TORTURE VICTIMS HAVE A RIGHT TO REHABILITATION

A guide for service providers to assist victims of torture in securing their right to rehabilitation

Developed by the Pan-African Reparations Initiative (PARI)

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ABBREVIATIONS

ACHPR	African Commission on Human and Peoples' Rights
ACTV	African Centre for the Treatment and Rehabilitation of Torture Victims
BACP	British Association for Counselling and Psychotherapy
CHRR	Centre for Human Rights and Rehabilitation
CIDTP	cruel, inhuman or degrading treatment or punishment
CPTA	Committee for the Prevention of Torture inAfrica
CSO	civil society organisation
CSU	Counselling Services Unit
CSVR	Centre for the Study of Violence and Reconciliation
DRC	Democratic Republic of the Congo
FGM	female genital mutilation
ICHHR	International Centre for Health and Human Rights
IMLU	Independent Medico-Legal Unit
IRCT	International Rehabilitation Council for Torture Victims
KHRC	Kenya Human Rights Commission
LAPS	Liberia Association of Psychosocial Services
LGBTQIA	lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual or allied
M&E	monitoring and evaluation
MHPSS	mental health and psychosocial support services
NGO	non-governmental organisation
PARI	Pan-African Reparations Initiative
PRAWA	Prisoners' Rehabilitation and Welfare Action
PTSD	post-traumatic stress disorder
SAR	Subject Access Request
UN	United Nations
UNCAT	United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

ABOUT PARI

This publication is a knowledge output of the Pan-African Reparations Initiative (PARI).

About PARI

The Pan-African Reparations Initiative (PARI) is a loose network of 47 organisations dealing with and advocating for the rights of victims of torture and ill-treatment in Africa. The network was birthed on the margins of the NGO Forum and the Open Session of the African Commission on Human and Peoples' Rights in the Ivory Coast in October 2012.

Objectives of PARI

PARI brings together organisations assisting victims of torture in Africa in accessing reparation, including restitution, compensation, rehabilitation, satisfaction, and guarantees of non-repetition. Through concerted advocacy and lobbying efforts, PARI aims to ensure that best practices in catering for the rights of victims are prioritised and highlighted, and that African human rights mechanisms such as the African Commission on Human and Peoples' Rights (ACHPR) prioritise the rights of victims of torture to reparation. Although reparation is a big component of the work of PARI, other problematic issues relating to torture jurisprudence also receive attention.

PARI achievements

PARI engages in various joint activities designed to strengthen torture and reparations jurisprudence and practice in Africa: These activities include:

- Joint events on the margins of sessions of the African Commission/NGO Forum;
- Making inputs to Draft General Comments;
- Specific advocacy initiatives of ACHPR mechanisms beyond the Committee for the Prevention of Torture in Africa (CPTA);
- The publication of the Pan-African Reparation Perspectives Newsletter; and
- Sharing learnings and best practices on reparation and torture prevention in Africa through an email list-serve.

Current members of the network include:

Actions pour la Protection des Droits de l'Homme; African Centre for Treatment and Rehabilitation of Torture Victims; African Policing Civilian Oversight Forum (APCOF); African Network Against Extrajudicial Killings and Enforced Disappearances (ANEKED); Amnesty International; Article 5 Initiative; Association for the Prevention of Torture; Basic Needs, Ghana; Cairo Institute for Human Rights Studies; Centre for Human Rights and Rehabilitation; Centre for the Study of Violence and Reconciliation (CSVR); Centre de Réhabilitation des Victimes de la Torture (AJPNV), Chad; Consortium des Associations de Jeunes pour la Défense des Victimes de Violences en Guinée; Collectif Des Familles de Disparus en Algérie; Counselling Services Unit; Egyptian Initiative for Personal Rights; Fédération internationale des ligues des droits de l'homme; Gambia Center for Victims of Human Rights Violations; Human Rights Implementation Centre; Healing of Memories; Independent Medico-Legal Unit; International Rehabilitation Council for Torture Victims; Kenya Human Rights Commission; Khulumani Support Group; Legal Resources Centre, South Africa; Liberian Association of Psychosocial Supporters (LAPS); Medical Association for Rehabilitation of Torture Victims; Mental Health Uganda; Pan-African Lawyers Union; Projet de Monitoring des Détentions Avant-Procès en Cote d'Ivoire; Prisoners' Rehabilitation and Welfare Action (PRAWA); REDRESS; Rencontre Africaine pour la Défense des Droits de l'Homme; Rescue Alternatives Liberia; Solidarity Action for Peace; Save Congo Human Rights NGO Forum; South Africa Trauma Centre; Tree of Life, Zimbabwe; National Working Group on Transitional Justice, Tunisia; Youth for Peace and Non-Violence Association; Dullah Omar Institute, University of the Western Cape; Validity Foundation; Women Empowerment and Rehabilitation Trust; Women in Liberation and Leadership (WILL); World Organization Against Torture; Zimbabwe Lawyers for Human Rights; Zimbabwe Human Rights NGO Forum.

For further information and/or to join PARI, please contact Sufiya Bray, CSVR, at **sbray@csvr.org.za** or Eva Nudd, REDRESS, at **EvaN@redress.org**.

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- African Centre for the Treatment and Rehabilitation of Torture Victims (ACTV), Uganda;
- Centre for Human Rights and Rehabilitation (CHRR), Malawi;
- Centre for the Study of Violence and Reconciliation (CSVR), South Africa;
- Dullah Omar Institute for Constitutional Law, Governance and Human Rights, South Africa;
- Healing of Memories, South Africa;
- Independent Medico-Legal Unit (IMLU), Kenya;
- International Rehabilitation Council for Torture Victims (IRCT), Denmark and Belgium;
- Kenya Human Rights Commission (KHRC), Kenya;
- Liberia Association of Psychosocial Services (LAPS), Liberia;
- Prisoners' Rehabilitation and Welfare Action (PRAWA), Nigeria;
- Redress, Netherlands and the United Kingdom,
- Tree of Life, Zimbabwe; and
- Validity Foundation, Hungary.

PARI also extends appreciation to the Centre for the Study of Violence and Reconciliation for publishing the manual in English and French with financial support from Dignity – Danish Institute against Torture.

DIGNITY

INTRODUCTION TO THIS GUIDE

For those who have experienced torture and other forms of cruel, inhuman or degrading treatment or punishment (CIDTP), reclaiming ownership over one's body, mind, spirit and environment through rehabilitation is often a long and challenging journey.

According to the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT), a victim of torture is entitled to 'as complete a rehabilitation as possible'.[1] However, in Africa (among other places in the world), this right is often not understood, practised, accessed, resourced or enforced. As practitioners, we have an obligation to improve access to rehabilitation.

> Rehabilitation is more than just care for those who have been tortured. It is a human right which belongs to every victim, regardless of who or where they are.

The Pan-African Reparations Initiative (PARI) is a network of organisations that works with, and advocates for the rights of, victims of torture and ill-treatment in Africa. The network was established on the margins of the 52nd Ordinary Session of the African Commission on Human and Peoples' Rights (ACHPR) in Côte d'Ivoire in October 2012. Organisations dealing with victims of torture which attended the session informally organised themselves into a network of organisations advocating for reparation for victims of torture in Africa. Through concerted advocacy and lobbying efforts, PARI aims to ensure that best practices in catering for the rights of victims are prioritised and highlighted, and that African human rights mechanisms such as the ACHPR prioritise the rights to achieve full and effective redress for victims of torture.

1 United Nations Convention against Torture (UNCAT). (2002). *Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment and Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Article 14.1)*. United Nations Treaty Collection. Retrieved from: https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9-b&chapter=4&clang=_en.

INTRODUCTION TO THIS GUIDE

Since December 2012, the Centre for the Study of Violence and Reconciliation (CSVR) has convened the PARI Regional Consultation meetings, in South Africa and in other PARI partner countries, at which a number of recommendations and specific actions have helped to shape the Pan-African reparations discourse. To date, PARI has lobbied for the development of a General Comment on Redress for Victims of Torture in Africa and for the adoption of a Resolution on Rehabilitation for Torture Victims in Africa.[2] This resulted in the ACHPR's adoption of General Comment No. 4 on the African Charter on Human and Peoples' Rights: The Right to Redress for Victims of Torture and other CIDTP in March 2017.[3] The General Comment is a significant step forward for Africa in recognising and responding to the harm from torture, both present and past. However, there is still a need to bring this resolution to life through implementation. This is a responsibility that must be accepted by states, but also by civil society.

2 African Commission on Human and Peoples' Rights (ACHPR). (2015). *303 Resolution on the Right to Rehabilitation for Victims of Torture – ACHPR/Res.303(LVI)*2015. Retrieved from: https://www.achpr.org/sessions/resolutions?id=333.

3 African Commission on Human and Peoples' Rights (ACHPR). (2017). *General Comment No. 4: The Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment (Article 5)*. Retrieved from: https://www.achpr.org/legalinstruments/detail?id=60.

DEVELOPING A GUIDE TO ASSIST TORTURE SURVIVORS WITH ACCESS TO THEIR RIGHT TO REHABILITATION

Rehabilitation is not about simply offering a person services – it is also about informing torture victims of their *right* to rehabilitation, and assisting them in choosing whether and how they will exercise that right. PARI identified the need for a resource that would help those who engage with torture survivors to be better equipped to assist such survivors in accessing this right.

The guide was conceptualised by PARI in 2017. The development of the guide followed a collaborative approach which involved frequent group meetings to discuss what should be included in the guide, and how the guide should be structured in order to be both informative and useful in practice. Large sections of this guide were written through collaborative in-person and virtual meetings. After each group meeting, in-depth sessions with torture rehabilitation experts and practitioners from several African countries were held to ensure that the guide reflected the knowledge and experiences of a broad spectrum of African regions, cultures and backgrounds.

It is important to note that torture rehabilitation is an evolving field, and that improved methods and information are continuously being produced. The information in this guide is based on current best practice. It represents the collective knowledge and experience of seasoned torture rehabilitation experts.

The guide includes several case studies which serve to provide deeper insight into the lived experiences of torture survivors. The case studies are based on real-life events and people and were provided by torture rehabilitation practitioners with the consent of their clients. All information that could identify persons was removed from the case studies, and pseudonyms were used to replace real names in order to protect the privacy of the clients and their families who are mentioned in the case studies.

WHO IS THIS GUIDE FOR?

This guide is intended for use by those who provide services to victims of torture. Such service providers include, but are not limited to:

Lawyers and legal service providers

Doctors, nurses, and other health providers in clinics, hospitals and community services

Physiotherapists, occupational therapists, art therapists, and other allied and complementary health services

Psychologists, counsellors, social workers, and other mental health and psychosocial support services (MHPSS)

Formal and informal community programmes and services, including programmes provided by non-governmental organisations (NGOs), faith-based bodies, cultural institutions, and communities themselves

The state and other government services, which can also use this guide to better understand victims of torture, the rights of the tortured, the state's obligations to provide rehabilitation services and seek ways to communicate with victims and the service providers who work with them

Note that this guide is not intended for use by victims of torture themselves. However, service providers may wish to use material from this guide to assist victims to better understand their rehabilitation rights.

WHAT ARE THE OBJECTIVES OF THIS GUIDE?

The overall objective of this guide is to enhance African service providers' understanding of torture and how they can assist torture survivors in securing their right to rehabilitation.

This guide is divided into two parts:

PART 1

PART ONE introduces the reader to the formal definition of torture and CIDTP. It describes who is vulnerable to torture and the effects which torture can have on victims (including their families, communities and the broader society), as well as how the effects of torture may vary across different population groups. Although special mention is made of specific contexts and situations, such as sexual torture and the effects of torture on children, the guide does not go into these particular topics in great detail. The various forms of torture reparation are also outlined and described. Part 1 concludes with an overview of torture rehabilitation.

PART 2

PART TWO offers practical guidelines on how to approach and engage with torture survivors, including: how to explain reparation and rehabilitation to clients; how to manage the challenges that are typical of torture rehabilitation; how to offer support to clients; how to manage client records and data; as well as when and how to make referrals. Guidance on how to approach torture rehabilitation on multiple societal levels is provided, whereafter some practical considerations are provided for reintegrating clients back into their communities. The guide concludes with an essential set of considerations for service providers on how to care for and protect themselves against vicarious trauma.

PRINCIPLES OF THIS GUIDE

This guide is founded upon a *rights-based approach* to torture rehabilitation. The rights-based approach emphasises the importance of valuing the autonomy and self-determination of the torture survivor. It encourages service providers to offer support to torture survivors in such a way that survivors can make informed decisions about when, how and where they access rehabilitation services. Torture survivors should be in a position where they can continuously make informed decisions throughout the course of their rehabilitation journey; hence, we encourage service providers to commit to adopting the following rights-based principles to torture rehabilitation:

CLIENT-LED	Respecting and empowering the client as the person who leads all decision-making and actions where he/she wishes and is able to. Where the client is unable to take the lead, service providers should provide skills and guidance and work with the client, offering participatory, supported decision-making. This also includes the right to access rehabilitation services without the requirement to institute legal proceedings.
HOLISTIC	Rehabilitation is not a single service but includes a range of both formal and informal services and support structures. These services should be multidisciplinary and multidimensional.
SAFETY-FOCUSED	The well-being of the client is paramount, and all decisions made by both the client and the service provider must include a consideration of any risks for the client or the service provider.
CULTURALLY SENSITIVE	It is essential that service providers understand and respect the cultural background and practices of their clients. This includes not making assumptions about an individual's perspective and cultural practices, and working with the client to find ways to align his/her culture and rehabilitation needs.
CONTEXTUALLY RELEVANT	Service providers should be mindful of the unique context in which clients find themselves, especially with regard to safety and resources. These considerations should be taken into account when rehabilitation programmes and treatment plans are being developed.

PRINCIPLES OF THIS GUIDE

NON-DISCRIMINATION	Access to quality services should be provided equally regardless of race, colour, ethnicity, age, religious belief or affiliation, political or other opinions, national or social origin, gender, sexual orientation, gender identity, disability (including psychosocial and intellectual disability), health status, economic or indigenous status, the reason for which one is detained (including accusations of committing political offences or terrorist acts), asylum-seekers, refugees, or others under international protection, or any other status or adverse distinction, which includes those marginalised or made susceptible on bases such as those above.[4]
ETHICAL	Service providers should undertake their work within an ethical framework, which should include: knowing and working within their clients' limitations; always acting with integrity; and ensuring that their actions do not cause further harm to clients. This includes compliance with local laws and professional codes of ethics and following best-practice guidelines when documenting torture cases.
CONFIDENTIAL	Any information revealed by the client should not be shared with any other party unless the client gives fully informed consent for this, in line with national legislation, guidelines and best practices. Clients must be made aware of the scope and possible limitations of confidentiality. Confidentiality can be broken if the person is at risk of harming themselves or others, or if the service provider is subpoenaed to appear in court. However, this may differ between countries and organisations.

