRBODIES/UPR/Pages/UPRMain.aspx
- Special Rapporteur on Torture: http://www2.ohchr.org/english/issues/torture/rapporteur/index.htm
- Committee against Torture: http://www2.ohchr.org/english/bodies/cat/index.htm
- Subcommittee on Prevention of Torture: http://www2.ohchr.org/english/bodies/cat/opcat/index.htm

- European Committee for the Prevention of Torture and Inhuman or Degrading Treatment and Punishment: http://www.cpt.coe.int/en/
- Committee on the Rights of the Child: http://www2.ohchr.org/english/bodies/crc/

Medical examination in places of detention

- Reyes, Hernan, MD, DMSc, Doctors in prison: documenting torture in detention, Torture Volume 18, 3 Nov. 2008, http://www.irct.org/Admin/Public/DWSDownload.aspx?File=%2FFiles%2FFiler%2FTortureJournal%2F18_03_2008%2F176-182_Doctors_in_prison.pdf
- Association for the Prevention of Torture, Visiting places of detention: What role for physicians and other health professionals. http://www.apt.ch/index.php?option=com_docman&task=cat_view&gid=121&Itemid=259&lang=en

Information related to stress management

- The International Federation of Red Cross and Red Crescent Societies (IFRC), Managing Stress in the Field: http://www.ifrc.org/Global/Publications/Health/managing-stress-en.pdf
- The Antares Foundation, Managing Stress in Humanitarian Workers: Guidelines for Good Practice: http://www.antaresfoundation.org/documents/antares_guidelines2.pdf
- People in Need, Code of Good Practice in the Management and Support of Aid Personnel: http://www.peopleinaid.org/pool/files/code/code-en.pdf

Informed consent

- WHO Informed Consent Form Templates: http://www.who.int/rpc/research_ethics/informed_consent/en/
- British Medical Association Consent Tool Kit: http://www.bma.org.uk/ethics/consent_and_capacity/consenttoolkit.jsp

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International Rehabilitation Council for Torture Victims

Borgergade 13
P.O.BOX 9049
1022 Copenhagen K
Denmark

Phone
+45 33 76 06 00

Fax
+45 33 76 05 00

E-mail
irct@irct.org

Website
www.irct.org

The International Rehabilitation Council for Torture Victims (IRCT) is an independent international health professional organization which promotes and supports the rehabilitation of torture survivors and works for the prevention of torture worldwide