This guide focuses specifically on torture.
However, service providers working with those subjected
to other forms of CIDTP as well as other human rights abuses
can still apply the materials presented in this guide.

4 Ibid., para. 20.

PART 1

WHAT SERVICE PROVIDERS NEED TO KNOW

Part 1 outlines what service providers need to know about torture – from both an international and regional perspective – in order to assist their clients in accessing rehabilitation and other forms of reparation.

1 | What is torture and cruel, inhuman and degrading treatment or punishment?

One of the most recognised definitions of torture is that of the UNCAT.[5] The UNCAT indicates that, for an act to be characterised as torture, four key features must be present:

1. There must be severe pain or suffering (either physical or mental);
2. The pain or suffering must be intentionally inflicted;
3. The pain or suffering must be inflicted for a purpose (i.e. to obtain information or a confession; to punish, intimidate or coerce; or any other purpose that is based on discrimination); and
4. The pain or suffering must be inflicted by a public official or other person acting in an official capacity (or be instigated by them or inflicted with their consent or agreement).

Torture is an evolving concept, and new forms of torture are always being reported. Some possible examples of torture are:

- Police beating a suspect in custody to make him/her confess;
- Military personnel forcing a person to watch while his/her family is harmed or threatened because he/she does not support the government;
- Immigration officials raping asylum-seekers in exchange for food in a refugee camp;
- Captors depriving prisoners of sleep as punishment; and
- State security forces applying hot metal to burn someone during an interrogation.

Acts of torture can be committed by the state, but also by those acting in an official capacity, that is, by someone who is exercising official or government functions. This could potentially include rebel groups, terrorist groups, militia groups, or private security firms.

There are a number of acts which, while abusive, lack one or more of the four elements of the definition of torture under Article 1 of the UNCAT definition outlined above. These acts are considered other forms of CIDTP. Therefore, an act would constitute CIDTP rather than torture if it lacks the required intention or the required purpose (or discrimination), or if the pain or suffering it causes is not considered to be severe. However, acts of CIDTP are prohibited under international law, just like torture.

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5 United Nations Convention against Torture (UNCAT). (2002). *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Article 1)*. United Nations Treaty Collection. Retrieved from: https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-9-b&chapter=4&clang=_en.

CASE STUDY

Paul

Paul, a Kenyan male, lives with an intellectual disability and is partly deaf. He was arrested by the police and detained at a police station because they falsely believed that he had committed a crime. The police officers ignored the fact that Paul is intellectually disabled and partly deaf, and, instead, physically assaulted him when he was unable to answer their questions. The beating resulted in Paul losing consciousness. When he regained consciousness, he realised that the police officers were already in the process of taking him to court. Paul was terrified of the court because of everything that he had experienced while in detention at the police station. While in court, Paul's ears rang (because of the beating) and he could not hear anything. Owing to his fear of the court and his disability, he ended up pleading guilty to the charges that were laid against him, even though he was innocent. Paul was subsequently sentenced and sent to the psychiatric unit of a local prison. There, he was locked up for long periods at a time, in a small prison cell, despite suffering from claustrophobia. After his eventual release from prison, Paul now prefers to sleep outside and look at the stars.

In practice, the absolute prohibition of CIDTP is interpreted broadly and aims to secure respect for the physical and mental integrity and dignity of all individuals at all times.

Some acts which are considered to be CIDTP rather than torture by the courts include:

- Poor conditions of detention (such as over-crowding);
- Being detained without access to outside communication;
- Excessive periods in police custody or prison remand;
- The use of hard labour in prisons;
- Being spoken to in a way that causes shame or humiliation; and
- Having to remove or change one's clothes in front of other people.

CASE STUDY

Zed

Zed, a Congolese male, was arrested and tortured by the government because of his involvement with an opposition party. He was abducted in front of his wife and two daughters and imprisoned. Whilst in prison, Zed was denied food and was psychologically tortured through threats to kill his family and rape his wife. Zed was also physically tortured – he was beaten and electrocuted and was subjected to falanga (blunt trauma to the soles of the feet). His wife was also detained and faced continuous threats of rape. The couple was forced to flee to South Africa to seek safety and security.

CASE STUDY

Elton

Elton was arrested and detained for two weeks while being interrogated by two women about his political affiliation. While in custody, he was forced to strip naked in front of them on several occasions. They would make comments about the size of his manhood while touching him inappropriately. The women also asked Elton to demonstrate what he did to his wife when they were being intimate. They laughed at him, made sarcastic comments and mocked him repeatedly. The women also physically assaulted him. After two weeks, he was released without any charges being laid against him. However, the interrogation had a severe effect on his relationship with his wife. Elton started to drink heavily and became violent, beating both his wife and children. As a result, his wife took their children and moved to a rural area. Elton also landed in trouble with the police on two occasions for fighting at the local beer hall. His relatives were upset and embarrassed by his behaviour and started to believe that he was going "'mad"'. Elton's situation became increasingly hopeless, and he became depressed – to the point where he even considered taking his own life.

In some cases, these kinds of treatment may still be considered torture. Courts will often spend considerable time debating whether treatment reaches the level or threshold for torture or CIDTP.

States not only have an obligation to refrain from torture and CIDTP; they also have a duty to put in place adequate measures to prevent, investigate, prosecute and punish acts by private individuals. Acts by private individuals, such as family violence or criminal acts, are still reprehensible forms of human behaviour; however, they are not the same as torture or CIDTP, because they are acts which are committed by members of society, not by those acting on behalf of the state.

Whether or not an act is considered torture can also depend on the local context – both within each country and across the African continent. It can be helpful to know what local legislation and case law (findings in previous cases that have been handed down by the courts) state about torture, as this may change what kind of redress and rehabilitation is available. The UNCAT definition of torture should, however, always be kept in mind. Even when an act of torture may be lawful, allowed or tolerated at a national level, it may still be prohibited under the UNCAT and international law. Still other considerations as to whether a practice could amount to torture include:

- Whether there is a local legal definition or local understanding of torture;
- Whether acts which could be considered torture are allowed under national law (such as some forms of force by the police or military);
- Whether acts which could be considered torture are culturally allowed (such as corporal punishment). However, note that the United Nations Convention against Torture and other CIDTP (Article 1) does not always prohibit 'pain or suffering arising only from, inherent in or incidental to lawful sanctions';[6]
- Whether the person believes that what they have experienced is torture; and
- Whether there has been suffering, or any significant impact on the individual as well as his/her family, community and society.

6 Ibid.

Susan

Susan, a medical doctor from Kenya, approached the court to have the Kenyan Prohibition of Female Genital Mutilation (FGM) Act declared unconstitutional for violating her right to cultural expression. Several members from different communities supported her claim that FGM is a form of cultural expression. The petition was opposed by the Kenyan government and several human rights organisations. The court refused to make a ruling, stating that it is difficult to find a balance between individual protection under the law and rights and freedoms of girls and women under the Constitution concerning cultural practices. The case was referred to arbitration, and, while Susan was unsuccessful in declaring the FGM Act unconstitutional, she continues to lobby for the legalisation of FGM.

Maria

Maria, a 70-year-old Malawian woman, was regularly accused of witchcraft by her community. One fateful night, a boy accused her of being a witch. This accusation brought about an attack on her home, where she was beaten with sticks. Her attackers also repeatedly stepped on her chest. Maria was seriously injured and rendered unconscious during the attack. Soon thereafter, Maria died of her injuries. In response to this, the Malawian government renewed its efforts to review the national Witchcraft Act. This Act prohibits trial by ordeal in which those suspected of witchcraft are subjected to painful and unpleasant experiences to 'prove' their innocence.

In what way is torture different from other forms of violence?

Unlike other forms of violence, torture is used by the state and other authorities – the very structures set up to protect their citizens from violence and threats. Torture is employed as a weapon to control, punish and terrorise people.

The following table outlines how torture differs from other forms of violence, as seen from the perspective of various service providers:

How torture is different from other forms of violence, as seen by various service providers:	
For lawyers and other legal service providers	Torture holds a unique place in the law as a particularly heinous crime. It is forbidden in international law in all cases, and at all times. Most nations also prohibit it under their own domestic legislation.
For doctors and other healthcare workers	Torture wounds are often complex to manage, with long-term health consequences and an increased risk of developing secondary illnesses.
For complementary and allied healthcare providers	Torture survivors can have multiple and complex needs, with a heightened risk of chronic conditions and permanent disability.
For MHPSS workers	Torture causes a particular kind of harm which extends further than only physical impacts, as it has the aim of destroying the person and his/her dignity. Rebuilding the mental health of a tortured person is complex and often takes a long time.
For community workers	The consequences of torture extend beyond the individual person and cause a ripple effect through families, communities and societies. These consequences are not limited only to the time and place they occurred – they can also transcend borders and generations.

2 | Who are the victims of torture?

The most direct victim of torture is the individual who has been tortured. However, torture not only aims to break down the victim, but also seeks to ensure that the harm and the fear of torture have a broad reach. The effects of torture, therefore, typically extend beyond the individual who has been tortured – torture also affects the victim's family members, communities, and even broader society. Consequently, both those who have been directly and indirectly exposed to torture and CIDTP could be considered victims of torture.

Torture can be inflicted on any person, but some characteristics can place an individual at greater risk of being tortured. Torture may be inflicted because of who the person is, or because of where they are, or simply because of the national political situation that they find themselves in. Furthermore, a person should be considered a victim regardless of whether or not the perpetrator of the violation is identified, apprehended, prosecuted or convicted, and regardless of any familial or other personal relationship between the perpetrator and the victim.[7]

7 Ibid., para. 3.

There is a greater risk of a person being tortured if they are:

- Detained by the police (especially immediately after arrest or whilst being transported by the police);
- Detained in prison (both during remand and after conviction);
- Detained in secret or uncommon places (such as torture bases, army facilities or intelligence facilities);
- A supporter of a government opposition party (especially if they are actively involved in activism, political meetings, rallies or protests);
- Seeking asylum (including while trying to get to safety, during immigration detention, and while in communities);
- Detained in a state institution (such as facilities for prisoners of war as well as institutions for the elderly, disabled people, children and psychiatric patients);
- Part of a marginalised group; or
- Related to, or associated with, others in these categories.

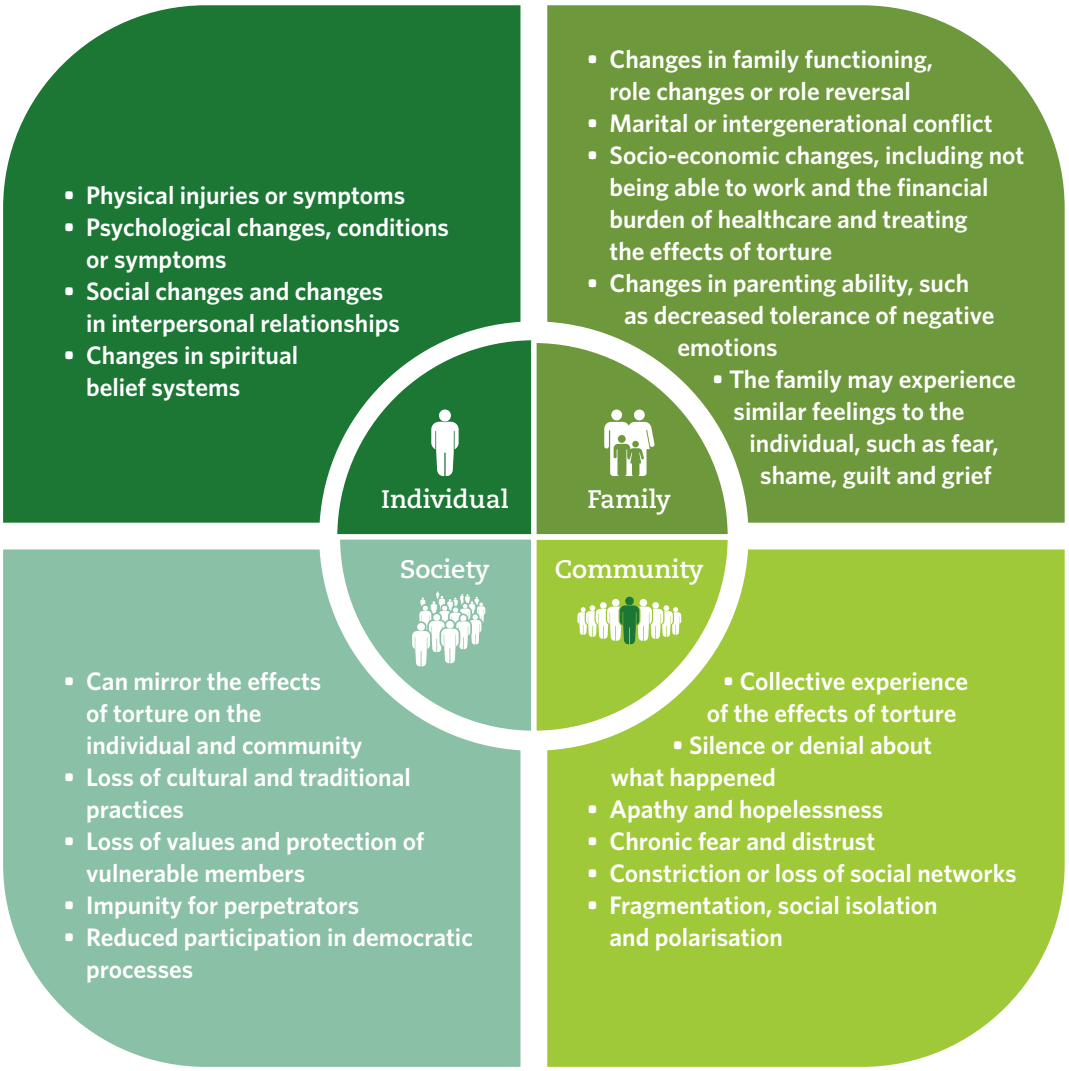
People who have been tortured in the past will often still carry the same risks with them and can be at greater risk of being tortured again in the future. This includes people who flee their home country after being tortured, only to be tortured again while travelling to another country.

Mohammed

Mohammed fled from his home in North Africa after his father was killed by the military. He initially aimed to seek asylum in South Africa, as his family believed he would be able to find work there. However, Mohammed was apprehended by immigration officials as he was transiting through another country. Mohammed was detained in prison there as an illegal immigrant. While in prison, he was assaulted by a violent criminal and subsequently placed in solitary confinement for three months. During this time, he had no access to legal assistance and was not able to make contact with the outside world. Mohammed was also unable to properly communicate with others and answer the prison guards' questions, as he could not speak the local language. His inability to answer their questions frustrated the guards, who physically assaulted him on several occasions.

3 | What are the effects of torture?

Torture is typified by the horror it creates in both the victim and society. The consequences of torture vary widely and, as a result, each individual who is affected may experience different effects. The consequences impact individuals in multiple ways and across various levels of society, as can be seen from the figures below.[8]



8 The Centre for Victims of Torture. (2005). *Healing the Hurt*. Retrieved from: https://healtorture.org/content/healing-hurt.

PHYSICAL

- Head and spinal cord injuries
- Bone fractures
- Muscle and nerve damage
- Skin damage and scarring
- Hearing and vision damage
- Stomach and gastric conditions
- Damage to sexual organs
- Chronic body pain
- Headaches
- Back pain
- Chest pain and palpitations
- Dizziness and weakness
- Stomach pain
- Burning, tingling and numbness
- Nausea, diarrhoea and constipation

PSYCHOLOGICAL

- Post-traumatic stress disorder (PTSD)
- Depressive disorders
- Anxiety disorders
- Sleep disorders
- Psychosis
- Substance abuse
- Sexual disorders
- Somatisation disorders
- Nightmares and sleeping difficulties
- Extreme fear, worry and anxiety
- Guilt and shame
- Feelings of worthlessness and hopelessness
- Anger and aggression
- Extreme fatigue
- Confusion and memory difficulties
- Self-harm
- Suicidal thoughts and behaviours

SOCIAL

- Social isolation and withdrawal
- Loss of friends and other support
- Loss of employment or ability to work
- Financial stress or poverty
- Marginalisation or stigma in the community
- Disruption or loss of education potential
- Loss of home or livelihood

SPIRITUAL

- Changes in beliefs
- Loss of trust in the world
- Changed sense of self
- Loss or questioning of faith
- Thoughts of death and dying
- Loss of sense of autonomy or agency

A special note on perpetrators

The line between perpetrator and victim can often be blurred, as the perpetrator may also be subject to the rule of a state or authority which oppresses and terrifies its population. Perpetrators of torture can be affected by their actions, especially when they are unwilling or reluctant perpetrators – for example when they are forced by their superiors to commit acts of torture, when they or their family members are threatened with violence, when they are in a position where they are unable to resist (such as in the case of child soldiers), or when their own poverty or family situation makes it difficult to remove themselves from their role as a perpetrator. Former perpetrators may present with symptoms of PTSD and high levels of guilt, numbness and, in some cases, aggression and violence

CASE STUDY

Ezra

On the instructions of his superiors, Ezra frequently assaulted and tortured people in the community who were believed to be rebels. He, together with his colleagues, would intimidate people, forcing them to vote for a particular political candidate. Although Ezra was reluctant to assault people, he could not disobey his superiors' instructions for fear of being fired or even killed. It was challenging for him, resulting in him having feelings of shame, guilt and self-blame. One day, his superiors told him to beat his brother. Ezra refused and was arrested and accused of stealing. He was released after six months and subsequently fired. Ezra's relatives and community members were delighted that he had been fired, as they thought that he was being punished by God because of what he did. However, nobody in his community trusted him, and nobody wanted to be seen in his company. This made Ezra feel very miserable. His family and community did not realise that he was perpetrating violence against his will and that he was also a victim.

A special note on children

Children can be significantly affected by torture as victims, witnesses, or as part of a family or community where torture occurs. Some of the effects children experience as a result of being a direct or indirect victim of torture include:

- Acting out by way of aggression, overactivity or being out of control, or, alternatively, becoming unusually quiet, introverted and withdrawn;
- Difficulty or inability in articulating or making sense of what has happened, which may lead to feelings of confusion and helplessness;
- Blaming themselves for what has happened or blaming their family, which may lead to extreme guilt and anxiety – making it more difficult for them to express their concerns;
- Regression (i.e. acting like a much younger child) and failure to thrive and develop; or, alternatively, acting like an adult (particularly if they have to care for a parent or their siblings, or if they have become responsible for running the household); and being unable to, or uninterested in, engaging in usual activities that are appropriate to their age (such as playing and going to school);

- Having greater difficulty separating reality from imagination, and having nightmares that seem vivid and real; and
- Worries and fears being expressed through the body (i.e. psychosomatic anxiety), particularly stomach complaints.

Calvin

Calvin, an eight-year-old boy, and his father were awoken by a loud knock on the front door at four o'clock in the morning. Calvin's mother, an informal trader, was away at the time, and Calvin thought that it may be his mother who had returned home from her travels. He eagerly followed his father to the front door to meet his mother. However, once Calvin's father unlocked and opened the front door, it quickly became clear that this was not the case. Two uniformed men with covered faces stood in front of them. The men immediately started to shout at Calvin's father, and started to beat and kick him. They accused him of supporting the opposition party and of being involved in the party's activities. Calvin witnessed the entire incident. The experience was very frightening and traumatic for the young boy. Afterwards, Calvin struggled to sleep and would routinely wake up at around four o'clock every morning, the same time that the event took place. Calvin also started to wet his bed and lost interest in food. He refused to play with his friends, instead preferring to always be close to his father. Calvin also struggled to concentrate, which caused his school performance to deteriorate.

A special note on sexual torture

Sexual torture is any act which is consistent with the definition of torture and includes acts of a sexual nature. It may encompass, but is not necessarily limited to: forced nakedness, sexual humiliation, sexual abuse, rape, sexual violence, forced sterilisation or castration, forced prostitution or sexual slavery, as well as harming a person's genitalia (e.g. by stabbing, cutting, kicking or applying electrical shocks to the genitalia). Women, children and people who are in detention are particularly vulnerable to being subjected to sexual torture.

A common misconception is that certain types of torture are gender-specific. It is often assumed that the victims of sexual torture will always be female, based on the belief that women are more likely to be raped than men. However, this is not the case. Men can be raped as well, but they are less likely to report the incident to the authorities or even their loved ones due to shame and the fear of ridicule and discrimination. Therefore, it is important not to assume that, just because someone is male, they could not have been raped or sexually assaulted by either male or female perpetrators.

Sexual torture can have multiple health impacts, including physical injuries (particularly to the genitals and internal organs), the risk of contracting HIV and other sexually transmitted infections, increased risk of infertility or sexual dysfunction, and the risk of an unwanted pregnancy, which creates further stigma for the victims. Victims of sexual torture are at a high risk of developing PTSD, and often also report struggling with feelings of self-disgust, worthlessness, humiliation and shame.

In some cases, sexual torture is used when rebels or militia come into homes to threaten families, because either the father or husband was involved in a political party or is suspected of being a spy. As a means of threat, female family members are sometimes raped. It has been a challenge trying to get the family to speak about the incident.

– Mental health practitioner

It is important to keep in mind that different cultures will have different ways of understanding and conveying what has happened to the victim of sexual torture. The victims themselves may also have different ways of making sense of what they experienced. In many cultures, rape is a particularly sensitive topic which is not typically discussed. Moreover, in some cultures, rape victims are considered to be responsible for what has happened to them and are therefore often rejected by their spouses, family and the rest of the community. As a result,, a victim of sexual torture may find it difficult to disclose and explain what has happened to her/him due to shame and fear that, by reporting sexual torture, they will be rejected by their family, friends and community.

Victims of sexual torture may also find it hard to work with service providers who are in one way or another similar to their torturers. For example, if the perpetrator was a man, the victim may have difficulty engaging with male service providers.

Lucille

Lucille was a victim of gang rape in the Democratic Republic of the Congo (DRC). She suffered severe mental health consequences due to this experience, including suicide ideation. According to her culture, rape is not seen as a criminal offence, but rather as infidelity. Victims of rape are often blamed for being raped and face discrimination, intimidation and even ostracism from their community. Although Lucille's husband continues to be under pressure to leave her and is mocked by their community for staying with her, he understands that it was not her fault and refuses to abandon her. Some community members accuse Lucille of being a witch, as they cannot find any other plausible explanation as to why her husband does not divorce her. Lucille was making good progress with her psychosocial therapy until one day when she was attacked by members from her community. Since the attack, Lucille is depressed and fearful of being attacked again.

A special note on persons with disabilities

Persons with disabilities are particularly vulnerable to torture. Specific acts of torture may disproportionately affect persons with disabilities. For example:

- Forced or non-consensual medical interventions, particularly against persons with psychosocial or intellectual disabilities. This may include forced treatment with psychotropic medicines, sterilisation, electroconvulsive therapy, and behaviour-modification procedures;

- Abusive practices such as chaining, cuffing, segregation, seclusion, restraints (physical, chemical or mechanical), particularly against persons with psychosocial disabilities, persons with autism, and older persons with Alzheimer's or other age-related impairments;
- Denying persons with physical impairments (e.g. paraplegics) assistance to move, eat, drink or use the toilet; and
- Subjecting someone with epilepsy to flashing lights and noise or depriving them of sleep for prolonged periods.

For persons with disabilities or other pre-existing impairments, torture can have a debilitating, long-lasting impact. Examples of the enduring effects of torture on a person with a disability may include:

- The exacerbation of impairments – for example by further reducing the mobility of a person with a physical disability; by increasing feelings of terror and insecurity on the part of persons with psychosocial disabilities; and by harming the cognitive functioning of persons with intellectual disabilities;
- Rendering the person with a disability unable to take care of themselves or limiting their ability to live independently and exercise their autonomy. This may require the person to live in a place of safety where they could become subject to further abuse; and
- An avoidance or unwillingness to engage with healthcare professionals, particularly if the victim was tortured by healthcare workers in the past.

A special note on gender

Gender is a social construct and refers to the roles, behaviours, activities, attributes and opportunities that society considers appropriate for girls and boys, women and men. We learn what it is to be a man, woman, girl or boy through a process called 'socialisation'. This can be captured in common sayings like 'Boys don't cry' and 'Girls should be seen and not heard'.

CASE STUDY

Mark

Mark, a disability rights activist, was in possession of documents that were being sought by government officials. Mark refused to hand over the documents as they were critical to the survival of the disability trust of which he was one of the beneficiaries. On his way to work one day, Mark was kidnapped by four armed men in an unmarked vehicle. The men assaulted Mark, whereafter they threw him out of the moving vehicle. Mark sustained severe injuries as a result of the fall. A metal rod, which was implanted in one of his legs years earlier, tore through his skin and both his legs were broken due to the fall. The incident caused several health complications for Mark, including the possibility that he might need to have one of his legs amputated.

Gender determines what is expected, allowed and valued in a woman or a man in a given context. In most societies, there are differences and inequalities between women and men in terms of responsibilities assigned, activities undertaken, access to and control over resources, as well as decision-making opportunities. The figures below offer some examples of how men and women are uniquely affected by torture.

Being raped and tortured, he was so emasculated. Now he sits in a position where he is not providing for his family; culturally, that is how he was raised, that's how he understands his role as a man. And as much as you try, for example, to ask him what other forms of support he provides to his family, the financial support is the most important one. His children complain that he is not giving them what they need, and hence they do not want to listen to him nor obey him. Providing for his family is what he believes makes him a man in the house.

– Mental health practitioner

Torture can have an enduring impact on a torture victim's ability to fulfil their traditional or culturally-valued gender roles within their families and communities, adding additional strain on relationships and negatively impacting the victim's self-worth.[9]

The unique ways torture affects women and girls	
	A women's role as nurturer and caretaker in the family may be challenged by an inability to take care of her family due to psychological distress, unemployment and lack of support.
	Discrimination and rejection by partners, family and the community, as they may be seen as 'damaged', resulting in broken marriages. A girl's eligibility for marriage can also be negatively affected by torture.
	Pregnancy as a result of rape, which results in conflict within the household, as the child may not be accepted by the family.
	Women are often silenced by the family or communities so as not to bring shame to the home and tribe.
	Feelings of stress, fear, guilt, emotional distress, helplessness, anguish, shame and humiliation.

9 Goodman, R. & Bandeira, M. (2014). *Gender and Torture. Does it Matter? An Exploration of the Ways in Which Gender Influences the Impact of Torture and Rehabilitation Services*. Johannesburg: Centre for the Study of Violence and Reconciliation.

The unique ways torture affects men and boys	
	A man's role as protector and provider may be challenged as he faces physical disability due to torture and detention, or the possibility of exile or fleeing to another country. This decreases his ability to provide stability and security for his family.
	Loss of manhood and a sense of self, as he may no longer see himself, or be seen by his family, as capable of being the head of the household.
	Sexual difficulties, impotence and uncertainty about his sexual orientation following sexual torture.
	Feelings of guilt, distress, anguish, self-judgement, anxiety, anger and depression, as well as substance abuse.
	Men often refrain from seeking help, as they are concerned that others may perceive them as weak.
	As roles and responsibilities shift within the familly, the man's marital relationship and relationship with his children may change significantly.

Lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual or allied (LGBTQIA) victims of torture

Persons from the LGBTQIA community are particularly vulnerable to torture and CIDTP. Owing to cultural, religious and political belief systems which deem homosexuality to be immoral or unnatural, persons from the LGBTQIA community are at particularly high risk of stigmatisation, discrimination, intimidation and rejection by their families and communities.

Given these belief systems, people sometimes justify subjecting persons from the LGBTQIA community to interventions, medical procedures, abuse and violence in an effort to change or 'correct' the individual's sexual orientation or gender identity.[10] This may include psychotherapy, electroconvulsive therapy, physical beatings, the administration of psychoactive and hormone medication, forced confinement, ritual cleansing, as well as sexual assault and rape. The perpetrators of such abuse are typically healthcare professionals (both trained and untrained) as well as traditional healers, the victim's family, the police, prison guards, and other security officials.

In certain countries, homosexuality and homosexual activities are illegal and punishable by law. The punishment varies across different countries, but, generally, includes fines, imprisonment, public beatings, stoning, and even the death penalty. During times of social unrest and conflict, persons from the LGBTQIA community are often marked as scapegoats and easier targets for persecution.

10 International Rehabilitation Council for Torture Victims (IRCT). (2020). *It's Torture Not Therapy. A Global Overview of Conversion Therapy: Practices, Perpetrators, and the Role of States*. Retrieved from: https://irct.org/uploads/media/IRCT_research_on_conversion_therapy.pdf.

CASE STUDY

Tessa and Matthew

Tessa and Matthew are a married couple with two children. They both experienced sexual torture during the war. The couple struggles to speak to each other about these experiences and avoids doing so if they can. However, the impact that these experiences has had on them is notable in the continuous power struggle in their marriage. The sexual torture and the resulting impact that it has had on him has left Matthew feeling emasculated, disempowered and ashamed. His lost sense of masculinity has resulted in him trying to regain it through different business ventures in order to fulfil his role as a man who provides for his family. He wants to be somebody significant and important. His quest to do so often results in him neglecting the needs of his family, both emotionally and financially. Tessa reports wanting to be supportive of her husband as his wife but also feels frustrated by his inability to provide for the family. She wants to stay at home and look after her children, but she has to go to work to feed the children and pay the rent. She has started to sell small things on the street, which Matthew thinks is a worthless endeavour. He dismisses her efforts, as these further emasculate him. Tessa and Matthew feel disconnected from each other. Tessa reports that Matthew seems distant of late, is hardly ever at home and is more engrossed with his business ventures than ever before.

> With the client group we work with, individuals that belong to the LGBTI communities, when their sexual identity comes out, they have faced death threats.
>
> *– Mental health practitioner*

As a result, persons from the LGBTQIA community often hide their sexual identity and orientation for fear of persecution by the state, their family and the community. They may also attempt to flee from their country of origin and seek asylum in another country where they will be safe and less likely to be mistreated. Given the stigma and fear of discrimination and persecution, persons from the LGBTQIA community are less likely to report instances where their rights have been violated. Past negative experiences with service providers may also contribute to them being distrustful of service providers and hesitant to seek out medical, legal, psychosocial and other support services. As a result of a lack of social support from their families and communities, coupled with limited access to support services, persons from the LGBTQIA community are at a heightened risk of living with untreated PTSD, thus worsening their outcome for a full recovery in the long term.

CASE STUDY

Samuel

Samuel has been the victim of repeated torture, discrimination and mistreatment by his community and security agents due to his sexual orientation. As a result, he has become very sensitive and vulnerable to the responses and actions of others. During his screening at the rehabilitation centre, Samuel's clinician asked him a question about his sexual orientation. This visibly bothered Samuel, and he expressed offence, fear and distrust at being asked this question. During his treatment sessions, Samuel appeared to be suspicious of, and threatened by, the clinic staff and could not maintain eye contact with his clinician. However, his clinician continued to work with him, and, over time, was able to build a relationship with Samuel. After gaining Samuel's trust during the course of several therapy sessions, Samuel finally felt comfortable and secure enough to share his sexual orientation with his clinician. The clinician and the other clinic staff who worked with Samuel deemed it critical to always remain non-judgemental and empathetic towards him. This would help him to feel more comfortable to share more details about: the discrimination he experienced by his community; the several incidences of unlawful arrest and torture which he endured due to his sexual orientation; and the ongoing challenges which he faces in accessing services. After making progress in psychotherapy, Samuel was referred to another organisation, where he joined a social support group for persons from the LGBTQIA community. The support group serves as a safe space where group members can recount their personal stories, talk about the challenges which they face, and provide encouragement and support for each other.

A special note on detainees in prisons and other detention centres

Many current and former detainees are torture survivors. During arrest and police interrogation, while awaiting trial, as well as during detention, detainees are vulnerable to various forms of torture and CIDTP. Detainees (including those who are awaiting trial and those serving a prison sentence) are often subjected to a wide array of painful physical and psychological torture and CIDTP acts, which may include: inhumane living conditions; intimidation; cruel interrogation methods to compel suspects to make false confessions; verbal abuse; sensory deprivation; extreme isolation and movement restrictions; highly uncomfortable sitting and standing positions; sleep deprivation; starvation; sensory overstimulation; beatings, burnings, suffocation and other forms of physical torture; as well as sexual abuse and rape.

Given that they are deprived of their liberty and have limited contact with the outside world, detainees face the additional stressor of not being able to escape the torture and CIDTP and of not having any control over when it will end. Their isolation from family and other supportive social structures, as well as limited access to medical and psychosocial support, adds further strain to their ability to cope with the effects of torture. Moreover, access to detention facilities by independent monitors remains a considerable challenge in many countries. This helps to keep much of the torture and CIDTP that occurs in prisons unexposed.

The accumulated effects of long-term torture on detainees can take the form of physical and psychological trauma that may endure long after their release from detention. Not only can torture leave detainees with lifelong scars, disfigurements, brain injuries or physical disabilities, but the torture can also lead to PTSD, which includes symptoms such as chronic fatigue, memory loss, concentration problems, difficulty sleeping, aggressive behaviour, anxiety, depression, and suicide ideation.

Once detainees are released from detention, they often face rejection, stigmatisation and discrimination by their community. They may also have limited access to torture rehabilitation and community reintegration support services. Given the lack of support and community stigmatisation, former detainees who have been tortured are less likely to disclose their experiences of torture and CIDTP and carry the physical and psychological scars with them without receiving the support that they need.

CASE STUDY

Augustine

Augustine, a young Nigerian informal trader, was sitting in his house one day when police barged in and dragged him out of his home. They suspected him of being involved in a robbery in the neighbourhood. Augustine was taken to the police station, where he was held for seven days. During this time, Augustine was severely beaten and tortured. He was charged with armed robbery, and, after a swift court case, was found guilty and sentenced to three years in prison. While serving his sentence, Augustine made productive use of his time by learning new skills. However, upon his release from prison, Augustine and his family experienced relentless stigmatisation and rejection by their community. He struggled to find a job, despite his newly acquired skills. Moreover, nobody in the community wanted to associate with him, leaving him feeling very alone and isolated. After suffering from rejection and stigmatisation for two years, Augustine took his own life. Augustine's case is one of many examples of torture victims who are left to suffer the harmful consequences of torture with little or no support.

4 | Why do we need reparation for torture?

The overarching goal of reparation is to bring about transformation and healing for victims of torture. Recovery involves making whole that which has been broken and wounded. It seeks to restore the dignity, humanity and trust that were violated by torture.[11] Reparation encompasses five distinct measures, as outlined below:

REPARATION				
 Rehabilitation	 Restitution	 Compensation	 Satisfaction and the right to the truth	 Guarantees of non-repetition

Rehabilitation is a holistic approach to healing, encompassing the process which allows a person to heal, to have improved functioning in their day-to-day life, to recover from their experiences of torture, and to return to what they see as a meaningful personal life and role in their family and community.

Restitution, **compensation**, **satisfaction** and **guarantees of non-repetition** are primarily situated within legal and judicial processes. Some people who have experienced torture will feel that it is vital for them to pursue the legal route to achieve reparation, as they may see this as the most effective way to obtain justice and move on with their life. However, for other people, the legal route may seem time-consuming, unsafe, difficult or traumatising.

All clients have a right to understand all of their reparation options.

The main focus of this guide is on how to facilitate torture survivors' right to access rehabilitation; however, it is also useful to understand the other forms of reparation:

What is restitution?

Restitution is a form of redress to return the victim to a situation which resembles what their life was like before the violation was committed. States are obligated to ensure that the victim who is receiving restitution is not placed in a position where they are at risk of repetition of torture or re-victimisation. For restitution to be adequate, efforts should be made to address structural causes of the violation, including any kind of discrimination related to, for example, gender, sexual orientation, disability, political or other opinions, ethnicity, age and religion, as well as any other grounds of discrimination.[12]

11 African Commission on Human and Peoples' Rights (ACHPR). (2017). *General Comment No. 4: The Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment (Article 5) (para. 10)*. Retrieved from: https://www.achpr.org/legalinstruments/detail?id=60.

12 Ibid., para. 36.

What is compensation?

Prompt, fair and adequate compensation for torture is multilayered. Compensation awarded to a victim should be sufficient to compensate him/her for any economic harm resulting from torture. This could include:

- Reimbursement of medical expenses and provision of funds to cover future medical or rehabilitative services needed by the victim to ensure as full a rehabilitation as possible;
- Compensation for the consequences arising from the physical and mental harm caused – taking into account the loss of earnings and earning potential due to disabilities caused by the torture or ill-treatment; and
- Compensation for the loss of future employment and education opportunities.

In addition, adequate compensation awarded by states to victims of torture should provide for legal or specialised assistance and other costs associated with bringing a claim for redress.[13] Limited resources should not justify a state's failure to fulfil its obligation to provide comprehensive reparation.[14] Some states have established national compensation funds for victims of torture specifically, or for criminal injuries generally, as a practical way to respect their obligation to provide adequate compensation for victims.

What is satisfaction?

'Satisfaction' refers to various judicial and non-judicial measures that recognise the gross human rights violations committed at the hands of state officials and the harm suffered by victims. Such measures can be requested by the victim or ordered by the state and can include:

- Effective measures aimed at stopping ongoing violations;
- Verification of the facts as well as full and public disclosure of the truth;
- Searching for missing persons;
- Assistance in the recovery, identification and reburial of the remains of victims in accordance with the expressed or presumed wishes of the victims or affected families;
- An official declaration or judicial decision restoring the dignity, reputation and rights of the victim and of persons closely connected with the victim;
- Judicial and administrative sanctions against persons liable for the violations;
- Public apologies, including acknowledgement of the facts and acceptance of responsibility; and
- Commemorations and tributes relating to the victims.[15]

What are the guarantees of non-repetition?

To guarantee that torture will not be repeated or continued, states should undertake measures to combat impunity for violations. Such measures include establishing clear instructions to public officials on the provisions of the UNCAT, especially the absolute prohibition of torture. Guarantees of non-repetition can be far-reaching and could include any or all of the following:

- Strengthening the independence of the judiciary;
- Protecting human rights defenders and legal, health and other professionals who assist torture victims;

13 Ibid., para. 37–39.

14 Ibid., para. 34.

15 Ibid., para. 44.

- Providing training for law enforcement officials as well as the military and security forces in human rights law;
- Reviewing and reforming laws which contribute to, or allow, torture to occur; and
- Ensuring the availability of services for victims of torture, both at an individual and a group level.[16]

Reparation for collective harm

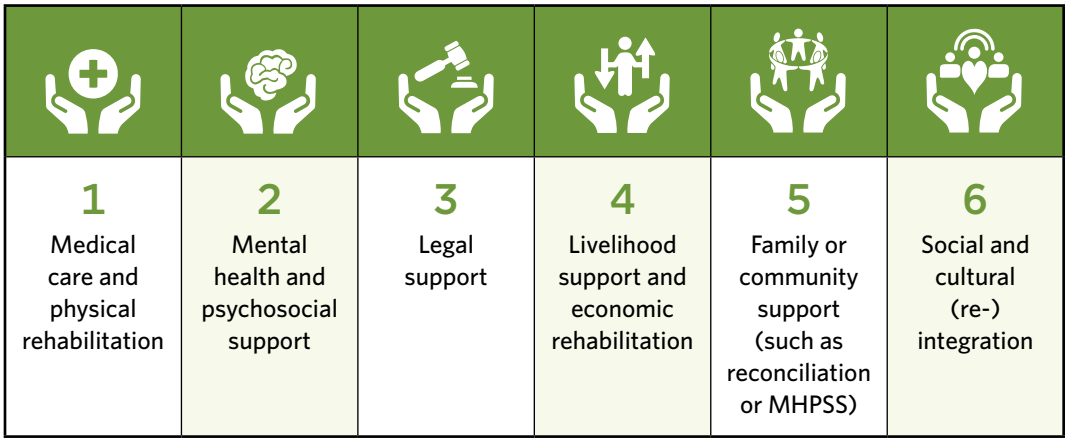
The ACHPR's General Comment No. 4 recognises that states have an obligation to provide redress for collective harm, or harm to a larger group of people who have suffered as a result of torture. While violations of torture are essentially perpetrated against individual persons, they may nevertheless also be directed against, and impact upon, groups of persons who are targeted collectively.[17]

Since collective reparations can potentially encompass large numbers of victims, compensation may not always be the most feasible or appropriate form of reparation. Other forms of collective reparation may include acts at the community level which are aimed at publicly recognising the harm caused, recovering the memory of the victims, re-establishing victims' reputations, transmitting a message of official condemnation of the violations, and a public commitment by the state to take all measures necessary to guarantee non-repetition.

5 | What is rehabilitation?

Rehabilitation is the process which allows a person to heal, to have improved functioning in their day-to-day life, to recover from their experiences of torture, and to return to what they see as a meaningful life and role in their family and community.

'Holistic rehabilitation' means working with the individual within the context of the individual's needs, and their context in the family, community and society. Holistic service provision includes providing, offering or facilitating services across six key service areas (with other services offered based on individual needs). These six key service areas include:



16 Ibid., para. 45–49.

17 Ibid., para. 50.

Guidance for ensuring access to holistic rehabilitation includes:

- Explaining holistic rehabilitation to clients, and encouraging clients to engage with each of the key service areas;
- Tailoring rehabilitation to the needs and wants of the individual and ensuring that the rehabilitation is in line with a rights-based approach, which is characterised by being client-led, holistic, culturally sensitive, safety-focused, non-discriminatory, contextually relevant, ethical and confidential;
- Understanding what service and community structures are locally available and establishing links for referrals (This may also include accepting that there may be some services which are not available.); and
- Referring clients to different service providers so that all their needs are met as well as directing clients to other appropriate services in the event that the client is not interested in the specific service that you offer (For example, the torture survivor may not want to commence with a legal case or engage in psychotherapy.).

As will be further explored in Part 2, rehabilitation may have completely different meanings for torture survivors and for the service providers who work with them. The torture survivor client and service provider must work together to align their understanding so that they can work towards a common goal.

2

PART 2

PRACTICAL GUIDANCE FOR SERVICE PROVIDERS

In Part 1, we took a closer look at torture and what needs to be in place for service providers to assist their clients in accessing rehabilitation or other forms of reparation. **Part 2** provides some tools and guidelines that will help service providers to put into practice the information that was covered in Part 1. This section is by no means exhaustive, but it does offer ideas and guidance from the perspective of service providers working with clients from across Africa.

1 | National contextualisation

Although the horror of torture is a universal experience, there tend to be differences in the way that torture occurs and how it is experienced by individuals and communities across different countries and world regions. It is, therefore, important that service providers apply their technical knowledge and expertise to their own unique country context.

To understand the relevant local context, service providers should seek to understand the following three points:

- **What legislation is there which regulates conduct?** Rehabilitation rights may be included in instruments and resources, such as:
  - » Constitutions, including whether torture is prohibited and the rights of those that have been tortured;
  - » Acts relating to criminal procedure, including specifications regarding what happens when rights are breached;
  - » Acts related to mental healthcare, specifically care for people with mental health conditions associated with torture;
  - » Acts related to support for people with disabilities, including care for people with disabilities which resulted from torture;
  - » Case law, in particular trials which have dealt with torture cases; and
  - » Reports and recommendations drawn up by government or by national or international organisations on the topic of torture and torture rehabilitation.

- **What does torture look like in the national context?**
  - » Who is tortured or who have been victims of torture historically?
  - » Who currently commits acts of torture or who has historically committed acts of torture?
  - » What forms of torture are used and have been used in the past? Are the forms of torture being reported, including forms of torture that people do not speak about or that are hidden? Is torture condoned or institutionalised by law or practice?
  - » What are the attitudes and cultural understandings of different groups with respect to torture? Groups with different interpretations of torture could include the general public, government, civil society, religious groups, and community or cultural leaders.

- **What response has there been to torture?**
  - » Gaining deeper insight into the state's response to torture is vital to understanding the progress it has made in stopping the practice of torture and achieving improved access to reparation and rehabilitation.

2 | Approach to clients

In the introduction to this guide, we emphasised the importance of a rights-based approach to torture rehabilitation. The eight principles that underlie this rights-based approach are:

 1 **Client-led**	 2 **Holistic**	 3 **Safety-focused**	 4 **Culturally sensitive**
 5 **Non-discriminatory**	 6 **Ethical**	 7 **Confidential**	 8 **Contextually relevant**

Global standards on torture rehabilitation services

In 2020, the General Assembly of the IRCT adopted the first global standards on torture rehabilitation services. These standards specify what is required from the international donor community and those who work with torture victims to ensure that victims receive quality support. The global standards on torture rehabilitation services can be found on the IRCT's website: https://irct.org/uploads/media/IRCT_Global_Standards_on_Rehabilitation_of_torture_victims_2020.pdf.

All clients should be approached with care, respect, and in ways which always ensure that their dignity is maintained.

The principles underlying the rights-based approach are of the utmost importance when working with any person who has been a victim of torture, either directly or indirectly. Keep the following considerations in mind when you are providing care for someone who has experienced torture:

- Service providers are in a position of authority over those whom they serve. Victims of torture may view a service provider as an authority figure and, due to their experiences of torture, unwittingly start to see similarities between those who tortured them and the service provider.
- Service providers, including interpreters, may also share other similarities with perpetrators, such as being of the same cultural background, tribe or gender. This can create an immediate distrust or fear of service providers. In contrast, service providers may have similarities to their clients which could make it personally or culturally difficult for the torture survivor to trust and share information with the service provider.
- Torture rehabilitation services can sometimes be very limited in scope – leaving torture survivors with limited options. This may lead torture survivors to feel disempowered and unable to express

their concerns, and, ultimately, compelled to resign themselves to not being able to access other services and of having to accept the narrow service opportunities that they currently have.

- Torture involves committing and being subjected to horrific and unspeakable acts. To 'speak of the unspeakable' can be very challenging, and even finding the words to describe the acts can be difficult. Moreover, torture survivors may have experienced the worst of indignities, including sexual torture and humiliation. Speaking about these experiences may be extremely difficult.
- Torture survivors may experience fluctuations in their mood as well as confusion, frustration and anger. To service providers who do not understand these behaviours, they may come across as aggressive or uncooperative.
- The mental and physical injuries torture survivors have sustained as a result of torture may impede their ability to access, and participate in, rehabilitation services.

Gladys

Gladys had been in psychotherapy as part of her torture rehabilitation for two years. On many occasions, Gladys had told her psychologist that she considered her a friend and family member because she had told her things about her life that she had never told anyone. At the first interview, Gladys reported that her sister had been gang-raped by soldiers in front of her family, and that her sister was incredibly ashamed because their father was present and had witnessed the rape. Something about the way that she described the incident made the psychologist think that Gladys may have been speaking about herself. However, when the psychologist asked her about this, Gladys denied having ever experienced rape. Several months later, while being interviewed by a lawyer for her Refugee Appeal Board hearing, Gladys finally disclosed that she had been gang-raped on two separate occasions by soldiers. The lawyer had made it clear that she needed to provide all information about her experience of torture correctly if she hoped to win the appeal case and so be classified as a documented refugee. She reported that she was so ashamed that she did not want to even admit that it had happened.

Empathy

Service providers should approach torture survivors with empathy. Empathy is 'the ability to communicate an understanding of another person's experience from that person's perspective'.[18] This necessitates being non-judgemental, open and approachable, gentle and patient, and providing appropriate care, treatment and interventions. It requires you to consider how torture survivors see the world and how they might be feeling, and to communicate that understanding to them. This is essential in helping to validate the survivors' experiences and to normalise their reactions to the traumatic events which they have endured.

18 British Association for Counselling and Psychotherapy (BACP). (2018). *Ethical Framework for the Counselling Professions*. Retrieved from: https://www.bacp.co.uk/media/3103/bacp-ethical-framework-for-the-counselling-professions-2018.pdf.

In order to convey this understanding, one must learn: to be non-judgemental; to listen carefully to what the other person is saying; to acknowledge their thoughts and feelings; to pay attention to your tone of voice and choice of words; and to be present to bear witness to their personal story of trauma.

Non-judgemental: This means accepting the person as they are, and accepting what they say as the truth. This is especially important when people are from vulnerable and marginalised groups, such as sex workers, people from the LGBTQIA community, child soldiers and asylum-seekers. Being non-judgemental also means examining your own prejudices and limitations, and ensuring you feel the same empathy for every client, regardless of who they are or what they have experienced.

Listening: Anyone who works directly with torture survivors should master basic listening skills. These skills include reflective listening, open questioning, paraphrasing and using positive body language. Allow extra time and space to listen to clients who have experienced torture.

Acknowledging: 'Acknowledging' means showing through your words, actions and responses that you are hearing and accepting who they are and what they have to say to you. Let the person know that you understand that receiving services can be difficult.

Engaging victims of suspected sexual torture:

- Try using indirect questioning, for example: 'Many of our clients have told us they were forced to take their clothes off. I'm wondering if you had the same experience.'
- Ask about cultural perceptions of sexual torture, for example: 'In your culture, community and/or family, what do people think about rape?'
- Provide education, and offer or suggest broad screening tests or referrals for sexually transmitted infections and pregnancy.
- Check with the person who they feel comfortable working with. They may prefer someone of a different gender or age to the perpetrator, someone who is the same age and gender as them, or someone who is entirely different from them.
- Make an effort to accommodate clients with special needs, including children, people who are living with disabilities, and people from the LGBTQIA community.

Careful phrasing and trauma-sensitive questioning: For those who have experienced torture, there can be a range of possible triggers (e.g. smells, sounds, thoughts, emotions, people or places) which remind them of their experiences of torture and thus activate their trauma responses. As a service provider, you need to be aware of the tone of your questions and the words that you use to ensure that they are as sensitive as possible, while still addressing the trauma.

Bearing witness: It is extremely difficult for torture survivors to express what happened to them. When they share details about their experiences of torture, others often respond with horror or disbelief. As a service provider, you have the opportunity to bear witness to the torture survivor's personal story and the trauma which he/she continues to endure. It is one of the most relieving things for victims when they encounter someone who carefully listens to their stories without being judgemental.

3 | Using interpreters and same-language support

Language can be one of the first barriers that people face when accessing torture-related services. Consequently, language support is vital in all cases where there are language-based communication barriers between the person receiving services and the service provider. This support can be provided by professional interpreters or other forms of language support such as intermediaries, community liaison workers, emotional-support workers or other cultural-support workers.

Selecting the right language support

There are many things to consider when deciding what language support will be required. These include technical needs, availability, cost, and client comfort and security. The distinct roles of the service provider and the interpreter must always be clearly defined, and special consideration should be given to the situation where an interpreter is also a torture survivor. The use of language and communication support is an extensive area; however, some of the most important considerations are described below:

Technical needs: In some cases, professional and/or specialist interpreters will be required. Their specialist expertise may be necessary when speaking to a client about his/her medical conditions, or when the details of a legal case are discussed or presented. For example, courts may want proof that a registered professional was used in order for them to be confident that the correct information was recorded. This is important for service providers to keep in mind, not only for their own protection, but also for that of their client.

Availability and cost: Some organisations may not be able to cover the costs of interpreters, or may be confident that in-house staff or a client's family members or friends can provide interpretation services. It is not recommended to use a family member or anyone who is known to the client. Not only do family members not have the recommended training, but they are also not bound by the rules of professional conduct, such as maintaining confidentiality. The service provider cannot know how family dynamics are influencing the client's interaction or level of comfort with the situation.

Where possible, any language-support person should have professional training and experience, and be offered continued professional support. It is the responsibility of service providers to ensure the comfort and safety of their clients, including recognising when the use of an interpreter is not working well and deciding to end the session or to seek another option.

Gabriel

Gabriel is half Rwandese and half Congolese. His father, a supporter of the Kabila government, was brutally murdered because of his political views. Gabriel was also attacked and, fearing further attacks, decided to flee to South Africa. Gabriel was able to access psychotherapy at a trauma clinic in South Africa. Still, he needed an interpreter, as he was unfamiliar with the local languages. Because there were tensions between Rwanda and the DRC, and Gabriel was half Rwandese, he did not feel comfortable speaking about certain things in front of the clinic's Congolese interpreter. When asked if he wanted to replace the interpreter with a different one, Gabriel refused, as he believed that this would make the Congolese interpreter suspicious.

Client comfort and security: Some clients may prefer an interpreter from the same tribe or of the same religion, or someone who shares the same experiences or background, because they feel that this would make it easier for them to trust the interpreter and to develop a good working relationship with him/her. Conversely, other clients may refuse to work with an interpreter who is in some way similar to themselves. For example: clients may feel that an interpreter has traits that are similar to those of

their torturers; the interpreter may have a tribal or family relationship with the client; or there could be any of a number of attributes which may make the person feel unsafe. When selecting interpreters, carefully consider matters such as gender, dialect, tribal issues and religion. Where possible, the referrer or the clients themselves should be asked if there is a particular profile of interpreter that they prefer.

Richard and his family

Richard was captured and tortured by soldiers in the DRC for marrying a woman, Helen, who was not from his tribe. Helen's family was furious and decided to punish Richard by asking relatives in the military to capture him and torture him. To get her husband released from detention, Helen decided to go to the military base where he was held in order to negotiate with the soldiers. They forced her to have sex with them, and, as a result, she contracted HIV. Richard was released from detention shortly afterwards and fled to another country to evade further persecution. It took two years before Richard, Helen and their two sons were able to reunite as a family. Helen was pregnant with their third child, a girl, when Richard left the country. By the time they were reunited, their daughter was two years old, and their two sons had grown up.

Due to the torture which Richard had endured, he developed PTSD. His children, of course, did not understand this – all they knew was that their father did not sleep, and, when he did, he woke up screaming. At times when Richard spoke to his children, he did not make sense to them, and at other times he yelled at Helen. Richard sometimes disappeared for hours or days on end, and there were days when he just cried.

Watching Richard suffer was hard on the family, yet they were also scared of him, and, at the same time, they also had to worry about food, school and shelter. Although Richard wanted to provide for his family, his illness always got in the way. This frustrated Richard greatly. Richard was angry most days because he could not afford to buy food, clothes, school supplies and other necessities for his children. He could not understand why his children were not listening to him or why they were scared of him. The youngest, whose paternity was questionable because of the military gang rape two years earlier, was especially afraid of Richard.

Helen and the children kept pulling further away from Richard because of his violent outbursts. Their home had become a scary place whenever he was around, because they never knew what he was going to do. Richard did not feel safe with himself, and the whole family did not feel safe around him. Their eldest son, John, felt the need to protect his siblings and their mother from their father – the man whom they did not recognise anymore. He looked like their father, but he certainly did not act like their father.

Richard was eventually hospitalised in order to receive treatment for HIV-related conditions and his mental health. However, he refused medication because he still could not come to terms with what had happened to him.

Defining roles: Interpreters may have multiple roles, especially if they are from the same community as the organisation's clients. Before the start of the session, the role of the interpreter should be clearly defined to clarify any potential misunderstanding. The exact role of the interpreter should also be repeated at the beginning of the session with the client so that he/she is made aware of what the nature of the interpreter's participation in the session will be.

Supporting people who are survivors: Interpreters and others who act as intermediaries may be torture survivors themselves, or personally know people who have gone through similar experiences. Service providers should be mindful of the possible risk of re-traumatisation that interpreters may experience. Even where interpreters have not been direct victims, they are also at risk of vicarious trauma due to their daily work with torture survivors. Interpreters, therefore, require the same level of support as all service-providing staff. Whilst always respecting the privacy of the interpreter, service providers must be aware of this risk and ensure that interpreters have access to ongoing support and debriefing. Additional efforts should be made to ensure that the interpreter understands the work and client group.

4 | Explaining reparation and rehabilitation to clients

Explaining rehabilitation to a client can be difficult. What has been done cannot be undone, and the idea of moving forward with recovery and life can seem incredibly daunting.

Clients may be fixated on one idea of what justice is and not consider that their rehabilitation is related to justice. Explaining reparation and rehabilitation requires understanding what the person's concept of justice is, and then (if needed) broadening this understanding to ensure that all aspects of reparation are understood.

One way to explain reparation and rehabilitation to a client is, firstly, to introduce them to the five forms of reparation; secondly, to give them a clear summary of key points which define each form of reparation; and, thirdly, to apply that definition to the individual's specific situation by asking: 'What does this mean in your situation?' The table below outlines the five forms of reparation and indicates how a service provider might explain them to a client.

Form of reparation	Key points	Case example
Restitution	Restitution entails putting the person back in the position he/she was in before the torture (e.g. out of prison, back in employment, and in his/her home with his/her family).	Restitution would mean that they stop monitoring my house and that I can work in my fields.
Compensation	Compensation has to be fair, adequate, and proportionate to the harm suffered (e.g. paying for medical expenses, loss of earnings and lost opportunities).	Compensation would cover the loss of my crops when I was unable to work, and would pay for my medication and counselling.
Rehabilitation	Restoring the person's functioning, or enabling him/her to acquire new skills, with as much independence as possible (e.g. restoring physical, mental, social, cultural, spiritual and vocational ability).	Rehabilitation would mean that my leg has healed enough so that I can work again. I would be able to sleep normally and do all the normal things in my community.

Form of reparation	Key points	Case example
Satisfaction and the right to truth	Satisfaction and the right to the truth mean that the state recognises its responsibilities, records complaints, investigates cases and prosecutes perpetrators.	Satisfaction would mean that the people who did this to me and everyone else are tried in court, and that their deeds will be known to the public.
Guarantees of non-repetition	Guarantees of non-repetition mean that the state puts measures in place to ensure that the particular incident does not happen to others, and that there is no impunity for torturers.	Guarantees would mean that any people who do this would be arrested and tried. The police would be trained to recognise this and to always respond.

Based on this exercise, the service provider and the client can work together to understand what may be possible in the client's specific case.

While discussing all five forms of reparation is essential, the conversation on rehabilitation will likely be the most important. Talking about their rights to rehabilitation, their specific needs and wants, as well as what would be possible given the national context that they are in, allows the service provider to provide appropriate services and make referrals that are in line with what clients want and need.

Rehabilitation can be subdivided into six categories. Whilst discussing rehabilitation, service providers should explore each category by asking the client: 'What do you think is needed to restore this as much as possible?' The table below lists the six rehabilitation categories, and offers practical case examples for each one.

Rehabilitation category	Case example
Physical	Physical rehabilitation would mean that I could move around by myself. It would mean that, even if I am in pain, I could still get my work done. I would need the right medication and someone to help me to find ways for my legs to move better.
Mental	Mental rehabilitation would mean I would be at peace and not feel afraid and angry. I would sleep normally and not have nightmares. I would need a professional person who knows about these things.
Social	Social rehabilitation would mean returning to my community without people judging me. I would be able to be a good parent to my children and make new friends who don't know what happened to me. I need some good people in my community to help bring me back to that.
Cultural	Cultural rehabilitation would entail people respecting me as a parent and as an older person. I would be free to speak my language and safely sit outside sharing cultural stories. I need help not to feel afraid to express my culture and to connect with other people in my situation.
Spiritual	Spiritual rehabilitation would be going back to my faith. It would be having someone to talk to about the path which I have travelled. A person who understands my spiritual or religious needs could help.
Vocational	Vocational rehabilitation would mean working in my fields again. I would perhaps need some new equipment and seeds for farming, and maybe something to help with my legs so I can move around in the fields.

Managing expectations is key to explaining rehabilitation. Service providers should identify what the client's expectations are and seek to ensure that these expectations are realistic. Some of the expectations which torture survivors typically have, and which may need to be managed are explored in the table below. Service providers should look for gaps in their knowledge so that they can respond appropriately to these expectations.

Expectation	Realistic response example	Encouragement
Reparation and rehabilitation can be achieved quickly.	Most of the time, these processes will take many months or years.	Going through rehabilitation leads to recovery for many people.
The final outcome will be a significant amount of money being awarded.	Even if money is awarded by the court, it may not be as much as hoped for, or the state or perpetrator may be unable to pay.	Even without money, the truth coming out means that crimes are no longer hidden and that there is no more impunity.
Rehabilitation will mean that life is the same as it was before.	Life may never be exactly the same as it used to be.	Even if life is not the same, rehabilitation helps to move you forward to a new chapter in your life.
If I move to a different location or country, then the situation will improve.	Leaving may not be possible for you, and, sometimes, moving to other locations can cause new difficulties.	Learning to heal and reintegrate where you are now can be a good first step, and we will be here with you.
Social assistance is needed to be able to cope.	The options for obtaining social assistance are very limited or may not be available at all.	Let's look at what you now have in your life to help you cope.

5 | Managing client expectations and dealing with challenging clients

Managing client expectations

When clients approach you or are referred to you for support services, they may have their own goals and expectations, which may or may not match the services that are available to them. Managing client expectations is one of the most important skills for service providers. Poorly managed expectations can have detrimental consequences on the well-being of clients. Clients with unmet expectations may feel angry and disappointed. Clients may also unwillingly go through difficult processes (such as psychotherapy or testifying in court), thus increasing their risk of re-traumatisation. Trust in service providers and clients' willingness to engage with future services can be affected in this process, which can have long-term effects on their rehabilitation outcomes.

Whilst not exhaustive, the following list summarises some of the key considerations that a service provider should keep in mind when managing client expectations:

- Ensure that the principles of this guide are being respected, particularly with regard to ensuring that service delivery is client-led;
- Before commencing services at regular intervals, clearly state what services you can and cannot provide, now and in the future;

- Develop joint agreements with clients in which you specify what you are working on and what you will be working towards;
- Set boundaries, including time limitations;
- Avoid bargaining with the client (e.g. Service provider: 'I will offer you legal advice if you stop complaining.') or agreeing to something that is set up by the client (e.g. Client: 'If you get me a job, my mental health will improve.');
- Emphasise when it is especially important that the client be truthful about his/her case (For example, in legal proceedings, it is vital that all information be factually correct; whereas, with other rehabilitation services (e.g. psychotherapy), the exact factual details of the case may not be as important.);
- Be clear about what will happen if you meet clients outside of the service-provider setting, especially if you are a member of the same community as many of the clients; and
- Acknowledge when you are not being effective or helpful, and know when and how to refer a client to a colleague or a different service.

Josiah

Josiah was referred for counselling services, but when he arrived for his first session, he said that he wanted support for resettlement in Europe for himself and his wife. When the counsellor explained that they were unable to assist with resettlement, Josiah became very angry. He shouted at the counsellor and the reception staff, saying that they did not care about his situation and that they were not listening to what he needed.

Dealing with challenging clients

Service providers may find some clients more challenging to work with than others. Each individual service provider may have clients whom they feel are more challenging to work with, or whom they think they are less able to assist. Every service provider should know their personal limitations and preferences and should work with their team members to complement each other's limitations and ensure balanced caseloads. More challenging clients may be better suited to more experienced service providers, or it may be more appropriate to draw up a safety plan for the needs of both the client and the service provider.

As a service provider, you must always protect yourself. Share issues, complications and problems with your peers and your organisation as quickly as you can; keep notes and records up to date; and never hide any problems, even if you have made an error.

CASE STUDY

Mr M and Mr T

Mr M and Mr T, two male asylum-seekers from Angola, were admitted to the same trauma clinic in South Africa for psychotherapy. The two gentlemen had become acquainted with each other on their journey to South Africa. When asylum-seekers arrive in South Africa, there are a number of legal criteria which need to be met in order for a person to be classified as a refugee. An asylum-seeker is only allowed to stay in the country once he/she has secured refugee status. Mr M and Mr T were both in the process of applying for refugee status; however, their prospects were not looking good.

Their admission to therapy was not reliant on their refugee status; however, Mr M and Mr T both assumed that they needed a clinical diagnosis from a clinician to strengthen their refugee application. This ended up having a significant impact on the effectiveness of their psychotherapy and their relationship with their clinician.

Based on a careful review of their cases, it became clear that the two men had an agenda that was different from the clinic's therapeutic mandate. It was decided that the issue needed to be confronted. The clinician made it clear to them that the clinic had an interest in their mental well-being and that reports concerning their mental health would be released only if requested by the relevant agencies.

This was not well received by Mr M and Mr T. They refused to accept this and became very aggressive whenever they interacted with their clinician in subsequent therapy sessions. The clinician started to become increasingly concerned for her safety. To manage this situation, the clinic manager was informed each time the clinician had a session with either Mr M or Mr T. In order to make a quick escape in the event that either client became violent during a session, the clinician also sat close to the counselling room's door and remained mindful of how she communicated with them. In the end, because the goals of the two men and the clinic were not aligned, it was ultimately decided to discharge both of them. Even after the discharge, both Mr M and Mr T still showed up at the clinic from time to time. When this happened, the clinic staff remained respectful towards them and kept reminding them of the reasons for their discharge.

Service providers should keep the following issues in mind when engaging with challenging clients:

Issues of consent and confidentiality: Legislation, age of consent, competency (where the client may not be able to give fully informed consent), and the presence of family members can complicate consent and confidentiality. Cultural issues of consent are more likely to negatively affect people with other vulnerabilities, particularly women, youths and the elderly. It can be particularly difficult when clients do not want to continue with services, despite it being clear to the service provider that the service is in their best interests. The following are some further considerations regarding consent and confidentiality:

- The law plays a large part in what confidentiality means, and service providers need to be aware of what is legal in their country;
- Where clients have fled or migrated, they may be moving from one legal system to another; hence the service provider may also need to understand the law of the client's country of origin;
- A clear explanation of consent is essential and clients need to be informed of all the available options; however, the final decision should always lie with the client;
- In most cases, the client has the final say regarding consent, and, as long as there is no legal reason to dispute this, the service provider must respect the client's decision;
- Be aware of issues such as culture, family structure and age (Sometimes, clients may need to be served separately from their family members so that they can give fully informed consent without the family's involvement.); and
- Services should not be rendered if the provider is not convinced that there is consent (e.g. if they think a person is being forced to access services).

Transfer of clients from other service providers and 'service shopping': Clients have the right to receive services from a provider of their choice, including changing services when they are dissatisfied. However, in some cases, this can lead to clients approaching multiple service providers, and services may then be duplicated, thus wasting valuable time and resources and potentially causing further harm. Whilst having a duty to respect the client, service providers also have a responsibility to be honest with their client, including disclosing if they are aware of any duplication of services and using good judgement in deciding whether or not to accept or continue with a client.

When clients are being transferred from one service to another, or when it becomes apparent that a client is seeing multiple service providers at the same time, it is recommended that service providers:

- Try to understand why the client is accessing multiple similar services;
- Always obtain consent from the client to share information with other services providers (This will allow you to openly discuss the client's case with other service providers, which will assist in decision-making. The following is an example of how this could be explained to the client: 'We can provide the best services for you if we are also talking with the different people and organisations that work with you. Can we look at a consent form regarding what information we can share?';
- Try to involve the client in the decision-making processes concerning which service is the most appropriate; and
- Develop relationships with other service providers so that issues can be discussed (This can be challenging in some contexts, for instance where providers may be competing for clients or funds; however, service providers must find a way to manage this to best serve and protect their clients as well as themselves.).

Transient clients and clients who are unable to return: Some clients may be unable to commit to a course of treatment or support. This is especially true of clients who frequently move due to insecure living arrangements; of those who are on their way to another country or area and who are merely transiting through the service provider's area; of clients who have to travel long distances to reach service providers; as well as of clients with difficult home or work environments which prevent them from using services regularly.

The following is recommended for service providers who are working with transient clients or those who are unable to return for further services:

- During your first contact session with the client, try to establish if he/she will be able to return for follow-up services (Find out how much time the client has so that you can work with him/her on a plan that will allow you to use the available time optimally.);

- Screen for any emergency needs, such as safety, protection, suicidality, and serious health concerns;
- For clients who are not returning, ensure that their expectations are managed, keeping in mind that it is not possible to resolve complex client issues in a single session; and
- Follow up with clients who indicated that they would be returning for more sessions, but who subsequently fail to attend these sessions (This is especially important in cases where safety concerns have been noted. Document all your follow-up attempts.).

Acknowledge that the client is a person with self-agency. If a client does not attend a session, one has to accept this. Some people who have experienced torture will get worse before they get better, and they may feel unable to engage with services at a particular time. Even if they are only seen once, a positive first experience could increase the likelihood of them returning for services in the future.

Highly at-risk clients: Clients who are considered to be at risk include clients who are engaging in self-harm and suicide attempts; clients who have serious medical and psychiatric issues; and clients who are living in an unsafe environment, including those who are homeless, those experiencing family violence, and those living in detention. The complexities of managing highly at-risk clients are beyond the scope of this document. However, some of the most basic steps to consider include the following:

- Ensure that your organisation has clear policies for at-risk clients (If it does not have such policies, raise this as an issue or work with your organisation to develop appropriate policies.);
- Ensure that there are clear referral systems for clients who are identified as being at risk;
- Where clients are at risk of immediate harm, explore all options for removing them from the dangerous situation or location; and
- Where possible, service providers should receive specific training on working with at-risk clients – at a minimum, each provider should be able to do a risk assessment.

Service providers must also consider their own protection and safety, including their physical safety when they intervene, their emotional safety in working with at-risk clients, and their legal safety should the client come to harm.

Highly distressed clients: Service providers should try to anticipate and prepare themselves for instances where they will have to work with a highly distressed client.

- Crying a lot: If a client is distraught, crying a lot and seemingly inconsolable, try to set up counselling support for the client as soon as possible. Be patient and remind the client that the counselling support will be their safe space to express their feelings.
- Aggression and violence: Stay calm and remove yourself from the space if a client becomes uncontrollably angry or violent. Service providers should have a plan in place which specifies their options to de-escalate the situation and protect themselves and other clients from harm. The plan could include details on how to leave the room quickly and safely when needed; when to have a second person in the room if a client is known to be aggressive and violent; when to involve law enforcement without creating additional risk; and how to terminate services and refer aggressive clients.
- Clients in extreme poverty: Clients who are struggling with long-term unemployment, food insecurity and homelessness may be so overwhelmed by these survival challenges that they are unable to effectively engage with rehabilitation services. Service providers are encouraged to be familiar with the options that are available in the client's area, including where clients could go to seek support from local structures such as churches, community organisations, traditional bodies and community leaders.

CASE STUDY

Margaret

Margaret came from an affluent family in Rwanda. One day, rebels attacked their home and murdered both her parents as a way to punish the family for her father's political views. During the attack, Margaret was kidnapped by the rebels and taken into the mountains where she was made to be the rebels' 'wife'. This entailed being forced to work for them and being raped repeatedly by them. After several years, Margaret was able to escape and fled to South Africa with her husband and three children. However, her husband later abandoned the family, leaving Margaret to raise their children on her own.

The ordeal left Margaret severely traumatised and disconnected from those around her. Consequently, she sought psychotherapy treatment at a trauma clinic. Her clinician noted that Margaret was highly uncontained in sessions, falling to the floor, wailing, grasping the clinician around her legs, and screaming at the top of her voice. Her children accompanied her to the psychotherapy sessions. The clinician also noted that the children appeared hypervigilant and fearful, and were completely silent throughout the sessions. Whenever Margaret started to cry, her 15-month-old daughter would climb onto her lap and stroke her face, trying to soothe her. However, Margaret never responded when her daughter did this.

In addition to not being present for her children, the clinician further noted that Margaret neglected her children because she was too afraid to leave the house to find work. For example, her youngest daughter had such a severe nappy rash that Margaret, at one point, thought that the girl might have been sexually abused. To investigate the suspicion of sexual abuse, the clinician referred the girl to the hospital for a medical examination, which came back negative for sexual assault.

Since her husband had abandoned the family, Margaret decided to appoint their 10-year-old son as the new head of the household and started calling him 'Pappa'. The son, in turn, was clearly terrified and overwhelmed at the expectation of being the provider of the family.

How to get informed consent

Tell respondents how you will use their data and why you need it:

- Explain. Clearly explain to clients how you will use their personal information.
- Provide a choice. Give clients a choice as to how their information is used and tell them whether that choice will affect the services offered to them.
- Meet expectations. Only use personal information in ways that clients have consented to.

Cultural differences: Cultural beliefs may influence how people respond to service providers from different genders, age groups or ethnicities, and may explain a client's preference for one service provider over another. Superstitions, as well as the belief in, and practice of, witchcraft and other cultural–spiritual traditions, may influence how a client engages with rehabilitation services. Service providers are encouraged to be accepting of alternative belief systems and, instead of fighting these, to use them as a tool for rehabilitation. It is essential to engage with traditional healers and cultural leaders, as they can sometimes serve as gatekeepers to successful service provision.

6 | Responsible record-keeping and data management

Responsible record-keeping and data management involve:

- Treating the information collected and recorded with respect and upholding the rights of the people whose information it is; and
- Being responsible and mindful of how your clients could be affected by your record-keeping, data collection, data handling, data storage, and data-usage practices.

If available, applicable local regulations and confidentiality policies should be understood and incorporated in your organisation's operations. Organisations should have internal procedures which cover the safekeeping of personal information. These procedures should include details about: (a) how data are collected; (b) how data are handled and stored; and (c) how data are used.

During **data collection**, *planning, risk assessment and informed consent* are essential elements to consider in order to minimise risk and unintended consequences. Every new client should be informed of why you are recording their information, how it will be stored, who will have access to it, and how it will be used. This is an important step to protect the client's right to privacy and their right to be informed. The client should provide you with their explicit and, where possible, written consent before any information is recorded. It is possible to have different levels of consent. For example, a client may provide consent for the service provider to write down their information in their client file. However, they may not give consent to have their information used for research or advocacy purposes.

Handling and storage include ensuring *safe data transfer*, *restricting access and securing data storage and sharing*. If data are moved or transferred digitally, through portable data-storage devices or by moving hard-copy records, care should be taken to ensure that files are not lost, damaged, stolen or exposed to unauthorised access. Digital devices, including computers, laptops and tablets that house or are used to access client information, should be encrypted.

It may be useful to conduct an assessment of where and how information is stored, and of who has access to it. For example, if paper records are used, assess whether they are stored in a safe and secure location. If digital records are used, ensure they are encrypted or at least password-protected. Backups of the data should be made and kept at secure locations. The level of protection can be increased through restricted access to the storage systems, so that only authorised personnel can access the data. Finally, it is important to consider if you will need to share client data for purposes of case management, donor reporting, monitoring and evaluation (M&E), research or advocacy. Clear systems and procedures which stipulate when, how and with whom data will be shared, both internally and externally, should be used to inform data sharing.

Consideration should also be given to whether the sharing of data could result in it unintentionally being traced back to an individual client, which may jeopardise their anonymity. For example, there may be identifying characteristics which, when put together, could lead to the person being identified, even if their personal information has been anonymised. Finally, policies on the retention and destruction of client data should be in place and should be aligned with national laws.

Confidentiality: Dos and Don'ts	
Do:	**Do NOT:**
• Safeguard the confidentiality of all person-identifiable or other information that you come into contact with; • Be aware that any recorded information about an individual should be protected, including notes and diaries; • Clear your desk at the end of each day, keeping all portable records containing person-identifiable or confidential information in recognised filing and storage places that are locked at times when access is not directly controlled or supervised; • Switch off computers with access to person-identifiable or confidential information, or put them into a password-protected mode, if you leave your desk for any length of time; • Ensure that you cannot be overheard when discussing confidential matters; • Where necessary, question and verify the identity of any person who is making a request for person-identifiable or confidential information, and ensure that they have 'a need to know'; • Share only the minimum information necessary; • Take care when sending correspondence by way of a fax or an email, and, where applicable, retain the delivery or 'read' receipt; • Transfer person-identifiable or confidential information securely (e.g. by using email encryption); • Seek advice if you need to share person-identifiable information without the identifiable person's consent, and record the decision and any action taken; • Report any actual or suspected breaches of confidentiality; and • Participate in induction, training and awareness-raising sessions on confidentiality issues.	• Share passwords or leave them lying around for others to see; • Share information without the consent of the person to which the information relates, unless there are statutory grounds to do so; • Use person-identifiable information unless absolutely necessary; anonymise the information where possible; • Collect, hold or process more information than you need; • Keep data for longer than necessary; • Think that comments or notes you make will only be seen by you; individuals have the right to access information about them by making a Subject Access Request (SAR); • Leave information unattended on your desk; • **NEVER leave files or information in the car, on the bus or at home – ensure that information is not accessible to anyone else but YOU.**

Indicators relating to torture victims' right to rehabilitation

The International Centre for Health and Human Rights (ICHHR) has developed a global indicator framework regarding torture victims' right to rehabilitation. This framework allows organisations that are involved in torture rehabilitation advocacy to:

- Measure the extent to which states are implementing the right to torture rehabilitation;
- Assess the progress that states have made in providing and giving torture victims access to their right to rehabilitation; and
- Promote constructive discourse between state and non-state stakeholders in order to advance the practical implementation of torture victims' right to rehabilitation.

The IRCT, ICHHR, and global members of the IRCT are currently working together to develop national indicator frameworks which reflect the unique contexts of different regions and countries. More information about this project can be found at: **https://irct.org/campaigns/rehabilitation-indicators**.

7 | Supporting people through the process

When engagement with the client, including the initial client contact, assessment and early referrals, has been supportive and client-led, a trust relationship can be built between the client and the service provider. Sometimes, the service provider is the first person who has heard the client's full story of torture, which can intensify this relationship.

David

One night, the police burst through David's front door, shouting at him and his small children to get out of the house. Although they did not have a search warrant, the police immediately started to search through David's house, breaking several household items in the process. The police harassed David and his family but never stated what they were looking for. David's children were very young at the time and did not understand what was going on.

The police eventually locked the house, arrested David and took him to the police station for further interrogation. David's children were left behind outside the locked house.

David was detained at the police station in a small, congested cell without access to food, water or a toilet. David was kept in this cell for seven days. After a gruelling interrogation which lasted nearly 36 hours, David was transferred to prison. David now needs not only legal support, but also medical and psychological assistance.

The process of rehabilitation is long, complicated, and likely to involve both physical and mental strain. The critical role of service providers is to 'walk alongside' their clients as they progress, and to maintain a supportive relationship. This involves:

- Being available for appointments with your clients – ideally, this should be face to face, although telephone, email or online chat and video conferencing can serve as a substitute where face-to-face contact is not possible;
- Keeping up to date with clients' progress with prior referrals and other service providers;
- Ensuring your clients have a personal safety plan which addresses any previous, current or future possible safety or security risks, including protection from the perpetrator, safety from the state, safety from dangers in the family or community, and economic safety, including food security; and
- Ensuring your clients have a personal well-being plan that identifies risks to their psychological well-being, such as managing triggers which remind them of the torture and what they can do when they are distressed or concerned.

In addition to referrals, some of the ways in which service providers can 'walk alongside 'their clients in different areas of their rehabilitation are detailed in the table below:

Service	Ways to 'walk alongside' your clients
Legal	• Ensuring legal processes are well understood; • Talking about concerns, including pre- and post-court counselling and support for the client, and about what the course of action will be if the court outcome is not favourable to the client; • Attending court proceedings or hearings with the client; • Assisting the client to prepare for any possible media attention; • Helping clients talk to family or community members about their legal case; • Assisting clients to follow up on any court findings or other outstanding legal issues; and • Visiting and helping clients if they are detained, including ensuring that their basic needs are provided for, that communication is facilitated, and that their family is supported.
Medical	• Ensuring that clients understand medical processes; • Supporting clients to manage pain or physical discomfort; • Assisting clients so that they can perform activities related to daily living (This may include providing mobility support and helping them with practical advice on how to make changes to their home in order to enhance their ability to move in and around their home.); • Assisting clients with guidance and support on how they should adapt to permanent disability; and • Helping clients to talk to family or community members about changes to their physical health.

Service	Ways to 'walk alongside' your clients
Mental health and psychosocial support	• Ensuring that clients understand the nature and purpose of counselling as well as the relevant psychological changes or processes that they may experience during counselling; • Ensuring consistency of counselling appointments (e.g. meeting every second day or meeting on the same day and at the same time every week); • Supporting clients to manage mental health symptoms; • Assisting clients to engage in activities that help to strengthen their mental health, such as hobbies, employment, or becoming more actively involved in their family and community; • Assisting clients to talk to family or community members about their mental health; • Helping clients to discover their strengths; • Assisting clients to find resources and support systems which are already available in their community; and • Helping clients to make connections with others who may have experienced similar events (when appropriate).

8 | Assessment and referral

Assessing a person who has experienced torture entails determining: the details of the torture experience; what the client's needs and wants are; as well as what possibilities they have for accessing appropriate rehabilitation services. There are some specific issues relating to medico-legal assessment that need to be considered in order to ensure that the right to rehabilitation is realised for your client.

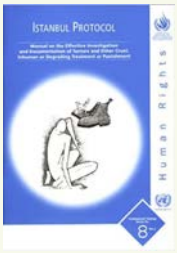
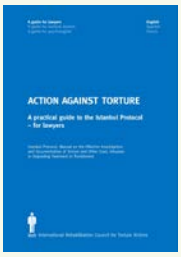
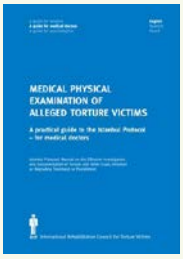
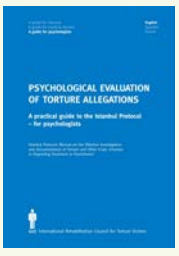
Ruth

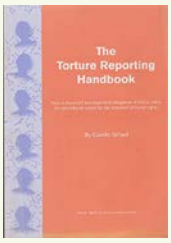
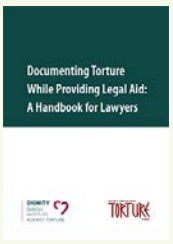
Ruth is a legal professional who regularly works with torture survivors. One day, a severely injured client walked into Ruth's office seeking legal assistance. The client was bleeding, appeared disoriented and alleged that he was tortured by soldiers. Ruth immediately referred the client for medical and psychological assistance. Ruth realised that she would not be able to take useful and reliable legal information from the client in the state that he was in at that moment. The first priority for him would be to obtain medical and psychological care. Ruth followed up with the client once he had been treated by doctors and was considered stable. This decision not only benefited the client's health and well-being, but also ensured that all relevant medico-legal evidence was collected and documented responsibly and accurately.

Medico-legal assessment

Appropriate assessment of the medical and legal situation of each person is vital at the earliest stage possible, as this evidence will form the basis of any future legal cases. There are many technical resources which can be used to investigate and document torture, or to gain a better understanding of what is required as regards further documentation and investigation. Whilst there may still be different considerations on how to document evidence, based on the local context and culture and the way the service is operated, all legal, medical and mental health staff should carry out assessments in a way that is consistent with the following well-established resources:

Click on the image of each resource for a hyperlink to the document.

Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment is a UN publication which outlines the legal, physical and psychological investigation of torture. It is widely recognised and is aimed at technical professionals.	
Action against Torture: A Practical Guide to the Istanbul Protocol for Lawyers is an auxiliary to the Istanbul Protocol. It provides guidance for lawyers who investigate alleged torture and describes various relevant legal considerations.	
Medical Physical Examination of Alleged Torture Victims: A Practical Guide to the Istanbul Protocol for Medical Doctors is an auxiliary to the Istanbul Protocol. It provides guidance for doctors who investigate alleged torture by giving detailed descriptions of the different types of torture and their physical impact.	
Psychological Evaluation of Torture Allegations: A Practical Guide to the Istanbul Protocol for Psychologists is an auxiliary to the Istanbul Protocol. It provides guidance for mental health professionals who investigate alleged torture by considering the unique role of the psychologist and of psychological evaluation.	

Torture Reporting Handbook: How to Document and Respond to Allegations of Torture within the International System for the Protection of Human Rights is a reference guide which can be used by anyone, but, in particular, by human rights organisation and NGOs, that encounter allegations of torture. It includes checklists and examples of how to document torture cases.	
Documenting Torture while Providing Legal Aid: A Handbook for Lawyers is aimed at lawyers and other human rights workers. It focuses on how to document torture in places of detention.	
Forensic Examination Missions by Medical Teams Investigating and Documenting Alleged Cases of Torture is a practical manual for agencies and individuals carrying out medical missions where torture is alleged. It also covers planning and safety considerations for such medical missions.	

Referrals

During your first contact session with a client, an assessment should be done to determine what services they are currently accessing, and what services they need or want but are not presently receiving. Making a referral essentially involves identifying and filling those 'gaps' between what the client needs or wants and what the client is currently receiving.

Service providers should network and build strategic partnerships with each other. This will not only help them to develop a referral network which consists of reputable service providers, but will also allow them to work closely with those partners through shared case management and collaborative projects.

Clients should access referrals themselves unless there are any real barriers such as discrimination, disability, financial limitations, safety concerns or language barriers which prevent them from accessing such services.

Referrals should always be made for a specific reason that will benefit the client. Service providers must always explain to the client why the referral is necessary, why the client is being referred to a service provider, and what the client can expect to happen next.

Wherever possible, all referrals must be client-led, meaning that referral options should be explained to a client, whereafter the client should then take the lead in deciding which referrals should be made and when the best time would be for him/her to access the selected service providers.

The Psychosocial Rights Forum – building strategic partnerships

A group of organisations that worked predominantly with refugees and asylum-seekers came together to form a network named the Psychosocial Rights Forum. The Forum started out as a space in which to manage the most complex, challenging and needy torture survivor cases that organisations in the Forum had to deal with. Over the years, the Forum expanded by developing a more robust referral network and greater cross-collaboration between member organisations.

The Forum provides a variety of services, such as mental health and psychosocial support services, legal services, and social assistance. The group of organisations decided that they would be able to make more of an impact on the lives of torture survivors if they worked together.

Instead of clients having to travel from one organisation to the next in search of all the services which they require, the collection of Forum services caters for all their needs. Access to services for torture survivors is thereby improved, and referrals are also easier to make and manage.

The Forum has grown into a platform for advocacy, the shaping of public discourse and knowledge sharing.

Service providers	Who are they?	What can they do?
Legal	• Lawyers • Legal advisors • Legal referral agencies • Human rights bodies • Paralegals	• Give people advice on whether they have a legal case; • Document the legal aspects of the case; • Assist people to prepare for court; • Represent people in court; • Follow up on outcomes from the court; and • Assist people to understand their rights and violations of those rights.
Protection	• Lawyers • The police • Protection services • Child protection services	• Ensure that the person is safe from further threats, intimidation or violence (including retaliation); • Receive and act on any reports where safety has been threatened; • Protect children by ensuring that their basic needs are met and that they are safe; and • Document any protection concerns.
Medical	• Medical doctors • Surgeons • Nurses • Paramedics • Clinicians • Community healthcare workers	• Provide medical assessment and treatment of any physical injuries or illnesses which have resulted from torture, or which have been exacerbated by torture; and • Provide education to increase understanding of the physical consequences of torture.
Forensic	• Forensic pathologists • Doctors • Coroners • Psychologists • Psychiatrists	• Document evidence of torture (including those instances where death has occurred); and • Make affidavits.
Occupational	• Physiotherapists • Occupational therapists • Art and craft therapists • Social workers • Job skill trainers	• Assist torture survivors in restoring and improving their functioning and in developing skills which will allow them to work and engage in their daily activities.
Psychological and mental health	• Psychologists • Psychiatrists • Therapists • Counsellors • Social workers • Community care workers	• Provide psychological assessment and mental health treatment; • Provide a range of therapeutic and counselling services for individuals, families and communities; • Assist people to return to their families and communities; and • Facilitate access to psychiatric assistance where needed.

Service providers	Who are they?	What can they do?
Community psychosocial support	• Community psychosocial support can be provided by any of the psychological and mental health professionals, as well as by specific psychosocial support services and by community support workers and support groups.	• Psychosocial support assists individuals and communities to heal from their psychological wounds and trauma and ultimately helps to rebuild social structures after torture. It can help transform people into active survivors rather than passive victims.
Spiritual	• The clergy • Sheikhs • Elders and respected community or family members • Religious institutions • Traditional healers	• Spiritual leaders can provide guidance and comfort to torture survivors, and can assist those whose spiritual values, moral principles or belief systems have been weakened by torture. Services may be religious or non-denominational; and • Traditional healers and spiritual counsellors can provide complementary treatments.

9 | Rehabilitation beyond the individual

Holistic service provision includes ensuring that services are provided at the individual, family, community and societal levels. While many services are focused on a single level, opportunities to engage at other levels should also be sought.

The figure below outlines some of the rehabilitation services which can be provided at the family, community and societal levels. Service providers should consider these and other rehabilitation services, and seek ways in which to work across multiple levels.

10 | Community reintegration

At a later point in the rehabilitation process, the client will be integrated back into the community. It should be clear from the beginning of the rehabilitation process that reintegration into the community will be one of the key outcomes of rehabilitation. Service providers should work with their clients to map out formal and informal structures in their communities that will serve as a support system for the client. Service providers should make a deliberate effort to reach out to these support structures with relevant information about torture, the effects of torture on victims, and the kind of support that victims need for complete integration into society.

Some of these support structures that may be targeted could include schools, places of worship, local governments, cultural leaders, traditional healers, opinion leaders, local civil society organisations (CSOs), healthcare service providers, the local police or security firms, unstructured local courts (where they exist), and the wider community.

FAMILY REHABILITATION

Engaging the family at all levels of care;

Recognising that family members can be 'secondary victims' and accordingly providing services and support for them;

Providing parenting skills orientation for parents; and

Educating the family about the effects of torture and how to support and meet the needs of affected family members.

COMMUNITY REHABILITATION

Awareness-raising regarding torture and the effects thereof (where appropriate);

Awareness-raising regarding social justice and well-being;

Providing services at a community level;

Undertaking community events that encourage connectedness;

Undertaking community events which create safe spaces for community members to remember and discuss collective traumas; and

Ensuring that community services are open and accessible to all community members.

SOCIETAL REHABILITATION

Participating in national truth-seeking and reconciliation activities;

Ensuring that truth and reconciliation processes take place from the local to the national level (healing should ideally take place on multiple levels);

Promoting participation in democratic exercises, such as voting;

Lobbying and influencing policy and legislation;

Working with national ministries or departments to contribute to perpetrators' rehabilitation and trauma healing;

Contributing to international mechanisms, such as UN shadow reports; and

Publishing reports for public use.

> As service providers, we hope that torture survivors will be welcomed back into the community with a sense of trust, which was previously destroyed by torture.
>
> *– Mental health practitioner*

Ways in which the community could be made aware of torture and torture rehabilitation could include:

- Organising meetings with the representatives of the support structures mentioned above (These meetings can serve as ways to build relationships with community leaders and gradually educate them on torture and how they could support torture survivors as they continue with their rehabilitation.);
- Facilitating community dialogues in order to provide community members with information about torture and support the identification and referral of torture victims;
- Utilising local media channels, such as radio, community newspapers and social media to spread awareness about torture; and
- Providing torture rehabilitation services in affected communities.

> It is important to examine and normalise the community's reactions to deal with the silencing and shame that comes with torture. Family and community members around the client should be assisted so that they can come to understand what has happened, the circumstances and its effects. This can help the community to acknowledge and own the experience (versus denying and disowning it), with the long-term aim of advocating for the prevention of torture.
>
> *– Mental health practitioner*

Clients tend to benefit significantly from the support which they receive from other torture survivors. Receiving support from others who endured similar hardships can help to lessen the isolation felt by the client. It can assist clients in learning from each other about how to deal with the effects of torture. Sharing personal experiences with others also helps to normalise the psychological and social consequences of torture by helping torture survivors to better understand their own thoughts, feelings and reactions. This helps them to realise that it is normal, in the circumstances, to think, feel and act in those ways, that they are not alone in this regard, and that they have nothing to be ashamed of. The presence of such a support group in the community will encourage clients to regain the trust in others which they lost due to torture and will promote their healing and rehabilitation.

Family members can also benefit from the community's support, as they have also been affected by torture, be it directly or indirectly. The support structures listed above can be an important source of much-needed support for them as well.

While working with communities can be deeply rewarding, it is not always easy. The following list summarises some of the challenges that service providers often experience when engaging in community-reintegration work:

- The lack of referral resources (such as healthcare specialists or legal experts) in the community;
- The lack of leadership, whether traditional or political (If a community does not have an apparent leader or where the leader is unavailable, it can be challenging to gain access to the community and effectively identify and address the community's needs.);
- Being seen as an outsider and not being able to become part of the community;
- The stigmatisation of torture victims, which leads to the silencing of those affected by torture and any discussion on torture and CIDTP;
- The lack of social cohesion in a community due to fragmentation;
- In poverty-stricken communities, where torture tends to be more prevalent, socio-economic hardships compel community members to prioritise survival over all other concerns (In such situations, it may be difficult to make people aware of how torture affects their lives.); and
- The apathy in a poverty-stricken community may be so overwhelming that the community may feel too powerless and hopeless to do anything about the situation.

Community dialogues – discussing and normalising a community's reactions

Organisation A recently started to hold weekly community dialogues in a community where torture at the hands of the police remained an ever-present source of fear for many. While the initial turnout at the dialogues was small, with only a handful of community members huddled together in the local primary school hall in the beginning, the dialogues gradually started to attract more people. One day, after an information session on torture, community members were given the opportunity to share their personal experiences and feelings about torture. Peter, an unemployed youth, responded that he was sceptical about the purpose of the dialogues, as he felt that it was hopeless to try to change the status quo. He said that their community was vulnerable, struggled with poverty and other socio-economic ills, and was essentially powerless against the police. Nina, a local teacher, agreed and reluctantly shared her personal story of how her son was beaten by the police in front of their home for no apparent reason. Although the fact that it had happened angered her and still haunted her daily, she admitted that she felt ashamed at what had happened and that she would not dare to report the incident, as she was afraid and distrustful of police officers and of state authorities in general. Maria, a retired factory worker, added her voice to the conversation by saying that she believed that young men on the street corners who were assaulted by the police were getting what they deserved and that they should stop loitering in the streets if they did not want the police to beat them.

While some of the community members gasped in bewilderment at Maria's blunt statement, others nodded their heads in agreement. It was clear that the long-standing torture and CIDTP that the community had been experiencing over the years had rendered it fragmented. Community members blamed torture victims for what had happened to them. Torture victims, in turn, felt ashamed, blamed themselves, and were afraid to report their experiences of torture to the authorities. Community members were disillusioned with the criminal justice system and had gradually become disempowered and helpless.

11 | Care for service providers

Service providers can also experience the same psychological effects as their clients. This is known as secondary or vicarious trauma and is generally well recognised in the mental health field, but less so with regard to service providers in areas such as law and medicine.

The act of working empathically with people and the continued exposure to torture narratives can build up over time, leading to a trauma response in the service provider. Some of the particular effects that service providers may experience include:

- Disbelief or denial of their own symptoms, as they may view themselves as strong or resilient, or may not see their suffering as significant compared with that of their clients;
- Increased frustration with the limitations of their role and their inability to change systemic issues;
- Increased frustration, sadness or other feelings in respect of their clients' circumstances which interrupt the working relationship, or, alternatively, feelings of numbness or a reduction in empathy;
- Reduced job performance or job attendance due to stress or withdrawal, or, alternatively, working for too long due to feelings of guilt or pressure; and
- Troublesome relationships with colleagues or having difficulty when participating in teamwork.

Without acknowledgement of the problem and the right support, service providers are at an increased risk of experiencing a decline in their physical, mental, social and spiritual well-being.

Both individuals and organisations have a responsibility to acknowledge and protect service providers who work with torture survivors. This should involve:

- Ensuring that service providers understand the various ways in which their work can affect them, and how it has already affected them;
- Creating a work environment where service providers and staff can talk safely (i.e. openly and confidentially) about the impact that the work has on them and their well-being;
- Developing policies, procedures and practices which support, protect, and respond to staff needs, both through preventative and appropriate reactions;
- Ensuring that staff who may have experienced a violation of their rights in the form of torture or CIDTP, or through experiencing secondary trauma, gain access to rehabilitation; and
- Encouraging individuals to set boundaries and know their limits.

Some of the questions which service providers can ask themselves should include questions about their work and their personal responses to it. Any exploration of the work is beneficial, and both individuals and organisations must ensure that there is a space for service providers to reflect on their work. Examples of the kinds of questions service providers can ask themselves whilst undertaking such reflection include:

- What are my greatest frustrations regarding this work?
- What are my greatest achievements as a result of doing this work?
- What do I find satisfying about this work?
- How have I changed as a practitioner and as a person while being in this role?
- What have I gained, and what have I lost, while being in this role?

Some of the areas which service providers should continually be encouraged to consider and work on are:

			
Ensuring a work-life balance, with enough time to relax, recover and spend time with loved ones, even during high-pressure periods.	**Engaging in stress-relieving activities for the body, mind and spirit.**	**Regularly sharing frustrations with peers, with the organisation, and with mentors or supervisors.**	**Regularly sharing achievements with peers, with the organisation, and with mentors or supervisors.**

Individual service providers should have a self-care plan that is updated regularly. The self-care plan should detail how they will care for their physical, mental and spiritual health, as well as how they will include new ideas in their plan so that they continue to grow personally and professionally.

APPENDIX 1:

YOUR RIGHT TO REHABILITATION AS A SURVIVOR OF TORTURE

Your right to freedom from torture is a fundamental human right guaranteed by international and regional instruments, including the African Charter on Human and Peoples' Rights (African Charter) as well as many national laws. The African Commission on Human and Peoples' Rights has expanded on Article 5 of the African Charter by providing an overview of victims' rights to redress when the right to dignity of the person has been violated. This overview is to be found in what is known as General Comment No. 4 on the African Charter: The Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment (Article 5). This important document acknowledges torture, whether perpetrated by a state or non-state actor.

This is an explanatory note for persons who have experienced or suffered torture or CIDTP to help them understand that their rehabilitation has legal backing, and to outline some of the specific rights that they have on the road to healing and recovery.

What are my rights?

Rehabilitation is the process which allows you to heal, to have improved functioning in your day-to-day life, to recover from your experiences of torture, and to return to what you view as a meaningful personal life and role in your family and community. It is essential to understand that rehabilitation does not necessarily mean that your life will return to the way it was. Instead, it means that you will be given an opportunity to heal and, as far as possible, become a well-adjusted person in your environment. Accordingly, you have:

- The right to determine how you wish to be identified, that is, either as a victim or as a survivor;
- The right to fair and adequate compensation which covers your rehabilitation costs;
- The right to be included in the process and to express what rehabilitation means for you;
- The right for the inclusion of both direct and secondary victims, where secondary victims may include family, dependants or other persons who have suffered harm as a result of the perpetrator's actions towards you;
- The right to full rehabilitation, which is to be provided by the state or through funded service providers, where full rehabilitation includes physical, medical, psychological, legal, social, community and family therapy;
- The right to receive rehabilitative treatment soon after the event(s) has taken place, and in a language that you can understand;
- The right to rehabilitation in a safe environment, and with prior assessment of risk and safety concerns regarding your well-being;
- The right to uphold your cultural beliefs alongside the rehabilitative process;
- The right to choose the service providers, and to be referred to a different service provider on a balanced consideration of your case;
- The right to protection from the state against reprisal attacks or intimidation; and
- The right to confidentiality.

Notes

Notes